



团体高端医疗险

High-end Medical Insurance

北京和睦家医院有限公司

United Family Healthcare

保单生效期间 Policy Period: 2023/05/01-2024/04/30

保障范围 Coverage Area: 中国大陆计划 Mainland China Plan

保障计划 Policy Design	
保额计划 Insurance Plan	中国大陆计划 Mainland China Plan
年度最高保额 Annual Maximum per Insured Person	¥15,000,000
保障区域 Area of Coverage	中国大陆 Mainland China
紧急医疗： 保险人对在保障地域以外发生的紧急医疗，被保险人在对应保障地域以外地区发生的保险责任范围内的费用也提供保险保障。 Emergency treatment: This benefit provides coverage for the medically necessary and reasonable expenses of emergency medical treatments outside the area of coverage.	涵盖 Covered
同一疾病（或因同一次事故引起的疾病）最高赔付上限 Maximum coverage limit for the same illness (or illness from same accident)	¥600,000
免赔额和自付比例 Policy Deductible and Copayment Percentages	
个人年免赔额 Annual Individual Deductible	¥3,500
家庭年免赔额 Annual Family Deductible	¥10,000
个人自付最高限额 Individual Out-of-Pocket Maximum	¥13,600
家庭自付最高限额 Family Out-of-Pocket Maximum	¥40,800
就诊医院范围和赔付比例 Hospital Scopes and Reimbursement Rates	
美国地区医院 Providers in the United States	不适用 Not Applicable
美国以外地区（非中国大陆） Providers Outside of Mainland China	不适用 Not Applicable
中国大陆和睦家医院及诊所（含深圳及海南地区） United Family Hospitals and Clinics (Including Shenzhen and Hainan)	80%
公立医疗机构（特需、外宾和国际部）（除深圳及海南地区） Public Hospitals (including VIP sections and international dept.) (excluding Shenzhen and Hainan)	50%

中国大陆和睦家以外的私立医疗机构 Non-UFH Private Providers in Mainland China	0%
核保规则 Underwriting Rules	
既往症 Pre-existing Conditions 在保险人对其保险责任生效前被保险人已就此接受诊断、医学咨询或治疗，或服用药物，或显现症状的疾病或损伤	既往症不究。 Medical history disregarded.
一般疾病(伤害)和一般项目住院医疗保险责任，无等待期 Inpatient Benefits, no waiting period	
双人病房（在中国大陆接受住院治疗的，可为标准单人病房）床位费 Semi-private room (Standard private room in Mainland China)	无单项限额 Fully Covered
膳食和营养配餐费 Semi-private room (Standard private room in Mainland China)	无单项限额 Fully Covered
重症监护病房费 Intensive Care Unit	无单项限额 Fully Covered
急诊室费 Emergency Room	无单项限额 Fully Covered
加床费(未满十八周岁附属被保险人住院期间其父亲或者母亲陪同住院加床费，女性被保险人住院期间其出生未满十六周的新生婴儿住院加床费) Companion Bed (For a parent accompanying a hospitalized insured child under 18 years of age and for a baby aged under 16 weeks accompanying a hospitalized female insured person)	无单项限额 Fully Covered
手术室和恢复室费,手术敷料费、手术医师费和麻醉师费 Operating theatre and recovery room, cost of surgical dressing, surgeon and Anesthesiologist Fee	无单项限额 Fully Covered
诊疗和护理费 Physician and nursing Fee	无单项限额 Fully Covered
检查费、药品费、化验费、吸氧费，输血、血浆、血浆扩容药物以及所	无单项限额

有相关化验、操作设备和服务费用、电子喉镜检查费 Examinations, medication and Prescription, laboratory tests, oxygen, blood transfusions, plasma, plasma expansion drugs, and all related tests, operating equipment and service fee and electronic laryngoscopy examination Fee	Fully Covered
康复护理 / 住院康复治疗 仅限于入院后需立即实施的治疗 Extended Care / Inpatient Rehabilitation Must be confined to a facility immediately following a hospital stay	赔付至 180 天 Fully covered up to 180 Days
矫形改造手术费 因遭受意外伤害或患疾病需要接受矫形改造手术恢复肢体功能或容貌的医学必需且合理的费用。 Reconstructive Surgery The benefit refers to medically necessary and reasonable expenses for inpatient orthopedic surgery, due to accidental injury or illness, to restore the function of the limb or its appearance.	无单项限额 Fully Covered
一般疾病(伤害)和一般项目门诊医疗保险责任, 无等待期 Outpatient Benefits, no waiting period	
门诊医疗责任累计限额 Overall Outpatient Maximum	不适用 Not Applicable
和睦家线上问诊 UFH Internet Hospital Consultations	年限额 10 次 Covered up to 10 visits
医师诊疗费 Doctor Fee	年限额 20 次 Covered up to 20 visits

