NOW HEALTH INTERNATIONAL

API 亚太财险 Asia-Pacific P&C

SimpleCare Policy Wording

Companies (April 2024)

Contents

A. Policy Wording
1. General

Asia-Pacific Property & Casualty Insurance Co., Ltd.
Companies SimpleCare Medical Insurance (April 2024) Policy Wording

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 except the insured and the insurer make special restrictions on the medical coverage of the dependent.
4. The direct insured and the dependant in this contract should also be named insured person.
5. This contract will not cover the applicant with US nationality who resides in the US for more than 90 days (including 90 days) every year. In addition, there are some mutually agreed excluded countries that the insurer cannot offer cover if the insured person resides in any of them. Such excluded country list will be communicated to the policyholder prior to the enrolment of the policy.

Article 4

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

2. Insurance Liability

Article 5 – Benefits

During the insured period of this contract, in case of any medical activities taken in this insurance contract, the insurer shall pay the insurance benefits (i.e. specific benefit will not exceed its corresponding benefit limit and the sum of the benefits paid will not exceed the annual maximum stipulated in the insurance contract) to the insured as follows. All cost actually incurred must be medically necessary and subject to reasonable and customary charges. The Benefits 1 to 24 under the Insurance Liability section are core benefits. The Benefits 25 to 38 under this Insurance Liability section are optional benefits.

1. Hospital Charges, Medical Practitioner and Specialist Fees

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

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

2. Diagnostic Procedures

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

3. Renal Failure and Renal Dialysis

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

4. Organ Transplant

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

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

In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Article 5, Benefit 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant.

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

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

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

5. Cancer Treatment

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

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

6. New Born Baby Cover

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

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

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

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

7. Congenital Disorders

The insurer will cover the actual incurred medical cost of the in-patient treatment for a congenital disorder. In circumstances where a congenital disorder manifests itself in a new born baby within 30 days of birth, cover for such medical conditions will be provided under Article 5, Benefit 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders. The maximum benefits should be mutually agreed between the policyholder and the insurer and stipulated in the insurance contract.

8. Parent Accommodation

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

9. Hospital Accommodation for New Born Accompanying their Mother

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

10. Reconstructive Surgery

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

11. Day-Patient or Out-Patient Surgery

The insurer will cover the actual incurred treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department. The benefits for such coverage should be mutually agreed between the policyholder and insurer and stipulated in the insurance contract.

12. In-Patient Emergency Dental Treatment

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

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

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

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

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

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

2. Insurance Liability

13. Rehabilitation

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

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

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

14. Nursing Care at Home

The insurer will cover the actual incurred medical cost of the care given by a qualified nurse in the insured person's own home, which is immediately received subsequent to treatment as an in-patient or day-patient on the recommendation of medical practitioner or specialist. This coverage needs to be pre-authorised.

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

15. Emergency Ambulance Transportation

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

16. Evacuation and Repatriation

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

a. Evacuation

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

Reasonable expenses for:

i. Transportation costs of an insured person in the event of emergency treatment and medically necessary transport and care not being readily available at the place of the incident. This includes an economy class airfare ticket for a locally-accompanying person who has travelled as an escort.
ii. Reasonable local travel costs to and from medical appointments when treatment is being received as a day-patient.
iii. Reasonable travel costs for a locally-accompanying person to travel to and from the hospital to visit the insured person following admission as an in-patient.
iv. Reasonable costs for non-hospital accommodation only for immediate pre and post-hospital admission periods provided that the insured person is under the care of a specialist.

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

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

b. Repatriation

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

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

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

17. Mortal Remains

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

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

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

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

18. Emergency Non-Elective Treatment Outside Area Of Cover

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

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

19. Hospital Cash Benefit

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

a. the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or

b. this policy being the secondary health insurance policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.

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

For this benefit exclusion 6.9 does not apply.

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

2. Insurance Liability

20. Out-Patient Charges

The insurer will cover the actual incurred medical cost of:

a. Medical Practitioner fees including consultations; Specialist fees; Diagnostic Tests;

b. Teleconsultation (Virtual Doctor appointments via electronic means).

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

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

c. Prescribed Drugs and Dressings.

d. Vitamins and Minerals:

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

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

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

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

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

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

21. Out-Patient Physiotherapy and Alternative Therapies

The insurer will cover the actual incurred medical cost of:

a. Physiotherapy by a Registered Physiotherapist.

b. Complementary medicine and treatment by a therapist. This benefit extends to chiropractors, chiropodists and podiatrists, osteopaths, homeopaths, dietician and acupuncture treatment.

c. Out-Patient Treatment for 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 a. and b. excluding dietician without the need of referral; any subsequent sessions need to be referred by a medical practitioner or specialist.

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

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

22. Menopause Hormone Replacement Therapy

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

23. Out-Patient Psychiatric Illness

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

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

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

24. Dental Care

The insurer will cover the actual incurred medical cost of:

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

This Benefit provides cover for the below dental Treatment:

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

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

No other Treatment is covered by this Benefit.

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

A co-insurance of 20% applies.

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

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

25. Mainland China option

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

Emergency non elective treatment outside of Mainland China:

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

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

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

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

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

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

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

27. High Cost Provider Restriction

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

28. In-Patient Co-Insurance at Private Hospital

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

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

2. Insurance Liability

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

During the insured period of this contract, in case of any medical activities taken in this insurance contract, the insurer shall pay the insurance benefits (i.e. specific benefit will not exceed its corresponding benefit limit and the sum of the benefits paid will not exceed the annual maximum policy limit of RMB 1,000,000.

30. Co-Insurance Out-Patient Treatment

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

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

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

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

31. Out-Patient Per Visit Excess

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

The out-patient per visit excess would apply to both Article 5, Benefits 20 - Out-Patient Charges and Benefits 21 – Out-Patient Physiotherapy and Alternative Therapies Benefits.

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

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

32. Removal of Drugs and Dressings Limit

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

For Compulsory Group Plans 3+ employees

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

33. Wellness and Vaccinations – Option 1

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

a. Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or

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

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

34. Wellness and Vaccinations – Option 2

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

a. Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or

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

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

35. Maternity – Option 1

The insurer will cover:

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

b. For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):

   – Ectopic pregnancy (where the foetus is growing outside the womb)

   – Hydatidiform mole (abnormal cell growth in the womb)

   – Retained placenta (afterbirth retained in the womb)

   – Placenta praevia

   – Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)

   – Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)

   – Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)

   – Miscarriage requiring immediate surgical treatment

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

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

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

For Compulsory Group Plans 10+ employees.

For this benefit exclusion 6.27 does not apply.

Deductible would apply to this benefit.

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

2. Insurance Liability

36. Maternity – Option 2

The insurer will cover:

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

b. For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):

   – Ectopic pregnancy (where the foetus is growing outside the womb)

   – Hydatidiform mole (abnormal cell growth in the womb)

   – Retained placenta (afterbirth retained in the womb)

   – Placenta praevia

   – Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)

   – Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)

   – Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)

   – Miscarriage requiring immediate surgical treatment

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

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

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

For Compulsory Group Plans 10+ employees.

