NOW HEALTH INTERNATIONAL

MINAN INSURANCE 民安保险

KPMG cutting through complexity

Arranged by

AON COFCO

WorldCare Policy Wording

companies (2014)

Contents

A. Policy Wording
1. General

Article 1

This insurance contract consists of the policy wording, group application form, insurance policy or certificate, benefit schedule and endorsement. Any other agreement related to this insurance contract shall be in written form.

Article 2

The policyholder is the group applying for the insurance policy on behalf of the insured persons. The number of the insured persons eligible to be insured persons shall not be less than five and three or more must be employees at the start date and each subsequent renewal date.

Article 3

1. Direct insured: all the active full time employees of the policyholder in service.

2. Dependant: the scope of dependant is decided by the policyholder during application that may include the family member(s) of the direct insured:

    a. Legal spouse or adult partner of the direct insured person. The legal spouse or adult partner refers to someone who is permanently living with the direct insured or is in similar relationship.

    b. Children (aged are not more than 18 or up to 28 for those registered as full time students at recognised educational institutions) of an insured person. It is subject to the consent of the insurer and shall be arranged by the policyholder for coverage under this policy.

    A new born baby will be accepted as insured person from birth. The acceptance of a new born baby is subject to written notification submitted within 30 days of birth and premium paid. The insurer will require details of the baby's medical history if the baby has been adopted, or was born as the result of any method of assisted conception. In such circumstances, the insurer reserves the right to apply particular restrictions to the cover and the insurer will notify the policyholder of those terms as soon as reasonably possible.

    In the event that the policyholder requests the spouses and children of the insured persons to be covered all the spouses and/or children of the insured persons must be included.

    The insurer can refuse to add a family member to the policy and the insurer will tell the policyholder if the insurer does.

3. Dependants must be covered under the same level of benefits as the direct insured.

4. The direct insured and the dependant in this contract should also be named insured person.

5. This contract will not cover the applicant with US nationality who resides in US for more than 90 days (including 90 days) every year. In addition, there are some mutually agreed excluded countries that the insurer cannot offer cover if the insured person resides in any of them. Such excluded country list will be communicated to the policyholder prior to the enrolment of the policy.

Article 4

The beneficiary of this insurance contract refers to insured person except for any agreement otherwise.

2. Insurance Liability

Article 5 – Benefits

During the insured period of this contract, in case of any medical activities taken in this insurance contract, the insurer shall pay the insurance benefits (i.e. specific benefit will not exceed its corresponding benefit limit and the sum of the benefits paid will not exceed the annual maximum stipulated in the insurance contract) to the insured as follows. All cost actually incurred must be medically necessary and subject to reasonable and customary charges. The Benefits 31 to 45 under this Insurance Liability section are optional benefits.

1. Hospital Charges, Medical Practitioner and Specialist Fees

a. Charges for in-patient or day-patient treatment made by a hospital including charges for accommodation (ward/semi-private or private); diagnostic tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a qualified nurse; drugs and dressings prescribed by a medical practitioner or specialist; and surgical appliances used by the medical practitioner during surgery. This includes pre and post-operative consultations while an in-patient or day-patient and includes charges for intensive care. The above benefit should be pre-authorised and its maximum benefit should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

b. Actual ancillary charges: purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an eligible medical condition which required in-patient or day-patient hospital treatment. The above maximum benefit should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

2. Diagnostic Procedures

The insurer will cover the actual incurred medical charges for the medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans. The diagnosis for PET needs to be pre-authorised. The maximum benefit should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

3. Emergency Ambulance Transportation

The insurer will cover the actual incurred emergency road ambulance transport costs to or between hospitals, or when considered medically necessary by a medical practitioner or specialist. The maximum benefit should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

4. Parent Accommodation

The insurer will cover the actual incurred cost of one parent staying in hospital overnight with an insured person under 18 years old while the child is admitted as an in-patient for eligible treatment. The maximum benefit should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

5. New Born Cover

The insurer will cover the actual incurred medical cost of the in-patient treatment of premature birth (i.e. prior to age 37 weeks gestation) or an acute condition being suffered by a new born baby of an insured person which manifests itself within 30 days following birth. Provided that the new born baby is added to the policy within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits agreed. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

6. Hospital Accommodation for New Born Accompanying their Mother

The insurer will cover the actual incurred medical cost of the hospital accommodation costs relating to a new born baby (up to 16 weeks old) to accompany its mother (being an insured person) while she is receiving eligible treatment as an in-patient in a hospital. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

7. Reconstructive Surgery

The insurer will cover the actual incurred medical cost of the reconstructive surgery required to restore natural function or appearance following an accident or following a surgical procedure for an eligible medical condition, which occurred after an insured person's entry date or start date whichever is later. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

8. In-Patient Emergency Dental Treatment

The insurer will cover the actual incurred medical cost of emergency restorative dental treatment required to sound, natural teeth following an accident which necessitates the insured person's admission to hospital for at least one night.

The dental treatment must be received within 10 days of the accident. This benefit covers all costs incurred for treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:

a. If the treatment involves replacing a crown, bridge facing, veneer or denture, the insurer will pay only the reasonable and customary cost of a replacement of similar type or quality

b. If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead

c. Damage to dentures providing they were being worn at the time of the injury.

The maximum benefits should be agreed between the policyholder and the insurer and stipulated in the insurance contract.

9. In-Patient Psychiatric Treatment

The insurer will cover the actual incurred medical cost of an in-patient treatment in a recognised psychiatric unit of a hospital. All treatment must be administered under the direct control of a registered psychiatrist.

The above benefit needs to be pre-authorised. The maximum benefit for such coverage as well as its maximum number of cover days per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

10. Terminal Illness

The insurer will cover the actual incurred medical cost of the palliative and hospice care. On diagnosis of a terminal illness, costs are covered for any in-patient, day-patient or out-patient treatment given on the advice of a medical practitioner or specialist for the purpose of offering temporary relief of symptoms. Charges for hospital or hospice accommodation, nursing care by a qualified nurse and prescribed drugs and dressings are covered.

The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

11. Emergency Non-Elective Treatment USA Cover

For planned trips up to 30 days of duration, the insurer will cover the actual incurred medical of a treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health.

Charges relating to routine pregnancy and childbirth are specifically excluded from this benefit.

The maximum benefit for such coverage as well as its maximum number of cover days per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

12. Hospital Cash Benefit

The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if an insured person is admitted for in-patient treatment before midnight, the treatment is received free of charge and would that have otherwise been eligible for benefit privately under this policy.

Cover under this benefit is limited to a maximum of 30 nights per period of cover.

For this benefit exclusion 6.12 does not apply.

The maximum benefits for such coverage should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

2. Insurance Liability

13. AIDS

The insurer will cover the actual incurred medical expenses, which arise from or are in any way related to Human Immune Deficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof as a result of proven occupation Accident* or blood transfusion**. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), hospital accommodation and nursing fees.

* For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the date of entry or start date, whichever is later; and the incident from which they contracted the HIV infection was reported, investigated and documented according to normal procedures for the insured person's occupation; and a test showing no HIV or antibodies to such a virus was made within five days of the incident; and a positive HIV test occurred within 12 months of the reported occupational accident.

**As long as the blood transfusion was received as an in-patient as part of medically necessary treatment.

The benefit is only available after three years of continuous membership.

The above benefit needs to be pre-authorised. The maximum benefit per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

14. Organ Transplant

The insurer will cover the actual incurred medical costs of the following items:

a. Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the insured person as a recipient.

   In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Article 5, Benefit 26 congenital disorder but excluded from Article 5, Benefit 14 Organ Transplant.

b. Medical costs associated with the donor as an in-patient or day-patient, with the exception of the cost of the donor organ search.

The insurer only pays for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.

The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

15. Cancer Treatment

The insurer will cover the actual incurred medical cost of the treatment given for cancer received as an in-patient, day-patient or out-patient.

The benefit includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

16. Pregnancy and Childbirth Medical Conditions

The insurer will cover the actual incurred medical cost of the in-patient treatment of an eligible medical condition which arises during the antenatal stages of pregnancy, or an eligible medical condition which arises during childbirth. As an illustration, the insurer would consider treatment of the following:

a. Ectopic Pregnancy (where the foetus is growing outside the womb)
b. Hydatidiform mole (abnormal cell growth in the womb)
c. Retained placenta (afterbirth retained in the womb)
d. Placenta praevia
e. Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia)
f. Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured will not be covered for any treatment for diabetes during pregnancy)
g. Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
h. Miscarriage requiring immediate surgical treatment
i. Failure to progress in labour

The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

17. Evacuation and Repatriation

The insurer will cover the actual incurred cost of the following:

a. Evacuation

Arrangements will be made to move an insured person who has a critical, life-threatening eligible medical condition to the nearest medical facility for the purpose of admission to hospital as an in-patient or day-patient.

Reasonable expenses for:

a. Transportation costs of an insured person in the event of emergency treatment and medically necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort.

b. Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.

c. Reasonable travel costs for a locally-accompanying person to travel to and from the hospital to visit the insured person following admission as an in-patient.

d. Reasonable costs for non-hospital accommodation only for immediate pre and post-hospital admission periods provided that the insured person is under the care of a specialist.

Excesses do not apply to transportation costs incurred under this benefit.

Costs of evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.

The insurer's medical advisers will decide the most appropriate method of transportation for the evacuation and **this benefit will not cover travel if it is against the advice of the insurer's medical advisers or where the medical facility does not have appropriate facilities to treat the eligible medical condition.**

b. Repatriation

An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment or the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment.

This benefit specifically excludes routine pregnancy and childbirth costs, except for Article 5, Benefit 16 – Pregnancy and Childbirth Medical Conditions.

The above benefit should be pre-authorised. The maximum benefit for such coverage as well as its maximum cost per evacuation should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

18. Mortal Remains

The insurer will cover the actual incurred cost in the event of death from an eligible medical condition, reasonable and customary charges for:

a. Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or

b. Burial or cremation costs at the place of death in accordance with reasonable and customary practice.

The above benefit should be pre-authorised. The maximum benefits for such coverages should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

19. Day-Patient or Out-Patient Surgery

The insurer will cover the actual incurred treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department. Any pre or post-operative consultations are payable under Article 5, Benefit 20 Out-Patient Charges. The benefits for such coverage should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

2. Insurance Liability

20. Out-Patient Charges

The insurer will cover the actual incurred medical cost of:

a. Medical practitioner fees including consultations; specialist fees; diagnostic tests; prescribed drugs and dressings.
b. Physiotherapy by a registered physiotherapist, when referred by a medical practitioner, or specialist.

Pre-authorisation will be needed after 10 sessions of physiotherapy. The maximum benefit for such coverage as well as its maximum session per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

21. Out-Patient Psychiatric Illness

The insurer will cover the actual incurred medical cost of out-patient treatment administered under the direct control of a registered psychiatrist when referred by a medical practitioner or specialist. The maximum benefit per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

22. Alternative Therapies

The insurer will cover the actual incurred medical cost of complementary medicine and treatment by therapist, when referred by a medical practitioner or specialist. This benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture treatment. The insurer does not cover charges for general chiropody or podiatry.

For this benefit exclusion 6.12 does not apply.

The maximum benefit for such coverage and its maximum number of visits per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

23. Traditional Chinese Medicine

The insurer will cover the actual incurred medical costs of the therapies administrated by a recognised traditional Chinese medicine practitioner.

For this benefit exclusion 6.12 does not apply.

The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

24. Nursing Care at Home

The insurer will cover the actual incurred medical cost of the:

a. Care given by qualified nurse in the insured person's own home, which is immediately received subsequent to treatment as an in-patient or day-patient on the recommendation of medical practitioner or specialist. Cover is limited to 30 days per medical condition. This coverage needs to be pre-authorised.
b. Medical Practitioner (GP) home visits for an emergency GP home call-out during out of normal clinic hours.

