Note: Before applying for this Policy, please carefully read and understand the terms and conditions of this Policy, especially the **exclusions**. Should you have any questions, please promptly contact the Company's salespersons.

# AIG Insurance China Limited

(Hereinafter referred to as the Company)

# AIG Inpatient and Special Outpatient Medical Insurance Policy

(1st Edition in 2024)

(Registration No.: C00003932512024090928263)

## Chapter I General Conditions

### Article 1 Entire Policy

The *AIG Inpatient and Special Outpatient Medical Insurance Policy*(hereinafter referred to as this Policy) consists of this Policy Wording, Proposal Form(including the application form attached thereto, the same below), Policy Schedule, **Benefit Schedule**, **Name List**, additional Terms and Conditions, endorsement and other agreements (if any). Any agreement concerning this Policy shall be made in writing.

### Article 2 Policyholder

The Policyholder hereof shall be the Insured having full capacity for civil conduct or other persons having an insurable interest in the Insured.

### Article 3 Insured Person(s)

The Insured under this Policy consists of the Main Insured and Dependant Insureds. The Main Insured shall be a natural person having full capacity for civil conduct. The spouse or **child/children** of the Main Insured are, with the consent of the Company, eligible for the coverage under this Policy as Dependant Insureds.

At the time of placement of this Policy, the Insured may be one or more persons, up to the number of insured prescribed by law, subject to the number of insured stated in this Policy. The age of the Insured shall meet the age requirements stated in this Policy. **Under no circumstance shall this insurance cover the terrorists or members of terrorist organizations recognized by any country or international organization, or the persons who illegally engage in the trading of drugs, nuclear weapons, biological or chemical weapons**.

If the Insured under this Policy is reduced pursuant to other terms and conditions hereof, such other terms and conditions shall prevail and the Company will notify the Policyholder in writing.

### Article 4 Addition of Insured Person(s)

After this Policy takes effect, the Policyholder may, with the consent from the Main Insured, submit a written application for incorporating the **child/children** of the Main Insured into this Policy, which

will become the Insured of this Policy with the consent of the Company.

For the Dependant Insured added during the **period of insurance** whose insurance premium accrues by the policy year, if the actual period of insurance for such Insured is less than one year, the Company will calculate the annual premium payable by such Insured on a pro-rata daily basis.

**Article 5 Reduction of Insured Person(s)**

The Company will reduce the Insured Person(s) under this Policy as follows:

1. During the term of this Policy, if the Company refuses to continue to cover any insured person under this Policy due to a material change in the underwriting risk, or the Policyholder applies for reduction of any insured person, the Insured under this Policy will no longer include the insured person from the date when the insured person is disqualified(**if the insured person is the Main Insured, the Insured under this Policy will no longer include his/her Dependent Insureds**)and his/her eligibility will lapse at 24:00 on the same day. Except as otherwise stipulated in this Policy, the Company will refund the corresponding **unearned net premium** under the insured person calculated on a daily basis.
2. Where the period of insurance is one year, an insured person will no longer be covered under this Policy as of 24:00 on the first expiry date of the policy after the insured person reaches the maximum underwriting age stated in this Policy. If the insured person is the Main Insured, **his/her Dependant Insured(s) will no longer be covered under this Policy**, unless otherwise agreed in this Policy.
3. **If any insured person is deceased or the cumulative payment to any insured person under this Policy reaches the sum insured corresponding to the insured person as stated in the Schedule, from the date of his/her death or the date when the cumulative payment to him/her reaches his/her total sum insured, the insured person will no longer be covered by the Company under this Policy.** If the insured person is the Main Insured, it shall not affect the coverage of his/her Dependant Insured(s) under this Policy during the **period of insurance**.

**Article 6 Determination of Age and Gender and Misstatement**

The age and gender of an Insured Person shall be the age and gender recorded on his/her legitimate identity document. The age and gender of the Insured Person covered under this Policy shall meet the age and gender requirements as set forth in this Policy. At the time of application, the Policyholder shall state the age last birthday and gender of the Insured Person. If the age or gender of the Insured Person is misstated, it shall be handled as follows:

1. If the amount of premium required to be charged pursuant to the age last birthday or gender of the Insured Person is higher than the amount of premium actually paid, the Company shall have the right to correct and require the Policyholder to make up the balance thereof; **if an insured event has occurred to the Insured Person, the Company shall calculate, as per the premium rate of the correct age or gender, the sum insured applicable to the amount of premium actually paid**.
2. If the amount of premium required to the charged pursuant to the age last birthday or gender of the Insured Person is lower than the amount of premium actually paid, the Company shall refund, without interest, the extra amount of premium paid and the sum insured purchased shall remain unchanged.
3. If, pursuant to the age last birthday or gender of the Insured Person, the Company cannot cover the Insured Person according to the Company's underwriting rules, the Company shall have right to terminate this Policy or the eligibility of the Insured Person and shall refund, without interest, the premium paid for such Insured Person as agreed.

**Article 7 Beneficiary**

The beneficiary of this Policy is the Insured, unless otherwise agreed herein.

**Article 8 Change of Domicile or Mailing Address**

The Company shall be informed immediately in writing of any change in the Policyholder's residence or mailing address. Otherwise, the notices sent by the Company according to the last residence or mailing address of the Policyholder set forth in this Policy shall be deemed to have been served to the Policyholder.

**Article 9 Change in the Insured Person's Risk**

**The Company shall be informed by the Policyholder or the Insured Person in writing immediately(but no later than 10 days)of any material change in risk on the part of any Insured Person during the period of insurance(including but not limited to change of residence and other changes that may increase the risks covered under this Policy). Otherwise, the Company reserves the right to deny payment or partially deny payment.**

**The Company shall have the right to adjust the terms and conditions of coverage for the Insured Person or decline to continue coverage for the Insured Person under this Policy after being informed of the material change in risk by the Policyholder or the Insured Person.**

**Article 10 Determination of Insurance Plan**

The insurance plan of this Policy and its riders shall be agreed upon by the Policyholder and the Company and stated in the Policy Schedule and **Benefit Schedule**.

**Article 11 Alterations**

The Policyholder may apply for alterations to the terms of this Policy pursuant to the provisions of this Policy during the term of this Policy. No alterations shall be considered valid unless being approved and recorded by the Company and endorsed onto this Policy.

In the event of death of any Insured Person, the Company will not accept the application for alterations to any terms in this Policy concerning the Insured Person.

## Chapter II Period of Insurance

**Article 12 Commencement of Coverage**

**The Company's liability under this Policy shall be dependent upon the Policyholder paying all the premiums of this Policy in one lump sum and the Company's acceptance of insurance.** The Company shall issue a Policy Schedule as the proof of acceptance.

The effective date of this Policy is set forth in the Schedule. The due date of premiums and the expiry date of the Policy Schedule are calculated as per such date.

**Article 13 Period of Insurance and Renewal**

This insurance is a non-guaranteed renewal product. The period of insurance of this Policy is one year, with the start time and end time as set forth in the Schedule, subject to Beijing time, unless otherwise agreed in this Policy.

Upon or before the expiration of the period of insurance of this Policy, the Policyholder may apply to the Company for a placement of this Policy. After the application is examined and approved by

the Company and the Policyholder has paid the premium for the renewal period, this Policy will continue to be valid for the next period of insurance.

### Article 14 Cooling-off Period

In the event of initial placement or non-renewal of this Policy, the Policyholder has a cooling-off period of an agreed number of days (as set forth in the Proposal Form) from the date of receipt of the Policy Schedule issued by the Company and acknowledgement of receipt in writing. **If the Policyholder cancels this Policy by making a written request to the Company within the cooling-off period, and returns all policy documents including the schedule, the medical card issued by the Company and related materials to the Company, this Policy shall not take effect and the Company shall have no liability whatsoever under this Policy.**

Where this Policy is so cancelled, the Company will refund all premiums paid by the Policyholder without interest.

## Chapter III Insuring Agreement

### Article 15 Covered Territory

The covered territory of this Policy is negotiated by the Policyholder and the Company, and set forth in the Policy Schedule and **Benefit Schedule** corresponding to each Insured Person.

**Unless other stated in this Policy, the Company shall only be liable for the Accident and Illness that occurs to the Insured in covered territory where the Insured Person chose to be covered under this Policy.**

However, where the covered territory is not worldwide, if any insured person travels outside the covered territory during the **period of insurance**, the Company shall still be liable according to the other terms of this Policy for the otherwise covered medical expenses under this Policy incurred outside the covered territory due to **sudden illness** or **accidental injury** during the **journey** of cumulative 30 days after the departure of the first extraterritorial trip. If the insured person is hospitalized at a **medical institution** outside the covered territory due to the covered **disability** under this Article during the cumulative covered **journey** mentioned above, and has notified the Company of such **hospitalization** before the expiration of the cumulative covered **journey** above, with the written consent of the Company, the extraterritorial travel coverage for the insured person under this Policy may be extended until the insured person is discharged from the **medical institution** outside the covered territory or does not need to be **hospitalized** due to the said **disability**(whichever is earlier).

### Article 16 Waiting period

In the event of initial placement or non-renewal of this Policy, the waiting period stated in this Policy (subject to the waiting period corresponding to the benefits set forth in the Benefit Schedule, no more than 180 days) shall apply from the effective date of this Policy or from the date when the insured person becomes eligible for coverage under this Policy (whichever is later). In the event of renewal of this Policy or treatment of the insured due to an **accident**, there is no waiting period, unless otherwise agreed in this Policy.

In the event that the insured applies the waiting period as agreed herein, the Company shall be liable to the insured under this Policy only from the next day after the expiration date of the applicable waiting period, and the Company shall only be liable to pay the insurance benefits for the insured event that occurs after the waiting period.

The waiting period of this Policy does not apply to the coverage for the insured under Article 17 "Successive Coverage" of this Policy. In the event of renewal of this Policy, there is no waiting period for the insurance liability. However, if the waiting period of any insured person has not yet expired at the time of renewal, the Company shall be liable to the insured person from the day

following the expiry date of the waiting period.