For this benefit exclusion 6.27 does not apply.

Deductible would apply to this benefit.

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

37. Capped Cover for Declared Pre-existing Medical Conditions

For Compulsory Group Plans 5 to 19 employees.

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

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

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

38. Medical History Disregarded

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

3. Exclusions

Article 6 – Exclusions

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

6.1 Act of terrorism, war and illegal acts

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

6.2 Administrative and shipping fees

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

6.3 Alcohol and drug abuse

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

6.4 Chemical exposure

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

6.5 Cosmetic treatment

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

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

6.6 Contamination

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

6.7 Chronic conditions

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

6.8 Coma or Vegetative State

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

3. Exclusions

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

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

6.10 Dental care

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

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

6.11 Developmental disorders

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

6.12 Dietary supplements and cosmetic products

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

6.13 Eating disorders

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

6.14 Experimental treatment and drugs

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

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

You are not covered for 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.

6.16 External appliance and or prosthesis

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

6.17 Failure to follow medical advice

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

6.18 Foetal surgery

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

6.19 Genetic testing

The insured person is not covered for the cost of genetic tests, when those tests are undertaken to establish whether or not the insured person may be genetically disposed to the development of a medical condition, whether the insured person has a medical condition when he/she has no symptoms or if there is a genetic risk of the insured person passing on a medical condition.

6.20 Hazardous sports and pursuits

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

6.21 HIV, AIDS or sexually transmitted disease

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

6.22 Hormone replacement therapy

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

6.23 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.

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

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

6.25 Palliative and Hospice care

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

3. Exclusions

6.26 Pre-existing medical conditions

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

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

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

6.27 Pregnancy or maternity

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

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

6.28 Professional sports

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

6.29 Psychiatric or Psychological Treatment

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

6.30 Reproductive treatment and drugs

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

6.31 Routine examinations, health screening and Vaccinations

You are not covered for routine medical examinations (including issuing medical certificates, health screening examinations or tests to rule out the existence of a condition for which You do not have any symptoms) and any types of Vaccination costs. (unless benefits are shown on the insured person's certificate of insurance.)

6.32 Second opinions

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

6.33 Self-inflicted injuries or attempted suicide

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

6.34 Sexual problems and gender re-assignment

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

6.35 Sleep disorders

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

6.36 Travel/accommodation costs

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

6.37 Travelling against medical advice

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

6.38 Treatment in High Cost Medical Facilities

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

6.39 Treatment by a family member

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

6.40 Treatment charges outside of our reasonable and customary range

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

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 for a period of time. The exact number of days should be agreed between the insurer and the policyholder. However, the waiting period cannot be exceeded 180 days. The insured person must have completed the waiting period before the benefit is payable irrespective of whether the policyholder renews the insurance or not.

Article 10 – Deductibles

The insurance product is designed to have deductible options. The agreed deductibles will apply when the insured person receives eligible in-patient, day-patient and out-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 and effective identity certificate;

d. Medical receipts issued by the hospital (emergency treatment stamp of the hospital is required for medical expense receipts for emergency treatment), original diagnosis certificate and medical records;

e. For medical evacuation, a written documentary proof issued by the legitimate rescue organisation recognised by the insured should be provided;

f. Other supporting documents and information related to confirmation of the nature, cause and degree of injury, etc.

Article 21 – Right of Claims

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

Article 22 – Compensation Principle

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

1) If the insured has obtained relevant medical expenses compensation from other channels (including but not restricted to social basic medical insurance, public medical insurance, medical insurance under employee benefits), the insurer will only pay the balance of the cost of the medical treatment, in accordance with the provisions of this insurance contract, after compensation has been obtained from other channels (including but not restricted to social basic medical insurance, public medical insurance, medical insurance under employee benefits).

2) If the insured is a member of social basic medical insurance or public medical insurance, but fails to get compensation in social basic medical insurance or public medical insurance when making a claim, the insurer will protect the rights and interests of the applicant according to the applicant's insurance certificate and policy, subject to the upper limit under the coverage and the compensation standards stated on the insurance certificate and the policy.

9. Dispute Resolution and Applicable Law

Article 23 – Dispute Resolution

Disputes arising from the performance of this contract should be resolved through the consultations by the parties concerned. If the dispute cannot be resolved between the parties having exhausted all 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 plans. The insured person's applications must be submitted to the insurer before the insured person leaves the group policy and acceptance is subject to written agreement from the insurer.

Article 26 – Termination of Contract

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

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

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

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

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

Within 30 days from the date of receipt of the above mentioned documents, the insurer will refund the minimum cash value of the insurance policy of the contract to the policyholder.

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

Article 27 – Use of Membership Card

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

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

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

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

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

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

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

10. Miscellaneous

Article 28 – Right of Waiver

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

Article 29 – Policy Administration

1. The policyholder undertakes that he/she will advise all eligible employees immediately if any reason this agreement should not be renewed or this agreement should be terminated in accordance with the provision of Article 26 above so that such eligible employees are made aware that all cover has ceased and that benefits will not be payable in respect of eligible employees or family members.

2. Actively at Work

   Actively at Work shall mean the direct insured is employed by the policyholder on a full time permanent basis and the direct insured is performing all their regular duties according to their employment terms on a customary manner and on a full time basis.

   If the direct insured is an employee, he/she needs to be Actively at Work on the day he/she becomes eligible to join the group plan. If insured person is not Actively at Work on the day he/she becomes eligible, his/her cover will only begin on the day he/she returns to work on an Actively at Work basis. The direct insured can only add his/her dependants when he/she returns to work.

   The direct insured is considered NOT being Actively at Work if:

   - The Insured person is working less than 80% of the required work hours or being paid less than 80% of the usual pay as stipulated in their employment terms
   - The direct insured has a medical condition that necessitates absence from his/her usual work place for more than 60 days, with the exception of maternity/paternity leave as allowed by the local regulations.

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

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

5. The policyholder hereby indemnifies the insurer from and against any and all costs, losses and expenses incurred by the insurer consequent upon any failure by the policyholder to discharge its obligations under this agreement. If the policyholder is not able to perform the responsibilities of any clause under Article 29 on the insurance contract that causes the insurer to be claimed, the policyholder should indemnify the insurer for all the losses, including but not limited to the dispute's resolution fees, claim amount, legal fee and others.

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

7. Break in cover

   Where there is a break in cover, for whatever reason, the insurer reserves the right to reapply exclusion 6.26 in respect of pre-existing medical conditions.

