International Healthcare Plans for China
Valid from 1st April 2020

BENEFIT GUIDE

AllianzJD

Welcome

You and your family can depend on Allianz Jingdong General Insurance Company Ltd., as your health insurer, to give you access to the best care possible.

For the administration of your policy service outside mainland China, we are working in partnership with the international health division of Allianz Care, a specialist provider of worldwide insurance within the Allianz Group. We are both backed by the resources and expertise of Allianz SE, one of the world's leading insurance companies, providing you with a service that is fast, flexible and totally reliable.

To make the most of your international healthcare plan, please read this guide together with your Insurance Certificate and Table of Benefits.

HOW TO USE YOUR COVER

TERMS AND CONDITIONS OF YOUR COVER

Allianz Jingdong General Insurance Company Ltd. is the insurer and the inside mainland China administrator of this policy. The company is registered in China and regulated by the China Banking and Insurance Regulatory Commission. Registered Office: Unit 01-05, 11 & 12, 34th Floor, Main Tower, Guangzhou International Finance Center, 5 Zhujiang Xilu, Tianhe District, Guangzhou, Guangdong, P.R. China. Registered No. 914400005517258765.

AWP Health & Life SA, acting through its Irish Branch, is engaged by the insurer for the administration of the insurance policy outside mainland China. AWP Health & Life SA is a limited company governed by the French Insurance Code. Registered in France: No. 401 154 679 RCS Bobigny. Irish Branch registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. Allianz Care and Allianz Partners are registered business names of AWP Health & Life SA.

HOW TO USE YOUR COVER

SUPPORT SERVICES

We believe in providing you with the top-quality service that you deserve.

In the following pages we describe the full range of member services we offer. Read on to discover what is available to you.

Talk to us, we love to help!

Our Helpline is available to handle any questions about your policy or if you need assistance in case of an emergency. The Helpline service is available 24 hours a day, 7 days a week, in both Chinese and English.

Helpline

4008866014
(from inside mainland China)

(+ 86) 10 85355624
(from outside mainland China)

@ Email: Health.ClientServices@allianz.cn

Did you know...

...that most of our members find that their queries are handled quicker when they call us?

"Allianz MyHealth" app

Our "Allianz MyHealth" app has been designed to give you easy and convenient access to your cover, no matter where you are. With "MyHealth" app you can access the following features from your mobile device:

MY CLAIMS
Submit your claims in 3 simple steps and view your claims history.

MY CONTACTS
Access our 24/7 bilingual Helpline and local emergency numbers.

SYMPTOM CHECKER
For a quick and easy evaluation of your symptoms.

Other Services *- access your policy documents and your Membership Card on the go, look up the local equivalent names of branded drugs and translate common ailments into one of 17 languages.*

All personal data within the "Allianz MyHealth" app are encrypted for data protection. Most features are accessible even when offline.

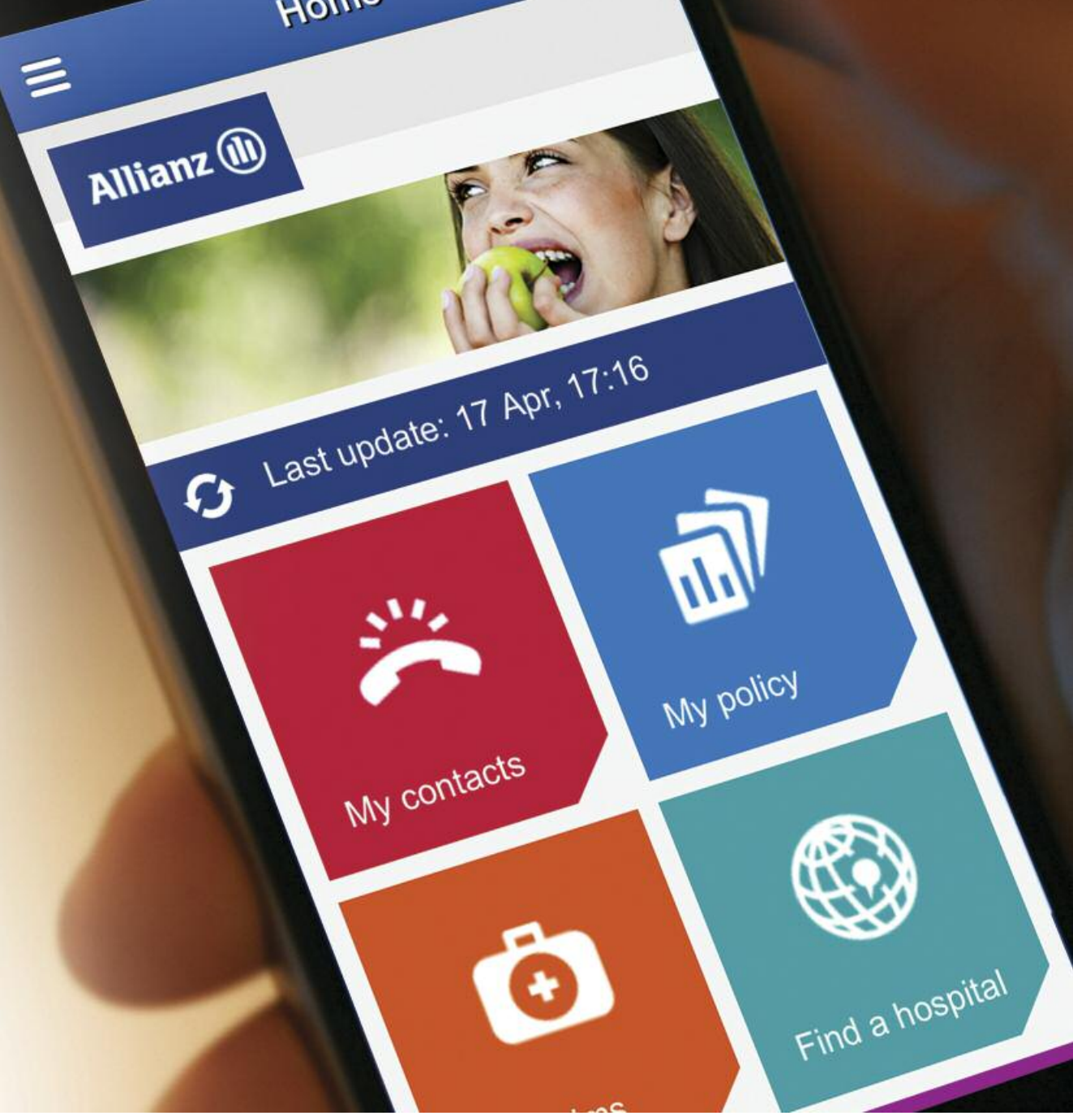
GETTING STARTED

Download – you can download the app from the Apple App Store by simply searching for "Allianz MyHealth" and following the on-screen instructions. If you have an Android device, please follow the instructions provided on https://www.allianzcare.com/en/support/member-resources/my-health-app/china.html

Initial setup – once downloaded, open the app and provide your policy number. Then, if prompted, register to receive a username and temporary password. Otherwise, please insert the login details available from your Membership Pack. When requested, change the temporary password provided to something you can easily remember. If you re-install the app or setup the app on another device, please use this setup information again. Please note that you can also use these details to login to our Online Services.

Set PIN – finally, set your own unique PIN number. In the future, this PIN number will be all you need to access the "Allianz MyHealth" app and all its features

Please note that the mobile app is a service offered via our sister company Allianz Care.


Allianz
Last update: 17 Apr, 17:16
My contacts
My policy
Find a hospital

Online Services

You can access our secure Online Services from the comfort of your home. Our Online Services allows you to:

- View and amend your personal details online.
- Download your policy documents, including your Membership Card, in the language you have selected for your policy (English or Chinese).
- View your Table of Benefits and check how much remains payable under each benefit.
- Confirm the status of any claims submitted to us and view claims related correspondence.

Please note that this facility is handled by our sister company Allianz Care and is provided in English language.

To access our secure Online Services, please log on to http://eservice.allianz.cn/sol/forms/index.jsp and:

1. Login using the unique username and temporary password included in your Membership Pack.
2. When requested, change the temporary password provided to something you can easily remember. Please keep this information safe, you'll need it again! Please note that you can also use these details to login to our "Allianz MyHealth" app.
3. Click on "login" and browse away!

If you have not received your login details, you can still access Online Services by selecting "Register" and providing the information requested. Your username and temporary password will be sent to the email address we have on record for you.

Web-based services

On **https://www.allianz360.com/allianzworldwidecare/index.htm** you can:

- Search for medical providers. You are not restricted to using the providers listed in our directory. The medical provider directory is handled by our sister company Allianz Care.
- Download forms.

By your side, when you need us

As part of your insurance cover with us, you have access to a range of concierge services designed to give you easy access to medical service in China:

Appointment booking
• Call our Helpline to book your (in-patient or out-patient) appointment with any hospital within our Network.
• If you haven't chosen an hospital, we can provide advice on hospital specialties for your consideration.

Hospital representative
• If you need it, our medical representative will meet you at the hospital for your treatment, helping you with any language challenges and assisting with your appointment.

Case management
• For oncology cases, we will help you make the right choices at the right time.
• Our Medical Team will follow your case and will advise you on your treatment.

Our concierge services will help you:

• Save time and reduce administration, as we handle that for you.
• Smoothly access an unfamiliar healthcare system, where you are an expatriate.
• Obtain direct assistance and advice in critical cases, when you need it most.

To access our concierge services, simply call us: we love to help!

Helpline 24/7:

4008866014 (from inside mainland China)

(+86) 10 85355624 (from outside mainland China)

Health.ClientServices@allianz.cn

Allianz Jingdong General Insurance Company Ltd. are responsible for organising access to treatment only. Allianz Jingdong General Insurance Company Limited, its administrators and reinsurers are not liable for any claim, loss or damage directly or indirectly resulting from any act or omission of the medical providers including, treatment, advice, diagnosis, misdiagnosis or failure to diagnose.

Expert medical advisory service from Advance Medical

As your health partner, we aim to make your life easier. Do you ever face situations where you are feeling ill but have no time to visit the doctor, or getting confused or unsure about a surgery or a particular diagnosis, or want expert help on where to get suitable treatment? You now have access to a range of free services designed to provide you with medical advice when you need it.

Talk to a doctor
Need to talk with a senior licensed doctor?
Want a clinical opinion on your symptoms over the phone?
Get clarity on next steps...

Expert medical opinion
Is my diagnosis correct?
I've been recommended a treatment plan, are there other alternatives?
Is surgery really necessary?

Overseas treatment recommendations
Can I get help in finding the right doctor for my treatment plan?
How do I make an appointment with the chosen treating expert?
Will I have a choice of hospitals that can treat me?