**Article 17 Successive Coverage**

Where any insured person has been insured by a **previous policy**, if any existing **disability** of the insured person while he/she is covered under this Policy could have been covered under the **previous policy** in the event that the **previous policy** is still valid, provided that the Policyholder informs the Company of the said **disability** in writing when applying for this Policy for the insured person and subject to the Company's written acceptance, coverage for the said **disability** of the insured person shall continue under this Policy.

**Article 18 Insuring Agreement**

The benefits of this Policy consist of basic benefits and optional benefits. The Policyholder may either only apply for basic benefits or apply for optional benefits along with basic benefits, **but shall not apply for optional benefits alone. The Company is not liable for the benefits marked "not covered" and each item under the corresponding benefit (or itemized charges and the combination thereof) in the Benefits Schedule.**

Under this Policy, the Company shall be liable for the reasonable and medically necessary charges incurred by any insured person during the **period of insurance** and within the scope of cover **up to the sum insured or limits and the number of claims (e.g. the number of claims submission and the number of consultations), the number of days (e.g. the days of coverage and the days of hospitalization, deductible, ratio(e.g. co-payment ratio and indemnity ratio) and period applicable to each benefit and each covered item under the corresponding benefit (or itemized charges and the combination thereof) as stated in this Policy, provided that the aggregate payment for all benefits and covered items (or itemized charges and the combination thereof) shall not exceed the total sum insured stated in this Policy.**

During the valid term of this Policy, the Company shall, subject to the terms and conditions of this Policy, be liable for the following:

**I. Coverages**
**(I) Hospitalization medical treatment benefit**

**1. Hospitalization and day surgery and parental accommodation (basic benefit)**

**(1) Hospitalization and day surgery costs**

If any insured person is required to be **hospitalized** or receive day surgery in a **medical institution** as diagnosed by the attending physician due to **covered disability**, the Company shall be liable for the following reasonable and medically necessary charges incurred by him/her during hospitalization or day confinement:

1) Room and board charges (including general nursing care), **but excluding the cost of personal items purchased during hospitalization and any private nursing care costs;**
2) Surgical cost, operating room and anesthesia recovery room costs, anesthesia fees, intensive care unit fees, intensive care nursing fees;
3) Pathological examination fee, imaging examination fee, diagnostic test and examination fee, including but not limited to the fees of X-ray fluoroscopy, CT scanning, MRI, B ultrasound scanning, laboratory examination , etc;
4) The costs of medical supplies, blood and plasma, surgical equipment;

5) **Doctor** fees, including internists, surgeons(including consultation before operation and follow-up consultation after operation), anesthetist, specialists, radiologists, physiotherapists and pathologists fees, etc.;

6) The cost of reasonable and medically necessary rehabilitation treatment recommended by the attending physician;

7) Ambulance fee.

8) Stem cell therapy hospitalization costs;

9) Reasonable and necessary hospitalization expenses other than those mentioned above, as set out in the Benefit Schedule.

**(2) Parental accommodation costs**

Where any insured person under the age of 18 must be **hospitalized** in a **medical institution** as diagnosed by the attending physician due to a **disability** and is required to be accompanied by his/her guardian, the Company shall be liable for the accommodation costs of an extra bed in the same **room** for his/her guardian **(no more than one person)** staying with him/her during **hospitalization**.

**2. Pre-hospitalization benefit (optional benefit)**

If any insured person is **hospitalized** or receives day surgery for treatment of a covered disability as stated in this Policy, the Company shall be liable for the reasonable and medically necessary charges incurred in the **medical institution** directly related to the covered **hospitalization** within the agreed number of days prior to the **hospitalization** or day surgery (including the day of admission or day surgery, subject to that set forth in the **Benefit Schedule**) **(but excluding the charges of special outpatient treatment, day surgery and emergency medical treatment).**

**3. Post-hospitalization Benefit (optional benefit)**

If any insured person is **hospitalized** for treatment of a covered **disability** as stated in this Policy and immediately receives treatment from a **physician** or medical services as instructed by a physician, the Company shall be liable for the reasonable and medically necessary charges incurred for the said **physician**'s treatment or medical service as a direct consequence of the **hospitalization** within the agreed number of days after discharge (including the day of discharge) **(but excluding the charges of special outpatient medical treatment, day surgery, global emergency medical treatment, and the medical services sought by the insured person outside the covered territory which is otherwise locally available, and excluding the charges of the medical services that can be postponed without permanent damage to life or health according to the opinion of the attending physician)**.

**4. Private nursing benefit during and after hospitalization (optional benefit)**

**(1) Private nursing during hospitalization**

If any insured person is **hospitalized** for treatment of a covered **disability** as stated in this Policy, and indeed needs private nursing for treatment of a special condition after **admission** as confirmed by the attending **physician**, the Company shall be liable for the reasonable and medically necessary private nursing costs incurred thereby during **hospitalization**.

**(2) Private nursing after discharge**

If any insured person is **hospitalized** or receives day surgery as stated in this Policy due to a covered **disability**, and indeed needs private nursing for treatment of a special condition provided by a **registered nurse** after discharge or day surgery as confirmed by the attending **physician**, the Company shall only be liable for the reasonable and medically necessary home nursing costs

incurred thereby after discharge or day surgery.

### 5. Medical auxiliary equipment benefit (optional benefit)

The Company is liable for the costs incurred by the Insured for using the following reasonable and medically necessary auxiliary equipment during **hospitalization, day surgery** or outpatient treatment (as set forth in the Benefit Schedule) as stated in this Policy due to a covered **disability**. The specific limitations (including, but not limited to, amounts or limits of coverage) applicable to the covered expense item or sub-expense items shall be subject to the **Benefit Schedule**:

(1) Built-in prosthesis, equipment and device: the cost of implanting prosthesis, equipment and device which is medically necessary and in line with common medical practice during the above treatment(including surgery);

(2) External prosthesis, equipment and device: the cost of using the external prosthesis, equipment and device, services associated with the selection, fitting or repair that is medically necessary and in line with common medical practice during the above treatment, provided that such external prosthesis, equipment and device should be needed immediately after surgery or for a short time during the recovery period. Under this benefit, the liability assumed by the Company is up to the corresponding limit stated in the Schedule. Under this benefit, **for the insured person aged under 18 years old, the Company is liable for the cost of initial installation and two replacements of no more than one external prosthesis, equipment or device during his/her period of insurance**;

(3) Crutches, wheelchairs and other equipment which mainly provide convenience for life.

### 6. Special disability benefit (optional benefit)

#### (1) Organ transplantation

If any insured person must undergo heart, liver, kidney, bone marrow, cornea, lung transplant surgery after being diagnosed by a **physician**, the Company will bear the direct surgery fee for removing such organ from the donor for the purpose of transplantation, but up to 30% of the total cost of organ transplantation treatment. **This benefit does not cover organ acquisition fees or the expenses incurred by the donor.**

The Company provides this benefit only when this benefit is set forth in the **Benefit Schedule**. **No other benefit under this Policy covers the cost of organ transplantation surgery.**

#### (2) Inpatient treatment for psychiatric or mental disorder

The Company bears the reasonable and medically necessary **treatment** costs and accommodation costs incurred by any insured person while receiving inpatient treatment in a **medical institution** due to psychiatric or mental disorder.

The Company provides this benefit only when this benefit is set forth in the **Benefit Schedule**. **No other benefit under this Policy provides coverage in connection with inpatient treatment for psychiatric or mental disorder.**

#### (3) AIDS/Human Immunodeficiency Virus (HIV)

If any insured person shows symptoms for the first time during the **period of insurance** and is diagnosed with a human immunodeficiency virus(HIV)-related **disease** by a specialist, including acquired immune deficiency syndrome(AIDS), AIDS-related syndromes and/or any mutation, derivation or variation thereof, the Company shall bear the reasonable and medically necessary expenses incurred therefrom (as set forth in the Benefits Schedule), **provided that the insured person enjoys 5 uninterrupted years of coverage for AIDS/human immunodeficiency virus(HIV)treatment costs or similar coverage under any medical insurance policy of the**

**Company before its initial effective date.**

The Company provides this benefit only when this benefit is set forth in the **Benefit Schedule**. **No other benefit under this Policy covers the AIDS/HIV treatment costs.**

**(4) Pregnancy complications hospitalization costs**

If any Insured has been diagnosed with pregnancy complications by the attending doctor during the period of insurance and has been diagnosed as having to be hospitalized in a medical institution, the Company shall be liable for the necessary and reasonable medical expenses actually incurred during her **hospitalization**, provided that the Company's aggregate indemnity amount for each and every case of pregnancy complications is up to the sum insured applicable to the Insured under the coverage as set forth in the **Benefit Schedule**. Multiple pregnancy complications arising from the same condition shall be regarded as one case.

**(5) Infertility medical expenses**

The Company is liable for reasonable and necessary medical expenses incurred by any Insured as a result of hospitalization or outpatient treatment (as set forth in the **Benefit Schedule**) for infertility. However, medical expenses related to assisted reproductive technology (including in vitro fertilization) and expenses related to Chinese herbal medicines, Chinese proprietary medicines, Chinese medicine extracts (including but not limited to aphrodisiacs and nourishments such as ginseng, sea horse, Lu Rong (velvet antler), Lu Bian (deer whip), etc.) will not be covered under this benefit.

**(6) Hospice care**

If any insured person accepts the physical, psychological, social and spiritual hospice and palliative treatment services provided by the legally established and officially registered hospice care service organization designated by the attending **physician** within his/her **covered territory**, the Company shall undertake reasonable and medically necessary expenses incurred due to the aforementioned hospice and palliative treatment services.

**(7) Outpatient Surgery or Invasive endoscopic examination**

If any Insured undergoes a reasonable and necessary surgical procedure or invasive endoscopy at the outpatient department of a medical institution for a covered disability, the Company will bear such Insured's expenses for doctor's diagnosis, imaging examination, pathology tests, medicines, accommodation and food, operation charges, dressings and surgical implants and two post-operation follow-up visits as a result of the treatment.