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

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

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

11. General Conditions

Article 30 – General Conditions

1. The insurer reserves the right to revise or discontinue the group policy with effect from any renewal date.
2. The agreement can only be varied in writing. No variation will be admitted unless it is in writing and stampled by the insurer.
3. Any notice to be sent under this insurance contract must be in writing and be sent either by post or by facsimile machine and shall be considered to have been given if sent to the insurer at the registered address on the day after it was posted or, if sent by facsimile machine, at the time of dispatch.
4. The introduction of any change by the insurer in interpretation or practice in respect of any term or condition of the policyholder's members' documents shall not prevent the subsequent enforcement of that term or condition and shall not be deemed to form a precedent for any subsequent interpretation or practice.
5. In case of any inconsistency between Chinese version and English version, Chinese version shall prevail.

12. Definitions

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

17. **Chronic Condition**	A disease, illness or injury which has at least one of the following characteristics: – It needs ongoing or long-term monitoring through consultations, examination, check-ups, drugs and dressings and/or tests – It needs ongoing or long-term control or relief of symptoms – It requires the insured person's rehabilitation or for the insured person to be specially trained to cope with it – It continues indefinitely – It has no known cure – It comes back or is likely to come back
18. Day-Patient	A patient who is admitted to a hospital or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.
19. Deductible	An uninsured amount payable by an insured person in respect of in-patient 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.
20. Dental Practitioner	A person who is legally licensed to carry out this profession by the relevant licensing authority to practise dentistry in the country where the dental treatment is given.
21. Dependants	One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with the insured person, or up to 28 years old if in full-time education (written proof may be required from the educational institute where they are enrolled), at the start date or any subsequent renewal date. The term partner shall mean husband, wife, civil partner or the person permanently living with the insured person in a similar relationship. All dependants must be named as insured persons in the certificate of insurance.
22. Diagnostic Tests	Investigations, such as x-rays or blood tests, to find or to help to find the cause of the insured person's symptoms.
23. Drugs and Dressings	Essential prescription drugs, dressings and medicines administered by a medical practitioner or specialist needed to relieve or cure a medical condition.
24. Eligible	Those treatments and charges, which are covered by the insured person's policy. In order to determine whether a treatment or charge is covered, all sections of the insured person's policy should be read together, and are subject to all the terms (including payment of premium due), benefits and exclusions set out in this policy.
25. Entry Date	The date shown on the certificate of insurance on which an insured person was included under this policy.
26. Evacuation or Repatriation Service	Moving the insured person to a hospital which has the necessary in-patient and day-patient repatriation service medical facilities either in the country where the insured person is taken ill or in another nearby country (evacuation) or bringing the insured person back to either the insured person's principal country of nationality or the insured person's principal country of residence (repatriation). The service includes any medically necessary treatment administered by the international assistance company appointed by the insurer while they are moving the insured person.
27. Excluded Countries	Refers to the list of countries that We cannot offer You cover if You reside in any one of them. For details of Our list of Excluded Countries, please contact Our customer service team.
28. Expatriate	Any persons living and/or working outside of the country for which they hold a passport. Usually for a period of more than 180 days per period of cover
29. Geographic Area	The geographic area used to calculate the premium that will apply to the insured person based on the insured person's principal country of residence at the start date or any subsequent renewal date of this policy.
30. High Cost Providers List	The list of medical providers the insurer excludes from cover. The insurer does not cover any treatment costs incurred in any medical provider that is within the insurer's High Cost Providers List. The insurer will update the High Cost Providers List on a periodic basis. For details of the insurer's High Cost Providers List, the insured may contact the insurer's customer service team.
31. Hospital	Any establishment, which is licensed as a medical or surgical hospital under the laws of the country where it operates. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.
32. Hospital Accommodation	Refers to standard private or semi-private accommodation as indicated in the benefit schedule. Deluxe, executive rooms and VIP suites are not covered.

12. Definitions

33. In-Network Medical Provider	An in-network medical provider is one contracted with the insured person's policy to provide services to policy members for specific pre-negotiated rates.
34. In-Patient	A patient who is admitted to hospital and who occupies a bed overnight or longer, for medical reasons.
35. Insured Person	The eligible employee and/or the dependants named on the certificate of insurance who are covered under this policy.
36. Insurer	Asia-Pacific Property & Casualty Insurance Co., Ltd.
37. Medical Condition	Any disease, injury, or illness, including psychiatric illness.
38. Medical Practitioner	A person who has attained primary degrees in medicine or surgery following attendance at a WHO-recognised medical school and who is licensed to practise medicine by the relevant authority in the country where the treatment is given. By "recognised medical school" the insurer means a medical school, which is listed in the current World Directory of Medical Schools published by the WHO.
39. Medically Necessary	Treatment which in the opinion of a qualified medical practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the insured person's condition or the quality of medical care rendered. Such treatment must be required for reasons other than the comfort or convenience of the patient or medical practitioner and provided only for an appropriate duration of time. As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, medically necessary also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an out-patient basis.
40. New Born	A baby who is within the first 16 weeks of its life following birth.
41. Now Health International Provider Network	Our published list of medical providers where the insurer/policy administrator has a direct billing provider network agreement.
42. Out of Network Medical Provider	An out of network medical provider is one not contracted with the insured person's policy.
43. Out-Patient	A patient who attends a hospital, consulting room, telemedicine appointment or out-patient clinic and is not admitted as a day-patient or an in-patient.
44. Out-Patient Direct Billing	Our published list of medical providers where the insurer has a direct billing provider network.
45. Out-Patient Per Visit Excess	An uninsured amount payable by an insured person in respect of out-patient expenses before any benefits are paid under the insurance policy, as specified in the insured person's certificate of insurance. Each visit refers to each consultation. The out-patient per visit excess applies per insured person, per out-patient consultation when you receive eligible out-patient treatment.
46. Period of Cover	The period from 00:00 of the insurance policy start date to 23:59 of the insurance policy end date. It is usually for a period of 12 months.
47. Physiotherapist	A practising physiotherapist who is registered and licensed to practise medicine in the country where treatment is provided.
48. Pre-Authorisation	A process whereby an insured person seeks approval from the insurer prior to undertaking any treatment or incurring costs. Such benefits requiring pre-authorisation from the insurer will denote pre-authorisation ☎ in the benefit schedule.
49. Plan	The contract between You and Us which set out terms and conditions of the cover provided. The full terms and conditions consist of the application form, Certificate of Insurance, Benefit Schedule and this members' handbook.
50. Policyholder	The person or company named as policyholder in the certificate of insurance.
51. Pregnancy	Refers to the period of time, from the date of the first diagnosis, until delivery.
52. Primary Health Insurance	If the insured person has more than one health insurance policy, this is the health insurance policy that pays claims first.
53. Primary Health Insurer	The insurer of the primary health insurance plan.
54. Private Room	Single occupancy accommodation in a private hospital. Deluxe, executive rooms and VIP suites are not covered.

55. Psychiatric Illness

The mental or nervous disorder that meets the criteria for classification under an international classification system such as Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation.

56. Qualified Nurse

A nurse whose name is currently on any register or roll of nurses, maintained by any statutory nursing registration body within the country where treatment is provided.