Advance Medical's independent medical advisors will help you in making your critical medical decisions!

Mandarin, Cantonese, English, Japanese, Korean, Bahasa and Thai!

+86 21 22236803
Service line open Monday to Friday 9:00 - 21:00 (CST time)

To access the service, please register through the following link. Your policy number is required to complete the registration.

https://allianzcare.advance-medical.com.cn/en.html

The Talk to a doctor, Expert medical opinion, and Overseas treatment recommendation services are made available by Advance Medical, subject to your acceptance of our terms and conditions. You understand and agree that Allianz Jingdong General Insurance Company Ltd. and Advance Medical are not responsible or liable for any claim, loss or damage directly or indirectly resulting from your use of the aforementioned services.

COVER OVERVIEW

Here is a summary of your health cover.

What am I covered for?

You are covered for all benefits indicated in your Table of Benefits. We generally cover pre-existing conditions (including any pre-existing chronic conditions) unless we say otherwise in your policy documents. If in doubt, please see the Special Conditions Form that we may have issued before the policy came into effect to confirm if pre-existing conditions are covered.

Where can I receive treatment?

You can receive treatment in any country within your area of cover, as shown in your Insurance Certificate.

If the treatment you need is available locally but you choose to travel to another country in your area of cover, we will reimburse all eligible medical costs incurred within the terms of your policy; except for your travel expenses.

If the eligible treatment is not available locally, and your cover includes "Medical evacuation", we will also cover travel costs to the nearest suitable medical facility. To claim for medical and travel expenses incurred in these circumstances, you will need to complete and submit the Treatment Guarantee Form before travelling.

You are covered for eligible costs incurred in your home country, provided that your home country is in your area of cover.

What are benefit limits?

Your cover may be subject to a maximum plan benefit. This is the maximum we will pay in total for all benefits included in the plan. Although many benefits included in your Table of Benefits are covered in full, some are capped to a specific amount (e.g. CNY84,000). This specific amount is a benefit limit.

For further information on benefit limits please see the 'Benefit limits' section of this guide.

Is your family growing?

Are you getting married or having a baby? Congratulations!

You can request to add your spouse or partner to the policy by simply completing our Application Form, available at:

https://www.allianz360.com/allianzworldwidecare/index.htm

To add a newborn child to your policy, simply send an email to our underwriting team, including a copy of the birth certificate. You should send your request within four weeks of the date of birth, to ensure that the child is accepted for cover without medical underwriting and for cover to start as early as possible.

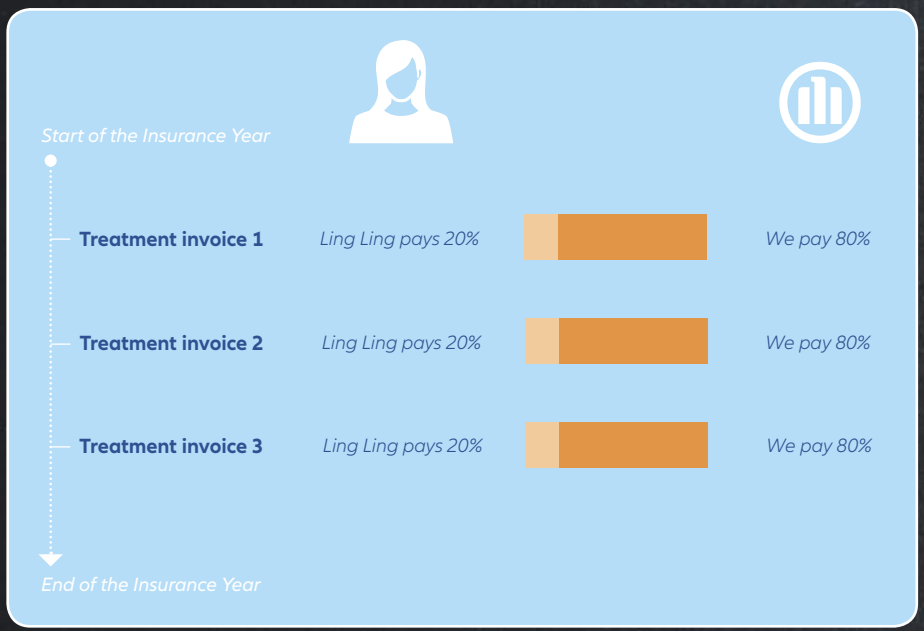
For further information on how to add dependants, including important information on how to add multiple babies, adopted and fostered children, please see the 'Adding dependants' section of this guide.

Following acceptance, we will issue a new Insurance Certificate to reflect the addition of a dependant. This new certificate will replace any earlier version(s) you may have from the start date shown on it.

What are co-payments?

Some plans and benefits may be subject to co-payments. Your Table of Benefits will show whether this applies to your plan.

A **co-payment** is when you pay a percentage of the medical costs. In the following example, Ling Ling requires several dental treatments throughout the year. Her dental treatment benefit has a 20% co-payment, which means that we will refund 80%. The total amount payable by us may be subject to a maximum plan benefit limit.



Insurer contribution
Insured person contribution

SEEKING TREATMENT?

We understand that seeking treatment can be stressful. Follow the steps below so we can look after the details – while you concentrate on getting better.

Check your level of cover

First, check that your plan covers the treatment you are seeking. Your Table of Benefits will confirm what is covered. However, you can always call our Helpline if you have any queries.

Some treatments require pre-authorisation

Your Table of Benefits will show which treatments require pre-authorisation (via a Treatment Guarantee Form). These are mostly in-patient and high cost treatments. The Treatment Guarantee process helps us assess each case, organise everything with the hospital before your arrival and make direct payment of your hospital bill easier, where possible.

Getting in-patient treatment

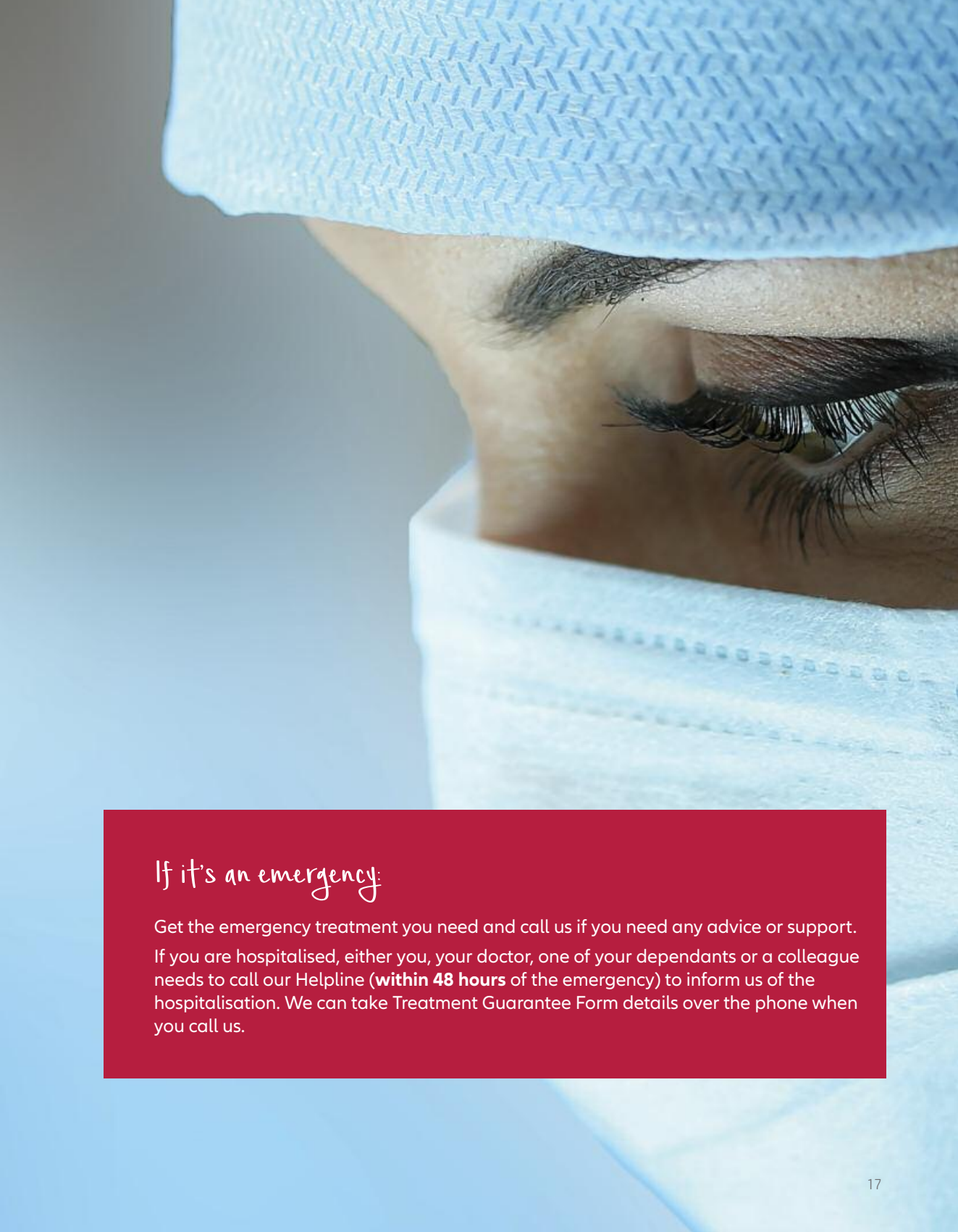
(pre-authorisation applies)

Download a Treatment Guarantee Form from our website:
https://www.allianz360.com/allianzworldwidecare/index.htm

Complete the form and send it to us at least **five working days before** treatment. You can send it by email, fax or post to the address shown on the form.

We contact the hospital to organise payment of your bill directly, where possible.

We can also take Treatment Guarantee Form details over the phone if treatment is taking place within 72 hours. Please note that we may decline your claim if Treatment Guarantee is not obtained. For full details of our Treatment Guarantee process, see the 'Terms and Conditions' section of this guide.



If it's an emergency:

Get the emergency treatment you need and call us if you need any advice or support.

If you are hospitalised, either you, your doctor, one of your dependants or a colleague needs to call our Helpline (**within 48 hours** of the emergency) to inform us of the hospitalisation. We can take Treatment Guarantee Form details over the phone when you call us.

Claiming for your out-patient, dental and other expenses

If your treatment does not require pre-authorisation and you are in China, simply present your Membership Card (and your Insurance Certificate, if special conditions apply to your cover) to your medical provider. Where available, the medical provider will provide treatment on a direct settlement basis, i.e. you will not need to pay your medical provider because he/she will liaise directly with us for payment of eligible expenses. You will be required however to settle any ineligible costs, deductible or co-payment amount that may apply to your policy, at the point of treatment.

