CLASS VI

Crew Injured Medical Liability

Edition 2018

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RULE 1 CONTRACT OF ENTRY

1.1 Application of the Contract

This Accidental Medical Rider Contract (henceforth, "the Rider Contract") is the contract attached to the Crew Injured Liability contract subject to the Rule of Association, Class VII Crew Injured Liability (henceforth, "the Basic Contract") which covers the liabilities of accidental injury for one or less than one year and established upon the application by the Applicant for the Basic Contract and approval by the Association. All terms and conditions herein, together with the Certificate of Entry and Application Form and other application documents, legitimate and valid statements, endorsements, notes and other agreement constitute the entire contract of this Rider.
"Rider Contract" herein is short for "Accidental Medical Rider Contract".

1.2 Composition of the Contract

The contract is an agreement of rights and obligations of assured(s) and the Association consists of the Certificate of Entry, attached clauses, endorsements, amendments, application form(s), insurance application documents, statements, and other relevant written agreements.

1.3 Establishment and Effect of the Contract

The Contract will be established after the assured(s) apply for entrance and the Association written agreement. The effect date will be stated in the Certificate of Entry.

1.4 Scope of Application

The Scope of Application of this Contract will consist with the Basic Contract.

RULE 2 COVERAGE CLAUSES

2.1 Limits

The total amount benefit payable to any individual Insured(s) person is limited to the sum assured which shall be decided upon agreement between the Applicant(s) and the Association and specified in the Contract.

2.2 Deductible and Benefit Ratio

The deductible and benefit ratio shall be decided upon agreement between the Applicant(s) and the Association and specified in the Contract. The deductible applies to each claim.

2.3 Period

The period of this contract is not longer than one year from the starting date to the expiry date of Certificate of Entry as specified in the Insurance Contract.

2.4 Coverage

During the period of the Accidental Medical Rider, whilst the Basic Policy and the Rider Contract are both in force, the Association shall be liable for compensation of reasonable and necessary medical expenses for the treatment incurred by an accidental injury (not conditioned by death or disability of the insured person) sustained by the insured person and covered in the scope of the Basic Contract, given that the relevant medical treatment is carried out in the hospital graded above the second class or which is recognized by the public health administrative authority. The compensation amount shall be derived

by applying the deductible and the schedule of benefits mutually agreed by the parties to the Rider Contract

If an insured person sustains an accidental injury which is covered in the Basic Policy and results in the medical treatment during the insurance period, and the medical treatment is not completed on the expiry day of the Rider Contract, the Company shall be liable for subsequent medical treatment as prescribed above, but the compensation liability shall not exceed 180 days for in-patient medical treatment and 30 days for out-patient medical treatment starting from the occurrence of the accident.

During the period, no matter the insured person receives medical treatment incurred by one or more than one accidental injury, if the amount of accumulated benefits paid by the Association to the same insured person has reached the corresponding sum assured, the Liability of the Association to such Insured Person shall thereby be terminate.

If the medical expense is reimbursed by any means other than basic social medical insurance, the benefits payable shall be limited to the medical expense excluding the amount reimbursed elsewhere and conform to the regulation of social medical insurance of the local region where the Rider Contract is issued.

2.5 Exclusions

The Association shall not be liable for any expense as follows and the expense arising from any one of the behavior and events as follows:

(1) The items specified in the "Exclusions" of the Basic Policy;

(2) Medical treatment out of the coverage stated in the Contract;

(3) Orthopedic surgery, plastic surgery, cosmetics, organ transplantation or repair, installation of appliances for the disabled (e.g. wheelchair, artificial limb, hearing aid, artificial eye, spectacles prescribing, false teeth, etc.)

(4) Routine medical examination not for the treatment of illness or injury, recuperation, rehabilitation, physical therapy, psycho-analytical treatment;

(5) Treatment in the hospital of which the grade does not meet the requirement as prescribed in the Rider Contract, but the condition specified in the Clause 6.1 is not included in this clause.

(6) The medical expenses of the insured shall be afforded by the third party in accordance with the law.

RULE 3 APPLICATION OF BENEFIT

3.1 Beneficiary

Unless stipulated otherwise, the beneficiary of disability is the insured person himself.

3.2 Application of Benefit

In the event of accident, the applicant of the benefit shall fill in the Benefit Claim as the claimant and provide the documents as follows:

(1) Certificate of Entry of the Main Contract and the Rider Contract.

(2) ID Card of the applicant of the benefit;

(3) Certification of diagnosis with reports about pathological examinations, lab tests and any other medical examination report attached, medical history of the patient, original receipts of medical treatment and expenses, schedule of expenses and prescription issued by the hospital graded of or above the second class which is recognized by the public health administrative authority;

(4) Other available proof and materials in connection with the nature, the cause, injury degree, etc of the accident.

