

亚太财产
保险有限公司
易全保团体
医疗保险



(2025年4月版)条款



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一. 条款

1. 总则

亚太财产保险有限公司

团体易全保医疗保险(2025年4月版)条款 (注册编号: C00003832512025033113743)

第一条

本保险合同由保险条款、团体投保单、保险单或保险凭证、保障一览表和批注构成。凡涉及本保险合同的任何其他协议, 均应采用书面形式, 并经保险人同意。

第二条

投保人是指为被保险人投保本保险的团体。在本保险合同的生效日期及随后的所有续保日期时, 符合被保险人资格的自然人不得少于3人。

第三条

- 直接被保险人: 投保人所有在职全职员工。
- 连带被保险人: 连带被保险人的范围由投保人在投保时决定, 其中可以包括以下直接被保险人的家庭成员:

- 直接被保险人的合法配偶。
- 直接被保险人的子女(年龄在18周岁以下的或在28周岁以下的且正在保险人认可的教育机构中注册的全日制学生)。该类连带被保险人的承保需获取保险人的同意, 并应由投保人确定其在本保单下享有的保障范围。
- 其他被保险人书面同意的人。

直接被保险人可申请将(直接被保险人或其配偶所生)新生儿加入本保单, 自婴儿出生之日起生效。如果直接被保险人在婴儿出生后30天内将其加入保单, 则无需填写婴儿的详细病史。直接被保险人可登陆[www.now-health.com](#), 在直接被保险人在线组合区进行申请。

但如果出现以下情况, 保险人将要求提供婴儿的详细病史:

- 婴儿在直接被保险人的保单生效日期或其配偶的保单生效日期(以最晚日期为准)起计的10个月内出生;
- 婴儿是被收养;
- 婴儿是通过辅助受孕方法或任何类型生育治疗(包括但不限于生育药物治疗)出生的。

在此情况下, 保险人保留其对所提供保障范围应用特别限制条款的权利, 且保险人应在合理的时间内将这些条款通知直接被保险人。这可能会限制直接被保险人的婴儿的现有医疗状况的医疗保障。这意味着直接被保险人的婴儿的保障范围不包括参保前因某些医疗状况所接受的治疗, 例如在新生儿特别护理病房进行治疗, 此类相关费用应由直接被保险人承担。

保险人有权拒绝将直接被保险人的某一或某几位家庭成员加入本保险合同, 并应在合理的时间告知投保人。

- 任何连带被保险人的医疗保障均应与直接被保险人相同, 但投保人和保险人对连带被保险人的医疗保障的保障范围作出特别限制的除外。
- 本保险合同中的直接被保险人和连带被保险人统称为被保险人。
- 拥有美国国籍, 并且每年在美国境内居住超过90日(包括90日)的自然人, 不能作为本保险合同的被保险人。如被保险人在任一投保人与保险人双方一致同意的排除在保障区域之外的国家/地区居住, 则保险人不能为其承保。在承保前, 保险人应将保障区域之外的国家/地区列表告知投保人。

第四条

除另有约定外, 本保险合同的受益人应指被保险人本人。

2. 保险责任

第五条 — 保险责任

在本保险合同的保险期间内，如果发生了本保险合同列明的医疗事项，保险人应按以下情况向被保险人支付保险金。**特定项目的保险金金额不得超过相应的保障限额，且支付的总保险金金额不得超过本保险合同中规定的年度最高保障限额。**实际发生的所有费用必须为医疗上必需的费用，并应在合理及惯常收费范围内。

本保险责任第1至第24款为必须选择的保障项目，第25至38款为可供选择的保障项目。

1. 医院收费、医生和专科医生费用

- a. 医院对住院或日间留院治疗的患者收取的费用包括：床位费（一般病房/双人病房或私人病房）；诊断检测费用；手术室费用（含外科医生与麻醉师收费）；合格护士护理的费用；由医生或专科医生开具的药物和敷料的费用；手术期间医生使用的手术器械费用；住院或日间留院期间手术前后的咨询费；重症监护费用。上述保障需要预先获得保险人书面同意，而且其最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。
- b. 辅助器材费用：属于保障范围内并因医疗所需，在住院或日间留院接受治疗的6个月内，用于购买及租赁拐杖、支撑架、辅助行走器和自推式非电子轮椅的费用。上述费用的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

2. 诊断程序

保险人应赔付由医疗必需而引致的实际医疗费用，包括：磁共振成像扫描(MRI)、正电子放射断层扫描(PET)和计算机断层成像扫描(CT)的费用。正电子放射断层扫描(PET)、磁共振成像扫描(MRI)和计算机断层成像扫描(CT)需要预先获得保险人书面同意。上述的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

3. 肾衰竭和肾透析

保险人应赔付被保险人住院、日间留院或在门诊部接受肾衰竭(包括肾透析)治疗时实际产生的医疗费用。上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

4. 器官移植

保险人应赔付以下项目实际产生的医疗费用：

被保险人是器官受赠人时，有关肾脏、胰脏、肝脏、心脏、肺、骨髓、角膜的人体器官移植治疗时产生的医疗费用。**当器官移植是由先天性疾病导致时，相关医疗费用应当依照本保险合同第五条项下第7款(先天性疾病)进行赔付，此时本保险合同第五条项下第4款(器官移植)对于相关费用一概不予赔付。**

保险人仅赔付满足以下条件的器官移植：在国际认可的医院并由获得认证的外科医生执行器官移植；并根据WHO指南获取的器官。

器官捐献者和寻找器官捐献者的相关医疗费用一概不予赔付。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

5. 癌症治疗

保险人应赔付因癌症而须住院、日间留院或门诊治疗时实际产生的医疗费用。

此保障包括从诊断之时起，产生的肿瘤科医生的费用、手术费用，放射疗法和化学疗法的单项或综合费用。上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

6. 新生儿保障

保险人应赔付被保险人的新生儿因早产(即妊娠未满37周分娩)或被保险人的新生儿在出生30日内出现急性的病症而需住院接受治疗时而发生的实际医疗费用。

此保障提供的前提是新生儿在出生之日起30日内已经加入本保险合同并且投保人已支付保险费。如果保险人在婴儿被加入保单之前需要详细了解新生儿的病史，则保险人保留其对所提供保障范围应用特别限制条款的权利。

请参阅第3条条款 — 新增新生儿保单条款有关详细信息。

此保障经投保人和保险人双方同意可适用于多胎分娩的情况。上述的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

7. 先天性疾病

保险人应赔付被保险人因先天性疾病进行住院治疗时实际产生的医疗费用。若新生儿出生30日内因先天性疾病接受治疗，将根据本保险合同第五条第6款——新生儿保障规定提供此类病症的保障，而本条款先天性疾病保障则不适用。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

8. 家长住宿费用

保险人应赔付18周岁以下的被保险人因接受符合保障范围内的住院治疗时，其一位家长在医院陪伴过夜而实际产生的住宿费用。上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

9. 新生儿陪伴母亲的医院住宿费用

保险人应赔付新生儿（出生16周及以下）在陪伴母亲（母亲为被保险人）接受住院治疗符合保障范围内的疾病时，医院为新生儿提供住宿而产生的实际费用。上述的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

10. 整形外科手术

保险人应赔付被保险人接受整形外科手术的实际医疗费用，此整形外科手术是为了恢复正常人体的功能或外貌，同时此整形外科手术是因被保险人在保险单生效日或批单签发日（二者以后发生日为准）之后遭遇符合本保险合同保障范围的意外事故或因接受符合本保险合同保障范围内的疾病而接受了外科手术后产生的。上述的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

11. 日间留院和门诊手术

保险人应赔付被保险人在外科诊所、医院、日间护理中心或门诊部进行的外科手术时实际产生的治疗费用。上述保障范围内的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

12. 紧急住院牙科治疗

被保险人因遭遇意外事故而必须住院一晚以上，其天然健全的牙齿因需进行紧急牙科修复治疗，保险人应按实际发生的医疗费用赔付给被保险人。

该牙科治疗必须在意外事故发生后的10日内进行。此保障包括因意外的外部撞击造成的口腔伤害而须接受治疗时产生的所有费用，但同时应满足以下条件：

- 如果上述治疗涉及更换齿冠、牙桥贴片、牙齿贴面或假牙，则保险人赔付合理惯常的费用，或赔付类似的或质量相当的更换费用；
- 如果临床角度上需要植牙，那么保险人赔付采用桥托产生的费用；
- 修复或重建在遭遇意外事故后损坏的假牙，但要求被保险人在遭遇意外事故时佩戴此类假牙。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

13. 康复治疗

专科医生针对被保险人所患疾病进行治疗时，推荐被保险人接受保险人认可的医院康复中心接受住院康复治疗，保险人应赔付此种情况下实际产生的康复治疗费用。但必须：被保险人连续三日住院；专科医生书面确认被保险人此时有必要接受康复治疗。应在出院后14日内办妥康复中心住院手续。上述治疗应接受专科医生的直接监管，并赔付如下费用：

- 专项治疗病房的使用费；
- 物理治疗费用；
- 语障治疗费用；
- 职业病治疗费用。

最高保障限额以及每一病症的最高保障天数，应经投保人与保险人双方同意，并在保险合同中列明。

2. 保险责任

14. 家居护理

保险人应赔付以下实际产生的医疗费用：

由医生或专科医生推荐，在被保险人接受住院或日间留院治疗后，由合格护士在被保险人家中提供护理的费用。**此保障必须预先获得保险人书面同意。**

最高保障限额及最高护理天数应经投保人与保险人双方同意，并在保险合同中列明。

15. 紧急救护运送费用

保险人应赔付陆上紧急救护交通运输工具接送或在医院之间转送途中，或经医生或专科医生认为医疗必需的交通运输工具实际产生的费用。上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

16. 转运和送返

保险人应赔付以下项目实际产生的费用：

a. 转运

保险人安排患有符合保障范围内的危重被保险人运送到最近的医疗机构进行住院或日间留院治疗。

赔付如下合理费用：

- i. 在被保险人须接受紧急治疗而事故发生地无法提供医疗上必需的救护接送与护理的情况下，运送被保险人时产生的交通费用。**其中包括一名随行照料人员陪护行程中的经济舱机票；**
- ii. 被保险人在接受日间留院治疗期间，往返医院就诊时的当地合理交通费用；
- iii. 被保险人入院后随行照料人员由于看望被保险人往返医院时产生的合理交通费用；
- iv. 仅限住院前或出院后短期内，被保险人接受专科医生护理时的合理非医院住宿费用。

在保险人认可的滑雪场或类似的冬季运动场所范围之外，进行任何海空营救或山地救援时产生的转运费用，一概不予赔付。

保险人的医学顾问将决定转运时的最合适的交通方式。**如违背保险人医学顾问的意见，保险人不赔付交通费用。**另外，如果被保险人前往的医院不具备合适医疗设施用以治疗被保险人之符合保障范围的医疗情况，则相关的交通费用将不予赔付。

b. 送返

经由医疗上必需且由保险人安排的转运之后，在被保险人完成治疗后的一个月内，在治疗地的被保险人与被保险人的一位随行照料人员将可获安排经济舱机票返回被保险人的国籍国或居住国。

此保障不包括单独送返，需要已经完成最初的医疗上必需的转运，才可赔付此符合保障范围的送返费用。

免赔额适用于此计划保障。

上述保障需要预先获得保险人书面同意。上述保障的最高保障限额以及每次转运过程中的最高保障限额，应经投保人与保险人双方同意，并在保险合同中列明。

17. 遗体运送

保险人应赔付被保险人因保障范围内的医疗状况导致死亡时产生的以下合理和惯常的费用：

- a. 将被保险人遗体或骨灰运往其国籍国或居住国的费用，或
- b. 在被保险人死亡所在地，根据合理的惯例进行土葬或火葬时产生的费用。

上述保障需要预先获得保险人书面同意。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

18. 保障区域以外的紧急非选择性治疗

在不超过30日（含30日）的计划行程中，被保险人在保障区域以外若遇到意外事故或因某种突发性医疗状况而形成对被保险人的健康构成威胁的突发危重疾病，而且其在上述紧急事件之后的24小时内接受医生或专科医生提供的治疗，则保险人应赔付该期间实际产生的医疗费用。

上述保障范围内的最高保障限额，应经投保人与保险人双方同意，并在保险合同中列明。

19. 住院现金津贴

保险人应赔付被保险人在医院接受住院治疗期间每一晚的现金住院津贴，但应满足以下条件：

- 被保险人在零时前于居住国家的公立医院接受选择性住院治疗；或
- 该计划是二级医疗保险计划。但是，如果被保险人的计划免赔额是人民币63,000或人民币94,500，被保险人不可享用此保障。

该保障仅限于每个保险期间内累计最长不超过30晚(含30晚)。

责任免除6.9条款并不适用于此保障。

上述保障范围内的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

20. 门诊医生费用

保险人应赔付以下实际发生的医疗费用：

- 包括咨询费在内的医生收费，专科医生费用，诊断检查费用；
- 远程医疗咨询(医生以电子方式进行远程医疗咨询)；

如果被保险人在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，符合保障范围内的治疗费用将全额赔付。

如果被保险人不是在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，则只会赔付符合保障范围内合理和惯常的医疗费用。

- 处方药和敷料的费用；
- 维生素和矿物质。

由医生开具处方的维生素和矿物质。由医生诊断的缺乏症及由医生开具处方的维生素、矿物质和滋润眼液将按照门诊保障d赔付符合保障范围的费用。

任何手术前和出院后的门诊费用将根据此保障进行赔付。

被保险人的保障范围不包括被保险人因调理慢性疾病而承担的费用。如果被保险人根据易全保翡翠计划，易全保水晶计划保险单选项投保则保险人将在本保险合同第五条项下第20款门诊医生费用承担调理慢性疾病的治疗费用。

请注意：如果索赔收据未显示所提供医疗服务的明细，我们将仅支付不超过处方药和敷料限额的符合条件的索赔。

年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

21. 门诊物理治疗和替代疗法

保险人应赔付以下项目实际产生的医疗费用：

- 由获得执业许可的物理治疗师提供的物理治疗费用。
- 被保险人接受理疗师的辅助药物和治疗，此类赔偿可包括整骨疗法、手足病治疗和足病治疗、整脊疗法、顺势疗法、饮食疗法和针灸疗法的费用。
- 中医执业医师或阿育吠陀医学执业医师对被保险人进行门诊中医治疗或阿育吠陀治疗时实际产生的医疗费用。

此保障包括所有符合保障范围的诊断、咨询费、治疗类型、治疗费、处方(包括药物详情和剂量)。

责任免除6.41条款适用此保障。

保险期内您可选择此保障a.或b，合计首5次治疗不需转介(饮食疗法除外)，其他后续治疗需医生或专科医生转介。

年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。

最高保障限额以及每个保险期间内的最高治疗次数应经投保人与保险人双方同意，并在保险合同中列明。

2. 保险责任

22. 更年期激素替代治疗

保险人应赔付被保险人因需要进行激素替代治疗以缓解更年期早发症状之门诊费用，但更年期发病和治疗须始于40岁以下。上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

23. 门诊精神疾病治疗

由法定资质的心理学家和/或法定资质的精神病医生的直接管理下，被保险人接受的门诊治疗。此项保障包括10次治疗，**赔付费用以本保障限额为准**。

前5次就诊无需医生转介，之后的就诊则需要有医生或专科医生的转介函和治疗计划。

最高保障限额以及每个保险期间的最高治疗次数应经投保人与保险人双方同意，并在保险合同中列明。

24. 牙科

保险人应赔付以下项目实际产生的医疗费用：

牙科治疗：牙科执业医师在牙科手术期间/牙科诊所进行牙科治疗的费用。牙科治疗包括：

- 牙齿检查(若有必要其中包括照牙科X光)；
- 预防性洗牙，抛光和窝沟封闭(每年一次)；
- 补牙和拔牙(非手术和手术性)；
- 根管治疗；
- 新装或修复牙冠，假牙，嵌体和牙桥；
- 进行牙根尖切除术；
- 处方药和敷料。

不包括种植牙和牙齿矫正治疗保障。

其他牙科治疗一概不属于此类保障。

等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。

此保障有20%的自付比例。

免赔额或门诊每次就诊免赔额并不适用于此保障。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

25. 中国大陆选择

保险人应赔付被保险人在中国大陆因住院、日间留院及接受门诊治疗时实际产生的符合保障范围的医疗费用。标准的保险单保障限额适用于本条。

中国大陆以外的紧急非选择性治疗：

在最长期限为30日的计划行程中，被保险人若在中国大陆以外的地区遇到意外事故或因某种突发性医疗状况而引致对其健康构成即时威胁的严重疾病，在上述紧急事件之后的24小时内接受的医生或专科医生提供的治疗。

因意外事故，需接受住院和日间留院治疗，保险人应全额赔付。

因疾病需接受住院和日间留院治疗，**以投保人和保险人双方同意的最高保障限额为限**。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

26. 病房限制(住宿最高限额800人民币)

如本保险合同第五条项下第1款(a)项所述，被保险人在中国大陆住院时，每日最高限额800人民币，从而在中国大陆医院接受保障范围内的住院或日间留院治疗及任何医生的治疗。医院的定义及范围由保险人事先约定。

最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

27. 昂贵医院限制

保险人将事先指定某些提供住院、日间留院或门诊治疗服务的医疗机构为昂贵医院。被保险人在中国大陆任何一家昂贵医院接受保障范围内的住院、日间留院或门诊治疗及任何医学专家的治疗时，保险人将不会赔付实际产生的有关医疗费用。

28. 私人医院住院自付比例

对属于保障范围内在私人医院的住院或日间留院治疗时实际产生的医疗费用，被保险人需承担20%自付比例。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

29. 年度最高保障限额1,000,000人民币

在本保险合同的保险期间内，如果发生了本保险合同涵盖的医疗事项，保险人应支付保险金额不得超过相应的保障限额，且支付的总保险金金额不得超过本保险合同中规定的年度最高保障限额1,000,000人民币。

30. 门诊费用的自付比例

保险人应赔付被保险人符合保障范围内的门诊治疗实际产生的医疗费用，但门诊治疗有20%的自付比例。

自付比例并不适用于以下治疗：

肾透析/肾衰竭、癌症或器官移植。

但此项不适用于6,300人民币免赔额或更高免赔额之计划。

最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

如果被保险人的保险单中含有生育保障、牙科保障或体检、疫苗保障，其相应的自付额将会在被保险人的保障一览表中列明。

31. 门诊每次就诊免赔额

被保险人接受属于保障范围的门诊治疗时，门诊每次就诊设有150人民币免赔额。

门诊每次就诊免赔额并不适用于肾透析/肾衰竭、癌症或器官移植的治疗。

但此项不适用于6,300人民币免赔额或更高免赔额之计划。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

32. 取消药物和敷料限额

通过选择此选项，保障20 c)下的处方药和敷料将全额赔偿，但受年度最高门诊限额限制。

适用于3名员工或以上的统一投保的团体保险单。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

33. 体检和疫苗 — 选项1

保险人应赔付以下项目实际产生的有关医疗费用：

- 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查(如直系家属有病史)、骨密度检查(50周岁以上女性被保险人每5年可做1次)、心血管系统检查，神经系统检查、生命体征检查(例如，血压、体重指数、尿分析和胆固醇)、儿童体检(至5周岁)的费用和/或
- 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。

适用于3名员工以上的统一投保的团体保险单。

责任免除6.9条款并不适用于此保障。上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

2. 保险责任

34. 体检和疫苗 — 选项2

保险人应赔付以下项目实际产生的有关医疗费用：

- a. 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查（如直系家属有病史）、骨密度检查（50周岁以上女性被保险人每5年可做1次）、心血管系统检查，神经系统检查、生命体征检查（例如，血压、体重指数、尿分析和胆固醇）、儿童体检（至5周岁）的费用和/或
- b. 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。

适用于3名员工以上的统一投保的团体保险单。

责任免除6.9条款并不适用于此保障。上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

35. 生育保障 — 选项1

保险人应赔付以下项目：

- a. 被保险人怀孕或分娩期间实际产生的医疗必需费用；包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。
- b. 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。
 - 宫外孕(胚胎在子宫以外的部位着床发育)；
 - 葡萄胎(异常细胞在子宫内生长)；
 - 胎盘滞留（胚胎滞留在子宫内）；
 - 前置胎盘；
 - 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)；
 - 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)；
 - 产后出血(分娩后多个小时及多日大出血)；
 - 需要实时接受外科治疗的流产。

本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。

等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。

因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。

适用于10名或以上的团体保单。

责任免除6.27条款并不适用于此保障。

免赔额适用于此保障。

每个保险期间的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

36. 生育保障 — 选项2

保险人应赔付以下项目：

- a. 被保险人怀孕或分娩期间实际产生的医疗必需费用；包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。
- b. 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。
 - 宫外孕(胚胎在子宫以外的部位著床发育)；
 - 葡萄胎(异常细胞在子宫内生长)；
 - 胎盘滞留(胚胎滞留在子宫内)；
 - 前置胎盘；
 - 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)；
 - 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)；
 - 产后出血(分娩后多个小时及多日大出血)；
 - 需要实时接受外科治疗的流产。

本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。

等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。

因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。

适用于10名或以上的团体保单。

责任免除6.27条款并不适用于此保障。

免赔额适用于此保障。

每个保险期间内的最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

37. 已声明的既往病症的限额

只适用于5-19名员工的统一投保的团体保险单。

此核保选项为已向保险人声明并被保险人接受的既往病症提供有限的承保。

等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。

上述最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。

38. 既往病史不咎

适用于10名员工以上的统一投保的团体保险单。

3. 责任免除

第六条 — 责任免除

即使根据医生或牙医开具的处方、建议或同意，被保险人因下列情形之一接受治疗或发生相关费用的，均不在保障范围之列。除在保险单和保险凭证中详细列明的所有除外责任外，以下团体保险单的除外责任亦同样适用。

6.1 恐怖主义行为、战争与违法行为

除非被保险人是无端受害的旁观者，否则被保险人由于战争、外国敌对行为（无论是否宣战）、内战、叛乱、革命、暴动、军事政变或篡夺政权、兵变、骚乱、罢工、戒严、试图推翻政府或其他任何恐怖活动而直接或间接产生的治疗费用不在保障范围之列。由于被保险人参与任何违法行为而产生的费用均不在保障范围之列。

6.2 行政与运输费用

由于被保险人要求医生或牙科医生填写理赔申请表或出具医疗报告而产生的任何费用均不在保障范围之列。被保险人在出具向警方报案证明时产生的任何费用均不在保障范围之列。被保险人因运输药物而产生的任何货运费用（包括关税）均不在保障范围之列。

6.3 酗酒与药物滥用

被保险人因依赖或滥用酒精、毒品或其他成瘾物质而产生的治疗费用，以及由于依赖或滥用酒精、毒品或其他成瘾物质而直接或间接导致的疾病或损伤均不在保障范围之列。

6.4 化学品暴露

由于任何核燃料燃烧后的核废物、或有放射性的、有毒，有爆炸性、或任何爆炸性核装置或其核成分的其他危险性质引起的电离辐射或放射性污染而直接或间接产生的或使被保险人承担的治疗费用均不在保障范围之列。

6.5 整容/美容治疗

被保险人由于进行美容或整形治疗而产生的治疗费用（无论是否出于心理因素目的）或与之前美容或整形手术相关的任何用于改善外观的治疗费用（包括但不限于痤疮治疗、牙齿美白、雀斑及脱发治疗）均不在保障范围之列，即使该治疗为医疗处方所建议。保险人仅赔付被保险人在参保期间内遭遇意外事故或因接受符合本保险合同保障范围内的疾病而接受了外科手术，其后为了恢复正常人体功能或外貌而接受的整形外科手术（仅限于初次手术）。

6.6 污染

被保险人由于化学或生物污染直接或间接引起（而无论如何造成）、或任何核材料引起的辐射污染而产生的治疗费用或索赔，或是因石棉沉着症治疗（包括由于战争或恐怖行为和以任何方式产生或导致的费用）而产生的任何病症的治疗费用或索赔，均不在保障范围之列。

6.7 慢性病

被保险人的保障范围不包括被保险人因调理慢性疾病而承担的费用。如果被保险人根据易全保翡翠计划，易全保水晶计划保险单选项投保则保险人将在本保险合同第五条项下第20款（门诊医生费用）承担治疗费用。

6.8 昏迷或植物人状态

保险人不承担被保险人在昏迷或植物人状态超过12个月的任何治疗费用。然而，保险人将承担在昏迷或植物人状态的前12个月内符合本保险合同保障范围内的疾病产生的积极治疗费用。

6.9 免赔额、门诊每次就诊免赔额或自付比例

被保险人的免赔额、门诊每次就诊免赔额或自付比例（需在保险合同中列明）不在保障范围之列。保险人对所有医疗机构提供的旨在向保险人索取更高赔偿金额以支付免赔额、门诊每次就诊免赔额或自付比例的安排均视为欺诈行为，并将采取法律行动。

6.10 牙科护理

被保险人因进行口腔护理而产生的任何费用均不在保障范围之列，除非这些保障包含在被保险人的保险凭证中。但是，保险人将承担由于意外事故而产生的紧急住院牙科治疗费用，详情请参阅保障一览表。在下列情形下，保险人不应承担因进行牙科医生咨询或相关治疗而产生的电话费或交通费、事故发生时假牙损伤的治疗费(除非因意外造成)或意外牙齿损伤而产生的必要治疗费用：

- 在进食或饮用过程中造成的损伤，即使其中包含异物；
- 损伤形成是由于口腔或牙齿正常的磨损和老化；
- 从事拳击或橄榄球运动（学生橄榄球除外）时造成的损伤，受伤时正确佩戴了适当的口部保护设备的除外；
- 因非外部撞击造成的口腔损伤；
- 刷牙或其他口部清洁过程引起的伤害；
- 损伤导致的伤害，此伤害的影响在发生损伤后的10日内并不明显；
- 损伤发生18个月后产生的治疗费用，即便此治疗是医学上必须进行的操作。

6.11 发育异常

被保险人因存在发育、行为或学习等方面问题（例如注意缺陷多动障碍、言语障碍或诵读障碍，以及身体发育问题）而接受治疗所产生的费用不在保障范围之列。

6.12 食物补充品和洗化产品

被保险人因购买以下产品而产生的费用不在保障范围之列：营养或膳食方面的相关咨询及食物补充品，包括但不限于，特殊婴儿食品，洗化产品（包括但不限于保湿霜、洁肤用品、乳液、肥皂、洗发水、防晒霜、漱口水、抗菌含片，无论其是否为医生推荐或处方或有公认的疗效）等。

6.13 进食失调

被保险人因接受与进食失调（包括但不限于神经性厌食症和贪食症）相关的治疗而产生的费用不在保障范围之列。

6.14 实验性治疗和药物

被保险人因接受尚未被证明有效或处于实验阶段的治疗或药物而产生的费用不在保障范围之列。此处的药物是指必须获得相关药品管理局或药品及医疗保健用品管理部门的使用许可，并在许可的条款范围内使用的药物。此处所指的被证明有效的治疗，系指治疗程序和方法已经过相应的临床试验和评估，已得到充分证明并发表在医学期刊上，和/或获得相关国家卫生医疗质量标准部门有关适用于特定目的并已被证明为安全有效治疗方法。

6.15 视力检查或视力矫正、听力检查、听力或视觉辅助

被保险人之助听器或人工耳蜗/人工耳蜗移植手术的费用均不在承保范围之列。被保险人进行常规听力检查的费用不在承保范围之列，除非体检保障包含在被保险人的保险凭证中。被保险人进行常规视力检查或眼镜、隐形眼镜或为矫正视力而进行的激光眼部手术的费用均不在承保范围之列，除非眼科保障包含在被保险人的保险凭证中。但是为治疗符合保障范围之医疗状况而进行的眼部手术的费用则在承保范围之列。

6.16 外部器械和/或假体

任何提供、维护或调试外用假体、器械或其它耐用医疗设备所产生的费用，均不在保障范围之列。除非此类费用明列于医院收费、医生和专科医生保险责任之内。

6.17 不遵医嘱

被保险人在下列情形中产生的治疗费用不在保障范围之列：因被保险人不合理的疏忽而无法寻求或遵从医生嘱咐和/或处方治疗，或被保险人不合理地推迟寻求或遵从此类医生嘱咐和/或处方治疗。被保险人因忽视此类嘱咐而产生的并发症治疗费用不在保障范围之列。

6.18 胎儿手术

被保险人胎儿尚在母亲子宫中所做手术的费用不在保障范围之列，除非该笔费用作为生育保障的一部分详细列在被保险人的保险合同中。

6.19 基因检测

当基因检测旨在确认被保险人拥有的基因是否可能发展成某种医疗状况，或者在毫无症状的情况下是否已得了病，或者是否有遗传风险产生的费用均不在保障范围之列。

3. 责任免除

6.20 高风险运动及工作

被保险人因进行以下活动导致受伤而产生的相关费用不在保障范围之列：定点跳伞、悬崖跳水、赛车运动、乘坐未经注册的飞机飞行、飞行学习、武术、自由攀岩、登山(不论是否使用绳索)、戴水肺潜水超过30米、徒步行至海拔4,000米或以上、蹦极、溪降、悬挂滑翔、滑翔伞运动或乘坐机动滑翔飞翼、跳伞、洞穴探险，在滑雪道外滑雪或进行其他冬季运动。

6.21 人类免疫缺陷病毒、艾滋病或性传染疾病

被保险人在下列情形下接受治疗所发生的费用不在保障范围之列，这些情形包括：因获得性免疫缺陷综合征(AIDS)、艾滋病相关综合征(ARCS) 和所有由人体免疫缺陷病毒(HIV)导致的或与之相关(或两者兼有)的疾病以及性传播疾病而接受的治疗。非医疗处方的艾滋病毒检测或签证申请筛查产生的费用均不在保障范围之列。

6.22 激素替代治疗

被保险人因接受激素替代治疗而产生的费用不在保障范围之列。保险人应赔付被保险人为治疗因医疗干预所致的停经而接受的医疗上必需的激素替代治疗和更年期激素替代治疗（更年期发病和治疗须始于40岁以下），含医生咨询费，皮埋给药、皮贴给药或口服药物的费用，该保障仅限于最长累计18个月的费用。

6.23 肥胖和减肥

被保险人因减肥手术或与之相关的治疗及其并发症相关的治疗而产生的费用不在承保范围之列。被保险人因从身体任何部位移除脂肪/多余的健康组织或与之相关的治疗及其并发症相关的治疗而产生的费用不在承保范围之列。被保险人因减肥包括减肥药物或与之相关的治疗及其并发症相关的治疗而产生的费用不在承保范围之列。

