FirstCare Plus Medical Insurance

The Policy

Please read this policy carefully

Your right to change your mind

If you are not completely satisfied, or our plan's coverage overlaps with your other existing protection plans coverage or exceed your needs, then please return the policy to us within 30 days. We will cancel this plan and refund any premium you have paid. Otherwise, we will assume you have accepted this plan subject to its terms and conditions.

Your right to cancel the policy is based on the following conditions:

- Your request to cancel must be signed by you and received directly by any HSBC branch or by AXA General Insurance Hong Kong Limited within 30 days after the date of the delivery of your policy. For further details, please refer to section 2 of Part 3 below;
- No refund can be made if a claim has already been paid.

Should you have any queries or need further explanation, you may contact Customer Care Hotline on (852) 2867 8678 (please note that tele-conversations may be recorded to ensure service quality) or write to us.

AXA General Insurance Hong Kong Limited

P.O. Box No. 90852 Tsim Sha Tsui Post Office, Kowloon, Hong Kong
23/F, One Kowloon, 1 Wang Yuen Street, Kowloon Bay, Kowloon, Hong Kong
Telephone: (852) 3070 5010
Customer Care Hotline: (852) 2867 8678

Personal Information Collection Statement

AXA General Insurance Hong Kong Limited (referred to hereinafter as the "**Company**") recognises its responsibilities in relation to the collection, holding, processing, use and/or transfer of personal data under the Personal Data (Privacy) Ordinance (Cap. 486) ("**PDPO**"). Personal data will be collected only for lawful and relevant purposes and all practicable steps will be taken to ensure that personal data held by the Company is accurate. The Company will take all practicable steps to ensure security of the personal data and to avoid unauthorised or accidental access, erasure or other use.

Please note that if you do not provide us with your personal data, we may not be able to provide the information, products or services you need or process your request.

Purpose: From time to time it is necessary for the Company to collect your personal data which may be used, stored, processed, transferred, disclosed or shared by us for purposes ("**Purposes**"), including:

1. offering, providing and marketing to you the products/services of the Company, other companies of the AXA Group ("**our affiliates**") or our business partners (see "**Use and provision of personal data in direct marketing**" below), and administering, maintaining, managing and operating such products/services;
2. processing and evaluating any applications or requests made by you for products/services offered by the Company and our affiliates;
3. providing subsequent services to you, including but not limited to administering the policies issued;
4. any purposes in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates, including investigation of claims;
5. evaluating your financial needs;
6. designing products/services for customers;
7. conducting market research for statistical or other purposes;
8. matching any data held which relates to you from time to time for any of the purposes listed herein;
9. making disclosure as required by any applicable law, rules, regulations, codes of practice or guidelines or to assist in law enforcement purposes, investigations by police or other government or regulatory authorities in Hong Kong or elsewhere;
10. conducting identity and/or credit checks and/or debt collection;
11. complying with the laws of any applicable jurisdiction;
12. carrying out other services in connection with the operation of the Company's business; and
13. other purposes directly relating to any of the above.

Transfer of personal data: Personal data will be kept confidential but, subject to the provisions of any applicable law, may be provided to:

1. any of our affiliates, any person associated with the Company, any reinsurance company, claims investigation company, your broker, industry association or federation, fund management company or financial institution in Hong Kong or elsewhere and in this regard you consent to the transfer of your data outside of Hong Kong;
2. *The Hongkong and Shanghai Banking Corporation Limited ("**HSBC**") for any of the Purposes and for the following additional bank related purposes: ensuring ongoing credit worthiness of customers, creating and maintaining credit and risk related models, providing the personal data to credit reference agencies for the purposes of conducting credit checks and other directly related purposes, determining the amount of indebtedness owed to or by customers and collection of amounts outstanding from customers and those providing security for customers' obligations;
3. any person (including private investigators) in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates;
4. any agent, contractor or third party who provides administrative, technology or other services (including direct marketing services) to the Company and/or our affiliates in Hong Kong or elsewhere and who has a duty of confidentiality to the same;
5. credit reference agencies or, in the event of default, debt collection agencies;
6. any actual or proposed assignee, transferee, participant or sub-participant of our rights or business; and
7. any government department or other appropriate governmental or regulatory authority in Hong Kong or elsewhere.

For our policy on using your personal data for marketing purposes, please see the section below "**Use and provision of personal data in direct marketing**".

Transfer of your personal data will only be made for one or more of the Purposes specified above.

Use and provision of personal data in direct marketing: The Company intends to:

1. use your name, contact details, products and services portfolio information, transaction pattern and behaviour, financial background and demographic data held by the Company from time to time for direct marketing;

2. conduct direct marketing (including but not limited to providing reward, loyalty or privileges programmes) in relation to the following classes of products and services that the Company, our affiliates, our co-branding partners and our business partners may offer:
   a) insurance, banking, provident fund or scheme, financial services, securities and related products and services;
   b) products and services on health, wellness and medical, food and beverage, sporting activities and membership, entertainment, spa and similar relaxation activities, travel and transportation, household, apparel, education, social networking, media and high-end consumer products;
3. the above products and services may be provided by the Company and/or:
   a) any of our affiliates;
   b) third party financial institutions;
   c) the business partners or co-branding partners of the Company and/or affiliates providing the products and services set out in 2. above;
   d) third party reward, loyalty or privileges programme providers supporting the Company or any of the above listed entities.
4. in addition to marketing the above products and services, the Company also intends to provide the data described in 1. above to all or any of the persons described in 3. above for use by them in marketing those products and services, and the Company requires your written consent (which includes an indication of no objection) for that purpose;

Before using your personal data for the purposes and providing to the transferees set out above, the Company must obtain your written consent, and only after having obtained such written consent, may use and provide your personal data for any promotional or marketing purpose.

You may in future withdraw your consent to the use and provision of your personal data for direct marketing.

If you wish to withdraw your consent, please inform us in writing to the address in the section on "**Access and correction of personal data**". The Company shall, without charge to you, ensure that you are not included in future direct marketing activities.

Access and correction of personal data: Under the PDPO, you have the right to ascertain whether the Company holds your personal data, to obtain a copy of the data, and to correct any data that is inaccurate. You may also request the Company to inform you of the type of personal data held by it.

Requests for access and correction or for information regarding policies and practices and kinds of data held by the Company should be addressed in writing to:

Data Privacy Officer
AXA General Insurance Hong Kong Limited
11/F, AXA Southside, 38 Wong Chuk Hang Road, Wong Chuk Hang, Hong Kong

A reasonable fee may be charged to offset the Company's administrative and actual costs incurred in complying with your data access requests.

* This is applicable only if you are applying for a product and/or service of, or making a request to, the Company through HSBC as the Company's distribution agent. Your personal data will not be provided to HSBC for any of the Purposes and the additional purposes and for direct marketing by HSBC set out in the paragraphs above if you do not apply for the product and/or service of, or make a request to, the Company through HSBC as the Company's distribution agent.

Contents

Terms and Conditions

PART 1

DEFINITIONS

In this Policy, words and expressions used shall have the following meanings -

"**Accident**" shall mean a sudden, unforeseen and unexpected event occurring entirely beyond the control of the Insured Person and caused by violent, external and visible means.

"**Advanced Diagnostic Imaging Test**" shall mean computed tomography ("CT" scan), magnetic resonance imaging ("MRI"), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

"**Age**" shall mean the attained age of the Insured Person.

"**Anaesthetist**" shall mean any person who is qualified to provide anaesthetic services and is registered under the Anaesthesiology Specialist Registry of the Medical Council of Hong Kong or equivalent and qualified to render anaesthetic services, according to the qualified anaesthetic speciality, but in no circumstance shall include the following persons – the Insured Person, the Policyholder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policyholder and/or Insured Person (unless approved in advance by the Company in writing).

"**Application**" shall mean any forms of the application submitted to the Company in respect of this Policy, including any questionnaires, evidence of insurability, documents or information submitted and any statements and declarations made in relation to such application.

"**AXA Signature Network**" shall mean, when used to describe a Healthcare Facility or Registered Medical Practitioner, that such Healthcare Facility or Registered Medical Practitioner has entered into and is covered by a valid written agreement with the Company to provide specified Medical Services to the Insured Person. The directory of AXA Signature Network may be accessed on the Company's mobile application (MyAXA) after appropriate user verification. The directory may be varied, updated and amended from time to time at the Company's discretion, and any change shall be deemed as effective on the date of publication irrespective of whether any separate notice is given.

"**Benefit Provisions**" shall mean the terms under Part 8 of these Terms and Conditions.

"**Card**" or "**Cards**" shall mean the "FirstCare Plus Medical Card" (including both physical and/or electronic card, as the context requires) issued by the Company to the Insured Person.

"**Case-based Exclusion**" shall mean the exclusion of a particular Sickness, Disease or Illness from the Benefit Provisions that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.

"**Cancer**" shall mean a malignant neoplasm or tumour characterised by the uncontrolled and unregulated growth and spread of abnormal cells and tissue. The term Cancer will include all stages of malignant cancer, but will specifically exclude the following:

(i) All tumours which are histologically described as benign, pre-malignant or dysplasia;

(ii) All tumours in the presence of any human immunodeficiency virus;

(iii) Cervical Intra-epithelial Neoplasia (CIN I, CIN II, CIN III); and

(iv) Non-melanoma skin cancer

"**Child**" shall mean any child of the Policyholder who is financially dependent on the Policyholder and aged between fifteen (15) days, and seventeen (17) years old at the time of Application for insurance cover (or up to twenty-three (23) years old if still in full-time education).

"**Company**" shall mean AXA General Insurance Hong Kong Limited.

"**Confinement**" or "**Confined**" shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for treatment and as an Inpatient for a period of no less than six (6) consecutive hours as a result of a Medically Necessary condition and such Confinement must be evidenced by daily room and board charged by the Hospital. No minimum period is required for Confinement in connection with any Emergency Treatment in a Hospital as a result of an Emergency for the performance of a Medically Necessary treatment in a Hospital.

"**Congenital Condition**" shall mean any condition or Disability existing at the time of birth or as a result of prematurity, as well as neo-natal physical abnormalities developing within six (6) months of birth. They shall include:

(i) all major, intermediate or minor congenital malformations presenting at any age;

(ii) all inguinal hernias and all hydroceles (or their complications) presenting from birth to the Age of fifteen (15) years old;

(iii) congenital hernias, for example, umbilical, internal intra-abdominal, thoracoabdominal congenital or congenital ventral hernias;

(iv) undescended testicle; and

(v) other conditions not listed here which would be regarded as congenital by prevailing medical opinion.

"**Day Case Procedure**" shall mean a Medically Necessary surgical procedure provided in connection with investigation or Treatment for a Disability to the Insured Person performed in a Healthcare Facility where the Insured Person has not been Confined.

"**Day Patient**" shall mean an Insured Person being admitted to a Healthcare Facility for a Medically Necessary Day Case Procedure (but not for Confinement).

"**Dependant**" shall only mean (i) the spouse or partner of the Policyholder who is aged between eighteen (18) years old and eighty (80) years old at the date of Application, or (ii) any Child of the Policyholder, including those legally adopted by the Policyholder.

"**Disability**" or "**Disabilities**" shall mean a Sickness, Disease, Illness or Injury, including any and all complications arising therefrom.

"**Eligible Expenses**" shall mean Reasonable and Customary and Medically Necessary expenses incurred with respect to a Disability.