In some cases (for example, if you require treatment outside of China) the medical provider may advise you that it is not possible to arrange for the treatment costs to be settled directly with us. In such cases, please settle the bill with the medical provider at the point of treatment and claim back the eligible expenses from us. Simply follow these steps

Receive your medical treatment and pay the medical provider

Get a FaPiao* invoice from your medical provider
This should state your name, invoice amount, invoice date etc.
Get a copy of your medical report
This should include your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.

Claim back your eligible costs via our "Allianz MyHealth" app
Simply enter a few key details, add your invoice(s) and press 'submit'.

As an alternative to "Allianz MyHealth" app, you can also claim your treatment costs by completing and submitting a Claim Form, downloadable at:

https://www.allianz360.com/allianzworldwidecare/index.htm

You will need to complete section 5 and 6 of the Claim Form only if the information requested in those sections is not already provided on your FaPiao/medical invoice. You will need to include a FaPiao* with your claim – the FaPiao must state your name, treatment date(s), the diagnosis/medical condition that you received treatment for, the date of onset of symptoms, the nature of the treatment and the fees charged.

Please send us the Claim Form and all supporting documentation, FaPiao/invoices and receipts by email or post (details on the form)**.

Please refer to "Medical Claims" in the Terms and Conditions section of this guide for more information about our claims process.

**FaPiao: a FaPiao is an official receipt that Chinese businesses have to issue to their customers, upon receipt of payment for a service/product. If you receive medical treatment in China, your doctor will give you a FaPiao upon the payment of an invoice. For claims of CNY 3,000 and over you will need to send us the original by post in order to seek reimbursement for your medical costs incurred in China.*

***Claims by email: if you receive treatment in China, you should request a FaPiao from your doctor. You have the option of emailing the FaPiao with your Claim Form – however, where applicable, you need to send us the original FaPiao separately by post so that we can process your claim. This applies only to treatment received in China: if you receive treatment outside of China, we do not need the original supporting documents and will process your claim on the scanned documents only.*

Quick claim processing

Once we have all the information required, we can process and pay a claim within 48 hours. However, we can only do this if you have told us your diagnosis, so please make sure you include this with your claim. Otherwise, we will need to request the details from you or your doctor.

We will email or write to you to let you know when the claim has been processed.

High Cost Providers (list appears in your Table of Benefits)

Unless you have chosen to have unrestricted access to High Cost Providers at policy inception or at renewal, a 20% co-payment will apply to treatment received at a list of specific providers as detailed in the "Notes" section of your Table of Benefits. When this co-payment applies, you will be required to settle 20% of the medical costs with your provider at the point of treatment.

Treatment at public hospitals

Medical costs for treatment received at public hospitals in China will not be subject to the out-patient deductible (where this applies to your policy).

Evacuations and repatriations

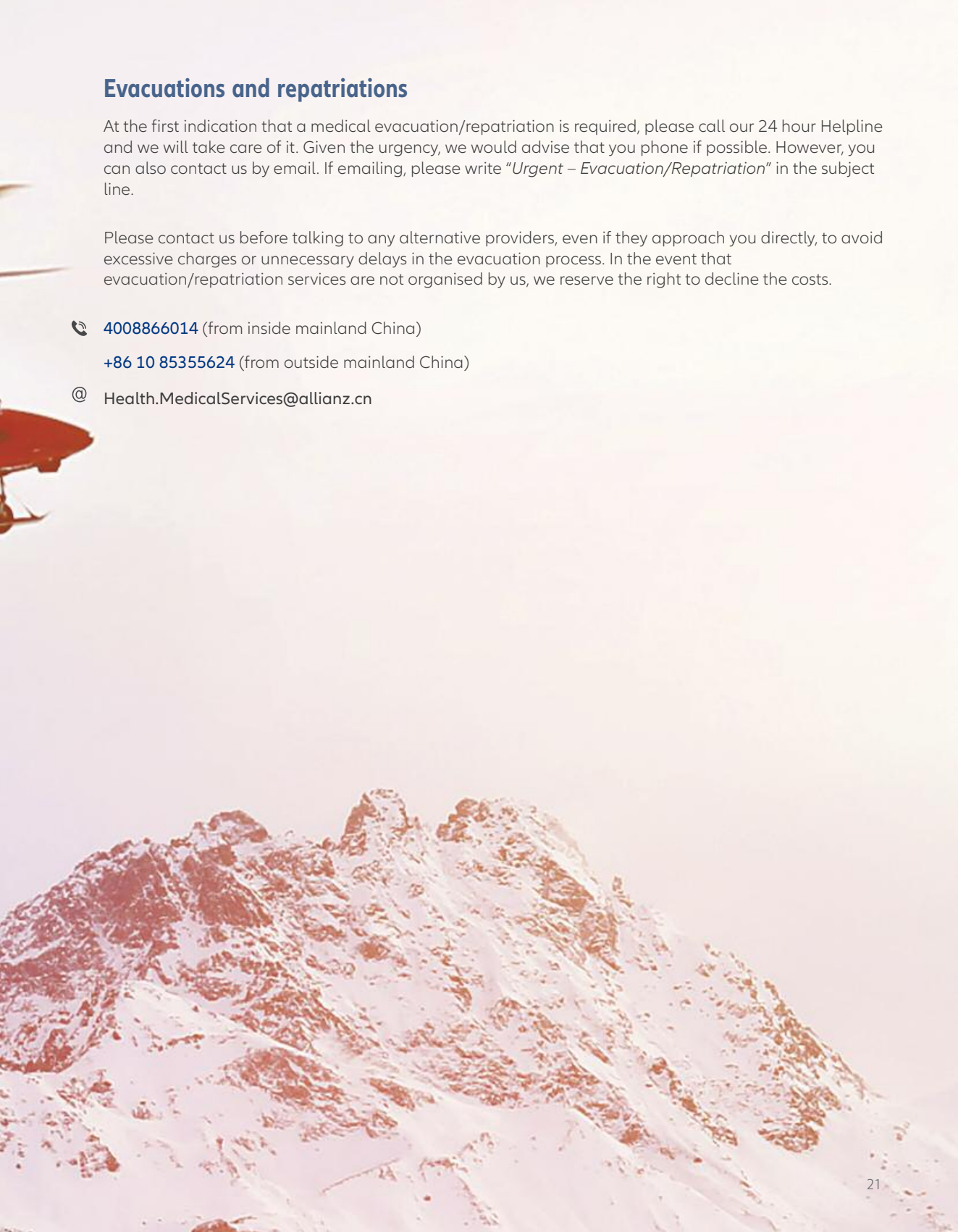
At the first indication that a medical evacuation/repatriation is required, please call our 24 hour Helpline and we will take care of it. Given the urgency, we would advise that you phone if possible. However, you can also contact us by email. If emailing, please write "*Urgent – Evacuation/Repatriation*" in the subject line.

Please contact us before talking to any alternative providers, even if they approach you directly, to avoid excessive charges or unnecessary delays in the evacuation process. In the event that evacuation/repatriation services are not organised by us, we reserve the right to decline the costs.

4008866014 (from inside mainland China)

+86 10 85355624 (from outside mainland China)

@ Health.MedicalServices@allianz.cn



Seeking treatment in the USA

To find a provider

If you have worldwide cover and are looking for a provider in the USA, go to:

www.allianzcare.com/olympus

For more information or an appointment

If you have a query about a medical provider, or if you have selected a provider and wish to arrange an appointment, please call us.

(+1) 800 541 1983
(toll-free from the USA)

For a prescription

You can apply for a discount pharmacy card, which you can use for any prescription that is not covered by your plan. To register and obtain your discount pharmacy card, simply go to the following website and click on “Print Discount Card”:

http://members.omhc.com/awc/prescriptions.html

TERMS AND CONDITIONS OF YOUR COVER

TERMS AND CONDITIONS

This section describes the standard benefits and rules of your health insurance policy. Please read it together with your Insurance Certificate and Table of Benefits.

Your health insurance policy is an annual contract between Allianz Jingdong General Insurance Company Ltd. and the insured person(s) named on the Insurance Certificate. The contract is made up of:

- The **Benefit Guide** (this document) and the **Product Provision Document**, which set out the standard benefits and rules of your health insurance policy. You should read them together with your Insurance Certificate and Table of Benefits.
- The **Insurance Certificate**. This states the plan(s) chosen, the start date and renewal date of the policy (and effective dates of when dependants were added), and the geographical area of cover. If any other terms apply which are specific to your cover, these will be stated in the Insurance Certificate. They will also have been detailed on a Special Conditions Form which we send you before you're placed on cover. We'll send you an updated Insurance Certificate if you request a change which we accept, such as adding a dependant, or if we apply a change that we're entitled to make.
- The **Table of Benefits**. This shows the plan(s) selected, the benefits available to you, and states which benefits/treatments require submission of a Treatment Guarantee Form. It also confirms any benefits where specific benefit limits, waiting periods, deductibles and/or co-payments apply.
- Information you (or someone on your behalf) gave us in the signed Application Form, Confirmation of Health Status Form or others (we'll refer to all of these collectively as the "relevant application form") or other supporting medical information.

We will be updating our solvency results and risk rating levels on our website on a quarterly basis:

https://www.jdallianz.com/zh/public-info/public-info.html#power

YOUR COVER EXPLAINED

The plans that you selected are indicated in your Table of Benefits, which lists all the benefits you are covered for and any limits that apply. For an explanation of how your benefit limits apply to your plan, please see the section "Benefit limits".

Your benefits are also subject to:

- Policy definitions and exclusions (also available in this guide).
- Any special conditions shown on your Insurance Certificate (and on the Special Condition Form issued before the policy comes into effect, where relevant).

What we cover

- The extent of your cover is determined by your Table of Benefits, the Insurance Certificate, any policy endorsements, these policy terms and conditions, as well as any other legal requirements. We will reimburse, in accordance with your Table of Benefits and individual terms and conditions, medical costs arising from the occurrence or worsening of a medical condition. Your policy is a fee recovery policy. The amount of claims payable by us will not exceed the total amount of medical expenses incurred by you.
- Allianz Jingdong General Insurance Company Ltd. will only be liable for medical costs that are eligible according to the terms and conditions of this policy. You are liable to pay your medical provider for treatments that are not eligible under your policy, as you are not entitled to payment of such non-eligible costs by us. In the event that we receive a claim from a medical provider in relation to costs incurred by you (or your insured dependants) that you have not paid for and that are not covered for under your policy with us, we may settle the claim with the medical provider and then seek a refund from the policyholder (i.e. the principal member). We will contact the principal member with respect to these non-eligible claims and request that the principal member arranges full payment of the amount due within 21 days. Failure to refund this amount within a maximum of 28 days may result in the suspension of cover for all members covered under the policy. During the suspension period, no claims will be paid. Furthermore, if the outstanding amount is not settled by the expiration date of the suspension period (14 days), the contract may be terminated in writing with immediate effect and we shall thereby be exempt from paying any benefits to you. In these circumstances we will refund the premium amount(s) paid in respect of the period after the termination date minus the cost of any ineligible medical claims already paid and minus any amounts owing to us under the terms described in this paragraph. If the cost of claims paid for the relevant Insurance Year exceeds the amount of premium received and retained by us for that period, we will seek reimbursement of this amount from you.