<p>处方药费（不受限于免赔额及门诊医师费年限额）</p> <ol style="list-style-type: none"> 1. 常用药可用时，需使用常用药 2. 保险计划免赔额不适用于处方药福利 3. 您的自付部分也不会累计到您的保险计划的自付上限中 4. 由执业医师对于可保疾病开据的治疗性非处方药仅在大中华地区涵盖 <p>Prescription Drugs (not subject to medical deductible and outpatient physician visit limits)</p> <ol style="list-style-type: none"> 1. Generic drugs are required if available 2. The medical plan Deductible does not apply to the pharmacy benefit 3. The Coinsurance or Copayment amounts for the pharmacy benefit do not accrue to the medical plan Out-of-Pocket Maximum <p>OTC (Over-The-Counter) medicine is covered only in Greater China area when it is prescribed by a licensed physician that a treatment is an eligible benefit</p>	<p>无单项限额，每次配药量以 90 天为限</p> <p>Fully covered, 90-day per refill</p>
<p>检查费和化验费</p> <p>Diagnostic and laboratory test</p>	<p>无单项限额</p> <p>Fully Covered</p>
<p>大型检查费：计算机断层扫描费；正电子发射计算机断层扫描费；核磁共振检查费；内窥镜检查费（如，胃镜检查，结肠镜检查，膀胱镜检查，阴道镜检查）；磁共振血管成像费；计算机辅助断层成像费；消化道造影费。</p> <p>Advanced Imaging: CT: Computed tomography scan; PET: Positron emission tomography; MRI: Magnetic resonance imaging; Endoscopy (e.g., gastroscopy, colonoscopy, cystoscopy, colposcopy); MRA: Magnetic Resonance Angiogram; CTA: CT angiography scan; GI scan: gastrointestinal radiology.</p>	<p>无单项限额</p> <p>Fully Covered</p>
<p>门诊手术费：手术医师费和麻醉师费、手术室和恢复室费</p> <p>Outpatient Surgery or Daycare Treatments: Operating theatre and recovery room、surgeon and Anesthesiologist Fee</p>	<p>无单项限额</p> <p>Fully Covered</p>

急诊室费 Emergency Room	无单项限额 Fully Covered
针灸治疗、顺势疗法费 Acupuncture, Homeopathy	累计赔付限额 8,000 元 Covered up to ¥8,000
理疗费 Therapeutic Services	
中医治疗费 Traditional Chinese Treatment	
牙科意外伤害治疗费 Emergency Dental Treatment	无单项限额 Fully covered
旅行预防接种 Travel Vaccinations	无单项限额 Fully covered
15 岁以下被保险人子女每年 1 次常规视力和听力检查 One routine eye and hearing test for child under the age of 15	无单项限额 Fully covered
特殊疾病和特殊项目医疗保险责任 Special Disease and Medical Care Benefits 如无特别说明，限于年度最高保额、住院医疗、门诊医疗上限、免赔额及自付比例、既往症的限制。 Subject to Annual Maximum, Inpatient Maximum, Outpatient Maximum, Deductible and Co-payments, and Pre-existing condition limitations, unless specified otherwise. 如无特殊说明，特殊疾病和特殊项目医疗保险责任在年度最高保额的基础上同时受限于门诊、住院的各项福利限制。 Special disease and medical care benefits are subject to outpatient and inpatient benefits sub-limitations unless specified otherwise.	
门诊肾透析、门诊恶性肿瘤电疗、化疗或放疗 Out-Patient Kidney Dialysis and Out-patient Cancer Treatment including Electrotherapy, Chemotherapy and Radiotherapy	赔付至年度最高保额，且不受限于门诊各项福利限制及门诊医疗上限。 Covered up to annual maximum, and not subject to outpatient benefits sub limitations and maximum.