57. Reasonable and Customary Charges

The standard fee that would typically be made in respect of the insured person's customary charges treatment costs, in the country the insured person received treatment. The insurer may require such fees to be substantiated by an independent third party, such as a practising surgeon/physician/specialist or government health department/medical providers within the SimpleCare Provider Network..

58. Minimum Cash Value

1) Termination before the effective date of insurance: Minimum cash value = Premium already paid by the policyholder.

2) Termination after the effective date of insurance (if the insurance premium is one-time payment):

   Minimum Cash Value= Net premium ×(1-m/n), where m is the number of effective days on cover and n is the number of days in the insurance period. The outstanding hours less than one day will be regarded as one day.

   Net premium = Premium already paid by the policyholder x (1 - Cost Ratio). Unless agreed, otherwise the cost ratio is 15%.

3) Termination after the waiting period of insurance (if the premium is paid in installments):

   Minimum Cash Value= Net premium for the month ×(1-m/n), where m is the number of effective days on cover of that month and n is the number of days of that month. The outstanding hours less than one day will be regarded as one day.

   Net premium for the month = Premium of that month already paid by the policyholder x (1 - Cost Ratio). Unless agreed, otherwise the cost ratio is 15%.

59. Rehabilitation

Medically necessary treatment aimed at restoring independent activities of daily living and the normal form/and or function of an insured person following a medical condition.

60. Related Conditions

A related condition is any disease, injury or illness including psychiatric illness that is caused by a pre-existing medical condition or results from the same underlying cause as a pre-existing medical condition.

61. Renewal Date

The anniversary of the start date of the insurance policy.

62. Secondary Health Insurance

If the insured person has more than one health insurance policy, Secondary Health Insurance is the payer that pays claim after the Primary Health Insurance has paid its portion. If the insured person has more than one health insurance policy, this insurance policy will be the health insurance policy that pays last. If the insured person buys this insurance policy as a Secondary Health Insurance Policy, the insurer will only pay a claim if:

– the claim was submitted to the Primary Health Insurer but the claim was not paid/ fully settled due to ineligibility or the benefit limits have been exhausted under the Primary Health Insurance contract, and

– the unpaid claim amount is considered as eligible claim under this insurance policy.

The insured person will need to provide a copy of the certificate of insurance of the insured person's Primary Health Insurance when the insured person applies for this insurance policy.

In any case, We will only pay the remaining balance of an Eligible claim amount that was not settled by the Primary Health Insurance.

63. Semi-Private Room

Dual occupancy accommodation in a private hospital. Deluxe, executive rooms and VIP suites are not covered.

64. SimpleCare Comprehensive Network

The insurer's list of medical providers that is available to the insured person if the insured person has extended the area of cover to Worldwide Excluding USA.

12. Definitions

65. Specialist	A surgeon, anaesthetist or physician who has attained primary degrees in medicine or surgery following attendance at a WHO recognised medical school and who is licensed to practise medicine by the relevant authority in the country where the treatment is given, and is recognised as having a specialised qualification in the field of or expertise in, the treatment of the disease, illness or injury being treated. By "recognised medical school" the insurer means a medical school, which is listed in the current World Directory of Medical Schools published by the WHO.
66. Start Date	The start date shown on the insured person's certificate of insurance.
67. Surgical Procedure	An operation requiring the incision of tissue or other invasive surgical intervention.
68. Terminal Illness	Following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition with death anticipated within 12 months of diagnosis.
69. Treatment	Surgical or medical services (including Diagnostic Tests) that are needed to diagnose, relieve or cure a medical condition.
70. Vaccinations	Refers to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis.
71. Waiting Period	Is a period of time starting on the entry date of the insured person's, during which the insured person is not entitled to cover for particular benefits. The insured person's benefit schedule will indicate which benefits are subject to waiting periods.
72. Group	Legal organisation established not for purchasing insurance in China including state owned organisation, colleagues and universities, enterprises and government-sponsored institutions, trade organisation, career union, etc.
73. Emergency	A sudden, serious, and unforeseen acute medical condition or injury requiring immediate medical treatment, that without treatment commencing within 48 hours of the emergency event could result in death or serious impairment of bodily function.
74. WHO	The World Health Organisation.

B. Benefit Schedule

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

Benefit	SimpleCare Amber
Annual Maximum Group Policy Limit ***24/7 helpline and assistance services available on all Plans***	**RMB 6,300,000**
Geographical Area Default:	**Worldwide Excluding USA**
Default Network:	**SimpleCare Comprehensive Network**
1. Hospital Charges, Medical Practitioner and Specialist Fees: *a) Charges for in-patient or day-patient treatment made by a hospital including charges for accommodation (ward/semi-private or private); diagnostic tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a qualified nurse; drugs and dressings prescribed by a medical practitioner or Specialist; and surgical appliances used by the medical practitioner during surgery. This includes pre and post-operative consultations while an in-patient or day-patient and includes charges for intensive care.* *b) Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an eligible medical condition which required in-patient or day-patient hospital treatment.*	a) ▶ *Full refund* ***Pre-Authorisation ☎*** b) ▶ *Up to RMB 9,450 per medical condition*
2. Diagnostic Procedures: *Medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an in-patient, day-patient or out-patient.*	▶ *Full Refund for in-patient pre and post-operative scans* ***Pre-Authorisation for MRI, PET and CT ☎***
3. Renal Failure and Renal Dialysis: *a) Treatment of renal failure, including renal dialysis on an in-patient basis.* *b) Treatment of renal failure, including renal dialysis on a day-patient or out-patient basis.*	a) ▶ *In-Patient pre and post-operative care up to six weeks full refund per Period of Cover* b) ▶ *Up to RMB 310,000 per period of cover*
4. Organ Transplant: *Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow or cornea, in respect of the insured person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Article 5, Benefit 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant.* *The insurer only pays for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.* *Medical costs associated with the donor and the cost of the donor organ search are excluded from this Benefit.*	▶ *Up to RMB 630,000 per period of cover*
5. Cancer Treatment: *Treatment given for cancer received as an in-patient, day-patient or out-patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.*	▶ *Full refund*

Benefit	SimpleCare Amber
6. New Born Baby Cover: *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 157,500 per period of cover*
7. 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 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders.*	*Up to RMB 157,500 per period of cover*
8. 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*
9. 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*
10. 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*
11. Day-Patient and Out-Patient Surgery: *Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department.*	*Full refund*
12. In-Patient Emergency Dental Treatment: *The insurer will cover the actual incurred medical cost of emergency restorative dental treatment required to sound, natural teeth following an accident which necessitates the insured person's admission to hospital for at least one night.* *The dental treatment must be received within 10 days of the accident. This benefit covers all costs incurred for treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:* *a) If the treatment involves replacing a crown, bridge facing, veneer or denture, the insurer will pay only the reasonable and customary cost of a replacement of similar type or quality* *b) If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead* *c) Damage to dentures providing they were being worn at the time of the injury.*	*Full refund*
13. 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*
14. Nursing Care at Home: *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.*	*Not Covered*