6.24 在护理院、疗养院、康体水疗院和自然疗法门诊的治疗

被保险人在护理院、疗养院、康体水疗院、自然疗法门诊或类似场所接受治疗的费用均不在保障范围之列。相关疗养费用或被保险人出于观察目的而住院的费用不在保障范围之列。如果延长护理的原因是被保险人年老体衰，和/或医院实际上已经成为被保险人的休息居住场所，则延长护理的费用不在保障范围之列。

6.25 姑息治疗和临终关怀

如果被保险人被医生或专科医生诊断为终末期疾病起，医生或专科医生以暂时缓解症状为目的开立医嘱，保险人不赔付因姑息治疗与临终关怀而产生的住宿费用或任何其他治疗费用。

6.26 投保前疾病

被保险人的保险计划不承保投保前疾病及其相关医疗状况疾病（不包括事先得到保险人书面同意承保的投保前疾病）。

投保前疾病的定义为任何疾病或损伤在保险单起始日期或者保险单加入日期前：

1. 曾接受过治疗、测试或检查，或曾被确切诊断，或曾接受过住院治疗；或者
2. 曾出现过症状，无论是否有过确切诊断

6.27 怀孕或分娩

被保险人因怀孕或分娩、医疗上必需的和/或紧急剖腹产、自愿剖腹产、怀孕或分娩的医疗状况，包括产前、分娩或产后出现的医疗状况而产生的费用不在承保范围之列，除非生育保障a)列在被保险人的保险合同中。

这些费用仅包含在生育保障福利a)中，不包含在任何其他保障福利中或不能从任何其他保障福利中获得赔付。

6.28 职业体育运动

由于被保险人参与任何形式的职业运动造成损伤或疾病而产生的任何费用不在保障范围之列。保险人所指的职业运动指被保险人有偿参与的运动。

6.29 精神或心理治疗

被保险人因精神疾病或任何心理状况相关的治疗而产生的费用不在保障范围之列，除非列明在被保险人保障计划中。

6.30 不育症相关的治疗

被保险人因接受有关不孕症和生育力、绝育（或其反面）或辅助受孕相关的检查或治疗而产生的费用不在保障范围之列。被保险人承担的与避孕相关的费用不在保障范围之列。

6.31 例行检验、健康检查、疫苗

如果相关保障未列在被保险人的保险合同中，则被保险人因接受常规医疗检查而产生的费用（包括签发健康证明、健康检查或为排除被保险人罹患未表现出症状的某一病症的可能性而进行的检查等）和任何类型的疫苗费用不在保障范围之列，除非保障列明在被保险人的保险合同中。

6.32 第二诊疗意见

未经保险人书面同意，被保险人因医生或专科医生就同一个医疗状况产生的、被保险人保险合同中列明的医疗意见以外的任何补充性或后续医疗意见而产生的费用不在保障范围之列。

6.33 自残或试图自杀

因被保险人自残损伤、自杀或试图自杀直接或间接产生的治疗费用不在保障范围之列。

6.34 性问题和变性

被保险人因接受与性功能障碍、变性手术等性问题相关的治疗费用，以及由变性直接或间接引起的包括心理治疗或类似服务在内的手术或其他治疗费用，均不在保障范围之列。被保险人接受性传播疾病治疗的费用不在保障范围之列。

6.35 睡眠失调

被保险人接受包括睡眠测试或矫正手术在内的针对打鼾、失眠、时差综合征、疲劳、或睡眠呼吸暂停等的治疗费用不在保障范围之列。

6.36 旅行/住宿费用

被保险人为获得医疗治疗而进行的旅行期间所产生的交通或住宿费用不在保障范围之列，除非此类费用是出于紧急医疗转运目的，且已经保险人预先书面同意。因被保险人未经保险人预先书面同意及安排便进行的紧急医疗转运或送返被保险人而产生的费用不在保障范围之列。

6.37 违反医生嘱咐旅行的费用

如果被保险人不听从主治医生的嘱咐而出行，则被保险人产生的医疗费用或其他费用不在保障范围之列。

6.38 昂贵医疗机构的治疗

被保险人在保险人昂贵医疗机构名单内的昂贵医疗机构接受任何治疗而产生的费用不在保障范围之列。

6.39 来自家庭成员的治疗

来自家庭成员或用于自我疗法的治疗所产生的费用不在保障范围之列。

6.40 超出合理及惯常收费范围的治疗费用

超出合理及惯常收费范围的治疗费用不在保障范围之列。

6.41 中医治疗

以下被保险人产生的费用不在承保范围之列：接受治疗前的预付治疗计划或预付套餐、非处方中药、以滋补/进补/补药/补品/美容为目的的治疗或体重管理的治疗。被保险人因下列的中医治疗/中药而产生的费用（无论是否是处方药）不在承保范围之列：包括虫草/冬虫夏草；灵芝；鹿角；燕窝；阿胶；海马；参；红参；西洋参；野生人参；羚羊角粉；人胎盘；姬松茸；麝香；珍珠粉；犀牛角以及来自亚洲象、马来熊、老虎或其他濒危物种的物质。每天超过一次的治疗而产生的费用不在承保范围之列。

4. 保险金额和保险费

5. 保险期间

第七条 — 保险金额和保险费

1. 本保险合同中的保险金额即为保险人承担的最高保障责任。在本保险合同的保险期间内，保险人为每一项的保障承担的保障金额不应超过每一项保障的最高保障限额，且累计的保障金额不应超过保险保障总额。

保险保障总额和每一项保障的最高保障限额均经保险人和投保人一致同意，并在保险合同中列明。
2. 投保人应按照本保险合同的约定支付保险费。
3. 保险费根据投保人与保险人商定的保险金额计算，并在本保险合同中列明保险费率。

第八条 — 保险期间与续保

本保险合同的保险期间为一年。具体起讫时间由投保人、保险人双方约定，并载明于本保险合同中。

本保险合同为不保证续保合同，保险期间届满，投保人需要重新向保险人申请投保本产品，并经保险人同意，交纳保险费，获得新的保险合同。

第九条 — 等待期

等待期是指从保险单生效日或批单签发日(二者以后发生日为准)开始，保险人不承担某项特定保险责任的一段时间，具体天数由保险人和投保人协商确定，但最长不超过180天。不管投保人续保与否，被保险人必须完成等待期才可赔付该保障。

第十条 — 免赔额

本保险合同有免赔额选项。年度免赔额适用于所有符合保障范围的住院和日间留院治疗而产生的费用（无论被保险人于医疗网内或医疗网外医疗机构治疗）。如果投保人选择其中一项年度免赔额选项，投保人需要就门诊费用的自付比例或门诊每次就诊免赔额的其中一项作出相关选择。免赔额选项和其他相关的选项应经投保人与保险人双方同意，并在保险合同中列明。

6. 保险人义务

第十一条 — 明确说明义务

签订保险合同时，由于采用的是保险人提供的格式条款，保险人向投保人提供的投保单应当附上格式条款，并向投保人说明及披露所有条款和条件。对于保险合同中免除保险人责任的条款，保险人应在团体投保单、保险单或其他保险凭证中给予明确提示，并对该条款的内容向投保人以口头或书面形式作出明确说明。如无提示或者明确说明的，该条款不产生效力。

第十二条 — 保险单签发

保险人应在签订保险合同后为投保人及时签发保险单或其他保险凭证。

第十三条 — 理赔资料的补充

如果保险人按照本保险合同的约定认为申请人提供的理赔申请或有关证明和资料不完整的，则应一次性及时通知投保人/被保险人提交所需的补充信息。

第十四条 — 保险金的核定与支付

保险人收到被保险人或受益人提交的理赔申请书及合同约定的证明和资料后，应及时核定。若案件情况比较复杂，除保险合同中另有约定外，保险人应在30日内作出核定。

保险人应将核定结果通知被保险人或受益人。对属于保险责任范围的，保险人应在与被保险人或受益人达成支付保险金的协议后的10日内履行支付保险金义务。如果双方在支付保险金协议中对于支付保险金的期限另有约定，则保险人应根据协议约定的期限支付保险金，以履行相应义务。经核定不属于保险责任范围的，保险人应在作出核定之日起3日内向被保险人或者受益人发出拒绝支付保险金通知书，并说明理由。

第十五条 — 保障期内的理赔处理

保险人自收到理赔申请和有关证明、资料之日起60日内，对其给付保险金的数额不能确定的，应当根据已有证明和资料可以确定的数额先予支付；保险人最终确定给付保险金的数额后，应当支付相应的差额。

7. 投保人、被保险人和受益人义务

第十六条 — 支付保险费

本保险合同保险费交纳方式由投保人和保险人在投保时约定，并在保险单中载明。

如约定一次性交纳保险费的，投保人应在保险合同成立时一次性交清保险费，**投保人未按约定交纳保险费的，本保险合同不生效。**

约定以分期付款方式交纳保险费的，需经投保人申请并经保险人同意，在保险合同中载明分期交纳的周期，投保人应按约定交纳首期保险费。**如投保人未按保险合同约定交纳首期保险费，保险合同不生效。**

如投保人未按约定日期交纳第二期或以后任何一期保险费的，投保人自保险人催告之日起超过三十日未支付当期保险费的，本保险合同效力中止；在本保险合同解除前发生保险事故的，保险人按照本保险合同约定给付保险金，但需在保险金额中扣减保险期间内投保人所有未交期间的保险费，投保人已交纳的保险费与保险人扣减的保险费之和应等于本保险合同约定的保险费总额。

投保人应为本保险合同包括的所有符合资格的被保险人支付保险费。

除非被保险人更改居住国，否则被保险人在续保时不得把保费计划更改成其他货币的保费计划。并且被保险人如需更改成其他货币的保费计划时，被保险人必须经过保险人同意。

第十七条 — 如实告知义务

签订保险合同后，保险人可能会调查投保人或被保险人的相关情况，投保人应如实告知。

如果投保人故意不履行或由于重大过失而未能履行其如实告知的义务，从而影响保险人对保险申请进行承保或增加保险费率的决定，则保险人有权解除合同。

如果投保人故意不履行其如实告知的义务，则保险人不承担合同解除前发生的保险事故的保险金赔付责任，并且不会退回保险费。

如果投保人因重大过失而未能履行其如实告知的义务，并成为导致保险事故发生的主要原因，则保险人不应承担合同解除前发生的保险事故的保险金赔付责任，但应退回保险费。

第十八条 — 地址或通知方式变更

如果投保人的居住地址或通信方式发生变更，则投保人应以书面通知形式及时告知保险人。如果投保人未能及时书面告知保险人，则保险人将通知寄送至投保人的最后已知地址时，视为通知已送达给投保人。

第十九条 — 保险事故通知

投保人、被保险人或者受益人知道保险事故发生后，应当及时通知保险人。**故意或者因重大过失未及时通知，致使保险事故的性质、原因、损失程度等难以确定的，保险人对无法确定的部分，不承担赔偿或者给付保险金的责任。**

8. 保险赔偿和支付

第二十条 — 理赔申请

向保险人提交理赔申请时，保险金申请人应出具以下材料。如果出于任何特殊原因导致申请人无法出具以下材料，则应出具其他必需的法律材料或相关材料。如果因申请人无法提供材料而导致保险人无法确认理赔申请的真实性的，则保险人不应承担损失中无法确认部分的赔偿责任：

- 理赔申请表；
- 保险单或其他保险凭证；
- 申请人合法身份证明；
- 医院签发的医疗收据（紧急治疗医疗费用收据应盖有医院的紧急治疗印章）、诊断证明和医疗记录等资料的原始凭证；
- 医疗转运方面，应出具由保险人认可的合法救援组织签发的书面证明文件；
- 与损伤性质、原因和程度的确认等相关的其他支持文档和信息。

第二十一条 — 保险金请求权的诉讼时效

申请人向保险人请求给付保险金的诉讼时效期间以现行有效的法律规定为准。

第二十二条 — 赔偿原则

本保险合同的保障费用赔偿，应按照以下赔偿原则。

- 如被保险人已经从其它途径（包括但不限于社会基本医疗保险、公费医疗保险、工作单位之医疗保险、被保险人所持有任何商业保险机构之医疗保险）获得相关医疗费用赔付，保险人仅需按被保险人从其他途径（包括但不限于社会基本医疗保险、公费医疗保险、工作单位之医疗保险、被保险人所持有任何商业保险机构之医疗保险）获得医疗费用赔付后之余额及保险合同条款进行赔付。
- 如被保险人是社会基本医疗保险或公费医疗保险之成员，但理赔时未能在社会基本医疗保险或公费医疗保险获得赔偿的，保险人将会按申请人保险凭证及保单保障权益之保障上限及赔偿标准进行赔付。

9. 争端解决与适用法律

第二十三条 — 争端解决

履行本保险合同期间产生的争端应由有关各方通过协商解决。如果协商失败，则各方均有权向中华人民共和国（香港、澳门和台湾地区除外）有管辖权的人民法院提起诉讼。

第二十四条 — 适用法律

本保险合同适用中华人民共和国法律（香港、澳门和台湾地区的相关法律除外）。

10. 其他条款

第二十五条 — 连续转移条款

如果被保险人将现有其他保险单转至本保险单，则保险人将维持被保险人在现有保险单项下所列明的承保条件或特约条款（例如延期偿付或特别约定的责任免除事项等），且被保险人与保险人之间的保险合同也将受其约束。被保险人现有保险单的最早批单签发日也将适用于本保险单，任何保险单的转移须以不增加本保险单所提供的保障为条件且须获得保险人的书面同意。

当被保险人于保险人之团体医疗保险终止时，被保险人可以申请转移至保险人之个人医疗保险项下的某一保险计划。被保险人的该转移申请须在其脱离团体医疗保险之前提交给保险人并须获得保险人的书面同意方可被接纳。

第二十六条 — 合同的解除

投保人可在14日的犹豫期内联系保险人取消保险单。14日的犹豫期从本保险合同签订之日起计算，或从投保人收到全部的保险单条款和条件之日起计算，以两者中较后者为准。14日犹豫期同样也从每个续保日期起生效。如果投保人在犹豫期内没有发生任何索赔或不存在任何在这14日内发生的可能导致索赔的情况，保险人应向投保人退还投保人已缴纳的保险费，同时投保人与保险人签署的保险合同终止。如果在保险期间产生了符合条件的理赔费用，则保险人保留在法律允许的范围内向投保人要求支付为保险单提供的有关服务费用的权利，保险人有权从退回的保险费中扣除保险人就此发生的服务费用。

在本保险合同生效后，投保人可以以书面形式通知保险人解除本保险合同，但保险人已根据本保险合同规定支付保险金的，投保人不得要求解除本保险合同。

投保人在要求解除本保险合同时应出具以下证明和文件：

- 保险单原件；
- 保险费支付证明；
- 投保人有效身份证明；
- 投保人可提供的其他与本保险合同相关的任何文件。

本保险合同自保险人收到解除合同申请书及收齐相关证明和文件时起终止。在本保险合同终止后30天内，保险人将向投保人退回本保险合同的最低现金价值。

本保险合同的任何终止应不影响保险费已支付期间内各方应有的权利和应承担的义务。

第二十七条 — 使用会员卡

- 直接结算会员卡为保险人所有。此会员卡仅适用于被保险人接受符合本保险单条件的治疗时，享受直接付费服务。
- 任何情况下，被保险人在接受本条款第六条责任免除和/或保险凭证中列明的责任免除事项相关的治疗时，不可以使用直接结算会员卡。保险人对其误用此类直接结算会员卡的行为不承担任何责任。
- 如果被保险人通过门诊直接结算选择接受不符合本保险单条件的治疗，被保险人作为第一责任人需要承担由此产生的费用，且被保险人必须自保险人追偿之日起，15个工作日内将保险人就此已支付的费用退还给保险人。保险人可从有效理赔保险金中抵扣被保险人到期应付而未付的款项，同时，保险人也可以中止被保险人的保障直到被保险人全额支付其应付款项为止。
- 如果保险人确定投保人、被保险人或受益人使用任何欺诈的行为骗取保险金，则保险人有权解除本保险合同，且该终止将立即生效。被保险人必须自保险人追偿之日起，15个工作日内将与该保险欺诈相关的理赔保险金退还给保险人。
- 如果被保险人拥有直接结算会员卡，当投保人取消保险单或停止对保险单进行续保时，则应由投保人负责将被保险人(含连带被保险人)的所有此类会员卡退还给保险人。保险人对被保险人在保障停止后误用此类直接结算会员卡的行为不承担任何责任。
- 若被保险人(包括连带被保险人)的直接结算会员卡遗失，投保人应立即通知保险人。
- 投保人应为被保险人的担保人。任何被保险人未清偿之款项，由投保人负责偿还。

10. 其他条款

第二十八条 — 弃权

保险人放弃对违反本保险合同任何条款或条件的任何行为进行追究的权利不妨碍该条款或条件的后续执行，也不应视为对随后的任何违反行为放弃追究的权利。

第二十九条 — 保险单管理

1. 投保人保证，如果出于任何原因导致本保险合同无法续保或本保险合同应根据上述第二十六条中的条款予以解除，则会立即告知其所有符合资格的员工，从而确保此类符合资格的员工知道保障已经解除，且对符合资格的员工或其家庭成员而言保险金无法支付。
2. 在职员工：在职员工指投保人以全职、永久的方式聘用的直接被保险人，直接被保险人按照聘用条款以全职形式履行其所有常规职责。
如果直接被保险人是雇员，则直接被保险人在合格加入团体计划的当天起需要保持在职状态。如果直接被保险人在合格加入团体计划的当天为非在职状态，则该直接被保险人只能在其重返工作岗位及其恢复在职状态的当天起享有团体计划保障。直接被保险人只有其重返工作岗位时才能申请添加连带被保险人。
如果出现以下任何的情况，直接被保险人被视为“非在职员工”：
 - 直接被保险人的工作时间少于规定工作时间的80%，或者工资低于雇佣条款所规定正常工资的80%
 - 直接被保险人因健康状况需要离开正常工作场所60天以上，当地法规准许的产假/陪产假除外。
3. 由于本保险合同旨在为符合资格的员工和连带被保险人提供保障，因此投保人保证将保险人送达投保人的任何更改后的保险条款或保障一览表修订版、或任何保险人送达投保人的与保障范围有关的通知及时送交所有符合资格的员工。
4. 投保人应通知团体被保险人有关本团体保险单的条款和条件以及批注的任何变更。投保人还应通知团体被保险人有关本保险单与任何之前团体保险单相关的条款和条件的任何变更。
5. 投保人保证使保险人免于承担因投保人未能履行本保险合同中自身义务而产生的成本、损失及开支。如果由于投保人未履行本保险合同第二十九条“保险单管理”的任何一项义务，导致保险人被索赔的，投保人将赔偿保险人由此产生的全部损失，包括但不限于争端解决费用、保险赔偿金、律师费以及其他一切费用。
6. 投保人应指定一名负责人员(即保险单管理员)根据本保险合同的条款以及保险人经常发布的指引来管理本保险合同，投保人并应以书面形式告知保险人有关指定人员的任何变更。
7. 保障中断：无论因何种原因导致的保障中断，保险人均保留再次对投保前疾病使用责任免除6.26的权利。
8. 尽管投保人已将有关本保险合同的全部或部分义务委托给视为投保人代理人的中介或代理人，投保人仍应承担本保险合同中投保人的义务和责任。
9. 如果投保人进入破产程序或指定了管理人、接收人或接管人对投保人的全部或部分业务或资产进行监管，则投保人应立即书面告知保险人。
10. 如果被保险人的地址或职业发生变更，则保险单管理员应立即书面告知保险人。

11. 通用条款

第三十条 — 通用条款

1. 保险人保留修改或终止团体保险单的权利，修改或终止从任意续保日期起生效。
2. 本保险合同的修改必须采用书面形式，并加盖保险人印章，否则所作修改将不予承认。
3. 根据本保险合同送达的通知必须采用书面形式并通过邮递或传真机送达，如果是发送给保险人的通知，则应将邮件寄送到保险人注册地址后视为已送达；如果使用传真机寄送通知，则应将发送时间视为送达时间。
4. 保险人为解释或实施投保人的被保险人文档中的任何条款或条件而进行的任何修改均不妨碍该条款或条件随后的实施，也不应被视为任何随后的解释或实施的先例。
5. 本保险合同若中文条款与英文条款存在不一致的，以中文条款为准。

12. 释义

1. **事故：**指保险期间在被保险人身上发生的突然的、意外的、不可预见的、非自愿的、并对被保险人造成可识别的人身损伤的外部事件。
2. **急性的病症：**对旨在使被保险人恢复健康状态的治疗可能做出快速回响的疾病、病症或损伤。且被保险人可完全康复至疾病、病症、损伤的因素出现以前的情况。
3. **恐怖主义行为：**指恐怖分子或恐怖组织为达到政治、军事、社会或宗教目的而对平民采用隐蔽的暴力手段进行胁迫或恐吓的举动。
4. **周岁：**指按有效身份证件文件中记载的出生日期计算的年龄，自出生之日起为零周岁，每经过1年增加1岁，不足1年的不计。
5. **结算协议：**保险人与时康国际公司公布的医疗机构网络中列明的每一家医院、日间看护所或扫描中心之间达成的协议。
6. **替代疗法：**指在医疗机构以外采用传统医学进行治疗和诊断的治疗。此类医学包括由具备资质的理疗师提供的整脊治疗、手足病治疗和足病治疗、整骨疗法、饮食疗法、顺势疗法和针灸疗法。
7. **根尖切除术：**指为牙齿移除根尖及附近受感染组织而进行的牙科手术，牙齿虽经过根管手术，但其末端的骨质区仍存在炎症和感染的牙槽脓肿。进行根尖切除术是为了治疗以下病症：
 - 齿根断裂；
 - 齿根严重弯曲；
 - 牙齿上有牙帽或牙桩；
 - 根管治疗无法治愈的囊肿或感染；
 - 根管穿孔；
 - 反复发作的疼痛和感染；
 - 无法通过X光确定问题根源的持续症状；
 - 钙化；
 - 需要进行手术的牙根表面和周围骨质的损伤。
8. **保障区域：**预设保障区域为全球(不包括美国)，即保险人提供全球符合保障范围的保障，但不包括在美国的任何选择性治疗。如预设保障区域为全球(不包括美国)，保障区域以外是指美国。如投保人选择“中国大陆选择”的保障项目，保障区域则为中国大陆(不包括香港、澳门、台湾一下同)，保障区域以外是指中国大陆以外的区域。
9. **保障：**本保险单和保险凭证中列明的任何扩展条款或限制、或任何批注（如果可用）中提供的保险保障，这些保障均以保险人收到应付的保险费为前提。
10. **保障一览表：**适用于本保险单并列明保险人应支付的最高保障限额。
11. **癌症：**指恶性肿瘤、组织或细胞，其特征是恶性细胞不受控制地生长、蔓延并侵入到组织中。
12. **保险凭证：****指由保险人提供格式的**，列明被保险人、保险期间、保险人、批单签发日、保障等级和任何适用批注的保险单详情的证明。
13. **先天性疾病：**指一出生就显现的或被认为自出生开始就存在的一种医疗状况，无论该医疗状况是遗传的还是受环境因素影响。
14. **自付比例：**指被保险人在对费用进行理赔时，应由自己支付的理赔费用中的不保费用部分。
15. **国籍国：**指被保险人持有其合法护照的国家。
16. **居住国：**被保险人在保险单生效日期或批单签发日或随后的每一个续保日期习惯性居住的国家（在每个保险期间内通常不少于6个月）。

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- 17. 慢性疾病：**至少拥有以下特征之一的疾病、病症或损伤：
- 需要通过咨询、检查、体检、药物和敷料和/或实验室检查进行持续或长期监控；
 - 需要持续或长期控制症状或缓解症状；
 - 需要被保险人进行康复治疗或接受特别培训以应对疾病；
 - 持续时间不定；
 - 尚未有已知治愈方法；
 - 会复发或可能复发。
- 18. 日间留院患者：**由于康复需要一段时间的医疗监控而在医院或日间看护所住院、但不会占用医院床位过夜的患者。
- 19. 免赔额：**被保险人的保险凭证中指明、在根据保险单支付住院或日间留院保障以前应由被保险人支付的不保金额。保险单免赔额适用于每名被保险人的每个保险期间。
- 20. 牙科医生：**在提供牙科治疗的所在国家/地区拥有由相关许可机构颁发的许可、可以合法从事牙科治疗的人士。
- 21. 连带被保险人：**在保险合同生效日期或随后的任何续保日期与被保险人居住在一起的一位配偶/成年伴侣和/或18周岁以下的未婚子女、或接受全日制教育的28周岁以下的子女(需要提供其注册教育机构出具的书面证明)。术语“伴侣”可能指丈夫、妻子或以类似关系和被保险人永久居住在一起的人士。所有受养人均应在保险凭证中被称为连带被保险人。
- 22. 诊断检查：**为查明或帮助查明被保险人的病因而进行的调查，例如X光或血检。
- 23. 药物和敷料：**由医生或专科医生开具的、为减轻或治疗某一个医疗状况所必须的基本处方药、敷料和药物。
- 24. 符合保障范围：**被保险人的保险单覆盖的治疗和费用。为确定治疗或费用是否在覆盖范围内，应一同阅读被保险人保险单的所有章节，并应遵守保险单列明的所有条款(包括应付保险费的支付)、保障和责任免除。
- 25. 批单签发日：**在保险凭证中列明的、被保险人被本保险单接纳的日期。
- 26. 转运或送返：**将被保险人转移至拥有必要住院及日间留院送返服务医疗设施的医院，医疗机构可以位于被保险人生病时所在的国家，也可位于另一个邻近国家(转运)、或将被保险人送回被保险人的主要国籍国或被保险人的主要居住国(送返)。服务内容包括由保险人在转移被保险人时指定的国际救援公司认可的所有医疗上必需的治疗。
- 27. 排除在外的国家：**指的是我们无法为您提供保障的国家列表(如果您居住在其中任何一个排除在外的国家)。有关我们的排除在外国家/地区列表的详细信息，请联系我们的客户服务团队。
- 28. 外国国籍的人士：**在其持有合法护照的国家以外的国家/地区居住和/或生活的所有人士。通常居住和/或生活的时间为每个保险期间内超过180日。
- 29. 地理区域：**用于在本保险合同的生效日期或任何后续的续保日期根据被保险人的主要居住国计算适用于被保险人的保险费的地理区域。
- 30. 昂贵医疗服务机构名单：**保险人排除在承保范围之外的医疗服务机构名单。保险公司不承保被保险人在昂贵医疗服务机构名单中所产生的任何治疗费用。保险公司将定期更新昂贵医疗服务机构名单。有关保险公司的昂贵医疗服务机构名单的详细信息，被保险人可以联系保险公司的客户服务团队。

12. 释义

31. 医院：经其经营所在国家/地区的法律许可注册为医院或外科医院的任何机构。以下机构不视为医院：休养护理院、水疗中心和疗养胜地等机构。
32. 医院床位：指保障一览表中列明的标准单人病房或双人病房。豪华病房、行政病房和特需套房不包括在内。
33. 网内医疗机构：网内医疗机构指与被保险人之保险单已签订合同，并按预先商定的特定费率为保险单的被保险人提供服务的医疗机构。
34. 入院患者：出于医学原因被医院接收，并在病床上待上一夜或更长时间的患者。
35. 被保险人/你/你的：本保险单提供保障的、在保险凭证中提及的符合资格的被保险人和/或连带被保险人。
36. 保险人：亚太财产保险有限公司。
37. 医疗状况：任何疾病、损伤或病症，包括精神疾病。
38. 医生：在WHO认可的医学院校就读并获得药物或手术初级学位，并获得提供治疗所在国家/地区的相关权威机构之行医资质的人士。术语“认可的医学院校”指列在WHO公布的世界医学院校名录中的医学院校。
39. 医疗上必需的治疗：指符合资格的医生认为适当的、与诊断一致的、根据一般公认的医学标准不能被忽略的、一旦忽略将对被保险人的病症或施与的医疗护理造成负面影响的相关治疗。提供此类治疗时不能只考虑到患者或医生的舒适方便，且只能持续提供一段时间。“适当”用于此定义中时是指充分考虑患者的安全和经济效益。当特指住院治疗时，医疗上必需的还指诊断无法执行或门诊治疗无法安全和有效地提供。
40. 新生婴儿：出生时间为16周以内的婴儿。
41. 医疗网络/
时康国际医疗网络：保险人/保单管理人公布的与其签有直接结算协议的医疗机构网络。
42. 网络外医疗机构：网络外医疗机构是未与被保险人的保险单签订合同的医疗机构。
43. 门诊患者：前往医院、诊疗室、门诊诊所或进行远程医疗治疗，但不需要被接纳为日间留院或住院的患者。
44. 门诊直接结算：保险人公布的与其签有直接结算协议的医疗机构网络。
45. 门诊每次就诊免赔额：被保险人的保险凭证中指明、在根据保险单支付门诊保障以前应由被保险人支付的不保金额。每次就诊均视为一次谘询。门诊每次就诊免赔额适用于每名被保险人的每一次门诊谘询。
46. 保险期间：约定起保日的零时开始到约定期满日24小时止通常为12个月的一段时间。
47. 物理治疗师：在提供治疗的国家/地区注册并获得执业许可的执业物理治疗师。
48. 预先书面同意：指被保险人在接受任何治疗或承担任何费用前从保险人处寻求审批的流程。需要保险人预先书面同意的保障将会在保障一览表中注明需预先书面同意。
49. 计划：您与我们之间的合同，其中列出所提供保障的条款和条件。完整的保障条款和条件包括申请表、保险单、福利表和本会员手册。
50. 投保人：在保险单或保险凭证中被称为投保人的团体。
51. 怀孕：指从首次确诊到分娩的一段时间。
52. 主医疗保险单：如果被保险人拥有不止一份健康保险单，则这是指最先支付理赔的健康保险单。
53. 主医疗之保险人：主医疗保险单的保险人。