女性宫颈涂片筛查 • 每保单年度限 1 次 Pap Smear • Once per policy year	
乳腺癌筛查或诊断 • 35-39 周岁无症状女性每保单年度一次基础乳房 X 光检查 • 40-49 周岁无症状女性每两年一次乳房 X 光检查, 如果医疗必需可以增加次数 • 50 周岁以上女性每年一次乳房 X 光检查 Mammograms for Breast Cancer Screening and/or Diagnoses • One baseline mammogram per policy year for asymptomatic women aged 35-39 • One mammogram for asymptomatic women aged 40-49 every two years, or more if medically necessary • One Mammogram every year for women aged 50 and over	无单项限额; 不受限于免赔额及门诊限额, 受限于自付比例及最高限额 Fully covered; not subject to annual deductible and outpatient maximum/outpatient physician visits limit, but subject to policy copayment and maximum benefits
男性前列腺癌筛查 • 50 周岁以上男性每保单年度一次 Prostate Cancer Screening • Once per policy year for eligible males over 50	
一次重要器官衰竭移植费用 (重要器官、骨髓、干细胞移植) 责任免除: 器官移植供体寻找及获得等费用 Major Organ Failure and Transplant (Major Organs, Bone Marrow, Stem Cell) Expenses for donor are not covered	无单项限额 Fully covered
专业护士家庭护理费 Home Nursing Fee	无单项限额 Fully covered
耐用医疗设备购买或租赁费 Durable Medical Equipment	无单项限额 Fully covered
糖尿病辅助设备 (包括胰岛素泵及相关用品) Diabetic Supplies (insulin pumps and associated supplies)	无单项限额 Fully covered
假肢装置 用以替代人体局部构造的假肢及其它装备 责任免除: 助听器 Prosthetic Devices Limbs and other devices intended to replace the functionality of a body part; hearing aids are excluded	无单项限额 Fully covered

获得性免疫缺陷综合症（艾滋病），人体免疫缺损病毒（艾滋病病毒）， 艾滋病相关综合症及性传播疾病 Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV +), AIDS Related Complex (ARC), Sexually Transmitted Diseases and related conditions	无单项限额 Fully covered
精神和心理障碍治疗费（包括酒精和药物滥用戒断治疗）： Mental Health and Psychotherapeutic Treatment (including rehabilitation Treatment for alcohol and drug abuse)	
门诊费用 Outpatient	累计赔付次数限额 20 次 Covered up to 20 visits
住院费用 Inpatient	年限额 30 天 Covered up to 30 days
睡眠检查和治疗费 Sleep Studies/Tests and Treatment	无单项限额 Fully covered
医疗及身故援助保险责任：医疗及身故援助保险责任受限于年度最高保额、既往症的限制 Medical Emergency and Death Assistance Benefits: Medical Emergency and Death Assistance Benefits is subject to Overall Limits and Pre-existing Conditions	
地面救护车服务 Ground Ambulance Services	无单项限额 Fully covered
紧急医疗转运费 Emergency Medical Evacuation Fees	无单项限额 Fully covered
其中：陪同人员住宿费 For an accompanying person during Medical Evacuation	无单项限额 Fully covered
遗体运返或安葬费 Repatriation or Local Burial of Mortal Remains	赔付至 ¥140,000 Covered up ¥140,000
牙科福利 Dental Benefits	
年度牙科福利限额 Annual Dental Maximum Per Covered Person	¥8,000
牙科年免赔额 Annual Dental Deductible	个人 Individual: ¥350 家庭 Family: ¥1,000