Full refund Not covered Subject to limits Optional

Benefit	SimpleCare Amber
15. 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*
16. Evacuation and Repatriation:	
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.*** *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.***	***Pre-Authorisation ☎*** *Combined limit up to RMB 630,000* ***a) Evacuation*** *i)* ▶ *Full Refund* *ii)* ▶ *Full Refund* *iii)* ▶ *Full Refund* *iv)* ▶ *Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*
b) Repatriation *An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment to the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment.* *Such transportation cost is only eligible if there was a medical need for an initial evacuation that has taken place.* ***Deductible would apply to medically necessary treatment required under this benefit.***	***Pre-Authorisation ☎*** ***b) Repatriation*** ▶ *Full refund*
17. Mortal Remains: *In the event of death from an eligible medical condition, reasonable and customary charges for:* *a) Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or* *b) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.*	***Pre-Authorisation ☎*** *a)* ▶ *Full Refund* *b)* ▶ *Up to RMB 63,000*
18. Emergency Non-Elective Treatment outside Area of 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.*	▶ *Accident: Full Refund for in-patient and day-patient treatment following accident* ▶ *Illness: In-patient and day-patient care up to RMB 157,500 per period of cover*
19. Hospital Cash Benefit: *The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if:* *a) the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or* *b) this policy being the Secondary Health Insurance Policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.* *Cover under this benefit is limited to a maximum of 30 nights per period of cover.* ***For this Benefit exclusion 6.9 does not apply.***	▶ *RMB 790 per night*

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

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

Additional Options	SimpleCare Amber
25. Mainland China option: *The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Mainland China and will be subject to the standard policy limits.* *Emergency non-elective treatment outside of Mainland China:* *For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health.* *Full refund for accident requiring in-patient and day-patient care.* *Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover*	*Optional* *Emergency non-elective treatment outside of Mainland China: illness limit up to RMB 150,000 per period of cover*
26. Hospital Room Restriction – Hospital Room & Board Limit RMB 800: *As described in Article 5 Benefit 1 a) on the insurance contract, but with a restriction to limit the hospital accommodation for hospital admission in Mainland China up to RMB 800 per day for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.*	*Optional* *In-patient or day-patient treatment received in any in-patient or day-patient facility in Mainland China up to RMB 800 per day*
27. 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.*	*Optional*
28. In-Patient Co-Insurance at Private Hospital: *The insurer will cover the actual medical costs associated with the benefits for eligible in-patient or day-patient treatment at a private hospital subject to 20% co-insurance.*	*Optional* *20% co-insurance*
29. Annual Maximum Policy Limit RMB 1,000,000: *During the insured period of this contract, in case of any medical activities taken in this insurance contract, the insurer shall pay the insurance benefits (i.e. specific benefit will not exceed its corresponding benefit limit and the sum of the benefits paid will not exceed the annual maximum policy limit of RMB 1,000,000.*	*Optional*
30. Co-Insurance Out-Patient Treatment: *A 20% co-insurance will apply on all eligible out-patient treatment.* *Please note co-insurance does not apply to cancer treatment, organ transplant or renal failure and renal dialysis.* *This option is not available for policies with deductibles of RMB 6,300 or higher. Should the plan includes maternity, dental care or wellness and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.*	*Not Covered*
31. Out-Patient Per Visit Excess: *An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment. The out-patient per visit excess would apply to both Article 5, Benefits 20 – Out-Patient Charges and Benefits 21 – Out-Patient Physiotherapy and Alternative Therapies Benefits.* *This option is not available for Group Plans with deductibles of RMB 6,300 or higher.*	*Not Covered*
32. Removal of Drugs and Dressings Limit: *By selecting this option, cover for Prescribed Drugs and Dressings under Benefit 20 c) will be Full Refund, subject to annual Out-Patient limit.* *For Compulsory Group Plans 3+ employees*	*Not Covered*

Additional Options	SimpleCare Amber
33. Wellness and Vaccinations – Option 1: *Compulsory group policies 3+ employees* *a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or* *b) Vaccinations: Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.* ***For this Benefit exclusion 6.9 does not apply.***	*a)* ▶ *Not covered* *b)* ▶ *Not covered*
34. Wellness and Vaccinations – Option 2: *Compulsory group policies 3+ employees* *a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or* *b) Vaccinations: Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.* ***For this Benefit exclusion 6.9 does not apply.***	*a)* ▶ *Not covered* *b)* ▶ *Not covered*
35. Maternity – Option 1: *a) Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.* ***Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.*** *b) For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):* *– Ectopic pregnancy (where the foetus is growing outside the womb)* *– Hydatidiform mole (abnormal cell growth in the womb)* *– Retained placenta (afterbirth retained in the womb)* *– Placenta praevia* *– Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* *– Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* *– Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* *– Miscarriage requiring immediate surgical treatment* *This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.* ***Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *For Compulsory Group Plans 10+ employees* ***For this Benefit exclusion 6.27 does not apply.*** ***Deductible would apply to this benefit.***	*a)* ▶ *Not covered* *b)* ▶ *Not covered*

Additional Options	SimpleCare Amber
36. Maternity – Option 2:	
a) *Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopath.* ***Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.***	a) ▶ *Not covered*
b) *For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):* – *Ectopic pregnancy (where the foetus is growing outside the womb)* – *Hydatidiform mole (abnormal cell growth in the womb)* – *Retained placenta (afterbirth retained in the womb)* – *Placenta praevia* – *Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* – *Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* – *Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* – *Miscarriage requiring immediate surgical treatment* *This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.* ***Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *For Compulsory Group Plans 10+ employees* ***For this Benefit exclusion 6.27 does not apply.*** ***Deductible would apply to this benefit.***	b) ▶ *Not covered*

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

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

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

Benefit	SimpleCare Jade
Annual Maximum Group Policy Limit ***24/7 helpline and assistance services available on all Plans***	**RMB 9,450,000**
Geographical Area Default:	**Worldwide Excluding USA**
Default Network:	**SimpleCare Comprehensive Network**
1. Hospital Charges, Medical Practitioner and Specialist Fees: *a) Charges for in-patient or day-patient treatment made by a hospital including charges for accommodation (ward/semi-private or private); diagnostic tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a qualified nurse; drugs and dressings prescribed by a medical practitioner or Specialist; and surgical appliances used by the medical practitioner during surgery. This includes pre and post-operative consultations while an in-patient or day-patient and includes charges for intensive care.* *b) Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an eligible medical condition which required in-patient or day-patient hospital treatment.*	*a)* ▶ *Full refund* ***Pre-Authorisation ☎*** *b)* ▶ *Up to RMB 9,450 per medical condition*
2. Diagnostic Procedures: *Medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an in-patient, day-patient or out-patient.*	▶ *Full Refund* ***Pre-Authorisation for MRI, PET and CT ☎***
3. Renal Failure and Renal Dialysis: *a) Treatment of renal failure, including renal dialysis on an in-patient basis.* *b) Treatment of renal failure, including renal dialysis on a day-patient or out-patient basis.*	*a)* ▶ *Up to six weeks full refund per period of cover* *b)* ▶ *Up to RMB 310,000 per period of cover*
4. Organ Transplant: *Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow or cornea, in respect of the insured person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Article 5, Benefit 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant.* *The insurer only pays for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.* *Medical costs associated with the donor and the cost of the donor organ search are excluded from this Benefit.*	▶ *Up to RMB 945,000 per period of cover*
5. Cancer Treatment: *Treatment given for cancer received as an in-patient, day-patient or out-patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.*	▶ *Full refund*