54. 私人病房：私人医院中只设有一张床位的病房。豪华病房、行政病房和特需套房不包括在内。
55. 精神疾病：符合精神疾病诊断与统计手册(DSM) 或国际疾病分类(ICD) 等国际分类系统的分类标准的精神或神经紊乱。紊乱应与个人当前的痛苦或其进行重要日常活动(例如工作) 能力的严重受损有关。上述病症必须具有显著的临床表现，而不仅是由某一特定事件造成的预期反应，例如丧亲之痛、人际关系或学术问题，以及文化适应等。
56. 合格护士：目前在提供治疗的国家/地区的任何法定护士登记机构管理的或护士名册上有登记的护士。
57. 合理及惯常收费：在被保险人接受治疗的国家/地区根据被保险人的惯常收费治疗费用通常应收取的费用。保险人有权要求独立的第三方对此类费用进行证实，例如执业外科医生/医生/专科医生或政府卫生部门/易全保综合医疗网络等。
58. 最低现金价值：
- 1) 保险生效日前退保的，最低现金价值=投保人已交纳保险费。
 - 2) 保险生效日后退保的，若保险费为一次性支付的：
最低现金价值=净保费 $\times(1-m/n)$ ，其中， m 为已生效天数， n 为保险期间的天数，经过日期不足一日的按一日计算。净保费=投保人已交纳保险费 $\times(1-$ 费用比例)，除另有约定外，费用比例为15%。
 - 3) 等待期后退保的，若保险费为分期支付的：
最低现金价值=当月净保费 $\times(1-m/n)$ ，其中， m 为当月已生效天数， n 为当月的总天数，经过日期不足一日的按一日计算。当月净保费=投保人已交纳当月保险费 $\times(1-$ 费用比例)，除另有约定外，费用比例为15%。
59. 康复治疗：医疗上必需的治疗，旨在使被保险人经受某一医疗状况后恢复在日常生活中独立行动的能力及其正常机能。
60. 相关医疗状况：相关医疗状况是指由已存在的医疗状况所导致或与已存在的医疗状况由同一原因导致的任何疾病、损伤或病症，包括精神疾病。
61. 续保日期：指保险单的生效日期的周年对应日。
62. 二级医疗保险：
- 如果被保险人拥有一份以上的健康保险保单，则二级医疗保险是在主医疗保险支付其部分后支付理赔的付款人。如果被保险人拥有超过一份健康保险单，则该保险单将是最后支付的健康保险单。如果被保险人购买本保险单作为二级医疗保险单，保险人将仅在以下情况下支付理赔：
- 索赔已提交给主医疗保险公司，但由于不符合资格或主医疗保险合同规定的福利限额已用尽，索赔未支付/未完全支付索赔的金额，并且
 - 未支付的索赔金额被视为本保单下的合格索赔。
- 被保险人投保本保险时，需提供被保险人主医疗保险的保险凭证复印件。
在任何情况下，我们只会支付主医疗保险未赔付的合格索赔金额的余额。
63. 双人病房：私人医院中设有两张床位的病房。豪华病房、行政病房和特需套房不包括在内。
64. 易全保综合医疗网络：如果被保险人已将保障区域扩展到全球(不包括美国)，则保险人的医疗提供者名单可提供给被保险人。
65. 专科医生：在WHO认可的医学院校就读并获得药物或手术初级学位，并获得提供治疗所在国家/地区的相关权威机构之行医资质的外科医生、麻醉师或医生，并被认为在所治疗的疾病、病症或损伤的治疗领域拥有专业资格或专业技术。术语“认可的医学院校”指列在WHO公布的世界医学院校名录中的医学院校。
66. 生效日期：保险凭证中显示的保险单生效日期。
67. 外科手术：需要切开组织并进行其他侵入性手术干预的手术。

12. 释义

- 68. 终末期疾病：**得出病症为终末期和无药可救的诊断，且无法对病症进行治愈治疗，并且确诊后12个月内可能死亡。
- 69. 治疗：**诊断、缓解、治愈某一个医疗状况所必需的手术或医疗服务（包括诊断检查）。
- 70. 疫苗：**指提供治疗的国家/地区法律所规定的全部基本免疫疫苗和加强药物注射，包括医疗上必需的任何旅行疫苗和疟疾预防。
- 71. 等待期：**指从保险单生效日或批单签发日（二者以后发生日为准）后的一定时期。在等待期内，保险人不承担某项特定保险责任。等待期结束后，该项保险责任才正式生效。
- 72. 团体：**在中国境内成立的不以购买保险为目的的合法机构，包括国有企业、高等院校、企事业单位、贸易组织和职业联盟等。
- 73. 紧急：**突然的、严重的、不可预见的急性医疗状况或需要立即进行医学治疗的损伤，如果不接受治疗，在未来48小时可能导致死亡或对身体机能造成严重损害。
- 74. WHO：**世界卫生组织。
- 75. 中医治疗或阿育吠陀治疗：**中医治疗或阿育吠陀治疗是指医疗机构以外采用传统医学教授的治疗。它们是整体治疗系统，侧重于个人而非疾病。两种系统都使用各种干预措施，包括草药、饮食和生活方式的变更。

二. 亚太财产保险有限公司

易全保团体医疗保险(2025年4月版): 保障一览表

本保障一览表仅供参考。详情请参阅保险合同条款。

保障	易全保琥珀
年度最高保障限额 所有计划均提供24/7热线和援助服务	6,300,000人民币
保障区域:	全球保障 (不含美国)
指定网络:	易全保综合医疗网络
1. 医院收费、医生和专科医生费用 a) 医院对住院或日间留院治疗的患者收取的费用包括：床位费（一般病房/双人病房或私人病房）；诊断检测费用；手术室费用（含外科医生与麻醉师收费）；合格护士护理的费用；由医生或专科医生开具的药物和敷料的费用；手术期间医生使用的手术器械费用；住院或日间留院期间手术前后的咨询费；重症监护费用。 b) 辅助器材费用：属于保障范围内并因医疗所需，在住院或日间留院接受治疗的6个月内，用于购买及租赁拐杖、支撑架、辅助行走器和自推式非电子轮椅的费用。	a)  全额赔偿 上述保障需要预先获得书面同意  b)  每个医疗状况 最高限额9,450人民币
2. 诊断程序 保险人应赔付由医疗必需而引致的实际医疗费用，包括：磁共振成像扫描(MRI)、正电子放射断层扫描(PET)和计算机断层成像扫描(CT)的费用。	 住院前和手术后扫描 全额赔偿 磁共振成像扫描(MRI)、正电子放射断层扫描(PET)和计算机断层成像扫描(CT)需要预先获得书面同意 
3. 肾衰竭和肾透析 a) 保险人应赔付被保险人住院接受肾衰竭(包括肾透析)治疗时实际产生的医疗费用。 b) 保险人应赔付被保险人日间留院或在门诊部接受肾衰竭(包括肾透析)治疗时实际产生的医疗费用。	a)  住院手术前后治疗 每个保险期内最高达6周 全额赔偿 b)  日间留院或门诊治疗 每个保险期内 最高限额310,000人民币
4. 器官移植 被保险人是器官受赠人时，有关肾脏、胰脏、肝脏、心脏、肺、骨髓、角膜的人体器官移植治疗时产生的医疗费用。 当器官移植是由先天性疾病导致时，相关医疗费用应当依照本保险合同第五条项下第7款(先天性疾病)进行赔付，此时本保险合同第五条项下第4款(器官移植)对于相关费用一概不予赔付。 保险人仅赔付满足以下条件的器官移植：在国际认可的医院并由获得认证的外科医生执行器官移植；并根据WHO指南获取的器官。 器官捐献者和寻找器官捐献者的相关医疗费用一概不予赔付。	 每个保险期内 最高限额630,000人民币
5. 癌症治疗 保险人应赔付因癌症而须住院、日间留院或门诊治疗时实际产生的医疗费用。此保障包括从诊断之时起，产生的肿瘤科医生的费用、手术费用，放射疗法和化学疗法的单项或综合费用。	 全额赔偿

保障	易全保琥珀
6. 新生儿保障 保险人应赔付被保险人的新生儿因早产（即妊娠未满37周分娩）或被保险人的新生儿在出生30日内出现急性的病症而需住院接受治疗时发生的实际医疗费用。 此保障提供的前提是新生儿在出生之日起30日内已经加入本保险合同并且投保人已支付保险费。此保障经投保人和保险人双方同意可适用于多胎分娩的情况。 如果保险人在婴儿被加入保单之前需要详细了解新生儿的病史，则保险人保留其所提供承保范围应用特别限制条款的权利。 请参阅第3条条款 — 新增新生儿保单条款有关详细信息。	每个保险期内 最高限额157,500人民币
7. 先天性疾病 保险人应赔付被保险人因先天性疾病进行住院治疗时实际产生的医疗费用。若新生儿出生30日内因先天性疾病接受治疗，将根据本保险合同第五条第6款 — 新生儿保障规定提供此类病症的保障，而本条款先天性疾病保障则不适用。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。	每个保险期内 最高限额157,500人民币
8. 家长住宿费用 保险人应赔付18周岁以下的被保险人因接受符合保障范围内的住院治疗时，其一位家长在医院陪伴过夜而实际产生的住宿费用。	全额赔偿
9. 新生儿陪伴母亲的医院住宿费用 保险人应赔付新生儿(出生16周及以下)在陪伴母亲(母亲为被保险人)接受住院治疗符合保障范围内的疾病时，医院为新生儿提供住宿而产生的实际费用。	全额赔偿
10. 整形外科手术 保险人应赔付被保险人接受整形外科手术的实际医疗费用，此整形外科手术是为了恢复正常人体的功能或外貌，同时此整形外科手术是因被保险人在保险单生效日或批单签发日(二者以后发生日为准)之后遭遇符合本保险合同保障范围的意外事故或因接受符合本保险合同保障范围内的疾病而接受了外科手术后产生。	全额赔偿
11. 日间留院和门诊手术 保险人应赔付被保险人在外科诊所、医院、日间护理中心或门诊部进行的外科手术时实际产生的治疗费用。	全额赔偿
12. 紧急住院牙科治疗 被保险人因遭遇意外事故后而必须住院一晚以上，其天然健全的牙齿因需进行紧急牙科修复治疗，保险人应按实际发生的医疗费用赔付给被保险人。 该牙科治疗必须在意外事故发生后的10日内进行。此保障包括因意外的外部撞击造成的口腔伤害而须接受治疗时产生的所有费用，但同时应满足以下条件： a) 如果上述治疗涉及更换齿冠、牙桥贴片、牙齿贴面或假牙，则保险人赔付合理惯常的费用，或赔付类似的或质量相当的更换费用； b) 如果临床角度上需要植牙，那么保险人赔付采用桥托产生的费用； c) 修复或重建在遭遇意外事故后损坏的假牙，但要求被保险人在遭遇意外事故时佩戴此类假牙。	全额赔偿
13. 康复治疗 专科医生针对被保险人所患疾病进行治疗时，推荐被保险人接受保险人认可的医院康复中心接受住院康复治疗，保险人应赔付此种情况下实际产生的康复治疗费用。但必须：被保险人连续三日住院；专科医生书面确认被保险人此时有必要接受康复治疗。应在出院后14日内办妥康复中心住院手续。上述治疗应接受专科医生的直接监管，并赔付如下费用： a) 专项治疗病房的使用费； b) 物理治疗费用； c) 语障治疗费用； d) 职业病治疗费用。	符合保障范围的住院治疗 每个医疗状况 最高达30日全额赔偿
14. 家居护理 由医生或专科医生推荐，在被保险人接受住院或日间留院治疗后，由合格护士在被保险人家中提供护理的费用。 此保障必须预先获得保险人书面同意。	不予承保

保障	易全保琥珀
15. 紧急救护运送费用 保险人应赔付陆上紧急救护交通运输工具接送或在医院之间转送途中，或经医生或专科医生认为医疗必需的交通运输工具实际产生的费用。	 全额赔偿
16. 转运和送返 a) 转运 保险人安排患有符合保障范围内的危重被保险人运送到最近的医疗机构进行住院或日间留院治疗。 赔付如下合理费用： i) 在被保险人须接受紧急治疗而事故发生地无法提供医疗上必需的救护接送与护理的情况下，运送被保险人时产生的交通费用。其中包括一名随行照料人员陪护行程中的经济舱机票。 ii) 被保险人在接受日间留院治疗期间，往返医院就诊时的当地合理交通费用。 iii) 被保险人入院后随行照料人员由于看望被保险人往返医院时产生的合理交通费用。 iv) 仅限住院前或出院后短期内，被保险人接受专科医生护理时的合理非医院住宿费用。 在保险人认可的滑雪场或类似的冬季运动场所范围之外，进行任何海空营救或山地救援时产生的转运费用一概不予赔付。 保险人的医学顾问将决定转运时的最合适的交通方式。如违背保险人医学顾问的意见，保险人不赔付交通费用。另外，如果被保险人前往的医院不具备合适医疗设施用以治疗被保险人之符合保障范围的医疗情况，则相关的交通费用将不予赔付。 b) 送返 经由医疗上必需且由保险人安排的转运之后，在被保险人完成治疗后的一个月內，在治疗地的被保险人与被保险人的一位随行照料人员将可获安排经济舱机票返回被保险人的国籍国或居住国。 此保障不包括单独送返，需要已经完成最初的医疗上必需的转运，才可赔付此符合保障范围的送返费用。 免赔额适用于此计划保障。	综合最高限额630,000人民币 该保障需要预先获得书面同意 a) 转运 i)  全额赔偿 ii)  全额赔偿 iii)  全额赔偿 iv)  每日最高限额1,200人民币 每人每次转运最高限额47,000人民币 该保障需要预先获得书面同意 b) 送返  全额赔偿
17. 遗体运送 保险人应赔付被保险人因保障范围内的医疗状况导致死亡时产生以下合理和惯常的费用： a) 将被保险人遗体或骨灰运往其国籍国或居住国时的费用，或 b) 在被保险人死亡所在地，根据合理的惯例进行土葬或火葬时产生的费用。	该保障需要预先获得书面同意 a)  全额赔偿 b)  最高限额63,000人民币
18. 保障区域以外的紧急非选择性治疗 — 在不超过30日(含30日)的计划行程 被保险人在保障区域以外若遇到意外事故或因某种突发性医疗状况而形成对被保险人的健康构成威胁的突发危重疾病，而且其在上述紧急事件之后的24小时内接受医生或专科医生提供的治疗，则保险人应赔付该期间实际产生的医疗费用。	 意外：意外后的住院和日间留院治疗全额赔偿  疾病：住院和日间留院护理 每个保险期内最高限额157,500人民币
19. 住院现金津贴 保险人应赔付被保险人在医院接受住院治疗期间每一晚的现金住院津贴，但应满足以下条件： a) 被保险人在零时前于居住国家的公立医院接受选择性住院治疗；或 b) 该计划是二级医疗保险计划。但是，如果被保险人的计划免赔额是人民币63,000或人民币94,500，被保险人不可享用此保障。 该保障仅限于每个保险期间内累计最长不超过30晚(含30晚)。 责任免除6.9条款并不适用于此保障。	 每晚最高限额790人民币

保障	易全保琥珀
年度门诊限额： 适用于保险合同第20款和21款，受年度最高保险计划限额限制。	每个保险期内 每个医疗状况手术前的 门诊医生费用， 从入院前的15日至 出院后最长30日内的 门诊费用，最高限额 4,700人民币。
20. 门诊医生费用 a) 含括咨询费在内的医生收费，专科医生费用，诊断检查费用； b) 远程医疗咨询(医生以电子方式进行远程医疗咨询)； 如果被保险人在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，符合保障范围内的治疗费用将全额赔付。 如果被保险人不是在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，则只会赔付符合保障范围内合理和惯常的医疗费用。 c) 处方药和敷料的费用； d) 维生素和矿物质。 由医生开具处方的维生素和矿物质。由医生诊断的缺乏症及由医生开具处方的维生素、矿物质和滋润眼液将按照门诊保障d赔付符合保障范围的费用。 任何手术前和出院后的门诊费用将根据此保障进行赔付。 被保险人的保障范围不包括被保险人因调理慢性疾病而承担的费用。如果被保险人根据易全保翡翠计划，易全保水晶计划保险单选项投保则保险人将在本保险合同第五条项下第20款门诊医生费用承担调理慢性疾病的治疗费用。 请注意：如果索赔收据未显示所提供医疗服务的明细，我们将仅支付不超过处方药和敷料限额的符合条件的索赔。 年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。	a) 和 b)  每个保险期内 每个医疗状况手术前的 门诊医生费用， 从入院前的15日至 出院后最长30日内的 门诊费用，最高限额 4,700人民币 c)  不予承保 d)  不予承保 a), b), c), d) 受年度最高 门诊限额限制。
21. 门诊物理治疗和替代疗法 保险人应赔付以下项目实际产生的医疗费用： a) 由获得执业许可的物理治疗师提供的物理治疗费用。 b) 被保险人接受理疗师的辅助药物和治疗，此类赔偿可包括整骨疗法、手足病治疗和足病治疗、整脊疗法、顺势疗法、饮食疗法和针灸疗法的费用。 c) 中医执业医师或阿育吠陀医学执业医师对被保险人进行门诊中医治疗或阿育吠陀治疗时实际产生的医疗费用。 此保障包括所有符合保障范围的诊断、咨询费、治疗类型、治疗费、处方(包括药物详情和剂量)。 责任免除6.41条款适用此保障。 保险期内您可选择此保障a)或b)，合计首5次治疗不需转介(饮食疗法除外)，其他后续治疗需医生或专科医生转介。 年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。	 不予承保

保障	易全保琥珀
22. 更年期激素替代治疗 需要进行激素替代治疗以缓解更年期早发症状之门诊费用，但更年期发病和治疗须始于40岁以下。	 不予承保
23. 门诊精神疾病治疗 由法定资质的心理学家及/或法定资质的精神病医生的直接管理下，被保险人接受的门诊治疗。此项保障包括10次治疗，赔付费用以本保障限额为准。 前5次就诊无需医生转介，之后的就诊则需要有医生或专科医生的转介函和治疗计划。	 不予承保
24. 牙科 保险人应赔付以下项目实际产生的医疗费用： 牙科治疗：牙科执业医生在牙科手术期间/牙科诊所进行牙科治疗的费用。牙科治疗包括： — 牙齿检查(若有必要其中包括照牙科X光)； — 预防性洗牙，抛光和窝沟封闭(每年一次)； — 补牙和拔牙(非手术和手术性)； — 根管治疗； — 新装或修复牙冠，假牙，嵌体和牙桥； — 进行牙根尖切除术； — 处方药和敷料。 不包括种植牙和牙齿矫正治疗保障。 其他牙科治疗一概不属于此类保障。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 此保障有20%的自付比例。 免赔额或门诊每次就诊免赔额并不适用于此保障。	 不予承保

附加选项	易全保琥珀
25. 中国大陆选择 保险人应赔付被保险人在中国大陆因住院、日间留院及接受门诊治疗时实际产生的符合保障范围的医疗费用。标准的保险单保障限额适用于本条。 中国大陆以外的紧急非选择性治疗： 在最长期限为30日的计划行程中，被保险人若在中国大陆以外的地区遇到意外事故或因某种突发性医疗状况而引致对其健康构成即时威胁的严重疾病，在上述紧急事件之后的24小时内接受的医生或专科医生提供的治疗。 因意外事故，需接受住院和日间留院治疗，保险人应全额赔付。 因疾病需接受住院和日间留院治疗，以投保人和保险人双方同意的最高保障限额为限。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。	 可供选项 中国大陆以外的紧急非选择性治疗，因疾病治疗的最高限额150,000人民币
26. 病房限制(住宿最高限额800人民币) 如本保险合同第五条项下第1款(a)项所述，被保险人在中国大陆住院时，每日最高限额800人民币，从而在中国大陆医院接受保障范围内的住院或日间留院治疗及任何医生的治疗。医院的定义及范围由保险人事先约定。	 可供选项 于中国大陆医院接受住院或日间留院治疗每日最高限额800人民币
27. 昂贵医院限制 保险人将事先指定某些提供住院、日间留院或门诊治疗服务的医疗机构为昂贵医院。被保险人在中国大陆任何一家昂贵医院接受承保范围内的住院、日间留院或门诊治疗及任何医学专家的治疗时，保险人将不会赔付实际产生的有关医疗费用。	 可供选项
28. 私人医院住院自付比例 对属于保障范围内在私人医院的住院或日间留院治疗时实际产生的医疗费用，被保险人需承担20%自付比例。	 可供选项 20%自付比例
29. 年度最高保障限额1,000,000人民币 在本保险合同的保险期间内，如果发生了本保险合同涵盖的医疗事项，保险人应支付保险金额不得超过相应的保障限额，且支付的总保险金金额不得超过本保险合同中规定的年度最高保障限额1,000,000人民币。	 可供选项
30. 门诊费用的自付比例 保险人应赔付被保险人符合保障范围内的门诊治疗实际产生的医疗费用，但门诊治疗有20%的自付比例。 自付比例并不适用于以下治疗：肾透析/肾衰竭、癌症或器官移植。 但此项不适用于6,300人民币免赔额或更高免赔额之计划。 如果被保险人的保险单中含有生育保障、牙科保障或体检、疫苗保障，其相应的自付额将会在被保险人的保障一览表中列明。	 不予承保
31. 门诊每次就诊免赔额 被保险人接受属于保障范围的门诊治疗时，门诊每次就诊设有150人民币免赔额。 门诊每次就诊免赔额并不适用于肾透析/肾衰竭、癌症或器官移植的治疗。 但此项不适用于6,300人民币免赔额或更高免赔额之计划。	 不予承保
32. 取消药物和敷料限额 通过选择此选项，保障20 c)下的处方药和敷料将全额赔偿，但受年度最高门诊限额限制。 适用于3名员工或以上的统一投保的团体保险单。	 不予承保

附加选项	易全保琥珀
33. 体检和疫苗 — 选项1 适用于3名员工或以上的统一投保的团体保险单。 a) 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查(如直系家属有病史)、骨密度检查(50周岁以上女性被保险人每5年可做1次)、心血管系统检查，神经系统检查、生命体征检查(例如，血压、体重指数、尿分析和胆固醇)、儿童体检(至5周岁)的费用和/或 b) 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。 责任免除6.9条款并不适用于此保障。	a)  不予承保 b)  不予承保
34. 体检和疫苗 — 选项2 适用于3名员工或以上的统一投保的团体保险单。 a) 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查(如直系家属有病史)、骨密度检查(50周岁以上女性被保险人每5年可做1次)、心血管系统检查，神经系统检查、生命体征检查(例如，血压、体重指数、尿分析和胆固醇)、儿童体检(至5周岁)的费用和/或 b) 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。 责任免除6.9条款并不适用于此保障。	a)  不予承保 b)  不予承保
35. 生育保障 — 选项1 a) 被保险人怀孕或分娩期间实际产生的医疗必需费用；包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。 请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。 b) 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。 — 子宫外孕(胚胎在子宫以外的部位著床发育)； — 葡萄胎(异常细胞在子宫内生长)； — 胎盘滞留(胚胎滞留在子宫内)； — 前置胎盘； — 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)； — 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)； — 产后出血(分娩后多个小时及多日大出血)； — 需要实时接受外科治疗的流产。 本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。 适用于10名或以上的团体保单。 责任免除6.27条款并不适用于此保障。 免赔额适用于此保障。	a)  不予承保 b)  不予承保

附加选项	易全保琥珀
36. 生育保障 — 选项2 a) 被保险人怀孕或分娩期间实际产生的医疗必需费用：包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。 请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。 b) 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。 — 宫外孕(胚胎在子宫以外的部位着床发育)； — 葡萄胎(异常细胞在子宫内生长)； — 胎盘滞留(胚胎滞留在子宫内)； — 前置胎盘； — 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)； — 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)； — 产后出血(分娩后多个小时及多日大出血)； — 需要实时接受外科治疗的流产。 本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。 适用于10名或以上的团体保单。 责任免除6.27条款并不适用于此保障。 免赔额适用于此保障。	a)  不予承保 b)  不予承保

核保选项	易全保琥珀
37. 已声明的既往病症的限额 只适用于5-19名员工的统一投保的团体保险单。 此核保选项为已向保险人声明并被保险人接受的既往病症提供有限的承保。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。	 可供选项 只适用于5-19名员工的统一投保的团体保险单 等待期结束后： 每个已声明的既往病症的 限额12,600人民币 等待期结束后和 团体计划来年续保后： 每个保险期内 每个已声明的既往病症的 限额25,200人民币
38. 既往病史不告 适用于10名员工或以上的统一投保的团体保险单。	 可供选项

免赔额选项	易全保琥珀
标准免赔额	3,150人民币
自选免赔额 请注意：63,000人民币或94,500人民币免赔额仅适用于拥有不止一份健康保险单的投保人。如果投保人购买本保险单作为二级医疗保险单，投保人只能选择63,000人民币或94,500人民币免赔额选项。被保险人投保本保险时，需提供投保人主医疗保险的保险详情。	零 950人民币 1,570人民币 6,300人民币 15,700人民币 31,500人民币 63,000人民币 94,500人民币

本保障一览表仅供参考。详情请参阅保险合同条款。

保障	易全保翡翠
年度最高保障限额 所有计划均提供24/7热线和援助服务	9,450,000人民币
保障区域:	全球保障 (不含美国)
指定网络:	易全保综合医疗网络
1. 医院收费、医生和专科医生费用 a) 医院对住院或日间留院治疗的患者收取的费用包括：床位费（一般病房/双人病房或私人病房）；诊断检测费用；手术室费用（含外科医生与麻醉师收费）；合格护士护理的费用；由医生或专科医生开具的药物和敷料的费用；手术期间医生使用的手术器械费用；住院或日间留院期间手术前后的咨询费；重症监护费用。 b) 辅助器材费用：属于保障范围内并因医疗所需，在住院或日间留院接受治疗的6个月内，用于购买及租赁拐杖、支撑架、辅助行走器和自推式非电子轮椅的费用。	a)  全额赔偿 上述保障需要预先 获得书面同意  b)  每个医疗状况 最高限额9,450人民币
2. 诊断程序 保险人应赔付由医疗必需而引致的实际医疗费用，包括：磁共振成像扫描(MRI)、正电子放射断层扫描(PET)和计算机断层成像扫描(CT)的费用。	 住院、日间留院或 门诊全额赔偿 磁共振成像扫描(MRI)、 正电子放射断层扫描(PET)和 计算机断层成像扫描(CT)， 需要预先获得书面同意 
3. 肾衰竭和肾透析 a) 保险人应赔付被保险人住院接受肾衰竭(包括肾透析)治疗时实际产生的医疗费用。 b) 保险人应赔付被保险人日间留院或在门诊部接受肾衰竭(包括肾透析)治疗时实际产生的医疗费用。	a)  每个保险期内住院 最高达6周全额赔偿 b)  日间留院或门诊治疗 每个保险期内 最高限额310,000人民币
4. 器官移植 被保险人是器官受赠人时，有关肾脏、胰脏、肝脏、心脏、肺、骨髓、角膜的人体器官移植治疗时产生的医疗费用。 当器官移植是由先天性疾病导致时，相关医疗费用应当依照本合同第五条项下第7款(先天性疾病)进行赔付，此时本合同第五条项下第4款(器官移植)对于相关费用一概不予赔付。 保险人仅赔付满足以下条件的器官移植：在国际认可的医院并由获得认证的外科医生执行器官移植；并根据WHO指南获取的器官。 器官捐献者和寻找器官捐献者的相关医疗费用一概不予赔付。	 每个保险期内 最高限额945,000人民币
5. 癌症治疗 保险人应赔付因癌症而须住院、日间留院或门诊治疗时实际产生的医疗费用。此保障包括从诊断之时起，产生的肿瘤科医生的费用、手术费用，放射疗法和化学疗法的单项或综合费用。	 全额赔偿

保障	易全保翡翠
6. 新生儿保障 保险人应赔付被保险人的新生儿因早产（即妊娠未满37周分娩）或被保险人的新生儿在出生30日内出现急性的病症而需住院接受治疗时而发生的实际医疗费用。 此保障提供的前提是新生儿在出生之日起30日内已经加入本保险合同并且投保人已支付保险费。此保障经投保人和保险人双方同意可适用于多胎分娩的情况。 如果保险人在婴儿被加入保单之前需要详细了解新生儿的病史，则保险人保留其对所提供承保范围应用特别限制条款的权利。 请参阅第3条条款 — 新增新生儿保单条款有关详细信息。	每个保险期内 最高限额220,500人民币
7. 先天性疾病 保险人应赔付被保险人因先天性疾病进行住院治疗时实际产生的医疗费用。若新生儿出生30日内因先天性疾病接受治疗，将根据本保险合同第五条第6款 — 新生儿保障规定提供此类病症的保障，而本条款先天性疾病保障则不适用。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。	每个保险期内 最高限额220,500人民币
8. 家长住宿费用 保险人应赔付18周岁以下的被保险人因接受符合保障范围内的住院治疗时，其一位家长在医院陪伴过夜而实际产生的住宿费用。	全额赔偿
9. 新生儿陪伴母亲的医院住宿费用 保险人应赔付新生儿(出生16周及以下)在陪伴母亲(母亲为被保险人)接受住院治疗符合保障范围内的疾病时，医院为新生儿提供住宿而产生的实际费用。	全额赔偿
10. 整形外科手术 保险人应赔付被保险人接受整形外科手术的实际医疗费用，此整形外科手术是为了恢复正常人体的功能或外貌，同时此整形外科手术是因被保险人在保险单生效日或批单签发日(二者以后发生日为准)之后遭遇符合本保险合同保障范围的意外事故或因接受符合本保险合同保障范围内的疾病而接受了外科手术后产生。	全额赔偿
11. 日间留院和门诊手术 保险人应赔付被保险人在外科诊所、医院、日间护理中心或门诊部进行的外科手术时实际产生的治疗费用。	全额赔偿
12. 紧急住院牙科治疗 被保险人因遭遇意外事故后而必须住院一晚以上，其天然健全的牙齿因需进行紧急牙科修复治疗，保险人应按实际发生的医疗费用赔付给被保险人。 该牙科治疗必须在意外事故发生后的10日内进行。此保障包括因意外的外部撞击造成的口腔伤害而须接受治疗时产生的所有费用，但同时应满足以下条件： a) 如果上述治疗涉及更换齿冠、牙桥贴片、牙齿贴面或假牙，则保险人赔付合理惯常的费用，或赔付类似的或质量相当的更换费用； b) 如果临床角度上需要植牙，那么保险人赔付采用桥托产生的费用； c) 修复或重建在遭遇意外事故后损坏的假牙，但要求被保险人在遭遇意外事故时佩戴此类假牙。	全额赔偿
13. 康复治疗 专科医生针对被保险人所患疾病进行治疗时，推荐被保险人接受保险人认可的医院康复中心接受住院康复治疗，保险人应赔付此种情况下实际产生的康复治疗费用。但必须：被保险人连续三日住院；专科医生书面确认被保险人此时有必要接受康复治疗。应在出院后14日内办妥康复中心住院手续。上述治疗应接受专科医生的直接监督，并赔付如下费用： a) 专项治疗病房的使用费； b) 物理治疗费用； c) 语障治疗费用； d) 职业病治疗费用。	每个医疗状况 最高达90日全额赔偿
14. 家居护理 由医生或专科医生推荐，在被保险人接受住院或日间留院治疗后，由合格护士在被保险人家中提供护理的费用。 此保障必须预先获得保险人书面同意。	每个医疗状况 最高达30日全额赔偿 此保障需要预先 获得书面同意