The maximum benefit for such coverage and its maximum number of days/visits cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

25. Rehabilitation

The insurer will cover the actual incurred medical rehabilitation cost on the advice of a specialist as an integral part of treatment for a medical condition necessitating admission to a recognised rehabilitation unit of a hospital. Where the insured person was confined to a hospital as an in-patient for at least three consecutive days, and where a specialist confirms in writing that rehabilitation is required. Admission to a rehabilitation unit must be made within 14 days of discharge from hospital. Such treatment should be under the direct supervision and control of a specialist and would cover:

a. Use of special treatment rooms
b. Physical therapy fees
c. Speech therapy fees
d. Occupational therapy fees

The maximum benefit for such coverage as well as its maximum number of cover days per medical condition should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

26. Congenital Disorder

The insurer will cover the actual incurred medical cost of the in-patient treatment for a congenital disorder. In circumstances where a congenital disorder manifests itself in a new born baby within 30 days of birth, cover for such medical conditions will be provided under Article 5, Benefit 5 but excluded from Article 5, Benefit 26 -Congenital Disorders. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

27. Maintenance of Chronic Medical Conditions

The insurer will cover the actual incurred maintenance cost of chronic medical conditions such as but not limited to asthma, diabetes and hypertension requiring on-going or long-term monitoring through consultations, examinations, check-ups, drugs and dressings and/or tests up to the benefit mutually agreed between the policyholder and the insurer and stipulated in the insurance contract limits following the insured person's date of entry.

This benefit does not cover renal failure and dialysis. Claims for this will fall under Article 5, Benefit 28. Claims for cancer will fall under Article 5, Benefit 15.

28. Renal Failure and Renal Dialysis

The insurer will cover the actual incurred medical cost of the treatment of renal failure, including renal dialysis on an in-patient, day-patient or out-patient basis. This includes pre and post-operative renal dialysis and as part of intensive care. The maximum benefit should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

29. Dental Care

The insurer will cover the actual incurred medical cost of:

a. Routine dental treatment: Fees of a registered dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment means:
    - Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including x-rays where necessary,
    - Preventive scaling, polishing, and sealing (once per year),
    - Fillings (standard amalgam or composite fillings) and extractions, and
    - Root-canal treatment (but not the fitting of a crown following root-canal treatment).

No other treatment is covered under the routine dental treatment benefit.

Waiting period: Any costs incurred within nine months from the start date are excluded.

A co-insurance of 20% applies.

For this benefit exclusion 6.12 does not apply.

2. Insurance Liability

b. Complex dental treatment: Fees of a registered dental practitioner and associated costs for the following procedures: eligible complex dental treatment: including for example, an apicoectomy done to treat the following – a fractured tooth root; a severely curved tooth root; teeth with caps or posts; cyst or infection which is untreatable with root canal therapy; root perforations; new or repair of crowns, dentures, in lays and bridges; recurrent pain and infection; persistent symptoms that do not indicate problems from x-rays; calcification; damaged root surfaces and surrounding bone requiring surgery.

No other treatment is covered by this benefit.

Waiting period: any costs incurred within nine months from the start date are excluded.

A co-insurance of 20% applies.

A 50% co-insurance applies in respect of all orthodontic treatment.

For this benefit exclusion 6.12 does not apply.

The maximum benefit per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

30. Maternity

The insurer will cover the actual incurred medically necessary costs incurred during normal pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups, scans and delivery costs for a natural birth or caesarean section, well-baby examination, paediatrician costs for the first examination/check-up of a new born baby if the examination is made within 24 hours of delivery.

Any costs incurred within 12 months from the start date are excluded.

Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.

The insurer will not cover costs relating to routine pregnancy or childbirth unless maternity care benefits are shown on the certificate of insurance.

For this benefit exclusion 6.23 does not apply.

The maximum benefit per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

31. USA Elective Treatment

The insurer will cover the actual incurred medical costs associated with eligible in-patient and day-patient treatment in the USA where treatment is received in a hospital listed in our issued international provider network.

Treatment that is received in a hospital that is not listed in our issued international provider network will be subject to a 50% co-insurance.

The above benefit needs to be pre-authorised. The maximum benefit for such coverage should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

32. Co-Insurance Out-Patient Charges

The insurer will cover the actual incurred medical cost, as described in Article 5, Benefit 20, but with a 20% co-insurance in addition to the policy excess per medical condition. The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

33. Out-Patient Direct Billing

The insured person can maintain the standard policy excess of a mutually agreed figure, but when the insured person receives eligible out-patient treatment within the issued international provider network list, a nil excess will apply. Any eligible out-patient treatment outside of the direct billing network will be subject to the policy excess applicable per insured person, per medical condition, per period of cover.

34. Wellness, Optical Benefits and Vaccinations

The insurer will cover the actual incurred medical costs associated with:

a. Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol) and/or

b. Optical benefit: this benefit also provides a contribution towards optician charges including an annual eye test carried out by an opthalmic optician, prescribed spectacles including frames and lenses; and/or contact lenses within the combined benefit limits to a maximum mutually agreed amount per period of cover for an optical claim and/or

c. Vaccinations: cost of drugs and consultations to administer all medically necessary basic immunisation and booster injection and any medically necessary travel vaccinations and malaria prophylaxis.

This clause applies to compulsory group policies of 3+ employees.

35. Medical History Disregarded

This clause applies to compulsory group policies of 10+ employees.

36. Greater China option

The insurer will cover the actual incurred medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Greater China and will be subject to the standard policy limits.

Emergency non elective treatment outside of Greater China:

For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health.

Charges relating to routine pregnancy and childbirth are specially excluded from emergency non elective treatment outside of Greater China.

Greater China means Mainland China, Hong Kong, Macau and Taiwan.

Full Refund for accident requiring in-patient and day-patient care.

Illness: in-patient and day-patient care up to a mutually agreed amount per period of cover.

The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

37. Hospital Room Restriction – PRC Residents Only

As described in Article 5, Benefit 1. a), but with a restriction to limit the hospital accommodation to a ward or semi-private room for hospital admission in Hong Kong; or with a 15% co-insurance, up to an out-of-pocket-limit of a mutually agreed amount per medical condition for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical professionals, should the in-patient or day-patient be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.

The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

38. High Cost Provider Co-Insurance

The insurer will cover the actual incurred medical costs associated with eligible in-patient, day-patient or out-patient treatment made by the hospital, and by any medical professional, should the in-patient, day-patient or out-patient treatment be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer and will be subject to a 20% co-insurance, up to an out of pocket limit of a mutually agreed amount per medical condition.

The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

2. Insurance Liability

39. High Cost Provider Restriction

The insurer will not cover the actual incurred medical costs associated with eligible in-patient, day-patient or out-patient treatment made by the hospital, and by any medical professional, should the in-patient, day-patient or out-patient treatment be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.

40. Out-Patient Restriction

The insurer will cover the actual incurred medical cost of Article 5, Benefits 20, 22, 27, 28, but restricted to a mutually agreed amount per Period of Cover in aggregate.

The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

41. Optional Maternity

The insurer will cover the medically necessary cost incurred under the Article 5, Benefit 30 under the Excel or Advance plan.

The maximum benefit per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

This clause applies to compulsory group policies 10+ employees.

42. Optional Dental Benefit under the Advance Plan

The insurer will cover the medically necessary cost incurred under the Article 5, Benefit 29 under the Advance plan.

The maximum benefit per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

This clause applies to compulsory group policies 10+ employees.

43. Removal of Co-Insurance for Dental Care

As described in Article 5, Benefit 29, but with no co-insurance applicable to either routine or complex dental treatment including orthodontic treatment.

This clause applies to compulsory group policies 10+ employees.

44. In-Patient and Out-Patient Co-Insurance

The insurer will cover the actual medical costs associated with the benefits for eligible in-patient, day-patient or out-patient treatment subject to 20% co-insurance, up to an out-of-pocket limit of a mutually agreed amount per medical condition.

45. Excess

The insurance product is designed to have various excess options. The agreed excesses do not apply to Article 5, Benefits 12, 22, 23 and 29. Excesses also do not apply to transportation costs incurred under Article 5, Benefit 17, but would apply to any medically necessary treatment required under Article 5, Benefit 17.

The amount of the excess should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

3. Exclusions

Article 6 – Exclusions

The insurer will not bear any liabilities for insurance claim compensation if the following treatments or expense fees are incurred by the insured person or the dependant as a result of any of the following situations even through the medical activities have obtained the prescription, recommendation or consent of physician or dentist. Also, below are group policy exclusions that apply in addition to any personal exclusions detailed in the insured person's certificate of insurance.

6.1 Act of terrorism, war and illegal acts

The insurer will not pay for treatment of any condition resulting directly or indirectly from, or as a consequence of war, acts of foreign hostilities (whether or not war is declared) civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, unless the insured person is an innocent bystander. The insured person is not covered for costs arising from taking part in any illegal act.

6.2 Administrative and shipping fee

The insured person is not covered for any charges made by a medical practitioner or dental practitioner for filling in claim forms or providing medical reports. The insured person is not covered for any charges where a police report is required. The insured person is not covered for the cost of shipping (including customs duty) on transporting medication.

6.3 Alcohol and drug abuse

The insured person is not covered for costs for treatment resulting from dependency on or abuse of alcohol, drugs, or other addictive substances and any illness or injury arising directly or indirectly from such dependency or abuse.

6.4 Chemical exposure

The insured person is not covered for treatment costs directly or indirectly caused by or contributed to or arising from: ionizing radiations or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel; the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

6.5 Cosmetic surgery

The insured person is not covered for treatment costs relating to cosmetic or aesthetic treatment or any treatment related to previous cosmetic or reconstructive surgery (whether or not for psychological purposes), such as but not limited to acne, teeth whitening, lentigo and alopecia.

6.6 Contamination

The insured person is not covered for the treatment of any conditions, or for any claim arising directly or indirectly from chemical or biological contamination, however caused, or from contamination by radioactivity from any nuclear material whatsoever, asbestosis, including expenses in any way caused by or contributed to by an act of war or terrorism.

6.7 Chronic conditions

If the insured person is insured under the Essential policy option, the insured person does not have cover for costs relating to the maintenance of chronic conditions. For Advance, Excel and Apex policy options, cover up to the limits in the benefit schedule are a maximum limit per period of cover and not per medical condition.

3. Exclusions

6.8 Dental care

The insured person is not covered for any dental care unless these benefits are included on the insured person's certificate of insurance. However the insurer will pay for emergency in-patient dental treatment following an accident as detailed in the benefit schedule. The insurer will not pay for any telephone or travelling expenses incurred in seeking dental advice or treatment, damage to dentures unless being worn at the time of the accident, or the cost of treatment made necessary by an accidental dental injury if:

- **The injury was caused by eating or drinking anything, even if it contains a foreign body**
- **The damage was caused by normal wear and tear**
- **The injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn**
- **The injury was caused by any means other than extra-oral impact**
- **The damage was caused by tooth brushing or any other oral hygiene procedure**
- **The damage is not apparent within 10 days of the impact which caused the injury**
- **The costs are incurred more than 18 months after the date of the injury which made the treatment necessary.**

6.9 Developmental disorders

The insured person is not covered for treatment of developmental, behavioural or learning problems such as attention deficit hyperactivity disorder, speech disorders or dyslexia and physical developmental problems.

6.10 Dietary supplements

The insured person is not covered for naturally available substances that can be purchased without prescription, including but not limited to vitamins, minerals, and organic substances.

6.11 Eating disorders

The insured person is not covered for costs relating to treatment of eating disorders such as, but not limited to, anorexia nervosa and bulimia.

6.12 Excess or co-insurance

The insured person is not covered for the amount of the excess or co-insurance that is shown on the insured person's certificate of insurance. The insurer will treat any arrangement with or any offer by a provider to charge the insurer a higher fee to cover the amount of the excess or co-insurance as fraud and the insurer will take legal action.