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

Benefit	SimpleCare Jade
6. 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 220,500 per period of cover*
7. 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 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders.*	*Up to RMB 220,500 per period of cover*
8. 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*
9. 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*
10. 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*
11. Day-Patient and Out-Patient Surgery: *Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department.*	*Full refund*
12. In-Patient Emergency Dental Treatment: *The insurer will cover the actual incurred medical cost of emergency restorative dental treatment required to sound, natural teeth following an accident which necessitates the insured person's admission to hospital for at least one night.* *The dental treatment must be received within 10 days of the accident. This benefit covers all costs incurred for treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:* *a) If the treatment involves replacing a crown, bridge facing, veneer or denture, the insurer will pay only the reasonable and customary cost of a replacement of similar type or quality* *b) If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead* *c) Damage to dentures providing they were being worn at the time of the injury.*	*Full refund*
13. 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 up to 90 days per medical condition*
14. Nursing Care at Home: *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.*	*Full Refund up to 30 days per medical condition* ***Pre-Authorisation ☎***

Full refund Not covered Subject to limits Optional

Benefit	SimpleCare Jade
15. 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*
16. Evacuation and Repatriation: **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.*** *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** *An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment to the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment.* *Such transportation cost is only eligible if there was a medical need for an initial evacuation that has taken place.* ***Deductible would apply to medically necessary treatment required under this benefit.***	***Pre-Authorisation ☎*** *Combined limit up to RMB 630,000* ***a) Evacuation*** *i)* ▶ *Full Refund* *ii)* ▶ *Full Refund* *iii)* ▶ *Full Refund* *iv)* ▶ *Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation* ***Pre-Authorisation ☎*** ***b) Repatriation*** ▶ *Full refund*
17. Mortal Remains: *In the event of death from an eligible medical condition, reasonable and customary charges for:* *a) Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or* *b) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.*	***Pre-Authorisation ☎*** *a)* ▶ *Full Refund* *b)* ▶ *Up to RMB 63,000*
18. Emergency Non-Elective Treatment outside Area of 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.*	▶ *Accident: Full Refund for in-patient and day-patient treatment following accident* ▶ *Illness: In-patient and day-patient care up to RMB 220,500 per period of cover*
19. Hospital Cash Benefit: *The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if:* *a) the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or* *b) this policy being the Secondary Health Insurance Policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.* *Cover under this benefit is limited to a maximum of 30 nights per period of cover.* ***For this Benefit exclusion 6.9 does not apply.***	▶ *RMB 1,575 per night*

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

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

Additional Options	SimpleCare Jade
25. Mainland China option: *The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Mainland China and will be subject to the standard policy limits.* *Emergency non-elective treatment outside of Mainland China:* *For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health.* *Full refund for accident requiring in-patient and day-patient care.* *Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover*	*Optional* *Emergency non-elective treatment outside of Mainland China: illness limit up to RMB 150,000 per period of cover*
26. Hospital Room Restriction – Hospital Room & Board Limit RMB 800: *As described in Article 5 Benefit 1 a) on the insurance contract, but with a restriction to limit the hospital accommodation for hospital admission in Mainland China up to RMB 800 per day for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.*	*Optional* *In-patient or day-patient treatment received in any in-patient or day-patient facility in Mainland China up to RMB 800 per day*
27. 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.*	*Optional*
28. In-Patient Co-Insurance at Private Hospital: *The insurer will cover the actual medical costs associated with the benefits for eligible in-patient or day-patient treatment at a private hospital subject to 20% co-insurance.*	*Optional* *20% co-insurance*
29. Annual Maximum Policy Limit RMB 1,000,000: *During the insured period of this contract, in case of any medical activities taken in this insurance contract, the insurer shall pay the insurance benefits (i.e. specific benefit will not exceed its corresponding benefit limit and the sum of the benefits paid will not exceed the annual maximum policy limit of RMB 1,000,000.*	*Optional*
30. Co-Insurance Out-Patient Treatment: *A 20% co-insurance will apply on all eligible out-patient treatment.* *Please note co-insurance does not apply to cancer treatment, organ transplant or renal failure and renal dialysis.* *This option is not available for policies with deductibles of RMB 6,300 or higher. Should the plan includes maternity, dental care or wellness and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.*	*Optional*
31. Out-Patient Per Visit Excess: *An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment. The out-patient per visit excess would apply to both Article 5, Benefits 20 – Out-Patient Charges and Benefits 21 – Out-Patient Physiotherapy and Alternative Therapies Benefits.* *This option is not available for Group Plans with deductibles of RMB 6,300 or higher.*	*Optional* *RMB 150*
32. Removal of Drugs and Dressings Limit: *By selecting this option, cover for Prescribed Drugs and Dressings under Benefit 20 c) will be Full Refund, subject to annual Out-Patient limit.* *For Compulsory Group Plans 3+ employees*	*Not Covered*

Additional Options	SimpleCare Jade
33. Wellness and Vaccinations – Option 1: *Compulsory group policies 3+ employees* *a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or* *b) Vaccinations: Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.* ***For this Benefit exclusion 6.9 does not apply.***	*Optional* *a) and b)* *Combined limit up to RMB 950 per period of cover*
34. Wellness and Vaccinations – Option 2: *Compulsory group policies 3+ employees* *a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or* *b) Vaccinations: Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.* ***For this Benefit exclusion 6.9 does not apply.***	*Optional* *a) and b)* *Combined limit up to RMB 1,570 per period of cover*
35. Maternity – Option 1: *a) Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.* ***Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.*** *b) For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):* *– Ectopic pregnancy (where the foetus is growing outside the womb)* *– Hydatidiform mole (abnormal cell growth in the womb)* *– Retained placenta (afterbirth retained in the womb)* *– Placenta praevia* *– Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* *– Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* *– Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* *– Miscarriage requiring immediate surgical treatment* *This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.* ***Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *For Compulsory Group Plans 10+ employees* ***For this Benefit exclusion 6.27 does not apply.*** ***Deductible would apply to this benefit.***	*Optional* *For Compulsory Group Plans 10+ employees* *a) Up to RMB 31,500 per Period of Cover* *b) Up to RMB 75,600 per Period of Cover*