"**Effective Date**" shall mean the "Original Commencement Date" as specified in the Policy Schedule.

"**Emergency**" shall mean an event or situation that treatment is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.

"**Emergency Treatment**" shall mean consultation or treatment required in an Emergency. The Emergency event or situation, and the required consultation or treatment cannot be and are not separated by an unreasonable period of time.

"**Endorsement**" shall mean any document attached to this Policy which amends the existing Terms and Conditions (including but not limited to the Benefit Provisions as specified in Part 8) of this Policy.

"**Expiry Date**" shall mean the last date of the Period of Insurance as specified in the Policy Schedule.

"**Government**" shall mean the Government of the Hong Kong Special Administrative Region.

"**Healthcare Facility**" shall mean a medical clinic, a Day Case Procedure centre or a Hospital.

"**High Dependency Unit**" shall mean that part or unit of a Hospital established for and devoted to providing extra nursing care and monitoring for Inpatients.

"**HKD**" shall mean Hong Kong dollars.

"**Hong Kong**" shall mean the Hong Kong Special Administrative Region of the People's Republic of China.

"**Hospital**" shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for the care and treatment of sick and injured persons as Inpatients, and which -

(a) has facilities for diagnosis and major operations;

(b) provides twenty-four (24) hours nursing services by licensed or registered nurses;

(c) has one or more Registered Medical Practitioners; and

(d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.

"**Hospital Authority**" shall mean the statutory body established under the Hospital Authority Ordinance (Cap.113 of the Laws of Hong Kong).

"**Injury**" shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.

"**Inpatient**" shall mean an Insured Person who is Confined.

"**Insurance Ordinance**" shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).

"**Insured Person**" shall mean the Dependant or the Policyholder who is insured under this Policy and named as the "Insured Person" in the Policy Schedule or the subsequent Endorsement to this Policy.

"**Intensive Care Unit**" shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.

"**Lifetime Benefit Limit**" shall mean the maximum amount of benefits paid by the Company to the Policyholder cumulatively since the inception of the Policy, irrespective of whether any limits of any benefits stated in the Policy Schedule have been reached or whether the Overall Annual Benefit Limit in a policy year has been reached.

"**Medical Services**" shall mean Medically Necessary services provided to the Insured Person, including, as the context requires, Confinement, Treatments, tests, examinations or other related services for the investigation or treatment of a Disability.

"**Medically Necessary**" shall mean the need to have Medical Services in accordance with the generally accepted standards of medical practice and such Medical Services must -

(a) require the expertise of, or be referred by, a Registered Medical Practitioner;

(b) be consistent with the diagnosis and necessary for the treatment of the Disability;

(c) be rendered in accordance with standards of good and prudent medical practice, and, in the prudent professional judgment of the attending Registered Medical Practitioner, not be rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner;

(d) be rendered in the setting most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice for Medical Services; and

(e) be furnished at the most appropriate level which, in the prudent professional judgment of the attending Registered Medical Practitioner, can be safely and effectively provided to the Insured Person.

For the purpose of this Policy, without prejudice to the generality of the foregoing, circumstances where a Confinement is considered Medically Necessary include, but not limited to -

(i) the Insured Person is having an Emergency that requires urgent treatment in Hospital; and/or

(ii) surgery is performed under general anaesthesia; and/or

(iii) equipment for surgery / procedure is available in Hospital and procedure cannot be done on a Day Patient basis; and/or

(iv) there is significantly severe co-morbidity of the Insured Person; and/or

(v) taking into account the individual circumstances of the Insured Person, the attending Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, the treatment or service should be conducted in Hospital; and/or

(vi) in the prudent professional judgment of the attending Registered Medical Practitioner, the length of Confinement of the Insured Person is appropriate for the treatment or service concerned; and/or

(vii) in the case of diagnostic procedures or allied health services prescribed by a Registered Medical Practitioner, such Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, such procedures or services should be conducted in Hospital.

For the purpose of exercising his prudent professional judgment in (v) to (vii) above, the attending Registered Medical Practitioner shall have regard to whether the Confinement -

1) is in accordance with standards of good and prudent medical practice in the locality for the treatment or service rendered, and, in the prudent professional judgment of the attending Registered Medical Practitioner, not rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner; and

2) is in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice in the locality for the treatment or service rendered.

"**Outpatient**" shall mean the Insured Person receives Medically Necessary non-surgical services and supplies in connection with treatment for a Disability in the office or clinic of a Registered Medical Practitioner, or in the Outpatient department or emergency treatment room of a Hospital where the Insured Person has not been Confined.

"**Out-of-AXA Signature Network**" shall mean the relevant Medical Services are

(i) conducted by a Registered Medical Practitioner who is listed in the AXA Signature Network directory and such Medical Services are performed at a Healthcare Facility which is not listed in the AXA Signature Network directory; or

(ii) conducted by a Registered Medical Practitioner who is not listed in the AXA Signature Network directory and such Medical Services are performed at a Healthcare Facility which is listed in the AXA Signature Network directory; or

(iii) conducted by a Registered Medical Practitioner who is not listed in the AXA Signature Network directory and such Medical Services are performed at a Healthcare Facility which is not listed in the AXA Signature Network directory.

"**Overall Annual Benefit Limit**" shall mean the maximum aggregate amount of benefits payable by the Company under Part 8 of these Terms and Conditions in any one (1) policy year and is shown in the Policy Schedule for the applicable plan option. The Overall Annual Benefit Limit is counted afresh in each and every policy year.

"**Period of Insurance**" shall mean the period as specified as "Period of Insurance" in the Policy Schedule or subsequent Endorsement to this Policy.

"**Physiotherapist**" shall mean a duly qualified practitioner in the field of physiotherapy registered and legally authorised in the geographical area of his practice to render physiotherapy treatment, but in no circumstance shall include the following persons – the Insured Person, the Policyholder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policyholder and/or Insured Person (unless approved in advance by the Company in writing).

"**Policy**" shall mean this "FirstCare Plus Medical Insurance" policy underwritten and issued by the Company, which is the entire contract between the Policyholder and the Company including but not limited to these Terms and Conditions, Application, declarations, Policy Schedule and any Endorsements, supplements, schedules or attachments attached to this Policy, the Company's Schedule of Surgical Procedure for Day Case Procedure may be supplied with this Policy or published or notified to the Policyholder from time to time.

"**Policyholder**" shall mean the person who owns this Policy and who is aged between eighteen (18) years old and eighty (80) years old at the date of Application, and named as the "Policyholder" in the Policy Schedule or the subsequent Endorsement to this Policy.

"**Policy Schedule**" shall mean a schedule attached to this Policy, which sets out the insurance details including the Effective Date, the name and the relevant particulars of the Policyholder and Insured Person(s), the eligible benefits and premium details under this Policy.

"**Pre-authorisation**" shall mean the authorisation issued by the Company to the Insured Person before the performance of relevant Medical Services, evidencing that the Company has received and approved the pre-authorisation request prior to the performance of such Medical Services.

"**Pre-existing Conditions**" shall mean: -

(a) Disabilities which existed before the Effective Date in respect of an Insured Person and which presented signs or symptoms of which the Insured Person was aware or should reasonably have been aware.

(b) Without prejudice to (a), the following Disabilities when occurring during the first year from the Effective Date (but not to the exclusion of all others):
    (i) tumours of internal organs;
    (ii) haemorrhoids;
    (iii) diseased tonsils requiring surgery;
    (iv) pathological abnormalities of nasal septum or turbinates;
    (v) hyperthyroidism;
    (vi) cataracts;
    (vii) sinus conditions requiring surgery;
    (viii) hallux valgus.

(c) Without prejudice to (a) and (b), the following Disabilities when occurring during the first 6 months from the Effective Date (but not to the exclusion of all others):
    (i) tuberculosis;
    (ii) anal fistulae;
    (iii) gall stones;
    (iv) calculi of kidney, urethra or bladder;
    (v) hypertension, cardiac disease or vascular disease;
    (vi) gastric or duodenal ulcer;
    (vii) tumours of skin, muscular tissue, bone tumours or malignancies of blood or bone marrow;
    (viii) diabetes mellitus.

"**Public Hospital**" shall mean any Hospital that is run, operated, controlled or subsidised by the Government or the Hospital Authority of Hong Kong.

"**Reasonable and Customary**" shall mean, in relation to a charge for Medically Necessary Medical Services, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar Medical Services or supplies to individuals of the same sex and similar Age, for a similar Disability, as reasonably determined by the Company in good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred.

In determining whether a charge is Reasonable and Customary, the Company shall make reference to the following (if applicable) -

(a) Medical Services fee statistics and surveys in the insurance or medical industry;

(b) internal or industry claim statistics;

(c) gazette published by the Government; and/or

(d) other pertinent source of reference in the locality where the Medical Services or supplies are provided.

The Company reserves the right to adjust any and all benefits payable under these Terms and Conditions which in the opinion of the Company's medical examiner is not a Reasonable and Customary charge.

"**Registered Medical Practitioner**" shall mean, as the context requires, a Specialist or Surgeon,

(a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in good faith); and

(b) legally authorised for rendering relevant western Medical Services in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Services are provided to the Insured Person,

but in no circumstance shall include the following persons – the Insured Person, the Policyholder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policyholder and/or Insured Person (unless approved in advance by the Company in writing). If the practitioner is not duly qualified and registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in good faith), the Company shall exercise reasonable judgment to determine whether such practitioner shall nonetheless be considered qualified and registered.

"**Renewal**", "**Renew**", "**Renewed**" or "**Renewable**" shall mean the Policy is renewed for another policy year on the condition that the applicable premium is paid in full in accordance with these Terms and Conditions without any discontinuance.

"**Renewal Date**" or "**Renewal Dates**" shall mean a date twelve (12) months after the first day of the Period of Insurance, unless it is otherwise defined in by any Endorsement(s).

"**Schedule of Surgical Procedure for Day Case Procedure**" shall mean the list of surgical procedures attached to these Terms and Conditions that set out the surgical procedures which are required to be performed as Day Case Procedures. The schedule is published from time to time and subject to regular review by the Company.

"**Shortfall**" shall mean any shortfall resulting from payment by the Company of any expenses incurred by the Insured Person which are not Eligible Expenses or that exceed the relevant benefit limit and/or the Overall Annual Benefit Limit as specified in the Policy Schedule.

"**Sickness**", "**Disease**" or "**Illness**" shall mean a physical or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occurs to the Insured Person and whether or not any diagnosis is confirmed.

"**Specialist**" shall mean a Registered Medical Practitioner who is registered in the Specialist Register of the Medical Council of Hong Kong or equivalent and qualified to practise specialist care according to the qualified speciality.

"**Terms and Conditions**" shall mean the terms and conditions in Part 1 to Part 11 of this Policy.

"**Treatment**" or "**Treatments**" shall mean surgical procedures or Day Case Procedure (as the context requires) and the sole purpose of which is the cure or relief of a Disability.

"**Within AXA Signature Network**" shall mean (i) any Medical Service which is conducted by a Registered Medical Practitioner who is listed in the AXA Signature Network directory; and (ii) such Medical Service is performed at a Healthcare Facility which is listed in the AXA Signature Network directory.

"**Working Day**" or "**Working Days**" shall mean any business day on which the Company normally operates.

PART 2

1. INSURING CLAUSE

During the period of time the Policy is in force, if the Insured Person suffers from a Disability, the Company shall pay the Eligible Expenses in accordance with the Terms and Conditions of this Policy.

