NOW HEALTH INTERNATIONAL

API 亚太财险 Asia-Pacific P&C

亚太财产保险有限公司

全球保团体医疗保险

（2021版）条款

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亚太财产保险有限公司
团体全球医疗保险（2021版）条款
（注册编号: C000038325120210324296l2）

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在职员工不得少于3人。

第三条

1. 直接被保险人：投保人所有在职全职员工。
2. 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：
   a. 直接被保险人的合法配偶。
   b. 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承保范围。
   c. 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）新生婴儿加入本保单，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承保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。这意味著直接被保险人的婴儿的承保范围不包括参保前因某些医疗状况所接受的治疗，例如在新生婴儿特别护理病房进行的治疗，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。
3. 任何连带被保险人的医疗保障均应与直接被保险人相同。
4. 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。
5. **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承保范围之外的国家/地区居住，则保险人不能为其承保。**在承保前，保险人应将承保范围之外的国家/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30款为必须选择的保障项目，第31至48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)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. **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。

4. **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。

5. **新生婴儿保障**

   保险人应赔付被保险人的新生婴儿因早产（即妊娠未满37周分娩）或被保险人的新生婴儿在出生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婴儿在出生之日起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婴儿的病史，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 – 新增新生婴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。

6. **新生婴儿陪伴母亲的医院住宿费用**

   保险人应赔付新生婴儿（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，医院为新生婴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。

7. **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。

8. **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：**

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；

此项保障还包括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，并要求遭遇意外事故导致至少住院一晚。

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. **住院精神疾病治疗**

被保险人在保险人认可的医院的精神科接受住院治疗的，保险人应赔付被保险人实际产生的相关医疗费用。所有治疗必须在具有法定资质的精神病医生的直接管理下进行。

上述保障需要预先获得保险人书面同意。上述保障范围内的最高保障限额以及每一保险期间内最长的赔付天数，应经投保人与保险人双方同意，并在保险合同中列明。

10. **终末期疾病**

保险人应赔付因姑息治疗与临终关怀而实际产生的医疗费用。即自被保险人被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，而根据该医嘱提供任何住院、日间留院或门诊治疗时产生的费用。保险人应赔付有关医院或临终关怀的住宿、合格护士护理，以及医嘱药物和敷料的费用。

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。

11. **美国境内的紧急非选择性治疗**

在不超过30日（含30日）的计划行程中，被保险人在美国境内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。

此类保障不包括正常生育及怀孕和分娩期间出现的医疗状况有关的费用。

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. **住院现金津贴**

被保险人在次日零时前住院接受本保险合同保障范围内的治疗，并且未产生任何费用。保险人应赔付被保险人在医院接受治疗期间每一晚的现金住院津贴（次日零时前住院算一晚，自次日零时起每满24小时算一晚）。

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6.10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。

2. 保险责任

13. 艾滋病

被保险人因有证明的工作意外事故或输血而感染上人类免疫缺陷病毒(HIV) 和/或人类免疫缺陷病毒(HIV)相关疾病，包括获得性免疫缺陷综合征(AIDS) 或艾滋病相关综合征(ARCS)和/或上述疾病的任何突变病症或异种，保险人应赔付与之相关或由其引起的实际医疗费用，**赔付费用仅限于与诊断前后咨询、针对性例行检查、药物和敷料（试验性或未经审批的除外）、医院住宿及护理相关的费用。**

对于急诊室服务人员、从事医疗职业或牙科的人员、实验室助理、药剂师或医疗机构服务人员，须出示证明证实其在执行本职工作任务时意外感染上人类免疫缺陷病毒(HIV)；在保险单生效日或批单签发日（二者以后发生日为准）起的三年后感染上人类免疫缺陷病毒(HIV)；根据被保险人职业对应的正常程序，导致自身感染上人类免疫缺陷病毒(HIV)的工作事故已上报，并经调查及备案；感染后的五日内接受了检查，结果显示体内没有人类免疫缺陷病毒(HIV)或人类免疫缺陷病毒抗体(HIV 抗体)；上报职业意外事故后的12个月内进行了人类免疫缺陷病(HIV)呈阳性测试。

被保险人由于输血感染上述病毒或疾病适用前提是在住院期间进行的医疗上必需的输血治疗。

该保障提供仅限于被保险人已连续投保三年或以上。

上述保障需要预先获得保险人书面同意。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。

14. 器官移植

保险人应赔付以下项目实际产生的医疗费用：

a. 被保险人是器官受赠人时，有关肾脏、胰脏、肝脏、心脏、肺、骨髓、角膜或心及肺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26款(先天性疾病) 进行赔付，此时本保险合同第五条项下第14款(器官移植)对于相关费用一概不予赔付。**

b. 器官捐献者在住院或日间留院期间的相关医疗费用，**但寻找器官捐献者的费用除外。**

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。

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。

15. 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。

16. 怀孕期间医疗状况

保险人应赔付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。符合保险人许可的医疗状况包括以下情形：

a. 子宫外孕(胚胎在子宫以外的部位著床发育)；
b. 葡萄胎(异常细胞在子宫内生长)；
c. 胎盘滞留(胚胎滞留在子宫内)；
d. 前置胎盘；
e. 子痫(怀孕期间发生在先兆子痫之后的昏迷或抽搐)；
f. 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除外责任，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**)；
g. 产后出血(分娩后多个小时及多日大出血)；
h. 需要即时接受外科治疗的流产。

本保障不包括医疗上必需的和/或紧急剖腹产的费用。

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。

如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。

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。

17. 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，往返医院赴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，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治疗地、或被保险人的国籍国或居住国。

此类保障不适用于正常怀孕及分娩有关的费用，但本保险合同第五条第16款(即怀孕期间医疗状况)除外。

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。

18. 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。

19. 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。**手术前后的任何咨询就诊费用将根据本保险合同第五条第20款（门诊医生费用）进行赔付。**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：

含括谘询费在内的医生收费；专科医生费用；远程医疗费用；诊断检查费用；处方药和敷料的费用。

任何手术前的谘询及出院后的门诊费用将根据此保障进行赔付。

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

21. 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（尊乐）/15次（尊爱）/20次（尊享）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。

2. 保险责任

22. 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、整脊治疗、顺势疗法、饮食疗法和针灸疗法的费用。物理治疗的医疗费用第五条项下22款(a)将不包含于此保障。

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。

门诊每次就诊免赔额并不适用于此保障。

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。

23. 中医治疗和阿育吠陀治疗

保险人应赔付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治疗时实际产生的医疗费用。

门诊每次就诊免赔额并不适用于此保障。

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。

24. 家居护理

保险人应赔付以下实际产生的医疗费用：

a. 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。**

b. 在出现紧急出诊要求的情况下，全科医生在正常门诊时间之外的出诊费用。

最高保障限额及最高护理天数或出诊次数应经投保人与保险人双方同意，并在保险合同中列明。

25. 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。

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。

26. 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。**若新生婴儿出生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5款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。

27. 慢性疾病

保险人应赔付被保险人就慢性疾病包括但不限于哮喘、糖尿病和高血压等需要通过咨询、检查、体检、服用药物和敷料和/或诊断测试以实现持续或长期监控的疾病进行治疗所实际产生的医疗费用。最高保障限额应经投保人与保险人双方同意，按其批单签发日，在保险合同中列明。

本保障不包括肾衰竭和肾透析。肾衰竭和肾透析的赔付适用本保险合同第五条第28款。癌症的赔付适用本保险合同第五条第15款。

28. 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。其中包括手术前后肾透析和重症监护的费用。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。

29. **牙科**

保险人应赔付以下项目实际产生的医疗费用：

a. 例行牙科治疗：牙科执业医生在牙科手术期间进行例行牙科治疗的费用。
例行牙科治疗包括：
— 牙齿检查（**每年两次**），即评估坏牙、缺牙、填充牙，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（**标准牙科汞齐合金或复合材料**）和拔牙；
— 根管治疗（**但不包括在接受牙根管治疗后装上牙冠**）。

其他牙科治疗一概不适用上述例行牙科治疗保障。
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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。
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。

b. 复杂牙科治疗：牙科执业医生的收费以及以下治疗的费用：承保范围内的复杂牙科治疗，例如针对以下项目进行牙根尖切除术：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、新装或修复牙冠、假牙、嵌体和牙桥、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、牙髓钙化/根管钙化、需要进行手术的牙根表面和周围骨质的损伤。

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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。
此保障有20% 的自付比例。
所有畸齿矫正治疗有50%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。

30. **生育保障**

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;包括产前与产后六周内检查、CT扫描、自然分娩或自愿剖腹产的接生费用。本保障亦包含出生24小时内儿科医生就新生婴儿首次检查/体检的收费，以及幼儿2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。

b. 医疗上必需的和/或紧急剖腹产的费用

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。
如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。
保险人对于育儿或其他相关课程一概不予赔付。
除非保险凭证中明确约定包含生育保障，否则保险人不会赔付正常怀孕、分娩及医疗上必需的和/或紧急剖腹产的有关的费用。
责任免除6.27条款并不适用于此保障。

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。

31. **美国境内的选择性治疗**

保险人应赔付以下实际产生的医疗费用：

a. 被保险人在美国住院或日间留院治疗符合保障范围内疾病时的相关医疗费用。**若被保险人在保险人公布的国际医疗网络内医院接受治疗，医疗费用可获全额赔付。**

b. 被保险人在美国门诊治疗符合保障范围内疾病时的相关医疗费用。**若被保险人在保险人公布的国际医疗网络内接受治疗，医疗费用可获全额赔付。**

若在保险人公布的国际医疗网络外医院接受治疗，则赔付50%的医疗费用。

上述保障必须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。

2. 保险责任

32. 门诊费用的自付比例 — 选项1

保险人应赔付被保险人实际产生的医疗费用，**但对所有符合保障范围内疾病的门诊治疗有10%自付额**。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、眼科、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。

自付额并不适用于以下项目:

a. 癌症治疗、器官移植、肾衰竭和肾透析。
b. 如果被保险人在保险人公布的国际医疗网络内中国大陆任何一家公立共医院接受门诊治疗。

33. 门诊费用的自付比例 — 选项2

保险人应赔付被保险人实际产生的医疗费用，**但对所有符合保障范围内疾病的门诊治疗有20%的自付额**。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、眼科、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。

自付额并不适用于以下项目:

a. 癌症治疗、器官移植、肾衰竭和肾透析。
b. 如果被保险人在保险人公布的国际医疗网络内中国大陆任何一家公立共医院接受门诊治疗。

34. 体检、眼科、疫苗

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、生命体徵检查(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. 眼科保障：保险人应赔付眼科医生的收费，其中包括光学眼镜配镜师每年进行眼科检查的费用，包括当被保险人的医疗处方变更时所需的眼镜框与眼镜片在内的眼镜配镜费用，和/或隐形眼镜费用，但须保证总保障费用不大于双方同意的每个保险期内最高眼科保障金额（**即使是处方的太阳眼镜或光致变色镜片亦不在承保范围之内**），和/或
c. 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6.10条款并不适用于此保障。

35. 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。

36. 大中华区选择

保险人应赔付被保险人在大中华区因住院、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。

大中华区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，被保险人若在大中华区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。

大中华区以外的紧急非选择性治疗赔偿不包括正常怀孕和分娩，及怀孕和分娩期间出现的医疗状况有关的费用。

大中华区指中国大陆、香港、澳门和台湾。

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。

37. **病房限制（仅适用于中国大陆居民）**

如本保险合同第五条第1款(a)项所述，当中国大陆居民在香港住院时，限于一般病房或双人病房住宿；被保险人或可选择15%的自付比例，从而在中国大陆任何一家昂贵医院接受承保范围内的住院或日间留院治疗及任何医生的治疗。昂贵医院的定义及范围由保险人事先约定，而自付比例的最高金额则由投保人与保险人双方就每个医疗状况进行商定。

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。

38. **昂贵医院自付比例**

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，保险人应赔付实际产生的医疗费用，但被保险人需承担20%的自付比例。**该自付比例的最高金额应经投保人与保险人双方就每个医疗状况进行商定。

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。

39. **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。**

40. **尊安计划下的门诊医生费用保障**

保险人应赔付以下实际发生的医疗费用：

a. 含括谘询费内部的医生收费；专科医生费用；远程医疗费用；诊断检查费用；处方药和敷料的费用。

b. i. 由获得执业许可的物理治疗师提供的物理治疗费用。

ii. 被保险人接受理疗师的辅助药物和治疗，保险人应赔付实际产生的有关医疗费用。此类补偿可包括整骨疗法、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。

iii.保险人应赔付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治疗时实际产生的医疗费用。

保险期内您可选择此保障bi)或bii)，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。

此可供选项的保障应替代本保险合同第五条第20款（门诊医生费用）。

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

41. **门诊限制**

保险人应赔付本保险合同第五条项下第20、22、27和28款项下实际产生的医疗费用，**但赔偿总额应以投保人和保险人双方同意的每个保险期内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。