Under this benefit, the Company shall not be liable for any expenses incurred as a result of the following examinations and surgical procedures unless Outpatient Benefits are purchased: laryngoscopy, nasopharyngoscopy, otoscopy, outpatient skin and subcutaneous tissue surgery (except for surgery following a diagnosis of cancer).

**7. No-Claims hospitalization allowance**

If any Insured is hospitalized according to this Policy for a covered disability during the period of insurance, for the reasonable and necessary medical expenses incurred as a result of such treatment within the scope of the coverage under the Policy, if the Insured does not claim to the Company for the Hospitalization Medical Insurance Benefit under the Policy, but instead claims to the Company for the No-Claim Hospitalization Allowance under this Provision, the Company will pay the No-Claim Hospitalization Allowance based on the actual number of days of hospitalization and the Insured's corresponding daily Hospitalization sum assured as specified in the Benefit Schedule.

For multiple hospitalization treatments within the same Benefit Period, the total number of days

for which the Company will pay for under this benefit for any Insured's inpatient days shall be limited to the maximum number of days as specified in the Benefit Schedule.

For the same hospitalization treatment within the same period of insurance, if the Insured has already claimed for the Hospitalization Medical Insurance Benefit under this Policy, he/she shall not be allowed to claim for the No-Claim Hospitalization Allowance under this benefit. If the Insured receives a No-Claim Hospitalization Allowance under this benefit and then claims for the Hospitalization Medical Insurance Benefit under this Policy, the Company will deduct the No-Claim Hospitalization Allowance already paid by the Company from the corresponding Hospitalization Medical Insurance Benefit under this Policy.

**(II) Global emergency medical treatment benefit (optional benefit)**

The Company is liable for the following reasonable and medically necessary costs incurred by the Insured Person. Where any item under this benefit applies, the covered territory applicable to the Insured shall extend to the world:

**(1) Cost of ambulance for sudden illness and accidental injury**

The cost of the ambulance for sending the Insured Person to the local medical institution due to an accident and emergency condition;

**(2) Cost of treatment for sudden illness and accidental injury**

The cost of treatment in the emergency room due to accident and emergency needs;

**(3) Emergency dental treatment (due to accident)**

The Insured Person's teeth are damaged due to an **accident** and receive medically necessary analgesia, inspection, repair or restoration of the damaged teeth from a qualified dentist within 14 days after the accident, **provided that the damaged teeth must be originally healthy and natural teeth before the accident, provided further that the accident must occur during the coverage period and is not directly or indirectly caused by biting or chewing;**

**(4) Emergency Assistance Benefits**

(1) Emergency medical evacuation and repatriation

Where evacuation of the insured person is determined to be medically necessary for by the support service organization designated by the Company or its authorized representative due to a covered disability, the Company will arrange for evacuation of the insured person to the local or other nearby medical institutions that meet the treatment requirements; where the insured person completes the medically necessary treatment for the covered disability in the local area and intends to return to the place of residence set forth in his/her legal and valid certificate for subsequent treatment or recuperation, the Company will make arrangement to return the insured person to the place of residence, if his/her physical condition is suitable for returning to the place of residence and medical care or supporting medical facilities are required during the return process as determined by the support service organization designated by the Company or its authorized representative.

The support service organization designated by the Company or its authorized representative has the discretion to decide on the method of transport and return (including transportation vehicles) and the destination of transport based on the physical condition or treatment needs of the insured person and the advice of the insured person's attending **physician**. **The Company does not bear any related costs for the services not provided or arranged by the support service organization designated by the Company or its authorized representative.**

Evacuation and repatriation costs include the costs of transportation, medical care during

transportation and medical equipment and supplies arranged by the support service organization designated by the Company or its authorized representative. **The costs required for evacuation and repatriation shall be paid directly to the support service organization designated by the Company after verification and confirmation by the Company. The total amount of the costs is up to the sum insured applicable to the insured person under this benefit. If the actual amount of the costs exceeds such sum insured, the excess shall be borne by the insured person.**

(2) Cost of compassionate visit

If the Insured is medically determined by the Company's designated rescue service agency or its authorized representative as requiring hospitalization for a covered disability, and the estimated period of hospitalization exceeds the number of days as provided in the Benefit Schedule, or if the necessary treatment is completed and the Insured returns to his/her place of residence, the Company will bear any one or more of the following expenses incurred by an adult relative or friend (hereinafter referred to as the "compassionate visitor") of the Insured who travels to the place where the Insured is being treated for compassionate visits during the period of treatment, the specific items under this benefit shall be subject to the Benefit Schedule:

① The expense of a one-way or round-trip economy class flight ticket(s) for the compassionate visitor to the Insured's place of treatment, capped at the cost of the economy class airfare at the same time if other transportations are utilized;

② Lodging expenses at the Insured's place of treatment. The Company shall indemnify the compassionate visitor for the actual lodging expenses, subject to the aggregated maximum number of days of indemnity, limit of indemnity, and daily limit of indemnity as provided in the **Benefit Schedule**;

③ The transportation expenses between the airport, port, or other transportation hub and the place of lodging or medical institution after the compassionate visitor's arrival at the place where the Insured is being treated;

④ Local transportation expense for compassionate visitor to and from the place of lodging to the **medical institution**.

(3) Repatriation of mortal remains

Where the insured person is deceased during the **period of insurance** due to a covered disability, the support service organization designated by the Company or its authorized representative will arrange for repatriation of the remains. The support service organization designated by the Company or its authorized representative will arrange for such repatriation based on the actual local conditions. The costs required for the return of the remains, including the costs of materials and services such as corpse embalmment, preservation, cremation, transportation and cremation urn, shall be paid directly to the support service organization designated by the Company after verification and confirmation by the Company. **The total amount of the costs is up to the sum insured applicable under this benefit. If the actual amount of the costs exceeds such sum insured, the excess shall be paid by the insured person's heir. The Company does not bear any related costs for the services not provided or arranged by the support service organization designated by the Company or its authorized representative.**

(4) Travel expenses for funeral handling

If the death of the Insured occurs for a covered disability during the period of insurance, resulting in a person traveling to the place of death of the Insured to deal with funeral-handling related affairs, the Company shall bear the cost of a one-way or round-trip economy class flight ticket to the place of death of the Insured incurred by the person and the cost of the actual accommodation incurred in the place of death of the Insured, of which the maximum amount of actual accommodation expenses shall be subject to the number of days and the daily limit of indemnity set out in the Benefit Schedule.

(5) Repatriation expense for accompanying relatives

If any Insured's relative (including spouse and children) traveling with the Insured terminate the same trip due to sudden illness, accidental injury or death of the Insured, and the Company's designated rescue service agency or its authorized representative determines that transportation (or repatriation) or repatriation of remains is medically necessary, the Company shall bear the cost of a one-way economy class flight ticket for the Insured's relative's return to the Insured's country of nationality or residence as a result of the termination of the trip with the applicable limit of indemnity and the number of Insured's relative to be indemnified as provided in the **Benefit Schedule**.

(6) Expenses for condolence visits

If any immediate family member of the Insured in the Insured's country of nationality or residence dies or becomes critically ill during the Insured's trip, resulting in the Insured going to the place of death or critically ill to offer condolences or visit, the Company's designated rescue service agency or its authorized representative will arrange for an appropriate transportation for the Insured to go to the place of death or critical illness of its immediate family member from the place where the Insured is travelling. The actual transportation cost incurred for the foregoing purpose shall be paid directly to the Company's designated rescue service agency after verification by the Company, provided that the actual transportation cost borne by the Company shall not be more than the cost of an economy class flight ticket at the same time, and that, for any Insured, the cost borne by the Company under this Benefit shall be no more than the cost of the one-way or round-trip transportation and the limit of indemnity as set out in the Benefit Schedule.

**(III) Special outpatient benefit (optional benefit)**

**1. Oncology**

If any insured person shows symptoms for the first time within his/her covered territory after the waiting period and is diagnosed as tumor by a specialist, the Company is liable for the reasonable and medically necessary outpatient treatment costs incurred by the insured person for receiving **chemotherapy, radiotherapy**, **tumor immunotherapy**, **tumor-targeted drugs therapy**, **tumor endocrine therapy**, and **proton heavy ion therapy** in a **medical institution**.

**2. Kidney dialysis**

If any insured person must receive **kidney dialysis** outpatient treatment at a **medical institution** as diagnosed by a **physician** after the waiting period within his/her covered territory due to **illness**, the Company shall be liable for the reasonable and medically necessary outpatient **kidney dialysis** expenses incurred thereby.

The Company provides coverage under this section only when this benefit is included in the **Benefit Schedule**. **No other type of benefit under this Policy provides coverage in connection with kidney dialysis.**

**3. Outpatient treatment for psychiatric or mental disorder**

The Company bears the reasonable and medically necessary treatment costs incurred by any insured person for receiving outpatient treatment in a **medical institution** due to psychiatric or mental disorder.

The Company provides this benefit only when this benefit is set forth in the **Benefit Schedule**. **No other benefit under this Policy provides coverage in connection with outpatient treatment for psychiatric or mental disorder.**

**4. Other Special Outpatient Medical Expenses**

The Company will bear reasonable and necessary medical expenses incurred by any Insured for

outpatient treatment at a medical institution for any other special disabilities, and the specific covered disability under this benefit shall be subject to the Benefit Schedule.

**(IV) Expenses for health examinations and vaccinations (optional benefit)**
The Company will bear the expenses incurred by any Insured for the following reasonable and necessary health examinations or vaccinations at a medical examination facility or outpatient or inpatient department of a medical institution (the specific coverage under this benefit shall be subject to the Benefit Schedule):

1. Routine Medical check up

2. Adult Preventive Screening

Mammography for female, pap smear for female, prostate screening for male, adult routine examination, neonatal routine examination, cancer screening, family medical history screening, and other covered health examinations, and the specific covered health examinations shall be subject to the Benefit Schedule.

3. Vaccinations

Routine vaccinations, travel vaccinations, child vaccinations and other covered vaccine programs, subject to that set forth in the Benefit Schedule.