保障	易全保翡翠
15. 紧急救护运送费用 保险人应赔付陆上紧急救护交通运输工具接送或在医院之间转送途中，或经医生或专科医生认为医疗必需的交通运输工具实际产生的费用。	 全额赔偿
16. 转运和送返 a) 转运 保险人安排患有符合保障范围内的危重被保险人运送到最近的医疗机构进行住院或日间留院治疗。 赔付如下合理费用： i) 在被保险人须接受紧急治疗而事故发生地无法提供医疗上必需的救护接送与护理的情况下，运送被保险人时产生的交通费用。其中包括一名随行照料人员陪护行程中的经济舱机票。 ii) 被保险人在接受日间留院治疗期间，往返医院就诊时的当地合理交通费用。 iii) 被保险人入院后随行照料人员由于看望被保险人往返医院时产生的合理交通费用。 iv) 仅限住院前或出院后短期内，被保险人接受专科医生护理时的合理非医院住宿费用。 在保险人认可的滑雪场或类似的冬季运动场所范围之外，进行任何海空营救或山地救援时产生的转运费用一概不予赔付。 保险人的医学顾问将决定转运时的最合适的交通方式。如违背保险人医学顾问的意见，保险人不赔付交通费用。另外，如果被保险人前往的医院不具备合适医疗设施用以治疗被保险人之符合保障范围的医疗情况，则相关的交通费用将不予赔付。 b) 送返 经由医疗上必需且由保险人安排的转运之后，在被保险人完成治疗后的一个月內，在治疗地的被保险人与被保险人的一位随行照料人员将可获安排经济舱机票返回被保险人的国籍国或居住国。 此保障不包括单独送返，需要已经完成最初的医疗上必需的转运，才可赔付此符合保障范围的送返费用。 免赔额适用于此计划保障。	综合最高限额630,000人民币 该保障需要预先获得书面同意 a) 转运 i)  全额赔偿 ii)  全额赔偿 iii)  全额赔偿 iv)  每日最高限额1,200人民币 每人每次转运最高限额47,000人民币 该保障需要预先获得书面同意 b) 送返  全额赔偿
17. 遗体运送 保险人应赔付被保险人因保障范围内的医疗状况导致死亡时产生以下合理和惯常的费用： a) 将被保险人遗体或骨灰运往其国籍国或居住国时的费用，或 b) 在被保险人死亡所在地，根据合理的惯例进行土葬或火葬时产生的费用。	该保障需要预先获得书面同意 a)  全额赔偿 b)  最高限额63,000人民币
18. 保障区域以外的紧急非选择性治疗 — 在不超过30日(含30日)的计划行程 被保险人在保障区域以外若遇到意外事故或因某种突发性医疗状况而形成对被保险人的健康构成威胁的突发危重疾病，而且其在上述紧急事件之后的24小时内接受医生或专科医生提供的治疗，则保险人应赔付该期间实际产生的医疗费用。	 意外：意外后的住院和日间留院治疗全额赔偿  疾病：住院和日间留院护理 每个保险期内最高限额220,500人民币
19. 住院现金津贴 保险人应赔付被保险人在医院接受住院治疗期间每一晚的现金住院津贴，但应满足以下条件： a) 被保险人在零时前于居住国家的公立医院接受选择性住院治疗；或 b) 该计划是二级医疗保险计划。但是，如果被保险人的计划免赔额是人民币63,000或人民币94,500，被保险人不可享用此保障。 该保障仅限于每个保险期间内累计最长不超过30晚(含30晚)。 责任免除6.9条款并不适用于此保障。	 每晚最高限额1,575人民币

保障	易全保翡翠
年度门诊限额： 适用于保险合同第20款和21款，受年度最高保险计划限额限制。	年度门诊限额： 6,300人民币
20. 门诊医生费用 a) 含括咨询费在内的医生收费，专科医生费用，诊断检查费用； b) 远程医疗咨询(医生以电子方式进行远程医疗咨询)； 如果保险人在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，符合保障范围内的治疗费用将全额赔付。 如果被保险人不是在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，则只会赔付符合保障范围内合理和惯常的医疗费用。 c) 处方药和敷料的费用； d) 维生素和矿物质。 由医生开具处方的维生素和矿物质。由医生诊断的缺乏症及由医生开具处方的维生素、矿物质和滋润眼液将按照门诊保障d赔付符合保障范围的费用。 任何手术前和出院后的门诊费用将根据此保障进行赔付。 被保险人的保障范围不包括被保险人因调理慢性疾病而承担的费用。 如果被保险人根据易全保翡翠计划，易全保水晶计划保险单选项投保则保险人将在本保险合同第五条项下第20款门诊医生费用承担调理慢性疾病的治疗费用。 请注意：如果索赔收据未显示所提供医疗服务的明细，我们将仅支付不超过处方药和敷料限额的符合条件的索赔。 年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。	a) 和 b)  全额赔偿受年度最高门诊限额限制 c)  全额赔偿受年度最高门诊限额限制 d)  每个保险期内最高限额940人民币 a), b), c), d) 受年度最高门诊限额限制。
21. 门诊物理治疗和替代疗法 保险人应赔付以下项目实际产生的医疗费用： a) 由获得执业许可的物理治疗师提供的物理治疗费用。 b) 被保险人接受理疗师的辅助药物和治疗，此类赔偿可包括整骨疗法、手足病治疗和足病治疗、整脊疗法、顺势疗法、饮食疗法和针灸疗法的费用。 c) 中医执业医师或阿育吠陀医学执业医师对被保险人进行门诊中医治疗或阿育吠陀治疗时实际产生的医疗费用。 此保障包括所有符合保障范围的诊断、咨询费、治疗类型、治疗费、处方(包括药物详情和剂量)。 责任免除6.41条款适用此保障。 保险期内您可选择此保障a)或b)，合计首5次治疗不需转介(饮食疗法除外)，其他后续治疗需医生或专科医生转介。 年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。	a)  每次380人民币 b)  每次380人民币 c)  每次190人民币 每个保险期内a), b), c) 综合最高达10次，受年度最高门诊限额限制

保障	易全保翡翠
22. 更年期激素替代治疗 需要进行激素替代治疗以缓解更年期早发症状之门诊费用，但更年期发病和治疗须始于40岁以下。	 每个保险期内 最高限额1,200人民币
23. 门诊精神疾病治疗 由法定资质的心理学家及/或法定资质的精神病医生的直接管理下，被保险人接受的门诊治疗。 此项保障包括10次治疗，赔付费用以本保障限额为准。 前5次就诊无需医生转介，之后的就诊则需要有医生或专科医生的转介函和治疗计划。	 每个保险期内最高10次， 综合最高限额1,850人民币
24. 牙科 保险人应赔付以下项目实际产生的医疗费用： 牙科治疗：牙科执业医生在牙科手术期间/牙科诊所进行牙科治疗的费用。牙科治疗包括： — 牙齿检查(若有必要其中包括照牙科X光)； — 预防性洗牙，抛光和窝沟封闭(每年一次)； — 补牙和拔牙(非手术和手术性)； — 根管治疗； — 新装或修复牙冠，假牙，嵌体和牙桥； — 进行牙根尖切除术； — 处方药和敷料。 不包括种植牙和牙齿矫正治疗保障。 其他牙科治疗一概不属于此类保障。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 此保障有20%的自付比例。 免赔额或门诊每次就诊免赔额并不适用于此保障。	 不予承保

附加选项	易全保翡翠
25. 中国大陆选择 保险人应赔付被保险人在中国大陆因住院、日间留院及接受门诊治疗时实际产生的符合保障范围的医疗费用。标准的保险单保障限额适用于本条。 中国大陆以外的紧急非选择性治疗： 在最长期限为30日的计划行程中，被保险人若在中国大陆以外的地区遇到意外事故或因某种突发性医疗状况而引致对其健康构成即时威胁的严重疾病，在上述紧急事件之后的24小时内接受的医生或专科医生提供的治疗。 因意外事故，需接受住院和日间留院治疗，保险人应全额赔付。 因疾病需接受住院和日间留院治疗，以投保人和保险人双方同意的最高保障限额为限。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。	 可供选项 中国大陆以外的紧急非选择性治疗，因疾病治疗的最高限额150,000人民币
26. 病房限制(住宿最高限额800人民币) 如本保险合同第五条项下第1款(a)项所述，被保险人在中国大陆住院时，每日最高限额800人民币，从而在中国大陆医院接受保障范围内的住院或日间留院治疗及任何医生的治疗。医院的定义及范围由保险人事先约定。	 可供选项 于中国大陆医院接受住院或日间留院治疗每日最高限额800人民币
27. 昂贵医院限制 保险人将事先指定某些提供住院、日间留院或门诊治疗服务的医疗机构为昂贵医院。被保险人在中国大陆任何一家昂贵医院接受承保范围内的住院、日间留院或门诊治疗及任何医学专家的治疗时，保险人将不会赔付实际产生的有关医疗费用。	 可供选项
28. 私人医院住院自付比例 对属于保障范围内在私人医院的住院或日间留院治疗时实际产生的医疗费用，被保险人需承担20%自付比例。	 可供选项 20%自付比例
29. 年度最高保障限额1,000,000人民币 在本保险合同的保险期间内，如果发生了本保险合同涵盖的医疗事项，保险人应支付保险金额不得超过相应的保障限额，且支付的总保险金额不得超过本保险合同中规定的年度最高保障限额1,000,000人民币。	 可供选项
30. 门诊费用的自付比例 保险人应赔付被保险人符合保障范围内的门诊治疗实际产生的医疗费用，但门诊治疗有20%的自付比例。 自付比例并不适用于以下治疗：肾透析/肾衰竭、癌症或器官移植。 但此项不适用于6,300人民币免赔额或更高免赔额之计划。 如果被保险人的保险单中含有生育保障、牙科保障或体检、疫苗保障，其相应的自付额将会在被保险人的保障一览表中列明。	 可供选项
31. 门诊每次就诊免赔额 被保险人接受属于保障范围的门诊治疗时，门诊每次就诊设有150人民币免赔额。 门诊每次就诊免赔额并不适用于肾透析/肾衰竭、癌症或器官移植的治疗。 但此项不适用于6,300人民币免赔额或更高免赔额之计划。	 可供选项 150人民币
32. 取消药物和敷料限额 通过选择此选项，保障 20 c) 下的处方药和敷料将全额赔偿，但受年度最高门诊限额限制。适用于3名员工或以上的统一投保的团体保险单。	 不予承保

附加选项	易全保翡翠
33. 体检和疫苗 — 选项1 适用于3名员工或以上的统一投保的团体保险单。 a) 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查(如直系亲属有病史)、骨密度检查(50周岁以上女性被保险人每5年可做1次)、心血管系统检查，神经系统检查、生命体征检查(例如，血压、体重指数、尿分析和胆固醇)、儿童体检(至5周岁)的费用和/或 b) 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。 责任免除6.9条款并不适用于此保障。	 可供选项 a) 和 b)  每个保险期内的 综合最高限额950人民币
34. 体检和疫苗 — 选项2 适用于3名员工或以上的统一投保的团体保险单。 a) 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查(如直系亲属有病史)、骨密度检查(50周岁以上女性被保险人每5年可做1次)、心血管系统检查，神经系统检查、生命体征检查(例如，血压、体重指数、尿分析和胆固醇)、儿童体检(至5周岁)的费用和/或 b) 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。 责任免除6.9条款并不适用于此保障。	 可供选项 a) 和 b)  每个保险期内的 综合最高限额1,570人民币
35. 生育保障 — 选项1 a) 被保险人怀孕或分娩期间实际产生的医疗必需费用；包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿婴儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。 请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。 b) 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。 — 宫外孕(胚胎在子宫以外的部位着床发育)； — 葡萄胎(异常细胞在子宫内生长)； — 胎盘滞留(胚胎滞留在子宫内)； — 前置胎盘； — 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)； — 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)； — 产后出血(分娩后多个小时及多日大出血)； — 需要实时接受外科治疗的流产。 本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。 适用于10名或以上的团体保单。 责任免除6.27条款并不适用于此保障。 免赔额适用于此保障。	 可供选项 适用于10名或以上的 团体保单 a)  每个保险期内 最高限额31,500人民币 b)  每个保险期内 最高限额75,600人民币

附加选项	易全保翡翠
36. 生育保障 — 选项2 a) 被保险人怀孕或分娩期间实际产生的医疗必需费用；包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。 请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。 b) 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。 — 宫外孕(胚胎在子宫以外的部位著床发育)； — 葡萄胎(异常细胞在子宫内生长)； — 胎盘滞留(胚胎滞留在子宫内)； — 前置胎盘； — 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)； — 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)； — 产后出血(分娩后多个小时及多日大出血)； — 需要实时接受外科治疗的流产。 本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。 适用于10名或以上的团体保单。 责任免除6.27条款并不适用于此保障。 免赔额适用于此保障。	可供选项 适用于10名或以上的团体保单 a) 每个保险期内最高限额44,100人民币 b) 每个保险期内最高限额94,500人民币

核保选项	易全保翡翠
37. 已声明的既往病症的限额 只适用于5-19名员工的统一投保的团体保险单。 此核保选项为已向保险人声明并被保险人接受的既往病症提供有限的承保。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。	 可供选项 只适用于5-19名员工的统一投保的团体保险单 等待期结束后： 每个已声明的既往病症的 限额12,600人民币 等待期结束后和 团体计划来年续保后： 每个保险期内 每个已声明的既往病症的 限额25,200人民币
38. 既往病史不告 适用于10名员工或以上的统一投保的团体保险单。	 可供选项

免赔额选项	易全保翡翠
标准免赔额	3,150人民币
自选免赔额 请注意：63,000人民币或94,500人民币免赔额仅适用于拥有不止一份健康保险单的投保人。如果投保人购买本保险单作为二级医疗保险单，投保人只能选择63,000人民币或94,500人民币免赔额选项。被保险人投保本保险时，需提供投保人主医疗保险的保险详情。	零 950人民币 1,570人民币 6,300人民币 15,700人民币 31,500人民币 63,000人民币 94,500人民币

本保障一览表仅供参考。详情请参阅保险合同条款。

保障	易全保水晶
年度最高保障限额 所有计划均提供24/7热线和援助服务	9,450,000人民币
保障区域:	全球保障 (不含美国)
指定网络:	易全保综合医疗网络
1. 医院收费、医生和专科医生费用 a) 医院对住院或日间留院治疗的患者收取的费用包括：床位费（一般病房/双人病房或私人病房）；诊断检测费用；手术室费用（含外科医生与麻醉师收费）；合格护士护理的费用；由医生或专科医生开具的药物和敷料的费用；手术期间医生使用的手术器械费用；住院或日间留院期间手术前后的咨询费；重症监护费用。 b) 辅助器材费用：属于保障范围内并因医疗所需，在住院或日间留院接受治疗的6个月内，用于购买及租赁拐杖、支撑架、辅助行走器和自推式非电子轮椅的费用。	a)  全额赔偿 上述保障需要预先获得书面同意  b)  每个医疗状况 最高限额9,450人民币
2. 诊断程序 保险人应赔付由医疗必需而引致的实际医疗费用，包括：磁共振成像扫描(MRI)、正电子放射断层扫描(PET)和计算机断层成像扫描(CT)的费用。	 住院、日间留院或 门诊全额赔偿 磁共振成像扫描(MRI)、 正电子放射断层扫描(PET)和 计算机断层成像扫描(CT)。 需要预先获得书面同意 
3. 肾衰竭和肾透析 a) 保险人应赔付被保险人住院接受肾衰竭(包括肾透析)治疗时实际产生的医疗费用。 b) 保险人应赔付被保险人日间留院或在门诊部接受肾衰竭(包括肾透析)治疗时实际产生的医疗费用。	a)  每个保险期内住院 最高达6周全额赔偿 b)  日间留院或门诊治疗 每个保险期内 最高限额310,000人民币
4. 器官移植 被保险人是器官受赠人时，有关肾脏、胰脏、肝脏、心脏、肺、骨髓、角膜的人体器官移植治疗时产生的医疗费用。 当器官移植是由先天性疾病导致时，相关医疗费用应当依照本保险合同第五条项下第7款(先天性疾病)进行赔付，此时本保险合同第五条项下第4款(器官移植)对于相关费用一概不予赔付。 保险人仅赔付满足以下条件的器官移植：在国际认可的医院并由获得认证的外科医生执行器官移植；并根据WHO指南获取的器官。 器官捐献者和寻找器官捐献者的相关医疗费用一概不予赔付。	 每个保险期内 最高限额945,000人民币
5. 癌症治疗 保险人应赔付因癌症而须住院、日间留院或门诊治疗时实际产生的医疗费用。此保障包括从诊断之时起，产生的肿瘤科医生的费用、手术费用，放射疗法和化学疗法的单项或综合费用。	 全额赔偿

保障	易全保水晶
6. 新生儿保障 保险人应赔付被保险人的新生儿因早产（即妊娠未满37周分娩）或被保险人的新生儿在出生30日内出现急性的病症而需住院接受治疗时发生的实际医疗费用。 此保障提供的前提是新生儿在出生之日起30日内已经加入本保险合同并且投保人已支付保险费。此保障经投保人和保险人双方同意可适用于多胎分娩的情况。 如果保险人在婴儿被加入保单之前需要详细了解新生儿的病史，则保险人保留其对所提供承保范围应用特别限制条款的权利。 请参阅第3条条款 — 新增新生儿保单条款有关详细信息。	每个保险期内 最高限额220,500人民币
7. 先天性疾病 保险人应赔付被保险人因先天性疾病进行住院治疗时实际产生的医疗费用。若新生儿出生30日内因先天性疾病接受治疗，将根据本保险合同第五条第6款 — 新生儿保障规定提供此类病症的保障，而本条款先天性疾病保障则不适用。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。	每个保险期内 最高限额220,500人民币
8. 家长住宿费用 保险人应赔付18周岁以下的被保险人因接受符合保障范围内的住院治疗时，其一位家长在医院陪伴过夜而实际产生的住宿费用。	全额赔偿
9. 新生儿陪伴母亲的医院住宿费用 保险人应赔付新生儿(出生16周及以下)在陪伴母亲(母亲为被保险人)接受住院治疗符合保障范围内的疾病时，医院为新生儿提供住宿而产生的实际费用。	全额赔偿
10. 整形外科手术 保险人应赔付被保险人接受整形外科手术的实际医疗费用，此整形外科手术是为了恢复正常人体的功能或外貌，同时此整形外科手术是因被保险人在保险单生效日或批单签发日(二者以后发生日为准)之后遭遇符合本保险合同保障范围的意外事故或因接受符合本保险合同保障范围内的疾病而接受了外科手术后产生。	全额赔偿
11. 日间留院和门诊手术 保险人应赔付被保险人在外科诊所、医院、日间护理中心或门诊部进行的外科手术时实际产生的治疗费用。	全额赔偿
12. 紧急住院牙科治疗 被保险人因遭遇意外事故后而必须住院一晚以上，其天然健全的牙齿因需进行紧急牙科修复治疗，保险人应按实际发生的医疗费用赔付给被保险人。 该牙科治疗必须在意外事故发生后的10日内进行。此保障包括因意外的外部撞击造成的口腔伤害而须接受治疗时产生的所有费用，但同时应满足以下条件： a) 如果上述治疗涉及更换齿冠、牙桥贴片、牙齿贴面或假牙，则保险人赔付合理惯常的费用，或赔付类似的或质量相当的更换费用； b) 如果临床角度上需要植牙，那么保险人赔付采用桥托产生的费用； c) 修复或重建在遭遇意外事故后损坏的假牙，但要求被保险人在遭遇意外事故时佩戴此类假牙。	全额赔偿
13. 康复治疗 专科医生针对被保险人所患疾病进行治疗时，推荐被保险人接受保险人认可的医院康复中心接受住院康复治疗，保险人应赔付此种情况下实际产生的康复治疗费用。但必须：被保险人连续三日住院；专科医生书面确认被保险人此时有必要接受康复治疗。应在出院后14日内办妥康复中心住院手续。上述治疗应接受专科医生的直接监管，并赔付如下费用： a) 专项治疗病房的使用费； b) 物理治疗费用； c) 语言治疗费用； d) 职业病治疗费用。	每个医疗状况 最高达90日全额赔偿
14. 家居护理 由医生或专科医生推荐，在被保险人接受住院或日间留院治疗后，由合格护士在被保险人家中提供护理的费用。 此保障必须预先获得保险人书面同意。	每个医疗状况 最高达30日全额赔偿 此保障需要预先 获得书面同意

保障	易全保水晶
15. 紧急救护运送费用 保险人应赔付陆上紧急救护交通运输工具接送或在医院之间转送途中，或经医生或专科医生认为医疗必需的交通运输工具实际产生的费用。	 全额赔偿
16. 转运和送返 a) 转运 保险人安排患有符合保障范围内的危重被保险人运送到最近的医疗机构进行住院或日间留院治疗。 赔付如下合理费用： i) 在被保险人须接受紧急治疗而事故发生地无法提供医疗上必需的救护接送与护理的情况下，运送被保险人时产生的交通费用。其中包括一名随行照料人员陪护行程中的经济舱机票。 ii) 被保险人在接受日间留院治疗期间，往返医院就诊时的当地合理交通费用。 iii) 被保险人入院后随行照料人员由于看望被保险人往返医院时产生的合理交通费用。 iv) 仅限住院前或出院后短期内，被保险人接受专科医生护理时的合理非医院住宿费用。 在保险人认可的滑雪场或类似的冬季运动场所范围之外，进行任何海空营救或山地救援时产生的转运费用一概不予赔付。 保险人的医学顾问将决定转运时的最合适的交通方式。如违背保险人医学顾问的意见，保险人不赔付交通费用。另外，如果被保险人前往的医院不具备合适医疗设施用以治疗被保险人之符合保障范围的医疗情况，则相关的交通费用将不予赔付。 b) 送返 经由医疗上必需且由保险人安排的转运之后，在被保险人完成治疗后的一个月內，在治疗地的被保险人与被保险人的一位随行照料人员将可获安排经济舱机票返回被保险人的国籍国或居住国。 此保障不包括单独送返，需要已经完成最初的医疗上必需的转运，才可赔付此符合保障范围的送返费用。 免赔额适用于此计划保障。	综合最高限额630,000人民币 该保障需要预先获得书面同意 a) 转运 i)  全额赔偿 ii)  全额赔偿 iii)  全额赔偿 iv)  每日最高限额1,200人民币 每人每次转运最高限额47,000人民币 该保障需要预先获得书面同意 b) 送返  全额赔偿
17. 遗体运送 保险人应赔付被保险人因保障范围内的医疗状况导致死亡时产生以下合理和惯常的费用： a) 将被保险人遗体或骨灰运往其国籍国或居住国时的费用，或 b) 在被保险人死亡所在地，根据合理的惯例进行土葬或火葬时产生的费用。	该保障需要预先获得书面同意 a)  全额赔偿 b)  最高限额63,000人民币
18. 保障区域以外的紧急非选择性治疗 — 在不超过30日(含30日)的计划行程 被保险人在保障区域以外若遇到意外事故或因某种突发性医疗状况而形成对被保险人的健康构成威胁的突发危重疾病，而且其在上述紧急事件之后的24小时内接受医生或专科医生提供的治疗，则保险人应赔付该期间实际产生的医疗费用。	 意外：意外后的住院和日间留院治疗全额赔偿  疾病：住院和日间留院护理 每个保险期内最高限额220,500人民币
19. 住院现金津贴 保险人应赔付被保险人在医院接受住院治疗期间每一晚的现金住院津贴，但应满足以下条件： a) 被保险人在零时前于居住国家的公立医院接受选择性住院治疗；或 b) 该计划是二级医疗保险计划。但是，如果被保险人的计划免赔额是人民币63,000或人民币94,500，被保险人不可享用此保障。 该保障仅限于每个保险期间内累计最长不超过30晚(含30晚)。 责任免除6.9条款并不适用于此保障。	 每晚最高限额1,575人民币

保障	易全保水晶
年度门诊限额： 适用于保险合同第20款和21款，受年度最高保险计划限额限制。	年度门诊限额： 15,750人民币
20. 门诊医生费用 a) 含括咨询费在内的医生收费，专科医生费用，诊断检查费用； b) 远程医疗咨询(医生以电子方式进行远程医疗咨询)； 如果被保险人在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，符合保障范围内的治疗费用将全额赔付。 如果被保险人不是在时康国际公布的易全保综合医疗网络内列明的医疗服务提供方接受治疗，则只会赔付符合保障范围内合理和惯常的医疗费用。 c) 处方药和敷料的费用； d) 维生素和矿物质。 由医生开具处方的维生素和矿物质。由医生诊断的缺乏症及由医生开具处方的维生素、矿物质和滋润眼液将按照门诊保障d赔付符合保障范围的费用。 任何手术前和出院后的门诊费用将根据此保障进行赔付。 被保险人的保障范围不包括被保险人因调理慢性疾病而承担的费用。如果被保险人根据易全保翡翠计划，易全保水晶计划保险单选项投保则保险人将在本保险合同第五条项下第20款门诊医生费用承担调理慢性疾病的治疗费用。 请注意：如果索赔收据未显示所提供医疗服务的明细，我们将仅支付不超过处方药和敷料限额的符合条件的索赔。 年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。	a) 和 b)  全额赔偿受年度最高门诊限额限制 c)  每个保险期内最高限额7,875人民币 d)  每个保险期内最高限额940人民币 a), b), c), d) 受年度最高门诊限额限制。
21. 门诊物理治疗和替代疗法 保险人应赔付以下项目实际产生的医疗费用： a) 由获得执业许可的物理治疗师提供的物理治疗费用。 b) 被保险人接受理疗师的辅助药物和治疗，此类赔偿可包括整骨疗法、手足病治疗和足病治疗、整脊疗法、顺势疗法、饮食疗法和针灸疗法的费用。 c) 中医执业医师或阿育吠陀医学执业医师对被保险人进行门诊中医治疗或阿育吠陀治疗时实际产生的医疗费用。 此保障包括所有符合保障范围的诊断、咨询费、治疗类型、治疗费、处方(包括药物详情和剂量)。 责任免除6.41条款适用此保障。 保险期内您可选择此保障a)或b)，合计首5次治疗不需转介(饮食疗法除外)，其他后续治疗需医生或专科医生转介。 年度门诊限额：适用于保险合同第20款和21款，受年度最高保险计划限额限制。	a)  每次500人民币 b)  每次500人民币 c)  每次250人民币 每个保险期内a), b), c) 综合最高达10次，受年度最高门诊限额限制

保障	易全保水晶
22. 更年期激素替代治疗 需要进行激素替代治疗以缓解更年期早发症状之门诊费用，但更年期发病和治疗须始于40岁以下。	 每个保险期内 最高限额1,850人民币
23. 门诊精神疾病治疗 由法定资质的心理学家及/或法定资质的精神病医生的直接管理下，被保险人接受的门诊治疗。 此项保障包括10次治疗，赔付费用以本保障限额为准。 前5次就诊无需医生转介，之后的就诊则需要有医生或专科医生的转介函和治疗计划。	 每个保险期内最高10次， 综合最高限额2,500人民币
24. 牙科 保险人应赔付以下项目实际产生的医疗费用： 牙科治疗：牙科执业医生在牙科手术期间/牙科诊所进行牙科治疗的费用。牙科治疗包括： — 牙齿检查(若有必要其中包括照牙科X光)； — 预防性洗牙，抛光和窝沟封闭(每年一次)； — 补牙和拔牙(非手术和手术性)； — 根管治疗； — 新装或修复牙冠，假牙，嵌体和牙桥； — 进行牙根尖切除术； — 处方药和敷料。 不包括种植牙和牙齿矫正治疗保障。 其他牙科治疗一概不属于此类保障。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 此保障有20%的自付比例。 免赔额或门诊每次就诊免赔额并不适用于此保障。	 每个保险期内 最高限额1,900人民币

附加选项	易全保水晶
25. 中国大陆选择 保险人应赔付被保险人在中国大陆因住院、日间留院及接受门诊治疗时实际产生的符合保障范围的医疗费用。标准的保险单保障限额适用于本条。 中国大陆以外的紧急非选择性治疗： 在最长期限为30日的计划行程中，被保险人若在中国大陆以外的地区遇到意外事故或因某种突发性医疗状况而引致对其健康构成即时威胁的严重疾病，在上述紧急事件之后的24小时内接受的医生或专科医生提供的治疗。 因意外事故，需接受住院和日间留院治疗，保险人应全额赔付。 因疾病需接受住院和日间留院治疗，以投保人和保险人双方同意的最高保障限额为限。最高保障限额应经投保人与保险人双方同意，并在保险合同中列明。	 可供选项 中国大陆以外的紧急非选择性治疗，因疾病治疗的最高限额 150,000人民币
26. 病房限制(住宿最高限额800人民币) 如本保险合同第五条项下第1款(a)项所述，被保险人在中国大陆住院时，每日最高限额800人民币，从而在中国大陆医院接受保障范围内的住院或日间留院治疗及任何医生的治疗。医院的定义及范围由保险人事先约定。	 可供选项 于中国大陆医院接受住院或日间留院治疗每日最高限额800人民币
27. 昂贵医院限制 保险人将事先指定某些提供住院、日间留院或门诊治疗服务的医疗机构为昂贵医院。被保险人在中国大陆任何一家昂贵医院接受承保范围内的住院、日间留院或门诊治疗及任何医学专家的治疗时，保险人将不会赔付实际产生的有关医疗费用。	 可供选项
28. 私人医院住院自付比例 对属于保障范围内在私人医院的住院或日间留院治疗时实际产生的医疗费用，被保险人需承担20%自付比例。	 可供选项 20%自付比例
29. 年度最高保障限额1,000,000人民币 在本保险合同的保险期间内，如果发生了本保险合同涵盖的医疗事项，保险人应支付保险金额不得超过相应的保障限额，且支付的总保险金金额不得超过本保险合同中规定的年度最高保障限额1,000,000人民币。	 可供选项
30. 门诊费用的自付比例 保险人应赔付被保险人符合保障范围内的门诊治疗实际产生的医疗费用，但门诊治疗有20%的自付比例。 自付比例并不适用于以下治疗：肾透析/肾衰竭、癌症或器官移植。 但此项不适用于6,300人民币免赔额或更高免赔额之计划。 如果被保险人的保险单中含有生育保障、牙科保障或体检、疫苗保障，其相应的自付额将会在被保险人的保障一览表中列明。	 可供选项
31. 门诊每次就诊免赔额 被保险人接受属于保障范围的门诊治疗时，门诊每次就诊设有150人民币免赔额。 门诊每次就诊免赔额并不适用于肾透析/肾衰竭、癌症或器官移植的治疗。 但此项不适用于6,300人民币免赔额或更高免赔额之计划。	 可供选项 150人民币
32. 取消药物和敷料限额 通过选择此选项，保障 20 c) 下的处方药和敷料将全额赔偿，但受年度最高门诊限额限制。 适用于3名员工或以上的统一投保的团体保险单。	 可供选项 适用于3名员工或以上的统一投保的团体保险单