Additional Options	SimpleCare Jade
36. Maternity – Option 2:	Optional For Compulsory Group Plans 10+ employees
a) *Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.* ***Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.***	a) Up to RMB 44,100 per Period of Cover
b) *For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):* – *Ectopic pregnancy (where the foetus is growing outside the womb)* – *Hydatidiform mole (abnormal cell growth in the womb)* – *Retained placenta (afterbirth retained in the womb)* – *Placenta praevia* – *Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* – *Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* – *Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* – *Miscarriage requiring immediate surgical treatment*	b) Up to RMB 94,500 per Period of Cover
This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions. ***Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *For Compulsory Group Plans 10+ employees* ***For this Benefit exclusion 6.27 does not apply.*** ***Deductible would apply to this benefit.***	

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

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

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

Benefit	SimpleCare Crystal
Annual Maximum Group Policy Limit ***24/7 helpline and assistance services available on all Plans***	**RMB 9,450,000**
Geographical Area Default:	**Worldwide Excluding USA**
Default Network:	**SimpleCare Comprehensive Network**
1. Hospital Charges, Medical Practitioner and Specialist Fees: *a) Charges for in-patient or day-patient treatment made by a hospital including charges for accommodation (ward/semi-private or private); diagnostic tests; operating theatre charges including surgeon and anaesthetist charges; and charges for nursing care by a qualified nurse; drugs and dressings prescribed by a medical practitioner or Specialist; and surgical appliances used by the medical practitioner during surgery. This includes pre and post-operative consultations while an in-patient or day-patient and includes charges for intensive care.* *b) Ancillary charges: Purchase and rental of crutches, canes, walking aids and self-propelled non-electronic wheelchairs within six months of an eligible medical condition which required in-patient or day-patient hospital treatment.*	*a)* ▶ *Full refund* ***Pre-Authorisation*** ☎ *b)* ▶ *Up to RMB 9,450 per medical condition*
2. Diagnostic Procedures: *Medically necessary diagnostic magnetic resonance imaging (MRI), positron emission tomography (PET) and computerised tomography (CT) scans received as an in-patient, day-patient or out-patient.*	▶ *Full Refund* ***Pre-Authorisation for MRI, PET and CT*** ☎
3. Renal Failure and Renal Dialysis: *a) Treatment of renal failure, including renal dialysis on an in-patient basis.* *b) Treatment of renal failure, including renal dialysis on a day-patient or out-patient basis.*	*a)* ▶ *Up to six weeks full refund per period of cover* *b)* ▶ *Up to RMB 310,000 per period of cover*
4. Organ Transplant: *Treatment for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow or cornea, in respect of the insured person as a recipient. In circumstances where an organ transplant is required as a result of a congenital disorder, cover will be provided under Article 5, Benefit 7 – Congenital Disorder but excluded from Article 5, Benefit 4 – Organ Transplant.* *The insurer only pays for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO guidelines.* *Medical costs associated with the donor and the cost of the donor organ search are excluded from this Benefit.*	▶ *Up to RMB 945,000 per period of cover*
5. Cancer Treatment: *Treatment given for cancer received as an in-patient, day-patient or out-patient. Includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis.*	▶ *Full refund*

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

Benefit	SimpleCare Crystal
6. 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 220,500 per period of cover*
7. 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 6 – New Born Baby Cover but excluded from Article 5, Benefit 7 – Congenital Disorders.*	*Up to RMB 220,500 per period of cover*
8. 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*
9. 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*
10. 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*
11. Day-Patient and Out-Patient Surgery: *Treatment costs for a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department.*	*Full refund*
12. In-Patient Emergency Dental Treatment: *The insurer will cover the actual incurred medical cost of emergency restorative dental treatment required to sound, natural teeth following an accident which necessitates the insured person's admission to hospital for at least one night.* *The dental treatment must be received within 10 days of the accident. This benefit covers all costs incurred for treatment made necessary by an accidental injury caused by an extra-oral impact, when the following conditions apply:* *a) If the treatment involves replacing a crown, bridge facing, veneer or denture, the insurer will pay only the reasonable and customary cost of a replacement of similar type or quality* *b) If implants are clinically needed the insurer will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead* *c) Damage to dentures providing they were being worn at the time of the injury.*	*Full refund*
13. 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 up to 90 days per medical condition*
14. Nursing Care at Home: *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.*	*Full Refund up to 30 days per medical condition* ***Pre-Authorisation ☎***

Full refund Not covered Subject to limits Optional

Benefit	SimpleCare Crystal
15. 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*
16. Evacuation and Repatriation:	
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.*** *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.***	***Pre-Authorisation ☎*** *Combined limit up to RMB 630,000* ***a) Evacuation*** *i)* ▶ *Full Refund* *ii)* ▶ *Full Refund* *iii)* ▶ *Full Refund* *iv)* ▶ *Up to RMB 1,200 per day. Up to RMB 47,000 per person, per evacuation*
b) Repatriation *An economy class airfare ticket to return the insured person and a locally-accompanying person who has travelled as an escort to the site of treatment to the insured person's principal country of nationality or principal country of residence, as long as the journey is made within one month of completion of treatment.* *Such transportation cost is only eligible if there was a medical need for an initial evacuation that has taken place.* ***Deductible would apply to medically necessary treatment required under this benefit.***	***Pre-Authorisation ☎*** ***b) Repatriation*** ▶ *Full refund*
17. Mortal Remains: *In the event of death from an eligible medical condition, reasonable and customary charges for:* *a) Costs of transportation of body or ashes of an insured person to his/her country of nationality or country of residence, or* *b) Burial or cremation costs at the place of death in accordance with reasonable and customary practice.*	***Pre-Authorisation ☎*** *a)* ▶ *Full Refund* *b)* ▶ *Up to RMB 63,000*
18. Emergency Non-Elective Treatment outside Area of 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.*	▶ *Accident: Full Refund for in-patient and day-patient treatment following accident* ▶ *Illness: In-patient and day-patient care up to RMB 220,500 per period of cover*
19. Hospital Cash Benefit: *The insurer will cover the benefit payable for each night an insured person receives in-patient treatment and only if:* *a) the insured person is admitted for an elective in-patient treatment before midnight and the treatment is received within the public hospitals of the insured person's country of residence; or* *b) this policy being the Secondary Health Insurance Policy. However, if the insured person has a RMB 63,000 or RMB 94,500 deductible policy, the insured person is not eligible for the benefit.* *Cover under this benefit is limited to a maximum of 30 nights per period of cover.* ***For this Benefit exclusion 6.9 does not apply.***	▶ *RMB 1,575 per night*