**(V) Maternity Benefit**

1. Maternity Medical Expenses

If any insured person starts pregnancy after the agreed corresponding waiting period, the Company shall be liable for the necessary and reasonable prenatal and postnatal diagnosis and treatment costs, termination of pregnancy costs, and childbirth costs (including hospital and physician fees), medical expenses for pregnancy complications and baby nursing expenses for a maximum of 7 days from the date of birth of the newborn, provided that the Company's aggregate indemnity amount for each and every case of pregnancy is up to the sum insured applicable to the insured person under this Policy

Under this benefit, the medical expenses for pregnancy complications liable by the Company shall not include any hospitalization costs covered under the Hospitalization Module for pregnancy complications.

2. No-Claim maternity allowance

If any Insured’s child/children born during the period of insurance becomes an additional Insured as agreed in the Policy, and the reasonable and necessary maternity medical expenses is covered under the Policy, but the Insured does not claim to the Company for the maternity medical insurance benefit under the Policy, but instead claims to the Company for the No-Claim Maternity Allowance under this benefit, the Company will pay the No-Claim Maternity Allowance per delivery and the Insured's corresponding Maternity Insurance Allowance per pregnancy as set out in the Benefit Schedule.

If the Insured has already applied for the Maternity Medical Insurance Benefit under the Policy for the same maternity medical treatment within the same period of insurance, the Company will not pay the No-Claim Maternity Allowance as provided under this benefit; if the Insured receives the No-Claim Maternity Allowance under this benefit and then applies for the Maternity Medical Insurance Benefit under the Policy, the Company will deduct the No-Claim Maternity Allowance that has already been paid prior to the corresponding Maternity Medical Insurance Benefit payable under the Policy.

**II. Extension of hospitalization benefit**

If any insured person is **hospitalized** as stated in this Policy for treatment of a covered **disability**

during the **period of insurance**, but has not been discharged from the hospital upon expiration of the **period of insurance**, the Company shall be liable for the **hospitalization** charges incurred by the insured person from the expiry date of the **period of insurance** to the date of first discharge, but **up to a maximum of 90 days. The benefit for such hospitalization shall be included in the period of insurance into which the date of admission falls, and the cumulative payment is up to the maximum sum insured or number of services in the corresponding period of insurance of each charge item.**

**III. Claim payment standard**

**The deductible (if any) set forth in the Policy Schedule shall apply when the Company reimburses the covered medical charges. The Company shall not be liable for the said charges less than the deductible (if any). If the said charges reaches the deductible (if any), the Company shall be liable for indemnity as per the applicable indemnity ratio set forth in the Policy Schedule after application of the deductible (if any). Unless otherwise stated in this Policy, the deductible stated in this Policy for any insured person will apply to each and every benefit and each and every covered charge (or itemized charges and the combination thereof) that the insured person enjoys under this Policy.**

For the medical expenses insured by the insured person **in the territory of** China, if the insured person has and has received reimbursement from public medical insurance, social basic medical insurance or other expense-reimbursement medical insurance, the Company shall determine the limit of claim payment of the corresponding sum insured for the insured person under this Policy set forth in the Policy Schedule or Benefit Schedule as follows:

(1) If the insured person has no public medical insurance, social basic medical insurance, or other expense reimbursement medical insurance, or the insured person has never received reimbursement from public medical insurance, social basic medical insurance, or other expense-reimbursement medical insurance, the Company shall make the claim payment up to the ninety eight percent (98%) of the corresponding sum insured for the insured person under this Policy set forth in the Policy Schedule or Benefit Schedule;

(2) If the insured person has and has received reimbursement from public medical insurance, social basic medical insurance or other expense reimbursement medical insurance, the Company will determine the claim payment according to the following formula up to the corresponding sum insured for the insured person under this Policy as set forth in the Policy Schedule or Benefit Schedule:

**Medical expense reimbursement = (Medically necessary and reasonable actual medical expenses incurred in a medical institution - Any medical expense reimbursement received – Applicable Deductible as set forth in the Policy Schedule) × Applicable coinsurance percentage ratio**

The above "any medical expense reimbursement received" includes the medical expense reimbursement received from public medical insurance, social basic medical insurance, all commercial expense reimbursement medical insurance, other government agencies or social welfare agencies.

## Chapter IV Exclusions

**Article 19 Exclusions**

**The Company shall not be liable for any costs incurred during the following periods or caused by the following reasons, or under any of the following circumstances:**

**1.** **Related costs arising from pre-existing disabilities,** unless disclosed to and accepted in writing by the Company;

**2.** **Care or treatment for which payment by the Policyholder or the insured person**

**is not required or to the extent which is payable by any other insurance, policy or indemnity, including but not limited to accidental injury, illness or disease covered by work-related injury insurance or other insurance.**

**3.** **Routine medical examinations or check-ups, check-ups for employment or travel, routine eye or ear examinations, vitamins, nutritional supplements, vaccinations, medical certificates, chelation therapy**(except for heavy metal poisoning), **hydro colon therapy, counseling, Custodial or Maintenance Care, rest cures, and homey ward or treatment, or services or treatment received at any nonmedical institution,** unless explicitly stated in the **Benefit Schedule** as being covered by this Policy;

**4.** **Medical charges incurred for prevention, health care and other non-medical treatment, including but not limited to inpatient medical examination, smoking cessation treatment, medical identification or certification, genetic testing, tattoos, etc, unless explicitly stated in the Benefit Schedule as being covered by this Policy;**

**5.** **Dental treatment, treatment of disorders of the temporomandibular joint, periodontal treatment, damage to dentures when not worn, cosmetic surgery and plastic surgery not caused by an accident, except for the costs of emergency repairs after tooth damage caused by an accident and breast remodeling after treatment of malignant tumors;**

**6.** **Any diseases, tests, treatments related to infertility, assisted conception, surrogacy, impotence or erectile dysfunction, contraception, sterilization, sterilization reversal surgery, male and female birth control, vasectomy or repair, artificial insemination, trans-sexual treatment or surgery, birth defects, congenital diseases, hereditary conditions, developmental abnormalities, behavioural or developmental disorders, or abortion for psychological or social reasons, and the consequences thereof;**

**7.** **Pregnancy (including ectopic pregnancy), miscarriage (including miscarriage and induced abortion caused by any reason whatsoever) or childbirth (including caesarean section and pre-natal and post-natal examination or care) and any pregnancy complications, unless explicitly stated in the Benefit Schedule as being covered by this Policy;**

**8.** **Orthoses and durable medical equipment; treatment that is either not part of Western (allopathic) medicine (except for the medical benefits that is explicitly stated in the Benefit Schedule as covered by this Policy), or which is not medically necessary, or complications or disabilities consequential thereupon;**

**9.** **All costs relating to human cornea, bone marrow, muscular, skeletal, or tissue transplant from a donor to a recipient and all expenses directly or indirectly related to Organ Transplantation (including conditions requiring or likely to require transplantation and post transplantation conditions), unless the organ transplantation expenses are explicitly stated in the Benefit Schedule as being covered by this Policy;**

**10.** **Examination or treatment arising from mental factors, psychological factors, mental and nervous conditions and any physical or psychological causes or manifestations (except for those stated in the Benefit Schedule as covered by this Policy), self-mutilation, suicide or suicide attempt, deliberate exposure to an unusually dangerous environment (except for the purpose of saving lives), excessive drinking, smoking or drug abuse, sleep disorders, learning difficulties, behavioral disorders, venereal diseases;**

**11.** **Any treatment or test of human immunodeficiency virus(HIV)-related illness(including AIDS and AIDS-related syndromes (ARC) and/or any mutation, derivation or variation thereof), except for AIDS/HIV costs explicitly stated in the Benefit Schedule as being covered by this Policy. (The above definition is subject to the definition set by the World Health Organization. If the above virus or its**

**antibody is found in the blood sample of the insured person, the insured person shall be deemed to have been infected by the virus);**

**12.** **Experimental or pioneering diagnosis and treatment technology that has not been approved or licensed by the medical and health regulatory agency of the country where the medical behavior occurs, except for those that obtained written consent by the Company in advance;**

**13.** **Medical services that are not recommended and prescribed by the insured person's attending physician, except for a second medical opinion service before surgery, and the continuing treatment after the insured person's original attending physician has referred the insured person to another physician or specialist;**

**14.** **Refractive defects of the eye (such as myopia, hyperopia, astigmatism), and any optometry, optics, vision correction, or glasses purchase (including but not limited to frame glasses, monocles, or contact lenses);**

**15.** **Medical treatment arising from injury as a result of participation in any professional or semi-professional sports, driving or taking non-commercial flights, diving(with a depth of greater than 30 meters), skydiving, rock climbing, bungee jumping, driving a glider or paraglider, adventure activities, martial arts competitions, wrestling competitions, stunt performances, horse racing, car racing and other high-risk sports;**

**16.** **Disabilities arising from the police or military service with any country or international organization, or participation in war, civil war, invasion, riot, revolution, use of armed forces, usurpation of political or military power, any known or suspected terrorist activities or any illegal activities. Any medical services received by the insured person while in prison, detention center, any other correctional facility (including reintegration school or similar facilities), or any psychiatric institution;**

**17.** **Exposure to any kind of ionizing radiation or radioactive pollutants;**

**18.** **Rehabilitation , recovery and follow-up monitoring hospitalization where the Company's medical consultant believes that the insured person can be properly treated through outpatient clinic without hospitalization;**

**19.** **Travel expenses incurred for the sole purpose of receiving medical services (except for the approved emergency medical escort services), and all emergency medical transfer services without prior approval of the Company or its designated rescue service organization or its authorized representative;**

**20.** **Any expenses not reasonable and medically necessary;**

**21.** **Any medical expenses not incurred during the period of insurance, as well as the disability that is examined during the waiting period but diagnosed after the waiting period;**

**22.** **Any nourishing Chinese herbal medicines and various alcoholic preparations thereof and brewing fees, ointment fees, and pharmaceutical-related expenses (except for those covered by this Policy);**

**23.** **Outpatient medical expenses, except for those stated in the Benefit Schedule as covered by this Policy;**

**24.** **Medical treatment caused by or arising from terrorist activities using or threatening to use nuclear weapons, nuclear devices or biochemical preparations;**

**25.** **Medical expenses incurred by the insured person for driving under the influence of alcohol or driving without a legal or valid driving license;**

**26.** **Medical expenses beyond the maximum number of covered days of hospitalization or care as stated in this Policy;**

**27. Medical expenses incurred outside the covered territory as stated in this Policy, unless otherwise stated in this Policy;**

**28. Nursing care of newborns in medical institutions, unless otherwise stated in this Policy;**

**29. Failure to obtain the certificate issued by a medical institution or physician;**

**30. The usage of non-medically necessary robotic surgery which can be replaced by a conventional surgery;**

**31. Medical expenses incurred by services performed by medical institutions owned by you, your parents, your children, or any entity in which you, your parents, or your children either are an employee or director or have a greater than 1% ownership interest.**

## Chapter V Premium

### Article 20 Determination of Premium

The premium under this Policy is determined according to the **covered territory**, insurance plan and the age and risk profile of the insured person defined at the time of application and is agreed upon by the Policyholder and the Company at the time of application and stated in the Schedule.