6.13 Experimental treatment and drugs

The insured person is not covered for treatment or drugs which have not been established as being effective or which are experimental. For drugs this means they must be licensed for use by the appropriate Medicines Agency or the Medicines and Healthcare products Regulatory Agency and be used within the terms of that license. For established treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced and published medical journals and/or approved by the appropriate National Institute for Health and Clinical Excellence for specific purposes to be considered proven safe and effective therapies.

6.14 External prosthesis

The insured person is not covered for any costs relating to providing, maintaining and fitting of any external prosthesis or appliance or other equipment, medical or otherwise except as is specified under the Hospital Charges, Medical Practitioner and Specialists fees benefit.

6.15 Eyes and ears

The insured person is not covered for routine eyesight or hearing tests or the cost of eyeglasses, contact lenses, hearing aids or cochlear implants. The insurer will not pay for eye surgery to correct vision, however eye surgery to correct an eligible medical condition under the insurance liability is covered.

6.16 Failure to follow medical advice

The insured person is not covered for treatment arising from or related to the insured person's unreasonable failure to seek or follow medical advice and/or prescribed treatment, or the insured person's unreasonable delay in seeking or following such medical advice and/or prescribed treatment. The insurer will not pay for complications arising from ignoring such advice.

6.17 Foetal surgery

The insured person is not covered for the costs of surgery on a child while in its mother's womb except as part of the maternity benefits detailed in the insured person's certificate of insurance.

6.18 Genetic testing

The insured person is not covered for the cost of genetic tests, when those tests are undertaken to establish whether or not the insured person may be genetically disposed to the development of a medical condition.

6.19 HIV, AIDS or sexually transmitted disease

The insured person is not covered for treatment for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by or related to Human Immunodeficiency Virus (HIV) (or both) and sexually transmitted disease, other than stated in the benefit schedule.

6.20 Morbid obesity

The insured person is not covered for the costs of treatment for, or related to, morbid obesity. The insured person is not covered for costs arising from or relating to removing fat or surplus healthy tissue from any part of the body.

6.21 Nursing homes, convalescence homes, health hydros, and nature cure clinics

The insured person is not covered for treatment received in nursing homes, convalescence homes, health hydros, nature cure clinics or similar establishments. The insured person is not covered for convalescence or where the insured person is in hospital for the purpose of supervision. The insured person is not covered for extended nursing care if the reason for the extended nursing care is due to age related infirmity and/or if the hospital has effectively become the insured person's home.

6.22 Pre-existing medical conditions

The insured person is not covered for treatment of pre-existing medical conditions and related conditions unless accepted by the insurer in writing.

A pre-existing medical condition means any disease, injury or illness for which:

1. **The insured person has received treatment, test or investigations for, been diagnosed with or been hospitalised for; or**
2. **The insured person has suffered from or experienced symptoms; whether the medical condition has been diagnosed or not, at any time before the insured person's start date/entry date into the policy.**

6.23 Pregnancy or maternity

The insured person is not covered for costs relating to normal pregnancy or childbirth, voluntary caesarean section, unless maternity benefits are shown on the insured person's certificate of insurance.

6.24 Professional sports

The insured person is not covered for any costs resulting from injuries or illness arising from the insured person taking part in any form of professional sport. By professional sport, the insurer means where the insured person is being paid to take part.

3. Exclusions

6.25 Reproductive treatment and drugs

The insured person is not covered for costs relating to investigations into or treatment of infertility and fertility, sterilisation (or its reversal) or assisted conception. The insured person is not covered for the costs in connection with contraception.

6.26 Routine examinations, health screening

The insured person is not covered for routine medical examinations including issuing medical certificates, health screening examinations or tests to rule out the existence of a condition for which the insured person does not have any symptoms, unless these benefits are shown on the insured person's certificate of insurance.

6.27 Second opinions

The insured person is not covered for the costs of any second or subsequent medical opinions from a medical practitioner or specialist for the same medical condition other than stated in the insured person's certificate of insurance, unless authorised by the insurer.

6.28 Self-inflicted injuries or attempted suicide

The insured person is not covered for any costs for treatment resulting directly or indirectly from self-inflicted injury, suicide or attempted suicide.

6.29 Sexual problems and gender re-assignment

The insured person is not covered for treatment costs relating to sexual problems including impotence, or gender reassignment operations or any other surgical or medical treatment including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment. The insured person is not covered for the costs of treating sexually transmitted infections.

6.30 Sleep disorders

The insured person is not covered for treatment costs related to snoring, insomnia, jet-lag, fatigue, or sleep apnoea including sleep studies or corrective surgery.

6.31 Travel/accommodation costs

The insured person is not covered for transport or accommodation costs the insured person incur during trips made specifically to get medical treatment unless these costs are for an emergency medical evacuation that the insurer pre-authorises. The insured person is not covered for any costs of emergency medical evacuation or repatriating the insured person's body that the insurer did not pre-authorise and arrange.

6.32 Travelling against medical advice

The insured person is not covered for medical or other costs the insured person incurred if the insured person travelled against the advice given by the insured person's treating medical practitioner.

6.33 Treatment by a family member

The insured person is not covered for the costs of treatment by a family member or for self-therapy.

6.34 Treatment charges outside of our reasonable and customary range

The insured person is not covered for treatment charges when they are above the reasonable and customary charges level.

4. Insurance Sum Assured and Insurance Premium
5. Coverage Period

Article 7 – Insurance Sum Assured and Insurance Premium

1. The insurance sum assured stated in this contract is the maximum liability for the insurer to cover. During the insurance contract's coverage period, the amount of benefit that the insurer covers for each item shall not be higher than its maximum sum assured per item, and the accumulated amount of benefits shall not be higher than the total sum assured. The total insurance sum assured and the maximum sum assured per coverage are mutually agreed by the insurer and the policyholder, and stated in the insurance policy.

2. The insurer reserves its right to terminate the renewal right of this contract and shall be entitled to adjust premium rates upon renewal date.

3. The policyholder is responsible for paying the insurance premium according to the insurance contract.

4. The insurance premium is calculated as per the agreed sum assured and its premium rate stated in the insurance contract. The policyholder is responsible to pay the total premium on or before the agreed date unless there is another agreement. If the policyholder does not pay the required full premium, the insurer is not liable to cover the insurance liabilities incurred before the date policyholder pays the premium in full.

5. Without prejudice to the above clause, the insurer may at its own discretion continue to make payment of benefits to the insured person where the premium for the relevant period remains outstanding. If the agreement is subsequently terminated, the company shall forthwith refund to the insurer the full amount of any benefits paid during the period for which premium was due but not received by the insurer from the policyholder.

Article 8 – Coverage Period

The insurance coverage period shall be one year.

6. Insurer's Obligations

Article 9 – Clear Disclosure

When the insurance contract is being established, since the policy wording content is a standard version, the insurer will enclose the standard policy wording, and explain and disclose all the terms and conditions to the policyholder. In particular related to the exclusion clauses in the contract, the insurer will provide clear reminders in the individual application form and policy. There will also be verbal or written explanations about this particular clause. Without that, such exclusion is not enforceable.

Article 10 – Policy Issuance

The insurer shall issue an insurance policy or other insurance certificates to the policyholder in time after the insurance contract is established.

Article 11 – Request for Further Claim Details

If the insurer thinks that the evidence of claim submissions and information provided is not sufficient, the insurer will inform the policyholder/insured person promptly of the required supplementary information at one time.

Article 12 – Prompt Claim Assessment and Payment Obligations

After the insurer receives the claim submission applications from the insured person or beneficiary, the insurer shall review and determine in time if it is under insurance cover. For complicated cases, the insurer shall determine within 30 days unless there is another agreement in the insurance contract.

The insurer shall notify the claim assessment result to the insured person or beneficiary. If the claim application request is under the policy coverage, the insurer shall perform the obligation of paying the claim reimbursement within 10 days after the insurer reaches agreement on the insurance claim payment with the insured person or beneficiary. In case of any other agreement on the claim payment period, the insurer shall perform its obligations to pay the insurance claim amount as per the agreement. The insurer shall issue decline letter with reason in three days from the date of determinations of the request is not covered.

Article 13 – Claim Settlement during Validity Period

The insurer shall pay in advance the claim amount confirmed as per the existing available proofs and information within 60 days from the date insurer receives the request and related certificates or materials for payment of insurance claim amount, in case that the total amount of payment cannot be determined, the insurer shall settle the claim balance after the final amount is confirmed.

7. Policyholder, Insured Person and Beneficiary's Obligations

Article 14 – Premium Payment

Unless there is another agreement, the policyholder will pay for the insurance premium when the insurance contract is being established. If the policyholder does not pay for the insurance premium as per the agreement, the insurer will not cover any claim reimbursement incurred from any insurance liability before the insurance premium is paid in full.

The policyholder shall be responsible for the payment of the premium for all dependants included in this agreement.

Article 15 – Full and Frank Disclosure

Upon establishment of the insurance contract, should the insurer have inquiries on relevant conditions regarding the policyholder/insured person, the policyholder should provide full and frank disclosure to the insurer.

Should the policyholder fail to perform its obligation of full and frank disclosure by intention or due to material default attributable to influence the insurer's decision on underwriting the insurance proposal or increasing the premium rate, the insurer is entitled to terminate the contract.

Should the insurer fail to exercise the termination right as mentioned above within 30 days upon knowing the cause should be deemed as waiver of such right. Once the establishment of the insurance contract has more than two years, the insurer has no right to terminate the contract. When there is a claim incident, the insurer should pay the claim payment accordingly.

Should the policyholder fail to perform its obligation of full and frank disclosure intentionally, the insurer is not liable for any claim payment of the insured incident happened before the termination of the contract, and shall not refund the premium.

Should the policyholder fail to perform its obligation of full and frank disclosure due to material default, significantly attributable to the occurrence of the insured incident, the insurer shall not be liable for the claim payment of the insured incident happened before the termination of the contract, but shall refund the insurance premium.

The insurer cannot terminate the insurance contract if the insurer is aware of the situation that the policyholder has failed to provide full and frank disclosure upon execution of the contract. If there is an insured incident, the insurer should be responsible for the claim benefit payment.

Article 16 – Change of Address or Notification Method

If there is a change of the policyholder's resident address or communication method, the policyholder shall inform the insurer a timely manner by providing written notification to the insurer. If the policyholder fails to inform the insurer, the insurer shall send notice to the last known address and it would be considered that the notice has been sent to the policyholder.

Article 17 – Insured Incident Notification

The policyholder, the insured person or the beneficiary shall notify the insurer in a timely manner when they are aware of an occurrence of the insured incident. Should the policyholder, insured person, beneficiary deliberately fail to disclose any matter relating to an insured incident or fail to disclose any material issue relating to the insured incident to the insurer of such insured incident which causes difficulty in the identification of the nature of the incident, cause, degree of loss, etc. in a timely manner, the insurer is not liable to the claim payment for the portion that cannot be identified, with exception to the case where the insurer had known or ought to have known such insured incident through other channels.

The above obligation does not include the delay caused by force majeure.

8. Claim and Payment of Insurance Compensation

Article 18 – Claim Application

The applicant of claim payment should provide the following materials when submitting their claim to the insurer. The applicant should provide other required legal or related materials if the applicant is not able to provide the following materials for any special reasons. If the applicant is not able to provide materials so as the insurer is unable to confirm the authenticity of the claim application, the insurer should not undertake the liability of compensation for the portion that is unable to be determined:

a. Claim application form;
b. Insurance policy or policyholder's certificate;
c. Applicant's legitimate identity certificate;
d. Medical receipts issued by the hospital (emergency treatment stamp of the hospital is required for medical expense receipts for emergency treatment), original diagnosis certificate and medical records;
e. For medical evacuation, a written documentary proof issued by the legitimate rescue organisation recognised by the insured should be provided;
f. Other supporting documents and information related to confirmation of the nature, cause and degree of injury, etc.

