Allianz JD

Benefit Guide

International Healthcare Plans for China
Valid from 1st August 2024

Welcome

You and your family can depend on us, as your insurer, to give you access to the best care possible. We are working in partnership with Allianz Care, a specialist provider of international health insurance, and are 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 ensure that you receive expert assistance that is local, we have appointed MSH China as your policy administrator. MSH China will provide you with a consistent quality service including, for example, helpline, medical and claim-related services, member app and WeChat program.

This guide has two parts: 'How to use your cover' is a summary of all important information you are likely to use on a regular basis; 'Terms and conditions of your cover' explains your cover in more detail.

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

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Allianz Jingdong General Insurance Company Ltd. ('AZJD'), is the insurer of this policy and is registered in China at Unit 01-05, 11& 12, 34th Floor, Main Tower, Guangzhou International Finance Centre, 5 Zhujiang Xilu, Tianhe District, Guangzhou, Guangdong, P.R. China. Registered No.: 914400005517258765. Regulated by the National Financial Regulatory Administration.

MSH China Enterprise Services Co., Ltd of 5/F, Building 9, Lujiazui Software Park, Lane 91, E Shan Road, Pudong, Shanghai, P.R.C 200127 is appointed by AZJD to provide health management services and member support for this policy.

This policy is supported by AWP Health & Life SA, a limited company governed by the French Insurance Code and acting through its Irish Branch. Part of the Allianz Group, AWP Health & Life SA is registered in France: No. 401 154 679 RCS Bobigny. Irish Branch is registered in the Irish Companies Registration Office, registered No.: 907619, address: 15 Joyce Way, Park West Business Campus, Nangor Road, Dublin 12, Ireland. AWP Health & Life SA is the Reinsurer of this policy. Allianz Partners and Allianz Care 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 services we offer. Read on to discover what is available to you.

Talk to us, we love to help!

You can contact MSH China, our expert policy administrator, for any query or assistance need related to your policy with us. MSH's Service Hotline is available 24 hours a day, 7 days a week, in both Chinese and English.

Service Hotline

(+86) 21 6060 5196

allianzhealth@mshasia.com

Did you know...

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

Digital member services**

Access the online service platform for easy and convenient access to your cover, no matter where you are. Via the MSH SERVICES APP or MSH WeChat service platform, you can:

- View your digital member card.
- Find a direct billing network provider.
- Check your plan benefits.
- Submit a claim or pre-authorisation request.

Download

MSH SERVICES APP download

MSH WeChat service platform access

Registration instructions are included in your welcome email.

Member services included in your cover

Your policy doesn't just cover your medical expenses. It also includes a range of free member services. Check your Table of Benefits to confirm which ones are included in your cover.

EAP — Expat Assistance Programme

When challenging situations arise in life or at work, our EAP provides you and your dependants with immediate confidential support. The service includes:

- **Confidential professional counselling** via phone, video or in person, on topics such as stress, work/life balance, parenting, anxiety, cultural shock, addiction concerns, etc.
- **Legal and financial referral services**, for example to help buying a home, handling a legal dispute or creating a financial plan.

Travel Security Services

24/7 access to personal security information and advice for your travels, helpful as the world continues to witness an increase in security treats. You can access:

- **Emergency hotline**, to talk to a specialist for any safety concerns associated with your travel destination.
- **Country intelligence**, which offers information and advice about many countries.
- **Daily security news updates**, to receive email alerts about high-risk events in or near your location, including terrorism or severe weather risks.

To know more or to access the above member services, visit:

EAP: **www.allianzcare.com/en/personal-international-health-insurance/products-and-services/eap.html**

*Login with **Username: AllianzCare / Password: Expatriate**

Travel Security Services: **www.allianzcare.com/en/personal-international-health-insurance/products-and-services/travel-security-services.html**

*Login with your email address and the Member ID: **ALLIANZTSS**

Other member services

The below services are accessible at: **www.allianzcare.com/servicescn**. You will need to register by using your policy number.