### Article 21 Payment of Premium

The Policyholder shall pay the premium assessed by the Company in one lump sum within the time limit stated in this Policy.

### Article 22 Renewal Premium

The renewal premium is calculated as per the rates approved by the Company then according to the age of the insured person at the time of renewal and other risks covered by this Policy. In case of any change, the Company will notify the policyholder in writing. If the Company has explicitly decline renewal, the Company will refund the renewal premium paid without interest.

## Chapter VI Cancellation and Termination of the Policy

### Article 23 Duty of Disclosure and Policy Validity

The Policyholder or the Insured Person(s) shall provide truthful information in response to written inquiries by the Company.

**(1) If any intentional withholding of the truth, when discovered, is sufficient to affect the judgment of the Company in deciding whether to provide coverage or increase the premium rate, the Company have the right to terminate this Policy based on relative laws without any refund of the premium, no matter whether a covered Accident and Illness has occurred or not at the time of such discovery. The Company shall not be liable for any otherwise covered Accident and Illness which has occurred prior to the termination of this Policy. If such intentional withholding is sufficient to affect the judgment of the Company in deciding whether to provide coverage to one Insured Person, the eligibility of the Insured Person shall be terminated, and the Company shall not be liable for any otherwise covered Accident and Illness which has occurred prior to the termination of his/her eligibility.**

(2) If any withholding of the truth due to gross negligence, when discovered, is sufficient to affect the judgment of the Company in deciding whether to provide coverage or increase the premium

rate, the Company have the right to terminate the policy based on relative laws, no matter whether a covered Accident has occurred or not at the time of such discovery, and the Company will refund the premium without interest. If such withholding is sufficient to affect the judgment of the Company in deciding whether to provide coverage to one Insured Person, the eligibility of the Insured Person shall be terminated and the Company will refund the premium of this Insured Person without interest. **If such withholding has a material impact on a covered Accident and Illness which occurred prior to the cancellation of the Policy or loss of eligibility, the Company shall not be liable for this Accident and Illness.**

(3) If any withholding of the truth is sufficient to affect the judgment of the Company in deciding whether or not to increase the premium rate and the Company agree to continue to provide coverage, the Policyholder shall pay additional premiums accumulated as of the effective date of this Policy together with the interest accrued thereon [Note].

[Note] The interest is calculated at the interest rate as agreed in this Policy.

**Article 24 Cancellation of the Policy**

The Policyholder may cancel this Policy by giving written notice to the Company at least thirty days in advance after the cooling-off period during the valid term of this Policy. This Policy shall terminate at 24 o'clock on the termination date stated in the written notice. If the Policyholder cancels the policy according to the foregoing provision, the Company will refund the **unearned net premiums** paid by the Policyholder under this Policy on a daily basis.

If the insured covered by this Policy has a change in occupation/occupation class/area of cover o/country of residence, or the insured is subject to sanctions by relevant international organizations or countries, which affects the basis of the Company's acceptance. The Company may cancel this Policy by giving a thirty-day written notice within during the valid term of this Policy. This Policy shall terminate at 24 o'clock on the termination date stated in the written notice. The written notice shall be sent to the insured person's residence address or mailing address by hand or other similar means. The Company will refund the **unearned net premiums** on a pro-rata daily basis.

**Article 25 Termination of the Policy**

This Policy will automatically terminate under any of the following circumstances:

(1) The insured person has no intention to renew this Policy or the Company does not accept the renewal at the expiration of the period of insurance;

(2) This Policy terminates due to the circumstances set forth in other terms.

Note: Under the circumstance mentioned in Item (1), this Policy will automatically terminate at 24:00 on the expiry date of the period of insurance.

## Chapter VII Request for Benefits

**Article 26 Pre-authorization**

Before receiving any of the following treatments or medical items, the Policyholder or the insured person concerned shall apply to the Company for pre-authorization 5 days in advance via the service hotline. **Obtaining pre-authorization does not necessarily mean the Company will be liable for the treatment or medical items involved under this Policy.** "Pre-authorization" refers to the determination of the necessity of treatment or medical items on a preliminary basis of in principle by the Company based on the completeness and accuracy of the data provided by the Policyholder or the insured person insured. Only when the Policyholder or the insured person complies with the provisions of this Article, the Company shall be liable under this Policy. The Company has the

discretion to question, challenge and withdraw the necessity of previous treatment based on the relevant information obtained.

1. Any hospitalization, surgery, day care (if applicable) or childbirth;
2. The use of any medical auxiliary equipment;
3. Any outpatient emergency examination and treatment items with unit price above RMB 8,000 (such as those covered by a rider) and emergency medical expenses in the **covered territory**;
4. Emergency medical treatment outside the **covered territory**;
5. Chemotherapy, radiation therapy, blood or peritoneal dialysis received for the first time(if applicable);
6. Mental illness treatment;
7. Hospitalization for treatment of AIDS/infected human immunodeficiency virus;
8. Emergency rescue;
9. Treatment outside the network hospitals (if applicable).
10. Other applicable items that require pre-authorization as set forth in the Policy Schedule.

If the insured person fails to apply for pre-authorization in a timely manner in case of emergency, the insured person shall notify the Company within 48 hours after starting to receive the above-mentioned treatment or medical items. **If the insured person fails to notify the Company within the given time limit without obtaining pre-authorization or in case of emergency before receiving the above-mentioned treatment or medical items, the Company has the discretion to pay a benefit in the amount equivalent to the amount calculated according to the claim payment standard multiplied by 60% with respect to the reasonable and medically necessary expenses incurred by the insured person,** except where the insured person fails to apply for pre-authorization in advance or notify the Company in time due to **force majeure**.

**Notwithstanding the foregoing, the Policyholder may negotiate with the Company at the time of placement to determine whether the treatment or medical items covered under the defined insurance plan apply to all or some of the above pre-authorization requirements, and set it out in the Policy Schedule or Benefit Schedule.**

**Article 27 Notification of Claims**

Except for the circumstances set forth in Article 26"Pre-authorization" of this Policy, the Policyholder and the insured person shall notify the Insurer in time after knowing that an claim has occurred.

**If any Insured Person fails to notify the Company, whether intentionally or due to gross negligence, the Company shall be under no obligation to make payment for any Loss to the extent that the Company is unable to ascertain its nature, cause, and degree** unless the Company, through other means has known or should have known, about such information notwithstanding the absence of notification by the Insured Person.

**Article 28 Duties of Claim Prevention**

**The insured person shall take any and all reasonable steps to prevent and reduce the occurrence of any accidents, bodily injuries, disabilities or the expenses thereof.**

**Article 29 Supporting Documents/Claim Application**

Upon occurrence of an accident, when the insured person (in the case of a minor, his/her parents or other guardians)file a claim to the Company, the insured person shall fill out the claim form and provide the following original supporting documents to the Company so as to apply for benefits under this Policy:

1. Outpatient and emergency medical records, diagnoses, and prescriptions
2. Inpatient medical records or hospitalization summary;
3. Original invoices, receipts, letters and complete cost itemization of treatment costs;
4. Medical report, examination report or other information about the insured person's condition;
5. Other materials related to this application that the insured person can provide.

If the insured person entrusts another person to file a claim, it shall also provide the original letter of authorization, identity certificates of the principal and the trustee and relevant documentary evidence.

If the Company determines that the claim information is incomplete, it shall promptly request additional information from the insured person at one time.

If the insured person cannot provide the aforesaid supporting documents for special reasons, he/she shall provide other relevant supporting documents recognized by law to file a claim. **If the insured person fails to provide relevant materials, as a result of which the Company is unable to verify the authenticity of the claim, the Company shall not be liable to pay for the portion of the claim that cannot be verified.**

**Article 30 Cooperation in Investigation**

Upon occurrence of an accident to the insured person, the Company shall have the right to conduct an investigation on the insured person's physical condition or degree of injury, including but not limited to questionnaire, physical examination, medical examination, investigation, evaluation and identification. In handling the claims concerning this Policy, the insured person is obliged to cooperate fully and obtain and provide all medical reports, records and related data as required by the Company, and shall allow the company to access a complete and comprehensive medical history, including but not limited to the medical records and reports of the treatment. If the insured person dies, the Company shall have the right to request identification of the insured person, unless otherwise prohibited by law.

If the insured person receives medically necessary examination as required by the Company, the cost shall be borne by the Company.

**Article 31 Direct Payment**

If the insured person receives treatment at the network hospital as stated in this Policy, the Company shall directly settle with the medical institution concerned the portion of the covered costs incurred by the insured person to be borne by the Company, which do not need to be advanced by the insured person.

**Even in the case of direct billing, the Company is not liable to advance any expenses within the deductible amount as stated in this Policy,** and the insured person is still obligated to settle the expenses with the medical institution.