Article 19 – Right of Claims

The applicant's right of claims will be two years from the day on which the applicant becomes aware of the occurrence of the insured incident.

9. Dispute Resolution and Applicable Law

Article 20 – Dispute Resolution

Disputes arising from the performance of this contract should be resolved through the consultations by the parties concerned. If the dispute cannot be resolved between the parties having exhausted all resonable attempts to do so, the disputes should be submitted to the People's Court of Litigation for its ultimate and binding decision on all parties.

Article 21 – Applicable Law

The law of the People's Republic of China shall be applicable to this insurance contract as well as any dispute related to the performance of this contract (laws of HK, Macau, and Taiwan are excluded).

10. Miscellaneous

Article 22 – Continuous Transfer Terms

The insurer will maintain the insured person's existing underwriting or special acceptance terms, as shown by the insured person's current insurer, such as any moratoria or specific exclusions and the insured person's group policy with the insurer will be governed by the terms and conditions of this group policy. The acceptance by the insurer of the insured person's original entry date will be applied to the insured person's group policy with the insurer and any transfer will be subject to no enhanced benefits being provided. The above term is subject to the insurer's written approval.

Should the insured person's group policy come to an end the insured person can apply to transfer to one of the insurer's individual WorldCare plans. The insured person's applications must be submitted to the insurer before the insured person leaves the group policy and acceptance is subject to written agreement from the insurer.

Article 23 – Termination of Contract

The policyholder may cancel this policy by contacting the insurer during the 14 day cooling off period. The 14 day cooling off period starts on the date that the contract is concluded or the day that full policy terms and conditions are received, whichever is the later. The 14 day cooling off period also applies from each renewal date. If the policy is cancelled during the 14 day cooling off period the insurer will return any premium paid for the policy to the policyholder providing no claims have been made on the policy in relation to the period of cover before cancellation (being no more than 14 days' cover). If eligible claims costs are incurred within that period of cover the insurer reserves the right to require the policyholder to pay for the services provided in connection with the policy to the extent permitted by law and any return of premium is subject to this.

Upon the formation of the insurance contract, the policyholder may provide written notice to the insurer to terminate this contract with the exception that the insurer has paid the insurance claim compensation expense as per the agreement of the contract.

When the policyholder requires termination of this contract, they should provide the following certificates and documents:

a. Original copy of the insurance policy
b. Insurance premium payment certificate
c. Identification proof of the policyholder
d. Any other insurance contract related documents and information that could be provided by the policyholder.

This contract terminates upon the receipt of the termination application, related proofs and documentations by the insurer.

Within 30 days from the date of receipt of the above mentioned documents, the insurer will refund the unearned net premium of the insurance policy of the contract to the policyholder.

Any termination of this agreement shall be without prejudice to any accrued rights and obligations of both parties in respect of the period for which the premium has been paid.

Article 24 – Use of Membership Card

24.1 The direct billing membership card is the insurer's property. It can only be used for the purpose of receiving direct billing for medical treatment covered under the terms and conditions of the Policy and the Member Handbook.

24.2 Under no circumstance may an insured person use the direct billing membership card to receive medical treatment related to a personal exclusion and/or an exclusion as listed under Article 6 – Exclusions of the Policy. The insurer will not be liable for any misuse by his/her of such direct billing membership cards.

24.3 If an insured person receives treatment that is not eligible under the policy through the out-patient direct billing option, the insured person is first liable for the costs incurred and the insured person must provide a refund to the insurer within 15 working days from the date of request of reimbursement by the insurer. The insurer may offset valid claims against outstanding funds due to the insurer or the insurer may suspend the insured person's benefits until the insured person has settled the outstanding amounts in full.

24.4 If the insurer determines that a claim was fraudulent, the insurer may terminate the insured person from the policy with immediate effect. The insured person must refund to the insurer all incurred costs associated with the fraudulent claim within 15 working days from the date of request of reimbursement by the insurer.

24.5 If the insured person has a direct billing membership card, it is the policyholder's responsibility to return the direct billing membership cards of the insured person and dependant(s) to the insurer if the insured person's cover has been cancelled under the group policy or is not renewed under the group policy. The insurer will not be liable for any misuse by of such direct billing membership cards after the cancellation date.

24.6 The policyholder shall immediately notify the insurer of the loss of a direct billing membership card by any of its insured person(s) (including dependents).

24.7 The policyholder shall act as guarantor for the insured person. Any failure to discharge a liability by the insured person to the Insurer shall be met by the policyholder acting as guarantor.

Article 25 – Right of Waiver

Waiver by the insurer of any breach of any term or condition of this insurance contract shall not prevent the subsequent enforcement of that term or condition and shall not be deemed to be a waiver of any subsequent breach.

Article 26 – Policy Administration

1. The policyholder undertakes that he/she will advise all eligible employees immediately if any reason this agreement should not be renewed or this agreement should be terminated in accordance with the provision of Article 23 above so that such eligible employees are made aware that all cover has ceased and that benefits will not be payable in respect of eligible employees or family members.

2. As the purpose of the agreement is to provide cover for eligible employees and dependants, the policyholder undertakes to ensure that any revised policy wording or benefit schedule sent by the insurer to the policyholder, or any notice sent by the insurer to the policyholder relating to the cover, are issued without delay to all eligible employees.

3. The policyholder shall notify group members of any change in the terms and conditions of this group policy and any endorsements. The policyholder shall also notify group members of the changes in the terms and conditions of this group policy with those of any previously held policy.

4. The policyholder hereby indemnifies the insurer from and against any and all costs, losses and expenses incurred by the insurer consequent upon any failure by the policyholder to discharge its obligations under this agreement. If the policyholder is not able to perform the responsibilities of any clause under the Article 26 that causes the insurer to be claimed, the policyholder should indemnify the insurer for all the losses, including but not limited to the disputes resolution fees, claim amount, legal fee and others.

5. The policyholder shall designate a responsible person (the policy administrator) to administer this agreement in accordance with its terms and any guidance issued by the insurer from time to time and shall notify the insurer in writing, of any change in the person designated.

6. The policyholder shall remain responsible for ensuring its obligations under this agreement are fully discharged notwithstanding that all or any part of those obligations are delegated to an intermediary or agent who shall be deemed to be the agent of the company.

7. The policyholder shall advise the insurer immediately if it goes into liquidation or becomes bankrupt, or if an administrator or receiver or an administrative receiver is appointed in respect of all or any part of the business or assets of the company.

8. The policyholder must write and inform the insurer if the insured person changes their address or occupation.

9. When expense occurred for the medical condition caused by another party who is liable for the incident, and the insurer paid the claim for such expense to the insured person, thereafter the insurer exercise the subrogation right to claim against the other party for remuneration of the amount paid, and the insured person shall provide the insurer with necessary documents and all relevant information known.

   Should the insured person successfully recover compensation from the third party, that amount shall be deducted from the eligible benefits of the claim settlement paid by the insurer. If the insured person obtains any compensation from the other party after receiving payment from the insurer, the insured person should repay that compensation to the insurer within 21 days of receipt, while the repayment does not exceed the settlement of the claim.

   When a medical condition is caused by another party, should the insured person waive the right to recover compensation from the other party before the claim is paid by the insurer, the insurer shall not be responsible for the claim; should the insured person waive the right to recover compensation from the other party without a consent from the insurer after the claim is paid by the insurer, such waiver is invalid; should any intension or negligence on the part of the insured person result in the insurer unable to exercise subrogation right for recovery, the insurer may deduct the settlement paid from other eligible benefits or demand a refund of the settlement.

11. General Conditions

Article 27 – General Conditions

1. The insurer may alter the policyholder policy wording terms or benefit schedule from time to time but no alternation shall take effect until the next annual renewal of this agreement.

2. The insurer shall notify such changes to the policyholder and to the members (either directly or via the policyholder) in writing.

3. The insurer may amend the terms of this agreement from time to time (subject to giving 60 days prior notice in writing to the company where possible) to reflect any changes in insurance premium tax or any levy or imposition made under any legislation or regulation to which the insurer or any insurance under the agreement may from time to time be subject.

4. The insurer reserves the right to revise or discontinue the group policy with effect from any renewal date.

5. The agreement can only be varied in writing. No variation will be admitted unless it is in writing and signed on behalf of the insurer by an authorised employee.

6. Any notice to be sent under this agreement must be in writing and be sent either by post or by facsimile machine and shall be considered to have been given if sent to the insurer at the registered address on the day after it was posted or, if sent by facsimile machine, at the time of despatch.

7. The introduction of any change by the insurer in interpretation or practice in respect of any term or condition of the policyholder's members' documents shall not prevent the subsequent enforcement of that term or condition and shall not be deemed to form a precedent for any subsequent interpretation or practice.

8. In case any inconsistency between Chinese version and English version, Chinese version shall prevail.

12. Definitions

1. Accident	A sudden, unexpected, unforeseen and involuntary external event resulting in identifiable physical injury occurring to an insured person whilst the insured person's policy is in force.
2. Acute Condition	A disease, illness or injury that is likely to respond quickly to treatment which aims to return the insured person to the state of health the insured was in immediately before suffering the disease, illness or injury, or which leads to the insured person's full recovery.
3. Act of Terrorism	Any clandestine use of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal.
4. Age	Based on the date of birth of the effective identify document to calculate the age. Started from the date of birth, it is age 0 and increased by 1 after 1 year. It is not counted if the period is less than 1 year.
5. Agreement	An agreement the insurer has with each of the hospitals, day-patient units and scanning centres listed in the issued Now Health International provider network.
6. Alternative Therapies	Refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional medicine is taught. Such medicine includes Chinese medicine, chiropractic treatment, osteopathy, dietician, homeopathy and acupuncture as practiced by approved therapists.
7. Apicoectomy	Is a dental surgery performed to remove the root tip and the surrounding infected tissue of an abscessed tooth, when inflammation or infection persists in the bony area around the end of a tooth after a root canal procedure. Apicoectomy is done to treat the following: • Fractured tooth root • A severely curved tooth root • Teeth with caps or posts • Cyst or infection which is untreatable with root canal therapy • Root perforations • Recurrent pain and infection • Persistent symptoms that do not indicate problems from x-rays • Pulp calcification/calcified masses in canal • Damaged root surfaces and surrounding bone requiring surgery
8. Benefits	Insurance cover provided by this policy and any extensions or restrictions shown in the certificate of insurance or in any endorsements (if applicable) and subject always to the insurer having received the premium due.
9. Benefit Schedule	The table of benefits applicable to this policy showing the maximum benefits the insurer will pay.
10. Cancer	A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
11. Certificate of Insurance	The certificate giving details of the policy, the insured persons, the period of cover, the underwriters, the date of entry, the level of cover and any endorsements that may apply.
12. Congenital Disorder	A medical condition that is present at birth or is believed to have been present since birth, whether it is inherited or caused by environmental factors.
13. Co-Insurance	Is the uninsured percentage of the costs, which the insured person must pay towards the cost of a claim.
14. Country of Nationality	The country for which the insured person holds a passport.
15. Country of Residence	The country in which the insured person habitually resides (usually for a period of no less than six months per period of cover) at the policy start date or entry date or at each subsequent renewal date.