42. **可选择的生育保障**

保险人应根据尊爱或尊乐保险计划来赔付本保险合同第五条第30款项下实际产生的必需的医疗费用。

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。

适用于10名员工以上的统一投保的团体保险单。

43. **尊乐保险计划下的牙科保障**

保险人应根据尊乐保险计划来赔付本保险合同第五条第29款项下实际发生的医疗费用。

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。

适用于10名员工以上统一投保的团体保险单。

44. **取消牙科的自付比例**

被保险人为10名员工以上统一投保的团体保险，本保险合同第五条第29款项下的自付比例取消，包括例行及复杂牙科治疗（含畸齿矫正治疗）。

2. 保险责任

45. 住院及门诊自付比例

对属于保障范围内的住院、日间留院及门诊治疗时实际产生的医疗费用，被保险人承担20%自付比例。但不超出投保人和保险人双方同意的自付额限额。

46. 转运和送返的增强保障

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。转院地点须是最近的、位于被保险人居住国、国籍国或被保险人选定国家内的医疗机构。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，往返医院赴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。

被保险人选定的国家须具备合适医疗设施。保险人的医学顾问将判断被保险人选定的国家是否具备合适医疗设施以治疗被保险人符合保障范围的医疗状况。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，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治疗地、或被保险人的国籍国或居住国。

此类保障不适用于正常怀孕及分娩有关的费用，但本保险合同第五条第16款(即怀孕期间医疗状况)除外。

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。

47. 门诊每次就诊免赔额 - 选项1

门诊每次就诊设有150元人民币免赔额，并适用于被保险人在保险人公布的国际医疗网络内或网络外医疗机构接受属于保障范围的门诊治疗。但该免赔额不适用于本保险合同第五条第22、23和29款（替代疗法、中医治疗和阿育吠陀治疗和牙科）产生的费用。

48. 门诊每次就诊免赔额 - 选项2

门诊每次就诊设有90元人民币免赔额，并适用于被保险人在保险人公布的国际医疗网络内或网络外医疗机构接受属于保障范围的门诊治疗。但该免赔额不适用于本保险合同第五条第22、23和29款（替代疗法、中医治疗和阿育吠陀治疗和牙科）产生的费用。

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，均不在承保范围之列。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承保范围之列。由于被保险人参与任何违法行为而产生的费用均不在承保范围之列。

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承保范围之列。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承保范围之列。被保险人因运输药物而产生的任何货运费用（包括关税）均不在承保范围之列。

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承保范围之列。

6.4 过敏测试

任何过敏原检测均不在承保范围列，即使由医生开处方。

6.5 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承保范围之列。

6.6 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）均不在承保范围之列，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）。

6.7 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，或是因石棉沉滞症治疗（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，均不在承保范围之列。

6.8 慢性病

如果被保险人根据尊安保险单选项投保，则承保范围不包括被保险人因调理慢性疾病而承担的费用。尊乐、尊爱和尊享保险单选项在保障一览表中包括的最高限额是指按每个保险期内计算的该项保障最高限额，而不是按每个医疗状况计算的限额。

6.9 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的积极治疗费用。

6.10 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的金额(需在保险合同中列明)不在承保范围之列。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。

6.11 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承保范围之列，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。

3. 责任免除

6.12 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承保范围之列。

6.13 食物补充品、维生素或矿物质，及洗化产品

被保险人因购买以下产品而产生的费用不在承保范围之列：维生素或矿物质产品（除非是怀孕期间及治疗严重维生素缺乏症治疗所需），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，特殊洗化产品（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。

6.14 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承保范围之列。

6.15 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承保范围之列。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。

6.16 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，均不在承保范围之列。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 视力检查或视力矫正、听力检查、听力或视觉辅助

被保险人进行常规视力或听力检查的费用以及眼镜、隐形眼镜、助听器或人工耳蜗移植手术的费用均不在承保范围之列。为纠正视力而进行的眼部手术费用不在承保范围之列，但是为治疗符合上文保险责任条款中约定可以获得赔偿的医疗状况而进行的眼部手术费用在承保范围之列。

6.18 不遵医嘱

被保险人在下列情形中产生的治疗费用不在承保范围之列：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承保范围之列。

6.19 胎儿手术

被保险人胎儿尚在母亲子宫中时所做手术的费用不在承保范围之列，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。

6.20 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承保范围之列。

6.21 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承保范围之列：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。

6.22 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承保范围之列，这些情形包括：除在保障一览表中列明以外，还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承保范围列。

6.23 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承保范围之列。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，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。

6.24 病态肥胖症

保险人因接受病态肥胖症治疗或与之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分移除脂肪或多馀的健康组织而产生的费用以及与之相关的费用均不在承保范围之列。

6.25 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承保范围之列。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承保范围之列。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承保范围之列。

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

被保险人因正常怀孕或分娩、医疗上必需的和/或紧急剖腹产或自愿剖腹产手术而产生的费用不在承保范围之列，除非生育保障列在被保险人的保险合同中。

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承保范围之列。保险人所指的职业运动指被保险人有偿参与的运动。

6.29 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承保范围之列。被保险人承担的与避孕相关的费用不在承保范围之列。

6.30 例行检验、健康检查

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）不在承保范围之列。

6.31 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承保范围之列。

6.32 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承保范围之列。

6.33 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，均不在承保范围之列。被保险人接受性传播疾病治疗的费用不在承保范围之列。

6.34 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承保范围之列。

6.35 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承保范围之列，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承保范围之列。

6.36 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承保范围之列。

6.37 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。

6.38 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。

本保险合同为不保证续保，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），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（艾滋病保障除外）。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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得该项保障。

第十条 — 免赔额

本保险合同有免赔额选项。免赔额适用于所有符合保障范围的住院或日间留院产生的费用（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的免赔额选项，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。

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。

前款规定的合同解除权，自保险人知道有解除事由之日起，超过30日不行使而消灭。

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。

如果合同订立时，保险人已经知道投保人未如实告知的情况的，则保险人不得解除保险合同。如果发生保险事故，保险人应承担赔偿或者支付保险金的责任。

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，**但保险人通过其他途径已经及时知道或者应当及时知道保险事故发生的除外。

上述义务不包括由于不可抗力导致的延迟。

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，则保险人不应承担损失中无法确认部分的赔偿责任：**

a. 理赔申请表；
b. 保险单或其他保险凭证；
c. 申请人合法身份证明；
d. 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；
e. 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；
f. 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为2年，自申请人知道或者应当知道保险事故发生之日起计算。

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。

(1) **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馀额及保险合同条款进行赔付。**

(2) **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全球保团体医疗保险终止时，被保险人可以申请转移至保险人之全球保个人与家庭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全球保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，**但保险人已根据合同规定支付保险金的，投保人不得要求解除合同。**

投保人在要求解除本保险合同时应出具以下证明和文件：

a. 保险单原件；
b. 保险费支付证明；
c. 投保人身份证明；
d. 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已确认的净保险费。

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

1. 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。
2. **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。**
3. **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。**
4. **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个工作日内将与此保险欺诈相关的理赔保险金退还给保险人。**
5. 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。**
6. 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。
7. 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应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，并由保险人合法授权的员工代表保险人签名并加盖保险人印章，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. 定义

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. **直接结算协议：** 保险人与时康国际公司公布的国际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：** 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。

9. **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。

10. **癌症：** 指恶性肿瘤、组织或细胞，其特徵是恶性细胞不受控制地生长、蔓延并侵入到组织中。

11. **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。

12. **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。

13. **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。

14. **国籍国：** 指被保险人持有其合法护照的国家。

15. **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）。

16. 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。

17. 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。

18. 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。

19. 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。

20. 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配偶、成年伴侣、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。

21. 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。

22. 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。

23. 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。

24. 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。

25. 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。

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. 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。

28. 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。

29. 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、高等校、企事业单位、贸易组织和职业联盟等。

30. 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。

12. 定义

31. 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。

32. 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。

33. 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。

34. 被保险人： 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。

35. 保险人： 亚太财产保险有限公司。

36. 医疗状况： 任何疾病、损伤或病症，包括精神疾病。

37. 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。

38. 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。

39. 新生婴儿： 出生时间为16周以内的婴儿。

40. 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。

41. 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。

42. 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。

43. 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（无论被保险人于国际医疗网络内或网络外医疗机构治疗）。

44. 保险期间： 约定起保日的零时开始到约定期满日24小时止通常为期12个月的一段时间。

45. 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。

46. 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。

47. 投保人： 在保险单或保险凭证中被称为投保人的团体。

48. 怀孕： 指从首次确诊到分娩的一段时间。

49. 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。

50. 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。

51. 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 。

52. 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等 。

53. 已确认的保险费： 已确认的保险费 = 总已收保险费 — 未到期保险费 。未满一日的多余小时数将被视为一日 。

54. 未到期保险费计算如下： 未到期保险费 = 保险年度保险费总额 x (1 – m/n)，m为保障生效总天数，n为保险期间的总天数 。未满一日的剩馀时数将被视为一日计算 。

55. 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 。

56. 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 。

57. 续保日期： 指保险单的生效日期的周年对应日 。

58. 双人病房： 私人医院中设有两张床位的病房 。豪华病房 、行政病房和套房不包括在内 。

59. 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 。

60. 生效日期： 保险凭证中显示的保险单生效日期 。

61. 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 。

62. 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 。

63. 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）。

64. 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 。

65. 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 。

66. WHO： 世界卫生组织 。

二. 亚太财产保险有限公司 全球保团体医疗保险(2021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	尊安	尊乐	尊爱	尊享
年度最高保障限额	18,500,000人民币	22,000,000人民币	25,000,000人民币	28,000,000人民币
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6,300人民币*	*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6,300人民币*	*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*	*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12,600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 : 磁共振成象扫描(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* ***正电子放射断层扫描(PET)需要预先获得书面同意 ☎***	*住院 、日间留院或门诊全额赔偿* ***正电子放射断层扫描(PET)需要预先获得书面同意 ☎***	*住院 、日间留院或门诊全额赔偿* ***正电子放射断层扫描(PET)需要预先获得书面同意 ☎***	*住院 、日间留院或门诊全额赔偿* ***正电子放射断层扫描(PET)需要预先获得书面同意 ☎***
3. 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*	*全额赔偿*	*全额赔偿*	*全额赔偿*
4. 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*	*全额赔偿*	*全额赔偿*	*全额赔偿*
5. 新生婴儿保障 *保险人应赔付被保险人的新生婴儿因早产(即妊娠未满37周分娩)或被保险人的新生婴儿在出生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婴儿在出生之日起30日内已经加入本保单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婴儿的病史 , 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 – 新增新生婴儿保单条款有关详细信息 。*	*每个保险期内最高限额630,000人民币*	*每个保险期内最高限额630,000人民币*	*每个保险期内最高限额780,000人民币*	*每个保险期内最高限额940,000人民币*
6. 新生婴儿陪伴母亲的医院住宿费用 *保险人应赔付新生婴儿 (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 , 医院为新生婴儿提供住宿而产生的实际费用 。*	*全额赔偿*	*全额赔偿*	*全额赔偿*	*全额赔偿*
7. 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*	*全额赔偿*	*全额赔偿*	*全额赔偿*

全额赔偿 *不予承保* *有限承保* *可供选项*

保障	尊安	尊乐	尊爱	尊享
8. 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：*** ***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；*** *此项保障还包括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，并要求遭遇意外事故导致至少住院一晚。*	全额赔偿	全额赔偿	全额赔偿	全额赔偿
9. 住院精神疾病治疗 *被保险人在保险人认可的医院的精神科接受住院治疗的，保险人应赔付被保险人实际产生的相关医疗费用。所有治疗必须在具有法定资质的精神病医生的直接管理下进行。*	*每个保险期内* *全额赔偿* *最长期限为30日* ***上述保障需要预先获得书面同意*** ☎	*每个保险期内* *全额赔偿* *最长期限为30日* ***上述保障需要预先获得书面同意*** ☎	*每个保险期内* *全额赔偿* *最长期限为30日* ***上述保障需要预先获得书面同意*** ☎	*每个保险期内* *全额赔偿* *最长期限为30日* ***上述保障需要预先获得书面同意*** ☎
10. 终末期疾病 — 姑息治疗和临终关怀 *保险人应赔付因姑息治疗与临终关怀而实际产生的医疗费用。即自被保险人被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，而根据该医嘱提供任何住院、日间留院或门诊治疗时产生的费用。保险人应赔付有关医院或临终关怀的住宿、合格护士护理，以及医嘱药物和敷料的费用。*	*住院和日间留院治疗* *终生最高限额为* *310,000人民币*	*终生最高限额为* *310,000人民币*	*终生最高限额为* *470,000人民币*	*终生最高限额为* *630,000人民币*
11. 美国境内的紧急非选择性治疗 — 在不超过30日（含30日）的计划行程 *被保险人在美国境内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。* ***此类保障不包括正常生育及怀孕和分娩期间出现的医疗状况有关的费用。***	*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150,000人民币* *医院急诊部之门诊治疗：每个保险期内最高限额3,150人民币*	*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150,000人民币* *医院急诊部之门诊治疗：每个保险期内最高限额3,150人民币*	*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220,000人民币* *医院急诊部之门诊治疗：每个保险期内最高限额3,150人民币*	*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310,000人民币* *医院急诊部之门诊治疗：每个保险期内最高限额3,150人民币*
12. 住院现金津贴 *被保险人在次日零时前住院接受本保险合同保障范围内的治疗，并且未产生任何费用。保险人应赔付被保险人在医院接受治疗期间每一晚的现金住院津贴。* ***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6.10条款并不适用于此保障。***	*每晚最高限额* *630人民币*	*每晚最高限额* *945人民币*	*每晚最高限额* *1,260人民币*	*每晚最高限额* *1,575人民币*