If the insured person receives treatment for any **disability** not covered by this Policy, the insured person is obligated to bear and pay all the corresponding treatment costs. **If any insured person receives treatment at the network hospital stated in this Policy, the insured person shall return**

**the medical expenses incurred by the insured person which are not covered by this Policy and should be borne by the insured person but not charged by the medical institution from him/her within 30 days after receiving notice from the Company or its authorized organization; otherwise, the Company shall terminate the cover for the insured person without refund the premium, and the Company shall have the right to continue to recover the corresponding amount from him/her.**

**Article 32 Assessment of Claims and Payment of Benefits**

Upon receipt of the Insured's request for indemnity and complete claim materials, the Company will make a decision in a timely manner. In complicated cases, unless otherwise agreed in this Policy, the decisions shall be made within 30 days.

The Company shall notify the insured person of the result of the assessment; if a claim is covered, the Company shall perform the obligation of claim payment within 10 days after reaching an agreement on such payment with the insured person. If there is an agreement on the time limit for claim payment in this Policy, the Company shall perform the obligation to make claim payment in accordance with the agreement. After the Company makes the assessment in accordance with the preceding paragraph, if a claim is not covered, a notice of refusal to payment of insurance benefit specifying the corresponding reasons shall be sent to the Insured within the time limit provided by law from the date of the decision.

**Article 33 Obligation of Advance Payment**

If the Company cannot determine the amount of the payment within 60 days from the date of receipt of the claim and the relevant certificates and information, the Company will advance the amount that can be ascertained based on the existing certificates and information; after finally determining the amount payable, the Company will pay the corresponding difference.

**Article 34 Right of Recourse**

**In the event that authorization of payment and/or payment is made by the Company for a claim which is not covered under this Policy or when the corresponding sum insured is exceeded, the Company reserves the right to recover the said sum or excess from the insured person or the Policyholder, and has the right to directly deduct the previous overpaid amount of the insured person's other claims payment under this Policy.**

**Article 35 Exchange Rate of Benefit Payment**

If a foreign currency needs to be converted into RMB in claim payment, the exchange rate applicable when the Company makes payment shall be subject to the middle rate of RMB exchange rate published by the People's Bank of China on the day when the insured person fills out the claim form.

**Article 36 Limitation of Action**

The limitation of action for the relevant insured under this Policy to request compensation or payment of benefits from the Company is subject to the provisions of applicable law, starting from the day when he/she knows or should know that a claim occurs.

## Chapter VIII Miscellaneous

### Article 37 Dispute Resolution

If any dispute arises from the performance of this Policy or its riders, it shall be settled by either of the following two methods at the option of the parties subject to the terms and conditions of this Policy:

1. Any dispute arising from the performance of this Policy or its riders shall be resolved through negotiation by the parties. Should the negotiation fails, it shall be submitted to the arbitration committee agreed by the parties for arbitration;
2. Any dispute arising from the performance of this Policy or its riders shall be resolved through negotiation by the parties. Should the negotiation fails, either party may bring a lawsuit before the people's court according to law.

### Article 38 Governing Law

This Policy and its riders shall be governed by the laws of the People's Republic of China (for the purpose of this insurance only, excluding any laws of Hong Kong, Macau Special Administrative Region and Taiwan).

### Article 39 Interpretation

**1. Benefit Schedule**

Means the policy document that sets out the benefits available to the Insured Person under this Policy and the sum insured or limits and other information in respect of these benefits.

**2. Territory**

Means the mainland of the People's Republic of China, excluding Hong Kong Special Administrative Region, Macao Special Administrative Region and Taiwan.

**3. Child/Children**

Means unmarried child/children of the Main Insured who is/are 15 days after birth or has been in good health after birth and is/are 15 days from the date of departure from the **medical institution** but less than 18 years old (age last birthday) (or 23 years old if he/she is enrolled full time in a school), including children born in wedlock, children born out of wedlock, legally adopted children, and dependant stepchildren.

**4. Disability**

Means an Illness or **Accidental Injury**, including any of its symptoms, sequelae, or complication thereof. In the case of **Accidental Injury**, it means all injuries arising from the same event or series of contiguous **accidents**.

**5. Unearned Net Premium**

Unless otherwise stated in the Policy, means the net unearned premium calculated at the charge for policy cancellation set out in the policy and the following formula:

Unearned Net Premium = Insurance premium × (1- charge for policy cancellation) × (1－the number of days of insurance elapsed/the number of days of period of insurance), if the number of elapsed days is less than one day, it is calculated as one day.

**6. Accident**

Means external, sudden, unintended, non-**disease**, unforeseen visible objective events.

**7. Accidental Injury**

Means a visible physical injury caused solely and directly by an Accident and independently of any

**illness.**

**8. Illness**

Means a physical condition marked by a pathological deviation from the normal healthy state.

**9. Period of Insurance**

Means the period of time shown on the **Benefit Schedule**, **Name List** or any endorsement during which cover applies.

**10. Covered Territory**

Means the areas stated in the Policy Schedule and **Benefit Schedule** for which corresponding premiums have been paid. If not specified, it means worldwide.

**11. Length of a Journey**

Means the number of calendar days elapsed from the date when the insured person leaves the covered territory or arrives at the international border of any country outside the covered territory to the date when he/she returns to the covered territory or leaves the international border of any country outside the covered territory.

**12. Sudden Illness**

Means an illness suddenly suffered by the insured person solely and only on the date when the insured person leaves the covered territory, including the acute attack of a covered chronic condition that is stable when the insured person starts traveling outside the covered territory, but excluding the circumstances where the insured person is receiving treatment when he/she starts traveling outside the covered territory, or an illness existed before the start of the travel outside the covered territory and the insured person should have sought treatment as a sane person, or the purpose of the insured person's travels outside the covered territory itself is to receive treatment, or the travel outside the covered territory itself is against the physician's instructions or medical advice.

**13. Hospitalization or Hospitalized**

Means admission in a medical institution as a registered bed patient for treatment of no less than 18 hours.

**14. Day Surgery**

Means admission to a daytime ward of a medical institution for treatment for medical reasons.

**15. Initial Effective Date**

Means the date when the insured person becomes eligible for coverage under this Policy or its non-consecutive renewals.

**16. Preceding Policy**

Means a medical insurance policy covering the insured person's illness or bodily injury which terminates on the day before the **initial effective date** of this Policy, and a copy of which has been provided to the Company upon application. This does not include a travel policy which covers illness or bodily injury arising during the journey, or a travel policy which covers a single journey.

**17. Medical Institution**

Means the establishment designated by the Company (as shown in the Policy Schedule or **Benefit Schedule**) or the establishment that meets all the following conditions:

(1) Has a legal business license;

(2) Has complete facilities for diagnosis and treatment of illnesses and injuries;

(3) Has qualified physicians and nurses to provide management guidance or provide hospital treatment and nursing services during normal business hours;

(4) Including private medical institutions and public hospitals with special-need wards, foreign guest wards, cadre wards, joint wards, international medical centers, VIP departments or other high-

level wards that are not covered by social medical insurance.

**The laboratory, gene company, rehabilitation hospital, nursing, convalescence, alcohol, drug addiction or similar medical institutions do not fall into the scope of medical institutions mentioned in this Policy.**

**18. Room**

Means a room classified according to the following criteria. If any medical institution has two or more types of rooms at the same level, the reimbursement shall be calculated as per the cost of the type of the room at such level with the largest number.

(1) Single room: one bed in each room;

(2) Double room: two beds in each room (regardless of whether it is fully occupied);

(3) Multi-person room: three or more beds in each room (regardless of whether it is fully occupied);

(4) Intensive Care Unit: A section within a Hospital which is designated as an Intensive Care Unit by the Hospital and which is operating on a twenty-four (24) hour basis solely for the Treatment of patients in critical medical condition and which is equipped to provide specialized nursing and medical services not available elsewhere in the Hospital. This definition also includes a Coronary Care Unit which has facilities not less comprehensive than those described above.

**19. Physician**

Means a person qualified as a medical practitioner (who has no blood relationship, in-laws or adoption relationship with the insured person concerned), who is licensed by the competent medical authorities of the country in which treatment is provided and who, in rendering Treatment, is practicing within the scope of his/her licensing and training.

**20. Psychiatric or mental disorder**

Means any conditions classified as mental, behavioral and neurodevelopmental disorders, neurological disorders (F01-F99) in the International Statistical Classification of Diseases and Related Health Problems (ICD-10), excluding behavioral and developmental disorders and the disorders listed in F50-F52, F55.

**21. Behavioural and developmental disorders**

Means the diseases listed in Items from F53 to F54 and from F59 to F98 of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) issued by the World Health Organization.

**22. Pregnancy complications**

Means conditions whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as acute nephritis, renal disease, cardiac function reimbursement disorder, abortion, ectopic pregnancy, puerperal infection, convulsive toxaemia, and similar symptoms of severe internal medicine and surgical diseases requiring hospitalization.

**23. Hereditary conditions**

Means diseases caused by mutations or aberrations in the genetic material (chromosomes and genes) of germ cells or fertilized eggs, usually characterized by vertical transmission from parent to offspring.

**24. Invasive endoscopic examination**

Means invasive examinations of arthroscopy, colonoscopy, cystoscopy, enteroscopy, laparoscopy, mediastinoscopy, sigmoidoscopy, thoracoscopy/pleuroscopy, upper gastrointestinal endoscopy and ureteroscopy.

**25. Immediate family member**

Means the Insured's parents, child/children, and spouse.

**26. Chemotherapy**

Means the treatment of tumors by intravenous chemotherapy or taking drugs in a medical institution to kill cancer cells and inhibit the growth and reproduction of cancer cells according to medical advice.

**27. Radiotherapy**

Means the treatment of irradiating tumor tissues with various energy rays in specialized departments of medical institutions in order to suppress and kill cancer cells according to medical advice.

**28. Tumor immunotherapy**

Means the therapy which applies immunological principles and methods, uses tumor immunotherapy drugs to increase the immunogenicity of tumor cells and sensitivity to effector cell killing, stimulate and enhance the body's anti-tumor immune response, and applies immune cells and effect or molecules to the host to cooperate with the body's immune system to kill tumors and suppress tumor growth. The tumor immunotherapy drugs mentioned in this Policy shall meet the requirements of laws and regulations and be approved by the State Food and Drug Administration for clinical treatment.