All benefits shall be payable to the Policyholder or Insured Person or any other party rendering the benefits under this Policy, in accordance with the actual amount of Eligible Expenses incurred and are subject to the Overall Annual Benefit Limit and other conditions as stated in the Policy Schedule and the Terms and Conditions of this Policy.

Notwithstanding the above, no Lifetime Benefit Limit shall be applicable to this Policy.

2. THE POLICY

This Policy is made between the Policyholder and the Company and each of the party agrees that -

(a) This Policy shall consist of these Terms and Conditions, the Application, the Policy Schedule and any Endorsements, supplements, schedules, or Schedule of Surgical Procedure for Day Case Procedure as may be supplied with this Policy or as published or notified to the Policyholder from time to time or attachments attached to these Terms and Conditions, all of which shall be read together as one contract formed between the Policyholder and the Company.

(b) No alteration to these Terms and Conditions shall be valid unless it is made in accordance with these Terms and Conditions.

(c) All statements made by or for the Insured Person in the Application shall be treated as representations and not warranties.

(d) All information provided and all statements made by or for the Insured Person as required under, but not limited to, this Policy and the Application shall be provided to the best of his knowledge and in his utmost good faith.

(e) This Policy comes into force on the Effective Date as specified in the Policy Schedule on the condition that the Policyholder has paid the first premium in full.

(f) At the time this Policy is first issued and/or when the Company approves the Application of reinstatement, the Company may, by way of Endorsement, supplement, schedule or attachment to these Terms and Conditions, apply Case-based Exclusion due to a Pre-existing Condition or other factor that affects the insurability of the Insured Person notified to the Company in the Application.

(g) If the Policyholder or Insured Person fails to make the relevant disclosures, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right as provided in sections 15 and 16 of Part 3.

PART 3

GENERAL CONDITIONS

1. Interpretation

(a) Throughout this Policy, where the context so requires, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.

(b) Headings are for convenience only and shall not affect the interpretation of this Policy.

(c) A time of day is a reference to the time in Hong Kong.

(d) Day or days in this Policy is referring to calendar day unless otherwise specified.

(e) Unless otherwise defined, capitalised terms used in this Policy shall have the meanings ascribed to them under Part 1.

2. Cancellation within cooling-off period

The Policyholder may exercise the right of cancellation with full refund of premium paid during the cooling-off period. The cancellation right is subject to the following conditions -

(a) The request to cancel must be signed by the Policyholder and received by the Company within thirty (30) days after -

(i) The date of the delivery of the Policy; or

(ii) the issuance of a notice to the Policyholder or his representative stating that the Policy is available and when the cooling-off period would expire;

whichever is the earlier; and

(b) no refund can be made if a benefit payment has been made, is to be made or impending during the cooling-off period.

The above right shall not apply at Renewal.

To exercise this right, the Policyholder must -

(c) return the original Policy; and

(d) attach a letter, signed by the Policyholder, requesting cancellation or in other forms acceptable by the Company.

Subject to the Terms and Conditions, the Policy shall then be cancelled and the premium paid shall be fully refunded. In such event, this Policy shall be deemed to have been void from the Effective Date and the Company shall not be liable to pay any benefit.

3. Cancellation after cooling-off period

After the cooling-off period, the Policyholder can request to cancel the Policy by not renewing the Policy upon giving at least ten (10) Working Days prior written notice to the Company immediately before the Policy Renewal Date. Cancellation of the Policy under this section will take effect on the day immediately after the Expiry Date of the policy year during which the Policy remains valid.

4. Benefit entitlement

If Eligible Expenses are incurred for Medical Services provided to the Insured Person, the Policy Schedule and the Terms and Conditions of this Policy prevailing at the time such Eligible Expenses are incurred shall be applicable to the Eligible Expenses under the relevant section.

5. Assignment

The rights, benefits, obligations and duties of the Policyholder under these Terms and Conditions shall not be assignable. The Company shall be entitled to without the consent of the Policyholder and/or Insured Person assign any or all of its rights and duties under this Policy.

6. Clerical error

Clerical errors in keeping the records shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

7. Currency

Any claim for Eligible Expenses made by the Insured Person in any foreign currency shall be converted to HKD at the exchange rate adopted by the Company from time to time.

8. Discharge of Company's Liability

The payment of a benefit to the Insured Person or the Policyholder or a bank account at The Hongkong and Shanghai Banking Corporation Limited as nominated by the Policyholder, or to any other party rendering the benefits under this Policy shall be a full and an effective discharge of the Company's liability in respect of that benefit under this Policy.

9. Interest

Save as otherwise specified in this Policy, no benefit and expenses payable under this Policy shall carry interest.

10. Certification, information and evidence

All certificates, information and evidence as required by the Company shall be furnished at the expenses of the Insured Person and/or Policyholder.

11. Adjustment of the premium rate of this Policy

At the beginning of each policy year, the Company shall have the right to adjust the rate of the premiums payable on this Policy and on any supplemental provision. The Company shall, in accordance with section 4 of Part 6 of these Term and Conditions, specify the adjusted premium of Renewal in a written notice to be sent to the Policyholder not less than forty-five (45) days prior to the Renewal Date.

12. Governing law

This Policy is issued in Hong Kong and shall be governed by and construed in accordance with the laws of Hong Kong. The Company and Policyholder agree to be subject to the exclusive jurisdiction of the Hong Kong courts.

13. Dispute resolution

If any dispute, controversy or disagreement arises out of this Policy, including matters relating to the validity, invalidity, breach or termination of this Policy, the Company and Policyholder shall use their endeavours to resolve it amicably, failing which, it may (but is not obliged to) be referred to any form of alternative dispute resolution, including but not limited to mediation or arbitration, as may be agreed between the Company and the Policyholder, before it is referred to a Hong Kong court.

14. Liability

The Company shall not accept any liability under this Policy unless the Terms and Conditions of this Policy relating to anything to be done or not to be done are duly observed and complied with by the Policyholder and Insured Person, and the information, representations and declaration made and/or provided by the Policyholder and/or Insured Person are correct.

15. Misstatement of personal information

Without prejudice to the Company's right to declare this Policy (in whole or in part) void in the case of misrepresentation on health related information or fraud as provided in section 16 of this Part 3, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or other personal information) is misstated in the Application or in any subsequent document submitted to the Company for the purpose of the Application, the Company may adjust the premium, for the past, current or future policy years, on the basis of the correct information. Where additional premium is required, no benefits shall be payable unless such additional premium has been paid. If the additional required premium is not paid within a grace period of thirty (30) days after the due date as notified by the Company to the Policyholder, the Company shall have the right to terminate this Policy with effect from such due date, in which case section 17 of this Part 3 shall apply. Where there has been an overpayment of premium by the Policyholder, the Company shall refund the overpaid premium.

Where the Company, based on the correct information of the Insured Person and the Company's underwriting guidelines, considered that the Application of the Insured Person should have been rejected, the Company shall have the right to declare this Policy void as from the Effective Date or Date of Reinstatement as specified in section 4 under Part 4; and notify the Policyholder that no cover shall be provided for the Insured Person. In such circumstances, if a benefit has been paid in respect of the Insured Person, the Company shall have -

(a) the right to demand refund of the benefits previously paid; and

(b) the obligation to refund the premium received,

in each case for the current policy year and the previous policy years in which the Policy was in force, subject to a reasonable administration charge payable to the Company. This refund arrangement shall be the same as that in section 16 of this Part 3.

16. Misrepresentation or fraud

The Company has the right to declare this Policy (in whole or in part) void as from the Effective Date or Date of Reinstatement as specified in section 4 of Part 4; and refuse to provide coverage in case of any of the following events -

(a) any material fact relating to the health related information of the Insured Person which may impact the risk assessment by the Company is incorrectly stated in, or omitted from, the Application or any statement or declaration made for or by the Insured Person in the Application (including Application of reinstatement). The circumstances that a fact shall be considered "material" include, without limitation, the situation where the disclosure of such fact at the time of Application submission would have affected the underwriting decision of the Company, such that the Company would have imposed Case-based Exclusion, or rejected the Application. For the avoidance of doubt, this paragraph (a) shall not apply to non-health related information of the Insured Person, which shall be governed by section 15 of this Part 3; or

(b) any Application or claim submitted is fraudulent or where a fraudulent representation is made.

In the event of (a), the Company shall have -

(i) the right to demand refund of the benefits previously paid; and

(ii) the obligation to refund the premium received,

in each case for the current policy year and the previous policy years in which the Policy was in force, subject to a reasonable administration charge payable to the Company.

In the event of (b), the Company shall have -

(iii) the right to demand refund of the benefits previously paid; and

(iv) the right not to refund the premium received.

17. Termination of Policy

This Policy shall be automatically terminated on the earliest of the followings -

(a) when the Policy is terminated due to non-payment of premiums after the grace period as specified in section 15 of this Part 3 or section 3 of Part 5; or

(b) when the Shortfall is not settled within fifteen (15) days of the receipt of a Shortfall advice from the Company; or

(c) upon the death of all Insured Persons under the Policy; or

(d) the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write or continue to write this Policy.

If the Policy is terminated pursuant to this section 17, the termination shall be effective at 00:00 hours of the effective date of termination.

Immediately following the termination of this Policy, insurance coverage under this Policy shall cease to be in force. No premium paid for the current policy year and previous policy years shall be refunded, unless specified otherwise.

Where the Policy is terminated pursuant to (a), the effective date of termination shall be the date that the unpaid premium is first due.

Where the Policy is terminated pursuant to (b), the effective date of termination shall be fifteen (15) days after receipt of the Shortfall advice from the Company.

Where the Policy is terminated pursuant to (c) or (d), the Company shall refund the relevant premium paid for the current policy year on a daily pro-rata basis.

This Policy shall also be terminated if the Policyholder decides not to Renew this Policy in accordance with section 3 of this Part 3 or section 1 of Part 6, as the case may be, by giving the requisite written notice to the Company. If the Policy is terminated under section 3 of this Part 3, or is not Renewed under section 1 of Part 6, the effective date of termination shall be the day immediately after the Expiry Date of the policy year during which the Policy remains valid.

18. Notices to Company

All notices which the Company requires the Policyholder to give shall be in writing, or in other forms acceptable by the Company, addressed to the Company.

19. Notices from Company

Any notice to be given under this Policy shall be sent by post to the latest address of the Policyholder as notified to the Company, or sent by email to the latest email address of the Policyholder as notified to the Company. Any notice so served shall be deemed to have been duly received by the Policyholder as follows -

(a) if sent by post, four (4) Working Days after posting; or

(b) if sent by email, on the date and time transmitted.

20. Other insurance

If the Insured Person is being insured by other insurance policies besides this Policy, the Policyholder shall have the right to claim under any such other insurance policies or this Policy. However, if the Policyholder or Insured Person has already recovered all or part of the expenses from any such other insurance policies, the Company shall only be liable for such amount of Eligible Expense, if any, which is not compensated by any such other insurance policies.

21. Change of Policyholder

Subject to the approval of the Company at its discretion, the Policyholder may transfer the ownership of the Policy by completing the prescribed form and sending it to the Company. The change of ownership shall not be effective until the Company has approved the change and notified in writing to the Policyholder and transferee. From the effective date of the change of ownership, the transferee shall be treated as the Policyholder, and be responsible for the payment of the premiums including any outstanding premiums.

The Company shall not reject any Application by the Policyholder for the transfer of ownership to -

(a) the Insured Person if he has reached the Age of eighteen (18) years; or

(b) the parent or guardian of the Insured Person if he is under the Age of eighteen (18) years.