附加选项	易全保水晶
33. 体检和疫苗 — 选项1 适用于3名员工或以上的统一投保的团体保险单。 a) 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查(如直系家属有病史)、骨密度检查(50周岁以上女性被保险人每5年可做1次)、心血管系统检查，神经系统检查、生命体征检查(例如，血压、体重指数、尿分析和胆固醇)、儿童体检(至5周岁)的费用和/或 b) 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。 责任免除6.9条款并不适用于此保障。	可供选项 a) 和 b) 每个保险期内的综合最高限额950人民币
34. 体检和疫苗 — 选项2 适用于3名员工或以上的统一投保的团体保险单。 a) 体检保障：保险人应赔付例行健康检查，包括癌症筛查、乳腺癌1号和2号基因检查(如直系家属有病史)、骨密度检查(50周岁以上女性被保险人每5年可做1次)、心血管系统检查，神经系统检查、生命体征检查(例如，血压、体重指数、尿分析和胆固醇)、儿童体检(至5周岁)的费用和/或 b) 疫苗保障：医疗必需的免疫疫苗和加强药物注射，以及医疗必需的任何旅行疫苗和疟疾预防注射，保险人将赔付相关药物费用和咨询费用。 责任免除6.9条款并不适用于此保障。	可供选项 a) 和 b) 每个保险期内的综合最高限额1,570人民币
35. 生育保障 — 选项1 a) 被保险人怀孕或分娩期间实际产生的医疗必需费用；包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿婴儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。 请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。 b) 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。 — 宫外孕(胚胎在子宫以外的部位着床发育)； — 葡萄胎(异常细胞在子宫内生长)； — 胎盘滞留(胚胎滞留在子宫内)； — 前置胎盘； — 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)； — 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)； — 产后出血(分娩后多个小时及多日大出血)； — 需要实时接受外科治疗的流产。 本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。 适用于10名或以上的团体保单。 责任免除6.27条款并不适用于此保障。 免赔额适用于此保障。	可供选项 适用于10名或以上的团体保单 a) 每个保险期内最高限额31,500人民币 b) 每个保险期内最高限额75,600人民币

附加选项	易全保水晶
36. 生育保障 — 选项2 a) 被保险人怀孕或分娩期间实际产生的医疗必需费用：包括分娩费用、产前与产后六周内检查、扫描、自然分娩或自愿/紧急剖腹产的费用。本保障亦包含出生24小时内儿科医生就新生儿婴儿首次检查/体检的收费，以及幼儿2周岁生日前由医生或专科医生建议的儿科健康检查费用，包括体格检查，身高体重头围胸围等测量，视力听力等感知觉筛查，智能心理评估，生长发育检查，遗传病及代谢疾病筛查，疫苗注射，尿检，结核试验，血球容积比，血红蛋白及其他血液检查，包括镰状细胞贫血的筛查。 请注意此新生儿检查的费用保障，仅限于保险人已赔付本团体计划下被保险人的分娩费用，且新生儿已加入此团体计划并成为被保险人时，保险人才会赔付上述新生儿检查的费用。 b) 对于产前期间因保障范围内的医疗状况所产生的实际住院治疗费用或分娩期间因保障范围内的医疗状况所产生的实际住院治疗费用，保险人仅将治疗以下医疗状况视为此福利保障b)中符合保障范围内的医疗状况。 — 宫外孕(胚胎在子宫以外的部位著床发育)； — 葡萄胎(异常细胞在子宫内生长)； — 胎盘滞留(胚胎滞留在子宫内)； — 前置胎盘； — 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)； — 糖尿病(如果被保险人因自身与糖尿病有关的过往病史而有相应的责任免除，则被保险人不会因怀孕期间进行的任何糖尿病治疗而获得赔偿)； — 产后出血(分娩后多个小时及多日大出血)； — 需要实时接受外科治疗的流产。 本保障b)不包括自愿/紧急剖腹产或“产程进展不良”的费用，除非是上述保障b)所列之符合保障范围内的医疗状况之一。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。在第180日后至保单生效一年期间产生的费用，此保障有95%的自付比例。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。 因这是个人选择，保险人对于育儿或其他相关课程一概不予赔付。 适用于10名或以上的团体保单。 责任免除6.27条款并不适用于此保障。 免赔额适用于此保障。	 可供选项 适用于10名或以上的团体保单 a)  每个保险期内最高限额44,100人民币 b)  每个保险期内最高限额94,500人民币

核保选项	易全保水晶
37. 已声明的既往病症的限额 只适用于5-19名员工的统一投保的团体保险单。 此核保选项为已向保险人声明并被保险人接受的既往病症提供有限的承保。 等待期：被保险人保单生效日后的180日内产生的任何费用不予赔付。不管投保人续保与否，被保险人必须完成180日等待期才可赔付此保障。	 可供选项 只适用于5-19名员工的统一投保的团体保险单 等待期结束后： 每个已声明的既往病症的 限额12,600人民币 等待期结束后和 团体计划来年续保后： 每个保险期内 每个已声明的既往病症的 限额25,200人民币
38. 既往病史不告 适用于10名员工或以上的统一投保的团体保险单。	 可供选项

免赔额选项	易全保水晶
标准免赔额	3,150人民币
自选免赔额 请注意：63,000人民币或94,500人民币免赔额仅适用于拥有不止一份健康保险单的投保人。如果投保人购买本保险单作为二级医疗保险单，投保人只能选择63,000人民币或94,500人民币免赔额选项。被保险人投保本保险时，需提供投保人主医疗保险的保险详情。	零 950人民币 1,570人民币 6,300人民币 15,700人民币 31,500人民币 63,000人民币 94,500人民币



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SimpleCare Policy Wording



Companies (April 2025)



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A. Policy Wording

1. General

Asia-Pacific Property & Casualty Insurance Co., Ltd. Companies SimpleCare Medical Insurance (April 2025) Policy Wording (Registration No: C00003832512025033113743)

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 and agreed by insurer.

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 three natural persons 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 of the direct insured person.
 - b. Children (aged 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.
 - c. Any other person that the direct insured person agreed to enrol in writing.

The direct insured can apply to add new born babies (who are born to the direct insured or the direct insured's spouse) to the policy from their date of birth. This can normally be done without filling out details of their medical history, provided the direct insured adds them within 30 days of their date of birth. The direct insured can do this by applying via his/her online secure portfolio area at www.now-health.com.

However, the insurer will require details of the baby's medical history if :

- the baby was born within 10 months from the direct insured 's start date or the direct insured spouse's start date, whichever date is later; or
- the baby has been adopted; or
- the baby was born as the result of any method of assisted conception or following any type of fertility treatment, including but not limited to fertility drug treatment.

In such circumstances the insurer reserves the right to apply particular restrictions to the cover the insurer will offer, and the insurer will notify the direct insured of those terms as soon as reasonably possible. This may limit the direct insured baby's cover for existing medical conditions. This would mean that the direct insured's baby will not be covered for treatment carried out for medical conditions which existed prior to joining, such as treatment in a Special Care Baby Unit and the direct insured will be liable for these costs.

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 except the insured and the insurer make special restrictions on the medical coverage of the dependent.
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 the 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 1 to 24 under the Insurance Liability section are core benefits. The Benefits 25 to 38 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, MRI and CT need to be pre-authorised. The maximum benefit should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

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

4. Organ Transplant

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

Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow or cornea, 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 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant.

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.

Medical costs associated with the donor and the cost of the donor organ search are excluded from this Benefit.

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

5. 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.

6. New Born Baby 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.

In circumstances where the insurer requires details of the new born baby's medical history before the baby is being added to the policy, the insurer reserves the right to apply particular restrictions to the cover the insurer will offer.

Please refer to Article 3 - adding new born of this policy wording for details.

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

7. Congenital Disorders

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 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

8. 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.

9. 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.

10. 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.

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

12. 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.

2. Insurance Liability

13. Rehabilitation

The insurer will cover the actual incurred medical rehabilitation cost when referred by 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.

14. Nursing Care at Home

The insurer will cover the actual incurred medical cost of the care given by a 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. This coverage needs to be pre-authorised.

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

15. 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.

16. 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:

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

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 cost 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 to 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.

We do not cover standalone repatriation. This eligible repatriation expense will only be covered after the initial eligible medically necessary evacuation has been taken place.

Deductible would apply to medically necessary treatment required under this benefit.

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.

17. 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.

18. Emergency Non-Elective Treatment Outside Area Of Cover

For planned trips up to 30 days of duration outside Area Of Cover, the insurer will cover the actual incurred medical cost 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.

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.

19. Hospital Cash Benefit

The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if:

- a. the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or
- b. this policy being the secondary health insurance policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.

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

For this benefit exclusion 6.9 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

20. Out-Patient Charges

The insurer will cover the actual incurred medical cost of:

- a. Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests;
- b. Teleconsultation (Virtual Doctor appointments via electronic means).

Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the SimpleCare Comprehensive Network.

Treatment that is not received in the SimpleCare Comprehensive Network will pay Reasonable & Customary charges.

- c. Prescribed Drugs and Dressings.

- d. Vitamins and Minerals:

Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit d.

Any pre-operative and post-hospitalisation consultations are payable under this Benefit.

The insured does not have cover for costs relating to the maintenance of Chronic Conditions unless the insured is insured under SimpleCare Jade or SimpleCare Crystal, which the insurer will pay such eligible costs under Article 5, Benefit 20 – Out-Patient Charges.

Please note: If claim receipts do not show a breakdown of the medical services rendered, We will only pay Eligible claims up to the Prescribed Drugs and Dressings limit.

Annual Out-Patient Limit is applicable to Benefit 20- Out-Patient Charges and Benefit 21 - Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.

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 Physiotherapy and Alternative Therapies

The insurer will cover the actual incurred medical cost of:

- a. Physiotherapy by a Registered Physiotherapist.
- b. Complementary medicine and treatment by a therapist. This benefit extends to chiropractors, chiropodists and podiatrists, osteopaths, homeopaths, dietician and acupuncture treatment.
- c. Out-Patient Treatment for Traditional Chinese Medicine or Ayurvedic Medicine administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses.

Exclusion 5.41 applies.

You may choose 5 sessions for any combination of benefits in aggregate in a given period of cover for benefits a. and b. excluding dietician without the need of referral; any subsequent sessions need to be referred by a medical practitioner or specialist.

Annual Out-Patient Limit is applicable to Benefit 20- Out-Patient Charges and Benefit 21 - Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.

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.

22. Menopause Hormone Replacement Therapy

The insurer will cover the cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and treatment commence below the age of 40 years. The maximum benefit per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

23. Out-Patient Psychiatric Illness

The insurer will cover the actual incurred medical cost of out patient treatment administered by a registered psychologist and/or a registered psychiatrist, subject to 10 sessions and the cost limit under this section.

For the first 5 sessions you may choose to visit a registered psychologist directly without the need for referral. However, any subsequent sessions with a registered psychologist will require referral and a treatment plan with a medical practitioner or specialist.

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.

24. Dental Care

The insurer will cover the actual incurred medical cost of:

Fees of a registered Dental Practitioner carrying out dental Treatment in a dental clinic/surgery.

This Benefit provides cover for the below dental Treatment:

- Screening (including x-rays where necessary)
- Preventive scaling, polishing, and sealing (once per year)
- Fillings and extractions (non-surgical and surgical)
- Root canal treatment
- New or repair of crowns, dentures, inlays and bridges
- Apicoectomy
- Prescribed Drugs and Dressings

Dental implants and orthodontics Treatment are specifically excluded under this Benefit.

No other Treatment is covered by this Benefit.

Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.

A co-insurance of 20% applies.

For this benefit, the deductible or out-patient per visit excess 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.

25. Mainland 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 Mainland China and will be subject to the standard policy limits.

Emergency non elective treatment outside of Mainland 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.

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.

26. Hospital Room Restriction – Hospital Room & Board Limit RMB 800

As described in Article 5 Benefit 1 a) on the insurance contract, but with a restriction to limit the hospital accommodation for hospital admission in Mainland China up to RMB 800 per day for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any 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.

27. 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.

28. In-Patient Co-Insurance at Private Hospital

The insurer will cover the actual medical costs associated with the benefits for eligible in-patient or day-patient treatment at a private hospital subject to 20% co-insurance.

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

2. Insurance Liability

29. Annual Maximum Policy Limit RMB 1,000,000

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 policy limit of RMB 1,000,000.

30. Co-Insurance Out-Patient Treatment

The insurer will cover the actual incurred medical cost with a 20% co-insurance on all eligible out-patient treatment.

Co-insurance does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.

This option is not available for Group Plans with deductibles of RMB 6,300 or higher. The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

Should the plan includes maternity, dental care or wellness and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.

31. Out-Patient Per Visit Excess

An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment.

The out-patient per visit excess does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.

This option is not available for Group Plans with deductibles of RMB 6,300 or higher.

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

32. Removal of Drugs and Dressings Limit

By selecting this option, cover for Prescribed Drugs and Dressings under Benefit 20 c) will be Full Refund, subject to annual Out-Patient limit.

For Compulsory Group Plans 3+ employees

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

33. Wellness and Vaccinations – Option 1

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, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or
- b. Vaccinations: cost of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.

This clause applies to compulsory group policies of 3+ employees. For this benefit exclusion 6.9 does not apply. The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

34. Wellness and Vaccinations – Option 2

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, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or
- b. Vaccinations: cost of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.

This clause applies to compulsory group policies of 3+ employees. For this benefit exclusion 6.9 does not apply. The maximum benefit should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

35. Maternity – Option 1

The insurer will cover:

- a. Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy. Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.
- b. For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):
 - 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 the insured person's 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

This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.

Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.

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

For Compulsory Group Plans 10+ employees.

For this benefit exclusion 6.27 does not apply.

Deductible would apply to this benefit.

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

2. Insurance Liability

36. Maternity – Option 2

The insurer will cover:

- a. Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy. Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.
- b. For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):
 - 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 the insured person's 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

This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.

Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.

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

For Compulsory Group Plans 10+ employees.

For this benefit exclusion 6.27 does not apply.

Deductible would apply to this benefit.

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

37. Capped Cover for Declared Pre-existing Medical Conditions

For Compulsory Group Plans 5 to 19 employees.

This underwriting option provides limited cover for any pre-existing Medical Conditions that are declared and accepted by Us.

Waiting period: Any expenses incurred within 180 days after the start date of the insured Person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.

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

38. Medical History Disregarded

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

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 though 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 fees

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 treatment

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) to enhance your appearance, even when medically prescribed, such as but not limited to acne, teeth whitening, lentigo and alopecia.

The only exception is an initial reconstructive surgery necessary to restore function or appearance after a disfiguring accident, or following a surgical procedure for an eligible medical condition, if the accident or surgery occurs during the insured person's membership.

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

The insured does not have cover for costs relating to the maintenance of Chronic Conditions unless the insured is insured under SimpleCare Jade or SimpleCare Crystal, which the insurer will pay such eligible costs under Article 5, Benefit 20 – Out-Patient Charges.

6.8 Coma or Vegetative State

We will not pay for any treatment costs incurred by an insured person after being in a coma or in a vegetative state for more than 12 months. We will, however, pay for any active treatment costs of an eligible medical condition incurred within the first 12 months of the coma or the vegetative state.

3. Exclusions

6.9 Deductible, out-patient per visit excess or co-insurance

The insured person is not covered for the amount of the deductible, out-patient per visit 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 deductible, out-patient per visit excess or co-insurance as fraud and the insurer will take legal action.

6.10 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.

6.11 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.

6.12 Dietary supplements and cosmetic products

The insured person is not covered for nutritional or dietary consultations and supplements, including, but not limited to, special infant formula and cosmetic products including but not limited to moisturizers, cleansers, lotions, soaps, shampoos, sunscreen, mouth wash, antiseptic lozenges, even if medically recommended or prescribed or acknowledged as having therapeutic effects.

6.13 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.

6.14 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.

6.15 Eyesight tests or vision correction, hearing tests, hearing or visual aids

You are not covered for hearing aids or cochlear implants. You are not covered for routine hearing tests unless a Wellness Benefit is shown on Your Certificate of Insurance. You are not covered for routine eyesight tests or the cost of eyeglasses, contact lenses or laser eye surgery to correct vision unless an Optical Benefit is shown on Your Certificate of Insurance. We do pay for eye surgery to correct an Eligible Medical Condition.

6.16 External appliance and or 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.

6.17 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.

6.18 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.

6.19 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, whether the insured person has a medical condition when he/she has no symptoms or if there is a genetic risk of the insured person passing on a medical condition.

6.20 Hazardous sports and pursuits

The insured person is not covered for treatment of injuries sustained from base jumping, cliff diving, motor sports, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 30 metres, trekking to a height of over 4,000 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.

6.21 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. HIV test when not medically prescribed or screening for visa application purposes are not covered.

6.22 Hormone replacement therapy

The insured person is not covered for the costs of treatment for hormone replacement therapy. The insured person is covered for medical practitioner's fees including consultations, the cost of implants, patches or tablets which are medically necessary as a direct result of medical intervention, up to a maximum of 18 months from the date of medical intervention and for Menopause Hormone Replacement Therapy where onset and treatment commence below the age of 40 years.

6.23 Obesity and Weight Loss

You are not covered for costs of Treatment for, or related to Bariatric surgery and any complications arising from it. You are not covered for costs of Treatment for, or related to removing fat or surplus healthy tissue from any part of the body and any complications arising from it. You are not covered for the costs of Treatment for, or related to weight loss including weight loss medications and any complications arising from them.

6.24 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.

6.25 Palliative and Hospice care

The insured, on diagnosis of a terminal illness by a medical practitioner or specialist, is not covered for the costs of Hospital or Hospice accommodation or costs of any other treatment for the purpose of offering temporary relief of symptoms.

3. Exclusions

6.26 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, tests 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.

6.27 Pregnancy or maternity

The insured person is not covered for costs relating to pregnancy or childbirth, medically necessary and/or emergency caesarean section, voluntary caesarean section, unless maternity benefits a) are shown on the insured person's insurance policy or certificate of insurance.

These costs are only covered under the maternity benefit a) and are not covered or recoverable under any other benefits.

6.28 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.

6.29 Psychiatric or Psychological Treatment

You are not covered for Treatment costs related to psychiatric illness or any psychological conditions unless specified in your benefit schedule.

6.30 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.

6.31 Routine examinations, health screening and Vaccinations

You are 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 You do not have any symptoms) and any types of Vaccination costs. (unless benefits are shown on the insured person's certificate of insurance.)

6.32 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.

6.33 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.

6.34 Sexual problems and gender re-assignment

The insured person is not covered for treatment costs relating to sexual problems including sexual dysfunction, or gender re-assignment 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.

6.35 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.

6.36 Travel/accommodation costs

The insured person is not covered for transport or accommodation costs the insured person incurs 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.

6.37 Travelling against medical advice

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

6.38 Treatment in High Cost Medical Facilities

The insured person is not covered for costs of treatment incurred in any medical provider that is listed in the insurer's high cost providers list.

6.39 Treatment by a family member

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

6.40 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.

6.41 Traditional Chinese Medicine

You are not covered for the following: Pre-paid treatment Plan or pre-paid package prior to Treatment being received, Over-the-counter traditional Chinese Medicines, Treatments for tonic or cosmetic purposes or weight management. You are not covered for the following Traditional Chinese Medicines (whether prescribed or not): including cordyceps; ganoderma; antler; cubilose; donkey-hide gelatin; hippocampus; ginseng; red ginseng; American Ginseng; Radix Ginseng Silvestris; antelope horn powder; placenta hominis; Agaricus blazei murill; musk; pearl powder; rhinoceros horn and substances from Asian Elephant, Sun Bear, Tiger or other endangered species. You are not covered for more than one Treatment per day.

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 policyholder is responsible for paying the insurance premium according to the insurance contract.
3. The insurance premium is calculated as per the agreed sum assured and its premium rate stated in the insurance contract.

Article 8 – Coverage Period and Renewal

The insurance coverage period shall be one year. The specific start date and end date of the period of cover shall be agreed upon by the policyholder and the insurer and shall be stated in this insurance contract.

This insurance contract is non-guaranteed at renewal. Upon the expiry of the insurance period, the policyholder needs to reapply for this product from the insurer, get insurer approval, pay the insurance premium and receive a new insurance contract.

Article 9 – Waiting Period

Waiting Period is referred to after the policy effective date or the policy issued date (whichever is later). The insurer does not bear for insurance liability for a period of time. The exact number of days should be agreed between the insurer and the policyholder. However, the waiting period cannot be exceeded 180 days. The insured person must have completed the waiting period before the benefit is payable irrespective of whether the policyholder renews the insurance or not.

Article 10 – Deductibles

The insurance product is designed to have deductible options. The agreed annual deductibles will apply when the insured person receives eligible in-patient or day-patient treatment (for treatment inside or outside of the provider network).

If the policyholder has selected an annual deductible option, the policyholder is required to select either an out-patient co-insurance option or an out-patient per visit excess option.

The amount of the deductible and the option to be taken together with the deductible option should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

6. Insurer's Obligations

Article 11 – 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 12 – 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 13 – 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 14 – 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 a decline letter with reason in three days from the date of determinations if the request is not covered.

Article 15 – 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 16 – Premium Payment

The insurance premium payment method in the insurance contract should be agreed between the policyholder and the insurer during the insurance application stage. Also, the insurance premium payment method should be indicated clearly in the certificate of insurance.

If the agreed insurance premium payment method is paid annually, the policyholder is required to pay all the insurance premium once the policy has been set up. **If the policyholder does not pay the insurance premium on time as agreed, the insurance contract is not valid.**

If the agreed insurance premium payment method is paid by installments, the policyholder should apply and is required to be agreed by insurer. The payment cycle of installment is required to be indicated clearly in the insurance contract. Policyholder should pay the 1st installment of insurance premium on time as agreed. **If the policyholder does not pay the 1st installment of insurance premium on time as agreed, the insurance contract is not valid.**

If the policyholder does not pay the insurance premium from the 2nd installment onwards or any installment afterwards on time as agreed in insurance contract and the policyholder does not pay the insurance premium for the said installment within 30 days following the insurer sending reminder date, this insurance contract is terminated.

If there is any insurance incident happened before the termination of the insurance contract, the insurer is required to reimburse the claims in accordance with the terms and conditions of insurance policy. However, the outstanding insurance premium of the policyholder should be deducted from the reimbursed amount.

The sum of premium paid by policyholder and the premium deducted by insurer should be same as the total premium amount mentioned in the insurance contract.

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

Unless the insured changes the country of residence, the insured cannot change the premium plan to a premium plan in another currency when renewing the policy. If the insured needs to change the premium plan to a premium plan in another currency, the insured must obtain the insurer's written approval.

Article 17 – 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 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 that 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 that happened before the termination of the contract, but shall refund the insurance premium.

Article 18 – 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 in 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 19 – 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 or 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.

8. Claim and Payment of Insurance Compensation

Article 20 – 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 and effective 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 21 – Right of Claims

The applicant's right of claims will be subject to the currently valid legal provisions.

Article 22 – Compensation Principle

The payment of benefits under this insurance policy shall apply according to the following compensation principle.

- 1) If the insured has obtained relevant medical expenses compensation from other channels (including but not restricted to social basic medical insurance, public medical insurance, medical insurance under employee benefits), the insurer will only pay the balance of the cost of the medical treatment, in accordance with the provisions of this insurance contract, after compensation has been obtained from other channels (including but not restricted to social basic medical insurance, public medical insurance, medical insurance under employee benefits).
- 2) If the insured is a member of social basic medical insurance or public medical insurance, but fails to get compensation in social basic medical insurance or public medical insurance when making a claim, the insurer will protect the rights and interests of the applicant according to the applicant's insurance certificate and policy, subject to the upper limit under the coverage and the compensation standards stated on the insurance certificate and the policy.

9. Dispute Resolution and Applicable Law

Article 23 – 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 reasonable attempts to do so, the disputes should be submitted to the People's Court of Litigation in People's Republic of China (except Hong Kong, Macau, and Taiwan) for its ultimate and binding decision on all parties.

Article 24 – 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 25 – 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 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 26 – 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. Effective 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 minimum cash value 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 27 – Use of Membership Card

- 26.1 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.
- 26.2 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.
- 26.3 If an insured person receives treatment that is not eligible under the policy through out-patient direct billing, 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.
- 26.4 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.
- 26.5 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.
- 26.6 The policyholder shall immediately notify the insurer of the loss of a direct billing membership card by any of its insured person(s) (including dependants).
- 26.7 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.

10. Miscellaneous

Article 28 – 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 29 – 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 26 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. **Actively at Work**
 Actively at Work shall mean the direct insured is employed by the policyholder on a full time permanent basis and the direct insured is performing all their regular duties according to their employment terms on a customary manner and on a full time basis.
 If the direct insured is an employee, he/she needs to be Actively at Work on the day he/she becomes eligible to join the group plan. If insured person is not Actively at Work on the day he/she becomes eligible, his/her cover will only begin on the day he/she returns to work on an Actively at Work basis. The direct insured can only add his/her dependants when he/she returns to work.
 The direct insured is considered NOT being Actively at Work if:
 - The Insured person is working less than 80% of the required work hours or being paid less than 80% of the usual pay as stipulated in their employment terms
 - The direct insured has a medical condition that necessitates absence from his/her usual work place for more than 60 days, with the exception of maternity/paternity leave as allowed by the local regulations.
3. 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.
4. 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.
5. 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 Article 29 on the insurance contract that causes the insurer to be claimed, the policyholder should indemnify the insurer for all the losses, including but not limited to the dispute's resolution fees, claim amount, legal fee and others.
6. 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.
7. **Break in cover**
 Where there is a break in cover, for whatever reason, the insurer reserves the right to reapply exclusion 6.26 in respect of pre-existing medical conditions.
8. 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.
9. 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.
10. The policyholder must write and inform the insurer if the insured person changes their address or occupation.

11. General Conditions

Article 30 – General Conditions

1. The insurer reserves the right to revise or discontinue the group policy with effect from any renewal date.
2. The agreement can only be varied in writing. No variation will be admitted unless it is in writing and stamped by the insurer.
3. Any notice to be sent under this insurance contract 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 dispatch.
4. 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.
5. In case of 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 identity 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, chiropractic treatment, chiropodists and podiatrists treatment, osteopathy, dietician, homeopathy and acupuncture as practised 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
 - Calcification
 - Damaged root surfaces and surrounding bone requiring surgery
8. **Area of Cover:** Default area of cover is Worldwide excluding U.S.A. This means the insurer provides Worldwide Cover for eligible treatment, but it does not cover any elective treatment in U.S.A. If the default area of cover is Worldwide excluding U.S.A, out of area of cover means U.S.A. If the policyholder chooses "Mainland China Option" benefit, area of cover is Mainland China (excluding Hong Kong, Macau, Taiwan – same as below) and out of area of cover means area outside Mainland China.
9. **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.
10. **Benefit Schedule** The table of benefits applicable to this policy showing the maximum benefits the insurer will pay.
11. **Cancer** A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
12. **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.
13. **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.
14. **Co-Insurance** Is the uninsured percentage of the costs, which the insured person must pay towards the cost of a claim.
15. **Country of Nationality** The country for which the insured person holds a passport.
16. **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.

17. 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
18. 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.
19. Deductible	An uninsured amount payable by an insured person in respect of in-patient or day-patient expenses incurred before any benefits are paid under the insurance policy, as specified in the insured person's certificate of insurance. The deductible applies per insured person, per period of cover.
20. Dental Practitioner	A person who is legally licensed to carry out this profession by the relevant licensing authority to practise dentistry in the country where the dental treatment is given.
21. 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.
22. Diagnostic Tests	Investigations, such as x-rays or blood tests, to find or to help to find the cause of the insured person's symptoms.
23. Drugs and Dressings	Essential prescription drugs, dressings and medicines administered by a medical practitioner or specialist needed to relieve or cure a medical condition.
24. 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.
25. Entry Date	The date shown on the certificate of insurance on which an insured person was included under this policy.
26. 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.
27. Excluded Countries	Refers to the list of countries that We cannot offer You cover if You reside in any one of them. For details of Our list of Excluded Countries, please contact Our customer service team.
28. 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
29. 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.
30. High Cost Providers List	The list of medical providers the insurer excludes from cover. The insurer does not cover any treatment costs incurred in any medical provider that is within the insurer's High Cost Providers List. The insurer will update the High Cost Providers List on a periodic basis. For details of the insurer's High Cost Providers List, the insured may contact the insurer's customer service team.
31. 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.
32. Hospital Accommodation	Refers to standard private or semi-private accommodation as indicated in the benefit schedule. Deluxe, executive rooms and VIP suites are not covered.