12. Definitions

16. Chronic Condition	A disease, illness or injury which has at least one of the following characteristics: • It needs ongoing or long-term monitoring through consultations, examination, check-ups, drugs and dressings and/or tests • It needs ongoing or long-term control or relief of symptoms • It requires the insured person's rehabilitation or for the insured person to be specially trained to cope with it • It continues indefinitely • It has no known cure • It comes back or is likely to come back
17. Day-Patient	A patient who is admitted to a hospital or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
18. Dental Practitioner	A person who is legally licensed to carry out this profession by the relevant licensing authority to practice dentistry in the country where the dental treatment is given.
19. Dependants	One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with the insured person, or up to 28 years old if in full-time education (written proof may be required from the educational institute where they are enrolled), at the start date or any subsequent renewal date. The term partner shall mean husband, wife, civil partner or the person permanently living with the insured person in a similar relationship. All dependants must be named as insured persons in the certificate of insurance.
20. Diagnostic Tests / Procedures	Investigations, such as x-rays or blood tests, to find or to help to find the cause of the insured person's symptoms.
21. Drugs and Dressings	Essential prescription drugs, dressings and medicines administered by a medical practitioner or specialist needed to relieve or cure a medical condition.
22. Eligible	Those treatments and charges, which are covered by the insured person's policy. In order to determine whether a treatment or charge is covered, all sections of the insured person's policy should be read together, and are subject to all the terms (including payment of premium due), benefits and exclusions set out in this policy.
23. Entry Date	The date shown on the certificate of insurance on which an insured person was included under this policy.
24. Emergency	A sudden, serious, and unforeseen acute medical condition or injury requiring immediate medical treatment, that without treatment commencing within 48 hours of the emergency event could result in death or serious impairment of bodily function.
25. Evacuation or Repatriation Service	Moving the insured person to a hospital which has the necessary in-patient and day-patient repatriation service medical facilities either in the country where the insured person is taken ill or in another nearby country (evacuation) or bringing the insured person back to either the insured person's principal country of nationality or the insured person's principal country of residence (repatriation). The service includes any medically necessary treatment administered by the international assistance company appointed by the insurer while they are moving the insured person.
26. Excess	An uninsured amount payable by an insured person in respect of expenses incurred before any benefits are paid under the policy, as specified in the insured person's certificate of insurance. The policy excess applies per insured person, per medical condition, per period of cover.
27. Expatriate	Any persons living and/or working outside of the country for which they hold a passport. Usually for a period of more than 180 days per period of cover
28. Geographic Area	The geographic area used to calculate the premium that will apply to the insured person based on the insured person's principal country of residence at the start date or any subsequent renewal date of this policy.
29. Group	Legal organisation established not for purchasing insurance in China including state owned organisation, colleagues and universities, enterprises and government-sponsored institutions, trade organisation, career union, etc.

30. Hospital	Any establishment, which is licensed as a medical or surgical hospital under the laws of the country where it operates. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts
31. Hospital Accommodation	Refers to standard private or semi-private accommodation as indicated in the benefit schedule. Deluxe, executive rooms and suites are not covered.
32. In-Network Medical Provider	An in-network medical provider is one contracted with the insured person's policy to provide services to policy members for specific pre-negotiated rates.
33. In-Patient	A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.
34. Insured Person	The eligible employee and/or the dependants named on the certificate of insurance who are covered under this policy.
35. Insurer	Minan Property And Casualty Insurance Company Limited.
36. Medical Condition	Any disease, injury, or illness, including psychiatric illness.
37. Medical Practitioner	A person who has attained primary degrees in medicine or surgery following attendance at a WHO-recognised medical school and who is licensed to practice medicine by the relevant authority in the country where the treatment is given. By "recognised medical school" the insurer means a medical school, which is listed in the current World Directory of Medical Schools published by the WHO.
38. Medically Necessary	Treatment which in the opinion of a qualified medical practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the insured person's condition or the quality of medical care rendered. Such treatment must be required for reasons other than the comfort or convenience of the patient or medical practitioner and provided only for an appropriate duration of time. As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, medically necessary also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an out-patient basis.
39. New Born	A baby who is within the first 16 weeks of its life following birth.
40. Now Health International Provider Network	Our published list of medical providers where the insurer/policy administrator has a direct billing provider network agreement.
41. Out of Network	An out of network medical provider is one not contracted with the insured person's policy.
42. Out-Patient	A patient who attends a hospital, consulting room, or out-patient clinic and is not admitted as a day-patient or an in-patient.
43. Out-Patient Direct Billing	This is an option available for all but the Essential plan option that allows the insured person to maintain the standard policy excess of an mutually agreed amount stated in the contract. When the insured person receives eligible out-patient treatment within the insurer's direct billing network of providers however, a nil group excess will apply. Any eligible out-patient treatment outside of the direct billing network will be subject to the policy excess applicable per insured person, per medical condition, per period of cover. The insured person remains liable for treatment received that is not eligible, which must be settled on request. If the insured person does not act accordingly the insured person's policy will become void without refund of premium.
44. Period of Cover	The period of cover set out in the certificate of insurance. This will be a 12-month period starting from the start date or any subsequent renewal date as applicable.
45. Physiotherapist	A practising physiotherapist who is registered and licensed to practice in the country where treatment is provided.
46. Pre-Authorisation	A process whereby an insured person seeks approval from the insurer prior to undertaking any treatment or incurring costs. Such benefits requiring pre-authorisation from the insurer will denote pre-authorisation ☎ in the benefit schedule.

12. Definitions

47. Policy	The contract between the insured person and the insurer which set out terms and conditions of the cover provided. The full terms and conditions consist of the application form, certificate of insurance, benefit schedule and this policy wording.
48. Policyholder	The person or company named as policyholder in the certificate of insurance.
49. Pregnancy	Refers to the period of time, from the date of the first diagnosis, until delivery.
50. Private Room	Single occupancy accommodation in a private hospital. Deluxe, executive rooms and suites are not covered.
51. Psychiatric Illness	The mental or nervous disorder that meets the criteria for classification under an international classification system such as Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation.
52. Qualified Nurse	A nurse whose name is currently on any register or roll of nurses, maintained by any statutory nursing registration body within the country where treatment is provided.
53. Reasonable and Customary Charges	The standard fee that would typically be made in respect of the insured person's customary charges treatment costs, in the country the insured person received treatment. The insurer may require such fees to be substantiated by an independent third party, such as a practicing surgeon/physician/specialist or government health department.
54. Recognised Net Premium	Total collected premium – Unearned premium – administrative expenses. The outstanding hours less than one day will be regarded as one day.
55. Rehabilitation	Medically necessary treatment aimed at restoring independent activities of daily living and the normal form/and or function of an insured person following a medical condition.
56. Related Conditions	A related condition is any disease, injury or illness including psychiatric illness that is caused by a pre-existing medical condition or results from the same underlying cause as a pre-existing medical condition.
57. Renewal Date	The anniversary of the start date of the policy.
58. Semi-Private Room	Dual occupancy accommodation in a private hospital. Deluxe, executive rooms and suites are not covered.
59. Specialist	A surgeon, anaesthetist or physician who has attained primary degrees in medicine or surgery following attendance at a WHO recognised medical school and who is licensed to practice medicine by the relevant authority in the country where the treatment is given, and is recognised as having a specialised qualification in the field of or expertise in, the treatment of the disease, illness or injury being treated. By "recognised medical school" the insurer means a medical school, which is listed in the current World Directory of Medical Schools published by the WHO.
60. Start Date	The start date shown on the insured person's certificate of insurance. The insurer must have received premium payment in order for the insured person's contract to start.
61. Surgical Procedure	An operation requiring the incision of tissue or other invasive surgical intervention.
62. Terminal	Following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition with death anticipated within 12 months of diagnosis.
63. Treatment	Surgical or medical services (including Diagnostic Tests) that are needed to diagnose, relieve or cure a medical condition.
64. Vaccinations	Refers to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine, as well as the cost of the drug, is covered.
65. Waiting Period	Is a period of time starting on the insured person's policy start date (or entry date if you are a dependant), during which the insured person is not entitled to cover for particular benefits. The insured person's benefit schedule will indicate which benefits are subject to waiting periods.
66. WHO	The World Health Organisation.

B. Benefit Schedule

This is for illustration purposes, please refer to the policy wording for full details.

Benefit	Advance
Annual Maximum Group Policy Limit	**RMB 22,000,000**
1. Hospital Charges, Medical Practitioner and Specialist Fees: a) *Charges for in-patient or day-patient treatment made by a hospital including charges for accommodation (ward/semi-private or private); diagnostic tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a qualified nurse; drugs and dressings prescribed by a medical practitioner or Specialist; and surgical appliances used by the medical practitioner during surgery. This includes pre and post-operative consultations while an in-patient or day-patient and includes charges for intensive care.* b) *Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an eligible medical condition which required in-patient or day-patient hospital treatment.*	▶ *a) Full Refund* ▶ *b) Up to RMB 6,300 per medical condition*
2. Diagnostic Procedures: *Medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans.*	▶ *Full Refund when received as an in-patient, day-patient or out-patient*
3. Emergency Ambulance Transportation: *Emergency road ambulance transport costs to or between hospitals, or when considered medically necessary by a medical practitioner or specialist.*	▶ *Full Refund*
4. Parent Accommodation: *The cost of one parent staying in hospital overnight with an insured person under 18 years old while the child is admitted as an in-patient for eligible treatment.*	▶ *Full Refund*
5. New Born Baby Cover: *In-patient treatment of premature birth (i.e. prior to age 37 weeks gestation) or an acute condition being suffered by a new born baby of an insured person which manifests itself within 30 days following birth. Provided that the new born baby is added to the group plan within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits shown.*	▶ *Up to RMB 630,000 per period of cover*
6. Hospital Accommodation for New Born Accompanying their Mother: *Hospital accommodation costs relating to a new born baby (up to 16 weeks old) to accompany its mother (being an insured person) while she is receiving eligible treatment as an in-patient in a hospital.*	▶ *Full Refund*
7. Reconstructive Surgery: *Reconstructive surgery required to restore natural function or appearance following an accident or following a surgical procedure for an eligible medical condition, which occurred after an insured person's entry date or start date whichever is later.*	▶ *Full Refund*

▶ Full refund ▶ Not covered ▶ Subject to limits ▶ Optional

Benefit	Advance
8. In-Patient Emergency Dental Treatment: *This means emergency restorative dental treatment required to sound, natural teeth following an accident which necessitates the insured person's admission to hospital for at least one night.* *The dental treatment must be received within 10 days of the accident. This benefit covers all costs incurred for treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:* • *If the treatment involves replacing a crown, bridge facing, veneer or denture, the insurer will pay only the reasonable and customary cost of a replacement of similar type or quality* • *If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead* • *Damage to dentures providing they were being worn at the time of the injury*	*Full Refund*
9. In-Patient Psychiatric Treatment: *In-patient treatment in a recognised psychiatric unit of a hospital. All treatment must be administered under the direct control of a registered psychiatrist.*	*Full Refund limited to 30 days per period of cover* ***Pre-Authorisation ☎***
10. Terminal Illness: *Palliative and hospice care: on diagnosis of a terminal illness, costs for any in-patient, day-patient or out-patient treatment given on the advice of a medical practitioner or specialist for the purpose of offering temporary relief of symptoms. Charges for hospital or hospice accommodation, nursing care by a qualified nurse and prescribed drugs and dressings are covered.*	*Up to RMB 310,000 lifetime limit*
11. Emergency Non-Elective Treatment USA Cover: *For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health. Charges relating to routine pregnancy and childbirth are specifically excluded from this Benefit.*	*Accident: Full Refund* *Illness: in-patient and day-patient care up to RMB 150,000 per period of cover*
12. Hospital Cash Benefit: *This Benefit is payable for each night an insured person receives in-patient treatment and only if an insured person is admitted for in-patient treatment before midnight, and the treatment is received free of charge that would have otherwise been eligible for benefit privately under this group plan. Cover under this Benefit is limited to a maximum of 30 nights per period of cover.* ***For this benefit exclusion 6.12 does not apply.***	*RMB 945 per night*
13. AIDS: *Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof as a result of proven occupation accident* or blood transfusion**. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), hospital accommodation and nursing fees.* * *For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the entry date or start date, whichever is later; and the incident from which they contracted the HIV infection was reported, investigated and documented according to normal procedures for the insured person's occupation; and a test showing no HIV or antibodies to such a virus was made within five days of the incident; and a positive HIV test occurred within 12 months of the reported occupational accident.* ** *As long as the blood transfusion was received as an in-patient as part of medically necessary treatment.* *Waiting period: Cover only available after three years of continuous membership.*	*Up to RMB 150,000 per period of cover* ***Pre-Authorisation ☎***