- **Telehealth service**** – Need to talk with a senior licensed doctor? Want a clinical opinion on your symptoms over the phone? Get clarity on next steps...
- **Second medical opinion service**** – 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, in multiple languages, designed to provide you with medical advice when you need it:
  - **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?

***Certain services that may be included in your plan are provided by third party providers, such as the Expat Assistance Programme, Telehealth service, Second Medical Opinion and Overseas Treatment Recommendation services. If included in your plan, these services will show in your Table of Benefits. These services are made available to you subject to your acceptance of the terms and conditions of your policy and the terms and conditions of the third parties. These services may be subject to geographical restrictions. They are also not a substitute for the diagnosis, treatment, assessment or care that you may need from your own doctor. You understand and agree that the insurer, its reinsurers and its administrators are not responsible or liable for any claim, loss or damage, directly or indirectly resulting from your use of any of these third party services.*

Understanding how your cover works

What am I covered for?

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).

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.

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 Pre-authorisation 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 limit**. This is the maximum we will pay in total for all benefits included in the plan per member, per Insurance Year.

If your plan has a maximum plan limit, it will apply even where:

- the term 'Full refund' appears next to the benefit.
- a specific benefit limit applies – this is when the benefit is capped to a specific amount (e.g. CNY 5,000).

Benefit limits may be provided on a 'per Insurance Year' basis, on a 'per lifetime' 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. 80% refund).

Benefit limits related to maternity

The benefits **'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.

Limit for multiple-birth babies, adopted and fostered children

There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- is adopted.
- is fostered.
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is CNY 252,000 per child. Out-patient treatment is paid under the terms of the Out-patient Plan.

What are co-payments?

A **co-payment** is when you pay a percentage of the medical costs. Your Table of Benefits will show whether this applies to your plan. 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 pay 80% of the cost of each eligible treatment. The total amount payable by us may be subject to a maximum plan benefit limit.

Treatment invoice 1	Ling Ling pays 20%		We pay 80%
Treatment invoice 2	Ling Ling pays 20%		We pay 80%
Treatment invoice 3	Ling Ling pays 20%		We pay 80%

Ling Ling's contribution
Our contribution

What are deductibles?

A deductible (also known in health insurance as an 'excess') is a fixed amount you need to pay towards your medical bills per period of cover before we begin to contribute. Your Table of Benefits will show whether this applies to your plan. In the following example, Ming Li needs to receive medical treatment throughout the year. His plan includes a CNY 15,000 deductible.

Treatment invoice 1: CNY 10,000	Ming Li pays the medical bill in full (CNY 10,000)		We pay CNY 0
Treatment invoice 2: CNY 10,000	Ming Li pays CNY 5,000		We pay the remaining CNY 5,000
Treatment invoice 3: CNY 10,000	Ming Li pays CNY 0		We pay the medical bill in full (CNY 10,000)
Treatment invoice 4: CNY 10,000	Ming Li pays CNY 0		We pay the medical bill in full (CNY 10,000)

Ming Li's contribution
Our contribution

Terms and conditions of your cover

Terms and conditions

This section describes the 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 Pre-authorisation Form. It also confirms any benefits where specific benefit limits, waiting periods, deductibles and/or co-payments apply.
- Information provided to us by (or on behalf of) the insured person(s) 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.

Administration of your policy

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 that 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 18 birthday or up until the day before their 24 birthday if they are in full-time education. At that time, they may apply for cover in their own right under one of our Healthcare Plans for Individuals and Families.

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. With the exception of multiple birth babies, 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 will be underwritten and if accepted, cover will start from the date of acceptance.

There is a limit for in-patient treatment that takes place in the first three months following birth if the baby:

- is adopted
- is fostered
- is a multiple-birth baby born as a result of medically assisted reproduction.

This limit is CNY 252,000 per child and it applies before any other benefit in your plan. Out-patient treatment is paid under 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.

Renewing your 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 apply to us to continue 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 dependants' 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 by giving us written notice before the intended cancellation date. At the intended cancellation date, you must have paid all premiums due. 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.

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.