<p>预防治疗</p> <ul style="list-style-type: none"> - 必要的诊断检查及预防治疗, X 光片, 洁齿, 涂氟治疗 (限 19 周岁以下), 窝沟封闭 - 常规牙科检查、洁齿和抛光 (预防) 限每年两次 - 每年 X 光费限于 4 次牙翼咬片及 6 次口腔内 X 光, 以及每三年一次口腔曲面断层片 - 牙况全面评估限每年一次 <p>Preventive Dental Services (Class 1)</p> <ul style="list-style-type: none"> - Necessary diagnostic examinations and preventive treatment, X-ray, dental cleaning, fluoride treatment (available to insureds up to age 19), pit and fissure sealing - Examination and Scale & Polish will both be limited to 2 visits per year of insurance - X-rays will be limited to four Bitewings and six Intra Oral per year of insurance and OPG every 3 years <p>Full Case Assessment will be limited to one per year of insurance</p>	<p>100%</p>
<p>基础治疗</p> <ul style="list-style-type: none"> - 基础修复 (汞合金或复合树脂填充), 简单拔牙, 牙周治疗, 根面平整以及口腔外科手术 - 牙周病治疗每年限一个疗程 <p>Basic Dental Services (Class 2)</p> <ul style="list-style-type: none"> - Basic restoration (amalgam or composite fillings), basic extractions, periodontal treatments, root planning, and oral surgery <p>Prolonged Periodontal Treatment limit of one course per policy year</p>	<p>80%</p>
<p>重大治疗</p> <ul style="list-style-type: none"> - 根管充填、根管治疗、牙冠, 嵌体, 桥式义齿及智齿拔除。承担的费用包括必要的医生安装或更换用品费用及服务费 <p>Major Dental Services (Class 3)</p> <p>Root fillings, root canal, crowns, inlays, bridges, and extraction of wisdom teeth. Covered expenses include necessary supplies and services of a physician for installation or replacement</p>	<p>50%</p>

正畸治疗 <ul style="list-style-type: none">- 允许的被保险人最高年龄至 19 周岁- 包括：模型研究（包括口腔 X 光片），牙齿印模，矫正所需拔牙 Orthodontia (Class 4) <ul style="list-style-type: none">- Available up to age 19 Study models (including pan oral x-rays), impressions, removable string appliances (braces), fixed appliances (including adjustments), necessary extractions, and re-cementing of brackets	不涵盖 Not Covered	
眼科福利（每 24 个月一次）Vision Benefits (benefits limited to one time every 24 months) 保单免赔额和自付比例不适用于眼科福利；眼科福利不受限于门诊医师费年限额 Vision benefits are not subject to annual deductible and/or copayment; not subject to outpatient physician visits limit		
检查 Examination	无单项限额 Fully Covered	
镜框 Frame Allowance	¥680	
镜片 Lens Allowance <ul style="list-style-type: none">- 单焦 Single Lens- 双焦 Bifocal- 三焦 Trifocal- 隐形眼镜：一盒 Contact Lenses: One box		
体检福利 Wellness Benefits 不受限于免赔额、门诊限额、及门诊医师费年限额；受限于自付比例及最高限额 Not subject to annual deductible and outpatient maximum/outpatient physician visits limit, but subject to policy copayment and overall outpatient maximum		
成人常规检查 Routine Adult Physical Exams		¥3,500
成人疫苗 Adult Vaccination	无单项限额 Fully covered	
儿科保健及免疫 Child Wellness and Vaccination 包括儿童疫苗接种和常规医学检查 Includes child immunizations and routine medical exams		
适用于 0-2 周岁附属子女 For age 0-2 dependent children	¥3,500	
适用于 3-18 周岁附属子女 For age 3-18 dependent children	¥3,500	
生育福利 Maternity Benefits		
正常分娩包括医疗必须的剖腹产和产后检查 <ul style="list-style-type: none">- 保单自付比例在和睦家医院免除 Normal delivery or Medically Necessary caesarean section,	不涵盖 Not covered	

postnatal care Policy copayment waived if within UFH	
产前检查 - 不受限于门诊医师费年限额 Prenatal Care Not subject to Outpatient Physician Visit annual limits	不涵盖 Not covered
Complications of pregnancy 妊娠并发症	不涵盖 Not covered
不孕不育诊疗 - 包括因治疗不孕不育而发生的诊疗费、手术费和药费 Infertility Treatment Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility	不涵盖 Not covered
早产, 先天性疾病, 出生缺陷 Premature birth, congenital conditions, and birth anomalies	不涵盖 Not Covered

承保条件 Underwriting Rules:

既往症不究。

Medical history disregarded.