When cover starts

When you receive your Insurance Certificate, this is our confirmation that you've been accepted onto the policy. It will confirm the start date of your cover. Please note that no benefit will be payable under your policy until the initial premium has been paid, with subsequent premiums being paid when due.

Cover for dependants (if applicable) will start on the effective date shown on the most recent Insurance Certificate which lists them as your dependants. Their membership may continue for as long as you are the policyholder and, for children, as long as they remain under the defined age limit. Child dependants can be covered under your policy up until the day before their 18th birthday or up until the day before their 24th birthday if they are in full-time education. At that time, they may apply for their own cover.

Benefit limits

The Table of Benefits shows two kinds of benefit limits:

- The **maximum plan benefit** (which applies to certain plans) is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan.
- Some benefits also have a **specific benefit limit**, which may be provided on a "per Insurance Year" basis or on a "per event" basis (such as per trip, per visit or per pregnancy). In some instances, in addition to the benefit limit, we will only pay a percentage of the costs for the specific benefit e.g. "65% refund, up to CNY45,000".

The amount we refund is subject to the maximum plan benefit (if one applies to your plan), even where:

- A specific benefit limit applies or
- The term "Full refund" appears next to the benefit

All limits are per member and per Insurance Year, unless your Table of Benefits states otherwise. **"Routine maternity" and "Complications of pregnancy and childbirth"** are paid on either a "per pregnancy" or "per Insurance Year" basis. Your Table of Benefits will confirm this.

If your maternity benefits are payable on a "per pregnancy" basis

When a pregnancy spans two Insurance Years and the benefit limit changes at policy renewal, the following rules apply:

- In year one – the benefit limits apply to all eligible expenses.
- In year two – the updated benefit limits apply to all eligible expenses incurred in the second year, less the total benefit amount already reimbursed in year one.
- If the benefit limit decreases in year two and we have already paid up to or over this new amount for eligible costs incurred in year one, we will pay no additional benefit in year two.

For multiple-birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to CNY252,000 per child for the first three months following birth. Out-patient treatment is paid under the terms of the Out-patient Plan.

CLAIMS AND TREATMENT GUARANTEE PROCESS

Medical claims

Before submitting a claim to us, please pay attention to the following points:

- **Claiming more than CNY10,000:** If your claim is more than CNY10,000, a copy of the patient's ID document needs to be attached to your fully completed Claim Form. We do not require the original FaPiao for claims less than CNY3,000.
- **Claiming deadline:** You must submit all claims with original FaPiao and supporting documentation, invoices and receipts (via our "MyHealth" app or Claim Form) no later than within the statutory limitation period after the end of the Insurance Year. If cover is cancelled during the Insurance Year, you should submit your claim within the statutory limitation period after the date that your cover ended. After this time we are not obliged to settle the claim. However, for your convenience, we

recommend that you submit all outstanding claims within six months of termination of your insurance policy.

- **Claim Submission:** You must submit a separate claim for each person claiming and for each medical condition being claimed for.
- **Supporting documents:** When you send us copies of supporting documents (e.g. medical receipts), please make sure you keep the originals. We have the right to request original supporting documents/receipts for auditing purposes up to 12 months after settling your claim. We may also request proof of payment by you (e.g. a bank or credit card statement) for medical bills you have paid. We advise that you keep copies of all correspondence with us as we cannot be held responsible for correspondence that fails to reach us for any reason outside of our control.
- **Deductibles:** If the amount you are claiming is less than the deductible figure in your plan, you can either:
  - Collect all out-patient receipts until you reach an amount that exceeds this deductible figure.
  - Send us each claim every time you receive treatment. Once you reach the deductible amount, we'll start reimbursing you.

  Attach original FaPiao and all supporting receipts and/or invoices with your claim.
- **Currency:** Your claim will be reimbursed in CNY to a CNY bank account in China. However, if you are a non-Chinese national who received treatment outside of China and your bank account is not in China, we may reimburse your claim in CNY or in a foreign currency of your choice: please specify on the Claim Form the preferred bank account details and currency for payment. Unfortunately, on rare occasions, we may not be able to make a payment in that currency due to international banking regulations. If this happens, we will identify a suitable alternative currency. If we have to make a conversion from one currency to another, we will use the exchange rate that applied on the date the invoices were issued, or on the date that we pay your claim.

  Please note that we reserve the right to choose which currency exchange rate to apply.
- **Reimbursement:** we will only reimburse (within the limit of your policy) eligible costs after considering any Treatment Guarantee requirements, deductibles or co-payments outlined in the Table of Benefits.
- **Reasonable and customary cost:** We will only reimburse charges that are reasonable and customary and in accordance with standard and generally accepted medical procedures. If we consider a claim to be inappropriate, we reserve the right to decline your claim or reduce the amount we pay.
- **Deposits:** If you have to pay a deposit in advance of any medical treatment, we will reimburse this cost only after treatment has taken place.
- **Providing information:** You and your dependants agree to help us get all the information we need to process a claim. We have the right to access all medical records and to have direct discussions with the medical provider or the treating doctor. We may, at our own expense, request a medical examination by our doctors if we think it's necessary. All information will be treated confidentially. We reserve the right to withhold benefits if you or your dependants do not support us in getting the information we need.

Treatment needed as a result of someone else's fault

If you are claiming for treatment that you need when somebody else is at fault, you must write and tell us as soon as possible. For example, if you need treatment following a road accident in which you are a victim. Please take any reasonable steps we ask of you to obtain the insurance details of the person at fault. We can then recover from the other insurer the cost of the treatment paid for by us. If you are able to recover directly the cost of any treatment which we have paid for, you will need to repay that amount (and any interest) to us.

Treatment Guarantee

Some of the benefits available to you need pre-authorisation. These are usually marked with a 1 or a 2 in your Table of Benefits. To get pre-authorisation, please send us a Treatment Guarantee Form.

Here are the treatments/benefits which normally need pre-authorisation. This may vary depending on your cover, so please check your Table of Benefits to confirm:

- All in-patient benefits[1] listed (where you need to stay overnight in a hospital).
- Day-care treatment[2].
- Expenses for one person accompanying an evacuated/repatriated person[2].
- Kidney dialysis[2].
- Long term care[2].
- Medical evacuation[2] (or repatriation[2], where covered).
- MRI (Magnetic Resonance Imaging) scan. Treatment Guarantee is only needed for MRI scans if you wish us to settle your bill directly with the hospital.
- Nursing at home or in a convalescent home[2].
- Occupational therapy[2] (only out-patient treatment requires pre-authorisation).
- Oncology[2] (only in-patient or day-care treatment requires pre-authorisation).
- Out-patient surgery[2].
- Palliative care[2].
- PET[2] (Positron Emission Tomography) and CT-PET[2] scans.
- Rehabilitation treatment[2].
- Repatriation of mortal remains[2].
- Routine maternity[2], complications of pregnancy and childbirth[2] (only in-patient treatment requires pre-authorisation).
- Travel costs of insured family members in the event of an evacuation[2] (or repatriation, where covered).
- Travel costs of insured family members in the event of the repatriation of mortal remains[2]

Using the Treatment Guarantee Form helps us to settle your bill directly with hospitals, clinics and other medical facilities.

If you make a claim without obtaining Treatment Guarantee, the following will apply:

- If the treatment received is subsequently proven to be medically unnecessary, **we reserve the right to decline your claim**.
- For the benefits listed with a **1 in your Table of Benefits, we reserve the right to decline your claim**. If the treatment is subsequently proven to be medically necessary, we will pay 80% of the benefit.
- For the benefits listed with a **2 in your Table of Benefits we reserve the right to decline your claim.** If the treatment is subsequently proven to be medically necessary, we will pay 50% of the benefit.

PAYING PREMIUMS

Premiums for each Insurance Year are based on each member's age on the first day of the Insurance Year, their region of cover, the policyholder's country of residence, the premium rates in effect and other risk factors which may materially affect the insurance.

By accepting cover you have agreed to pay the premium amount shown on your quotation, by the payment method stated. You need to pay us in advance for the duration of your cover. The **initial premium** or first premium instalment is payable immediately after we accept your application. **Subsequent premiums** are due on the first day of the chosen payment period. You may choose between quarterly, half-yearly or annual payments depending on the payment method you choose. When you receive your invoice, please check that the premium matches the amount shown on your agreed quotation and contact us immediately if there is any difference. We are not responsible for payments made through third parties.

You should pay your premium in CNY. If you are unable to pay your premium for any reason, please contact us on:

4008866014 (from inside mainland China)

+86 10 85355624 (from outside mainland China)

Changes in payment terms can be made at policy renewal, via written instructions, which we must receive a minimum of 30 days before the renewal date. Please note that we may change the total amount you have to pay us if any new premium tax, levy or charge is introduced or changed.

If the initial premium is not paid in time, we are entitled to withdraw from the contract for as long as the payment remains outstanding. Payment of initial premium is required in order to activate your cover and we will not be liable for any claims until the initial premium due is received in full and on time. Failure to pay subsequent premium on time may result in the suspension of cover or in the loss of insurance cover. During a suspension period, no claims will be paid. Furthermore, if the outstanding amount is not settled by the expiration date of the suspension period, the contract may be deemed to be null and void or may be terminated and we will have no liability to pay benefits to you. We will issue reminder letters with respect to outstanding premium for the duration of your policy.

If we don't receive the initial premium, the insurance contract is deemed to be null and void unless we assert legal action to the premium within three months of the commencement date, the policy start date or the conclusion of the insurance contract. If a subsequent premium is not paid in time, we may, in writing and at your expense, set a time limit of not less than two weeks for you to pay the amount due. From then, we may terminate the contract in writing with immediate effect and will be exempt from paying any benefits.

The effects of termination will end if you make a payment within one month after the termination or, if the termination was combined with the setting of a time limit, within one month after the expiration of the time for payment, provided that no claims have been incurred in the intervening period.