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, the contract is not effective 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. During a suspension period, no claims will be paid. Furthermore, if the outstanding amount is not settled for two years after the expiry of the policy suspension, the contract may be terminated with written notice 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 suspend the contract in writing with immediate effect and will be exempt from paying any benefits.

The effects of suspension will end if you make a payment within one month after the suspension or, if the suspension 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.

If you need to discuss any of the points above, please contact:

- **Health.Underwriting@allianz.cn** for queries related to the administration of your policy (e.g. renewals).
- **Health.CreditControlIndividual@allianz.cn** for queries related to your premium payment.

The following terms also apply to your cover

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.

Sanctions suspension clause: Any benefits, cover and claims payments are suspended if any element of the cover, benefit, activity, business, or underlying business exposes us to:

- any applicable sanction, prohibition or restriction under the United Nations' resolutions, or
- the trade or economic sanctions, laws or regulations of the People Republic of China, European Union, United Kingdom, or United States of America.

The above suspension will continue until such time as we are no longer exposed to any such sanction, prohibition, or restriction.

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.

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.

When cover is provided by someone else: We may decline a claim 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 inform us and provide all necessary information. You and the third party cannot agree any final settlement or waive our right to recover expenses without our prior written agreement. Otherwise, we are entitled to get back from you any amount we have paid and to cancel your cover.

We have the right to claim back from a third party any amount we paid for a claim, if the costs were due from or also covered by them. We may take legal proceedings in your name, at our expense, to achieve this. This is called subrogation.

We will not make a contribution to any third-party insurer if the costs are fully or partly covered by that insurer. However, if our plan covers a higher amount than the other insurer, we'll pay the amount not covered by them.

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 that 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.

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.

- 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.
- 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.
- 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.

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 full medical underwriting.

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:

https://globalhealth.jdallianz.com/h5/#/pages/index/privacyPolicy?language=en

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

The MSH's Service Hotline 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:

(+86) 21 6060 5196

allianzhealth@mshasia.com

MSH CHINA Enterprise Services Co., Ltd
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Dispute resolution

- 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.
- 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 the MSH's Service Hotline.

Definitions

The following definitions apply to our Healthcare Plans. The benefits you are covered for are listed in your Table of Benefits. If your plan includes any benefit not defined below, 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

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

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

Sudden onset of symptoms or a medical condition.

Area of cover

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

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

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. If available, consultation costs will also be covered under this benefit.

The complementary treatment benefit does not cover pelotherapy, wax therapy, gas-bubble bath, balneotherapy, cupping, quick cupping, movable cupping, scraping, moxibustion, medicated baths, fumigation, ear candle, auricular and shortwave/microwave pulse, medicinal pastes/gels, Sanfu medicinal patches or Sanjiu medicinal patches.

Complications of childbirth

Post-partum haemorrhage and retained placental membrane only. Where your plan also includes the benefits 'Routine maternity' or 'Routine delivery and newborn care', '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

It 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

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

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

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

Also referred to as 'excess' in health insurance. It 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

Drugs 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

Crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Dental surgery

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

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

Dependant

Your spouse and unmarried children that are named as dependants on your Insurance Certificate. Children are covered up to the day before their 18 birthday; or up to the day before their 24 birthday if they are in full-time education.

Diagnostic tests

Investigations such as x-rays or blood tests, carried out for diagnostic purposes. These tests are covered when you are already displaying symptoms or when needed following other medical test results. This benefit does not cover annual check-ups or routine screenings.

Dietician fees

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

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

Doctor

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

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

Acute emergency dental treatment for the relief of pain 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

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

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

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

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

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

Full medical underwriting

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.

H

Health and wellbeing checks including screening for the early detection of illness or disease

Health checks, tests and examinations, performed at appropriate age intervals, that are undertaken at a licensed medical institution or a licensed health examination institution accepted by us and abiding by clinical practice guidelines without any clinical symptoms being present.

This benefit does not cover:

- Vaccinations
- Genetic testing
- Any consultation, treatment or therapy subsequent to the health and wellbeing check(s)

Home country

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

Hospital

Any establishment that 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

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

It is payable when you receive in-patient treatment for a medical condition that is covered by us but is free of charge for you and no claim is made or paid by us under any section of this policy. 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

Treatment received in a hospital where an overnight stay is medically necessary.