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

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

Additional Options	SimpleCare Crystal
25. Mainland China option: *The insurer will cover the medical costs associated with all eligible in-patient, day-patient, and out-patient treatment restricted to Mainland China and will be subject to the standard policy limits.* *Emergency non-elective treatment outside of Mainland China:* *For planned trips up to 30 days of duration. Treatment by a medical practitioner or specialist starting within 24 hours of the emergency event, required as a result of an accident or the sudden beginning of a severe illness resulting in a medical condition that presents an immediate threat to the insured person's health.* *Full refund for accident requiring in-patient and day-patient care.* *Illness: In-patient and day-patient care up to the sub-limit listed in various plans per period of cover*	*Optional* *Emergency non-elective treatment outside of Mainland China: illness limit up to RMB 150,000 per period of cover*
26. Hospital Room Restriction – Hospital Room & Board Limit RMB 800: *As described in Article 5 Benefit 1 a) on the insurance contract, but with a restriction to limit the hospital accommodation for hospital admission in Mainland China up to RMB 800 per day for any charge for eligible in-patient or day-patient treatment made by the hospital and by any medical practitioner, should the in-patient or day-patient be received in any in-patient/day-patient facility in Mainland China as pre-defined and advised by the insurer.*	*Optional* *In-patient or day-patient treatment received in any in-patient or day-patient facility in Mainland China up to RMB 800 per day*
27. 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.*	*Optional*
28. In-Patient Co-Insurance at Private Hospital: *The insurer will cover the actual medical costs associated with the benefits for eligible in-patient or day-patient treatment at a private hospital subject to 20% co-insurance.*	*Optional* *20% co-insurance*
29. Annual Maximum Policy Limit RMB 1,000,000: *During the insured period of this contract, in case of any medical activities taken in this insurance contract, the insurer shall pay the insurance benefits (i.e. specific benefit will not exceed its corresponding benefit limit and the sum of the benefits paid will not exceed the annual maximum policy limit of RMB 1,000,000.*	*Optional*
30. Co-Insurance Out-Patient Treatment: *A 20% co-insurance will apply on all eligible out-patient treatment.* *Please note co-insurance does not apply to cancer treatment, organ transplant or renal failure and renal dialysis.* *This option is not available for policies with deductibles of RMB 6,300 or higher. Should the plan includes maternity, dental care or wellness and vaccinations benefits, any applicable co-insurance will be detailed in insured person's benefit schedule.*	*Optional*
31. Out-Patient Per Visit Excess: *An RMB 150 out-patient per visit excess will apply when the insured person receives eligible out-patient treatment. The out-patient per visit excess would apply to both Article 5, Benefits 20 – Out-Patient Charges and Benefits 21 – Out-Patient Physiotherapy and Alternative Therapies Benefits.* *This option is not available for Group Plans with deductibles of RMB 6,300 or higher.*	*Optional* *RMB 150*
32. Removal of Drugs and Dressings Limit: *By selecting this option, cover for Prescribed Drugs and Dressings under Benefit 20 c) will be Full Refund, subject to annual Out-Patient limit.* *For Compulsory Group Plans 3+ employees*	*Optional* *For Compulsory Group Plans 3+ employees*

Full refund Not covered Subject to limits Optional

Additional Options	SimpleCare Crystal
33. Wellness and Vaccinations – Option 1: *Compulsory group policies 3+ employees* *a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or* *b) Vaccinations: Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.* ***For this Benefit exclusion 6.9 does not apply.***	*Optional* *a) and b)* *Combined limit up to RMB 950 per period of cover*
34. Wellness and Vaccinations – Option 2: *Compulsory group policies 3+ employees* *a) Wellness: this benefit is payable as a contribution towards the cost of routine health checks including cancer screening, BRCA I & II Test (where a direct family history exists), bone densitometry (once every five years for women aged 50+), cardiovascular examination, neurological examinations, vital signs (e.g. blood pressure, body mass index, urinalysis, cholesterol), well child test (Up to age of 5 Years), and/or* *b) Vaccinations: Costs of drugs and consultations to administer all medically necessary basic immunisation and booster injections and any medically necessary travel vaccinations and malaria prophylaxis.* ***For this Benefit exclusion 6.9 does not apply.***	*Optional* *a) and b)* *Combined limit up to RMB 1,570 per period of cover*
35. Maternity – Option 1: *a) Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.* ***Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.*** *b) For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):* *– Ectopic pregnancy (where the foetus is growing outside the womb)* *– Hydatidiform mole (abnormal cell growth in the womb)* *– Retained placenta (afterbirth retained in the womb)* *– Placenta praevia* *– Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* *– Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* *– Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* *– Miscarriage requiring immediate surgical treatment* *This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.* ***Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *For Compulsory Group Plans 10+ employees* ***For this Benefit exclusion 6.27 does not apply.*** ***Deductible would apply to this benefit.***	*Optional* *For Compulsory Group Plans 10+ employees* *a) Up to RMB 31,500 per Period of Cover* *b) Up to RMB 75,600 per Period of Cover*

Additional Options	SimpleCare Crystal
36. Maternity – Option 2:	
a) *Medically Necessary costs incurred during Pregnancy and childbirth: childbirth costs, including pre and post-natal check-ups for up to six weeks following birth, scans and delivery costs for a natural birth or voluntary/Emergency caesarean section. Paediatrician costs for the first examination/check-up of a New Born baby, if the examination is made within 24 hours of delivery and Well-baby examinations up to the child's second birthday and as recommended by a Medical Practitioner or Specialist. This includes physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, as well as hereditary and metabolic screening, immunisations, urine analysis, tuberculin tests and hematocrit, haemoglobin and other blood tests, including tests to screen for sickle haemoglobinopathy.* ***Please note We will pay for the above Well-baby examinations costs only if We have paid the delivery cost of the baby under this Group Plan, provided the baby is being added into the Group Plan as an Insured Person.***	*Optional* *For Compulsory Group Plans 10+ employees* a) *Up to RMB 44,100 per Period of Cover*
b) *For In-Patient Treatment of an Eligible Medical Condition which arises during the antenatal stages of Pregnancy or an Eligible Medical Condition which arises during childbirth, the insurer would only allow Treatment of the following as an Eligible Medical Condition under this Benefit b):* – *Ectopic pregnancy (where the foetus is growing outside the womb)* – *Hydatidiform mole (abnormal cell growth in the womb)* – *Retained placenta (afterbirth retained in the womb)* – *Placenta praevia* – *Eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)* – *Diabetes (If the insured person has exclusions because of the insured person's past medical history which relate to diabetes, then the insured person will not be covered for any treatment for diabetes during pregnancy)* – *Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)* – *Miscarriage requiring immediate surgical treatment* *This benefit b) does not provide any cover for voluntary/ Emergency caesarean section procedures or 'failure to progress in labour' unless for one of the above stated Eligible Medical Conditions.* ***Waiting period: Any expenses incurred within 180 days after the start date of the insured person's policy are not payable. For the expenses incurred after the 180th day to one year after the policy takes effect, this benefit has a 95% co-insurance. The insured person must have completed the waiting period of 180 days before the benefit is payable irrespective of whether the policyholder renews the insurance or not.*** ***Please note, the insurer does not pay for parenting or other teaching classes as these are a matter of personal choice.*** *For Compulsory Group Plans 10+ employees* ***For this Benefit exclusion 6.27 does not apply.*** ***Deductible would apply to this benefit.***	b) *Up to RMB 94,500 per Period of Cover*

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

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

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