全额赔偿　不予承保　有限承保　可供选项

保障	尊安	尊乐	尊爱	尊享
13. 艾滋病 *被保险人因有证明的工作意外事故或输血而感染人类免疫缺陷病毒(HIV)和/或人类免疫缺陷病毒HIV相关疾病，包括获得性免疫缺陷综合征(AIDS)或艾滋病相关综合征(ARCS)和/或上述疾病的任何突变病症或异种，保险人应赔付与之相关或由其引起的实际医疗费用。**赔付费用仅限于与诊断前后咨询、针对性例行检查、药物和敷料（试验性或未经审批的除外）、医院住宿及护理相关的费用。*** *对于急诊室服务人员、从事医疗职业或牙科的人员、实验室助理、药剂师或医疗机构服务人员，须出示证明证实其在执行本职工作任务时意外感染上人类免疫缺陷病毒(HIV)；在保险单生效日或批单签发日（二者以后发生日为准）起的三年后感染上人类免疫缺陷病毒(HIV)；根据被保险人职业对应的正常程序，导致自身感染上人类免疫缺陷病毒(HIV)的工作事故已上报，并经调查及备案；感染后的五日内接受了检查，结果显示体内没有人类免疫缺陷病毒(HIV)或人类免疫缺陷病毒抗体(HIV 抗体)；上报职业意外事故后的12个月内进行了人类免疫缺陷病毒(HIV)呈阳性测试。* ***被保险人由于输血感染上述病毒或疾病适用前提是在住院期间进行的医疗上必需的输血治疗。*** *该保障提供仅限于被保险人已连续投保三年或以上。*	*住院及日间留院治疗最高限额150,000人民币* ***上述保障需要预先获得书面同意☎***	*每个保险期内最高限额150,000人民币* ***上述保障需要预先获得书面同意☎***	*每个保险期内最高限额250,000人民币* ***上述保障需要预先获得书面同意☎***	*每个保险期内最高限额310,000人民币* ***上述保障需要预先获得书面同意☎***
14. 器官移植 *a) 被保险人是器官受赠人时，有关肾脏、胰脏、肝脏、心脏、肺、骨髓、角膜或心及肺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26款(先天性疾病)进行赔付，此时本保险合同第五条项下第14款(器官移植)对于相关费用一概不予赔付。*** *b) 器官捐献者在住院或日间留院期间的相关医疗费用，但寻找器官捐献者的费用除外。* *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。*	*a) 全额赔偿* *b) 每个保险期内最高限额310,000人民币*	*a) 全额赔偿* *b) 每个保险期内最高限额310,000人民币*	*a) 全额赔偿* *b) 每个保险期内最高限额310,000人民币*	*a) 全额赔偿* *b) 每个保险期内最高限额310,000人民币*
15. 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*	*全额赔偿*	*全额赔偿*	*全额赔偿*
16. 怀孕期间医疗状况 *保险人应赔付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。符合保险人许可的医疗状况包括以下情形：* • *子宫外孕（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）；* • *需要即时接受外科治疗的流产。* ***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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。*** ***本保障不包括医疗上必需的和/或紧急剖腹产的费用。***	*全额赔偿*	*全额赔偿*	*全额赔偿*	*全额赔偿*

全额赔偿 *不予承保* *有限承保* *可供选项*

保障	尊安	尊乐	尊爱	尊享
17. 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：*	***该保障需要预先获得书面同意 ☎***	***该保障需要预先获得书面同意 ☎***	***该保障需要预先获得书面同意 ☎***	***该保障需要预先获得书面同意 ☎***
*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。***	*i) 全额赔偿*	*i) 全额赔偿*	*i) 全额赔偿*	*i) 全额赔偿*
ii) 被保险人在接受日间留院治疗期间，往返医院赴诊时的当地合理交通费用。	*ii) 全额赔偿*	*ii) 全额赔偿*	*ii) 全额赔偿*	*ii) 全额赔偿*
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。	*iii) 全额赔偿*	*iii) 全额赔偿*	*iii) 全额赔偿*	*iii) 全额赔偿*
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。	*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*	*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*	*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*	*iv) 每日最高限额1,800人民币，每人每次转运最高限额63,000人民币*
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，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治疗地、或被保险人的国籍国或居住国。* ***此类保障不适用于正常怀孕及分娩有关的费用，但保险合同第五条第16款（即怀孕期间医疗状况）除外。***	***该保障需要预先获得书面同意 ☎*** *全额赔偿*	***该保障需要预先获得书面同意 ☎*** *全额赔偿*	***该保障需要预先获得书面同意 ☎*** *全额赔偿*	***该保障需要预先获得书面同意☎*** *全额赔偿*
18. 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：*	***该保障需要预先获得书面同意 ☎***	***该保障需要预先获得书面同意 ☎***	***该保障需要预先获得书面同意 ☎***	***该保障需要预先获得书面同意 ☎***
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	*a) 全额赔偿*	*a) 全额赔偿*	*a) 全额赔偿*	*a) 全额赔偿*
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。	*b) 最高限额63,000人民币*	*b) 最高限额63,000人民币*	*b) 最高限额94,000人民币*	*b) 最高限额126,000人民币*
19. 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。**手术前后的任何咨询就诊费用将根据保险合同第五条第20款（门诊医生费用）进行赔付。***	*全额赔偿*	*全额赔偿*	*全额赔偿*	*全额赔偿*
20. 门诊医生费用 *含括咨询费在内的医生收费；专科医生费用；远程医疗费用；诊断检查费用；处方药和敷料的费用。* *任何手术前的咨询及出院后的门诊费用将根据此保障进行赔付。*	*每个保险期内的每个医疗状况的门诊医生费用，包括手术前的咨询及诊断程序的费用，从入院前的15日至出院后的门诊费用，最长30日，综合最高总限额12,600人民币*	*全额赔偿*	*全额赔偿*	*全额赔偿*
21. 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（尊乐）/15次（尊爱）/20次（尊享）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*	*每个保险期内最高10次，综合最高总限额15,000人民币*	*每个保险期内最高15次，综合最高总限额31,000人民币*	*每个保险期内最高20次，综合最高总限额47,000人民币*

全额赔偿 *不予承保* *有限承保* *可供选项*

保障	尊安	尊乐	尊爱	尊享
22. 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、整脊治疗、顺势疗法、饮食疗法和针灸疗法的费用。物理治疗的医疗费用第五条项下22款a)将不包含于此保障。* *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。* ***门诊每次就诊免赔额并不适用于此保障。***	*a) 住院后30天内最多5次就诊。* *b) 不予承保*	*a) 每个保险期内最高20次全额赔偿* *b) 每个保险期内最高达15次，每次最高限额315人民币* *对于a) 和 b)，**在10次物理治疗后，需要预先获得授权☎***	*a) 每个保险期内最高25次全额赔偿* *b) 每个保险期内最高达15次，每次最高限额630人民币* *对于a) 和 b)，**在10次物理治疗后，需要预先获得授权☎***	*a) 每个保险期内最高30次全额赔偿* *b) 每个保险期内最高达15次，每次最高限额945人民币* *对于a) 和 b)，**在10次物理治疗后，需要预先获得授权☎***
23. 中医治疗和阿育吠陀治疗 *保险人应赔付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治疗时实际产生的医疗费用。* ***门诊每次就诊免赔额并不适用于此保障。***	*不予承保*	*每个保险期内最高限额4,700人民币*	*每个保险期内最高限额7,800人民币*	*每个保险期内最高限额12,600人民币*
24. 家居护理 *a) 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。*** *b) 在出现紧急出诊要求的情况下，全科医生在正常门诊时间之外的出诊费用。*	*a) 每日最高限额为630人民币，每个保险期内最高达30日* ***此保障需要预先获得书面同意☎*** *不予承保*	*a) 全额赔偿最高达45日* ***此保障需要预先获得书面同意☎*** *不予承保*	*a) 全额赔偿最高达60日* ***此保障需要预先获得书面同意☎*** *不予承保*	*a) 全额赔偿最高达120日* ***此保障需要预先获得书面同意☎*** *最高达五次*
25. 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。*	*每个医疗状况的符合条件住院治疗全额赔偿最高达30日*	*每个医疗状况全额赔偿最高达180日*	*全额赔偿*	*全额赔偿*
26. 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。**若新生婴儿出生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5款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630,000人民币*	*每个保险期内最高限额630,000人民币*	*每个保险期内最高限额787,000人民币*	*每个保险期内最高限额945,000人民币*
27. 慢性疾病 *保险人应赔付被保险人就慢性疾病包括但不限于哮喘、糖尿病和高血压等需要通过咨询、检查、体检、服用药物和敷料和/或诊断测试以实现持续或长期监控的疾病进行治疗所实际产生的医疗费用。最高保障限额应经投保人与保险人双方同意，按其批单签发日，在保险合同中列明。* ***本保障不包括肾衰竭和肾透析。肾衰竭和肾透析的赔付适用本保险合同第五条第28款。癌症的赔付适用本保险合同第五条第15款。***	*不予承保*	*全额赔偿*	*全额赔偿*	*全额赔偿*
28. 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。其中包括手术前后肾透析和重症监护的费用。*	*a) 住院期间手术前后护理全额赔偿* *b) 日间留院或门诊治疗每个保险期内最高限额150,000人民币*	*a) 住院期间全额赔偿* *b) 日间留院或门诊治疗每个保险期内最高限额630,000人民币*	*a) 住院期间全额赔偿* *b) 日间留院或门诊治疗每个保险期内最高限额630,000人民币*	*a) 住院期间全额赔偿* *b) 日间留院或门诊治疗每个保险期内最高限额630,000人民币*

全额赔偿 *不予承保* *有限承保* *可供选项*

保障	尊安	尊乐	尊爱	尊享
29. 牙科 *a) 例行牙科治疗：牙科执业医生在牙科手术期间进行例行牙科治疗的费用。例行牙科治疗包括：* • *牙齿检查（**每年两次**），即评估坏牙、缺牙、填充牙，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（**标准牙科汞齐合金或复合材料**）和拔牙；* • *根管治疗（**但不包括在接受牙根管治疗后装上牙冠**）。* ***其他牙科治疗一概不适用上述例行牙科治疗保障。*** ***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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。*** ***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	不予承保	*a) 每个保险期内最高限额6,300人民币*	*a) 每个保险期内最高限额9,400人民币*
b) 复杂牙科治疗：牙科执业医生的收费以及以下治疗的费用：承保范围内的复杂牙科治疗，例如针对以下项目进行牙根尖切除术：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、新装或修复牙冠、假牙、嵌体和牙桥、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、牙髓钙化/根管钙化、需要进行手术的牙根表面和周围骨质的损伤。 ***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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。*** ***此保障有20%的自付比例。*** ***所有畸齿矫正治疗有50%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	不予承保	*b) 每个保险期内最高限额12,600人民币*	*b) 每个保险期内最高限额18,900人民币*
30. 生育保障 *a) 被保险人怀孕或分娩期间实际产生的医疗必需费用；包括产前与产后六周内检查、CT扫描、自然分娩或自愿剖腹产的接生费用。本保障亦包含出生24小时内儿科医生就新生婴儿首次检查/体检的收费，以及幼儿2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。* *b) 医疗上必需的和/或紧急剖腹产的费用。* ***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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。*** ***除非保险凭证中明确约定包含生育保障，否则保险人不会赔付正常怀孕及分娩及医疗上必需的和/或紧急剖腹产的有关的费用。*** ***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。***	不予承保	不予承保	不予承保	*a) 自然分娩或自愿剖腹产每个保险期内最高限额110,250人民币* *b) 医疗上必需的和/或紧急剖腹产每个保险期内最高限额220,500人民币*
附加选项				
31. 美国境内的选择性治疗 *保险人应赔付以下实际产生的医疗费用：* *a.) 被保险人在美国住院或日间留院治疗符合保障范围内疾病时的相关医疗费用。若被保险人在保险人公布的国际医疗网络内医院接受治疗，医疗费用可获全额赔付。* *b.) 被保险人在美国门诊治疗符合保障范围内疾病时的相关医疗费用。若被保险人在保险人公布的国际医疗网络内接受治疗，医疗费用可获全额赔付。* ***若在保险人公布的国际医疗网络外接受治疗，则赔付50%的医疗费用。***	***该保障需要预先获得书面同意*** ☎ *可供选项* *每名被保险人于每个保险期内的最高限额9,450,000人民币*	***该保障需要预先获得书面同意*** ☎ *可供选项* *每名被保险人于每个保险期内的最高限额9,450,000人民币*	***该保障需要预先获得书面同意*** ☎ *可供选项* *每名被保险人于每个保险期内的最高限额9,450,000人民币*	***该保障需要预先获得书面同意*** ☎ *可供选项* *每名被保险人于每个保险期内的最高限额9,450,000人民币*