12. Definitions

33. 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.
34. In-Patient	A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.
35. Insured Person	The eligible employee and/or the dependants named on the certificate of insurance who are covered under this policy.
36. Insurer	Asia-Pacific Property & Casualty Insurance Co., Ltd.
37. Medical Condition	Any disease, injury, or illness, including psychiatric illness.
38. 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 practise 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.
39. 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.
40. New Born	A baby who is within the first 16 weeks of its life following birth.
41. Now Health International Provider Network	Our published list of medical providers where the insurer/policy administrator has a direct billing provider network agreement.
42. Out of Network Medical Provider	An out of network medical provider is one not contracted with the insured person's policy.
43. Out-Patient	A patient who attends a hospital, consulting room, telemedicine appointment or out-patient clinic and is not admitted as a day-patient or an in-patient.
44. Out-Patient Direct Billing	Our published list of medical providers where the insurer has a direct billing provider network.
45. Out-Patient Per Visit Excess	An uninsured amount payable by an insured person in respect of out-patient expenses before any benefits are paid under the insurance policy, as specified in the insured person's certificate of insurance. Each visit refers to each consultation. The out-patient per visit excess applies per insured person, per out-patient consultation when you receive eligible out-patient treatment.
46. Period of Cover	The period from 00:00 of the insurance policy start date to 23:59 of the insurance policy end date. It is usually for a period of 12 months.
47. Physiotherapist	A practising physiotherapist who is registered and licensed to practise medicine in the country where treatment is provided.
48. 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.
49. Plan	The contract between You and Us 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 members' handbook.
50. Policyholder	The person or company named as policyholder in the certificate of insurance.
51. Pregnancy	Refers to the period of time, from the date of the first diagnosis, until delivery.
52. Primary Health Insurance	If the insured person has more than one health insurance policy, this is the health insurance policy that pays claims first.
53. Primary Health Insurer	The insurer of the primary health insurance plan.
54. Private Room	Single occupancy accommodation in a private hospital. Deluxe, executive rooms and VIP suites are not covered.

55. 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.
56. 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.
57. 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 practising surgeon/physician/specialist or government health department/medical providers within the SimpleCare Provider Network..
58. Minimum Cash Value	1) Termination before the effective date of insurance: Minimum cash value = Premium already paid by the policyholder. 2) Termination after the effective date of insurance (if the insurance premium is one-time payment): Minimum Cash Value= Net premium $\times (1-m/n)$, where m is the number of effective days on cover and n is the number of days in the insurance period. The outstanding hours less than one day will be regarded as one day. Net premium = Premium already paid by the policyholder $\times (1 - \text{Cost Ratio})$. Unless agreed, otherwise the cost ratio is 15%. 3) Termination after the waiting period of insurance (if the premium is paid in installments): Minimum Cash Value= Net premium for the month $\times (1-m/n)$, where m is the number of effective days on cover of that month and n is the number of days of that month. The outstanding hours less than one day will be regarded as one day. Net premium for the month = Premium of that month already paid by the policyholder $\times (1 - \text{Cost Ratio})$. Unless agreed, otherwise the cost ratio is 15%.
59. 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.
60. 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.
61. Renewal Date	The anniversary of the start date of the insurance policy.
62. Secondary Health Insurance	If the insured person has more than one health insurance policy, Secondary Health Insurance is the payer that pays claim after the Primary Health Insurance has paid its portion. If the insured person has more than one health insurance policy, this insurance policy will be the health insurance policy that pays last. If the insured person buys this insurance policy as a Secondary Health Insurance Policy, the insurer will only pay a claim if: – the claim was submitted to the Primary Health Insurer but the claim was not paid/ fully settled due to ineligibility or the benefit limits have been exhausted under the Primary Health Insurance contract, and – the unpaid claim amount is considered as eligible claim under this insurance policy. The insured person will need to provide a copy of the certificate of insurance of the insured person's Primary Health Insurance when the insured person applies for this insurance policy. In any case, We will only pay the remaining balance of an Eligible claim amount that was not settled by the Primary Health Insurance.
63. Semi-Private Room	Dual occupancy accommodation in a private hospital. Deluxe, executive rooms and VIP suites are not covered.
64. SimpleCare Comprehensive Network	The insurer's list of medical providers that is available to the insured person if the insured person has extended the area of cover to Worldwide Excluding USA.

12. Definitions

65. 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 practise 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.
66. Start Date	The start date shown on the insured person’s certificate of insurance.
67. Surgical Procedure	An operation requiring the incision of tissue or other invasive surgical intervention.
68. Terminal Illness	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.
69. Treatment	Surgical or medical services (including Diagnostic Tests) that are needed to diagnose, relieve or cure a medical condition.
70. 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.
71. Waiting Period	Is a period of time starting on the entry date of the insured person’s, 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.
72. 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.
73. 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.
74. WHO	The World Health Organisation.
75. Traditional Chinese Medicine or Ayurvedic Medicine	Traditional Chinese Medicine (TCM) or Ayurveda Medicine exist outside the institutions where conventional medicine is taught. They are holistic healing systems that focus on the individual rather than the disease. Both systems use a variety of interventions, including herbs, diet, and lifestyle changes.

B. Benefit Schedule

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

Benefit	SimpleCare Amber
Annual Maximum Group Policy Limit <i>24/7 helpline and assistance services available on all Plans</i>	RMB 6,300,000
Geographical Area Default:	Worldwide Excluding USA
Default Network:	SimpleCare Comprehensive Network
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 Pre-Authorisation 📞 b)  Up to RMB 9,450 per medical condition
2. Diagnostic Procedures: Medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an in-patient, day-patient or out-patient.	 Full Refund for in-patient pre and post-operative scans Pre-Authorisation for MRI, PET and CT 📞
3. Renal Failure and Renal Dialysis: a) Treatment of renal failure, including renal dialysis on an in-patient basis. b) Treatment of renal failure, including renal dialysis on a day-patient or out-patient basis.	a)  In-Patient pre and post-operative care up to six weeks full refund per Period of Cover b)  Up to RMB 310,000 per period of cover
4. Organ Transplant: Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow or cornea, 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 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant. 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. Medical costs associated with the donor and the cost of the donor organ search are excluded from this Benefit.	 Up to RMB 630,000 per period of cover
5. 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

Benefit	SimpleCare Amber
6. New Born Baby Cover: <i>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.</i> <i>In circumstances where the insurer requires details of the new born baby's medical history before the baby is being added to the policy, the insurer reserves the right to apply particular restrictions to the cover the insurer will offer.</i> <i>Please refer to Article 3 – adding new born of this policy wording for details.</i>	 Up to RMB 157,500 per period of cover
7. Congenital Disorders: <i>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 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders.</i>	 Up to RMB 157,500 per period of cover
8. Parent Accommodation: <i>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.</i>	 Full refund
9. Hospital Accommodation for New Born Accompanying their Mother: <i>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.</i>	 Full refund
10. Reconstructive Surgery: <i>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.</i>	 Full refund
11. Day-Patient and Out-Patient Surgery: <i>Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department.</i>	 Full refund
12. In-Patient Emergency Dental Treatment: <i>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.</i> <i>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:</i> <i>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</i> <i>b) If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead</i> <i>c) Damage to dentures providing they were being worn at the time of the injury.</i>	 Full refund
13. Rehabilitation: <i>When referred by 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:</i> <i>a) Use of special treatment rooms</i> <i>b) Physical therapy fees</i> <i>c) Speech therapy fees</i> <i>d) Occupational therapy fees</i>	 Full Refund for eligible in-patient treatment only up to 30 days per medical condition
14. Nursing Care at Home: <i>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.</i>	 Not Covered

Benefit	SimpleCare Amber
15. Emergency Ambulance Transportation: <i>Emergency road ambulance transport costs to or between hospitals, or when considered medically necessary by a medical practitioner or specialist.</i>	 Full refund
16. Evacuation and Repatriation: a) Evacuation <i>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.</i> <i>Reasonable expenses for:</i> i) <i>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.</i> ii) <i>Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.</i> iii) <i>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.</i> iv) <i>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.</i> 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. <i>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.</i>	Pre-Authorisation 📞 Combined limit up to RMB 630,000 a) Evacuation i)  Full Refund ii)  Full Refund iii)  Full Refund iv)  Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation Pre-Authorisation 📞 b) Repatriation  Full refund
17. Mortal Remains: <i>In the event of death from an eligible medical condition, reasonable and customary charges for:</i> a) <i>Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or</i> b) <i>Burial or cremation costs at the place of death in accordance with reasonable and customary practice.</i>	Pre-Authorisation 📞 a)  Full Refund b)  Up to RMB 63,000
18. Emergency Non-Elective Treatment outside Area of Cover: <i>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.</i>	 Accident: Full Refund for in-patient and day-patient treatment following accident  Illness: In-patient and day-patient care up to RMB 157,500 per period of cover
19. Hospital Cash Benefit: <i>The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if:</i> a) <i>the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or</i> b) <i>this policy being the Secondary Health Insurance Policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.</i> <i>Cover under this benefit is limited to a maximum of 30 nights per period of cover.</i> For this Benefit exclusion 6.9 does not apply.	 RMB 790 per night

Benefit	SimpleCare Amber
Annual Out-Patient Limit Applicable to Benefit 20 and 21 only, subject to Annual Maximum Policy Limit	Pre-operative consultation within 15 days from the admission and post hospitalisation consultation within 30 days following discharge from hospital Up to maximum RMB 4,700 per medical condition per period of cover.
20. Out-Patient Charges: a) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; b) Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the SimpleCare Comprehensive Network. Treatment that is not received in the SimpleCare Comprehensive Network will pay Reasonable & Customary charges. No Out-Patient Co-Insurance or Out Patient visit Excess is applicable. c) Prescribed Drugs and Dressings. d) Vitamins and Minerals: Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit d). Any pre-operative and post-hospitalisation consultations are payable under this Benefit. The insured does not have cover for costs relating to the maintenance of Chronic Conditions unless the insured is insured under SimpleCare Jade or SimpleCare Crystal, which the insurer will pay such eligible costs under Article 5, Benefit 20 – Out-Patient Charges. Please note: If claim receipts do not show a breakdown of the medical services rendered, We will only pay Eligible claims up to the Prescribed Drugs and Dressings limit. Annual Out-Patient Limit is applicable to Benefit 20 – Out-Patient Charges and Benefit 21 – Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.	a) and b)  Pre-operative consultation within 15 days from the admission and post hospitalisation consultation within 30 days following discharge from hospital Up to maximum RMB 4,700 per medical condition per period of cover. c)  Not covered d)  Not covered
21. Out-Patient Physiotherapy and Alternative Therapies The insurer will cover the actual incurred medical cost of: a) Physiotherapy by a Registered Physiotherapist. b) Complementary medicine and treatment by a therapist. This benefit extends to chiropractors, chiropodists and podiatrists, osteopaths, homeopaths, dietician and acupuncture treatment. c) Out-Patient Treatment for Traditional Chinese Medicine or Ayurvedic Medicine administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses. Exclusion 5.41 applies.. You may choose 5 sessions for any combination of benefits in aggregate in a given period of cover for benefits a) and b) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist. Annual Out-Patient Limit is applicable to Benefit 20 – Out-Patient Charges and Benefit 21 – Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.	 Not Covered

Benefit	SimpleCare Amber
22. Menopause Hormone Replacement Therapy: <i>The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and treatment commence below the age of 40 years.</i>	 Not Covered
23. Out-Patient Psychiatric Illness: <i>Out patient treatment administered by a registered psychologist and/or a registered psychiatrist, subject to 10 sessions and the cost limit under this section.</i> <i>For the first 5 sessions you may choose to visit a registered psychologist directly without the need for referral. However, any subsequent sessions with a registered psychologist will require referral and a treatment plan with a medical practitioner or specialist.</i>	 Not Covered
24. Dental Care: <i>Fees of a registered Dental Practitioner carrying out dental Treatment in a dental clinic/surgery.</i> <i>This Benefit provides cover for the below dental Treatment:</i> – Screening (including x-rays where necessary) – Preventive scaling, polishing, and sealing (once per year) – Fillings and extractions (non-surgical and surgical) – Root canal treatment – New or repair of crowns, dentures, in lays and bridges – Apicoectomy – Prescribed Drugs and Dressings <i>Dental implants and orthodontics Treatment are specifically excluded under this Benefit.</i> <i>No other Treatment is covered by this Benefit.</i> <i>Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.</i> <i>A co-insurance of 20% applies.</i> <i>For this Benefit the deductible or out-patient per visit excess does not apply.</i>	 Not Covered

Additional Options	SimpleCare Amber
25. Mainland China option: <i>The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Mainland China and will be subject to the standard policy limits.</i> <i>Emergency non-elective treatment outside of Mainland China:</i> <i>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.</i> <i>Full refund for accident requiring in-patient and day-patient care.</i> <i>Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover</i>	 Optional <i>Emergency non-elective treatment outside of Mainland China: illness limit up to RMB 150,000 per period of cover</i>
26. Hospital Room Restriction – Hospital Room & Board Limit RMB 800: <i>As described in Article 5 Benefit 1 a) on the insurance contract, but with a restriction to limit the hospital accommodation for hospital admission in Mainland China up to RMB 800 per day for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.</i>	 Optional <i>In-patient or day-patient treatment received in any in-patient or day-patient facility in Mainland China up to RMB 800 per day</i>
27. High Cost Provider Restriction: <i>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.</i>	 Optional
28. In-Patient Co-Insurance at Private Hospital: <i>The insurer will cover the actual medical costs associated with the benefits for eligible in-patient or day-patient treatment at a private hospital subject to 20% co-insurance.</i>	 Optional <i>20% co-insurance</i>
29. Annual Maximum Policy Limit RMB 1,000,000: <i>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 policy limit of RMB 1,000,000.</i>	 Optional
30. Co-Insurance Out-Patient Treatment: <i>A 20% co-insurance will apply on all eligible out-patient treatment.</i> <i>Co-insurance does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.</i> <i>This option is not available for policies with deductibles of RMB 6,300 or higher. Should the plan includes maternity, dental care or wellness and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.</i>	 Not Covered
31. Out-Patient Per Visit Excess: <i>An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment.</i> <i>The out-patient per visit excess does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.</i> <i>This option is not available for Group Plans with deductibles of RMB 6,300 or higher.</i>	 Not Covered
32. Removal of Drugs and Dressings Limit: <i>By selecting this option, cover for Prescribed Drugs and Dressings under Benefit 20 c) will be Full Refund, subject to annual Out-Patient limit.</i> <i>For Compulsory Group Plans 3+ employees</i>	 Not Covered

Additional Options	SimpleCare Amber
33. Wellness and Vaccinations – Option 1: <i>Compulsory group policies 3+ employees</i> a) <i>Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or</i> b) <i>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.</i> For this Benefit exclusion 6.9 does not apply.	a)  Not covered b)  Not covered
34. Wellness and Vaccinations – Option 2: <i>Compulsory group policies 3+ employees</i> a) <i>Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or</i> b) <i>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.</i> For this Benefit exclusion 6.9 does not apply.	a)  Not covered b)  Not covered
35. Maternity – Option 1: a) <i>Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hemotocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.</i> Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person. b) <i>For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):</i> – 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 the insured person's 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 <i>This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.</i> Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not. Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice. <i>For Compulsory Group Plans 10+ employees</i> For this Benefit exclusion 6.27 does not apply. Deductible would apply to this benefit.	a)  Not covered b)  Not covered

Additional Options	SimpleCare Amber
36. Maternity – Option 2: a) Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopath. Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person. b) For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b): – 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 the insured person's 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 This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not. Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice. For Compulsory Group Plans 10+ employees For this Benefit exclusion 6.27 does not apply. Deductible would apply to this benefit.	a)  Not covered b)  Not covered

Underwriting Options	SimpleCare Amber
37. Capped Cover for Declared Pre-existing Medical Conditions: <i>For Compulsory Group Plans 5 to 19 employees.</i> <i>This underwriting option provides limited cover for any pre-existing Medical Conditions that are declared and accepted by Us.</i> Waiting period: Any expenses incurred within 180 days after the start date of the insured Person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.	 Optional <i>For Compulsory Group Plans 5 to 19 employees</i> <i>After Waiting Period:</i> RMB 12,600 <i>per declared pre-existing Medical Condition</i> <i>After Waiting Period and until the Group Plan renews:</i> RMB 25,200 <i>per declared pre-existing Medical Condition, per Period of Cover</i>
38. Medical History Disregarded: <i>Compulsory group policies 10+ employees</i>	 Optional

Deductible Options	SimpleCare Amber
Standard Deductible	RMB 3,150
Optional Deductible <i>Please note:</i> <i>RMB 63,000 or RMB 94,500 deductible is only available if the policyholder is covered by more than one health insurance policy. The policyholder can only select such deductible options if the policyholder buys this policy as a Secondary Health Insurance Policy. The policyholder will be required to provide details of the policyholder's Primary Health Insurance when the policyholder applies for cover under this policy.</i>	Nil RMB 950 RMB 1,570 RMB 6,300 RMB 15,700 RMB 31,500 RMB 63,000 RMB 94,500

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

Benefit	SimpleCare Jade
Annual Maximum Group Policy Limit <i>24/7 helpline and assistance services available on all Plans</i>	RMB 9,450,000
Geographical Area Default:	Worldwide Excluding USA
Default Network:	SimpleCare Comprehensive Network
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 Pre-Authorisation 📞 b)  Up to RMB 9,450 per medical condition
2. Diagnostic Procedures: Medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an in-patient, day-patient or out-patient.	 Full Refund Pre-Authorisation for MRI, PET and CT 📞
3. Renal Failure and Renal Dialysis: a) Treatment of renal failure, including renal dialysis on an in-patient basis. b) Treatment of renal failure, including renal dialysis on a day-patient or out-patient basis.	a)  Up to six weeks full refund per period of cover b)  Up to RMB 310,000 per period of cover
4. Organ Transplant: Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow or cornea, 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 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant. 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. Medical costs associated with the donor and the cost of the donor organ search are excluded from this Benefit.	 Up to RMB 945,000 per period of cover
5. 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

Benefit	SimpleCare Jade
6. New Born Baby Cover: <i>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.</i> <i>In circumstances where the insurer requires details of the new born baby's medical history before the baby is being added to the policy, the insurer reserves the right to apply particular restrictions to the cover the insurer will offer.</i> <i>Please refer to Article 3 – adding new born of this policy wording for details.</i>	 Up to RMB 220,000 per period of cover
7. Congenital Disorders: <i>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 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders.</i>	 Up to RMB 220,500 per period of cover
8. Parent Accommodation: <i>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.</i>	 Full refund
9. Hospital Accommodation for New Born Accompanying their Mother: <i>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.</i>	 Full refund
10. Reconstructive Surgery: <i>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.</i>	 Full refund
11. Day-Patient and Out-Patient Surgery: <i>Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department.</i>	 Full refund
12. In-Patient Emergency Dental Treatment: <i>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.</i> <i>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:</i> <i>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</i> <i>b) If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead</i> <i>c) Damage to dentures providing they were being worn at the time of the injury.</i>	 Full refund
13. Rehabilitation: <i>When referred by 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:</i> <i>a) Use of special treatment rooms</i> <i>b) Physical therapy fees</i> <i>c) Speech therapy fees</i> <i>d) Occupational therapy fees</i>	 Full Refund up to 90 days per medical condition
14. Nursing Care at Home: <i>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.</i>	 Full Refund up to 30 days per medical condition Pre-Authorisation 

Benefit	SimpleCare Jade
15. Emergency Ambulance Transportation: <i>Emergency road ambulance transport costs to or between hospitals, or when considered medically necessary by a medical practitioner or specialist.</i>	 Full refund
16. Evacuation and Repatriation: a) Evacuation <i>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.</i> <i>Reasonable expenses for:</i> i) <i>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.</i> ii) <i>Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.</i> iii) <i>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.</i> iv) <i>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.</i> 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. <i>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.</i>	Pre-Authorisation  Combined limit up to RMB 630,000 a) Evacuation i)  Full Refund ii)  Full Refund iii)  Full Refund iv)  Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation Pre-Authorisation  b) Repatriation  Full refund
17. Mortal Remains: <i>In the event of death from an eligible medical condition, reasonable and customary charges for:</i> a) <i>Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or</i> b) <i>Burial or cremation costs at the place of death in accordance with reasonable and customary practice.</i>	Pre-Authorisation  a)  Full Refund b)  Up to RMB 63,000
18. Emergency Non-Elective Treatment outside Area of Cover: <i>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.</i>	 Accident: Full Refund for in-patient and day-patient treatment following accident  Illness: In-patient and day-patient care up to RMB 220,500 per period of cover
19. Hospital Cash Benefit: <i>The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if:</i> a) <i>the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or</i> b) <i>this policy being the Secondary Health Insurance Policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.</i> <i>Cover under this benefit is limited to a maximum of 30 nights per period of cover.</i> For this Benefit exclusion 6.9 does not apply.	 RMB 1,575 per night

Benefit	SimpleCare Jade
Annual Out-Patient Limit Applicable to Benefit 20 and 21 only, subject to Annual Maximum Policy Limit	RMB 6,300
20. Out-Patient Charges: a) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; b) Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the SimpleCare Comprehensive Network. Treatment that is not received in the SimpleCare Comprehensive Network will pay Reasonable & Customary charges. c) Prescribed Drugs and Dressings. d) Vitamins and Minerals: Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit d). Any pre-operative and post-hospitalisation consultations are payable under this Benefit. The insured does not have cover for costs relating to the maintenance of Chronic Conditions unless the insured is insured under SimpleCare Jade or SimpleCare Crystal, which the insurer will pay such eligible costs under Article 5, Benefit 20 – Out-Patient Charges. Please note: If claim receipts do not show a breakdown of the medical services rendered, We will only pay Eligible claims up to the Prescribed Drugs and Dressings limit. Annual Out-Patient Limit is applicable to Benefit 20 – Out-Patient Charges and Benefit 21 – Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.	a) and b)  Full refund subject to Annual Out-Patient Limit c)  Full refund subject to Annual Out-Patient Limit d)  Up to RMB 940 per period of cover a), b), c) and d) subject to Annual Out-Patient Limit
21. Out-Patient Physiotherapy and Alternative Therapies The insurer will cover the actual incurred medical cost of: a) Physiotherapy by a Registered Physiotherapist. b) Complementary medicine and treatment by a therapist. This benefit extends to chiropractors, chiropodists and podiatrists, osteopaths, homeopaths, dietician and acupuncture treatment. c) Out-Patient Treatment for Traditional Chinese Medicine or Ayurvedic Medicine administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses. Exclusion 5.41 applies. You may choose 5 sessions for any combination of benefits in aggregate in a given period of cover for benefits a) and b) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist. Annual Out-Patient Limit is applicable to Benefit 20 – Out-Patient Charges and Benefit 21 – Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.	a)  Up to RMB 380 per visit b)  Up to RMB 380 per visit c)  Up to RMB 190 per visit Combined up to 10 visits for a), b) and c) per period of cover, subject to Annual Out-Patient Limit

Benefit	SimpleCare Jade
22. Menopause Hormone Replacement Therapy: <i>The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and treatment commence below the age of 40 years.</i>	 Up to RMB 1,200 per period of cover
23. Out-Patient Psychiatric Illness: <i>Out patient treatment administered by a registered psychologist and/or a registered psychiatrist, subject to 10 sessions and the cost limit under this section.</i> <i>For the first 5 sessions you may choose to visit a registered psychologist directly without the need for referral. However, any subsequent sessions with a registered psychologist will require referral and a treatment plan with a medical practitioner or specialist.</i>	 Up to RMB 1,850 and subject to a maximum of 10 sessions per period of cover
24. Dental Care: <i>Fees of a registered Dental Practitioner carrying out dental Treatment in a dental clinic/surgery.</i> <i>This Benefit provides cover for the below dental Treatment:</i> – Screening (including x-rays where necessary) – Preventive scaling, polishing, and sealing (once per year) – Fillings and extractions (non-surgical and surgical) – Root canal treatment – New or repair of crowns, dentures, in lays and bridges – Apicoectomy – Prescribed Drugs and Dressings <i>Dental implants and orthodontics Treatment are specifically excluded under this Benefit.</i> <i>No other Treatment is covered by this Benefit.</i> Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not. <i>A co-insurance of 20% applies.</i> For this Benefit the deductible or out-patient per visit excess does not apply.	 Not Covered

Additional Options	SimpleCare Jade
25. Mainland China option: <i>The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Mainland China and will be subject to the standard policy limits.</i> <i>Emergency non-elective treatment outside of Mainland China:</i> <i>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.</i> <i>Full refund for accident requiring in-patient and day-patient care.</i> <i>Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover</i>	 Optional <i>Emergency non-elective treatment outside of Mainland China: illness limit up to RMB 150,000 per period of cover</i>
26. Hospital Room Restriction – Hospital Room & Board Limit RMB 800: <i>As described in Article 5 Benefit 1 a) on the insurance contract, but with a restriction to limit the hospital accommodation for hospital admission in Mainland China up to RMB 800 per day for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.</i>	 Optional <i>In-patient or day-patient treatment received in any in-patient or day-patient facility in Mainland China up to RMB 800 per day</i>
27. High Cost Provider Restriction: <i>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.</i>	 Optional
28. In-Patient Co-Insurance at Private Hospital: <i>The insurer will cover the actual medical costs associated with the benefits for eligible in-patient or day-patient treatment at a private hospital subject to 20% co-insurance.</i>	 Optional <i>20% co-insurance</i>
29. Annual Maximum Policy Limit RMB 1,000,000: <i>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 policy limit of RMB 1,000,000.</i>	 Optional
30. Co-Insurance Out-Patient Treatment: <i>A 20% co-insurance will apply on all eligible out-patient treatment.</i> <i>Co-insurance does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.</i> <i>This option is not available for policies with deductibles of RMB 6,300 or higher. Should the plan includes maternity, dental care or wellness and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.</i>	 Optional
31. Out-Patient Per Visit Excess: <i>An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment.</i> <i>The out-patient per visit excess does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.</i> <i>This option is not available for Group Plans with deductibles of RMB 6,300 or higher.</i>	 Optional <i>RMB 150</i>
32. Removal of Drugs and Dressings Limit: <i>By selecting this option, cover for Prescribed Drugs and Dressings under Benefit 20 c) will be Full Refund, subject to annual Out-Patient limit.</i> <i>For Compulsory Group Plans 3+ employees</i>	 Not Covered

Additional Options	SimpleCare Jade
33. Wellness and Vaccinations – Option 1: Compulsory group policies 3+ employees a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or b) 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. For this Benefit exclusion 6.9 does not apply.	 Optional a) and b)  Combined limit up to RMB 950 per period of cover
34. Wellness and Vaccinations – Option 2: Compulsory group policies 3+ employees a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or b) 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. For this Benefit exclusion 6.9 does not apply.	 Optional a) and b)  Combined limit up to RMB 1,570 per period of cover
35. Maternity – Option 1: a) Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy. Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person. b) For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b): – 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 the insured person's 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 This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not. Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice. For Compulsory Group Plans 10+ employees For this Benefit exclusion 6.27 does not apply. Deductible would apply to this benefit.	 Optional For Compulsory Group Plans 10+ employees a)  Up to RMB 31,500 per Period of Cover b)  Up to RMB 75,600 per Period of Cover

Additional Options	SimpleCare Jade
36. Maternity – Option 2: a) Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy. Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person. b) For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b): – 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 the insured person's 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 This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not. Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice. For Compulsory Group Plans 10+ employees For this Benefit exclusion 6.27 does not apply. Deductible would apply to this benefit.	 Optional For Compulsory Group Plans 10+ employees a)  Up to RMB 44,100 per Period of Cover b)  Up to RMB 94,500 per Period of Cover

Underwriting Options	SimpleCare Jade
37. Capped Cover for Declared Pre-existing Medical Conditions: <i>For Compulsory Group Plans 5 to 19 employees.</i> <i>This underwriting option provides limited cover for any pre-existing Medical Conditions that are declared and accepted by Us.</i> Waiting period: Any expenses incurred within 180 days after the start date of the insured Person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.	 Optional <i>For Compulsory Group Plans 5 to 19 employees</i> After Waiting Period: RMB 12,600 per declared pre-existing Medical Condition After Waiting Period and until the Group Plan renews: RMB 25,200 per declared pre-existing Medical Condition, per Period of Cover
38. Medical History Disregarded: <i>Compulsory group policies 10+ employees</i>	 Optional

Deductible Options	SimpleCare Jade
Standard Deductible	RMB 3,150
Optional Deductible Please note: RMB 63,000 or RMB 94,500 deductible is only available if the policyholder is covered by more than one health insurance policy. The policyholder can only select such deductible options if the policyholder buys this policy as a Secondary Health Insurance Policy. The policyholder will be required to provide details of the policyholder's Primary Health Insurance when the policyholder applies for cover under this policy.	Nil RMB 950 RMB 1,570 RMB 6,300 RMB 15,700 RMB 31,500 RMB 63,000 RMB 94,500

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

Benefit	SimpleCare Crystal
Annual Maximum Group Policy Limit <i>24/7 helpline and assistance services available on all Plans</i>	RMB 9,450,000
Geographical Area Default:	Worldwide Excluding USA
Default Network:	SimpleCare Comprehensive Network
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 Pre-Authorisation 📞 b)  Up to RMB 9,450 per medical condition
2. Diagnostic Procedures: Medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an in-patient, day-patient or out-patient.	 Full Refund Pre-Authorisation for MRI, PET and CT 📞
3. Renal Failure and Renal Dialysis: a) Treatment of renal failure, including renal dialysis on an in-patient basis. b) Treatment of renal failure, including renal dialysis on a day-patient or out-patient basis.	a)  Up to six weeks full refund per period of cover b)  Up to RMB 310,000 per period of cover
4. Organ Transplant: Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow or cornea, 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 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant. 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. Medical costs associated with the donor and the cost of the donor organ search are excluded from this Benefit.	 Up to RMB 945,000 per period of cover
5. 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

Benefit	SimpleCare Crystal
6. New Born Baby Cover: <i>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.</i> <i>In circumstances where the insurer requires details of the new born baby's medical history before the baby is being added to the policy, the insurer reserves the right to apply particular restrictions to the cover the insurer will offer.</i> <i>Please refer to Article 3 – adding new born of this policy wording for details.</i>	 Up to RMB 220,500 per period of cover
7. Congenital Disorders: <i>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 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders.</i>	 Up to RMB 220,500 per period of cover
8. Parent Accommodation: <i>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.</i>	 Full refund
9. Hospital Accommodation for New Born Accompanying their Mother: <i>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.</i>	 Full refund
10. Reconstructive Surgery: <i>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.</i>	 Full refund
11. Day-Patient and Out-Patient Surgery: <i>Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department.</i>	 Full refund
12. In-Patient Emergency Dental Treatment: <i>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.</i> <i>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:</i> <i>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</i> <i>b) If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead</i> <i>c) Damage to dentures providing they were being worn at the time of the injury.</i>	 Full refund
13. Rehabilitation: <i>When referred by 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:</i> <i>a) Use of special treatment rooms</i> <i>b) Physical therapy fees</i> <i>c) Speech therapy fees</i> <i>d) Occupational therapy fees</i>	 Full Refund up to 90 days per medical condition
14. Nursing Care at Home: <i>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.</i>	 Full Refund up to 30 days per medical condition Pre-Authorisation 📞