**29. Tumor-targeted Drug Therapy**

Means the therapy which designs corresponding targeted therapeutic drugs at the molecular level targeted at the identified carcinogenic point, uses specific carriers to selectively transport drugs or other active substances that kill tumor cells to the tumor site to attack cancer cells. The targeted drug mentioned in this Policy shall meet the requirements of laws and regulations and be approved by the State Food and Drug Administration for clinical treatment.

**30. Tumor Endocrine Therapy**

Means the endocrine therapy for malignant tumors which specifically uses drugs to inhibit hormone production and hormone response, kill cancer cells, or inhibit the growth of cancer cells. The drugs mentioned in this Policy shall meet the requirements of laws and regulations and be approved by the State Food and Drug Administration for clinical treatment.

**31. Poton Heavy Ion Therapy**

Means a type of radiotherapy for tumors, but the medical institutions carrying out it shall be subject to those set forth in the Policy Schedule.

**32. Kidney Dialysis**

Means hemodialysis.

**33. Newborn**

Means a baby that has vital signs when leaving the mother.

**34. Pre-existing Condition**

Means any of the following disabilities:

(1) Which existed before the **Initial Effective Date** of any insured person, where the Pre-existing Condition presented with signs or symptoms of which the insured person was aware or should reasonably have been aware;

(2) For which treatment or medication has been sought or received, or medical advice or diagnosis has been received in two years prior to the **Initial Effective Date** of the insured person;

(3) Which was already known by the insured person to exist prior to the **Initial Effective Date** of him/her, whether or not treatment, medication, advice, or diagnosis was sought or received.

**35. Cosmetic Treatment**

Means any cutting, thermal destruction, cold therapy, phototherapy or chemical treatment of body tissue in order to reshape or modify the normal structure of the body or appearance.

**36. Reconstructive Surgery**

Means cutting or thermally destroying the abnormal structural tissues of the body to improve the

function or bring it closer to the normal appearance, regardless of whether the structural abnormalities are caused by **congenital conditions** or **developmental abnormalities**.

**37. Assisted Conception**

Means the use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra-uterine insemination (IUI), In vitro fertilization (IVF), Intracytoplasmic sperm injection (ICSI) or the use of any treatment to induce or increase ovulation.

**38. Developmental Abnormality**

Means manifestations or symptoms relating to nutritional metabolism and development as classified under the International Classification of Diseases (ICD).

**39. Congenital Condition**

Means the physical deformities or mental abnormalities listed as congenital conditions in the International Classification of Diseases (ICD).

**40. Psychiatric and Mental Condition**

Means psychiatric, psychological, or emotional mental or behavioral disorders caused by any known or unknown physiological causes, subject to the International Statistical Classification of Diseases and Related Health Problems(ICD-10) issued by the World Health Organization.

**41. Venereal Disease**

Means a condition classified as a Venereal Disease in the International Classification of Diseases (ICD).

**42. Commercial Air Transport**

Means the fixed-wing aircraft operated by airlines or charter companies which hold the public transport operating licenses duly issued by competent government authorities, legally carry passengers for charge, and operate fixed flights, the helicopters operated by airlines between two fixed commercial airports or between licensed commercial helicopter stations, and any fixed airport buses operating on fixed routes and schedules.

**43. War**

Means any wars, whether declared or not, or any military activities by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

**44. Nourishments**

Means non-prescription drugs and equipment, smoking cessation drugs, appetite suppressants, hair regrowth drugs, anti-photoaging drugs, beauty products, high-dose vitamins, vitamins, health tonic Chinese herbal medicines, including but not limited to the following:

(1) Single or compound Chinese herbal medicines and herbs, including Lu Rong (velvet antler), HouZao (rhesus macaque bezoar), GouBao (the stone of a dog's gallbladder, kidney or bladder), sea horse, Hai Long (pipe fish), Ma Nao (agate), Dai Mao (carapaxeretmochelyos), Dong Chong Xia Cao (cordyceps), Ma Bao(horse bezoar), Niu Huang (calculus bovis), Shan Hu (Japanese coral), musk, antelope horn powder, Xi Jiao (rhinoceros horn), Yan Wo (cubilose), ginseng(except for radix ginseng), as well as various medicinal animal organs (except for JiNei Jin (endothelium corneumgigeriaegalli)) and fetus, whip, tail, tendons, bones;

(2) Chinese herbal medicines and medicinal materials used in single flavor, including donkey-hide gelatin, donkey-hide gelatin beads, Lu Jiao Jiao (deerhorn glue), Bie Jia Jiao (turtle carapace glue), San Qi (radix notoginseng), tortoise-shell glue, Gui Lu Er Xian Jiao (glue of the two ingredients tortoise plastron and antler), tortoise-plastron glue, saffron, radix ginseng, antelope horn powder;

(3) The medicines listed above include crude medicines and prepared slices and herbs, Chinese medicine patches, Chinese medicine fumigation, and ointment, and powders, pills, capsules,

gums, or other preparations made of Chinese herbal medicines, except those which are otherwise stated as being covered by this Policy.

**45. Force Majeure**

Means objective circumstances that are unforeseen, unavoidable and insurmountable.

**46. Name List**

Means the document identifying the Insured Person(s) covered under this Policy and the **period of insurance**, the benefit plan and the required premium for the Insured Person(s).

**47. Registered Nurse**

Means the nurses who have registered in the relevant practice with the local health authority where he/she practices.

(The End)

# AIG Insurance China Limited

(Hereinafter referred to as the Company)

# AIG General Outpatient Medical Insurance Rider

(1st Edition in 2024)

(Registration No.: C00003932522024090928283)

(This rider is not valid unless being applied for)

**Article 1 Conclusion of the Rider and Entire Rider**

*The AIG General Outpatient Medical Insurance Rider* (hereinafter referred to as this Rider) was concluded with the approval of the Company in accordance with the application of the Policyholder of the Policy. This Rider is formed dependently on the Policy, the terms and conditions of the Policy shall also apply to this rider. In case of any conflict between the terms of the Policy and the terms of this Rider, this Rider shall prevail.

If the benefits covered in this Rider are not stated in the Policy Schedule or the endorsement, this Rider shall not take effect.

**Article 2 Effectiveness of this Rider**

The effective date of this Rider is the same as the effective date of the Policy, or is subject to the effective date stated in the endorsement of this Rider.

**Article 3 Insuring Agreement**

1. During the valid term of this Rider, if any insured person receives the outpatient treatment stated under this Rider in a medical institution due to a covered disability or chronic condition after the agreed waiting period (subject to that set forth in the Benefit Schedule, no more than 180 days), the Company shall be liable for the outpatient medical charges incurred thereby within the sum insured applicable to the insured person under this Rider as set forth in the Benefit Schedule up to the itemized sum insured or limit or the number of times (e.g. the number of claims submission and the number of consultations), the number of days (e.g. the days of coverage), deductible, ratio (e.g. co-payment ratio and indemnity ratio) and period applicable to each benefit and each covered charge (or itemized charges and the combination thereof) set forth in the Policy Schedule or Benefit Schedule:

**(1) General outpatient benefit**

If any insured person receives the following outpatient treatment at a **medical institution** due to a covered **disability**, the Company shall be liable for the medical charges incurred by the insured person therefor (but excluding the outpatient charges for chronic conditions):

1) Consultation and treatment by a **physician**;

2) Outpatient consultation and treatment by a **physiotherapist** recommended by the **attending physician**;

(3) Pathological examination, imaging examination, diagnostic test and examination;
(4) Drugs, dressings and surgical equipment, etc.

**(2) Supplementary outpatient medical benefit**

If any insured person receives the following outpatient treatment of physiotherapy (not required to be recommended by the attending **physician**), chiropractic, osteopathy, podiatry, speech rehabilitation therapy, nutritional therapy and homeopathy, traditional Chinese medicine therapy, acupuncture, orthopedics at a **medical institution** due to a covered illness, the Company shall be liable for the medical charges incurred by the insured person therefor:

This benefit applies only if the physicians providing the outpatient treatment above are systematically trained, legally qualified, have been registered and licensed to practice medicine, and have no blood, in-law or adoption relationship with the insured person.

**(3) Chronic condition outpatient benefit**

If any insured person receives outpatient treatment in a **medical institution** for a covered chronic condition, the Company shall be liable for the costs of consultation and treatment by a physician or specialist, pathological examination, imaging examination, diagnostic test and examination and prescription medical supplies incurred by the insured person.

**2. For the medical charges covered under this Rider, if the insured person obtains reimbursement from other social welfare institutions or any other third parties, or under any medical policy, the Company shall only pay the remaining portion.**

**3. The deductible (if any) set forth in the Policy Schedule or Benefit Schedule shall apply when the Company reimburses the medical charges covered under this Rider. The Company shall not be liable for the said charges less than the deductible (if any). If the said charges reaches the deductible (if any), the Company shall be liable for indemnity as per the applicable indemnity ratio set forth in the Policy Schedule or Benefit Schedule after application of the deductible (if any).**

**Article 4 Exclusions**

**All exclusions of the Policy are applicable to this Rider. In case of any conflict between the exclusions in the Policy and these exclusions, these exclusions shall prevail.**

**Except aforementioned terms, this rider shall not cover any outpatient expenses that has already been covered under the main contract.**

**Article 5 Supporting Documents/Claim Application**

Upon occurrence of an accident, when the insured person (in the case of a minor, his/her parents or other guardians) file a claim to the Company, the insured person shall fill out the claim form and provide the following original supporting documents to the Company so as to apply for benefits under this Policy:

1. The photocopy of the medical record and prescription made by the **physician** (if any);

2. The photocopy of inpatient medical records or hospitalization summary;

3. Original invoices, receipts, letters and complete cost itemization of treatment costs;

4. Medical report, examination report or other information about the insured person's condition;

5. Other materials related to this application that the insured person can provide.

If the insured person entrusts another person to file a claim, it shall also provide the original letter of authorization, identity certificates of the principal and the trustee and relevant documentary evidence.