全额赔偿 *不予承保* *有限承保* *可供选项*

保障	尊安	尊乐	尊爱	尊享
32. 门诊费用的自付比例 — 选项1 保险人应赔付被保险人实际产生的医疗费用，**但对所有符合保障范围内疾病的门诊治疗有10%的自付额**。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、眼科、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。 自付额并不适用于以下项目: a.) 癌症治疗、器官移植、肾衰竭和肾透析。 b.) 如果被保险人在保险人公布的国际医疗网络内中国大陆任何一家公立医院接受门诊治疗。	不予承保 (若投保人选择了尊安下的门诊费用保障选项，则可选此项)	可供选项	可供选项	可供选项
33. 门诊费用的自付比例 — 选项2 保险人应赔付被保险人实际产生的医疗费用，**但对所有属于保障范围内疾病的门诊治疗有20%的自付额**。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。 如果被保险人的团体保险单中含有生育保障或牙科保障，其相应的自付额将会在被保险人的保障一览表中列明。 如果被保险人的保险单中含有生育保障、牙科保障或体检、眼科、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。 自付额并不适用于以下项目: a) 癌症治疗、器官移植、肾衰竭和肾透析。 b) 如果被保险人在保险人公布的国际医疗网络内中国大陆任何一家公立医院接受门诊治疗。	不予承保 (若投保人选择了尊安下的门诊费用保障选项，则可选此项)	可供选项	可供选项	可供选项
34. 体检、眼科、疫苗 — 选项1,2 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、生命体徵检查(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) 眼科保障：保险人应赔付眼科医生的收费，其中包括光学眼镜配镜师每年进行眼科检查的费用，包括当被保险人的医疗处方变更时所需的眼镜框与眼镜片在内的眼镜配镜费用，和/或隐形眼镜费用，但须保证总保障费用不大于双方同意的每个保险期内最高眼科保障金额(即使是处方的太阳眼镜或光致变色镜片亦不在承保范围之内) 和/或 c) 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6.10条款并不适用于此保障。	**选项1** 不予承保 **选项2** 不予承保	**选项1** 可供选项 每个保险期内的综合最高限额 3,100人民币 (眼科保障最高限额 1,850人民币) **选项2** 可供选项 每个保险期内的综合最高限额 6,300人民币 (眼科保障最高限额 3,750人民币)	**选项1** 可供选项 每个保险期内的综合最高限额 3,100人民币 (眼科保障最高限额 1,850人民币) **选项2** 可供选项 每个保险期内的综合最高限额 6,300人民币 (眼科保障最高限额 3,750人民币)	**选项1** 可供选项 每个保险期内的综合最高限额 3,100人民币 (眼科保障最高限额 1,850人民币) **选项2** 可供选项 每个保险期内的综合最高限额 6,300人民币 (眼科保障最高限额 3,750人民币)
35. 既往病史不咎 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	可供选项	可供选项	可供选项
36. 大中华区选择 保险人应赔付被保险人在大中华区因住院、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。 **大中华区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，被保险人若在大中华区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。** **大中华区以外的紧急非选择性治疗赔偿不包括正常怀孕和分娩，及怀孕和分娩期间出现的医疗状况有关的费用。** **大中华区指中国大陆、香港、澳门和台湾。** 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 大中华区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	可供选项 大中华区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	可供选项 大中华区以外的紧急非选择性治疗，因疾病治疗的最高限额 220,000人民币	可供选项 大中华区以外的紧急非选择性治疗，因疾病治疗的最高限额 310,000人民币

全额赔偿　不予承保　有限承保　可供选项

保障	尊安	尊乐	尊爱	尊享
37. 病房限制（仅适用于中国大陆居民） ***如保险合同第五条第1款(a)项所述，当中国大陆居民在香港住院时，限于一般病房或双人病房住宿；被保险人或可选择15%的自付比例，从而在中国大陆任何一家昂贵医院接受承保范围内的住院或日间留院治疗及任何医生的治疗。***昂贵医院的定义及范围由保险人事先约定，而自付比例的最高金额则由投保人与保险人双方就每个医疗状况进行商定。	可供选项 于中国大陆的昂贵医院接受住院或日间留院治疗有15%自付比例，每个医疗状况最高自付额为47,000人民币	可供选项 于中国大陆的昂贵医院接受住院或日间留院治疗有15%自付比例，每个医疗状况最高自付额为47,000人民币	可供选项 于中国大陆的昂贵医院接受住院或日间留院治疗有15%自付比例，每个医疗状况最高自付额为47,000人民币	可供选项 于中国大陆的昂贵医院接受住院或日间留院治疗有15%自付比例，每个医疗状况最高自付额为47,000人民币
38. 昂贵医院自付比例 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，保险人应赔付实际产生的医疗费用，但被保险人需承担20%的自付比例。***该自付比例的最高金额应经投保人与保险人双方就每个医疗状况进行商定。	不予承保	可供选项 20%自付比例，每个医疗状况最高自付额为63,000人民币	可供选项 20%自付比例，每个医疗状况最高自付额为63,000人民币	可供选项 20%自付比例，每个医疗状况最高自付额为63,000人民币
39. 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。***	不予承保	可供选项	可供选项	可供选项
40. 尊安计划下的门诊医生费用保障 保险人应赔付以下项目实际产生的医疗费用: a) 含括咨询费在内的医生收费; 专科医生费用; 远程医疗费用; 诊断检查费用; 处方药和敷料的费用。 b) i. 由获得执业许可的物理治疗师提供的物理治疗费用。 ii. 被保险人接受理疗师的辅助药物和治疗，保险人应赔付实际产生的有关医疗费用。此类赔偿可包括整骨疗法、手足病治疗和足病治疗、整脊治疗、顺势疗法、饮食疗法和针灸疗法的费用。 iii. 保险人应赔付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治疗时实际产生的医疗费用。 保险期内您可选择此保障bi)或bii)，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。 投保人如果选择了自选免赔额，投保人需要就门诊费用的自付比例的其中一项作出相关选择。 ***此可供选项的保障应替代本保险合同第五条第20款(门诊医生费用)。*** 请注意，如果选择此选项，则只能选择免赔额: 6,300人民币、15,700人民币和31,500人民币。 投保人需要就门诊费用的自付比例的其中一项作出相关选择。	可供选项 a) 每个保险期内的最高限额28,350人民币及 b) 每个保险期内的综合最高限额限10次医生就诊最高全额赔偿。 此物理治疗就诊最高限额10次，此保障将包含于第五条项下第22款(门诊物理治疗和替代疗法)。	不予承保	不予承保	不予承保
41. 门诊限制 保险人应赔付本保险合同第五条第20、22、27和28款下实际产生的医疗费用，但赔偿总额应以投保人和保险人双方同意的每个保险期内的最高保障限额为限。	不予承保	可供选项 每个保险期内的最高限额31,000人民币	不予承保	不予承保

全额赔偿　不予承保　有限承保　可供选项

保障	尊安	尊乐	尊爱	尊享
42. 可选择的生育保障 *适用于10名员工或以上的统一投保的团体保单。* *保险人应根据尊爱或尊乐保险计划来赔付本保险合同第五条第30款项下实际产生的必需的医疗费用。* ***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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。***	▶ *不予承保*	▶ *可供选项： 每个保险期内的最高限额 53,500人民币 *选项包括： 零或20%自付比例*	▶ *可供选项： 每个保险期内的最高限额 78,750人民币*	*保障第30条已予承保*
43. 尊乐保险计划下的牙科保障 ***牙科护理 – 1*** *a) 例行牙科治疗* *b) 复杂牙科治疗*	▶ *不予承保*	▶ *可供选项： a) 每个保险期内的最高限额 3,100人民币 b) 每个保险期内的最高限额 6,300人民币*	*保障第29款已予承保*	*保障第29款已予承保*
或 ***牙科护理 – 2*** *a) 例行牙科治疗* *b) 复杂牙科治疗* ***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。如投保人按照合同约定续保，将不受此条款限制，自续保保单生效日起即可按照续保合同约定获得此项保障。*** ***此保障有20%的自付比例。所有畸齿矫正治疗有50%自付比例。*** *适用于10名员工或以上的统一投保的团体保单。*	▶ *不予承保*	▶ *可供选项： 每个保险期内 a) 和 b) 综合最高总限额 5,000人民币*	*保障第29款已予承保*	*保障第29款已予承保*
44. 取消牙科的自付比例 *被保险人为10名员工以上的统一投保的团体保险，本保险合同第五条第29款项下的自付比例取消，包括例行及复杂牙科治疗（含畸齿矫正治疗）。*	▶ *不予承保*	▶ *不予承保*	▶ *可供选项*	▶ *可供选项*
45. 住院及门诊自付比例 *对属于保障范围内的住院、日间留院及门诊治疗时实际产生的医疗费用，被保险人承担20%自付比例，但不超出投保人和保险人双方同意的自付额限额。*	▶ *不予承保*	▶ *可供选项 20%自付比例，每个医疗状况最高自付额为63,000人民币*	▶ *可供选项 20%自付比例，每个医疗状况最高自付额为63,000人民币*	▶ *可供选项 20%自付比例，每个医疗状况最高自付额为63,000人民币*
46. 转运和送返的增强保障 *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。转院地点须是最近的、位于被保险人居住国、国籍国或被保险人选定国家内的医疗机构。* *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，往返医院赴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。*** *被保险人选定的国家须具备合适医疗设施。保险人的医学顾问将判断被保险人选定的国家是否具备合适医疗设施以治疗被保险人符合保障范围的医疗状况。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。***	***该保障需要预先获得书面同意*** ☎ ▶ *可供选项* ▶ *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*** ☎ ▶ *可供选项* ▶ *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*** ☎ ▶ *可供选项* ▶ *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*** ☎ ▶ *可供选项* ▶ *i) 全额赔偿* ▶ *ii) 全额赔偿* ▶ *iii) 全额赔偿* ▶ *iv) 每日最高限额 1,800人民币 每人每次转运最高限额 63,000人民币*
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，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治疗地、或被保险人的国籍国或居住国。* ***此类保障不适用于正常怀孕及分娩有关的费用，但本保险合同第五条第16款（即怀孕期间医疗状况）除外。*** *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。*	***该保障需要预先获得书面同意*** ☎ ▶ *全额赔偿*	***该保障需要预先获得书面同意*** ☎ ▶ *全额赔偿*	***该保障需要预先获得书面同意*** ☎ ▶ *全额赔偿*	***该保障需要预先获得书面同意*** ☎ ▶ *全额赔偿*

▶ 全额赔偿 ▶ 不予承保 ▶ 有限承保 ▶ 可供选项

保障	尊安	尊乐	尊爱	尊享
47. 门诊每次就诊免赔额 — 选项1 *门诊每次就诊设有150人民币免赔额，并适用于被保险人在保险人公布的国际医疗网络内或网络外医疗机构接受属于保障范围的门诊治疗。但该免赔额不适用于本保险合同第五条第22、23和29款(替代疗法、中医治疗和阿育吠陀治疗和牙科)产生的费用。*	*不予承保*	*可供选项* *150人民币*	*可供选项* *150人民币*	*可供选项* *150人民币*
48. 门诊每次就诊免赔额 — 选项2 *门诊每次就诊设有90人民币免赔额，并适用于被保险人在保险人公布的国际医疗网络内或网络外医疗机构接受属于保障范围的门诊治疗。但该免赔额不适用于本保险合同第五条第22、23和29款(替代疗法、中医治疗和阿育吠陀治疗和牙科)产生的费用。*	*不予承保*	*可供选项* *90人民币*	*可供选项* *90人民币*	*可供选项* *90人民币*

免赔额选项

49. 标准免赔额	*零*	*零*	*零*	*零*
自选免赔额 *本保险有免赔额选项。免赔额适用于所有符合保障范围的住院或日间留院产生的费用(无论被保险人于网内或网外医疗机构治疗)。* *请注意：* *a) 如果投保人选择了尊乐、尊爱或尊享计划，并选择了其中一项的免赔额选项，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。* *b) 如果投保人选择了尊安计划下的门诊费用保障：* *i) 投保人如果选择了自选免赔额，投保人需要就门诊费用的自付比例的其中一项作出相关选择。* *ii) 投保人可选择最高免赔额为31,500人民币。*	*6,300人民币*	*6,300人民币*	*6,300人民币*	*6,300人民币*
	15,700人民币	*15,700人民币*	*15,700人民币*	*15,700人民币*
	31,500人民币	*31,500人民币*	*31,500人民币*	*31,500人民币*
	63,000人民币	*63,000人民币*	*63,000人民币*	*63,000人民币*
	94,500人民币	*94,500人民币*	*94,500人民币*	*94,500人民币*

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Policies are issued by Asia-Pacific Property & Casualty Insurance Co., Ltd.
Registered Office: 29-30F., Dutyfree Business Building, 1st Fuhua Road,
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WC CH 28010 04/2021

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NOW HEALTH INTERNATIONAL

API 亚太财险 Asia-Pacific P&C

WorldCare Policy Wording

companies (2021)

Contents

A. Policy Wording
1. General

Asia-Pacific Property & Casualty Insurance Co., Ltd. Companies International Medical Insurance (2021) Policy Wording (Registration No: C00003832512021032429612)

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 employees at the start date and each subsequent renewal date.