Insurance Certificate

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

Insurance Year

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

Insured person

You and your dependants as stated on your Insurance Certificate.

L

Local ambulance

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

Care over an extended period of time after the initial acute/curative treatment has been completed. This usually occurs for a chronic condition or disability requiring uninterrupted/continuous medical care, or where treatment options are limited to the existing level of care. Long-term care can be provided at home, in the community, in a hospital, a long-term care facility or in a nursing home.

M

Medical evacuation

It 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

Medical treatment, services or supplies that fulfil all of the following:

- Essential to identify or treat your condition, illness or injury.
- Consistent with your symptoms, diagnosis or treatment of the underlying condition.
- 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).
- Required for reasons other than the comfort or convenience of you or your doctor.
- Proven and demonstrated to have medical value (this does not apply to complementary treatment methods if they form part of your cover).
- Considered to be the most appropriate type and level of service or supply.
- Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of your medical condition.
- 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

Fees charged for non-surgical treatment performed or administered by a medical practitioner.

Medical practitioners

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. In China, they must be registered with the medical facility they are authorised to practice at, as required by the multi-site practice policy.

Medical repatriation

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.

Midwife fees

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

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, adopted and fostered children, in-patient treatment is limited to CNY 252,000 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

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 treatment uses artificial physical factors (such as light, electricity, magnetism, sound, warmth, cold) and includes electrotherapy, phototherapy, magnetic therapy, heat therapy, cold therapy, hydrotherapy and ultrasound therapy.

Physiotherapy does not include therapies such as Mud Therapy, Wax Therapy, Bubble Bath, Balneotherapy, Rolfing, Tuina, Massage, Pilates, Fango and Milta.

Nursing at home or in a convalescent home

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.

O

Obesity

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

Occupational therapy

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

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

Oncology

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

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

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

The use of devices to correct malocclusion (misalignment of your teeth and bite). We only cover orthodontic treatment that meets the medical necessity criteria described below. As the criteria are very technical, please contact us before starting treatment so we can verify if your treatment meets the criteria.

Medical necessity criteria:

- Increased overjet > 6mm but <= 9 mm
- Reverse overjet > 3.5 mm with no masticatory or speech difficulties
- Anterior or posterior crossbites with > 2 mm discrepancy between the retruded contact position and intercuspal position
- Severe displacements of teeth > 4
- Extreme lateral or anterior open bites > 4 mm
- Increased and complete overbite with gingival or palatal trauma
- Less extensive hypodontia requiring pre-restorative orthodontics or orthodontic space closure to obviate the need for a prosthesis
- Posterior lingual crossbite with no functional occlusal contact in one or more buccal segments
- Reverse overjet > 1 mm but < 3.5 mm with recorded masticatory and speech difficulties
- Partially erupted teeth, tipped and impacted against adjacent teeth
- Existing supernumerary teeth

You will need to send us some supporting information to show that your treatment is medically necessary and therefore covered by your plan. 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' benefit limit.

Orthomolecular treatment

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

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

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

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.

Periodontics

Dental treatment related to gum disease.

Podiatry

Medically necessary treatment carried out by a State Registered podiatrist.

Policyholder

The person appearing first in the Insurance Certificate.

Post-hospitalisation treatment

Out-patient treatment required in the 90 days following discharge from an in-patient or day-care treatment for the same acute medical condition. This benefit covers medical practitioners' fees, specialists' fees, out-patient surgery, prescribed drugs and dressings, MRI, PET and CT scans, X-rays, pathology and other diagnostic tests and procedures.

Post-natal care

Routine post-partum medical care received by the mother for up to six weeks after delivery.

Pre-authorisation Form

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 Pre-authorisation.

Pre-existing conditions

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 before the start date of the policy. 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

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

Pre-hospitalisation tests

Out-patient pre-hospitalisation tests carried out in the 72 hours before in-patient or day-care treatment covered under your plan.

Pre-natal care

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

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

Prescribed medical aids

Any device that 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.