If the Company determines that the claim information is incomplete, it shall promptly request additional information from the insured person at one time.

If the insured person cannot provide the aforesaid supporting documents for special reasons, he/she

shall provide other relevant supporting documents recognized by law to file a claim. **If the insured person fails to provide relevant materials, as a result of which the Company is unable to verify the authenticity of the claim, the Company shall not be liable to pay for the portion of the claim that cannot be verified.**

**Article 6 Termination of the Rider**

This Rider will automatically terminate under any of the following circumstances:

(1) The Policy terminates;

(2) The insured person has no intention to renew the Policy or the Company does not accept the renewal of this Rider at the expiration of the period of insurance;

(3) The policyholder applies to the Company for termination of this Rider within the valid term of this Rider;

(4) This Rider terminates due to the circumstances set forth in other terms.

Note: Under the circumstance set forth in Item (2), this Rider will automatically terminate at 24:00 on the expiry date of the Policy Schedule.

**Article 7 Interpretation**

Homeopathy referred to in this Rider: Means a treatment method that uses low-dose drug to gradually relieve or eliminate the patient's symptoms, including low-dose homeopathic therapy for diarrhea.

(The End)

# AIG Insurance China Limited

(Hereinafter referred to as the Company)

# AIG Dental and Optical Medical Insurance Rider

(1st Edition in 2024)

(Registration No.: C00003932522024090928273)

(This rider is not valid unless being applied for)

**Article 1 Conclusion of the Rider and Entire Rider**

*The AIG Dental Medical Insurance Rider* (hereinafter referred to as this Rider) was concluded with the approval of the Company in accordance with the application of the Policyholder of the Policy. This Rider is formed dependently on the Policy, the terms and conditions of the Policy shall also apply to this Rider. In case of any conflict between the terms of the Policy and the terms of this Rider, this Rider shall prevail.

If the benefits covered in this Rider are not stated in the Policy Schedule or the endorsement, this Rider shall not take effect.

**Article 2 Effectiveness of this Rider**

The effective date of this Rider is the same as the effective date of the Policy, or is subject to the effective date stated in the endorsement of this Rider.

**Article 3 Insuring Agreement**

Under this Rider, the insurance coverage includes dental coverage and vision coverage. The policyholder may select to add vision coverage in addition to dental coverage. The specific coverages selected will be agreed upon by the Company and the Policyholder, specified in the Policy Schedule, and cannot be changed during the validity period of this Rider.

For the medical charges covered under this Rider, if the insured person obtains reimbursement from other social welfare institutions or any other third parties, or under any medical policy, the Company shall only pay the remaining portion.

The deductible (if any) set forth in the Policy Schedule or Benefit Schedule shall apply when the Company reimburses the medical charges covered under this Rider. The Company shall not be liable for the said charges less than the deductible (if any). If the said charges reaches the deductible (if any), the Company shall be liable for indemnity as per the applicable indemnity ratio set forth in the Policy Schedule or Benefit Schedule after application of the deductible (if any).

**(1) Dental Treatment Expenses (basic benefit)**

During the valid term of this Rider, if any insured person receives the following treatments performed by a dentist or dental hygienist after the agreed corresponding waiting period (subject to that set forth in the Benefit Schedule, no more than 180 days), the Company will reimburse the insured person for the reasonable and medically necessary charges incurred thereby within the sum insured applicable to the insured person under this Rider as set forth in the Policy Schedule or Benefit Schedule up to the itemized sum insured or limit, the number of claims services, deductible, co-payment ratio, indemnity ratio applicable to each covered benefit and each covered charge under this Rider as set forth in the Policy Schedule or Benefit Schedule:

**1. Routine dental treatment (basic benefit)**

(1) Examination;

(2) Tooth cleaning(including fluoride treatment, tooth cleaning and polishing preventive treatment);

(3) Ordinary compound filling surgery;

(4) Inlay and onlay (excluding gold teeth);

(5) Dental extractions(excluding gold teeth);

(6) Sealing.

(7) Other routine dental treatment as set forth in the Benefits Schedule

**2. Major dental restoration (covered items subject to that set forth in the Benefit Schedule)**

(1) Extraction of impacted teeth, buried teeth or unsprouted teeth;

(2) Removal of root;

(3) Root canal treatment;

(4) Removal of solid odontomes;

(5) Apicectomy;

(6) New or repair of bridge work (excluding gold bridge work);

(7) New or repair of crowns (excluding all gold crowns);

(8) New or repair of upper and lower dentures.

(9) Treatment of disorders of the temporomandibular joint (TMJ);

(10) Periodontal Treatment;

(11) Other major dental treatment as set forth in the Benefits Schedule.

For the sake of clarity, the treatment costs covered under this Benefit include the examination fee, medical drug cost, material cost, etc. covered by the items above.

**(2) Optical Medical Expenses (optional benefit)**

During the valid term of this Rider, if any insured person receives examination or treatment related to his/her visual acuity in a medical institution due to a covered disability after the agreed corresponding waiting period (subject to that set forth in the Benefit Schedule, no more than 180 days), the Company shall reimburse the insured person for the following reasonable and medically necessary charges incurred thereby within the sum insured applicable to the insured person under this Rider as set forth in the Policy Schedule or Benefit Schedule up to the itemized sum insured or limit, deductible, co-payment ratio or indemnity ratio applicable to each covered charge (or itemized benefits and the combination thereof) set forth in the Policy Schedule or Benefit Schedule:

1. The cost of eye examination by an optometrist or ophthalmologist, up to one examination;
2. The cost of lenses for vision correction;
3. The cost of glasses frame.

**For the medical charges covered under this Rider, if the insured person obtains reimbursement from other social welfare institutions or any other third parties, or under any medical policy (including but not limited to emergency dental treatment (due to accident) benefit under the Policy), the Company will only pay the remaining portion.**

**The deductible (if any) set forth in the Policy Schedule or Benefit Schedule shall apply when the Company reimburses the covered medical charges. The Company shall not be liable for the aforesaid charges less than the deductible (if any). If the aforesaid charges reaches the deductible (if any), the Company shall be liable for reimbursement as per the applicable indemnity ratio set forth in the Policy Schedule or Benefit Schedule after application of the deductible (if any).**

**Article 4 Exclusions**

**Except for Item 5 under Article 19 Exclusions of Chapter IV of the Policy, all exclusions of the Policy are applicable to this Rider. In case of any conflict between the exclusions in the Policy and these exclusions, these exclusions shall prevail.**

**The Company shall not be liable for any and all vision examination and treatment costs directly or indirectly arising from, or related to or attributable to the following circumstances:**

1. Sunglasses, except those prescribed by a medical prescription;

2. Glasses or frames for such glasses that are not medically necessary and are not recommended by an optometrist or ophthalmologist;

3. LASIK Surgery.

**Article 5 Supporting Documents/Claim Application**

Upon occurrence of an accident, when the insured person (in the case of a minor, his/her parents or other guardians) file a claim to the Company, the insured person shall fill out the claim form and provide the following original supporting documents to the Company so as to apply for benefits under this Policy:

1. The photocopy of the medical record and prescription made by the physician;

2. The photocopy of inpatient medical records or hospitalization summary;

3. Original invoices, receipts, letters and complete cost itemization of treatment costs;

4. Medical report, examination report or other information about the insured person's condition;

5. Other materials related to this application that the insured person can provide.

If the insured person entrusts another person to file a claim, it shall also provide the original letter of authorization, identity certificates of the principal and the trustee and relevant documentary evidence.

If the Company determines that the claim information is incomplete, it shall promptly request additional information from the insured person at one time.

If the insured person cannot provide the aforesaid supporting documents for special reasons, he/she shall provide other relevant supporting documents recognized by law to file a claim. **If the insured person fails to provide relevant materials, as a result of which the Company is unable to verify the authenticity of the claim, the Company shall not be liable to pay for the portion of the claim that cannot be verified.**

**Article 6 Termination of the Rider**

This Rider will automatically terminate under any of the following circumstances:

(1) The Policy terminates;

(2) The insured person has no intention to renew the Policy or the Company does not accept the renewal of this Rider at the expiry date of the period of insurance;

(3) The policyholder applies to the Company for termination of this Rider within the valid term of this Rider;

(4) This Rider terminates due to the circumstances set forth in other terms.

Note: Under the circumstance set forth in Item (2), this Rider will automatically terminate at 24:00 on the expiry date of the Policy Schedule.

**Article 7 Interpretation**

1. Dentist referred to in this Rider: Means a person qualified as a medical practitioner other than a relative of any Insured Person by blood or marriage, who is licensed by the competent medical authorities of the country in which treatment is provided and who, in rendering dental treatment, is practicing within the scope of his/her licensing and training.

2. Oral hygienist referred to in this Rider: Means a person employed by or serving a dentist, who is licensed by the competent authority of the country where the dentist is practicing to provide tooth cleaning and anesthesia and other services, and provides these services under the guidance and direct supervision of the dentist.

3. Ophthalmologist referred to in this Rider: Means a person qualified as a medical practitioner other than a relative of any insured person by blood or marriage, who is licensed by the competent medical authorities of the country in which treatment is provided and who, in rendering ophthalmic treatment, is practicing within the scope of his/her licensing and training.

(The End)

# AIG Economic Sanctions Liability Exclusion Rider

(Registration No. C000039319220190529073 82, Record No. (AIG Property Insurance - others) [2019] (Rider) No. 017)

It is hereby understood and agreed that **if any insurance coverage, benefit or payment of any insurance indemnity by the Company/insurer under this Contract would result in the Company/insurer violating any sanctions, prohibitive or restrictive provisions under the resolutions of the United Nations, or any economic and trade sanctions, laws or regulations enacted by the People's Republic of China or the United States of America, then the Company/insurer shall not provide the aforementioned insurance coverage, benefits or pay the aforementioned insurance indemnity under this Contract.**

All other provisions of this Contract remain unchanged.

(End of this page.)