Benefit	Advance
14. Organ Transplant:	
a) *Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the insured person as a recipient.* *In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Article 5, Benefit 26 congenital disorder but excluded from Article 5, Benefit 14 Organ Transplant.*	*a) Full Refund*
b) *Medical costs associated with the donor as an in-patient or day-patient, with the exception of the cost of the donor organ search.* *The insurer only pays for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.*	*b) Up to RMB 310,000 per period of cover*
15. Cancer Treatment: *Treatment given for cancer received as an in-patient, day-patient or out-patient. includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.*	*Full Refund*
16. Pregnancy and Childbirth Medical Conditions: *In-patient treatment of an eligible medical condition which arises during the antenatal stages of pregnancy, or an eligible medical condition which arises during childbirth. As an illustration the insurer would consider treatment of the following:* • *Ectopic pregnancy (where the foetus is growing outside the womb)* • *Hydatidiform mole (abnormal cell growth in the womb)* • *Retained placenta (afterbirth retained in the womb)* • *Placenta praevia* • *Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* • *Diabetes (If the insured person has exclusions because of their past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* • *Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* • *Miscarriage requiring immediate surgical treatment* • *Failure to progress in labour*	*Full Refund*
17. Evacuation and Repatriation:	
Evacuation *Arrangements will be made to move an insured person who has a critical, life-threatening eligible medical condition to the nearest medical facility for the purpose of admission to hospital as an in-patient or day-patient.*	***Pre-Authorisation ☎***
Reasonable expenses for: a) *Transportation costs of an insured person in the event of emergency treatment and medically necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort.*	*a) Full Refund*
b) *Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.*	*b) Full Refund*
c) *Reasonable travel costs for a locally-accompanying person to travel to and from the hospital to visit the insured person following admission as an in-patient.*	*c) Full Refund*
d) *Reasonable costs for non-hospital accommodation only for immediate pre and post-hospital admission periods provided that the insured person is under the care of a specialist.*	*d) Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*
Excesses do not apply to transportation costs incurred under this Benefit. ***Costs of evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.*** *Our medical advisers will decide the most appropriate method of transportation for the evacuation and* ***this benefit will not cover travel if it is against the advice of the insurer's medical advisers or where the medical facility does not have appropriate facilities to treat the eligible medical condition.***	
Repatriation *An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment or the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment.* ***This Benefit specifically excludes routine pregnancy and childbirth costs, except for Article 5, Benefit 16 – pregnancy and childbirth medical conditions.***	***Pre-Authorisation ☎*** *Full Refund*

Full refund Not covered Subject to limits Optional

Benefit	Advance
18. Mortal Remains: *In the event of death from an eligible medical condition, reasonable and customary charges for:* *a) Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or* *b) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.*	***Pre-Authorisation ☎*** *a) Full Refund* *b) Up to RMB 63,000*
19. Day-Patient and Out-Patient Surgery: *Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department. Any pre or post-operative consultations are payable under Article 5, Benefit 20 – Out-Patient Charges.*	*Full Refund*
20. Out-Patient Charges: *a) Medical practitioner fees including consultations; specialist fees; diagnostic tests; prescribed drugs and dressings.* *b) Physiotherapy by a registered physiotherapist, when referred by a medical practitioner, or specialist.*	*Combined limit up to RMB 50,000 per period of cover* *a) Full Refund up to combined limit* *b) Full Refund up to combined limit and a maximum 50 sessions per period of cover*
21. Out-Patient Psychiatric Illness: *Out-patient treatment administered under the direct control of a registered psychiatrist when referred by a medical practitioner or specialist.*	*Up to RMB 15,000 per period of cover*
22. Alternative Therapies: *Complementary medicine and treatment by therapist, when referred by a medical practitioner or specialist. This benefit extends to osteopaths, chiropractors, homeopaths, dietician and acupuncture treatment.* *The insurer does cover charges for general chiropody or podiatry.* ***For this benefit exclusion 6.12 does not apply.***	*Full Refund up to a maximum of 30 visits per period of cover*
23. Traditional Chinese Medicine: *Medical costs of the therapies administrated by a recognised traditional Chinese medicine practitioner.* ***For this benefit exclusion 6.12 does not apply.***	*RMB 1,500 per visit up to a maximum of 30 visits per period of cover*
24. Nursing Care at Home: *a) Care given by qualified nurse in the insured person's own home, which is immediately received subsequent to treatment as an in-patient or day-patient on the recommendation of medical practitioner or specialist. Cover is limited to 30 days per medical condition.* *b) Medical practitioner (GP) home visits for an emergency GP home call-out during out of normal clinic hours.*	*a) Full Refund up to 45 days per period of cover* ***Pre-Authorisation ☎*** *b) Not covered*

Benefit	Advance
25. Rehabilitation: *On the advice of a specialist as an integral part of treatment for a medical condition necessitating admission to a recognised rehabilitation unit of a hospital. Where the insured person was confined to a hospital as an in-patient for at least three consecutive days, and where a specialist confirms in writing that rehabilitation is required. Admission to a rehabilitation unit must be made within 14 days of discharge from hospital. Such treatment should be under the direct supervision and control of a specialist and would cover:* *a) Use of special treatment rooms* *b) Physical therapy fees* *c) Speech therapy fees* *d) Occupational therapy fees*	*Full Refund up to 180 days per medical condition*
26. Congenital Disorders: *In-patient treatment for a congenital disorder. In circumstances where a congenital disorder manifests itself in a new born baby within 30 days of birth, cover for such medical conditions will be provided under Article 5, Benefit 5 but excluded from Article 5, Benefit 26 congenital disorders.*	*Up to RMB 630,000 per period of cover*
27. Maintenance of Chronic Medical Conditions: *Maintenance of chronic medical conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, drugs and dressings and/or tests up to the benefit limits detailed in the insured person's chosen group plan following the insured person's date of entry. This Benefit does not cover renal failure and dialysis. Claims for this will fall under Article 5, Benefit 28. Claims for cancer will fall under Article 5, Benefit 15.*	*Up to RMB 94,000 per period of cover*
28. Renal Failure and Renal Dialysis: *Treatment of renal failure, including renal dialysis on an in-patient, day-patient or out-patient basis. This includes pre and post-operative renal dialysis and as part of intensive care.*	*Full Refund*
29. Dental Care: *a) Routine dental treatment: Fees of a registed dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment means:* *• Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including X-rays where necessary,* *• Preventative scaling, polishing, and sealing (once per year)* *• Fillings (standard amalgam or composite fillings) and extractions, and* *• Root-canal treatment (but not the fitting of a crown following root-canal treatment).* ***No other treatment is covered under the routine dental treatment benefit.*** ***Waiting Period: Costs incurred within nine months from the start date are excluded.*** *A co-insurance of 20% applies.* ***For this benefit exclusion 6.12 does not apply.*** *b) Complex dental treatment: Fees of a registered dental practitioner and associated costs for the following procedures: Eligible complex dental treatment: including for example, apicoectomy is done to treat the following - fractured tooth root; a severely curved tooth root; teeth with caps or posts; cyst or infection which is untreatable with root canal therapy; root perforations; new or repair of crowns, dentures, in lays and bridges. Recurrent pain and infection; persistent symptoms that do not indicate problems from x-rays. Pulp calcification/calcified masses in canal; damaged root surfaces and surrounding bone requiring surgery.* ***No other treatment is covered by this benefit.*** ***Waiting Period: Costs incurred within nine months from the start date are excluded.*** *Co-insurance for individual plans of 20% applies.* *A 50% co-insurance applies in respect of all orthodontic treatment.* ***For this benefit exclusion 6.12 does not apply.***	*a) Not covered* *b) Not covered*

Full refund | Not covered | Subject to limits | Optional

Benefit	Advance
30. Maternity: *Medically necessary costs incurred during normal pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups, scans and delivery costs for a natural birth or caesarean section. Well-baby examination. Paediatrician costs for the first examination/check-up of a new born baby, if the examination is made within 24 hours of delivery.* ***Waiting period: Costs incurred within 12 months from the start date are excluded.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *The insurer does not cover costs relating to routine pregnancy or childbirth unless maternity care benefits are shown on the certificate of insurance.* ***For this benefit exclusion 6.23 does not apply.***	*Not covered*
Additional Options	
31. USA Elective Treatment: *Costs associated with eligible in-patient and day-patient treatment in the USA will be paid in full where treatment is received in a hospital listed in our international provider network. Treatment that is received in a hospital that is not listed in our international provider network will be subject to a 50% co-insurance.*	*Optional* *Up to RMB 9,450,000 per insured person, per period of cover* ***Pre-Authorisation ☎***
32. Co-Insurance Out-Patient charges: *As described in Article 5, Benefit 20, but with a 20% co-insurance in addition to the policy excess per medical condition.*	*Not covered*
33. Out-Patient Direct Billing: *The insured person can maintain the standard plan excess of RMB 630, but when the insured person receives eligible out-patient treatment within our international provider network, a nil excess will apply. Any eligible out-patient treatment outside of the direct billing network will be subject to the policy excess applicable per insured person, per medical condition, per period of cover.*	*Not covered*
34. Wellness, Optical Benefits and Vaccinations: a) *Wellness:* *This benefit is payable as a contribution towards the cost of routine health checks including cancer screening, cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol).* *and/or* b) *Optical benefits:* *This benefit also provides a contribution towards optician charges including an annual eye test carried out by an opthalmic optician, prescribed spectacles including frames and lenses; and/or contact lenses within the combined benefit limits to a maximum mutually agreed amount per period of cover for an optical claim.* *and/or* c) *Vaccinations:* *Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.*	*Not covered*
35. Medical History Disregarded:	*Applied*
36. Greater China option: *The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Greater China and will be subject to the standard policy limits.* *Emergency non elective treatment outside of Greater China:* *For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health.* ***Charges relating to routine pregnancy and childbirth are specially excluded from emergency non elective treatment outside of Greater China.*** *Greater China means Mainland China, Hong Kong, Macau and Taiwan.* *Full refund for accident requiring in-patient and day-patient care.* *Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover*	*Not covered*

Benefit	Advance
37. Hospital Room Restriction – PRC Residents only: *As described in Article 5, Benefit 1. a), but with a restriction to limit the hospital accommodation to a ward or semi-private room for hospital admission in Hong Kong; or with a 15% co-insurance, up to an out-of-pocket-limit of a mutually agreed amount per medical condition for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical professionals, should the in-patient or day-patient be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.*	*Not covered*
38. High Cost Provider Co-Insurance: *The insurer will cover the medical costs associated with eligible in-patient, day-patient or out-patient treatment made by the hospital, and by any medical professional, should the in-patient, day-patient or out-patient treatment be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer and will be subject to a 20% co-insurance, up to an out of pocket limit of a mutually agreed amount per medical condition.*	*Not covered*
39. High Cost Provider Restriction: *The insurer will not cover the medical costs associated with eligible in-patient, day-patient or out-patient treatment made by the hospital, and by any medical professional, should the in-patient, day-patient or out-patient treatment be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.*	*Not covered*
40. Out-Patient Restriction: *The insurer will cover the medical cost of Article 5, Benefits 20, but restricted to a mutually agreed amount per period of cover in aggregate.*	*Up to RMB 50,000 per period of cover*
41. Optional Maternity: *The insurer will cover the medically necessary cost incurred under the Article 5, Benefit 30 under the Advance plan.*	*Optional*
42. Optional Dental Benefit under the Advance Plan: **Dental Care** *a) Routine dental treatment* *b) Complex dental treatment* ***Costs incurred within nine months of plan start date are excluded. A co-insurance of 20% applies.***	*Optional*
43. Removal of Co-Insurance for Dental Care: *As described in Article 5, Benefit 29, but with no co-insurance applicable to either routine and complex dental treatment including orthodontic treatment.*	*Not covered*
44. In-Patient and Out-Patient Co-Insurance: *The insurer will cover the actual medical costs associated with the benefits for eligible in-patient, day-patient or out-patient treatment subject to agreed % of co-insurance, up to an agreed out-of-pocket limit per medical condition.*	*Not covered*
Excess	
45. Excess	*Nil*