Prescribed physiotherapy

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 treatment uses artificial physical factors (such as light, electricity, magnetism, sound, warmth, cold) and includes electrotherapy, phototherapy, magnetic therapy, heat therapy, cold therapy, hydrotherapy and ultrasound therapy.

Physiotherapy does not include therapies such as Mud Therapy, Wax Therapy, Bubble Bath, Balneotherapy, Rolfing, Tuina, massage, Pilates, Fango and Milta.

Prescription drugs

Products that 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. You can claim for a supply of up to three months from the prescription date, subject to length of time remaining on the policy.

Preventive treatment

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' benefit is listed in your Table of Benefits.

Principal country of residence

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

Psychiatry and psychotherapy

Treatment of mental, behavioural and personality disorders, including autism spectrum and eating disorder. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary.

All day-care or in-patient admissions must include prescription medication related to the condition.

Out-patient psychotherapy treatment (where covered) requires referral by a doctor and is limited to 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Counselling is available through our Expat Assistance Programme (EAP) and refers to short-term, solution-focused interventions, and typically deals with current issues that are easily resolved on the conscious level. This is not meant for longer-term situations or the treatment of clinical disorders. EAP can help you and your immediate family deal with challenging situations that may arise in life, such as stress, anxiety, bereavement, workplace challenges, relationship issues, cross-cultural transition, coping with isolation and loneliness. For more information see the 'Expat Assistance Programme (EAP)' section of this guide.

R

Reasonable and customary

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

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.

We cover in-patient or day-care accommodation costs only if admission to a rehabilitation facility was requested by your doctor and approved by us.

Repatriation of mortal remains

The transportation of the deceased insured person's 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

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 caesarean 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

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.

Specialist fees

Non-surgical treatment performed or administered by a licensed doctor. This benefit does not include cover for psychiatrist, psychologist fees or any treatment that is already covered by another benefit under your Table of Benefits. We don't cover specialist treatment that is excluded under your policy.

Speech therapy

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

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

A chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, podiatrist, 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

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

The 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

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). In the case of a deceased relative, travel must commence within 6 weeks of their date of death.

Reasonable transportation costs are considered to be round trip transport costs at economy rates.

A first-degree relative is a spouse, 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. Cover does not include hotel accommodation or other related expenses.

Treatment

Medical, surgical or therapeutic interventions received to diagnose, prevent, cure or relieve illness and injury, or physical and mental disorder.

Treatment of autism spectrum disorder

A range of therapies to improve the skills of an insured person with autism. This includes specialist medical treatment and accredited behavioural programmes. Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Out-patient Plan, if you have one. Check your Table of Benefit for any limits that may apply. We don't cover admissions, stays or day care treatment at specialised educational facilities.

Treatment of eating disorders

A combination of psychotherapies, including cognitive behavioural therapy, medical monitoring, prescribed medication and nutritional counselling to treat anorexia nervosa, bulimia nervosa and binge-eating disorder.

All day-care or in-patient admissions must include prescription medication related to the condition.

Out-patient therapy (where covered) requires referral by a doctor and is limited for 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Treatment is covered as part of the 'Psychiatry and psychotherapy' benefit of your Out-patient Plan, if you have one. Check your Table of Benefits for any limits that may apply.

V

Vaccinations

- All basic immunisations and booster injections in line with the international medical guidelines that apply in the country where they are administered.
- Vaccination against COVID-19*, where this is not offered for free or only partially sponsored by the government in your country of residence.
- Medically necessary travel vaccinations.
- Malaria prevention tablets.

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

*We cover any COVID-19 vaccine when:

- The vaccine has completed the necessary clinical development process, including all pre-licensure vaccine clinical trials (phase I, II and III) that demonstrate its efficacy and safety.
- The vaccine has completed the multi-step approval process for the relevant regulating authority and is approved for use in the jurisdiction where you require it.
- The vaccine is not offered for free or only partially sponsored by the government of the country in which you reside.

We cover the reasonable and customary cost of the COVID-19 vaccine, including the administration of the injection, in line with local public health policies related to the allocation of vaccines. We do not pay towards the travel cost if you decide to travel to a different country from where you normally reside in order to get the vaccination. Please note that cover is not intended to give you priority access to vaccines.