ADMINISTRATION OF YOUR POLICY

Adding dependants

You may apply to include any member of your family as a dependant by completing the relevant application form.

How do I add a newborn to my policy?
Please send an email to **Health.Underwriting@allianz.cn** within four weeks from birth and attach the birth certificate. We will accept the baby without medical underwriting if the birth parent has been insured with us for a minimum of ten continuous months. Cover will start at birth if we receive the notification within the birth month. Otherwise cover will start from the first day of the month in which we receive the notification.

What happens if I don't notify you within four weeks?
The newborn child will be underwritten and if accepted, cover will start from the date of acceptance.

What if I am adding multiple birth babies, adopted and fostered children?
Multiple birth babies, adopted and fostered children will be underwritten and if accepted, cover will start from the date of acceptance. Plus, in-patient treatment of multiple-birth babies born as a result of medically assisted reproduction is limited to CNY252,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

Changes to policyholder

If a request is made at renewal to change the policyholder, the proposed replacement policyholder will need to complete an application form and full medical underwriting will apply. Please refer to the section on "Death of the policyholder or a dependant" if the requested change is due to the death of the policyholder.

Death of the policyholder or a dependant

We hope you will never need to refer to this section; however, if a policyholder or a dependant dies, please inform us in writing within 28 days.

If the policyholder dies, the policy will be terminated and a pro rata repayment of the current year's premium will be made if no claims have been filed. We may request a death certificate and other supporting documentation before a refund is issued. Alternatively, if they wish to, the next named dependant on the Insurance Certificate can apply to become the policyholder and keep the other dependants on their policy. If they apply to do this within 28 days, we will, at our discretion, not add any further special restrictions or exclusions that didn't already apply at the time of the policyholder's death.

If a dependant dies, they will be taken off the policy and a pro rata repayment of the current year's premium for that person will be made, if no claims have been filed. We may request a death certificate and other supporting documentation before a refund is issued.

Changing your level of cover

If you want to change your level of cover, please get in touch with us before your policy renewal date to discuss your options. Changes to cover can only be made at policy renewal. If you want to increase your level of cover, we may ask you to complete a medical history questionnaire and/or to agree to certain exclusions or restrictions to any additional cover before we accept your application. If an increase in cover is accepted, an additional premium amount will be payable and waiting periods may apply.

Changing country or province of residence

It is important that you let us know when you change province or country of residence. This may affect your cover or premium, even if you are moving to a province or country within your geographical area of cover. Depending on the circumstances, Allianz Jingdong General Insurance Company Ltd. may no longer be able to provide you with cover. In addition, if you move to a country outside of your geographical area of cover, your existing cover will not be valid there. Please note that cover in some countries is subject to local health insurance restrictions, particularly for residents of that country. It is your responsibility to ensure that your healthcare cover is legally appropriate. If you are not sure, please get independent legal advice, as we may no longer be able to cover you. The cover we provide is not a substitute for local compulsory health insurance.

Changing your postal address or email address

We will send all correspondence to the address we have on record for you unless requested otherwise. You need to inform us in writing as soon as possible of any change in your home, business or email address.

Correspondence

When you write to us, please use email or post (with the postage paid). We do not usually return original documents to you, but if you ask us to, we will.

Renewal of cover

One month before the renewal date, you will receive a renewal notice indicating the premium for the next Insurance year along with details of any policy changes. You need to reapply to us for continuing the cover and pay the insurance premium, to obtain a new insurance contract.

Changes that we may apply at renewal

We have the right to apply revised policy terms and conditions, effective from the renewal date. The policy terms and conditions and the Table of Benefits that exist at renewal will apply for the duration of the Insurance Year. We may change the premium, benefits and rules of your membership on your renewal date, including how we calculate/determine premiums and/or the method or frequency of payment. These changes will only apply from your renewal date, regardless of when the change is made and we will not add any restrictions or exclusions which are personal to a member's cover in relation to medical conditions that started after their policy's inception, provided that they gave us the information we asked them for before incepting and they have not applied for an increase in their level of cover.

We will write to tell you about any changes. If you do not accept any of the changes we make, you can end your membership and we will treat the changes as not having been made if you end your membership within 30 days of the date on which the changes take effect, or within 30 days of us telling you about the changes, whichever is later.

Reasons your membership would end

Please remember that your membership (and that of all the other people listed on the Insurance Certificate) will end:

- If you do not pay any of your premiums on, or before, the date they are due.
- Upon the death of the policyholder. Please see the section on "Death of the policyholder or a dependant" for further details.
- If you fail to refund ineligible medical costs that have been reimbursed by us to your medical provider on your behalf.
- As outlined in the terms and conditions of this contract.

If your membership ends for reasons other than for fraud/non-disclosure, we will refund any premiums you have paid which relate to a period after your membership has ended, subject to the deduction of any money which you owe us.

Please note that if your membership ceases, your dependant's cover will also end.

Policy expiry

Please note that upon the expiry of your policy, your right to reimbursement ends. Within the statutory limitation period after the treatment, we will reimburse any eligible expenses incurred during the period of cover. For convenience, we recommend that you aim to submit all outstanding claims within six months of your policy's termination. However, we will no longer cover any on-going or further treatment that is required after the expiry date of your policy.

Policy cancellation

You have the right to cancel this policy at any time by giving us 14 days written notice before the intended cancellation date. We will refund premiums on a pro-rata basis in the currency in which the premiums were paid provided that no claims have been made. If you have made any claim during the insurance year, there will be no premium refund.

The amount of pro-rata refund is calculated as follows. The number of days on cover including the last day of cover. You must return the membership cards and certificate of insurance when you cancel a plan.

Pro-rata refund = the total premium paid x (1 – m/n)
m: the number of effective days on cover
n: the number of days in the insurance period

Upon cancellation of this policy, you must provide the following documents and materials to apply for the premium refund:

- Notice of cancellation of the insurance policy
- Your identification
- Invoices or supporting documents related to insurance premium (see explanation for details)

Definition of invoices or supporting documents related to insurance premium:

If you have obtained the VAT Fapiao (including VAT special invoice, VAT ordinary invoice and VAT electronic ordinary invoice) when cancelling the insurance policy, you must return the invoice or provide the following supporting documents according to the type of invoice:

- VAT special invoice with deduction certification: provide the information form of issuing VAT special invoice with red lettering in full amount;
- VAT special invoice without deduction certification: return the deduction form and the original copy of the invoice;
- VAT invoice: return the original copy of the invoice;
- VAT electronic ordinary invoice: no return required.

Upon receipt of the returned invoices or supporting documents, we will comply with the relevant provisions of the tax law. We will have the right to adjust the mentioned invoice requirements accordingly in the event of any change in the tax regulations. The above clauses also apply when we terminate the insurance contract.

THE FOLLOWING TERMS ALSO APPLY TO YOUR COVER

The following are important additional terms that apply to your policy with us:

1. **Applicable law:** The insurance cover and your membership are governed by Chinese law. Any dispute that cannot otherwise be resolved will be dealt with by courts in China or by a mutually agreed arbitration commission.
2. **Economic sanctions:** No (re)insurer will be deemed to provide cover or be liable to pay any claim or provide any benefit if the provision of such cover, payment of such claim or provision of such benefit can expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, P.R. of China, United States of America and/or any other applicable national economic or trade sanction law or regulations.
3. **The amounts we will pay:** Our liability to you is limited to the amounts indicated in the Table of Benefits and any policy endorsements. The amount reimbursed, whether under this policy, public medical scheme or any other insurance will not exceed the figure stated on the invoice.
4. **Who can make changes to your policy:** No one, except an appointed representative is allowed to make changes to your policy on your behalf. Changes are only valid when confirmed in writing by us.
5. **When cover is provided by someone else:** You must tell us if you or any of your dependants are eligible to claim benefits from:

   - A public scheme (such as social medical insurance or state-funded medical care)

   - Any other insurance policy

   - Any other third party

   If that is the case, you need to give us all necessary information. We will not pay for those expenses which you have already been reimbursed for by someone else. We'll pay the amount not covered/reimbursed by them.

   We will not make a contribution to any third-party insurer if the costs are fully or partly covered by that insurer.
6. **Circumstances outside of our control (force majeure):** We will always do our best for you, but we are not liable for delays or failures in our obligations to you caused by things which are outside of our reasonable control. Examples are extremely severe weather, floods, landslides, earthquakes, storms, lightning, fire, subsidence, epidemics, acts of terrorism, outbreaks of military hostilities (whether or not war is declared), riots, explosions, strikes or other labour unrest, civil disturbances, sabotage and expropriation by governmental authorities.

7. **Fraud:** You must disclose upon our request any material facts including, but not limited to, the information declared on the relevant application form, which may affect our assessment of the risk.

a) The information you and your dependants give us e.g. on the Application Form or supporting documents, needs to be accurate and complete. If it isn't correct or if you don't tell us about things that may affect our underwriting decision, it may invalidate your policy from the start date. You also need to tell us about any medical conditions that arise between completing the application form and the start date of the policy. Medical conditions that you don't tell us about will most likely not be covered.

b) The contract and/or your cover may be rendered null and void from the commencement date within 30 days after learning that you intentionally failed to make any required disclosure.

c) We may terminate/cancel the contract and/or your cover if you failed to make any disclosure or made an incorrect disclosure due to material negligence.

If you are not sure whether something is material, you are obliged to inform us.

If the contract and/or your cover is rendered null and void because of intentional incorrect disclosure, we will not refund the premium and will not pay any claims relating to the contract and/or your cover. Any claim payments made before the termination/cancellation of the contract and/or your cover will become immediately due and owing to us.

If the contract and/or your cover is terminated/cancelled because of incorrect disclosure due to material negligence, and if the non-disclosed facts and/or incorrectly-disclosed facts have a material impact on the claims, we will refund the premium paid to date minus the cost of any claims paid by us relating to the contract and/or your cover. If the cost of claims payments made by us before the termination/cancellation of the contract and/or your cover exceeds the balance of the premium amount, we will be entitled to the reimbursement of this amount.

If you or your dependants or anyone acting on your or their behalf claims for treatment that never took place, we will not pay any benefits for that claim and we will be entitled to terminate your and/or your dependants' cover with effect from the date of our discovery of the fraudulent event. If any false, fraudulent, forged proof/means/devices are used to exaggerate the loss for more than entitled, we will not pay for the exaggerated/false portion. If it transpires that any claim paid by us is not eligible to be reimbursed, any amount paid will become immediately due and owing to us.

8. **Cancellation:** We will cancel the policy where you have not paid the full premium due and owing. We will notify you of this cancellation and the contract will be deemed cancelled from the date that the premium payment became due and payable. However, if the premium is paid within 30 days after the due date, the insurance cover will be reinstated and we will cover any claims which occurred during the period of delay. If the outstanding premium is paid after the 30-day limit, you must complete a Confirmation of Health Status Form before your policy can be reinstated, subject to underwriting.