Article 3

1. Direct insured: all the active full time employees of the policyholder in service.
2. Dependant: the scope of dependant is decided by the policyholder during application that may include the family member(s) of the direct insured:
   a. Legal spouse 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.
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 30 under the Insurance Liability section are core benefits. The Benefits 31 to 48 under this Insurance Liability section are optional benefits.

1. Hospital Charges, Medical Practitioner and Specialist Fees

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

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

2. Diagnostic Procedures

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

3. Emergency Ambulance Transportation

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

4. Parent Accommodation

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

5. New Born Cover

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

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.

6. Hospital Accommodation for New Born Accompanying their Mother

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

7. Reconstructive Surgery

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

8. In-Patient Emergency Dental Treatment

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

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

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

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

This benefit also covers repair or reconstruction of dentures broken following an accident that necessitates the insured person's admission to a hospital for at least one night, provided that such dentures were being worn at the time of the accident.

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

9. In-Patient Psychiatric Treatment

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

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

10. Terminal Illness

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

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

11. Emergency Non-Elective Treatment USA Cover

For planned trips up to 30 days of duration, the insurer will cover the actual incurred medical 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.

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

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

12. Hospital Cash Benefit

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

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

For this benefit exclusion 6.10 does not apply.

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

2. Insurance Liability

13. AIDS

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

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

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

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

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

14. Organ Transplant

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

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

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

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

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

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

15. Cancer Treatment

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

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

16. Pregnancy Medical Conditions

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

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

Costs for medically necessary and/or emergency caesarian section are specifically excluded under this benefit.

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.

If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.

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

17. Evacuation and Repatriation

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

a. Evacuation

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

Reasonable expenses for:

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 if it is against the advice of the insurer's medical advisers or where the medical facility does not have appropriate facilities to treat the eligible medical condition.**

b. Repatriation

An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment or the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment. Such transportation cost is only eligible if there was a medical need for an initial evacuation that has taken place.

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

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

18. Mortal Remains

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

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

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

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

19. Day-Patient or Out-Patient Surgery

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

20. Out-Patient Charges

The insurer will cover the actual incurred medical cost of:

Medical practitioner fees including consultations; specialist fees; telemedicine fees; diagnostic tests; prescribed drugs and dressings.

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

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.

2. Insurance Liability

21. 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 10/15/20 (Advance/Excel/Apex) 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 per period of cover should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

22. 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 but excludes Physiotherapist covered in a.

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.

For this benefit, the out-patient per visit excess does not apply.

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

23. Traditional Chinese Medicine and Ayurvedic Treatment

The insurer will cover the out-patient treatment of the actual incurred medical costs of the therapies administrated by a recognised traditional Chinese medicine practitioner or an Ayurvedic Medical Practitioner.

For this benefit, the out-patient per visit excess does not apply.

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

24. Nursing Care at Home

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

a. Care given by 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.

b. Medical Practitioner (GP) home visits for an emergency GP home call-out during out of normal clinic hours.

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

25. Rehabilitation

The insurer will cover the actual incurred medical rehabilitation cost 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.

26. 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 5 but excluded from Article 5, Benefit 26 – Congenital Disorders. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

27. Maintenance of Chronic Medical Conditions

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

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

28. Renal Failure and Renal Dialysis

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

29. Dental Care

The insurer will cover the actual incurred medical cost of:

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

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

   Waiting period: Any 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. If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.

   A co-insurance of 20% applies.

   For this benefit, the deductible or out-patient per visit excess does not apply.

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

   No other treatment is covered by this benefit.

   Waiting period: Any 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. If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.

   A co-insurance of 20% applies.

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

   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.

2. Insurance Liability

30. Maternity

The insurer will cover:

a. The actual incurred medically necessary costs incurred during normal 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 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.

b. Cost associated with medically necessary and/or emergency caesarian section.

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.

If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.

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

The insurer will not cover costs relating to routine pregnancy or childbirth or costs for medically necessary and/or emergency caesarian section unless maternity care benefits are shown on the certificate of insurance.

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.

31. USA Elective Treatment

The insurer will cover the actual incurred medical cost of:

a. Costs associated with eligible in-patient and day-patient treatment in the USA will be paid in full where treatment is received in a hospital listed in the Now Health International Provider Network.

b. Costs associated with eligible out-patient treatment in the USA will be paid in full where treatment is received in the Now Health International Provider Network.

Treatment that is not received in the Now Health International Provider Network will be subject to a 50% co-Insurance.

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

32. Co-Insurance Out-Patient Treatment – Option 1

The insurer will cover the actual incurred medical cost, with a 10% co-insurance on all eligible out-patient treatment. Should the plan include the maternity, dental care or wellness, optical benefits and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.

Co-insurance does not apply to:

a. Cancer treatment, organ transplant, renal failure and renal dialysis

b. Any out-patient treatment received in public hospitals in Mainland China that are within the Now Health International Provider Network

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

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

33. Co-Insurance Out-Patient Treatment – Option 2

The insurer will cover the actual incurred medical cost, with a 20% co-insurance on all eligible out-patient treatment. Should the plan include the maternity, dental care or wellness, optical benefits and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.

Co-insurance does not apply to:

a. Cancer treatment, organ transplant, renal failure and renal dialysis

b. Any out-patient treatment received in public hospitals in Mainland China that are within the Now Health International Provider Network

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, optical benefits and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.

34. Wellness, Optical Benefits and Vaccinations

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

a. Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, 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. Optical benefit: this benefit also provides a contribution towards optician charges including an annual eye test carried out by an ophthalmic optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, within the combined benefit limits to a maximum mutually agreed amount per period of cover for an optical claim.

   Please note that there is no cover for prescription sunglasses or transition lenses; and/or

c. 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.

   For this benefit exclusion 6.10 does not apply.

35. Medical History Disregarded

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

36. Greater China option

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

Emergency non elective treatment outside of Greater China:

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

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

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

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

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

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

37. Hospital Room Restriction – PRC Residents Only

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

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

38. High Cost Provider Co-Insurance

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

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

39. High Cost Provider Restriction

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

2. Insurance Liability

40. Optional Out-Patient Charges under the Essential Plan

The insurer will cover the actual incurred medical cost of:

a. Medical practitioner fees including consultations; specialist fees; telemedicine fees; diagnostic tests; prescribed drugs and dressings.

b. i. Physiotherapy by a Registered Physiotherapist.

ii. Complementary medicine and treatment by a therapist. The insurer will cover the actual incurred medical cost. This benefit extends to chiropractors, chiropodists and podiatrists, osteopaths, homeopaths, dietician and acupuncture treatment.

iii. Out-patient treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner.

You may choose 5 sessions for any combination of benefits in aggregate in a given period of cover for benefits b)i) and b)ii) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist.

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

This optional benefit replaces Article 5, Benefit 20 – Out-Patient Charges.

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.

41. Out-Patient Restriction

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

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

42. Optional Maternity

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

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

This clause applies to compulsory group policies 10+ employees.

43. Optional Dental Benefit under the Advance Plan

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

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

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

44. Removal of Co-Insurance for Dental Care

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

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

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

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

46. Extended 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, country of residence, country of nationality or the insured person's country of choice 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 insured person's country of choice is subject to the availability of the appropriate medical facilities being in place. The insurer's medical advisers will determine whether the selected country has the suitable medical facility to treat the insured person's eligible medical condition. The insurer's medical advisers will decide the most appropriate method of transportation for the evacuation and this benefit will not cover travel if it is against the advice of the insurer's medical advisers or where the medical facility does not have appropriate facilities to treat the eligible medical condition.

b. Repatriation

An economy class airfare ticket to return the insured person and a locally-accompanying person who has traveled as an escort to the site of treatment or the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment. Such transportation costs is only eligible if there was a medical need for an initial evacuation that has taken place.

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

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.

47. Out-Patient Per Visit Excess - Option 1

An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment inside and outside of the Now Health International Provider Network.

The out-patient per visit excess does not apply to Article 5, Benefits 22, 23, and 29.

48. Out-Patient Per Visit Excess - Option 2

An RMB 90 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment inside and outside of the Now Health International Provider Network.

The out-patient per visit excess does not apply to Article 5, Benefits 22, 23, and 29.

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 Allergy Testing

You are not covered for any allergy testing even when prescribed by a physician.

6.5 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.

6.6 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.

6.7 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.

6.8 Chronic conditions

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

6.9 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.

6.10 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.

6.11 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.**

6.12 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.

6.13 Dietary supplements, vitamins or minerals and cosmetic products

The insured person is not covered for products classified as vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), 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.

6.14 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.

6.15 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.

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

You are not covered for routine eyesight or hearing tests or the cost of eyeglasses, contact lenses, hearing aids or cochlear implants. We do not pay for eye surgery to correct vision, however eye surgery to correct an Eligible Medical Condition is covered.

3. Exclusions

6.18 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.

6.19 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.

6.20 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.

6.21 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.

6.22 HIV, AIDS or sexually transmitted disease

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

6.23 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.

6.24 Morbid obesity

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

6.25 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.

6.26 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 normal pregnancy or childbirth, medically necessary and/or emergency caesarean section, voluntary caesarean section, unless maternity benefits are shown on the insured person's certificate of insurance.

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 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.

6.30 Routine examinations, health screening

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

6.31 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.

6.32 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.

6.33 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.

6.34 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.

6.35 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.

6.36 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.

6.37 Treatment by a family member

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

6.38 Treatment charges outside of our reasonable and customary range

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

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

Article 7 – Insurance Sum Assured and Insurance Premium

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

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 of particular item 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 except AIDS Benefit. The insured person must have completed the waiting period before the benefit is payable irrespective of whether the policyholder renews the insurance or not. If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.

Article 10 – Deductibles

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

If the policyholder has selected a deductible option, the policyholder is required to select either a co-insurance out-patient treatment 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.

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 insurer fail to exercise the termination right as mentioned above within 30 days upon knowing the cause should be deemed as waiver of such right.

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.

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

Article 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, with exception to the case where the insurer had known or ought to have known such insured incident through other channels.

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

8. Claim and Payment of Insurance Compensation

Article 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 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 two years from the day on which the applicant becomes aware of the occurrence of the insured incident.

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 resonable attempts to do so, the disputes should be submitted to the People's Court of Litigation for its ultimate and binding decision on all parties.

Article 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 WorldCare plans. The insured person's applications must be submitted to the insurer before the insured person leaves the group policy and acceptance is subject to written agreement from the insurer.

Article 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. Identification proof of the policyholder
d. Any other insurance contract related documents and information that could be provided by the policyholder.