If the Policyholder dies, the ownership of the Policy shall be transferred to -

(c) the Insured Person if he has reached the Age of eighteen (18) years; or

(d) the administrator or executor of the Policyholder's estate if the Insured Person is under the Age of eighteen (18) years.

The transfer of ownership of the Policy in accordance with the above paragraph shall be conditional upon the Company having received satisfactory evidence of the Policyholder's death.

22. Rights of third parties

Any person or entity who is not a party to this Policy shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap. 623 of the Laws of Hong Kong) to enforce any Terms and Conditions of this Policy.

23. Subrogation

After the Company has paid a benefit under this Policy, the Company shall have the right to proceed at its own expense in the name of the Policyholder and/or Insured Person against any third party who may be responsible for events giving rise to such benefit claim under this Policy. Any amount recovered from any such third party shall belong to the Company to the extent of the amount of benefits which has been paid by the Company in respect of the relevant benefit claim under this Policy. The Policyholder and/or Insured Person must provide full details in his possession or within his knowledge on the fault of the third party and fully cooperate with the Company in the recovery action. For the avoidance of doubt, the above subrogation right shall only apply if the third party is not the Policyholder or Insured Person.

24. Suits against third parties

Nothing in this Policy shall oblige the Company to join, respond to or defend (or indemnify in respect of the costs for) any suit or alternative dispute resolution process for damages for any cause or reason which may be instituted by the Policyholder or Insured Person against any Registered Medical Practitioner, Anaesthetist, Healthcare Facility or any healthcare services provider, including without limitation to any suit or alternative dispute resolution process for negligence, malpractice or professional misconduct or any other causes in relation to or arising out of the medical investigation or provision of Medical Services in connection with a Disability of the Insured Person under the Terms and Conditions of this Policy.

25. Waiver

No waiver by any party of any breach by any other party of any provisions of this Policy shall be deemed to be a waiver of any subsequent breach of that or any other provision of this Policy, and any forbearance or delay by any party in exercising any of its rights under this Policy shall not be construed as a waiver of such rights. Any waiver shall not take effect unless it is expressly agreed, and the rights and obligations of the Company and Policyholder under this Policy shall remain in full force and effect except and only to the extent that they are waived.

26. Compliance with Law

If this Policy is or becomes illegal under the law applicable to the Policyholder or Insured Person, the Company shall have the right to declare this Policy void from the date it becomes illegal and the Company shall refund the relevant premium received for such period this Policy is void on a pro rata basis.

27. Personal data privacy

The Company shall comply with the Personal Data (Privacy) Ordinance (Cap. 486 of the Laws of Hong Kong) and the related codes, guidelines and circulars.

PART 4

CONDITIONS FOR ELIGIBILITY AND PARTICIPATION

1. Additions and Deletions of Insured Person(s)

Subject to the Terms and Conditions in this Policy, the Policyholder may apply to add or remove any Insured Person(s) under this Policy by submitting a completed form prescribed by the Company pursuant to the paragraphs below:

(a) For any addition of an Insured Person, the request of addition of an Insured Person can be submitted at any time during the policy year. Subject to the Company's approval, the Policyholder shall pay the premium for the additional Insured Person calculated on a daily pro-rata basis from the date the addition is approved by the Company and the coverage for the additional Insured Person shall be deemed effective as of the date of such addition.

(b) For any deletion of an Insured Person, the Policyholder should submit a form to the Company at least ten (10) Working Days prior to the Renewal Date. Subject to the Company's approval, such deletion will be effective upon Renewal.

In the event that no claims have been paid or are payable by the Company in connection with the Insured Person to be deleted in that policy year, the request of deletion of that Insured Person can be submitted at any time during the policy year. Such deletion will be effective upon the Company's approval. On the condition that the Company has already fully received the annual premium for that policy year, the Company will refund the premium received in respect of that Insured Person to be deleted in accordance with the table as stipulated below:

Period covered	Premium refund (% of the total annual premium received)
Less than or up to 4 months	50%
More than 4 or up to 5 months	40%
More than 5 or up to 6 months	30%
More than 6 or up to 8 months	20%
Over 8 months	Nil

2. Duplicate Application

An Insured Person shall not be covered under more than one FirstCare Plus Medical Insurance policy issued by the Company. In the event that an Insured Person is covered under more than one such policy, the Company will consider that person to be insured under the policy which provides the greatest amount of benefit. When the benefit under each such policy is identical, the policy first issued by the Company will be the only one considered by the Company for payment of benefits. The Company will refund any duplicated insurance premium payment which may have been made by or on behalf of that Insured Person.

3. Take-over Membership

If this Policy shall have commenced immediately upon termination of a preceding policy, and subject to the Company's approval in writing and the Terms and Conditions of this Policy, and provided that the Company shall have prior to the Effective Date been provided with a copy of such preceding policy, the following shall apply:

(a) If an Insured Person shall have been afflicted with an existing Disability which has been disclosed to the Company at the Effective Date and for which benefits would have been available to him under the preceding policy had it remained in force, the Insured Person shall continue to be covered for such existing Disability under the Terms and Conditions of this Policy, but not exceeding the maximums or limits of the benefits under the preceding policy, or this Policy, which ever shall be the lesser and such existing Disability incurred during the period of preceding policy will not be excluded; and

(b) All references to "Effective Date" in the definition of "Pre-existing Condition" on Part 1 of this Policy shall be read as "Effective Date of the preceding policy"; and

(c) Any other Terms and Conditions endorsed to the Policy (if any).

4. Reinstatement

If this Policy is terminated for any reason, the Policyholder may apply to the Company in writing to reinstate this Policy within two (2) months after the Policy is lapsed. The application will be made on a form prescribed by the Company, acceptance and approval by the Company shall reinstate this Policy as of the date of such acceptance and approval ("Date of Reinstatement") provided the Policyholder shall have paid all overdue premium with interest as determined by the Company prior to the Date of Reinstatement. The reinstated Policy shall cover only medical expenses caused by a Disability commenced after the Date of Reinstatement.

5. Change of plan options

For any change of plan options, the Policyholder may apply to the Company in writing to change the plan option at least ten (10) Working Days prior to each Renewal Date. Such Application shall be made in a form prescribed by the Company and re-underwriting is only required for the change of plan option to a higher level. Subject to the Company's approval, such change of plan option will be effective on the Renewal Date.

PART 5

PREMIUM PROVISIONS

1. Premium payable

The premium payable for this Policy with respect to the coverage in these Terms and Conditions refers to the annual premium payable according to the prevailing premium schedule adopted by the Company which may be changed by the Company from time to time without prior notice.

2. Payment of premiums

The amount of premium payable is specified in the Policy Schedule or any Endorsements attached to this Policy. The premium paid annually shall be paid in advance according to these Terms and Conditions when due before any benefits under this Policy shall be paid.

Premium once paid shall not be refundable, unless otherwise specified in these Terms and Conditions.

Premium due dates, Renewal Dates and policy years are determined with reference to the Effective Date as shown in the Policy Schedule. The first premium is due on the Effective Date and the subsequent premium is due on each Renewal Date.

3. Grace period

The Company shall allow a grace period of thirty (30) days after the premium due date for payment of each premium. The Policy shall continue to be in effect during the grace period but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, the Policy shall be terminated immediately on the date on which the unpaid premium is first due.

PART 6

RENEWAL PROVISIONS

1. Renewal

This Policy shall be effective from the Effective Date in consideration of the payment of premium and is Renewable on an annual basis in accordance with the Terms and Conditions of this Part 6. Subject to the availability of the Policy, Renewal of this Policy is arranged automatically at each Policy Renewal Date subject to the necessary adjustment of the premium rate, Terms and Conditions and Policy Schedule applicable at the time of Renewal.

Renewal of this Policy shall not be subject to re-underwriting, save for the limited circumstances stated in section 5 of this Part 6.

2. Revision

The Company shall have the right to revise these Terms and Conditions or the Policy Schedule upon Renewal, and such revision will apply to the Policy automatically.

3. Premium

Irrespective of whether the Company revises these Terms and Conditions or the Policy Schedule under this Policy upon Renewal, the Company shall have the right to adjust the premium according to the prevailing premium schedule adopted by the Company.

During each policy year and upon Renewal, the Company shall not, subject to section 5 under this Part 6, impose any Case-based Exclusion on the Insured Person by reason of any change in the Insured Person's health conditions.

4. Notification of Renewal

Irrespective of whether the Company revises these Terms and Conditions or the Policy Schedule under this Policy upon Renewal, the Company shall give the Policyholder a written notice of not less than forty-five (45) days prior to the Renewal Date.

The written notice shall specify the adjusted premium for Renewal and the Renewal Date. If the Company revises these Terms and Conditions upon Renewal, the Company shall make available the revised Terms and Conditions to the Policyholder together with the written notice. The revised Terms and Conditions and premium for Renewal shall take effect on the Renewal Date.

5. No re-underwriting except in limited circumstances

No re-underwriting by the Company is needed for any change in the coverage under this Policy that applies on all policies of the same Terms and Conditions and Policy Schedule. This applies to any change including but not limited to where there is any upgrade or downgrade of any benefits, or any addition or removal of any benefits, whether they are in Endorsements or otherwise.

Notwithstanding the foregoing, re-underwriting by the Company is needed under the following circumstances -

(a) when the Policyholder requests to reinstate the Policy;

(b) when the Policyholder requests to switch to other plan options of the Policy which provides upgrade or addition of benefits as permitted under these Terms and Conditions.

  (i) However, at any time when the Policyholder requests to switch to other plan options of the Policy which provides downgrade of benefits as permitted under these Terms and Conditions, no re-underwriting of this Policy is required but the Company shall have the discretion to accept or reject the request according to its prevailing practices in handling similar requests;

  (ii) the Company shall not have the right to terminate or not to Renew this Policy if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policyholder.

The Company and Policyholder acknowledge that -

(c) if under the Terms and Conditions of this Part 6, the Company has the right, or is required, to re-underwrite this Policy based on certain factors at Renewal, the Company shall, in accordance with the Terms and Conditions of this Part 6 and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and

(d) as a result of re-underwriting, this Policy may be terminated, and/or new Case-based Exclusions may be applied.

PART 7

CLAIM PROVISIONS

1. Submission of claims

All claims incurred shall be submitted to the Company within ninety (90) days after the date on which the Insured Person is discharged from the Hospital, or (where there is no Confinement) the date on which the relevant Medical Service is performed and completed. For this purpose, a claim shall be deemed not valid or complete and benefit shall not be payable unless -

(a) all original receipts and/or original itemised bills together with the diagnosis, type of Medical Service provided shall have been submitted to the Company's satisfaction;

(b) all relevant information, certificates, reports, evidence, referral letter and other data or materials as reasonably required by the Company shall have been furnished to the Company for processing of such claim at the expenses of the Policyholder; and

(c) all documents including but not limited to those stated in (a) and (b) above shall be written in Chinese or English. Translation is required for any written language which is not in Chinese or English, and the cost of the arranging such translation shall be borne by the Policyholder.

Policyholders shall notify the Company with reasonable reasons together with the supporting documents (if any) if claims cannot be submitted to the Company within the above timeframe, otherwise the Company shall have the right to reject claims submitted after the above timeframe. All certificates, information and evidence that are reasonably required by the Company and which can be reasonably provided by the Policyholder shall be furnished at the expenses of the Policyholder.