Benefit	SimpleCare Crystal
15. Emergency Ambulance Transportation: <i>Emergency road ambulance transport costs to or between hospitals, or when considered medically necessary by a medical practitioner or specialist.</i>	 Full refund
16. Evacuation and Repatriation: a) Evacuation <i>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.</i> <i>Reasonable expenses for:</i> i) <i>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.</i> ii) <i>Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.</i> iii) <i>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.</i> iv) <i>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.</i> 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. <i>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.</i> b) Repatriation <i>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 to 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.</i> <i>We do not cover standalone repatriation. This eligible repatriation expense will only be covered after the initial eligible medically necessary evacuation has been taken place.</i> Deductible would apply to medically necessary treatment required under this benefit.	Pre-Authorisation 📞 Combined limit up to RMB 630,000 a) Evacuation i)  Full Refund ii)  Full Refund iii)  Full Refund iv)  Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation Pre-Authorisation 📞 b) Repatriation  Full refund
17. Mortal Remains: <i>In the event of death from an eligible medical condition, reasonable and customary charges for:</i> a) <i>Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or</i> b) <i>Burial or cremation costs at the place of death in accordance with reasonable and customary practice.</i>	Pre-Authorisation 📞 a)  Full Refund b)  Up to RMB 63,000
18. Emergency Non-Elective Treatment outside Area of Cover: <i>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.</i>	 Accident: Full Refund for in-patient and day-patient treatment following accident  Illness: In-patient and day-patient care up to RMB 220,500 per period of cover
19. Hospital Cash Benefit: <i>The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if:</i> a) <i>the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or</i> b) <i>this policy being the Secondary Health Insurance Policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.</i> <i>Cover under this benefit is limited to a maximum of 30 nights per period of cover.</i> For this Benefit exclusion 6.9 does not apply.	 RMB 1,575 per night

Benefit	SimpleCare Crystal
Annual Out-Patient Limit Applicable to Benefit 20 and 21 only, subject to Annual Maximum Policy Limit	RMB 15,750
20. Out-Patient Charges: a) Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests; b) Teleconsultation (Virtual Doctor appointments via electronic means). Costs associated with Eligible Treatment will be paid in full where Treatment is received from Medical Providers listed in the SimpleCare Comprehensive Network. Treatment that is not received in the SimpleCare Comprehensive Network will pay Reasonable & Customary charges. c) Prescribed Drugs and Dressings. d) Vitamins and Minerals: Vitamins and Minerals as prescribed by a Medical Practitioner. Vitamins, minerals and eye lubricants prescribed for a diagnosed deficiency will be paid as per the Out-Patient Benefit d). Any pre-operative and post-hospitalisation consultations are payable under this Benefit. The insured does not have cover for costs relating to the maintenance of Chronic Conditions unless the insured is insured under SimpleCare Jade or SimpleCare Crystal, which the insurer will pay such eligible costs under Article 5, Benefit 20 – Out-Patient Charges. Please note: If claim receipts do not show a breakdown of the medical services rendered, We will only pay Eligible claims up to the Prescribed Drugs and Dressings limit. Annual Out-Patient Limit is applicable to Benefit 20 – Out-Patient Charges and Benefit 21 – Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.	a) and b)  Full refund subject to Annual Out-Patient Limit c)  Up to RMB 7,875 per period of cover d)  Up to RMB 940 per period of cover a), b), c) and d) subject to Annual Out-Patient Limit
21. Out-Patient Physiotherapy and Alternative Therapies The insurer will cover the actual incurred medical cost of: a) Physiotherapy by a Registered Physiotherapist. b) Complementary medicine and treatment by a therapist. This benefit extends to chiropractors, chiropodists and podiatrists, osteopaths, homeopaths, dietician and acupuncture treatment. c) Out-Patient Treatment for Traditional Chinese Medicine or Ayurvedic Medicine administered by a recognised Traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner. All claims to include diagnosis, consultation fee, Treatment type, Treatment fee, prescription including detailed medication and number of doses. Exclusion 5.41 applies. You may choose 5 sessions for any combination of benefits in aggregate in a given period of cover for benefits a) and b) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist. Annual Out-Patient Limit is applicable to Benefit 20 – Out-Patient Charges and Benefit 21 – Out-Patient Physiotherapy and Alternative Therapies only, subject to Annual Maximum Policy Limit.	a)  Up to RMB 500 per visit b)  Up to RMB 500 per visit c)  Up to RMB 250 per visit Combined up to 10 visits for a), b) and c) per period of cover, subject to Annual Out-Patient Limit

Benefit	SimpleCare Crystal
22. Menopause Hormone Replacement Therapy: <i>The cost of Hormone Replacement Therapy when required to alleviate the symptoms of the early onset of menopause where onset and treatment commence below the age of 40 years.</i>	 <i>Up to RMB 1,850 per period of cover</i>
23. Out-Patient Psychiatric Illness: <i>Out patient treatment administered by a registered psychologist and/or a registered psychiatrist, subject to 10 sessions and the cost limit under this section.</i> <i>For the first 5 sessions you may choose to visit a registered psychologist directly without the need for referral. However, any subsequent sessions with a registered psychologist will require referral and a treatment plan with a medical practitioner or specialist.</i>	 <i>Up to RMB 2,500 and subject to a maximum of 10 sessions per period of cover</i>
24. Dental Care: <i>Fees of a registered Dental Practitioner carrying out dental Treatment in a dental clinic/surgery.</i> <i>This Benefit provides cover for the below dental Treatment:</i> – Screening (including x-rays where necessary) – Preventive scaling, polishing, and sealing (once per year) – Fillings and extractions (non-surgical and surgical) – Root canal treatment – New or repair of crowns, dentures, in lays and bridges – Apicoectomy – Prescribed Drugs and Dressings <i>Dental implants and orthodontics Treatment are specifically excluded under this Benefit.</i> <i>No other Treatment is covered by this Benefit.</i> <i>Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.</i> <i>A co-insurance of 20% applies.</i> <i>For this Benefit the deductible or out-patient per visit excess does not apply.</i>	 <i>Up to RMB 1,900 per period of cover</i>

Additional Options	SimpleCare Crystal
25. Mainland China option: <i>The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Mainland China and will be subject to the standard policy limits.</i> <i>Emergency non-elective treatment outside of Mainland China:</i> <i>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.</i> <i>Full refund for accident requiring in-patient and day-patient care.</i> <i>Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover</i>	 Optional <i>Emergency non-elective treatment outside of Mainland China: illness limit up to RMB 150,000 per period of cover</i>
26. Hospital Room Restriction – Hospital Room & Board Limit RMB 800: <i>As described in Article 5 Benefit 1 a) on the insurance contract, but with a restriction to limit the hospital accommodation for hospital admission in Mainland China up to RMB 800 per day for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.</i>	 Optional <i>In-patient or day-patient treatment received in any in-patient or day-patient facility in Mainland China up to RMB 800 per day</i>
27. High Cost Provider Restriction: <i>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.</i>	 Optional
28. In-Patient Co-Insurance at Private Hospital: <i>The insurer will cover the actual medical costs associated with the benefits for eligible in-patient or day-patient treatment at a private hospital subject to 20% co-insurance.</i>	 Optional 20% co-insurance
29. Annual Maximum Policy Limit RMB 1,000,000: <i>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 policy limit of RMB 1,000,000.</i>	 Optional
30. Co-Insurance Out-Patient Treatment: <i>A 20% co-insurance will apply on all eligible out-patient treatment.</i> <i>Co-insurance does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.</i> <i>This option is not available for policies with deductibles of RMB 6,300 or higher. Should the plan includes maternity, dental care or wellness and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.</i>	 Optional
31. Out-Patient Per Visit Excess: <i>An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment.</i> <i>The out-patient per visit excess does not apply to renal dialysis/renal failure, cancer or organ transplant treatment.</i> <i>This option is not available for Group Plans with deductibles of RMB 6,300 or higher.</i>	 Optional RMB 150
32. Removal of Drugs and Dressings Limit: <i>By selecting this option, cover for Prescribed Drugs and Dressings under Benefit 20 c) will be Full Refund, subject to annual Out-Patient limit.</i> <i>For Compulsory Group Plans 3+ employees</i>	 Optional For Compulsory Group Plans 3+ employees

Additional Options	SimpleCare Crystal
33. Wellness and Vaccinations – Option 1: <i>Compulsory group policies 3+ employees</i> a) <i>Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or</i> b) <i>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.</i> For this Benefit exclusion 6.9 does not apply.	 Optional a) and b)  Combined limit up to RMB 950 per period of cover
34. Wellness and Vaccinations – Option 2: <i>Compulsory group policies 3+ employees</i> a) <i>Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or</i> b) <i>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.</i> For this Benefit exclusion 6.9 does not apply.	 Optional a) and b)  Combined limit up to RMB 1,570 per period of cover
35. Maternity – Option 1: a) <i>Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hemotocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.</i> Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person. b) <i>For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):</i> – 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 the insured person's 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 <i>This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.</i> Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not. Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice. <i>For Compulsory Group Plans 10+ employees</i> For this Benefit exclusion 6.27 does not apply. Deductible would apply to this benefit.	 Optional For Compulsory Group Plans 10+ employees a)  Up to RMB 31,500 per Period of Cover b)  Up to RMB 75,600 per Period of Cover

Additional Options	SimpleCare Crystal
36. Maternity – Option 2: a) Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy. Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person. b) For 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, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b): – 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 the insured person's 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 This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not. Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice. For Compulsory Group Plans 10+ employees For this Benefit exclusion 6.27 does not apply. Deductible would apply to this benefit.	 Optional For Compulsory Group Plans 10+ employees a)  Up to RMB 44,100 per Period of Cover b)  Up to RMB 94,500 per Period of Cover

Underwriting Options	SimpleCare Crystal
37. Capped Cover for Declared Pre-existing Medical Conditions: <i>For Compulsory Group Plans 5 to 19 employees.</i> <i>This underwriting option provides limited cover for any pre-existing Medical Conditions that are declared and accepted by Us.</i> Waiting period: Any expenses incurred within 180 days after the start date of the insured Person's policy are not payable. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.	 Optional <i>For Compulsory Group Plans 5 to 19 employees</i> <i>After Waiting Period:</i> RMB 12,600 <i>per declared pre-existing Medical Condition</i> <i>After Waiting Period and until the Group Plan renews:</i> RMB 25,200 <i>per declared pre-existing Medical Condition, per Period of Cover</i>
38. Medical History Disregarded: <i>Compulsory group policies 10+ employees</i>	 Optional

Deductible Options	SimpleCare Crystal
Standard Deductible	RMB 3,150
Optional Deductible <i>Please note:</i> <i>RMB 63,000 or RMB 94,500 deductible is only available if the policyholder is covered by more than one health insurance policy. The policyholder can only select such deductible options if the policyholder buys this policy as a Secondary Health Insurance Policy. The policyholder will be required to provide details of the policyholder's Primary Health Insurance when the policyholder applies for cover under this policy.</i>	Nil RMB 950 RMB 1,570 RMB 6,300 RMB 15,700 RMB 31,500 RMB 63,000 RMB 94,500



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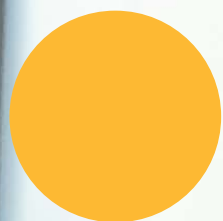
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Registered Office: 29-30F, Dutyfree Business Building, 1st Fuhua Road, Futian CBD, Shenzhen 518048, China.
Policies are administered by Now Health International (Shanghai) Limited.
Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.

《易全保》
会员手册
SimpleCare
Members'
Handbook



团体
Companies



您需要知道的国际医疗保险

Everything you need to know about your international health insurance

二零二三年八月生效
Effective August 2023

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简介

欢迎您加入亚太财险与时康的“易全保”国际医疗保险。您的公司或雇主选择了我们来为您提供国际医疗团体保险。本会员手册旨在为您提供明确的指引，以确保您了解如何使用您的保险计划。请仔细阅读本会员手册内容。

1. 如何使用本手册？

本手册是很重要的文件。它阐明了您的权利和我们对您的义务。您所选择的易全保保险计划的保障范围，请参见保险合同条款中的第五条 — 保险责任。

在这手册中，包含以下内容：

- 如何提交理赔
- 如何管理您的团体保险计划
- 如何提交投诉
- 您在团体保险计划中所能享受到的服务

我们为您提供的服务

当您需要使用您的医疗保险时，我们可以为您提供如下服务：

- 迅速处理您的理赔
- 24小时客户服务热线
- 帮助在您所在的地区寻找合适的医疗机构
- 提供预先书面同意服务，以减少您的医疗支出
- 通过国际化的理赔管理团队，为您提供专业医疗支持

如果您希望更进一步了解此项保险计划，或者您有任何建议，请通过以下方式联系我们：

时康管理顾问（上海）有限公司

中国上海市虹口区吴淞路218号宝矿国际大厦11楼1105室，邮编200080

电话 +86 400 077 7500 / +86 21 6156 0910 | 传真 +86 400 077 7900 | CustomerService@now-health.com

联系我们

请您务必仔细阅读本手册。同时您也可以致电我们的客户服务团队，我们将竭诚回答您的所有相关疑问。

如果您有任何与您的团体保险有关的疑问，您可以拨打电话 +86 400 077 7500 / +86 21 6156 0910 或发送邮件到 CustomerService@now-health.com。例如，如果您需要相关治疗，您可以在接受治疗以前通知我们，以便我们向您说明您的保障范围。

如果您有任何有关您个人信息的变更需要告知我们，您可以按以上联系方式联系我们，或者写信至：

时康管理顾问（上海）有限公司

中国上海市虹口区吴淞路218号宝矿国际大厦11楼1105室，邮编200080

请注意为了提高我们的服务质量，您的来电可能会被录音以作内部管理及培训之用。

客户服务团队

我们中国办公室的办公时间是周一到周五，早上9点至下午6点。

电话 +86 400 077 7500 / +86 21 6156 0910 | 传真 +86 400 077 7900

紧急转运及送返援助团队

我们的服务团队能够提供多种语言服务，每天24小时，全年365天随时为您服务。更多关于紧急转运及送返服务的信息请参考本手册第3.3项。

电话 +86 400 077 7600 / +86 21 6156 0914

如果有任何关于会员资格或理赔进展的疑问，您可以登录到 www.now-health.cn 进入您的网上安全组合区自助查询，或者发送邮件至 ClinicalService@now-health.com。

Introduction

Welcome to Now Health International's SimpleCare product distributed and underwritten in China by Asia-Pacific P&C. Your company or employer has chosen us to provide your international health insurance group plan.

The objective for this handbook is to provide you clear information about how your policy works and how to use it. Please read this handbook carefully.

1. How to use this handbook

This handbook is an important document. It sets out your rights and our obligations to you. Along with the insurance policy, Article 5 — insurance liability, it explains your SimpleCare group policy and the terms of your cover.

Inside you will find details of:

- How to make a claim
- How your group policy is administered
- How to make a complaint
- Other services available to you under your group policy

Our service for you

When you need to use your insurance, here's what you can expect from us:

- A commitment to process your claim as quickly as possible
- A 24-hour customer service team
- Help to find suitable healthcare providers in your area
- Pre-authorisation of certain claims where possible, to reduce your out-of-pocket expenses
- An international claims management team with the medical expertise to support you in making decisions about your healthcare

If you require more details about this group policy, or if you would like to tell us about any changes in your personal circumstances, please contact us through our administrator at:

Now Health International (Shanghai) Limited

Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China
T +86 400 077 7500 / +86 21 6156 0910 | F +86 400 077 7900 | CustomerService@now-health.com

Contacting Us

While it is important that you read and understand this group policy members' handbook, we understand that there are times when it is easier to call us for information. Our customer service team is ready to help with any queries you may have.

If you have any questions about your group policy, you can contact us on +86 400 077 7500 / +86 21 6156 0910 or email CustomerService@now-health.com. For example, if you need treatment, you can contact us first so we can explain the extent of your cover before you incur any costs.

If you need to let us know about any changes in your personal circumstances, you can do so using the contact details above, or write to us through our administrator at:

Now Health International (Shanghai) Limited

Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China

Please note that we may record and/or monitor calls for quality assurance and training and as a record of our conversation.

Customer service team

Our China team is available Monday to Friday from 9am to 6pm.

T +86 400 077 7500 / +86 21 6156 0910 | F +86 400 077 7900

Assistance team for emergency evacuation or repatriation

Our multilingual team is available 24 hours a day, 365 days a year. For details on how to use our emergency evacuation and repatriation service see section 3.3.

T +86 400 077 7600 / +86 21 6156 0914

If you have any questions about your membership or would like to request information on the progress of a claim, you can log in to your secure online portfolio provided by our administrator at www.now-health.cn or contact us via email at ClinicalService@now-health.com.

2. 在线管理您的保险

您的网上安全组合区简介

访问我们的网站 www.now-health.cn 通过网上安全组合区管理您的国际医疗保险，是最简单快捷的方法。

您的所有相关文件都保存在一个网上安全组合区里，您可以使用您的用户名和密码进行登录查询。

如果需要帮助，请致电 +86 400 077 7500 / +86 21 6156 0910。

关于我

在此项中，您可以查看并更新个人联系信息，登录信息，您的文档传递和您可以告诉我们如何支付您的索赔。

我的保单

在此项中，您可以查看并下载保险凭证，会员手册和理赔申请表。您可以要求更换会员证并查看您的计划细节。

我的索赔

在此项中，您可以找到最适合您的方式来提交理赔。在这里您可以在线提交索赔，并且实时跟踪理赔进展状态。

您可以查看所有的理赔记录，包括有关过去和现在理赔状态，就诊医院，理赔申请及赔付的金额与币种（只有发生在海外的理赔，可以允许选择赔付币种）等。所有的信息都是实时更新，以便让您随时查看您的理赔最新情况。

您也可以从这里提交预先授权申请表。

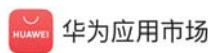
其他功能

除了以上各项功能，您也可以通过这个网站，通过网上安全组合区直接联系我们，下载各种表格以及向我们推荐您常就诊的医院，并在时康国际医疗机构网络中寻找到您的首选医疗机构。欲了解更多信息，请访问

www.now-health.cn 首页中的常见问题选项。

下载我们的移动应用程序

我们的移动应用程序提供了多项功能，适用于iPhone和小米(Mobile Internet)，您能够容易在时康国际医疗机构网络中查找您的首选医疗机构，同时您亦可透过移动应用程序提交索赔。



2. Manage your policy online

A guide to the secure online portfolio area

The simplest way to manage **Your Plan** is via the secure online portfolio area which **You** can access at www.now-health.cn. To access it **You** need the unique username and password **You** were supplied with when **You** joined. If **You** need help to retrieve this information, contact **Us** on +86 400 077 7500 / +86 21 6156 0910.

About me

In this section **You** can view and update **Your** personal contact and login details, **Your** document delivery settings and tell **Us** how **You** would like **Us** to pay **Your** claims.

My Plan

You can view **Your Plan** details and download **Your Certificate of Insurance**, members' handbook and claim form from here. **You** can order replacement membership cards and view **Your Benefit** limits.

My claims

Here **You** can make a claim online and track **Your** claims in real time. **You** can view information about all **Your** claims, past and present, including claim status, the medical provider and the amounts claimed and settled, in the currency **You** have selected. All updated are displayed as they happen so **You** always have the latest information. **You** can also submit a pre-authorisation request from here.

Other features

In addition to the above, **You** can use the secure online portfolio to download forms, introduce **Us** to **Your** preferred intermediary or medical provider and find a medical provider in the **Now Health International Provider Network**.

For more information, visit the FAQ section of the website, which **You** can access from **Our** homepage www.now-health.cn

Download our mobile app

Our mobile app, which is available for both iPhone and MI (Mobile Internet) has many useful functions including the ability to find a medical provider with the **Now Health International Provider Network** and submit a claim for **Treatment You** have already paid for in a few simple touches.



3. 如何理赔

您加入我们的保险计划后，可以联系我们的客户服务团队寻求相关帮助。

同时您可以拨打我们的24小时紧急援助热线。

在时康国际的会员网站上，您的网上安全组合区有一个专门的理赔区，通过此区域您可以查看您所有的理赔记录。除此以外您还可以找到最适合您的方式提交理赔。登录此网站仅需要您的时康会员用户名及密码。

为了让我们能快速审核您的理赔，请遵照以下步骤：

3.1 对于您已支付医疗费用的理赔

第一步

选择您提交理赔的方式

您可以通过 www.now-health.cn 登录您的网上安全组合区提交理赔。此外，您也可以通过移动应用程序或如果您更喜欢更传统的解决方案，您可以使用电子邮件，传真或邮寄方式向我们发送理赔申请表。

您可以通过 www.now-health.cn 登录您的网上安全组合区或“如何提交理赔”下载电子版理赔申请表。

如果需要帮助登录您的网上安全组合区，或者需要电子版或印刷版的理赔申请表，请致电 +86 400 077 7500 / +86 21 6156 0910 向我们的客户服务人员索取。

第二步

对于门诊和日间留院或住院治疗的每个医疗状况的医疗费用低于人民币3,000元的理赔

使用理赔申请表（印刷版或pdf）：

请完整填写理赔申请表的第一项和第二项，并签名。
然后连同您扫描的发票收据（请在每个发票收据上签名）以及您的身份证/护照复印件发送给我们。发票收据必须包括疾病病情，治疗详情，以及主治医生的姓名，职业资质，联系方式和盖章。（如果发票收据没有上述信息，请提供您的医疗记录和治疗费用明细。）

- 电邮至 ClaimsService@now-health.com 或
- 传真至 +86 400 077 7900，或
- 邮寄到时康管理顾问（上海）有限公司，上海市虹口区吴淞路218号宝矿国际大厦11楼1105室，邮编200080。

使用移动设备提交理赔：

完整填写理赔申请表，上传所要求的图像（包括您扫描的发票）（请在每个发票上签名）和身份证/护照复印件，接受声明和授权，然后点击“提交”。我们将在设置中保存您的信息。

使用网页设备提交理赔：

从下拉列表中选择被保险人，填写表单中的所有字段，上传所要求的图像，接受声明和授权，然后单击“提交理赔申请表”。

您的理赔需要包括以下资料：

- 正式的医疗费用发票
- 相关的医疗费用明细单
- 医疗病历/检查报告
- 身份证/护照复印件

第二步

对于日间留院或住院治疗的每个医疗状况的医疗费用等于或高于人民币3,000元的理赔

使用理赔申请表（印刷版或pdf）：

请完整填写理赔申请表的所有部分，签名并请求您的医生完成相关部分。使用以下方法之一并附上所有账单和副本的诊断报告，疾病病情和出院小结以及身份证/护照副本。请保留这些文件的副本，以备记录。

- 电邮至 ClaimsService@now-health.com 或
- 传真至 +86 400 077 7900，或
- 邮寄到时康管理顾问（上海）有限公司，上海市虹口区吴淞路218号宝矿国际大厦11楼1105室，邮编200080。

使用移动设备提交理赔：

您无法使用移动应用程序提交此理赔。

使用网页设备提交理赔：

扫描已完成的理赔表格，并附上所有账单和副本的诊断报告，疾病病情和出院小结（如果您是日间留院或住院病人）以及身份证/护照副本，然后单击“提交理赔申请表”。

您的理赔需要包括以下资料：

- 完整填写并签名的理赔申请表
- 正式的医疗费用发票
- 相关的医疗费用明细单
- 医疗病历/检查报告
- 身份证/护照复印件

第三步

在收齐所有必需的材料后，我们会审核您的理赔，并且在收到日起七个工作日内对所有在保障范围内的符合资格理赔进行审核。

第四步

您可以通过登录您的网上安全组合区对您所有的理赔进行跟踪查询（只提供英语服务）。

您可以随时登录网站查询您的理赔进展情况，包括理赔状态，就诊医院，申请及赔付的金额与币种，以及所有扣除的免赔额与自付比例。所有理赔都是实时更新以便您掌握最新情况。如果您的理赔状态发生变更，我们会第一时间发送邮件或短信通知您去登录查询。

重要提示：

您必须在接受治疗之日起六个月内向我们提交理赔（除非有不可抗力因素）。

如果您递交的理赔材料是复印件，请务必保存好原件。我们可能在您递交理赔的六个月之内请您重新递交原件。

如果您正在提交的或者已经提交的理赔的金额（以每位被保险人，每个医疗状况，每个保障期间为计）超过人民币3,000元，请确保让您的主治医生完整填写理赔单上的第三部份。

如果您不能确定每个医疗状况的理赔金额是否超过人民币3,000元，请您完整填写理赔单上的所有选项，并且也请您的主治医生完整填写相关医疗信息，然后将所有原始材料邮寄至我公司。地址见第三步。

以下情况，需同时提供被保险人的身份证/护照复印件：

1. 给付货币为人民币，索赔金额人民币10,000元或以上；或
2. 给付货币为非人民币。

请注意，上述提交理赔过程不适用于生育，牙科和体检、眼科、疫苗医疗保障费用。

3. How to claim

As soon as you join, you can contact our customer service team for support.

You also have access to our international helpline, which is open 24 hours a day, 365 days a year.

Your online secure portfolio area has a dedicated claims section with the latest information on past and present claims. You can also use this area to make a claim.

To log in, you just need your username and password provided by our administrator.

To help us assess your claim as quickly as possible, please follow these simple steps:

3.1 Claiming for treatment you have already paid for

Step 1

Choose how you would like to claim

You can claim using the secure online portfolio at www.now-health.cn, the mobile app or if you prefer a more traditional solution, you can send us a claim form using email, fax or post.

You can download a claim form from the secure online portfolio or the 'How to claim' page of www.now-health.cn.

Alternatively call us on +86 400 077 7500/ +86 21 6156 0910 to request a form or if you need help to access the secure online portfolio area.

Step 2

For all out-patient claims and in-patient/ day-patient claims under RMB 3,000 per medical condition:

Using the claim form (printed or pdf):

Complete sections 1 and 2 of the claim form, sign it, and send it to us with your scanned fapiao (please also sign your name on each medical fapiao) and a copy of your ID/passport if required. The fapiao must include details of the medical condition, treatment given and the name, qualifications, contact details and stamp of the attending medical practitioner. (If the fapiao does not have the above information, please provide your medical records.)

- Email to ClaimsService@now-health.com, or
- Fax to +86 400 077 7900, or
- Post to Now Health International (Shanghai) Limited, Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.

Using the mobile app:

Complete all the fields in the form, upload the requested images including your scanned fapiao (please also sign your name on each medical fapiao) and a copy of your ID/passport, accept the declaration and authorisation and click 'Submit'. We will save the information you include in your settings.

Using the secure online portfolio:

Select the Insured Person from the dropdown list, complete all the fields in the form, upload the requested images, accept the declaration and authorisation and click 'Submit form'.

Please include the following documents with your claim:

- Completed official Chinese fapiao
- Completed cost breakdown
- Completed medical notes/records
- ID/Passport copy

Step 2

For in-patient/day-patient claims equal to or over RMB 3,000 per medical condition:

Using the claim form (printed or pdf):

Complete all sections of the claim form, sign it and ask your medical practitioner to complete their relevant section. Sign the claim form and send all bills and copies of diagnostic reports, medical notes and a discharge summary (if you have been a day-patient or in-patient) plus a copy of your ID/passport using one of the methods below. Please keep a copy of these documents for your own records.

You can send us your completed claim form and supporting documents in one of the following ways:

- Email to ClaimsService@now-health.com, or
- Fax to +86 400 077 7900, or
- Post to Now Health International (Shanghai) Limited, Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China.

Using the mobile app:

You cannot use the mobile app to submit a claim of this value.

Using the secure online portfolio:

Scan the completed claim form and upload it along with all bills and copies of diagnostic reports, medical notes and a discharge summary (if you have been a day-patient or in-patient) plus a copy of your ID/passport, and click 'Submit form'.

Please include the following documents with your claim:

- Completed claim form with signature
- Completed official Chinese fapiao
- Completed cost breakdown
- Completed medical notes/records/discharge summary
- ID/Passport copy

Step 3

We will assess your claim. Provided we have all the information we need, we will assess all eligible claims within seven working days of receipt.

Step 4

You can track all your claims using your online secure portfolio area.

Log in at any time using your username and password to see how your claim is progressing. You will be able to view the status, the provider, the currency claimed and settled and the benefit for each individual claim, as well as any deductible, co-insurance or out-patient per visit excess applied. All updates are displayed as they happen so you always have the latest information on your claims. We will email or SMS you every time there is a change to the claims status on your account so you know the most relevant time to log in.

Important notes:

You must send us your claim within six months of treatment (unless this is not reasonably possible).

Please keep original records if you are sending us a copy, as we may ask you to forward these at a later date.

If we do, it will be within six months of when you told us about the claim.

If the total amount you are claiming now or have claimed (per insured person, per medical condition, per period of cover) is over RMB 3,000, please ensure Section 3 of the claim form is completed by the treating medical practitioner. If you don't know if your claim falls within the RMB 3,000 per medical condition guideline, please complete all sections of the claim form and ask your medical practitioner to complete their section then post it with the original receipts to the address in Step 3.

For any claim amount more than RMB 10,000 or any overseas claims (settlement in non RMB), please also enclose a copy of your ID/passport.

Please note that the above process applies to claims against both the maternity, dental and wellness, optical and vaccinations benefits, should you have opted for a policy with those Benefits.