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

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

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

Article 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 signed on behalf of the insurer by an authorised employee.
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. Benefits	Insurance cover provided by this policy and any extensions or restrictions shown in the certificate of insurance or in any endorsements (if applicable) and subject always to the insurer having received the premium due.
9. Benefit Schedule	The table of benefits applicable to this policy showing the maximum benefits the insurer will pay.
10. Cancer	A malignant tumour, tissues or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.
11. Certificate of Insurance	The certificate giving details of the policy, the insured persons, the period of cover, the underwriters, the date of entry, the level of cover and any endorsements that may apply.
12. Congenital Disorder	A medical condition that is present at birth or is believed to have been present since birth, whether it is inherited or caused by environmental factors.
13. Co-Insurance	Is the uninsured percentage of the costs, which the insured person must pay towards the cost of a claim.
14. Country of Nationality	The country for which the insured person holds a passport.
15. Country of Residence	The country in which the insured person habitually resides (usually for a period of no less than six months per period of cover) at the policy start date or entry date or at each subsequent renewal date.
16. Chronic Condition	A disease, illness or injury which has at least one of the following characteristics: • It needs ongoing or long-term monitoring through consultations, examination, check-ups, drugs and dressings and/or tests • It needs ongoing or long-term control or relief of symptoms • It requires the insured person's rehabilitation or for the insured person to be specially trained to cope with it • It continues indefinitely • It has no known cure • It comes back or is likely to come back

17. Day-Patient	A patient who is admitted to a hospital or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
18. Deductible	An uninsured amount payable by an insured person in respect of in-patient and 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.
19. 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.
20. 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.
21. 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.
22. Drugs and Dressings	Essential prescription drugs, dressings and medicines administered by a medical practitioner or specialist needed to relieve or cure a medical condition.
23. 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.
24. Entry Date	The date shown on the certificate of insurance on which an insured person was included under this policy.
25. 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.
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. Expatriate	Any persons living and/or working outside of the country for which they hold a passport. Usually for a period of more than 180 days per period of cover
28. Geographic Area	The geographic area used to calculate the premium that will apply to the insured person based on the insured person's principal country of residence at the start date or any subsequent renewal date of this policy.
29. Group	Legal organisation established not for purchasing insurance in China including state owned organisation, colleagues and universities, enterprises and government-sponsored institutions, trade organisation, career union, etc.
30. Hospital	Any establishment, which is licensed as a medical or surgical hospital under the laws of the country where it operates. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.
31. Hospital Accommodation	Refers to standard private or semi-private accommodation as indicated in the benefit schedule. Deluxe, executive rooms and VIP suites are not covered.
32. In-Network Medical Provider	An in-network medical provider is one contracted with the insured person's policy to provide services to policy members for specific pre-negotiated rates.
33. In-Patient	A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.

12. Definitions

34. Insured Person	The eligible employee and/or the dependants named on the certificate of insurance who are covered under this policy.
35. Insurer	Asia-Pacific Property & Casualty Insurance Co., Ltd.
36. Medical Condition	Any disease, injury, or illness, including psychiatric illness.
37. Medical Practitioner	A person who has attained primary degrees in medicine or surgery following attendance at a WHO-recognised medical school and who is licensed to 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.
38. Medically Necessary	Treatment which in the opinion of a qualified medical practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the insured person's condition or the quality of medical care rendered. Such treatment must be required for reasons other than the comfort or convenience of the patient or medical practitioner and provided only for an appropriate duration of time. As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, medically necessary also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an out-patient basis.
39. New Born	A baby who is within the first 16 weeks of its life following birth.
40. Now Health International Provider Network	Our published list of medical providers where the insurer/policy administrator has a direct billing provider network agreement.
41. Out of Network Medical Provider	An out of network medical provider is one not contracted with the insured person's policy.
42. Out-Patient	A patient who attends a hospital, consulting room, telemedicine appointment or out-patient clinic and is not admitted as a day-patient or an in-patient.
43. 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 inside and outside of the Now Health International Provider Network.
44. 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.
45. Physiotherapist	A practising physiotherapist who is registered and licensed to practise medicine in the country where treatment is provided.
46. Pre-Authorisation	A process whereby an insured person seeks approval from the insurer prior to undertaking any treatment or incurring costs. Such benefits requiring pre-authorisation from the insurer will denote pre-authorisation ☎ in the benefit schedule.
47. Policyholder	The person or company named as policyholder in the certificate of insurance.
48. Pregnancy	Refers to the period of time, from the date of the first diagnosis, until delivery.
49. Private Room	Single occupancy accommodation in a private hospital. Deluxe, executive rooms and VIP suites are not covered.
50. 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.
51. 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.

52. 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.
53. Recognised Premium	Recognised Premium = Total collected premium – Unearned premium. The outstanding hours less than one day will be regarded as one day.
54. Unearned Premium to be Refunded	The unearned premium shall be calculated as the following: The unearned premium = Total premium x (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.
55. Rehabilitation	Medically necessary treatment aimed at restoring independent activities of daily living and the normal form/and or function of an insured person following a medical condition.
56. Related Conditions	A related condition is any disease, injury or illness including psychiatric illness that is caused by a pre-existing medical condition or results from the same underlying cause as a pre-existing medical condition.
57. Renewal Date	The anniversary of the start date of the insurance policy.
58. Semi-Private Room	Dual occupancy accommodation in a private hospital. Deluxe, executive rooms and VIP suites are not covered.
59. Specialist	A surgeon, anaesthetist or physician who has attained primary degrees in medicine or surgery following attendance at a WHO recognised medical school and who is licensed to 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.
60. Start Date	The start date shown on the insured person's certificate of insurance.
61. Surgical Procedure	An operation requiring the incision of tissue or other invasive surgical intervention.
62. Terminal	Following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition with death anticipated within 12 months of diagnosis.
63. Treatment	Surgical or medical services (including Diagnostic Tests) that are needed to diagnose, relieve or cure a medical condition.
64. Vaccinations	Refers to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis.
65. 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.
66. WHO	The World Health Organisation.

B. Benefit Schedule

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

Benefit	Essential	Advance	Excel	Apex
Annual Maximum Group Policy Limit	**RMB 18,500,000**	**RMB 22,000,000**	**RMB 25,000,000**	**RMB 28,000,000**
1. Hospital Charges, Medical Practitioner and Specialist Fees:				
a) *Charges for in-patient or day-patient treatment made by a hospital including charges for accommodation (ward/semi-private or private); diagnostic tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a qualified nurse; drugs and dressings prescribed by a medical practitioner or Specialist; and surgical appliances used by the medical practitioner during surgery. This includes pre and post-operative consultations while an in-patient or day-patient and includes charges for intensive care.*	*a) Full Refund* ***Pre-Authorisation ☎***	*a) Full Refund* ***Pre-Authorisation ☎***	*a) Full Refund* ***Pre-Authorisation ☎***	*a) Full Refund* ***Pre-Authorisation ☎***
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.*	*b) Up to RMB 6,300 per medical condition*	*b) Up to RMB 6,300 per medical condition*	*b) Up to RMB 9,450 per medical condition*	*b) Up to RMB 12,600 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 PET ☎***	*Full Refund* ***Pre-Authorisation for PET ☎***	*Full Refund* ***Pre-Authorisation for PET ☎***	*Full Refund* ***Pre-Authorisation for PET ☎***
3. Emergency Ambulance Transportation: *Emergency road ambulance transport costs to or between hospitals, or when considered medically necessary by a medical practitioner or specialist.*	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*
4. Parent Accommodation: *The cost of one parent staying in hospital overnight with an insured person under 18 years old while the child is admitted as an in-patient for eligible treatment.*	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*
5. New Born Baby Cover: *In-patient treatment of premature birth (i.e. prior to age 37 weeks gestation) or an acute condition being suffered by a new born baby of an insured person which manifests itself within 30 days following birth. Provided that the new born baby is added to the group plan within 30 days of birth and premium paid. Cover for multiple births will be covered up to the same limits shown.* *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.*	*Up to RMB 630,000 per period of cover*	*Up to RMB 630,000 per period of cover*	*Up to RMB 780,000 per period of cover*	*Up to RMB 940,000 per period of cover*
6. Hospital Accommodation for New Born Accompanying their Mother: *Hospital accommodation costs relating to a new born baby (up to 16 weeks old) to accompany its mother (being an insured person) while she is receiving eligible treatment as an in-patient in a hospital.*	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*

Full refund Not covered Subject to limits Optional

Benefit	Essential	Advance	Excel	Apex
7. Reconstructive Surgery: *Reconstructive surgery required to restore natural function or appearance following an accident or following a surgical procedure for an eligible medical condition, which occurred after an insured person's entry date or start date whichever is later.*	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*
8. In-Patient Emergency Dental Treatment: *The insurer will cover the actual incurred medical cost of emergency restorative dental treatment required to sound, natural teeth following an accident which necessitates the insured person's admission to hospital for at least one night.* *The dental treatment must be received within 10 days of the accident. This benefit covers all costs incurred for treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:* *a) If the treatment involves replacing a crown, bridge facing, veneer or denture, the insurer will pay only the reasonable and customary cost of a replacement of similar type or quality* *b) If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead* *This benefit also covers repair or reconstruction of dentures broken following an accident that necessitates the insured person's admission to a hospital for at least one night, provided that such dentures were being worn at the time of the accident.*	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*
9. In-Patient Psychiatric Treatment: *In-patient treatment in a recognised psychiatric unit of a hospital. All treatment must be administered under the direct control of a registered psychiatrist.*	*Full Refund limited to 30 days per period of cover* ***Pre-Authorisation ☎***	*Full Refund limited to 30 days per period of cover* ***Pre-Authorisation ☎***	*Full Refund limited to 30 days per period of cover* ***Pre-Authorisation ☎***	*Full Refund limited to 30 days per period of cover* ***Pre-Authorisation ☎***
10. Terminal Illness: *Palliative and hospice care: on diagnosis of a terminal illness, costs for any in-patient, day-patient or out-patient treatment given on the advice of a medical practitioner or specialist for the purpose of offering temporary relief of symptoms. Charges for hospital or hospice accommodation, nursing care by a qualified nurse and prescribed drugs and dressings are covered.*	*Eligible in-patient and day-patient treatment only up to RMB 310,000 lifetime limit*	*Up to RMB 310,000 lifetime limit*	*Up to RMB 470,000 lifetime limit*	*Up to RMB 630,000 lifetime limit*
11. Emergency Non-Elective Treatment USA Cover: *For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health. Charges relating to routine pregnancy and pregnancy and childbirth medical conditions are specifically excluded from this benefit.*	*Accident: Full Refund for in-patient and day-patient treatment following accident* *Illness: in-patient and day-patient care up to RMB 150,000 per period of cover* *Out-patient treatment in an Accident and Emergency department in a hospital up to RMB 3,150*	*Accident: Full Refund for in-patient and day-patient treatment following accident* *Illness: in-patient and day-patient care up to RMB 150,000 per period of cover* *Out-patient treatment in an Accident and Emergency department in a hospital up to RMB 3,150*	*Accident: Full Refund for in-patient and day-patient treatment following accident* *Illness: in-patient and day-patient care up to RMB 220,000 per period of cover* *Out-patient treatment in an Accident and Emergency department in a hospital up to RMB 3,150*	*Accident: Full Refund for in-patient and day-patient treatment following accident* *Illness: in-patient and day-patient care up to RMB 310,000 per period of cover* *Out-patient treatment in an Accident and Emergency department in a hospital up to RMB 3,150*
12. Hospital Cash Benefit: *This Benefit is payable for each night an insured person receives in-patient treatment and only if an insured person is admitted for in-patient treatment before midnight, and the treatment is received free of charge that would have otherwise been eligible for benefit privately under this group plan.* *Cover under this Benefit is limited to a maximum of 30 nights per period of cover.* ***For this Benefit exclusion 6.10 does not apply.***	*RMB 630 per night*	*RMB 945 per night*	*RMB 1,260 per night*	*RMB 1,575 per night*