2. Legal action

No legal action shall be brought by the Policyholder to recover any claim amount payable under this Policy within the first sixty (60) days from which all proof of claims as required by the Policy has been received by the Company.

3. Medical examination

When a claim occurs, the Company shall have the right to require the Insured Person to be examined by a Registered Medical Practitioner appointed by the Company at the Company's cost.

PART 8

BENEFIT PROVISIONS

1. Territorial scope of cover

All benefits described in this Policy are applicable worldwide except the United States of America (USA).

2. Benefits covered

Subject to the Terms and Conditions of the Policy, if the Insured Person, while this Policy is in force, receives Medical Services, the Company will pay for the benefits subject to applicable limits set out in this Policy and further to the condition that the following reimbursement percentages of Eligible Expenses shall be applied to the calculation of the benefit payable under sections 3 to 13 of this Part 8 according to the requirements as set out below:

(i) Within AXA Signature Network Benefit

One hundred per cent (100%) of the actual Eligible Expenses will be payable, provided that

(a) The relevant Medical Service is conducted Within AXA Signature Network;

(b) The Insured Person has notified the Registered Medical Practitioner who is listed in the AXA Signature Network directory that the Insured Person is insured under this Policy by presenting the Card and identification document at least two (2) Working Days before the performance of the relevant Medical Service; and

(c) The Insured Person has received confirmation from the Company before the performance of the relevant Medical Service regarding the approval of the relevant Medical Services. In this regard, the receipt of the confirmation from the Company does not amount to acceptance by the Company of liability and/or responsibility for all of the charges of such relevant Medical Services.

For the avoidance of doubt, while only the above requirement (a) is fulfilled but not the requirements (b) and/or (c), the reimbursement percentage of Out-of-AXA Signature Network Benefit without Pre-authorisation under section 2(iii) of this Part 8 below shall apply.

(ii) Out-of-AXA Signature Network Benefit with Pre-authorisation

One hundred per cent (100%) of the actual Eligible Expenses will be payable, provided that

(a) The relevant Medical Service (excluding those Medical Services as specified under sections 2(iv) and 2(v) of this Part 8 below) is conducted at Out-of-AXA Signature Network;

(b) Request for Pre-authorisation has been submitted to the Company at least five (5) Working Days before the performance of the relevant Medical Service by (i) the Insured Person if the Medical Service is conducted by a Registered Medical Practitioner who is not listed in the AXA Signature Network directory or (ii) the Registered Medical Practitioner who is listed in the AXA Signature Network directory if the Medical Service is conducted by such Registered Medical Practitioner. In this regard, the Insured Person has to notify the Registered Medical Practitioner that he is insured under this Policy by presenting the Card and identification document at least five (5) Working Days before the performance of the relevant Medical Service; and

(c) The Insured Person has received confirmation from the Company before the performance of the relevant Medical Services regarding the approval of the relevant Medical Services. In this regard, the receipt of the confirmation from the Company does not amount to acceptance by the Company of liability and/or responsibility for all of the charges of such relevant Medical Services.

For the avoidance of doubt:

(d) while only the above requirement (a) is fulfilled but not requirements (b) and/or (c), the reimbursement percentage of Out-of-AXA Signature Network Benefit without Pre-authorisation under section 2(iii) of this Part 8 below shall apply; and

(e) if the relevant Medical Service is performed in a Public Hospital, the reimbursement percentage of Confinement in a public ward of a Public Hospital under section (2)(iv) of this Part 8 below shall apply.

(iii) Out-of-AXA Signature Network Benefit without Pre-authorisation

Eighty per cent (80%) of the actual Eligible Expenses will be payable for Standard Plan, Enhanced Plan and Top Plan; or none (0%) of the actual Eligible Expenses will be payable for Basic Plan and Saver Plan, provided that

(a) The relevant Medical Service (excluding those Medical Services as specified under sections 2(iv) and 2(v) of this Part 8 below) is conducted at Out-of-AXA Signature Network; and

(b) No request or late request for Pre-authorisation has been submitted to the Company before the performance of the relevant Medical Service ; and/or

(c) No confirmation from the Company is received by the Insured Person before the performance of the relevant Medical Service.

For the avoidance of doubt, if the relevant Medical Service is performed in a Public Hospital, the reimbursement percentage of Confinement in a public ward of a Public Hospital under section 2(iv) of this Part 8 below shall apply.

(iv) Confined in a public ward of a Public Hospital

One hundred per cent (100%) of actual Eligible Expenses will be payable, provided that the relevant Medical Service is conducted in a public ward of a Public Hospital. For the avoidance of doubt, no medical expense will be covered unless the relevant Medical Service is conducted in a public ward of a Public Hospital.

(v) Accident and Emergency

One hundred per cent (100%) of actual Eligible Expenses will be payable, provided that the relevant Medical Service, which is conducted in a Hospital, is due to an Emergency (including Emergency induced by Accident).

For the avoidance of doubt, if the relevant Medical Service is performed in a Public Hospital, the reimbursement percentage of Confinement in a public ward of a Public Hospital under section 2(iv) of this Part 8 above shall apply.

For the avoidance of doubt,

(i) the amount of Eligible Expenses payable under this Policy shall not exceed the actual costs for Medical Services provided to the Insured Person, subject to the applicable maximum limits (if any) as shown in the Policy Schedule and the applicable Overall Annual Benefit Limit of the plan option as stated in the Policy Schedule.

(ii) the Company shall treat any procedure or operation as a Day Case Procedure if such procedure or operation is listed under the Schedule of Surgical Procedure for Day Case Procedure, and accordingly benefit items under sections 6, 7, 8, 17 and 19 of this Part 8 will not be available. The Eligible Expenses payable under other benefit items (if any) of this Part 8 in relation to such procedure or operation shall be reduced accordingly to such level which does not exceed the Reasonable and Customary charges being charged for similar Day Case Procedure in the locality where the expenses are incurred.

(iii) only Eligible Expenses incurred for Medical Services provided to the Insured Person shall be payable under this Policy. Expenses incurred for Medical Services undergone by or provided to persons other than the Insured Person shall not be covered, unless otherwise specified.

3. Room and board

Actual Eligible Expenses on room and board incurred by the Insured Person for the cost of accommodation and meals charged by the Hospital shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured Person is Confined in a Hospital or undergoes any Day Case Procedure or Cancer Treatments and incurs charges in relation to such accommodation and meals, but in no event shall the benefit exceed the maximum number of days per policy year in relation to this section as specified in the Policy Schedule.

4. Miscellaneous charges

Actual Eligible Expenses on miscellaneous charges incurred shall be payable when the Insured Person is Confined in a Hospital or on the day he undergoes any Day Case Procedure for receiving Medical Services. These charges shall cover the following -

(a) Anaesthetic and oxygen administration;

(b) Administration charges for blood transfusion, but not the cost of blood or blood plasma;

(c) Dressing and plaster casts;

(d) Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;

(e) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing one (1) week of prolonged stay;

(f) Medical disposables, consumables and equipment; but excluding those medical implants which shall be covered under section 5 of this Part 8.

(g) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Advanced Diagnostic Imaging Tests which shall be covered under section 12 of this Part 8;

(h) Intravenous ("IV") infusions including IV fluids;

(i) Laboratory examinations, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure; and

(j) Physiotherapy during Confinement.

5. Specified Medical Implants

When Surgeon's fee under section 9 of this Part 8 is payable, the Company shall pay the actual Eligible Expenses for the medical implants implanted in the Insured Person during surgery (excluding replacement procedure), which are Medically Necessary, and required to perform the surgery. This benefit shall include but not limited to the following implants:

(a) pace maker;

(b) stents for Percutaneous Transluminal Coronary Angioplasty;

(c) monofocal intraocular lens;

(d) artificial cardiac valve;

(e) metallic or artificial joints for joint replacement;

(f) prosthetic ligaments for replacement or implantation between bones; and

(g) prosthetic intervertebral disc.

6. Attending doctor's visit fee

If on any day of Confinement it is Medically Necessary for the Insured Person to be treated by a Registered Medical Practitioner, the Company shall pay an amount equal to the actual Eligible Expenses on the charges charged by the attending Registered Medical Practitioner for such visit or consultation.

7. Specialist's fee

If on any day of Confinement it is Medically Necessary for the Insured Person to be treated by a Specialist (not being the attending Registered Medical Practitioner under section 6 of this Part 8) as recommended in writing by the attending Registered Medical Practitioner, the Company shall pay an amount equal to the actual Eligible Expenses charged by the Specialist for such visit or consultation.

8. Intensive care

If on any day of Confinement, the Insured Person is admitted to an Intensive Care Unit or High Dependency Unit as an Inpatient as recommended by the attending Registered Medical Practitioner, the Company shall pay an amount equal to the actual Eligible Expenses of Room and Board charges incurred for such Confinement, but in no event shall the benefit exceed the maximum number of days per policy year in relation to this section as specified in the Policy Schedule. For the avoidance of doubt, the Eligible Expenses so incurred and payable under this section shall not be payable under section 3 of this Part 8.

9. Surgeon's fee

Actual Eligible Expenses on Surgeon's fee charged by the attending Surgeon on a Medically Necessary Treatment performed during Confinement or in a setting for providing Day Case Procedure to a Day Patient shall be payable by the Company.

If any alternative procedures including radiosurgery and radiotherapy are used for treating noncancerous condition in place of any cutting operation, the Company shall pay a benefit which is Reasonable and Customary for such alternative procedures. The use of any procedures for Cancer Treatments shall be covered under section 13 of this Part 8.

10. Anaesthetist's fee

If Surgeon's fee is payable under section 9 of this Part 8, the Company shall pay the actual Eligible Expenses incurred for Medically Necessary services rendered by the Anaesthetist in relation to the Treatment of the Insured Person.

11. Operating theatre charges

If Surgeon's fee is payable under section 9 of this Part 8, the Company shall pay the actual Eligible Expenses incurred for the Medically Necessary use of an operating theatre (including but not limited to a Treatment room and recovery room) during the Treatment of the Insured Person.

12. Advanced Diagnostic Imaging Tests

Actual Eligible Expenses on charges incurred by the Insured Person for Medically Necessary Advanced Diagnostic Imaging Test during Confinement or in a setting for providing Day Case Procedure to a Day Patient recommended in writing by the attending Registered Medical Practitioner for the investigation or treatment of a Disability shall be payable.

13. Cancer Treatments

The Company shall pay the actual Eligible Expenses incurred for (i) radiotherapy, chemotherapy, targeted therapy, hormonal therapy and immunotherapy due to a cancer and any complications thereof (if applicable), and performed with the aim of prolonging the Insured Person's life or (ii) consultation, medication, and/or diagnostic test for and in the course of cancer treatments as specified in (i) above, performed on the Insured Person due to Cancer whether as an Inpatient, Day Patient or Outpatient, which is prescribed for the Insured Person by the Insured Person's attending Registered Medical Practitioner.

For the avoidance of doubt, this benefit shall not cover any charges incurred for any consultation, medication and/or diagnostic test performed on the Insured Person, which is solely to monitor the health condition of the Insured Person.

14. Pre-Confinement/Day Case Procedure outpatient care

The Company shall pay the actual Eligible Expenses for the Insured Person's Outpatient visit or Emergency consultation which, within thirty (30) days immediately after such visit or consultation, result in a Confinement or Day Case Procedure. The number of visit or consultation under this section 14 which will be reimbursed by the Company is limited to one (1) visit per each Confinement or Day Case Procedure.