9. **Making contact with dependants:** In order to administer your policy, we may need to request further information. If we need to ask about one of your dependants (e.g. when we need to collect an email address for an adult dependant), we may contact you as the person acting on behalf of the dependant, and ask you for the relevant information, provided it is not sensitive information. Similarly, for the purposes of administering claims, we may send you non-sensitive information that relates to a family member.

DATA PROTECTION

Our Data Protection Notice explains how we protect your privacy and process your personal data. You must read it before sending us any personal data. To read our Data Protection Notice visit:

allianz.cn/en/legal_notes/Private_Policy.jsp

Alternatively, you can contact us by phone to request a paper copy of our full Data Protection Notice:

400-800-2020 (inside China)
+86-20-8513 2999 (outside China)

If you have any queries about how we use your personal data, you can always contact us by email.

Health.ClientServices@allianz.cn

COMPLAINTS AND DISPUTE RESOLUTION PROCEDURE

Making a complaint

Our Helpline is always the first number to call if you have any comments or complaints. If we can't resolve the problem on the phone, please email or write to us at:

4008866014 (from inside mainland China)

+86 10 85355624 (from outside mainland China)

Health.ClientServices@allianz.cn

For Shanghai: Allianz Jingdong General Insurance Company Ltd., Shanghai Branch, Unit 1408, 14F Shanghai Tower, No.501 Middle Yincheng Road, Pudong New Area, Shanghai 200120, People's Republic of China.

For Beijng: Allianz Jingdong General Insurance Company Ltd., Beijing Branch, 16F & 17F, Tower 3, Han's Plaza, No.2 South Ronghua Road, BDA, Beijing 100176, People's Republic of China.

Dispute resolution

a) Any differences in respect of medical opinion in connection with the results of an accident or medical condition must be notified to us within nine weeks of the decision. Such differences will be settled between two medical experts appointed by you and us in writing.

b) Any dispute that cannot otherwise be resolved will be dealt with by courts in China or by a mutually agreed arbitration commission.

Legal action

You will not institute any legal proceedings to recover any amount under the policy after the expiry of legal terms from the date of treatment.

If you have any query on this regard, please contact our Helpline.

DEFINITIONS

The following definitions apply to the benefits in our Healthcare Plans and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. If any specific benefits apply to your plan(s), the definition will appear in the "Notes" section at the end of your Table of Benefits. Wherever these words/phrases appear in your policy documents, they will always have the following meanings:

A

Accident is a sudden, unexpected event that causes injury and is due to a cause external to the insured person. The cause and symptoms of the injury must be medically and objectively definable, allow for a diagnosis and require therapy.

Accommodation costs for one parent staying in hospital with an insured child refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, we will contribute the equivalent of the daily room rate in a three-star hotel towards any hotel costs incurred. We do not cover sundry expenses such as meals, phone calls or newspapers. Please check your Table of Benefits to confirm whether an age limit applies with regard to your child.

Acute refers to the sudden onset of symptoms or a medical condition.

Area of cover refers to the area in which your cover is valid. You may select one of the offered areas of cover available according to your country of residence and their travel requirements. The selected area of cover is stated in the Insurance Certificate. All insured persons within one policy are required to have the same area of cover: only insured persons in full-time education in a country outside the area of cover can have a different area of cover. Any changes in area of cover to include the USA within the geographical area of cover are subject to acceptance by us. We require supporting evidence of US residence or US citizenship.

C

Chronic condition is defined as a sickness, illness, disease or injury that lasts longer than six months or requires medical attention (such as check-up or treatment) at least once a year. It also has one or more of the following characteristics:

- Is recurrent in nature
- Is without a known, generally recognised cure
- Is not generally deemed to respond well to treatment
- Requires palliative treatment
- Leads to permanent disability

Please refer to the "Notes" section of your Table of Benefits to confirm whether chronic conditions are covered.

Complementary treatment refers to therapeutic and diagnostic treatment that exists outside of traditional Western medicine. Please refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practised by approved therapists.

Complications of childbirth refers only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage. and retained placental membrane. Where your plan also includes the benefit "Routine maternity", "Complications of childbirth" includes medically necessary caesarean sections.

Please note, this benefit is only available on the condition that the pregnancy starts after the waiting period is fully served.

Complications of pregnancy relates to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

Please note, this benefit is only available on the condition that the pregnancy starts after the waiting period is fully served.

Congenital Condition refers to any abnormality, deformity, disease, disorder, illness, malformation, defect, anomaly or injury that is hereditary or acquired before/during birth. A congenital condition can be diagnosed at birth or later in life.

Co-payment is the percentage of the costs which you must pay. These apply per person, per Insurance Year, unless the Table of Benefits states otherwise. Some plans may include a maximum co-payment per insured person, per Insurance Year and, if so, the amount will be capped at the figure stated in your Table of Benefits. Co-payments may apply individually to the Core, Out-patient, Dental, Health and Wellbeing or Repatriation Plans, or to a combination of these plans. In addition, a co-payment may apply to treatment carried out at a particular medical provider: if this applies, it will be indicated in the "Notes" section of your Table of Benefits. For more information on co-payments, please refer to "What are co-payments" section of this guide.

D

Day-care treatment is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductible is the part of the cost that is payable by you and that we deduct from the amount we will pay.

Where Core Plan Deductibles apply, they are payable per person per Insurance Year.

Where Out-patient Plan Deductibles apply, they are payable per person per out-patient consultation, unless your Table of Benefits states otherwise. Deductibles may apply to the Core,

Out-patient, Health and Wellbeing Plans individually, or to a combination of these plans.

Dental prescription drugs refers to those prescribed by a dentist for the treatment of dental inflammation or infection. The prescription drugs must be proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. They do not include mouthwashes, fluoride products, antiseptic gels and toothpastes.

Dental prostheses includes crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Dental surgery includes the surgical extraction of teeth, as well as other tooth-related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures that establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover surgical treatment that relates to dental implants.

Dental treatment includes an annual check-up, simple fillings related to cavities or decay, root canal treatment and dental prescription drugs.

Dependant is your spouse or partner and unmarried children (including any step, fostered or adopted children) who are financially dependent on you and are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18th birthday; or up to the day before their 24th birthday if they are in full-time education.

Diagnostic tests refers to investigations such as x-rays or blood tests, undertaken to determine the cause of the presented symptoms.

Dietician fees relate to charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practise in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

Direct family history exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

Doctor is a person who is licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

E

Emergency is the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Emergency in-patient dental treatment refers to acute emergency dental treatment that is due to a serious accident and requires admission to hospital. The treatment must take place within 24 hours of the emergency event. Cover does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

Emergency out-patient dental treatment is treatment received in a dental surgery or hospital emergency room for the immediate relief of dental pain caused by an accident or an injury to a sound natural tooth. Treatment may include pulpotomy or pulpectomy and the subsequent temporary fillings, limited to three fillings per Insurance Year. Treatment must take place within 24 hours of the emergency event. It does not include any form of dental prostheses, permanent restorations or the continuation of root canal treatment. However, if your policy also includes a Dental Plan, it will cover dental treatment in excess of the limit on emergency out-patient dental treatment benefit. In that case, the Dental plan terms will apply.

Emergency out-patient treatment is treatment received in a casualty ward or emergency room within 24 hours of an accident or sudden illness, where there is no medical necessity for you to occupy a hospital bed. If your policy includes an Out-patient Plan, it will cover you for out-patient treatment in excess of the limit on emergency out-patient treatment benefit. In that case, the Out-patient plan terms will apply.

Emergency treatment outside area of cover is treatment for medical emergencies which occur during business or holiday trips outside your area of cover. Cover is provided for up to six weeks per trip within the maximum benefit amount. It includes treatment required due to an accident or the sudden beginning or worsening of a severe illness which presents an immediate threat to your health. Treatment by a doctor must start within 24 hours of the emergency event. Cover is not provided for curative or follow-up non-emergency treatment, even if you are deemed unable to travel to a country within your geographical area of cover. Nor does it extend to charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth. You must tell us if you are going to be outside your area of cover for more than six weeks.

Expenses for one person accompanying an evacuated/repatriated person refer to the travel costs for one person accompanying the evacuated/repatriated person. If they can't travel in the same vehicle, we will pay for an alternative form of transport at economy rates. Following completion of treatment, we will also cover the cost of the companion's return trip, at economy rates, to the country where the evacuation/repatriation started from. Cover is not provided for hotel accommodation or other related expenses.

F

Family history exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

H

Health and wellbeing checks including screening for the early detection of illness or disease are health checks, tests and examinations, performed at appropriate age intervals, that are undertaken without any clinical symptoms being present. Checks are limited to:

- Physical examination
- Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test)
- Cardiovascular examination (physical examination, electrocardiogram, blood pressure)
- Neurological examination (physical examination)
- Cancer screening:
  - Annual pap smear
  - Mammogram (every two years for women aged 45+, or younger where a family history exists)
  - Prostate screening (yearly for men aged 50+, or from an earlier age where a family history exists)
  - Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists)
  - Annual faecal occult blood test
- Bone densitometry (every five years for women aged 50+)
- Well child test (for children up to the age of six years, four visits per insurance year for children under 2 years of age, two visits per insurance year for children aged 2 to 6 years)
- BRCA1 and BRCA2 genetic test (where a direct family history exists and where included in your Table of Benefits)

Home country is a country for which you hold a current passport or which is your principal country of residence.

Hospital is any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a doctor. The following are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospital accommodation refers to standard private or semi-private accommodation as shown in the Table of Benefits - deluxe, executive rooms and suites are not covered. The hospital accommodation benefit only applies when the hospitalisation is not related to any other in-patient benefit shown on the Table of Benefits. For example, if a member is hospitalised for cancer treatment, the hospital accommodation will be covered under the oncology benefit, and not under the hospital accommodation benefit. Examples of benefits that already include hospital accommodation (if included in your plan) are: Psychiatry and psychotherapy, Organ transplant, Oncology, Routine maternity, Palliative care and Long-term care.

I

In-patient cash benefit is payable when you receive in-patient treatment free of charge for a medical condition that is covered by us. Cover is limited to the amount and maximum number of nights specified in the Table of Benefits and is payable after you are discharged from hospital.

In-patient treatment refers to treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate is a document we issue that outlines the details of your cover. It confirms that an insurance relationship exists between you and us.

Insurance Year applies from the effective date of your policy, as shown on the Insurance Certificate and ends exactly one year later.