Full refund | Not covered | Subject to limits | Optional

二. 民安財產保險有限公司
全球保團體醫療保險：保障一覽表

本保障一覽表僅供參考。詳情請參閱保險合同條款。

保障	尊樂
年度最高保障限額	22,000,000人民幣
1. **醫院收費、醫生和專科醫生費用** *a) 醫院對住院或日間留院治療的患者收取的費用包括：床位費（一般病房/雙人病房或私人病房）；診斷檢測費用；手術室費用（含外科醫生與麻醉師收費）；合格護士護理的費用；由醫生或專科醫生開具的藥物和敷料的費用；手術期間醫生使用的手術器械費用；住院或日間留院期間手術前後的咨詢費；重症監護費用。* *b) 輔助器材費用：屬於保障范圍內並因醫療所需，在住院或日間留院接受治療的6個月內用於購買及租賃拐杖、支撐架、輔助行走器和自推式非電子輪椅的費用。*	*a) 全額賠償* *b) 每個醫療狀況最高限額6,300人民幣*
2. 診斷程序 *保險人應賠付由醫療必需而引致的實際醫療費用，包括：磁共振成象掃描(MRI)、正電子放射斷層掃描(PET) 和計算機斷層成像掃描(CT)的費用。*	*住院、日間留院或門診全額賠償*
3. 緊急救護運送費用 *保險人應賠付陸上緊急救護交通運輸工具接送或在醫院之間轉送途中，或經醫生或專科醫生認為醫療必需的交通運輸工具實際產生的費用。*	*全額賠償*
4. 家長住宿費用 *保險人應賠付18周歲以下的被保險人因接受符合保障范圍內的住院治療時，其一位家長在醫院陪伴過夜而實際產生的住宿費用。*	*全額賠償*
5. 新生嬰兒保障 *保險人應賠付被保險人的新生嬰兒因早產（即妊娠未滿37週分娩）或被保險人的新生嬰兒在出生30日內出現急性的病症而需住院接受治療時而發生的實際醫療費用。* ***此保障提供的前提是新生嬰兒在出生之日起30日內已經加入本保單並且投保人已支付保費。***此保障經投保人和保險人雙方同意可適用於多胎分娩的情況。	*每個保險期內最高限額630,000人民幣*
6. 新生嬰兒陪伴母親的醫院住宿費用 *保險人應賠付新生嬰兒（出生16周及以下）在陪伴母親（母親為被保險人）接受住院治療符合保障范圍內的疾病時，醫院為新生嬰兒提供住宿而產生的實際費用。*	*全額賠償*
7. 整形外科手術 *保險人應賠付被保險人接受整形外科手術的實際醫療費用，此整形外科手術是為了恢復正常人體的功能或外貌，同時此整形外科手術是因被保險人在參保日期或保單生效日期（以兩者中較後者為準）之後遭遇符合本保險合同保障範圍的意外事故或因接受符合本保險合同保障範圍內的疾病而接受了外科手術後產生。*	*全額賠償*

保障	尊樂
8. 緊急住院牙科治療 *被保險人因遭遇意外事故而必須住院一晚以上，其天然健全的牙齒因需進行緊急牙科修復治療，保險人應按實際發生的醫療費用賠付給被保險人。* ***該牙科治療必須在意外事故發生后的10日內進行**。此保障包括因意外的外部撞擊造成的口腔傷害而須接受治療時產生的所有費用，但同時應滿足以下條件：* a. ***如果上述治療涉及更換齒冠、牙橋貼片、牙齒貼面或假牙，則保險人賠付合理慣常的費用，或賠付類似的或質量相當的更換費用；*** b. ***如果從臨床角度上看需要植牙，那麼保險人賠付採用橋托產生的費用；*** c. ***受傷時如佩戴假牙，假牙損壞；***	▶ *全額賠償*
9. 住院精神疾病治療 *被保險人在保險人認可的醫院的精神科接受住院治療的，保險人應賠付被保險人實際產生的相關醫療費用。所有治療必須在具有法定資質的精神病醫生的直接管理下進行。*	▶ *每個保險期內全額賠償最長期限為30日* ***上述保障需要預先獲得書面同意*** ☎
10. 終末期疾病 - 姑息治療和臨終關懷 *保險人應賠付因姑息治療與臨終關懷而實際產生的醫療費用。即自被保險人被診斷為終末期疾病起，醫生或專科醫生以暫時緩解症狀為目的開立醫囑，而根據該醫囑提供任何住院、日間留院或門診治療時產生的費用。保險人應賠付有關醫院或臨終關懷的住宿、合格護士護理，以及醫囑藥物和敷料的費用。*	▶ *終生最高限額為310,000人民幣*
11. 美國境內的緊急非選擇性治療 – 在不超過30日(含30日)的計劃行程 *被保險人在美國境內若遇到意外事故或因某種突發性醫療狀況而形成對被保險人的健康構成威脅的突發危重疾病，而且其在上述緊急事件之後的24小時內接受醫生或專科醫生提供的治療，則保險人應賠付該期間實際產生的醫療費用。* ***但須特別注意的是，此類保障不包括正常懷孕及分娩有關的費用。***	▶ *意外：全額賠償* ▶ *疾病：住院和日間留院護理* *每個保險期內最高限額150,000人民幣*
12. 住院現金津貼 *被保險人在次日零時前住院接受治療，未產生任何費用，並且該治療在本保險合同保障範圍內。保險人應賠付被保險人在醫院接受治療期間每一晚的現金住院津貼。* ***該保障僅限於每個保險期內累計最長不超過30晚（含30晚）。*** ***責任免除6.12條款並不適用於此保障。***	▶ *每晚最高限額945人民幣*
13. 艾滋病 *被保險人因有証明的工作意外事故*或輸血**而感染人類免疫缺陷病毒 (HIV) 和/或人類免疫缺陷病毒HIV相關疾病，包括獲得性免疫缺陷綜合征 (AIDS) 或艾滋病相關綜合征 (ARCS)和/或上述疾病的任何突變病症或異種，保險人應賠付與之相關或由其引起的任何實際醫療費用，**但賠付費用僅限於與診斷前后咨詢、針對性例行檢查、藥物和敷料（試驗性或未經審批的除外）、醫院住宿及護理相關的費用**。* * *對於急診室服務人員、從事醫療職業或牙科的人員，實驗室助理、藥劑師或醫療機構服務人員，須出示証明証實其在執行本職工作任務時意外感染上人類免疫缺陷病毒(HIV)；在參保日期或保單生效日期（以兩者中較后者為准）起的三年后感染上人類免疫缺陷病毒(HIV)；根據被保險人職業對應的正常程序，導致自身感染上人類免疫缺陷病毒(HIV)的工作事故已上報，並經調查及備案；感染后的五日內接受了檢查，結果顯示體內沒有人類免疫缺陷病毒(HIV)或人類免疫缺陷病毒抗體(HIV 抗體)；上報職業意外事故后的12個月內進行了人類免疫缺陷病毒(HIV)呈陽性測試。* ** ***適用前提是在住院期間進行的醫療上必需的輸血治療。*** *等待期：該保障提供僅限於被保險人已連續投保三年或以上。*	▶ *每個保險期內最高限額150,000人民幣* ***上述保障需要預先獲得書面同意*** ☎

▶ *全額賠償* ▶ *不予承保* ▶ *有限承保* ▶ *可供選項*

保障	尊樂
14. 器官移植 a) 被保險人是器官受贈人時，有關腎臟、胰臟、肝臟、心臟、肺、骨髓、角膜或心及肺的人體器官移植治療時產生的醫療費用。 **當器官移植是由先天性疾病導致時，相關醫療費用應當依照本保險合同第五條項下第26款(先天性疾病)進行賠付，此時本保險合同第五條項下第14款(器官移植)對於相關費用一概不予賠付。** b) 器官捐獻者在住院或日間留院期間的相關醫療費用，但尋找器官捐獻者的費用除外。 保險人僅賠付滿足以下條件的器官移植：在國際認可的醫院並由獲得認証的外科醫生執行器官移植；並根據 WHO 指南獲取器官。	a) 全額賠償 b) 每個保險期內最高限額310,000人民幣
15. 癌症治療 保險人應賠付因癌症而須住院、日間留院或門診治療時實際產生的醫療費用。此保障包括從診斷之時起，包括腫瘤科醫生的費用、手術費用，放射療法和化學療法的單項或綜合費用。	全額賠償
16. 懷孕和分娩期間出現的醫療狀況 保險人應賠付產前期間因保障范圍內的醫療狀況所產生的實際住院治療費用；或分娩期間因保障范圍內的醫療狀況所產生的實際住院治療費用。上述醫療狀況包括以下： • 子宮外孕（胚胎在子宮以外的部位着床發育） • 葡萄胎（異常細胞在子宮內生長） • 胎盤滯留（胚胎滯留在子宮內） • 前置胎盤 • 子癇（懷孕期間發生在先兆子癇之后的昏迷或抽搐） • 糖尿病（**如果被保險人因自身與糖尿病有關的過往病史而有相應的責任免除，則被保險人不會因懷孕期間進行的任何糖尿病治療而獲得賠償**） • 產后出血（分娩后多個小時及多日大出血） • 需要即時接受外科治療的流產 • 產程進展不良	全額賠償
17. 轉運和送返 ***轉運*** 保險人安排患有符合保障范圍內的危重被保險人運送到最近的醫療機構進行住院或日間留院治療。 賠付如下合理費用： a) 在被保險人須接受緊急治療而事故發生地無法提供醫療上必需的救護接送與護理的情況下運送被保險人時產生的交通費用，**其中包括一名隨行照料人員陪護行程中的經濟艙機票**。 b) 被保險人在接受日間留院治療期間，往返醫院赴診時的當地合理交通費用。 c) 被保險人入院后隨行照料人員由於看望被保險人往返醫院時產生的合理交通費用。 d) 僅限住院前或出院后短期內，被保險人接受專科醫生護理時的合理非醫院住宿費用。 免賠額不適用本保障下的交通費用。 **在認可的滑雪場或類似的冬季運動場所范圍之外，進行任何海空營救或山地救援時產生的轉運費用，一概不予賠付。** 保險人的醫學顧問將決定轉運時的最合適的交通方式，**如違背保險人醫學顧問的意見，保險人不賠付交通費用，另外，如果被保險人前往的醫院不具備合適醫療設施用以治療被保險人之符合保障范圍的醫療情況，則相關的交通費用將不予賠付。** ***送返*** 在被保險人完成治療后的一個月內，被保險人與被保險人的一位隨行照料人員將可獲安排經濟艙機票安排返回治療地、或被保險人的國籍所屬國或其經常居住地。 **此類保障不適用於正常懷孕及分娩有關的費用，但保險合同第五條項下第16款（即懷孕和分娩期間的醫療狀況）除外。**	***該保障需要預先獲得書面同意 ☎*** a) 全額賠償 b) 全額賠償 c) 全額賠償 d) 每日最高限額1,200人民幣，每人每次轉運最高限額47,000人民幣 ***該保障需要預先獲得書面同意 ☎*** 全額賠償