Full refund Not covered Subject to limits Optional

Benefit	Essential	Advance	Excel	Apex
13. AIDS: *Medical expenses, which arise from or are in any way related to Human Immunodeficiency Virus (HIV) and/or HIV related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof as a result of proven occupation accident* or blood transfusion**. Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, drugs and dressings (except experimental or those unproven), hospital accommodation and nursing fees.* ** For members of emergency services, medical or dental professions, laboratory assistants, pharmacist or an employee in a medical facility that provides evidence that they contracted the HIV infection accidentally while carrying out normal duties of their occupation; and they contracted the HIV infection three years after the entry date or start date, whichever is later; and the incident from which they contracted the HIV infection was reported, investigated and documented according to normal procedures for the insured person's occupation; and a test showing no HIV or antibodies to such a virus was made within five days of the incident; and a positive HIV test occurred within 12 months of the reported occupational accident.* *** As long as the blood transfusion was received as an in-patient as part of medically necessary treatment.* *The benefit is limited to the insured person who has been insured for three consecutive years or more.*	*In-patient and day-patient treatment only. Up to RMB 150,000 per period of cover* ***Pre-Authorisation ☎***	*Up to RMB 150,000 per period of cover* ***Pre-Authorisation ☎***	*Up to RMB 250,000 per period of cover* ***Pre-Authorisation ☎***	*Up to RMB 310,000 per period of cover* ***Pre-Authorisation ☎***
14. Organ Transplant: *a) Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the insured person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Article 5, Benefit 26 – Congenital Disorder but excluded from Article 5, Benefit 14 – Organ Transplant.* *b) Medical costs associated with the donor as an in-patient or day-patient, with the exception of the cost of the donor organ search. The insurer only pays for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.*	*a) Full Refund* *b) Up to RMB 310,000 per period of cover*	*a) Full Refund* *b) Up to RMB 310,000 per period of cover*	*a) Full Refund* *b) Up to RMB 310,000 per period of cover*	*a) Full Refund* *b) Up to RMB 310,000 per period of cover*
15. Cancer Treatment: *Treatment given for cancer received as an in-patient, day-patient or out-patient. includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.*	*Full Refund*	*Full Ref und*	*Full Refund*	*Full Refund*
16. Pregnancy Medical Conditions: *In-patient treatment of an eligible medical condition which arises during the antenatal stages of pregnancy, or an eligible medical condition which arises during childbirth. The insurer would allow treatment of the following as eligible:* • *Ectopic pregnancy (where the foetus is growing outside the womb)* • *Hydatidiform mole (abnormal cell growth in the womb)* • *Retained placenta (afterbirth retained in the womb)* • *Placenta praevia* • *Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* • *Diabetes (If the insured person has exclusions because of their past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* • *Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* • *Miscarriage requiring immediate surgical treatment* *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.* *If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.* *Costs for medically necessary and/or emergency caesarian section are specifically excluded under this benefit.*	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*

Full refund Not covered Subject to limits Optional

Benefit	Essential	Advance	Excel	Apex
17. Evacuation and Repatriation:				
a) Evacuation	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***
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.	*i) Full Refund*	*i) Full Refund*	*i) Full Refund*	*i) Full Refund*
ii) Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.	*ii) Full Refund*	*ii) Full Refund*	*ii) Full Refund*	*ii) Full Refund*
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.	*iii) Full Refund*	*iii) Full Refund*	*iii) Full Refund*	*iii) Full Refund*
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.	*iv) Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*	*iv) Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*	*iv) Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*	*iv) Up to RMB 1,800 per day. Up to RMB 63,000 per person, per evacuation*
Costs of evacuation do not extend to include any air-sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.				
Our medical advisers will decide the most appropriate method of transportation for the evacuation and ***this benefit will not cover travel if it is against the advice of the insurer's medical advisers or where the medical facility does not have appropriate facilities to treat the eligible medical condition.***				
b) Repatriation	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***
An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment or the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment.	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*
Such transportation cost is only eligible if there was a medical need for an initial evacuation that has taken place.				
This Benefit specifically excludes routine pregnancy and childbirth costs, except for Article 5, Benefit 16 – Pregnancy Medical Conditions on the insurance contract.				
18. Mortal Remains:	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***
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	*a) Full Refund*	*a) Full Refund*	*a) Full Refund*	*a) Full Refund*
b) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.	*b) Up to RMB 63,000*	*b) Up to RMB 63,000*	*Up to RMB 94,000*	*b) Up to RMB 126,000*
19. Day-Patient and Out-Patient Surgery:				
Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department. Any pre or post-operative consultations are payable under Article 5, Benefit 20 – Out-Patient Charges on the insurance contract.	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*

Full refund | Not covered | Subject to limits | Optional

Benefit	Essential	Advance	Excel	Apex
20. Out-Patient Charges: *Medical practitioner fees including consultations; specialist fees; telemedicine fees; diagnostic tests; prescribed drugs and dressings.* *Any pre-operative and post-hospitalisation consultations are payable under this benefit.*	*Pre-operative consultation within 15 days from the admission and post hospitalisation consultation within 30 days following discharge from hospital Up to maximum RMB 12,600 per medical condition per period of cover*	*Full Refund*	*Full Refund*	*Full Refund*
21. Out-Patient Psychiatric Illness: *Out patient treatment administered by a registered psychologist and/or a registered psychiatrist, subject to 10/15/20 (Advance/Excel/Apex) 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.*	*Not covered*	*Up to RMB 15,000 and subject to a maximum of 10 sessions per period of cover*	*Up to RMB 31,000 and subject to a maximum of 15 sessions per period of cover*	*Up to RMB 47,000 and subject to a maximum of 20 sessions per period of cover*
22. 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 but excludes Physiotherapist covered in a).* *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.* ***For this benefit, the out-patient per visit excess does not apply.***	*a) Up to 5 sessions within 30 days after hospitalisation* *b) Not covered*	*a) Full refund up to a maximum 20 sessions per period of cover* *b) Up to RMB 315 per visit up to a maximum of 15 visits per period of cover* ***Pre-Authorisation for a) and b) after every 10 visits ☎***	*a) Full refund up to a maximum 25 sessions per period of cover* *b) Up to RMB 630 per visit up to a maximum of 15 visits per period of cover* ***Pre-Authorisation for a) and b) after every 10 visits ☎***	*a) Full refund up to a maximum 30 sessions per period of cover* *b) Up to RMB 945 per visit up to a maximum of 15 visits per period of cover* ***Pre-Authorisation for a) and b) after every 10 visits ☎***
23. Traditional Chinese Medicine and Ayurvedic Treatment: *Out-patient medical costs of the therapies administrated by a recognised traditional Chinese Medicine Practitioner or an Ayurvedic Medical Practitioner.* ***For this benefit, the out-patient per visit excess does not apply.***	*Not covered*	*Up to RMB 4,700 per period of cover*	*Up to RMB 7,800 per period of cover*	*Up to RMB 12,600 per period of cover*
24. Nursing Care at Home: *a) Care given by qualified nurse in the insured person's own home, which is immediately received subsequent to treatment as an in-patient or day-patient on the recommendation of medical practitioner or specialist.* *b) Medical practitioner (GP) home visits for an emergency GP home call-out during out of normal clinic hours.*	*a) RMB 630 per day up to 30 days per period of cover* ***Pre-Authorisation ☎*** *b) Not covered*	*a) Full Refund up to 45 days per period of cover* ***Pre-Authorisation ☎*** *b) Not covered*	*a) Full Refund up to 60 days per period of cover* ***Pre-Authorisation ☎*** *b) Not covered*	*a) Full Refund up to 120 days per period of cover* ***Pre-Authorisation ☎*** *b) Up to five visits per period of cover*

Full refund Not covered Subject to limits Optional

Benefit	Essential	Advance	Excel	Apex
25. Rehabilitation: *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*	*Full Refund for eligible in-patient treatment only up to 30 days per medical condition*	*Full Refund up to 180 days per medical condition*	*Full Refund*	*Full Refund*
26. Congenital Disorders: *In-patient treatment for a congenital disorder. In circumstances where a congenital disorder manifests itself in a new born baby within 30 days of birth, cover for such medical conditions will be provided under Article 5, Benefit 5 but excluded from Article 5, Benefit 26 – Congenital Disorders.*	*Up to RMB 630,000 per period of cover*	*Up to RMB 630,000 per period of cover*	*Up to RMB 787,000 per period of cover*	*Up to RMB 945,000 per period of cover*
27. Maintenance of Chronic Medical Conditions: *Maintenance of chronic medical conditions such as but not limited to asthma, diabetes and hypertension requiring ongoing or long-term monitoring through consultations, examinations, check-ups, drugs and dressings and/or tests up to the benefit limits detailed in the insured person's chosen group plan following the insured person's date of entry. This Benefit does not cover renal failure and dialysis. Claims for this will fall under Article 5, Benefit 28. Claims for cancer will fall under Article 5, Benefit 15.*	*Not covered*	*Full Refund*	*Full Refund*	*Full Refund*
28. Renal Failure and Renal Dialysis: *Treatment of renal failure, including renal dialysis on an in-patient, day-patient or out-patient basis. This includes pre and post-operative renal dialysis and as part of intensive care.*	*a) Full Refund for in-patient pre and post-operative care* *b) Up to RMB 150,000 per period of cover for day-patient or out-patient care*	*a) Full Refund for in-patient care* *b) Up to RMB 630,000 per period of cover for day-patient or out-patient care*	*a) Full Refund for in-patient care* *b) Up to RMB 630,000 per period of cover for day-patient or out-patient care*	*a) Full Refund for in-patient care* *b) Up to RMB 630,000 per period of cover for day-patient or out-patient care*

Benefit	Essential	Advance	Excel	Apex
29. Dental Care:				
a) *Routine dental treatment: Fees of a registed dental practitioner carrying out routine dental treatment in a dental surgery. Routine dental treatment means:* • *Screening (twice per year), i.e. the assessment of diseased, missing and filled teeth, including X-rays where necessary,* • *Preventative scaling, polishing, and sealing (once per year)* • *Fillings (standard amalgam or composite fillings) and extractions, and* • *Root-canal treatment (but not the fitting of a crown following root-canal treatment).* ***No other treatment is covered under the routine dental treatment benefit.*** ***Waiting period: 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. If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.*** *A co-insurance of 20% applies.* ***For this Benefit the deductible or out-patient per visit excess does not apply.***	*a) Not covered*	*a) Not covered*	*a) Up to RMB 6,300 per period of cover*	*a) Up to RMB 9,400 per period of cover*
b) *Complex dental treatment: Fees of a registered dental practitioner and associated costs for the following procedures: Eligible complex dental treatment: including for example, apicoectomy is done to treat the following - fractured tooth root; a severely curved tooth root; teeth with caps or posts; cyst or infection which is untreatable with root canal therapy; root perforations; new or repair of crowns, dentures, in lays and bridges. Recurrent pain and infection; persistent symptoms that do not indicate problems from x-rays. Pulp calcification/ calcified masses in canal; damaged root surfaces and surrounding bone requiring surgery.* ***No other treatment is covered by this benefit.*** ***Waiting period: 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. If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.*** *Co-insurance for group plans of 20% applies.* *A 50% co-insurance applies in respect of all orthodontic treatment.* ***For this Benefit the deductible or out-patient per visit excess does not apply.***	*b) Not covered*	*b) Not covered*	*b) Up to RMB 12,600 per period of cover*	*b) Up to RMB 18,900 per period of cover*
30. Maternity:				
a) *Medically necessary costs incurred during normal 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 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.* b) *Cost associated with medically necessary and/or emergency caesarian section.* ***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.*** ***If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *The insurer does not cover costs relating to routine pregnancy or childbirth or costs for medically necessary and/or emergency caesarian section unless maternity care benefits are shown on the certificate of insurance.* ***For this Benefit exclusion 6.27 does not apply.*** ***Deductible would apply to this benefit.***	*Not covered*	*Not covered*	*Not covered*	*a) Up to RMB 110,250 per period of cover* *b) Up to RMB 220,500 per period of cover*

Full refund | Not covered | Subject to limits | Optional

Benefit	Essential	Advance	Excel	Apex
Additional Options				
31. USA Elective Treatment: a) *Costs associated with eligible in-patient and day-patient treatment in the USA will be paid in full where treatment is received in a hospital listed in the Now Health International Provider Network.* b) *Costs associated with eligible out-patient treatment in the USA will be paid in full where treatment is received in the Now Health International Provider Network.* *Treatment that is not received in the Now Health International Provider Network will be subject to a 50% co-insurance.*	***Pre-Authorisation*** ☎ *Optional* *Up to RMB 9,450,000 per insured person, per period of cover*	***Pre-Authorisation*** ☎ *Optional* *Up to RMB 9,450,000 per insured person, per period of cover*	***Pre-Authorisation*** ☎ *Optional* *Up to RMB 9,450,000 per insured person, per period of cover*	***Pre-Authorisation*** ☎ *Optional* *Up to RMB 9,450,000 per insured person, per period of cover*
32. Co-Insurance Out-Patient Treatment – Option 1: *A 10% co-insurance will apply on all eligible out-patient treatment. Should the plan include the maternity, dental care or wellness, optical benefits and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.* *Please note co-insurance does not apply to:* a) *Cancer treatment, organ transplant, renal failure and renal dialysis.* b) *Any out-patient treatment received in public hospitals in Mainland China that are within the Now Health International Provider Network.*	*Not covered* *(If the policyholder chooses Optional Out-Patient Charges under the Essential plan, the policyholder can select this option.)*	*Optional*	*Optional*	*Optional*
33. Co-Insurance Out-Patient Treatment – Option 2: *A 20% co-insurance will apply on all eligible out-patient treatment. Should the plan include the maternity, dental care or wellness, optical benefits and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.* *Please note co-insurance does not apply to:* a) *Cancer treatment, organ transplant, renal failure and renal dialysis.* b) *Any out-patient treatment received in public hospitals in Mainland China that are within the Now Health International Provider Network.*	*Not covered* *(If the policyholder chooses Optional Out-Patient Charges under the Essential plan, the policyholder can select this option.)*	*Optional*	*Optional*	*Optional*
34. Wellness, Optical Benefits and Vaccinations – Option 1 and 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) *Optical benefits: This benefit also provides a contribution towards optician charges including an annual eye test carried out by an ophthalmic optician, prescribed spectacles including frames and lenses; and/or contact lenses when the member's prescription has changed, within the combined benefit limits to a maximum mutually agreed amount per period of cover for an optical claim.* *Please note that there is no cover for prescription sunglasses or transition lenses.* *and/or* c) *Vaccinations: Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.* ***For this Benefit exclusion 6.10 does not apply.***	***Option 1*** *Not covered* ***Option 2*** *Not covered*	***Option 1*** *Optional* *Combined limit RMB 3,100 (Optical sub-limit RMB 1,850 per period of cover)* ***Option 2*** *Optional* *Combined limit RMB 6,300 (Optical sub-limit RMB 3,750 per period of cover)*	***Option 1*** *Optional* *Combined limit RMB 3,100 (Optical sub-limit RMB 1,850 per period of cover)* ***Option 2*** *Optional* *Combined limit RMB 6,300 (Optical sub-limit RMB 3,750 per period of cover)*	***Option 1*** *Optional* *Combined limit RMB 3,100 (Optical sub-limit RMB 1,850 per period of cover)* ***Option 2*** *Optional* *Combined limit RMB 6,300 (Optical sub-limit RMB 3,750 per period of cover)*
35. Medical History Disregarded: *Compulsory group policies 10+ employees*	*Optional*	*Optional*	*Optional*	*Optional*