Insured person is you and your dependants as stated on your Insurance Certificate.

L

Local ambulance is ambulance transport that is required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

Long-term care refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.

M

Medical evacuation applies in the following scenarios:

- If the necessary treatment you are covered for is not available locally
- If adequately screened blood is unavailable in an emergency

We will evacuate you to the nearest appropriate medical centre (which may or may not be in your home country) by

ambulance, helicopter or aeroplane. The medical evacuation should be requested by your doctor, and will be carried out in the most economical way that is appropriate to your medical condition. Following completion of treatment, we will also cover the cost of your return trip at economy rates to your principal country of residence.

If you can't travel or be evacuated for medical reasons following discharge from an **in-patient episode of care**, we will cover the reasonable cost of hotel accommodation in a private en-suite room for up to seven days. We do not cover costs for hotel suites, four or five-star hotel accommodation or hotel accommodation for an accompanying person.

If you are evacuated to the nearest appropriate medical centre for **ongoing treatment**, we will cover the reasonable cost of hotel accommodation in a private en-suite room. This cost must be more economical than the cost of a series of journeys between the nearest appropriate medical centre and your principal country of residence. Hotel accommodation for an accompanying person is not covered.

Where adequately screened blood is not available locally, we will, where appropriate, try to locate and transport screened blood and sterile transfusion equipment, if this is advised by the treating doctor and our own medical experts. We and our agents accept no liability if we are unsuccessful or if contaminated blood or equipment is used by the treating authority.

You must contact us at the first indication that you need an evacuation. From this point onwards, we will organise and coordinate the evacuation until you arrive safely at your destination of care. If evacuation services are not organised by us, we reserve the right to decline all costs incurred.

Medical necessity refers to medical treatment, services or supplies that fulfil all of the following:

a) Essential to identify or treat your condition, illness or injury
b) Consistent with your symptoms, diagnosis or treatment of the underlying condition
c) In accordance with generally accepted medical practice and professional standards of care in the medical community at the time (this does not apply to complementary treatment methods if they form part of your cover)
d) Required for reasons other than the comfort or convenience of you or your doctor
e) Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover)
f) Considered to be the most appropriate type and level of service or supply
g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition
h) Provided only for an appropriate duration of time

In this definition, the term "appropriate" means taking patient safety and cost effectiveness into consideration. In respect to in-patient treatment, "medically necessary" also means that diagnosis can't be made or treatment can't be safely and effectively provided on an out-patient basis.

Medical practitioner fees refers to non-surgical treatment performed or administered by a medical practitioner.

Medical practitioners are doctors who are licensed to practise medicine under the law of the country in which treatment is given and where they are practising within the limits of their licence.

Medical repatriation is an optional level of cover and where provided will be shown in the Table of Benefits. If the necessary treatment for which you are covered isn't available locally you can choose to be medically evacuated to your home country for treatment, instead of to the nearest appropriate medical centre. This only applies when your home country is within your geographical area of cover. Following completion of treatment, we will also cover the cost of your return trip at economy rates, to your principal country of residence. The return journey must take place within one month after treatment has been completed.

You must contact us at the first indication that repatriation is required. From this point onwards we will organise and coordinate all stages of the repatriation until you arrive safely at your destination of care. If the repatriation is not organised by us, we reserve the right to decline all costs incurred.

Medical underwriting is the assessment of insurance risk based on information that you give us when applying for cover. Our underwriting team uses this information to decide the terms of our offer.

Midwife fees refers to fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has completed the necessary training and passed the necessary state examinations.

N

Newborn care includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth.

Cover doesn't include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the child needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependant). For multiple birth babies born as a result of medically assisted reproduction, in-patient treatment is limited to CNY252,000 per child for the first three months following birth. Out-patient treatment is paid within the terms of the Out-patient Plan.

Non-prescribed physiotherapy refers to treatment provided by a registered physiotherapist without being referred by a

doctor in advance. Cover is limited to the number of sessions indicated in your Table of Benefits. A doctor must prescribe any additional sessions over this limit, which will be covered under the prescribed physiotherapy benefit. Physiotherapy does not include therapies such as Rolfing, Tuina, Massage, Pilates, Fango and Milta.

Nursing at home or in a convalescent home refers to nursing received immediately after, or instead of, eligible in-patient or day-care treatment. We will pay the benefit listed in the Table of Benefits if the treating doctor decides that it is medically necessary for you to stay in a convalescent home or have a nurse in attendance at home. This benefit also needs to be approved by our Medical Director. This benefit doesn't cover spas, cure centres, health resorts, palliative care or long term care (see "Palliative care" and "Long-term care" definitions).

O

Obesity is diagnosed when a person has a Body Mass Index (BMI) of over 30.

Occupational therapy is treatment that helps you develop skills needed for daily living and interactions with other people and the environment. These refer to:

- Fine and gross motor skills (how you perform small, precise tasks and whole-body movement).
- Sensory integration (how the brain organises a response to your senses).
- Coordination, balance and other skills such as dressing, eating and grooming.

We will need to see a progress report after every 20 sessions.

Oculomotor therapy is a specific type of occupational therapy that aims to synchronise eye movement when there is a lack of coordination between eye muscles.

Oncology refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges related to the treatment of cancer from the point of diagnosis. We also cover the cost of an external prosthetic device for cosmetic purposes, for example a wig for hair loss or a prosthetic bra after breast cancer treatment.

Oral and maxillofacial surgical procedures refers to surgical treatment on the mouth, jaws, face or neck performed in a hospital by an oral and maxillofacial surgeon for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours.

Unless you hold a Dental Plan, we do not cover the following procedures even if they are performed by an oral and maxillofacial surgeon:

- Surgical removal of impacted teeth
- Surgical removal of cysts
- Orthognathic surgeries for the correction of malocclusion

Organ transplant refers to the following organ or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea. We do not reimburse the costs of acquiring organs.

Orthodontics is the use of devices to correct malocclusion (misalignment of your teeth and bite). We will ask you to submit supporting information with your claim to show that your treatment is medically necessary and therefore eligible for cover. The information we ask for may include, but is not limited to:

- A medical report issued by the specialist, stating the diagnosis (type of malocclusion) and a description of your symptoms caused by the orthodontic problem.
- A treatment plan showing the estimated duration and cost of the treatment and the type/material of the appliance used.
- The payment arrangement agreed with the medical provider.
- Proof of payment for orthodontic treatment.
- Photographs of both jaws clearly showing dentition before the treatment.
- Clinical photographs of the jaws in central occlusion from frontal and lateral views.
- Orthopantomogram (panoramic x-ray).
- Profile x-ray (cephalometric x-ray).
- Any other document we may need to assess the claim.

We will only cover the cost of standard metallic braces and/or standard removable appliances. However, we'll cover cosmetic appliances such as lingual braces and invisible aligners up to the cost of metallic braces, subject to the "Orthodontic treatment and dental prostheses" benefit limit.

Orthomolecular treatment refers to alternative treatment that aims to restore the individual biochemical balance through supplements. It uses natural substances such as vitamins, minerals, enzymes and hormones.

Out-patient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require you to stay overnight out of medical necessity.

Out-patient treatment refers to treatment provided in the practice or surgery of a medical practitioner, therapist or specialist that does not require you to be admitted to hospital.

P

Palliative care refers to ongoing treatment that aims to alleviate the physical/psychological suffering associated with

progressive, incurable illness and to maintain quality of life. It includes in-patient, day-care and out-patient treatment following the diagnosis of a terminal condition. We will pay for physical care, psychological care, hospital or hospice accommodation, nursing care and prescription drugs.

Partner refers to a person you have lived with in a conjugal relationship for a continuous period of 12 months.

Periodontics refers to dental treatment related to gum disease.

Podiatry refers to medically necessary treatment carried out by a State Registered podiatrist.

Policyholder is the person appearing first in the Insurance Certificate.

Post-natal care refers to the routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-existing conditions are medical conditions for which one or more symptoms presented at some point during your or your dependants' lifetime. This applies regardless of whether you or your dependants sought any medical advice or treatment. We would deem any such condition to be pre-existing if we could reasonably assume you or your dependants would have known about it. Your policy will cover pre-existing conditions unless we tell you otherwise in writing.

We will also treat as pre-existing any medical conditions that arise between the date you completed the application form and the later of the following:

- The date we issued your Insurance Certificate or
- The start date of your policy

Such pre-existing conditions will also be subject to full medical underwriting and if they are not disclosed, they will not be covered. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

Pregnancy refers to the period of time when you are expecting a baby, from the date of the first diagnosis until delivery.

Pre-natal care includes common screening and follow-up tests required during pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple and Spina Bifida tests, amniocentesis and, if directly linked to an eligible amniocentesis, DNA-analysis.

Prescribed glasses and contact lenses including eye examination refers to cover for a routine eye examination carried out by an optometrist or ophthalmologist (one check-up per Insurance Year) and for lenses or glasses to correct vision.

Prescribed medical aids refers to any device which is prescribed and medically necessary to enable you to carry out everyday activities. Examples include:

- Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines.
- Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
- Hearing and speaking aids such as an electronic larynx.
- Medically graduated compression stockings.
- Long-term wound aids such as dressings and stoma supplies.

We do not cover costs for medical aids that form part of palliative care or long-term care (see the definitions of "Palliative care" and "Long-term care").

Prescribed physiotherapy refers to treatment provided by a registered physiotherapist following referral by a doctor. Physiotherapy (either prescribed, or a combination of non-prescribed and prescribed treatment) is initially restricted to 12 sessions per condition, after which treatment must be reviewed by the doctor who referred you. If you need further sessions, you must send us a new progress report after every set of 12 sessions, indicating the medical necessity for more treatment. Physiotherapy does not include therapies such as Rolfing, massage, Pilates, Fango and Milta.

Prescription drugs refers to products which you can't buy without a prescription and are to treat a confirmed diagnosis or medical condition or to compensate a lack of vital bodily substances. Examples are antibiotics, sedatives, etc. Prescription drugs must be clinically proven to be effective for the diagnosed condition. They must also be recognised by internationally accepted medical guidelines.

Preventive treatment refers to treatment you receive without any clinical symptoms being present at the time of treatment (e.g. the removal of a pre-cancerous growth). This benefit is covered when the Preventive treatment is listed in your Table of Benefits.

Principal country of residence is the country where you and your dependants (if applicable) live for more than six months of the year.

Psychiatry and psychotherapy refers to the treatment of mental disorders carried out by a psychiatrist or clinical psychologist.