Advanced Diagnostic Imaging Tests and Cancer Treatments shall not be covered under this section.

15. Post-Confinement/Day Case Procedure outpatient care

The Company shall pay the actual Eligible Expenses for the Insured Person's follow-up Outpatient visit, limited to two (2) visits per each Confinement or Day Case Procedure and seven (7) days' medication supply per visit, as recommended by the attending Registered Medical Practitioner within six (6) weeks immediately following the Insured Person's discharge from Hospital or completion of Day Case Procedure, provided that such Outpatient visit is directly related to and a resulted from the condition arising from the same Disability (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

Advanced Diagnostic Imaging Tests and Cancer Treatments shall not be covered under this section.

16. Post-Confinement/Day Case Procedure outpatient ancillary services

The benefit under this section is only applicable to the following plan options of this Policy: Saver Plan, Standard Plan, Enhanced Plan and Top Plan.

The Company shall pay the actual Eligible Expenses for the Insured Person's follow-up outpatient physiotherapeutic treatment which is recommended by the attending Registered Medical Practitioner and conducted by a Physiotherapist after the Insured Person's discharge from Hospital or completion of Day Case Procedure, provided that such physiotherapeutic treatment is directly related to the same Disability necessitating such Confinement or Day Case Procedure. In no event shall the benefit exceed the maximum benefits per policy year in relation to this section as stated in the Policy Schedule.

17. Companion Bed

The Company shall pay the actual Eligible Expenses levied by the Hospital for the cost of companion bed during the Insured Person's Confinement. This benefit shall not cover guest meals and is limited to the maximum number of days in relation to this section per policy year as specified in the Policy Schedule.

18. Renal Dialysis

The Company shall pay the actual Eligible Expenses for Medically Necessary haemodialysis or peritoneal dialysis performed on the Insured Person, whether as an In-Patient or Day Patient, due to a Disability, provided that the Insured Person is suffering from chronic and irreversible kidney failure, and haemodialysis or peritoneal dialysis is prescribed by the Insured Person's attending Registered Medical Practitioner.

19. Local Ambulance between Hospitals

The benefit under this section is only applicable to the following plan options of this Policy: Standard Plan, Enhanced Plan and Top Plan.

The Company shall pay the actual Eligible Expenses on charges incurred for road ambulance service between Hospitals when the Insured Person is Confined in a Hospital or on the day he undergoes any Day Case Procedure in Hospital for receiving Medically Necessary Medical Services.

20. Emergency Outpatient Treatment

The benefit under this section is only applicable to the following plan options of this Policy: Enhanced Plan and Top Plan.

The Company shall pay the actual Eligible Expenses charged by the Hospital solely for Emergency Treatment performed on the Insured Person if he sustains an Injury and is treated as a Day Patient or Outpatient within seventy-two (72) hours of the Accident resulting in such Injury.

21. Maternity Benefit

The benefit under this section is only applicable to the following plan option of this Policy: Top Plan.

The benefit under this section is only available to the Insured Person who is aged between eighteen (18) years to forty-nine (49) years old.

The Company shall pay the actual Eligible Expenses charged for the Insured Person's Confinement and surgical procedure in a Hospital due to natural childbirth, normal caesarean section, miscarriage, termination of pregnancy because of foetal abnormalities and material physical health hazard, threatened abortion or medically prescribed induced abortion. This benefit only becomes available after the Insured Person has been continuously covered under Top Plan of this Policy for twelve (12) consecutive months and has effected the Renewal of the same plan option for the subsequent policy year.

For the avoidance of doubt, the benefit shown in the Policy Schedule in relation to this section is the maximum amount that the Company shall pay for each policy year, even if there is more than one pregnancy in that policy year. This Maternity Benefit would be terminated on the Policy Renewal Date on or immediately following the Insured Person's forty-ninth (49) birthday.

22. Maternity Complications

The benefit under this section is only applicable to the following plan options of this Policy: Enhanced Plan and Top Plan.

The Company shall pay the actual Eligible Expenses charged for the Insured Person's Confinement and/or surgical procedure in a Hospital due to Emergency maternity complications as listed below as recommended by the attending Registered Medical Practitioner.

The covered maternity complications are only limited to ectopic pregnancy, molar pregnancy, antepartum haemorrhage, disseminated intravascular coagulopathy, pre-eclampsia which is the leading cause of proteinuria, foetal death, postpartum haemorrhage requiring hysterectomy, amniotic fluid embolism and pulmonary embolism during pregnancy. This benefit only becomes available after the Insured Person has been continuously covered under Enhanced Plan or Top Plan of this Policy for twelve (12) consecutive months and has effected the Renewal of Enhanced Plan or Top Plan of this Policy for the subsequent policy year.

23. Adjustment Factor

When the Insured Person is Confined, whether voluntarily or involuntarily, to a type of room of a Hospital which is of a class higher than his entitled room type as specified in the Policy Schedule, a percentage corresponding to the relevant room type as set out in the table below shall be applied to the calculation of benefit payable under sections 3 to 13, sections 17 to 18 and sections 21 to 22 ("Applicable Sections") of this Part 8 of the Policy. The benefit payable will be calculated by multiplying the Eligible Expenses payable under the Applicable Sections with the adjustment factor as listed below:

Entitlement	Incurred Room Type	Adjustment Factor
General Ward	Semi-Private Room	50%
General Ward	Standard Private Room	25%
Semi-Private Room	Standard Private room	50%

For the avoidance of doubt, in the case of any Confinement in a room of a class higher than Standard Private Room, whether voluntary or involuntary, no Eligible Expenses under Applicable Sections shall be payable by the Company.

24. Limitations of Benefit

The Company is not liable for any Medical Services for which compensation or reimbursement is payable under any law, medical program, or insurance policy provided by any government, company or other insurer except to the extent that such charges are not reimbursed by such law, medical program or insurance policy.

PART 9

EXCLUSIONS

The Company shall not cover the following -

1. Treatment, procedure, medication, test or service which is not Medically Necessary.

2. Medical Services, supplies or services which are experimental, or not specifically included under Part 8. Without prejudice to the generality of the foregoing, Medical Services that have not been proven to be safe, scientifically established therapies or found to have a demonstrable benefit for a particular Disability shall not be covered. Further, any claims in respect of expenses incurred for services or supplies which are experimental in nature, including the treatment procedure, facility, equipment, drugs, drug usage, devices or supplies which have not been recognised as accepted medical practice shall not be covered.

3. (i) Medicines and drugs which are not consumed in a Hospital or prescribed by a Registered Medical Practitioner unless otherwise specified under Part 8;
   (ii) Vitamins, contraceptives or contraceptive devices, antibacterial soaps and detergents, vaccines and allergenic extracts, tonic, appetite stimulants or depressants, unless specifically covered; or
   (iii) Prescription drugs used in connection with drug addiction alcoholism, weight reduction, smoking cessation and treatment of baldness and experimental drugs.

4. Confinement primarily for diagnosis scanning, X-ray examinations or physical therapy that can be provided in an Outpatient or Day Case Procedure setting.

5. Cost of blood, blood plasma, and blood donor fees, including storage fees.

6. Expenses that are recoverable from a third party including but not limited to Medical Services rendered or compensation in connection with any Disability claimable under the Employees' Compensation Ordinance, (Cap. 282 of the Laws of Hong Kong), or any amendments thereto.

7. Cosmetic and/or, plastic surgery and/or any Medical Services solely for the purpose of beautification.

8. Congenital Conditions and Pre-existing Conditions.

9. Dental oral or oro-surgical care and treatment of any kind including orthodontic, endodontic, and periodontic services; and restorative services such as bonding, crowns, bridges, spacing devices, and dentures. The only services related to dental treatment which shall be covered under the Policy are:
   a. medical care immediately following an Accident which causes Injury to the mouth and teeth. Any following treatment thereof shall not be covered; and
   b. oral surgery when properly referred for reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant neoplasm of the jaw.

10. Eye refraction, eye refractive surgery (radial keratotomy), eye tests or fitting of glasses and all forms of treatment for strabismus.

11. Surgical or chemical contraceptive methods of birth control or treatment pertaining to infertility or in-vitro fertilisation, or sterilisation or sex reassignment of either sex.

12. Maternity, pregnancy, childbirth (including diagnostic tests for pregnancy, sex determination, surgical delivery), miscarriage, abortion, prenatal or postnatal care, fertility or infertility treatment (including reversal of voluntary sterilisation), regardless of cause except where specifically included for coverage as specified under Maternity Benefit and/or Maternity Complications in sections 21 and 22 of Part 8 respectively.

13. Trans-sexual surgery or sexual dysfunction treatment including but not limited to impotence, erectile dysfunction or premature ejaculation.

14. Circumcision unless Medically Necessary.

15. Expenses directly or indirectly arising from Human Immunodeficiency Virus (HIV) related Disability, including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutation, derivations or variations thereof, which proceeds from an HIV infection occurring prior to the Effective Date. For purposes of this exclusion, an HIV related Disability emerging within five (5) years of the Effective Date will be conclusively presumed to proceed from an HIV infection occurring prior to the Effective Date, in the absence of clear and convincing evidence to the contrary.

16. Routine or general checkups or routine blood tests, health examinations, checkups or tests not incidental to treatment or diagnosis of a covered Disability, inoculation, medication or vaccination for immunisation or quarantine purposes except where specifically listed as a covered service.

17. Any charges in respect of surgical or non-surgical cosmetic treatment, or hearing tests, vaccinations or inoculations, Hair Mineral Analysis (HMA), health supplements or body weight control, eye refraction including but not limited to routine eye tests, or any costs of fitting of spectacles or lens.

18. Treatment for mental illness and emotional disorders including treatment directly or indirectly arising from any insanity, geriatric, psycho-geriatric or psychiatric condition including but not confined to psychoses, neuroses, depression of any kind, anxiety, anorexia nervosa, bulimia, schizophrenia, and other behavioural disorders.

19. Procurement or use of special braces, appliances, hearing aids, wheelchairs, crutches, continuous positive airway pressure (CPAP) machine, drug infusion therapy equipment or any other similar equipment.

20. Procurement for the use of medical implants specified in section 5 of Part 8 for the purpose of replacement of the existing medical implants.

21. Medical or other health care services or treatment rendered in connection with any Disability directly or indirectly resulting from or consequent upon: -
    (a) Drug addiction, alcoholism, sexually transmitted disease, venereal disease or wilful misuse of drugs or alcohol, attempted suicide or intentional self-inflicted injury or participating in an illegal activity.
    (b) High risk occupations or activities including but not limited to engaging in or taking part in: -
        (i) naval, military or air force service or operations;
        (ii) aviation other than as a fare-paying passenger in an aircraft provided and operated by an airline or air charter company which is duly licensed for the regular transportation of fare-paying passengers;
        (iii) deep sea diving, mountaineering, parasailing, daring feats or stunts, potholing, driving or riding in any kind of race, or work or activities involving dangerous or contaminable substances; or
        (iv) sport activity in a professional capacity or where the Insured Person would or could earn income or remuneration from engaging in such sport.
    (c) War or any act of war (declared or undeclared), invasion, act of foreign enemies, hostilities, civil war, rebellion, revolution, insurrection, military or usurped power or terrorist act.
    (d) Any nuclear radiation or contamination or the use of ionisation or combustion of any nuclear weapons, materials energy or power or any nuclear waste. For the purpose of this exclusion, combustion shall include any self-sustaining process of nuclear fission.