3. 如何理赔

3.2 安排直付服务

3.2.1 住院及日间留院治疗

如果您需要接受住院治疗或日间留院治疗，我们会尽力安排与合作医疗机构进行直接结算。

第一步

在您住院前5个工作日（或尽可能提前），您可以通过以下方式联系我们的客户服务团队：
电话 +86 400 077 7500 / +86 21 6156 0910 | 传真 +86 400 077 7900 | ClinicalService@now-health.com
请告知您即将接受住院治疗或日间留院治疗的医疗机构的名称，电话号码，传真号码，医院联络人姓名及主治医生姓名。



第二步

选择您提交理赔的方式

您的医生应需要填写预先授权申请表。
您可以从时康网站的“如何提交理赔”或您的网上安全组合区下载此表。
如果您的医生完整填写理赔申请表上所有相关选项，他们可以直接将其提交给我们，或者您可以使用理赔申请表中的一种方法提交或登录网上安全组合区，通过“我的理赔”提交。我们将作适当安排并与您联系。



第三步

在您接受治疗当天，到达医疗机构后请您先出示您的会员卡，并告知工作人员我们已经为您安排了直付服务。
我们可能会请您填写一些附加的表格，您可以通过 www.now-health.cn 登录您的网上安全组合区找到所有相关文件。
在您离开之前，您需要支付您的保险合同下所有相关免赔额或自付比例。



第四步

在您离开的时候，请让医疗机构工作人员将所有原始理赔申请表和账单邮寄给我们以申请赔付。您可以使用您的用户名和密码通过登录时康国际的网站 www.now-health.cn，通过您的网上安全组合区跟踪查询您所有的理赔记录。

重要提示：
如果您需要接受住院治疗，日间留院治疗或者重大门诊治疗，请务必在接受治疗前告知我们。我们会尽力安排与合作医疗机构进行直接结算。这意味着您可能需要向医疗机构支付押金甚至全额支付您的账单。
如果您需要再次接受住院治疗或日间留院治疗，尽管可能是因为相同的疾病，我们仍然需要您提交新的理赔申请表。
在您离开之前，您需要支付您的保险合同下所有相关免赔额或自付比例。

3. How to claim

3.2 Arranging Direct Settlement

3.2.1 *For in-patient and day-patient treatment*

If you are referred for in-patient or day-patient treatment, we will try to arrange to settle the bill directly with the medical provider.

Step 1

Five working days before you are admitted (or whenever possible), contact our customer service team on
T +86 400 077 7500 / +86 21 6156 0910 | F +86 400 077 7900 | ClinicalService@now-health.com

Tell us the hospital name, telephone number, fax number, the contact name at the hospital and the name of the medical practitioner.



Step 2

Choose how you would like to claim.

Your medical practitioner should complete a Pre-authorisation Request Form. You can download this form from the 'How to claim' page of the website or from the secure online portfolio area.

Once your medical practitioner has completed the form, they can return it to us directly or you can do so using one of the methods on the form or using the secure online portfolio area in the My Claims page.

We will contact you once the arrangements have been made.



Step 3

When you arrive at the medical provider on the day of your treatment, show your membership card and tell them that Direct Billing has been arranged.

We may also ask you to fill in some extra forms. You can access all the forms you need from your online secure portfolio area at www.now-health.cn.

You will need to pay any deductible on your group plan to the medical provider before you leave.



Step 4

When you leave, ask the medical provider to send the original claim form and bill to us for payment. You can track all subsequent claims activity in your secure online portfolio area. Log in using your username and password at www.now-health.cn.

Important notes:

For in-patient treatment, day-patient treatment or major out-patient treatment, please contact us before you get treatment. If you don't make contact before your admission, we may not be able to arrange to pay the medical provider directly. This might mean that you have to pay a deposit to the medical provider or pay your bill in full.

If you need repeat in-patient or day-patient treatment, we need a new claim form for each stay, even if it's for the same medical condition.

You will need to pay any deductible or co-insurance on your group policy to the medical provider before you leave.

3. 如何理赔

3.3 当您需要紧急医疗治疗时

如果您因为紧急状况而接受住院治疗，或者您因为紧急状况需要被转运到另一个医疗机构，那么您，您的主治医生或者就诊医院必须在第一时间联系我们的24小时紧急援助服务团队。

通过联系我们的紧急援助服务团队，在条件允许的情况下，我们可以帮助直接结算您的医疗账单，并且确保尽快审核您的理赔申请。

第一步

您可以通过致电 +86 400 077 7600 / +86 21 6156 0914 或者发送邮件至 ClinicalService@now-health.com 联系我们的紧急援助服务团队。我们将竭诚为您提供全天24小时，全年365天无休的服务。他们可能需要核查相关信息，包括您的姓名，会员号码，医院名称，医院联络人姓名和联系方式，主治医生姓名等。



第二步

我们的紧急援助服务团队将会核查您的疾病是否在您的团体保险合同的保障范围内。



第三步

如果您的疾病在保险合同的保障范围内，我们的紧急援助服务人员将会审核您的紧急入院申请或者紧急转运申请。



第四步

如果我们的紧急援助服务人员认定您的紧急状况符合以下几种情况：

- 面临生命危险
- 在您的保险保障范围之内
- 当地无法提供相关治疗
- 需要立即住院治疗

他们将会采取各种必要措施用空中或地面转移的方式帮助您转运到最近的能够提供相关治疗的医疗机构，同时会确保安排您在目的地所发生的在保障范围内的医疗费用的直接结算，例如住院费。



第五步

在治疗结束以后，我们的紧急援助工作人员会在您的健康情况允许的情况下帮助安排交通帮您返回合适的目的地。

重要提示：

我们只赔付由我们的紧急援助服务团队预先书面同意及安排的医疗转运的费用。如果医疗转运的费用直接或间接与您的保险凭证中所列的责任免除或者与您的保险合同中所列明的责任免除相关，我们将不会赔付此次医疗转运的费用。

3. How to claim

3.3 When you need emergency medical treatment

If a hospital admits you for emergency medical treatment or if the hospital that is treating your emergency medical condition tells you that you need to be evacuated to another medical facility for treatment, you, the treating medical practitioner or the hospital, must contact our 24 hour emergency assistance service as soon as possible.

By contacting our emergency assistance service you will give us the opportunity to arrange to settle your hospital bills directly where possible. It will also ensure that your claim can be processed without any delays.

Step 1

Contact our emergency assistance service on +86 400 077 7600 / +86 21 6156 0914 or email ClinicalService@now-health.com. This service is available 24 hours a day, 365 days a year.

They will need your name and membership number as well as the hospital name, telephone number and fax number, a contact name at the hospital and the name of the medical practitioner.



Step 2

Our emergency assistance service will verify whether the medical condition you are claiming for is eligible under your group policy.



Step 3

If your claim is eligible, our emergency assistance service staff will consider your emergency admission or your request for evacuation in relation to your medical needs.



Step 4

If our emergency assistance service agrees that your medical condition meets all of the following:

- is life-threatening
- is covered by your policy
- cannot be treated adequately locally, and
- requires immediate in-patient treatment

They will make all the necessary arrangements to have you moved by air and/or surface transportation to the nearest hospital where appropriate medical treatment is available.

Our assistance service will also ensure that any eligible costs at the destination, such as admission costs, are settled directly with the hospital.



Step 5

Once you have received your medical treatment, if our emergency assistance service agrees that it is necessary, they will make all the necessary arrangements to repatriate you to your appropriate destination, provided that you are medically fit to travel.

Important notes:

We will only pay for evacuation costs that have been authorised and arranged by our emergency assistance service.

We will not pay for your evacuation costs if the evacuation is directly or indirectly related to a medical condition which has been specifically excluded on your certificate of insurance, or to any other medical condition or event specifically excluded in your group policy.

3. 如何理赔

3.4 在申请理赔时，您需要提供的资料

请您确保完整填写我们所要求的所有表格。

自接受治疗日起六个月内，您必须将所有相关理赔信息提供给我们（不可抗力因素情况除外）。

如果您所申请的日间留院或住院理赔金额或已经申请的理赔金额（以每名被保险人于每个保险期间的每个医疗状况）等于或超过人民币3,000元，请确保您的主治医生完整填写理赔申请表第三部分。

对于金额等于或超过人民币3,000元的理赔申请，您必须将原始单证提交给我们。以下情况，需同时提供被保险人的身份证/护照复印件：

1. 给付货币为人民币，索赔金额人民币10,000元或以上；或
2. 给付货币为非人民币。

3.5 我还需要提供其他信息吗？

有时候我们无法仅从您的理赔申请表来完成对您的理赔审核，这意味著我们可能需要您提供进一步的信息，这些将仅限于我们审核理赔所需要的合理信息。

我们可能需要您提供就诊病历记录，包括医疗转诊单。如果您无法合理提供给我们这些重要信息，我们将不得不拒绝赔付相关疾病理赔申请。这意味著我们将要求您返还我们此前已经赔付的与此疾病相关的理赔款。

当无法确定您的理赔是否在您的保险保障范围内时，我们可能会出资选择聘请医生复审您的理赔。他们可能会重新审查所有与此次理赔相关的医疗信息，或对您进行相关检查。我们会根据您的个人情况选择聘请相关医生进行复审。请您务必配合我们的医生，否则我们将不会赔付您的理赔。

3.6 如果同时投保了另一家保险公司，我应该如何申请理赔？

在提出理赔申请时，您必须向我们告知您是否能够从其他保险公司获得赔付。如果有其他的保单涉及此次理赔，我们将只对我们应当承担保险责任的合理的份额进行赔付。

如果您将此计划作为二级保险计划购买，在我们处理您的理赔之前，我们要求您提供以下信息：

- 您出于向主要医疗保险公司索赔为目的，已提交给您的主要医疗保险公司的理赔申请表、发票和收据的副本以及服务明细；和
- 一份由主保险公司出具的理赔通知书副本，其中显示了理赔情况评估详情，包括由您的主要医疗保险正在结算的理赔明细；和
- 您申请保险时未提供给我们的主要医疗保险的最新保险凭证的副本（如有）。

3.7 对于由他人导致的疾病或伤害，我应该如何申请赔付？

您必须在理赔申请表上注明您是否能够从他处或得任何赔偿。

如果您向我们提出申请赔付由他人导致的疾病所产生的治疗费用，我们仍将根据您的保险合同做出相关赔付。

如果您向我们提出申请赔付由他人所导致的受伤所产生的治疗费用，我们有权根据法律规定向该第三方追偿我们已向您赔付的款项。您必须尽快告知我们您对该第三方所采取的任何行动，并将采取行动后所产生的任何结果或解决方法及时通知我们。

如果您成功从第三方获得任何赔偿，您必须在收到此赔偿后的21天内根据以下约定将所得款项直接返还给我们。

- 如果您对第三方提出的索赔获得全额支付，您必须全额返还我们的理赔款；
- 如果您对所受到的伤害只获得了部分赔偿，您必须将这笔赔偿返还给我们已抵消我们已赔付的理赔款。

如果您没有将所获赔偿金返还给我们（包括从第三方处获偿的任何利益），我们有权要求您偿还我们金额。

3. How to claim

3.4 What documents do you need to provide to us during a claim?

Please make sure that you complete all the forms we ask you to.

You must send us all your claim information within six months of the first day of treatment (unless this is not reasonably possible).

If the total in-patient/day-patient treatment amount you are claiming now or have claimed (per insured person, per medical condition, per period of cover) is equal or over RMB 3,000, please ensure Section 3 of the claim form is completed by the treating medical practitioner.

For claims equal or over RMB 3,000 you must send us original receipts.

For any claim amount more than RMB 10,000 or any overseas claims (settlement in non RMB), please also enclose a copy of your ID / passport.

3.5 Do I need to provide any other information?

It may not always be possible to assess the eligibility of your claim from the claim form alone, which means we may sometimes ask you for additional information. This will only ever be reasonable information that we need to assess your claim.

We may request access to your medical records including medical referral letters. If you don't reasonably allow us access to this important information, we will have to refuse your claim. This means that we will also recoup any previous payments that we have made for that medical condition.

There may be instances where we are uncertain about the eligibility of a claim. If this is the case, we may, at our own cost, ask a medical practitioner chosen by us to review the claim. They may review the medical facts relating to a claim or ask to examine you in connection with the claim. In choosing a relevant medical practitioner, we will take into account your personal circumstances. You must co-operate with any medical practitioner chosen by us or we will not pay your claim.

3.6 What should I do if I also have cover on another insurance policy?

If You are making a claim, You must tell Us if You are able to claim any costs from another insurance policy. If another insurance policy is involved, We will only pay Our proper share.

If You are buying this Plan as a Secondary Insurance Plan, We request You to provide the following before We process Your claim:

- A copy of Your claim forms, invoices and receipts with service breakdown submitted to the Primary Health Insurer for the purpose of claim from Your Primary Health Insurance; and
- A copy of the claims settlement advices issued by the Primary Insurer which show the claims assessment details including the breakdown of claims being settled by Your Primary Health Insurance; and
- A copy of an updated Certificate Of Insurance of Your Primary Health Insurance that was not provided to Us when You applied for cover, if any.

3.7 What should I do if the benefits I am claiming relate to an injury or medical condition caused by another person?

You must tell us on the claim form if you are able to claim any of the cost from another person.

If you are claiming for treatment for a medical condition caused by another person, we will still pay for benefits that you can claim under the group policy.

If you are claiming for treatment for an injury caused by another person, we obtain the right by law, to recover the sum of the benefits paid from the other person. You must tell us as quickly as possible about any action against another person and keep us informed of any outcome or settlement of this action.

Should you successfully recover any monies from the third party, they should be repaid directly to us within 21 days of receipt on the following basis:

- if the claim against the third party settles in full, you must repay our outlay in full; or
- if you recover only a percentage of your claim for damages You must repay the same percentage of our outlay to us.

If you do not repay us (including any interest recovered from the third party), we are entitled to recover the same from you.

3. 如何理赔

3.8 如果您的保险合同中包含免赔额，门诊每次就诊免赔额和/或自付比例

免赔额，门诊每次就诊免赔额或自付比例都将显示在您的保险凭证上，并以于您的保费相同的币种收取。

免赔额，门诊每次就诊免赔额或自付比例是指当您的保险计划中的被保险人发生理赔时，您需对此承担的理赔成本。

当一个理赔申请可获赔付时，免赔额将会自动扣除，我们将先赔付保单范围内的住院或日间留院治疗的费用。

免赔额是基于每名被保险人于每个保险期间来扣除的。例如，如果被保险人在一个保险期间申请多于一次的住院治疗，则如果第一次理赔已经完成了免赔额可抵扣额，则该免赔额仅适用于首次符合条件的住院申请。如果第一次理赔后的免赔额未达到，则在支付任何合格理赔之前，可扣除免赔额的余额将从第二次索赔中扣除。

门诊每次就诊免赔额是基于每名被保险人于每次就诊来扣除的。例如，如果被保险人对单一或多重医疗状况的门诊咨询有不止一次的访问，则门诊每次就诊免赔额将适用于每次咨询。

自付比例是您在每个保险期限内支付合格理赔费用的百分比。例如，如果被保险人具有适用于符合门诊治疗的20%的自付比例，理赔额为1,000元，则被保险人必须支付200元，我们将支付理赔金额800元。

即使免赔额高于您的某次理赔申请金额，请您也务必将相关理赔申请表和账单提交给我们，以便我们正确地管理您的保险计划。当您向我们提交理赔时，我们将从应付理赔款中扣除免赔额，直至免赔额用完。

3.9 如何计算理赔应付款

所有中国大陆境内发生的理赔都只能以人民币进行结算。如果您的理赔是发生在中国大陆以外，我们也可以根据您的选择以您期望的币种进行支付（取决于当地货币和/或国际限制/监管规定）。我们会以就诊日期当天花旗银行的汇率为基准进行转换结算。

3. How to claim

3.8 If you have a deductible, an out-patient per visit excess and/or co-insurance on your policy

Any deductible, out-patient per visit excess or co-insurance applicable is shown on your certificate of insurance and charged in the same currency as your premium.

A deductible, an out-patient per visit excess or co-insurance is the amount you pay towards the cost of a claim for any insured person on your policy.

When a claim is made, any deductible is automatically deducted from the amount we pay in relation to eligible in-patient or day-patient treatment first.

The deductible applies per insured person, per period of cover. For example, if an insured person claims more than once for in-patient treatment during one period of cover, the deductible will only apply to the first eligible in-patient claim if the full deductible amount has already been fulfilled on the first claim. If the deductible has not been fulfilled after the first claim, the deductible balance will be taken from the second claim before any eligible claim amount is paid.

The out-patient per visit excess applies per insured person, per out-patient consultation in relation to eligible out-patient treatment. For example, if an insured person has more than one visit in relation to out-patient consultations for a single or multiple medical condition(s), then the out-patient per visit excess will be applied to each consultation.

A co-insurance is a percentage payment made by you towards the cost of an eligible claim per period of cover. For example, if an insured person has 20% co-insurance applicable on eligible out-patient treatment and the claimed amount is RMB 1,000, then the insured person will have to pay RMB 200 and we will pay RMB 800 towards this claim.

You need to submit your claim form and bills, even if the deductible or out-patient per visit excess is greater than the benefits you are claiming so we can administer your policy correctly. When you make a claim, we will reduce the amount we pay you until the deductible or out-patient per visit excess limit is used up.

3.9 How will claim reimbursements be calculated?

Claims reimbursements will in all cases be based on the date of treatment, and in the first instance will be paid in the same currency as the claim invoice. All medical expenses incurred in China can only be settled in RMB. If you incur medical expenses outside China, we will settle your claim reimbursement as per the currency you request (subject to local currency and/or international restrictions/ regulations). We will convert currencies based on the exchange rates quoted by Citibank as of the treatment date.

4. 保险保障范围内的福利

所有在易全保保障范围内的保险保障都将显示在保险条款和保障一览表中。所列保障限额都是针对每一位被保人或每一种医疗状况，或每一保险年度而言，但对终末期疾病的保障限额则是终生限额。

请记住此团体保险计划不是保障所有的不测事件。

在收到保费之后，我们将对此团体保险合同计划中所约定的条件提供保障。

4.1 易全保概述

《易全保》旨在保障对疾病或受伤的医疗上必需的治疗所产生的合理惯常费用。

《易全保》琥珀 保障住院治疗 and 日间留院治疗，您也可以选择较高的免赔额以降低保费。这一计划适用于您想获得高额医疗费用/不太频繁的重大治疗的保障。

《易全保》翡翠 包含《易全保》琥珀计划保障，更高的计划保障，加上一定限额的门诊治疗保障。

《易全保》水晶 包含《易全保》翡翠计划保障，更高的门诊治疗保障，及牙科治疗保障。

附加保障选项：

提供额外保障的灵活性，您还可以选择附加保障。

4.2 预先书面同意

请您务必在治疗开始之前联系我们。

您的团体保险计划仅对医疗上必需的合理及惯常的医疗费用提供保障。请您务必在接受治疗之前联系我们以确保您所接受的治疗在您的保险保障范围之内。

因此在接受治疗并产生医疗费用之前，请您联系我们取得预先书面同意。

在保险保障计划中详细注明了需要取得预先书面同意的保障，在其旁边标注了“预先书面同意”及电话图标。

您可以通过拨打电话+86 400 077 7500 / +86 21 6156 0910或传真至+86 400 077 7900联系我们的客户服务团队。

预先书面同意意味着有关该治疗项目的所有医疗费用必须获得我们的预先书面同意。

下列情况需要取得我们的预先书面同意：

- 所有住院治疗
- 所有预先计划的日间留院治疗
- 所有预先计划的手术
- 有关怀孕和/或分娩的日间留院治疗/住院治疗
- 所有预先计划的诊断程序 — 磁共振成像扫描(MRI)、正电子放射断层扫描(PET)和计算机断层成像扫描(CT)
- 化学疗法，放射疗法，内窥镜（胃镜、结肠镜检查、乙状结肠镜检查）
- 住院精神病治疗
- 转运和送返
- 遗体运送
- 被保险人接受10次以上的物理治疗（需医生或专科医生转介）
- 家庭护理
- 艾滋病
- 美国境内的选择性治疗
- 药物服用为期3个月以上
- 药物服用费用超过1,000美元

如果您在接受治疗前没有取得我们的预先书面同意，而所接受的治疗不是医疗必需的，我们保留拒绝支付理赔的权利。如果所接受的治疗确属医疗必需的，但您没有取得我们的预先书面同意，我们只赔付合理及惯常收费。

若有任何紧急情况，您的主诊医生或医院，应尽快联系我们的24小时援助热线。如未及时获得预先书面同意，对于保障范围内的医疗状况，您可能要自行承担一定比例的费用。

4. Benefits: What is covered?

All the benefits covered by SimpleCare are shown in the policy wording and benefit schedule. The benefit limits are per insured person and either per medical condition or per period of cover, with lifetime limits in place for terminal illness. Please remember that this group policy is not intended to cover all eventualities.

In return for payment of the premium, we agree to provide cover as set out in the terms of this group policy.

4.1 Summary of SimpleCare

SimpleCare has been designed to provide cover for Reasonable and Customary Charges for Medically Necessary and active Treatment of disease, illness or injury.

SimpleCare Amber Cover for In-Patient and Day-Patient Treatment, and various Deductible options to lower Your premiums, if You want to cover high cost/low frequency major medical events only.

SimpleCare Jade As with SimpleCare Amber and generally higher Plan limits, and limited cover for Out-Patient Treatment.

SimpleCare Crystal As with SimpleCare Jade, but with higher Out-Patient Benefit limits, and cover for dental.

Optional Benefits:

To provide extra flexibility, You can also select additional optional Benefits that might be important to You.

4.2 Pre-Authorisation

When you should contact us before treatment starts.

Your group policy with us will only cover reasonable and customary charges for treatment that is medically necessary. It is important that you contact us before treatment for us to confirm if such treatment is eligible under your group policy.

Pre-authorisation is therefore required before undertaking treatment and incurring charges.

The Benefit Schedule details those benefits requiring pre-authorisation by showing "Pre-Authorisation".

You should contact our customer service team on +86 400 077 7500 / +86 21 6156 0910 or Fax +86 400 077 7900.

Pre-authorisation means all costs under this benefit require Pre-Authorisation from us, which may or may not be included in your group policy.

Pre-authorisation is required for the following:

- All in-patient admissions and/or treatment
- All pre-planned day-patient treatment
- All pre-planned surgery
- In-patient/day-patient treatment related to pregnancy and/or maternity
- All pre-planned diagnostic procedures – magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans
- Chemotherapy, radiotherapy, endoscopies (gastroscopy, colonoscopy, sigmoidoscopy)
- In-patient psychiatric treatment
- Evacuation and repatriation
- Mortal remains
- Physiotherapy after the first 10 sessions (referral letter from medical practitioner or specialist)
- Nursing care at home
- AIDS
- USA elective treatment
- Medicines for more than three months duration
- Medicines cost exceeding USD 1,000

If pre-authorisation is not obtained and treatment is received and is subsequently proven not to be medically necessary, we reserve the right to decline your claim. If treatment is medically necessary, but you did not obtain pre-authorisation, we will pay only up to reasonable and customary charges.

In the case of any emergency, you, the treating medical practitioner or the hospital, must contact our 24 hour emergency assistance service as soon as possible. Failure to obtain pre-authorisation for treatment of an eligible medical condition means you may incur a proportion of the costs.

4. 保险保障范围内的福利

4.3 亚太财险与时康国际：易全保

易全保旨在对疾病或受伤所采取的医疗必需的治疗而发生的合理惯常费用提供保障。此处附加信息是保险条款的补充。

如果您不确定您的病情及其相关保障范围，请在接受治疗之前联系我们的客户服务团队。某些保障项目注明全额赔付，这是指对于保障范围内的疾病或受伤所采取的医疗必需的治疗而发生的合理及惯常的费用，在扣除相关的免赔额，门诊每次就诊免赔额或自付比例之后的全额赔偿。

4. Benefits: What is covered?

4.3 Asia-Pacific P&C and Now Health International: SimpleCare

SimpleCare has been designed to provide cover for reasonable and customary charges for medically necessary and active treatment of disease, illness or injury. This is additional information that should be read in conjunction with the policy wording.

Some cover states "Full Refund" and this means that eligible claims are covered up to the annual maximum plan limit, after any deduction of any deductible, out-patient per visit excess or co-insurance or similar condition, if reasonable and customary charges for medically necessary treatment are incurred.

5. 投诉

5.1 如何提出合理投诉？

我们与保险人致力向您提供直接明了的服务。其中很重要的一个环节便是在书面文件或电话交谈中向您提供清楚准确的信息。作为时康的会员，我们的客户服务团队将会为您提供最好的服务。他们能够帮助您提交理赔，并且提醒您关于您的保险计划中可能存在的限制（请记住您的保险并不是保障所有的不测事件）。

如果您对我们提供的服务不满意，或者您不认同我们的决定，我们将会尽力解决您的疑虑。您的反馈也会帮助我们改善服务。请联系我们的总经理，地址如下：

总经理

时康管理顾问（上海）有限公司

中国上海市虹口区吴淞路218号宝矿国际大厦11楼1105室，邮编200080

您亦可以发送电子邮件至 CustomerService@now-health.com 或您可在网址 www.now-health.cn 通过网上安全组合区提出您的投诉。

我们总经理将会在收到您的投诉之后告知您，同时展开相关调查并在十个工作日内给您回复。期间如果出现不可避免的延迟，我们也会通知您。

5.2 资料保障相关信息

请确保您向您的计划涵盖的其他人展示以下信息，或让他们了解其内容。

我们和保险人将对《个人信息保护法》要求提供的所有个人信息严格保密。我们和保险人收集您和您的家属的个人信息（包括健康、银行账户和职业），目的是建立和管理您的计划。这包括您提供的信息，如家庭成员、医疗机构或您的雇主（如适用）。您的信息可能会转交至负责管理您的保险计划的时康国际集团公司、保险人、医生、医疗援助公司及理赔管理人，包括位于中国大陆境外的机构。任何协助管理您的保险计划的第三方亦需承担相同的保密责任，包括位于中国大陆境外的第三方。在某些情况下可能会要求医疗机构（或其他人）提供进一步的信息，您的个人信息未经您的同意，不会向其他组织披露。

您有权访问和更正我们和保险人掌握关于您的信息。如果您想行使此等权利，请联系我们。我们或保险人收集关于您的一些信息可能被分类为“敏感”信息——即有关种族或民族血统以及身体或心理健康的信息。数据保护法对敏感信息施加了特定条件，包括在某些情况下，我们或保险人处理信息之前需要获得您的明确同意。

当您提供有关家庭成员的信息时，我们和保险人将认为您已经获得他们的同意。作为计划的合法持有人，有关计划的所有通信，包括理赔信件，将发送给计划持有人。如果受保于本计划的任何18岁以上的家庭成员不希望这种情况发生，他们应该自行申请加入该计划。

在某些情况下，法律要求向执法部门披露与涉嫌欺诈性索赔和其他犯罪有关的信息。如有需要，我们将向第三方（包括其他保险公司）披露信息，以预防或调查犯罪，包括欺诈或其他有合理怀疑的不当索赔。这可能涉及将非医疗信息发送给其他保险公司和执法机构可以访问的数据库中。此外，如果有理由认为一名医生的执业资格可能受到损害，将向国家卫生健康委员会或其他相关监管机构通报任何问题。

如果您希望时康国际集团公司通过信函、短信或电子邮件与您联系并提供其他IPMI或相关产品和服务的详细信息，请联系我们的客户服务团队或按本手册背面的地址写信给我们。时康国际集团公司名单及其联系方式，以及我们的数据隐私政策可在 www.now-health.cn 上找到。

时康国际集团公司可能会将您的健康声明信息转交至其他保险公司或再保险公司，以进行风险管理、合同谈判、研究、研发和分析，以及推广其他可能您感兴趣的产品。

5. Making a complaint

5.1 What should I do if I have reason to complain?

We and the insurer aim to provide you with a simple and straightforward service. Providing you with clear and accurate information, whether in writing or by telephone, is an important part of this service. Our customer services team is there to help you get the best from your Asia-Pacific P&C and Now Health membership. They can help you when you make a claim, as well as remind you of restrictions you may have on your group policy (please remember that your group policy is not intended to cover all eventualities).

If you are dissatisfied with the service we have provided or if you feel that we have made a wrong decision, we will of course try to address your concerns. Your feedback helps us improve our service to you. Please contact:

The General Manager
Now Health International (Shanghai) Limited
Room 1105, 11/F, BM Tower, No. 218 Wusong Road, Hongkou District, Shanghai 200080, China

You can also email the General Manager at CustomerService@now-health.com or make a complaint directly from your secure online portfolio area at www.now-health.cn.

We will acknowledge your letter upon receipt. Our General Manager will review your complaint and respond to you within 10 working days of receiving your letter. If there is an unavoidable delay, we will inform you.

5.2 How is my personal data protected?

Please ensure that You show the following information to others covered under Your Plan, or make them aware of its contents.

We and the insurer will deal with all personal information supplied in the strictest confidence as required by the Personal Information Protection Law. We and the insurer collect personal information about You and Your Dependents (including health, bank account and occupation) for the purpose of establishing and administering Your Plan. This includes information supplied by You, those family members, medical providers or Your employer (if applicable). Your information may be passed to Now Health group companies administering Your Plan, underwriters, Medical Practitioners, medical assistance companies and claims administrators for these purposes, including those located outside China. Confidentiality is required of any third parties to whom the administration of Your Plan may be subcontracted, including those based outside China. In certain circumstances medical service providers (or others) may be asked to supply further information. Your personal details will not be disclosed to other organisations without Your consent.

You have a right of access to, and correction of, information that We and the insurer hold about You. Please contact Us if You would like to exercise either of these rights. Some of the information We or the insurer collect about You may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain Your explicit consent before We or the insurer process the information.

When You provide information about family members, We and the insurer will take this as confirmation that You have their consent to do so. As the legal holder of the Plan all correspondence about the Plan, including claims correspondence, will be sent to the Planholder. If any family member over 18 insured under the Plan does not want this to happen they should apply for their own Plan.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the National Health Commission or other relevant regulatory body will be notified about any issue where there is reason to believe a Medical Practitioner's fitness to practise may be impaired.

Please contact Our Customer Services team or write to Us at the address on the back of this handbook if You wish Now Health International group companies to contact You via letter, SMS or email with details of other IPMI or related product and services. A list of Now Health group companies, their contact details and Our Data Privacy Policy is available at www.now-health.cn.

Your health claims information may be shared by Now Health International Group companies to other Insurance Companies or Reinsurance Companies in the objective of risk management, contract negotiations, research, development and analysis, as well as, to promote other products that may be of interest to You.



Now Health International

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保险合同由亚太财产保险有限公司签发，并委托时康管理顾问(上海)有限公司进行保单管理。亚太财产保险有限公司地址：中国深圳市福田区中心区福华一路免税商务大厦29-30楼，邮编：518048
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Policies are issued by Asia-Pacific Property & Casualty Insurance Co., Ltd.
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Policies are administered by Now Health International (Shanghai) Limited.
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