The condition must be clinically significant and not related to:

- Bereavement
- Relationship or academic problems
- Acculturation difficulties
- Work pressure

All day-care or in-patient admissions must include prescription medication related to the condition. We will cover psychotherapy (on an in-patient or out-patient basis) in cases where you or your dependants are initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment. Out-patient psychotherapy treatment (where covered) is for 10 sessions per condition initially. After every 10 sessions, the referring psychiatrist must review the treatment. If

you need more sessions, you must send us a progress report that indicates the medical necessity for further treatment.

R

Reasonable and customary refers to treatment costs that are usual within the country of treatment. We will only reimburse the cost of medical providers where their charges are reasonable and customary and in accordance with standard and generally accepted medical procedures.

Rehabilitation is treatment that combines therapies such as physical, occupational and speech therapy. It aims to restore original form or function after an acute illness, injury or surgery. Treatment must take place in a licensed rehabilitation facility and start within 14 days of discharge from acute medical and/or surgical treatment.

Repatriation of mortal remains is the transportation of the insured deceased remains from the principal country of residence to the country of burial. We cover costs such as: embalming, a container legally appropriate for transportation, shipping and the necessary government authorisations. Cremation costs will only be covered if the cremation is required for legal purposes. We do not cover costs incurred by anyone accompanying the remains unless this is listed as a specific benefit in your Table of Benefits.

Routine maternity refers to medically necessary costs incurred during pregnancy and childbirth. Please note this benefit is only available on the condition that the pregnancy starts after the waiting period is fully served. This includes hospital charges, specialist fees, the mother's pre-natal and post-natal care, midwife fees (during labour only) and newborn care (see the definition of "Newborn care" for what we cover under this benefit and for in-patient treatment limits that apply to multiple birth babies born as a result of medically assisted reproduction). We do not cover costs of complications of pregnancy and childbirth under the "Routine maternity" benefit. Caesarean sections that are not medically necessary are covered up to the cost of a routine delivery in the same hospital, subject to any benefit limits. Medically-necessary cesarean sections are paid for under the "Complications of childbirth" benefit.

In case of home deliveries, we will pay a lump sum up to the amount specified in the Table of Benefits if your plan includes the "Home delivery" benefit.

S

Specialist is a licensed doctor possessing the additional qualifications and expertise necessary to practise as a recognised specialist in diagnostic techniques, treatment and prevention in a particular field of medicine. This benefit does not include cover for psychiatrist or psychologist fees. Where covered, a separate benefit for psychiatry and psychotherapy will appear in the Table of Benefits.

Specialist fees refers to non-surgical treatment performed or administered by a specialist.

Speech therapy refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments. This includes conditions such as nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Surgical appliances and materials are those required for surgeries. They include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

T

Therapist refers to a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the laws of the country in which treatment takes place.

Travel costs of insured family members in the event of an evacuation/repatriation refers to the reasonable transportation costs of all insured family members of the evacuated or repatriated person, including minors who might otherwise be left unattended. If all family members can't travel in the same vehicle with the evacuated/repatriated person, we will pay for their round-trip transport at economy rates.

The "Travel costs of insured family members in the event of a repatriation" benefit is covered if you have a repatriation plan. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured family members in the event of the repatriation of mortal remains refers to reasonable transportation costs of any insured family members who had been living abroad with the insured person who died, to travel to the country of burial of the deceased. Reasonable transportation costs are considered to be round trip transport costs at economy rates. Cover does not include hotel accommodation or other related expenses.

Travel costs of insured members to be with a family member who is at peril of death or who has died refers to the reasonable transportation costs of insured family members to be with a first-degree relative who is at peril of death or who has died (up to the amount specified in your Table of Benefits). Reasonable transportation costs are considered to be round trip transport costs at economy rates.

A first-degree relative is a spouse or partner, parent, brother, sister or child, including adopted children, fostered children or

step-children. When claiming, please include copies of the travel tickets and the death certificate or a doctor's certificate supporting the reason for travel. We will cover one claim per insurance year. Cover does not include hotel accommodation or other related expenses.

Treatment refers to a medical procedure needed to cure or relieve illness or injury.

Treatment Guarantee Form is a form that you or your doctor must complete and submit before receiving certain treatments. Once submitted, we will assess the details of the impending treatment and advise you if cover is provided within the scope of your Table of Benefits. The Table of Benefits will outline those treatments requiring Treatment Guarantee.

V

Vaccinations refer to:

- All basic immunisations and booster injections that are required by law in the country in which they are administered.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

We cover the cost of consultation for administering the vaccine and the cost of the drug.

W

Waiting period is a period of time that begins on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits. Your Table of Benefits shows which benefits are subject to waiting periods.

We/Our/Us is Allianz Jingdong General Insurance Company Ltd. and its branch offices.

Y

You/Your refers to the policyholder and any dependants named on the Insurance Certificate.

EXCLUSIONS

Although we cover most medically necessary treatment, we do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement.

Acquisition of an organ
Expenses for the acquisition of an organ such as, but no limited to donor search, typing, harvesting, transport and administration costs.

Behavioural and personality disorders
Treatment for conditions such as conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, phobic disorders, attachment disorders, adjustment disorders, eating disorders, personality disorders or treatments that encourage positive social-emotional relationships, such as family therapy.

Chemical contamination and radioactivity
Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

Complementary treatment
Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

Complications caused by conditions not covered under your plan
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

Consultations performed by you or a family member
Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

Dental veneers
Dental veneers and related procedures.

Developmental delay
Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified medical professionals and documented as a delay in development of at least 12 months.

Drug addiction or alcoholism
Care and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments to stop smoking), death associated with drug addiction or alcoholism, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

Experimental or unproven treatment or drug therapy
Any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

Failure to seek or follow medical advice
Treatment required as a result of failure to seek or follow medical advice.

Family therapy and counselling
Costs in respect of a family therapist or counsellor for out-patient psychotherapy treatment.

Fees for the completion of a Claim Form
Doctor's fees for the completion of a Claim Form or other administration charges.

Genetic testing
Genetic testing, except:

a) Where specific genetic tests are included within your plan.

b) Where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.

c) Where testing for genetic receptor of tumours is covered.

Home visits
Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

Infertility treatment
Infertility treatment including medically assisted reproduction or treatment for any medical problems arising from it, unless you have a specific benefit for infertility treatment or have an Out-patient Plan. If you have an Out-patient plan we will only cover non-invasive investigations into the cause of infertility (within the limits of your Out-patient Plan).

Injuries caused by professional sports
Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

Intentionally caused diseases or self-inflicted injuries
Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

Loss of hair and hair replacement
Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

Medical error
Treatment required as a result of medical error.

Obesity treatment
Investigations into and treatment for obesity.

Orthomolecular treatment
Please refer to the definition of "Orthomolecular treatment".

Participation in war or criminal acts
Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:

- War
- Riots
- Civil disturbances
- Terrorism
- Criminal acts
- Illegal acts
- Acts against any foreign hostility

Plastic surgery
Treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes, and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or surgery occurs during your period of cover.

Pre- and post-natal
Pre- and post-natal classes.

Pre-existing conditions
Pre-existing conditions (including pre-existing chronic conditions) when:

- Indicated on a Special Conditions Form that we issue before your policy starts
- Conditions were not disclosed on the Application Form
- Conditions arise between completing the application form and the later of the following:
  - The date we issue your Insurance Certificate or
  - The start date of your policy

Such conditions will also be subject to medical underwriting and if not disclosed, will not be covered.

Products sold without prescriptions
Products that can be purchased without a doctor's prescription, except where a specific benefit covering these costs appears in the Table of Benefits.

Sex change
Sex change operations and related treatments.

Sleep disorders
Treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.

Speech therapy
Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

Stays in a cure centre
Stays in a cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.

Sterilisation, sexual dysfunction and contraception
Investigations into, treatment of and complications arising from:

- Sterilisation
- Sexual dysfunction (unless as a result of total prostatectomy following cancer surgery)
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons). The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.

Surrogacy
Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.

Termination of pregnancy
Termination of pregnancy, except where the life of the pregnant woman is in danger.

Travel costs
Travel costs to and from medical facilities (including parking costs) for treatment, except when covered under "Local ambulance", "Medical evacuation" and "Medical repatriation" benefits.

Treatment in the USA
Treatment in the USA if we believe that cover was taken out with the purpose of travelling to the USA to get treatment for a condition or symptoms you were aware of:

- before being insured with us
- before having the USA in your region of cover

If we paid any claims in these circumstances, we reserve the right to seek reimbursement from you.

Treatment outside the geographical area of cover
Treatment outside the geographical area of cover unless for emergencies or authorised by us.

Triple/Bart's, Quadruple or Spina Bifida tests
Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

Tumour marker testing
Tumour marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case cover is provided under the Oncology benefit.

Vessel at sea
Medical evacuation/repatriation from a vessel at sea to a medical facility on land.

Vitamins or minerals
Products classified as:

- Vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes).
- Supplements such as, infant formula and cosmetic products.

These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

Benefits that are not in your Table of Benefits
The following benefits or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:

- Complications of pregnancy.
- Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses. The only exception is oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.
- Dietician fees.
- Emergency dental treatment.
- Expenses for one person accompanying an evacuated/repatriated person.
- Health and wellbeing checks including screening for the early detection of illness or disease.
- Home delivery.
- Infertility treatment.
- In-patient psychiatry and psychotherapy treatment.
- Laser eye treatment.
- Medical repatriation.
- Out-patient psychiatry and psychotherapy treatment.
- Out-patient treatment.
- Prescribed glasses and contact lenses including eye examination.
- Prescribed medical aids.
- Preventive treatment.
- Rehabilitation treatment.
- Routine maternity and Complications of childbirth.
- Travel costs of insured family members in the event of an evacuation/repatriation.
- Travel costs of insured family members in the event of the repatriation of mortal remains.

- Travel costs of insured members to be with a family member who is at peril of death or who has died.
- Vaccinations.

Talk to us, we love to help!

If you have any queries, please do not hesitate to contact us:

4008866014 (from inside mainland China)

+86 10 85355624 (from outside mainland China)

Calls to our Helpline will be recorded and may be monitored for training, quality and regulatory purposes. Please note that only the policyholder (or an appointed representative) can make changes to the policy. Security questions will be asked of all callers to verify their identity.

The Helpline service is available 24 hours a day, 7 days a week in both Chinese and English.

Email: Health.ClientServices@allianz.cn

For Shanghai: Allianz Jingdong General Insurance Company Ltd., Shanghai Branch, Unit 1408, 14F Shanghai Tower, No.501 Middle Yincheng Road, Pudong New Area, Shanghai 200120, People's Republic of China.

For Beijng: Allianz Jingdong General Insurance Company Ltd., Beijing Branch, 16F & 17F, Tower 3, Han's Plaza, No.2 South Ronghua Road, BDA, Beijing 100176, People's Republic of China.

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