22. Occupational therapy and speech therapy services.

23. Alternative medicine including but not limited to massage therapy, naturopathy, hydropathy, chiropractic, podiatry, biofeedback, hypnosis, pain clinics and homeopathy unless otherwise specified.

24. Traditional Chinese Medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na.

25. Hospice services.

26. Services required as a result of an Accident caused by the Insured Person having more than the legally permitted level of alcohol in his blood whilst driving any kind of vehicle.

27. Expenses covered by any other existing insurance, or directly or indirectly arising from health care services provided by Government facilities or by Registered Medical Practitioners or Aanesthetist employed by Government facilities except for the statutory charges required to be paid for Medical Services.

28. Charges for accommodation and nursing in any establishment which for any reason is or has effectively become the place of domicile or permanent abode.

29. The costs of collecting donor organs or tissue for transplant surgery or any administration costs involved even if such transplants are allowed under the Terms and Conditions of the Policy.

30. Sanctions Exclusion Clause

    No insurer shall be deemed to provide cover and no insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment or such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanction, laws or regulations of the European Union, United Kingdom or United States of America.

PART 10

CONDITIONS FOR THE USE OF THE FIRSTCARE PLUS MEDICAL CARD

1. Cancellation or termination of Policy

If, for any reason, this Policy is cancelled or terminated, the Policyholder shall collect all Cards issued to all the Insured Persons and return the same to the Company within seven (7) days after the date of such cancellation or termination. The Policyholder shall indemnify the Company against all claims, losses, damages, actions, proceedings, costs and expenses which may be brought against the Company or incurred by the Company arising from the use of the Cards whilst this Policy is no longer in force, whether or not the Policyholder ultimately returns all the Cards to the Company. This section shall survive termination or cancellation of this Policy.

2. Claims Disputes

Should any medical expenses or claim arising from the use of the Card be the subject of a dispute, the Policyholder agrees to immediately reimburse the amount already paid by the Company pending the decision as to whether those medical expenses are payable under the Terms and Conditions of this Policy. This section shall survive termination or cancellation of this Policy.

3. Cost exceeding Benefits

In the event of the costs incurred by any Insured Person using the Card exceed the benefit payable in respect of that Insured Person, the Policyholder shall reimburse the Company immediately for any difference or Shortfall upon receipt of written notice from the Company of such difference or Shortfall together with an invoice in respect of the amount payable. An interest to be imposed by the Company equivalent to the latest best lending rate of The Hongkong and Shanghai Banking Corporation Limited will be added on a compound basis each month if the difference or Shortfall is not settled within fifteen (15) days from the date of the written notice. This section shall survive termination or cancellation of this Policy.

4. Ineligible Medical Services

If any Insured Person uses the Card for Medical Services that are not eligible for a benefit under the Terms and Conditions of this Policy, the Policyholder shall reimburse the Company in full for the costs of such ineligible Medical Services. This section shall survive termination or cancellation of this Policy.

5. Renewal of Policy

If, for any reason, this Policy is not renewed, the Policyholder shall return immediately to the Company all Cards issued to all Insured Persons within seven (7) days after the Expiry Date and shall reimburse the Company in respect of all costs and payments arising from the use of Cards whilst no Policy was in force, pending or without Renewal. This section shall survive termination or cancellation of this Policy.

6. Replacement Charge of Cards

A replacement charge will be levied for each replacement Card issued at an amount as notified to the Policyholder by the Company from time to time.

7. Termination of Coverage

In the event of the coverage of an Insured Person under this Policy shall be terminated or cancelled for any reason, the Policyholder agrees to obtain the Card from that Insured Person no later than the date of such termination or cancellation and the Card will be returned to the Company within twenty-eight (28) days from the date of termination or cancellation. Should a former Insured Person use the Card to obtain benefits after termination or cancellation, the Policyholder will be liable to reimburse in full the amount paid by the Company whether or not the Card shall have been subsequently returned to the Company. This section shall survive termination or cancellation of this Policy.

8. Theft or Loss of Card

In the event of loss or theft of the Card, the Policyholder agrees to notify the Company in writing within three (3) Working Days after such loss or theft of the full details thereof. The Policyholder is fully responsible for any transactions involving use of a lost or stolen Card issued to any Insured Person until such theft or loss is reported by submitting a duly completed "declaration of loss" form to the Company and such form shall be provided by the Company upon request.

9. Use of Cards

In all matters concerning the use of Cards, the Company shall deal solely with the Policyholder and not with individual Insured Person. The Policyholder shall be fully responsible for controlling and monitoring the use of the Cards by the Insured Persons in accordance with the Terms and Conditions of this Policy.

10. Withdrawal of Cards

The Company reserves the right to withdraw the use of any or all Cards at any time without prior notice. Any and all such Cards issued under this Policy shall at all times remain the absolute and sole property of the Company.

PART 11

VALUE-ADDED SERVICES PROVISION

For the details of the value-added services, please refer to the Policyholder User Guide of the Policy. All value-added services stated in the Policyholder User Guide is subject to change by the Company from time to time without prior notice.

Schedule of Surgical Procedure for Day Case Procedure

All surgical procedures listed in this schedule shall be performed as a Day Case Procedure. This Schedule of Surgical Procedure for Day Case Procedure is for reference only, and is subject to change from time to time without prior notice.

Procedure / Surgery	
ABDOMINAL AND DIGESTIVE SYSTEM	
Oesophageal / stomach /duodenum	Oesophagogastroduodenoscopy (OGD) with / without biopsy and/or polypectomy
	OGD with removal of foreign body
Jejunum, ileum and large intestine	Anal fissurectomy
	Incision & drainage of perianal abscess
	Colonoscopy with / without biopsy
	Colonoscopy with polypectomy
	Sigmoidoscopy
	Injection / banding of haemorrhoid
Liver	Fine needle aspiration (FNA) biopsy of liver
BRAIN AND NERVOUS SYSTEM	
Brain	Irrigation of cerebroventricular shunt
Spine	Lumbar puncture or cisternal puncture
ENDOCRINE SYSTEM	
Thyroid Gland	Fine needle aspiration (FNA) of thyroid gland with / without imaging guidance
EAR/ NOSE / THROAT / RESPIRATORY SYSTEM	
Ear	Haematoma auris, drainage / buttoning / excision
	Removal of foreign body
	Myringotomy with/without insertion of tube
Nose, mouth and pharynx	Antral puncture and lavage
	Cauterisation of nasal mucosa / control of epistaxis
	Closed reduction for fracture nasal bone
	Excision of lesion of nose
	Nasopharyngoscopy / rhinoscopy with/without including rhinoscopic biopsy with / without removal of foreign body
	Polypectomy of nose
	Sinoscopy with / without biopsy
Respiratory system	Arytenoid subluxation – laryngoscopic reduction
	Bronchoscopy with/without biopsy
	Bronchoscopy with foreign body removal
	Laryngoscopy with/without biopsy
	Micro laryngoscopy with/without Biopsy with/without excision of nodule / polyp / Reinke's edema
	Injection for vocal cord paralysis
	Tracheoesophageal puncture for voice rehabilitation
	Vocal cord operation, including use of laser (excluding carcinoma)

Procedure / Surgery	
EYE	
Eye	Excision / curettage / cryotherapy of lesion of eyelid
	Blepharorrhaphy / tarsorrhaphy
	Cataract surgery
	Repair of entropion or ectropion with/without wedge resection
	Excision / destruction of lesion of conjunctiva
	Excision of pterygium
	Removal of corneal foreign body
	Diagnostic aspiration of vitreous
	Biopsy of iris
	Biopsy of extraocular muscle or tendon
	Excision of lacrimal sac and passage
	Probing with/without syringing of lacrimal canaliculi / nasolacrimal duct
FEMALE GENITAL SYSTEM	
Cervix	Colposcopy with/without biopsy
	Conisation of cervix
	Destruction of lesion of cervix by excision/ cryosurgery / cauterisation / laser
	Endocervical curettage
	Loop electrosurgical excision procedure (LEEP)
	Marsupialisation of cervical cyst
	Repair of cervix
Fallopian tubes and ovaries^	Dilatation / insufflation of fallopian tube
	Aspiration of ovarian cyst
	^ *The category applies to both unilateral and bilateral procedures unless otherwise specified.*
Uterus	Dilatation and curettage of Uterine (D&C)
	Hysteroscopy with/without biopsy
Vagina	Destruction of lesion of vagina by excision / cryosurgery / cauterisation / laser
	Insertion / removal of vaginal supportive pessaries
	Marsupialisation of Bartholin's cyst
	Vaginal stripping of vaginal cuff
	Culdocentesis
	Culdotomy
	Excision of transverse vaginal septum
Vulva and introitus	Destruction of lesion of vulva by excision / cryosurgery / cauterisation / laser
	Wide local excision of vulva with cold knife or LEEP
	Excision of vestibular adenitis
	Excision biopsy of vulva
	Incision and drainage of vulva and perineum
	Lysis of vulvar adhesions
	Repair of fistula of vulva or perineum
	Suture of lacerations / repair of vulva and/or perineum

Procedure / Surgery	
HEMIC AND LYMPHATIC SYSTEM	
Lymph Nodes	Drainage of lesion / abscess of lymph node
	Biopsy / excision of superficial lymph nodes / simple excision of lymphatic structure
	Incisional biopsy of cervical lymph node / fine needle aspiration (FNA) biopsy of lymph nodes
MALE GENITAL SYSTEM	
Prostate	External drainage of prostatic abscess
	Prostate biopsy
Penis	Circumcision
Testicles^	Testicular biopsy
	Tapping of hydrocele
	^ *The category applies to both unilateral and bilateral procedures unless otherwise specified.*
Spermatic cord	Vasectomy
MUSCULOSKELETAL SYSTEM	
Joint	Joint aspiration / injection
	Manipulation of joint under anaesthesia
Muscle/ Tendon	Open biopsy of muscle
	Release of De Quervain's disease
	Release of trigger finger
	Release of tennis elbow
Fracture/ dislocation	Closed reduction of dislocation of temporomandibular / interphalangeal / acromioclavicular joint
	Closed reduction for fracture of clavicle / scapula / phalanges / patella without internal fixation
	Removal of screw, pin and plate, and other metal for old fracture except fracture femur
Others	Excision of ganglion / bursa
	Closed/ Percutaneous needle fasciotomy for Dupuytren disease
SKIN AND BREAST	
Skin	Curettage / cryotherapy / cauterisation / laser treatment of lesion of skin
	Drainage of subungual haematoma or abscess
	Excision of lipoma
	Excision of skin for graft
	Incision and /or drainage of skin abscess
	Incision and /or removal of foreign body from skin and subcutaneous tissue
	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue
	Suture of wound on skin
	Surgical toilet and suturing
	Wedge resection of toenail
Breast	Fine needle aspiration (FNA) of breast cyst
	Incisional breast biopsy

Procedure / Surgery	
URINARY SYSTEM	
Kidney	Percutaneous insertion of nephrostomy tube
	Renal biopsy
Bladder, ureter and urethra	Cystoscopy with/without biopsy
	Cystoscopy with catheterisation of ureter/ transurethral bladder clearance
	Excision of urethra caruncle
DENTAL	
	Any kind of dental surgery due to injury caused by an accident

Important Notes:
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Issued by AXA General Insurance Hong Kong Limited