重大既往症列表:

重大既往症定义:

- 1) 心血管疾病-包括冠心病、先天性心脏病、心肌梗塞、主动脉瘤;
- 2) 神经疾病-包括脑卒中、脑动脉瘤、阿尔茨海默病、帕金森病、脊髓空洞症、多发性硬化症;
- 3) 血液疾病-包括白血病、淋巴瘤、再生障碍性贫血、血小板减少性紫癜、血友病;
- 4) 肺部疾病-慢性阻塞性肺病、原发性肺动脉高压;
- 5) 消化疾病-肝硬化、重症肝炎;
- 6) 自身免疫性疾病-包括系统性红斑狼疮、系统性硬皮病、获得性免疫缺陷综合症(艾滋病)、艾滋相关综合征和其他与 HIV 病毒相关的性传染病或者症状;
- 7) 其他-包括所有恶性肿瘤、良性脑肿瘤、良性脊髓肿瘤、主要器官衰竭或移植、囊性纤维化、黑斑息肉病、III度烧伤。

List of Catastrophic Pre-existing Conditions:

Definition of Catastrophic Pre-existing Conditions:

- 1) Cardiovascular Diseases – including coronary heart disease, congenital heart disease, myocardial infarction, aortic aneurysm;
- 2) Neurological Diseases – including stroke, cerebral aneurysm, Alzheimer's Disease, Parkinson's Disease, syringomyelia, multiple sclerosis;
- 3) Blood Diseases – including leukemia, lymphoma, aplastic anemia, thrombocytopenic purpura, hemophilia;
- 4) Pulmonary Diseases – chronic obstructive pulmonary disease, primary pulmonary hypertension;
- 5) Digestive Diseases – cirrhosis, severe hepatitis;
- 6) Autoimmune Disorders – including systemic lupus erythematosus, systemic scleroderma, acquired immune deficiency syndrome (AIDS), HIV-related syndromes and other HIV-related sexually transmitted diseases or symptoms;
- 7) Others – including all malignant tumors, benign brain tumors, benign spinal cord tumors, major organ failure or transplantation, cystic fibrosis, macular polyposis, III degree burns

事先授权项目：

接受下列治疗前，被保险人须在预定开始治疗日期前至少两个工作日向医疗服务供应商提交事先授权申请表：

1. 住院；
2. 需全身麻醉的门诊手术，化学治疗，放射治疗，血液或者腹膜透析；
3. 购买或者租用非一次性耐用医疗设备，包括但不限于胰岛素泵及其配套器械；
4. 紧急医疗转运；
5. 牙科意外伤害修补治疗；
6. 每剂超过人民币 8,000 元的药剂或者疫苗；
7. 单价人民币 8,000 元以上的检查项目；
8. 临终关怀费；
9. 专业护士家庭护理及专业护理费；
10. 任何在和睦家以外医疗机构进行的住院治疗需和睦家管理层审核批复；

对于被保险人事先授权申请，医疗服务供应商将予以书面回复并有权要求被保险人在医疗服务网络内接受治疗。被保险人应当在收到书面许可回复后开始接受治疗，保险人要求被保险人在医疗服务网络接受治疗的，被保险人应当予以配合。未获得医疗服务供应商书面许可回复擅自接受治疗的，保险人保留不承担相关保险责任的权力。

发生紧急情况的，被保险人可在就近网络或者非网络医疗机构接受治疗，但须在开始接受治疗后四十八小时内通知医疗服务供应商。保险人将对该次治疗是否属紧急情况予以审核。

Pre-authorization Requirement:

Members must submit pre-authorization requests to us with related medical documents and diagnostic reports at least 2 business days before undergoing any of the below procedures/treatments:

1. Hospitalization;
2. Outpatient surgery requiring general anesthesia, chemotherapy and radiation treatment, hemodialysis or peritoneal dialysis;
3. Purchase or rental of Durable Medical Equipment (DME), including but not limited to insulin pumps and supplies;
4. Emergency medical evacuation;
5. Emergency dental treatments (immediate pain relief does not require pre-authorization);
6. Medications or immunizations priced in excess of ¥8,000 per refill;
7. Examinations of which the unit cost is ¥8,000 or above;
8. Hospice care;
9. Home health nursing and skilled nursing care;
10. Any inpatient care received at a non-UFH facility;

If the pre-authorization cannot be obtained due to emergency situations, members should inform Prosper Health Customer Service within 48 hours to ensure that treatment will be covered under their insurance policy.

In case that the insured member fails to get pre-authorization prior to treatment, and fails to notify Prosper Health with the specified time for emergency cases, or treatment is deemed as not an emergency, the insured member will be responsible for 40% co-payment of covered medical expenses.