Full refund | Not covered | Subject to limits | Optional

Benefit	Essential	Advance	Excel	Apex
36. Greater China option: *The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Greater China and will be subject to the standard policy limits.* *Emergency non-elective treatment outside of Greater China:* *For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health.* ***Charges relating to routine pregnancy and pregnancy and childbirth medical conditions are specially excluded from emergency non-elective treatment outside of Greater China.*** *Greater China means Mainland China, Hong Kong, Macau and Taiwan.* *Full refund for accident requiring in-patient and day-patient care.* *Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover*	*Optional* *Emergency non-elective illness limit up to RMB 150,000 per period of cover*	*Optional* *Emergency non-elective illness limit up to RMB 150,000 per period of cover*	*Optional* *Emergency non-elective illness limit up to RMB 220,000 per period of cover*	*Optional* *Emergency non-elective illness limit up to RMB 310,000 per period of cover*
37. Hospital Room Restriction – PRC Residents only: *As described in Article 5, Benefit 1 on the insurance contract. a), but with a restriction to limit the hospital accommodation to a ward or semi-private room for hospital admission in Hong Kong; or with a 15% co-insurance, up to an out-of-pocket-limit of a mutually agreed amount per medical condition for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.*	*Optional* *In-patient or day-patient treatment received in any high cost facility in Mainland China will be subject to a 15% co-insurance up to an out-of-pocket limit of RMB 47,000 per medical condition*	*Optional* *In-patient or day-patient treatment received in any high cost facility in Mainland China will be subject to a 15% co-insurance up to an out-of-pocket limit of RMB 47,000 per medical condition*	*Optional* *In-patient or day-patient treatment received in any high cost facility in Mainland China will be subject to a 15% co-insurance up to an out-of-pocket limit of RMB 47,000 per medical condition*	*Optional* *In-patient or day-patient treatment received in any high cost facility in Mainland China will be subject to a 15% co-insurance up to an out-of-pocket limit of RMB 47,000 per medical condition*
38. High Cost Provider Co-Insurance: *The insurer will cover the medical costs associated with eligible in-patient, day-patient or out-patient treatment made by the hospital, and by any medical professional, should the in-patient, day-patient or out-patient treatment be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer and will be subject to a 20% co-insurance, up to an out-of-pocket limit of a mutually agreed amount per medical condition.*	*Not covered*	*Optional* *20% co-insurance and up to an out-of-pocket limit of RMB 63,000 per medical condition*	*Optional* *20% co-insurance and up to an out-of-pocket limit of RMB 63,000 per medical condition*	*Optional* *20% co-insurance and up to an out-of-pocket limit of RMB 63,000 per medical condition*
39. High Cost Provider Restriction: *The insurer will not cover the medical costs associated with eligible in-patient, day-patient or out-patient treatment made by the hospital, and by any medical professional, should the in-patient, day-patient or out-patient treatment be received in any high cost in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.*	*Not covered*	*Optional*	*Optional*	*Optional*

Full refund Not covered Subject to limits Optional

Benefit	Essential	Advance	Excel	Apex
40. Optional Out-Patient Charges under the Essential Plan *The insurer will cover the actual incurred medical cost of:* *a) Medical practitioner fees including consultations; specialist fees; telemedicine fees; diagnostic tests; prescribed drugs and dressings.* *b) i) Physiotherapy by a Registered Physiotherapist.* *ii) Complementary medicine and treatment by a therapist. This benefit extends to chiropractors, chiropodists and podiatrists, osteopaths, homeopaths, dietician and acupuncture treatment.* *iii) Out-patient treatment for therapies administered by a recognised traditional Chinese Medical Practitioner or an Ayurvedic Medical Practitioner.* *You may choose 5 sessions for any combination of benefits in aggregate in a given period of cover for benefits b)i) and b)ii) excluding dietician without the need of referral; any subsequent sessions need to be referred by a Medical Practitioner or Specialist.* *For this Benefit the Plan Out-Patient Per Visit Excess does not apply.* *Any pre-operative and post-hospitalisation consultations are payable under this Benefit.* ***This benefit replaces Article 5, Benefit 20 – Out-Patient Charges.*** *Please note that if this option is chosen, the only deductible options that can be chosen are RMB 6,300, RMB 15,700 and RMB 31,500.* *If policyholder choose an optional deductible, policyholder must also select a co-insurance out-patient treatment option.*	*Optional* *a) Up to RMB 28,350 per period of cover* *b) Full Refund up to a maximum 10 sessions per period of cover cover in aggregate. Physiotherapy is limited to 10 sessions and not in addition to Article 5, Benefit 22.*	*Not covered*	*Not covered*	*Not covered*
41. Out-Patient Restriction: *The insurer will cover the medical cost of Article 5, Benefits 20, 22, 27, 28, but restricted to a mutually agreed amount per period of cover in aggregate.*	*Not covered*	*Optional* *Up to RMB 31,000 per period of cover*	*Not covered*	*Not covered*
42. Optional Maternity: *Compulsory group policies 10+ employees* *The insurer will cover the medically necessary cost incurred under the Article 5, Benefit 30 under the Excel or Advance plan.* ***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.*** ***If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.*** ***Deductible would apply to this benefit.***	*Not covered*	*Optional* *Up to RMB 53,500 per period of cover* **Available option: Nil and 20% co-insurance.*	*Optional* *Up to RMB 78,750*	*Already covered under Benefit 30*

Full refund | Not covered | Subject to limits | Optional

Benefit	Essential	Advance	Excel	Apex
43. Optional Dental Benefit under the Advance Plan: **Dental Care – 1** *a) Routine dental treatment* *b) Complex dental treatment* ***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. If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.*** ***A co-insurance of 20% applies.*** *A 50% co-insurance applies in respect of all orthodontic treatment.* *Compulsory group policies 10+ employees.* **or** **Dental Care - 2** *a) Routine dental treatment* *b) Complex dental treatment* ***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. If the policyholder renews the insurance in accordance with the contract, it is not subject to this restriction. The benefit can be obtained from the effective date of the renewal policy and based on the terms and conditions of renewal policy.*** ***A co-insurance of 20% applies.*** *A 50% co-insurance applies in respect of all orthodontic treatment.* *Compulsory group policies 10+ employees.*	*Not covered* *Not covered*	*Optional* *a) Up to RMB 3,100 per period of cover* *b) Up to RMB 6,300 per period of cover* *Optional* *a) and b) Up to RMB 5,000 in aggregate per period of cover*	*Already covered under Benefit 29* *Already covered under Benefit 29*	*Already covered under Benefit 29* *Already covered under Benefit 29*
44. Removal of Co-Insurance for Dental Care: *Compulsory group policies 10+ employees.* *As described in Article 5, Benefit 29, but with no co-insurance applicable to either routine and complex dental treatment including orthodontic treatment.*	*Not covered*	*Not covered*	*Optional*	*Optional*
45. In-Patient and Out-Patient Co-Insurance: *The insurer will cover the actual medical costs associated with the benefits for eligible in-patient, day-patient or out-patient treatment subject to agreed % of co-insurance, up to an agreed out-of-pocket limit per medical condition.*	*Not covered*	*Optional* *20% co-insurance and up to an out-of-pocket limit of RMB 63,000 per medical condition*	*Optional* *20% co-insurance and up to an out-of-pocket limit of RMB 63,000 per medical condition*	*Optional* *20% co-insurance and up to an out-of-pocket limit of RMB 63,000 per medical condition*

Benefit	Essential	Advance	Excel	Apex
46. Extended Evacuation and Repatriation:				
The insurer will cover the actual incurred cost of the following:				
a) Evacuation	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***
Arrangements will be made to move an insured person who has a critical, life-threatening eligible medical condition to the nearest medical facility, country of residence, country of nationality or the insured person's country of choice for the purpose of admission to hospital as an in-patient or day-patient.	*Optional*	*Optional*	*Optional*	*Optional*
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.	*i) Full Refund*	*i) Full Refund*	*i) Full Refund*	*i) Full Refund*
ii) Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.	*ii) Full Refund*	*ii) Full Refund*	*ii) Full Refund*	*ii) Full Refund*
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.	*iii) Full Refund*	*iii) Full Refund*	*iii) Full Refund*	*iii) Full Refund*
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.	*iv) Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*	*iv) Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*	*iv) Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*	*iv) Up to RMB 1,800 per day. Up to RMB 63,000 per person, per evacuation*
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 insured person's country of choice is subject to the availability of the appropriate medical facilities being in place. The insurer's medical advisers will determine whether the selected country has the suitable medical facility to treat the insured person's eligible medical condition. The insurer's medical advisers will decide the most appropriate method of transportation for the evacuation and ***this benefit will not cover travel if it is against the advice of the insurer's medical advisers or where the medical facility does not have appropriate facilities to treat the eligible medical condition.***				
b) Repatriation	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***	***Pre-Authorisation ☎***
An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment or the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment.	*Full Refund*	*Full Refund*	*Full Refund*	*Full Refund*
Such transportation cost is only eligible if there was a medical need for an initial evacuation that has taken place.				
This Benefit specifically excludes routine pregnancy and childbirth costs, except for Article 5, Benefit 16 – Pregnancy Medical Conditions on the insurance contract.				
47. Out-Patient Per Visit Excess – Option 1:				
An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment inside and outside of the Now Health International Provider Network.The out-patient per visit excess does not apply to Article 5, Benefits 22, 23, and 29. (Alternative Therapies, Traditional Chinese Medicine and Ayurvedic Treatment, and Dental Care)	*Not covered*	*Optional RMB 150*	*Optional RMB 150*	*Optional RMB 150*
48. Out-Patient Per Visit Excess – Option 2:				
An RMB 90 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment inside and outside of the Now Health International Provider Network. The out-patient per visit excess does not apply to Article 5, Benefits 22, 23, and 29. (Alternative Therapies, Traditional Chinese Medicine and Ayurvedic Treatment, and Dental Care)	*Not covered*	*Optional RMB 90*	*Optional RMB 90*	*Optional RMB 90*

Full refund | Not covered | Subject to limits | Optional

Benefit	Essential	Advance	Excel	Apex
Deductible Options				
49. Standard Deductible	*Nil*	*Nil*	*Nil*	*Nil*
Optional Deductible: *The insurance product is designed to have deductible options. The agreed deductibles will apply when the insured person receives eligible in-patient and day-patient treatment (for treatment inside and outside of the provider network).* *Please note:* *a) If the policyholder has chosen Advance, Excel or Apex plan, and has selected a deductible option, the policyholder is required to select either a co-insurance out-patient treatment option or an out-patient per visit excess option.* *b) If the policyholder has chosen Optional Out-Patient Charges under the Essential Plan:* *i) If the policyholder has selected a deductible option, the policyholder is required to select a co-insurance out-patient treatment option.* *ii) The highest deductible that can be chosen is RMB 31,500.*	*RMB 6,300* *RMB 15,700* *RMB 31,500* *RMB 63,000* *RMB 94,500*	*RMB 6,300* *RMB 15,700* *RMB 31,500* *RMB 63,000* *RMB 94,500*	*RMB 6,300* *RMB 15,700* *RMB 31,500* *RMB 63,000* *RMB 94,500*	*RMB 6,300* *RMB 15,700* *RMB 31,500* *RMB 63,000* *RMB 94,500*

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WC CH 28011 04/2021

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