If the proofs and documents provided by the Insured(s), are not sufficient, the Insurer shall request the Applicant(s) and/or the Insured(s) to provide additional materials in time and once for all.

3.3 Payment of Benefit

Upon receipt of a claim, the Insurer shall confirm whether the Damage is covered by this contract or not within five working days. For complicated cases, the Insurer shall make decision within thirty days, unless otherwise stipulated in the insurance contact.
If the Damage is covered by this contract, the Association shall make payment within ten days after reaching an agreement with the Insured(s).
If the Damage is not covered by this contract, within three days after the decision, the Association shall issue a declination letter and explain the reasons to the Insured(s). The Association shall allow an advance payment that can be determined by the available proofs or documents if the final settlement amount cannot be determined within sixty days after receipt of such claim and relevant documents, and pay the balance to the Insured(s) after the final amount of indemnity is adjusted.

3.4 Limitation of Action

The Insured shall have a 2-year valid litigation term to raise claims to the Insurer for indemnities, which term shall commence as of the date when he/she has known or should have known of any such insured accident as occurred.

RULE 4 PAYMENT

4.1 Payment

The Applicant(s) shall pay the premium in one installment.

RULE 5 TERMINATION AND CANCELLATION OF THE CONTRACT

5.1 Termination of the Contract

The Rider Contract shall be terminated under any one of the circumstance as follows:
(1) The Basic Policy is terminated; or
(2) The Rider Contract is terminated as a result of any other provision herein

5.2 Procedure and Risk of Cancellation

In the event of cancellation, the Applicant(s) of the benefit shall fill in the Benefit Claim as the claimant and provide the documents as follows:
(1) The original Certificate of Entry if have;
(2) Requisition for cancellation of the contract;
The insurance contract shall be terminated automatically from the date the Association receive the requisition, but the Association shall not refund the unearned premium.

RULE 6 OTHER MATTERS NEED TO BE CONCERNED

6.1 Emergency Treatment of Accidental Injury

The emergency treatment of accidental injury shall not be subject to the restriction on the level of the hospital as prescribed in the Rider Contract. However, once the physical status of the insured person is stabilized after emergency treatment, s/he should be transferred to the hospital graded of or above the second class which is recognized by the public health administrative authority.
Under special circumstances when the insured needs to be transferred for treatment to another hospital, the insured should provide group consultation report signed by chief (or above level) doctor and hospital transfer certificate, and is allowed to

transfer after getting approval from the insurer.

6.2 Others Apply to the Main Contract

Following Clauses are applied to the clauses of Main Contract:
(1) Notification of Accident;
(2) Assured(s) changing;
(3) Conceals facts deliberately and perform the duty of disclosure
(4) Restriction of the right of Cancellation
(5) Work Type Changing
(6) Content Changing
(7) Contact Changing
(8) Dispute Resolution

RULE 7 DEFINITIONS

7.1 Accident Injury: Refer to the injury caused by external, unexpected, unintentional, non-disease-related event that injuries the body of the insured.
7.2 Reasonable and necessary medical expenses: Refer to the medical expenses caused by accident that occurred during treatment according to the local government issued "the urban workers` basic medical insurance drug list", "basic medical insurance for urban workers", "treatment project directory urban workers` basic medical insurance medical service project" and the relevant provisions of the scope of medical expenses, but excluding the following expenses:
(1) In accordance with the provisions of the use of certain drugs, special inspection and special treatment, the Assured(s) need to pay a certain proportion of the medical expenses;
(2) In accordance with the provisions of transfer outside the hospital, the Assured(s) need to pay a certain proportion of the medical expenses;
(3) The medical expenses that out of the scope of the basic medical insurance;
(4) The medical expenses have nothing to do with the insurance accident.
7.3 In Hospital: Refer to the treatment admitted to in hospital formally, and the formal procedures for admission to the hospital, not included in the outpatient observation room, family bed, hanging bed and other unreasonable hospitalization.
7.4 Valid ID: Refers to the documents provided by the competent departments of the government to prove their identity, such as resident identity card, according to the provisions of valid passports, military officers, police officers, soldiers card, residence booklet and other documents.
7.5 Complex situation: Refer to the nature, the cause, the degree of injury of the insurance accident that the Association received the insurance payment application form and the contract agreed to prove and the information within 5 working days can not be determined, need further verification.
7.6 Unearned net premium: Unearned net premium = Annual premium X (number of days of the remaining insurance period/number of days of the insurance period) X (1-25%)
Accumulated amount of indemnity refers to such total sum of indemnities including both those having been paid by the Insurer and those having not been paid despite the occurrences of the Insured(s) accidents within the actual insurance period, exclusive, however, the arbitration or litigation expenses for which the Insurer remains to be responsible.