保障	尊樂
18. 遺體運送 *保險人應賠付被保險人因保障范圍內的醫療狀況引致死亡時產生以下合理和慣常的費用：* *a) 將被保險人遺體或骨灰運往其國籍所屬國或經常居住地時的費用，或* *b) 在被保險人死亡所在地，根據合理的慣例進行土葬或火葬時產生的費用。*	***該保障需要預先獲得書面同意 ☎*** *a) 全額賠償* *b) 最高限額 63,000人民幣*
19. 日間留院和門診手術 *保險人應賠付被保險人在外科診所、醫院、日間護理中心或門診部進行的外科手術時實際產生的治療費用。**手術前后的任何咨詢就診費用將根據保險合同第五條項下20款（門診醫生費用）進行賠付**。*	*全額賠償*
20. 門診醫生費用 *a) 含括咨詢費在內的醫生收費；專科醫生費用；診斷檢查費用；處方藥和敷料的費用。* *b) 醫生或專科醫生推薦的並由獲得執業許可的物理治療師提供的物理治療費用。*	*每個保險期內的綜合最高限額50,000人民幣* *a) 全額賠償 最高達綜合最高限額* *b) 每個保險期內最高50次全額賠償，最高達綜合最高限額*
21. 門診精神疾病治療 *由醫生或專科醫生推薦，並在具有法定資質的精神病醫生的直接管理下，被保險人接受的門診治療。*	*每個保險期內最高限額15,000人民幣*
22. 替代療法 *由醫生或專科醫生推薦，被保險人接受理療師的輔助藥物和治療，保險人應賠付實際產生的有關醫療費用。* *此類賠償可包括整骨療法、整脊治療、順勢療法、飲食療法和針灸療法的費用。**但保險人不賠付一般手足病治療或足病治療的費用**。* ***責任免除6.12條款並不適用於此保障**。*	*每個保險期內全額賠償最高30次*
23. 中醫治療 *保險人應賠付中醫執業醫師對被保險人進行治療時實際產生的醫療費用。* ***責任免除6.12條款並不適用於此保障**。*	*每個保險期內最高30次，每次最高限額1500人民幣*
24. 家居護理 *a) 由醫生或專科醫生推薦，在被保險人接受住院或日間留院治療后，由合格護士在被保險人家中提供護理的費用，**該保障僅限於每個病症最長為30日的護理費用。此保障必須預先獲得書面同意**。* *b) 在出現緊急出診要求的情況下，全科醫生在正常門診時間之外的出診費用。*	*a) 全額賠償最高達45日* ***此保障需要預先獲得書面同意 ☎*** *b) 不予承保*
25. 康復治療 *專科醫生針對被保險人所患疾病進行治療時，認為被保險人有必要接受認可的醫院康復中心接受住院康復治療，保險人應賠付此種情況下實際產生的康復治療費用。但必須：被保險人連續三日住院；專科醫生書面確認被保險人此時有必要接受康復治療。**應在出院后14日內辦妥康復中心住院手續**。上述治療應接受專科醫生的直接監管，並賠付如下費用：* *a) 專項治療病房的使用費* *b) 物理治療費用* *c) 語障治療費用* *d) 職業病治療費用*	*每個醫療狀況全額賠償最高達180日*

全額賠償 *不予承保* *有限承保* *可供選項*

保障	尊樂
26. 先天性疾病 *保險人應賠付被保險人因先天性疾病進行住院治療時實際產生的醫療費用。**若新生嬰兒出生30日內因先天性疾病接受治療，將根據本合同第五條項下第5款規定提供此類病症的保障，而本條例先天性疾病保障則不適用**。最高保障限額應經投保人與保險人雙方同意，並在保險合同中列明。*	*每個保險期內最高限額630,000人民幣*
27. 慢性病症 *保險人應賠付被保險人就慢性疾病包括但不限於哮喘、糖尿病和高血壓等需要通過咨詢、檢查、體檢、服用藥物和敷料和/或診斷測試以實現持續或長期監控的疾病進行治療所實際產生的醫療費用。最高保障限額應經投保人與保險人雙方同意，按其參保日期，在保險合同中列明。* ***本保障不包括腎衰竭和腎透析，腎衰竭和腎透析的賠付適用本保險合同第五條項下第28款。癌症的賠付適用本合同第五條項下第15款。***	*每個保險期內最高限額94,000人民幣*
28. 腎衰竭和腎透析 *保險人應賠付被保險人住院、日間留院或在門診部接受腎衰竭（包括腎透析）治療時實際產生的醫療費用。其中包括手術前后腎透析和重症監護的費用。*	*全額賠償*
29. 牙科 *a) 例行牙科治療：牙科執業醫生在牙科手術期間進行例行牙科治療的費用。例行牙科治療包括：* • *牙齒檢查（**每年兩次**）即評估壞牙、缺牙、填充牙、若有必要其中包括照牙科X光* • *預防性洗牙，拋光和窩溝封閉（**每年一次**）* • *補牙（**標准牙科汞齊合金或復合材料**）和拔牙，以及* • *根管治療（**但不包括在接受牙根管治療后裝上牙冠**）。* ***其他牙科治療一概不適用上述例行牙科治療保障。*** ***等待期：保險合同生效日期之后的9個月內產生的任何費用將不予賠付。*** ***此保障有20%的自付比例。*** ***責任免除6.12條款並不適用於此保障。*** *b) 復雜牙科治療：牙科執業醫生的收費以及以下治療的費用：承保范圍內的復雜牙科治療：例如針對以下項目進行牙根尖切除術 - 齒根斷裂、齒根嚴重彎曲、牙齒上有牙帽或牙樁、根管治療無法治愈的囊腫或感染、根管穿孔、新裝或修復牙冠、假牙、嵌體和牙橋、反復發作的疼痛和感染、無法通過 X 光確定問題根源的持續症狀、牙髓鈣化/根管鈣化、需要進行手術的牙根表面和周圍骨質的損傷。* ***其他牙科治療一概不屬於此類保障。*** ***等待期：保險合同生效日期之后的9個月內產生的任何費用將不予賠付。*** ***此保障有20%的自付比例。*** ***所有畸齒矯正治療有50%的自付比例。*** ***責任免除6.12條款並不適用於此保障。***	*a) 不予承保* *b) 不予承保*
30. 生育保障 *保險人應賠付被保險人正常懷孕或分娩期間實際產生的醫療必需費用：包括產前與產後檢查、掃描、自然分娩或剖腹產的接生費用、兒科健康檢查費用、出生24小時內兒科醫生就新生嬰兒首次檢查/體檢的收費。* ***保險合同的生效日期後的12個月內產生的任何用將不適用於此類保障。*** ***請注意，保險人對於育兒或其他相關課程一概不予賠付，因為是否參加該些課程是由被保險人的個人選擇決定的。*** ***除非保險憑證中明確約定包含生育保障，否則保險人不會賠付正常懷孕及分娩有關的費用。*** ***責任免除6.23條款並不適用於此保障。***	*不予承保*

附加選項

31. 美國境內的選擇性治療 *保險人應賠付被保險人在美國住院或日間留院治療屬於保障范圍內疾病時實際發生的醫療費用。如果在保險人公布的國際醫療網絡內醫院接受治療，醫療費用可獲全額賠付。**若在保險人公布的國際醫療網絡外醫院接受治療，則賠付50%的醫療費用**。*	***該保障需要預先獲得書面同意*** ☎ ▶ *可供選項* *每名被保險人於* *每個保險期內的* *最高限額9,450,000人民幣*
32. 門診費用的自付比例 *保險人應根據保險合同第五條項下第20款賠付被保險人實際產生的醫療費用，**但按每個醫療狀況超過免賠額部分有20%的自付額**。*	▶ *不予承保*
33. 門診直付醫療網絡 *被保險人可沿用經投保人和保險人雙方商定的標準免賠額，對屬於保障範圍內的病症當被保險人在保險人公佈的直付國際醫療網絡診所/醫院接受門診治療時，免賠額為零。在上述的直付國際醫療網絡外接受門診治療，將按每名被保險人於每個醫療狀況及每個保險期內適用的保單免賠額進行理算。*	▶ *不予承保*
34. 體檢、眼科、疫苗 *a) 體檢保障：保險人應賠付例行健康檢查（包括癌症篩查、心血管系統檢查、神經系統檢查、生命體征檢查（例如，血壓、體重指數）、尿分析和膽固醇）的費用，和/或* *b) 眼科保障：保險人應賠付眼科醫生的收費，其中包括光學眼鏡配鏡師每年進行眼睛檢查的費用，包括眼鏡框與眼鏡片在內的眼鏡配鏡費用，和/或隱形眼鏡費用，但須保証總保障費用不大於雙方同意的每個保險期內最高眼科保障金額，和/或* *c) 疫苗保障：醫療必需的免疫疫苗和加強藥物注射，以及醫療必需的任何旅行疫苗和瘧疾預防注射，保險人將賠付相關藥物費用和咨詢費用。*	▶ *不予承保*
35. 既往病史不咎	*適用*
36. 大中華區選擇 *保險人應賠付被保險人在大中華區因住院、日間留院及接受門診治療時實際產生的符合保障范圍的醫療費用。標準的保單保障限額適用於本條。* ***大中華區以外的緊急非選擇性治療：在最長期限為30日的計劃行程中，被保險人若在大中華區以外的地區遇到意外事故或因某種突發性醫療狀況而引致對其健康構成即時威脅的嚴重疾病，在上述緊急事件之後的24小時內接受的醫生或專科醫生提供的治療**。 ***大中華區以外的緊急非選擇性治療賠償不包括正常懷孕及分娩有關的費用***。 ***大中華區指中國大陸、香港、澳門和台灣***。 *因意外事故，需接受住院和日間留院治療，保險人應全額賠付。* *疾病: 每個保險期內的住院和日間留院護理賠償按每個計劃的疾病賠償最高限額*	▶ *不予承保*

附加選項

37. 病房限制（僅適用於中國大陸居民） ***如保險合同第五條項下第1款a項所述，當中國大陸居民在香港住院時，限於一般病房或雙人病房住宿；被保險人或可選擇15%的自付比例，從而在中國大陸任何一家昂貴醫院接受承保范圍內的住院或日間留院治療及任何醫學專家的治療。***昂貴醫院的定義及范圍由保險人事先約定，而自付比例的最高金額則由投保人與保險人雙方就每個醫療狀況進行商定。	不予承保
38. 昂貴醫院自付比例 保險人將事先指定某些提供住院、日間留院或門診治療服務的醫療機構為昂貴醫院。***被保險人在中國大陸任何一家昂貴醫院接受承保范圍內的住院、日間留院或門診治療及任何醫學專家的治療時，保險人應賠付實際產生的醫療費用，但被保險人需承擔20%的自付比例。***該自付比例的最高金額應經投保人與保險人雙方就每個醫療狀況進行商定。	不予承保
39. 昂貴醫院限制 保險人將事先指定某些提供住院、日間留院或門診治療服務的醫療機構為昂貴醫院。***被保險人在中國大陸任何一家昂貴醫院接受承保范圍內的住院、日間留院或門診治療及任何醫學專家的治療時，保險人將不會賠付實際產生的有關醫療費用。***	不予承保
40. 門診限制 保險人應賠付保險合同第五條項下第20款下實際產生的醫療費用，但賠償總額應以雙方同意的每個保險期內的賠償限額為准。	每個保險期內的最高限額 50,000人民幣
41. 可選擇的生育保障 保險人應根據保險計劃來賠付保險合同第五條項下第30款下實際產生的必需的醫療費用。	可供選項
42. 尊樂保險計劃下的牙科保障 ***牙科护理*** a) 例行牙科治療 b) 復雜牙科治療 ***保險合同生效日期起9個月內的牙科治療費用除外。*** ***此保障有20%的自付比例。***	可供選項
43. 取消牙科的自付比例 本合同第五條項下第29款內的自付比例取消，包括例行及復雜牙科治療（含畸齒矯正治療）。	不予承保
44. 住院及門診自付比例 對屬於保障范圍內的住院、日間留院及門診治療時實際產生的醫療費用，被保險人承擔20%自付比例。但不超出投保人和保險人雙方同意的自付額限額。	不予承保

免賠額

45. 免賠額	零

全額賠償　不予承保　有限承保　可供選項

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