W

Waiting period

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

Allianz Jingdong General Insurance Company Ltd.

Y

You/Your

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 not limited to donor search, typing, harvesting, transport and administration costs.

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.

COSMETIC TREATMENT

Any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. This includes treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes. The following exceptions apply:

- **Reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or initial surgery was also covered by this policy.**
- **Gender reassignment surgery, if you meet the criteria for gender dysphoria services.**

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 that 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:

- where specific genetic tests are included within your plan.
- where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
- 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 OR ILLNESSES CAUSED BY EXTREME OR PROFESSIONAL SPORTS OR ACTIVITIES

Treatment or diagnostic procedures for injuries or illnesses arising from taking part in extreme or professional sports or activities, including but not limited to:

- Mountain sports such as abseiling, mountaineering and racing of any kind (except for racing on foot).
- Snow sports such as bobsleigh, luge, mountaineering, skeleton, skiing off-piste and snowboarding off-piste.
- Equestrian sports such as hunting on horseback, horse jumping, polo, steeple chasing or horse-racing of any kind.
- Water sports such as potholing (solo caving) or cave diving, scuba diving to a depth of more than 10 metres, high diving, white water rafting and canyoning.
- Car and motorcycle sports such as motorcycle riding and quad biking.
- Combative sports.
- Air sports such as flying with a microlight, ballooning, hang gliding, paragliding, parascending and parachute jumping.
- Various other sports such as bungee jumping.

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.

NON-COVERED PROVIDERS

Treatment and services at a medical provider, to whom we have issued written notice that we will no longer recognise them as a medical provider for claims on our plans. Please contact us for our current list of non-covered providers.

NON-STANDARD COSTS

Costs beyond the provider's standard fee range, including but not limited to additional costs due to appointment of certain experts by the member.

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**

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**
- **The 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 related operations and related treatments such as:

- **Blepharoplasty**
- **Cheek/malar implants**
- **Chin/nose implants**
- **Collagen injections**
- **Face/forehead lift**
- **Facial bone reduction (osteoplasty)**
- **Hair removal/hair transplantation**
- **Jaw reduction**
- **Laryngoplasty**
- **Rhinoplasty**
- **Skin resurfacing (e.g., dermabrasion, chemical peels)**
- **Thyroid reduction chondroplasty**
- **Neck tightening**
- **Lip enhancement**
- **Botox and filler injections**

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 a total prostatectomy following cancer surgery).
- contraception (including the insertion and removal of contraceptive devices and all other contraceptives), unless prescribed for medical reasons that are unrelated to birth control.

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 IN THE FOLLOWING CASES

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.

VESSEL AT SEA

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

VITAMINS, MINERALS AND SUPPLEMENTS

Products classified as:

- Vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes).
- Supplements such as: infant formula, American Ginseng, Cordyceps Sinensis, ShiQuanDaBuGao(NiuLan), White Ginseng, Korean Ginseng, Hawksbill, Gecko, Coral, Dogbao, Seahorse, Red Ginseng, Amber, Glossy Ganoderma, Antelope Horn Powder, Calculus Equi, Agate, Calculus Bovis, Musk, Crocus sativus, Sanguis Draconis, Cubilose, Radix Ginseng, Transplanted Wild Ginseng, Pearl (powder), Dried Placenta Hominis, Medicinal Glue, Xuebao capsules, Guilingji Capsults, K of Hearts TM Heotopoietic Recipe, Cartialgenous, placenta, animal penis, tail, tendon, bone, as well as Chinese medicinal liquors made from drinking tablets or Chinese medicinal herbs.

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:

(+86) 21 6060 5196

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 MSH's Service Hotline is available 24 hours a day, 7 days a week in both Chinese and English.

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MSH China Enterprise Services Co., Ltd of 5/F, Building 9, Lujiazui Software Park, Lane 91, E Shan Road, Pudong, Shanghai, P.R.C 200127 is appointed by AZJD to provide health management services and member support for this policy.

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