PM/1/1000/201810E

滙豐

安盛

摯關懷超卓醫療計劃

保單

請詳細參閱本保單

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- 若您曾領取賠償，則不會獲發還已付保費。

如有任何疑問或需進一步詳細解說，歡迎致電客戶服務熱線（852）2867 8678（為確保服務質素，有關電話的談話內容或會被錄音）或致函與本公司聯絡。

安盛保險有限公司

香港九龍尖沙咀郵政局郵政信箱90852號

香港九龍九龍灣宏遠街1號壹號九龍23樓

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收集個人資料的聲明

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敬請注意，如果閣下不向本公司提供閣下的個人資料，我們可能無法提供閣下所需的資料、產品或服務，或無法處理閣下的要求。

目的：本公司不時有必要收集閣下的個人資料，並可能因下列各項目的（“**有關目的**”）而供本公司使用、存儲、處理、轉移、披露或共享該等個人資料：

1. 向閣下推介、提供和營銷本公司、安盛集團的其他公司（“**安盛關聯方**”）或***本公司***的商業合作夥伴（參閱下文“**在直接促銷中使用及將其個人資料提供予其他人士**”部分）之產品／服務，以及提供、維持、管理和操作該等產品／服務；
2. 處理和評估閣下就本公司及安盛關聯方所提供之產品／服務提出的任何申請或要求；
3. 向閣下提供後續服務，包括但不限於執行／管理已發出的保單；
4. 與就本公司和／或安盛關聯方提供的任何產品／服務而由閣下或針對閣下提出的或者其他涉及閣下的任何索賠相關的任何目的，包括索賠調查；
5. 評估閣下的財務需求；
6. 為客戶設計產品／服務；
7. 為統計或其他目的進行市場研究；
8. 不時就本條款所列的任何目的核對所持有的與閣下有關的任何資料；
9. 作出任何適用法律、規則、規例、實務守則或指引所要求的披露或協助在香港或香港以外其他地方的警方或其他***政府***或監管機構執法及進行調查；
10. 進行身份和／或信用核查和／或債務追收；
11. 遵守任何適用的司法管轄區的法律；
12. 開展與本公司業務經營有關的其他服務；及
13. 與上述任何目的直接有關的其他目的。

個人資料的轉移：個人資料將予以保密，但在遵守任何適用法律條文的前提下，可提供給：

1. 位於香港或香港以外其他地方的任何安盛關聯方、本公司的任何相關聯人士、任何再保險公司、索賠調查公司、閣下之保險經紀、行業協會或聯會、基金管理公司或金融機構，以及就此方面而言，閣下同意將閣下的資料轉移至香港境外；
2. *就任何有關目的和下列與銀行有關的額外目的提供給香港上海滙豐銀行有限公司（“**滙豐**”）：確保客戶信貸信譽度持續良好，建立和維持信貸及風險的相關模型，為進行信用核查以及其他直接相關的目的而向信貸資料服務機構提供個人資料，確定尚欠客戶的債務或客戶所欠債務的金額以及向客戶和為客戶的欠款提供擔保之人追收未償款項；
3. 與就本公司和／或安盛關聯方提供的任何產品／服務而由閣下或針對閣下提出的或者其他涉及閣下的任何索賠相關的任何人士（包括私家偵探）；
4. 在香港或香港以外其他地方向本公司和／或安盛關聯方提供行政，技術或其他服務（包括直接促銷服務）並對個人資料負有保密義務的任何代理、承包商或第三方；
5. 信貸資料機構或（在出現拖欠還款的情況下）追討欠款公司；
6. 本公司權利或業務的任何實際或建議的承讓人、受讓方、參與者或次參與者；及
7. 在香港或香港以外其他地方的任何政府部門或其他適當的政府或監管機關。

如欲了解本公司為促銷目的使用閣下的個人資料的政策，請參閱下文“**在直接促銷中使用及將其個人資料提供予其他人士**”部分。

閣下的個人資料將僅為上文中規定的一個或多個有關目的而被轉移。

在直接促銷中使用及將其個人資料提供予其他人士：本公司有意：

1. 使用本公司不時持有的閣下的姓名、聯絡資料、產品及服務的組合資料、交易模式及行為、財政背景及人口統計數據以進行直接促銷；

2. 就本公司，安盛關聯方，本公司合作品牌夥伴及商業合作夥伴可能提供關於下列類別的服務及產品而進行直接促銷（包括但不限於提供獎賞、客戶或會員或優惠計劃）：

   a) 保險、銀行、公積金或公積金計劃、金融服務、證券和相關產品及服務；

   b) 健康、保健及醫療、餐飲、體育運動及會員服務、娛樂、健身浴或類似的休閒活動、旅遊及交通、家居、服裝、教育、社交網絡、媒體的產品及服務及高級消費類產品；

3. 以上服務及產品將會由本公司及 / 或以下機構提供：

   a) 任何安盛關聯方；

   b) 第三方金融機構；

   c) 提供上文 2. 所列之服務及產品之本公司及 / 或安盛關聯方的商業合作夥伴或合作品牌夥伴；

   d) 向本公司或任何以上所列機構提供支援的第三方獎賞、客戶或會員或優惠計劃提供者；

4. 除由本公司促銷上述服務及產品外，本公司亦有意將上文 1. 段部分所述的資料提供予上文 3. 段部分所述的全部或任何人士，以供該等人士在促銷該等服務及產品中使用，而本公司為此目的須獲得客戶書面同意（包括表示不反對）。

在使用閣下的個人資料作上文所述的目的或提供予上文所述的人士之前，本公司須獲得閣下的書面同意，及只在獲得閣下的書面同意後方可使用閣下的個人資料及提供予其他人士作任何推廣及促銷用途。

閣下日後可撤回閣下給予本公司有關使用閣下的個人資料及提供予其他人士作任何促銷用途的同意。

閣下如欲撤回閣下給予本公司的同意，請發信至下文“**個人資料的查閱和更正**”部分所列的地址通知本公司。本公司會在不收取任何費用的情況下確保不會將閣下納入日後的直接促銷活動中。

個人資料的查閱和更正：根據條例，閣下有權查明本公司是否持有閣下的個人資料，獲取該資料的副本，以及更正任何不準確的資料。閣下還可以要求本公司告知閣下本公司所持個人資料的種類。

查閱和更正的要求，或有關獲取政策、常規及本公司所持的資料種類的資料，均應以書面形式發送至：

香港黃竹坑黃竹坑道38號安盛匯11樓
安盛保險有限公司
個人資料保護主任

本公司可能會向閣下收取合理的費用，以抵銷本公司為執行閣下的資料查閱要求而引致的行政和實際費用。

* 此僅適用於閣下透過滙豐（作為本公司的分銷代理人）申請本公司的產品和 / 或服務或者透過滙豐（作為本公司的分銷代理人）向本公司提出要求的情況。如果閣下並未透過滙豐（作為本公司的分銷代理人）申請本公司的產品和 / 或服務或者透過滙豐（作為本公司的分銷代理人）向本公司提出要求，閣下的個人資料將不會因上文所述的任何有關目的、額外目的或為讓滙豐進行直接促銷而提供給滙豐。

目錄

條款及細則

第一部分

釋義

本***保單***中的字詞及表述須按照以下所述解釋 -

「***意外***」是指以暴力、外在及可見形式所引致的突發、意想不到及意料之外的事故，而完全非***受保人***能控制的範圍 。

「***先進影像診斷檢查***」是指電腦斷層掃描（「CT」掃描）、磁力共振掃描（「MRI」）、正電子放射斷層掃描（「PET」掃描）、PET–CT組合及PET–MRI組合。

「***年齡***」是指***受保人***的實際年齡。

「***麻醉師***」是指符合資格提供麻醉服務並在香港醫務委員會麻醉科專科醫生名冊之下註冊的任何人，或具備同等資格按照合資格麻醉專科要求提供麻醉服務的任何人，但下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴（除非事先經***本公司***的書面批准）。

「***申請***」是指以任何形式向***本公司***就本***保單***遞交的***申請***，包括問卷、可保性的證明、任何向***本公司***提交的文件或資料，及任何就該***申請***作出的陳述和聲明。

「***AXA安盛特選醫療網絡***」是指當描述***醫療機構***或***註冊醫生***時，該***醫療機構***或***註冊醫生***已與***本公司***簽訂有效的書面協議並受該協議所涵蓋以向***受保人***提供指定的***醫療服務***。經過適當的用戶驗證後便可於***本公司***的流動電話應用程式（MyAXA）內獲得***AXA安盛特選醫療網絡***名單，***本公司***可自行決定不時更改、更新和修改此名單，不論是否有另行通知，任何更改將於公布之日被視為生效。

「***保障利益條款***」是指本***條款及細則***第八部分之條款。

「***醫療卡***」是指由***本公司***向***受保人***發出的「摯關懷超卓醫療卡」（根據文義要求，包括實體卡及 / 或電子卡）。

「***個別不承保項目***」是指***本公司***按影響***受保人***的可保性的***投保前已存在的病症***或其他因素而附加的不保項目條款，並從***保障利益條款***中排除而不予保障的***不適***、***疾病***或***病痛***。

「***癌症***」是指惡性生長物或腫瘤，其特徵為異常細胞及組織不受控地生長和擴散。***癌症***此定義將包括所有階段的惡性腫瘤，但不包括以下情況：

(i) 所有經病理組織學分析為良性、潛在惡性或發育不良的腫瘤；

(ii) 所有與人類免疫缺陷病毒同存的腫瘤；

(iii) 子宮頸上皮內贅瘤（CIN I、CIN II 或CIN III）；及

(iv) 非黑色素瘤的皮膚癌。

「***子女***」是指***保單持有人***的任何子女，在財政上依靠***保單持有人***，及於***申請***保險保障時的年齡介乎十五（15）日及十七（17）歲（若為全日制學生則不超過二十三（23）歲）。

「***本公司***」是指安盛保險有限公司。

「***住院***」是指***受保人***在***醫療需要***的情況下，按***註冊醫生***的建議作為***住院病人***入住***醫院***不少於連續六（6）小時以接受治療。***住院***須以***醫院***開出的每日病房費單據作證明。惟就***緊急治療***有關之***住院***，即在***緊急情況***下在***醫院***進行***醫療需要***的治療時，則沒有最低***住院***時間要求。

「***先天性疾病***」是指出生時存在或因早產而導致的任何病況或***傷病***，以及出生後六（6）個月內出現的新生嬰兒身體缺陷。這類缺陷包括下列各項：

(i) 在任何年齡出現的各種嚴重、中度或輕度先天性畸形；

(ii) 由出生至十五（15）歲期間出現的各種腹股溝疝氣及水囊腫（或其併發症）；

(iii) 先天疝氣，例如臍疝、腹內疝、先天性胸腹疝或先天性腹疝；

(iv) 睪丸未降；及

(v) 主流醫學意見判斷為先天缺陷而未在此列出的其他情況

「***日間手術***」是指***受保人***於***醫療機構***內就***傷病***的檢查或治療進行***醫療需要***的外科手術，惟***受保人***並非***住院***。

「***日症病人***」是指於***醫療機構***接受***醫療需要***的***日間手術***(並非為***住院***) 的***受保人***。

「***受供養人***」僅指 (i) ***保單持有人***的配偶或伴侶，其***年齡***於***申請***時須介乎十八 (18) 至八十 (80) 歲，或 (ii) ***保單持有人***的任何***子女***，包括***保單持有人***合法領養的***子女***。

「***傷病***」是指***不適***、***疾病***、***病痛***或***受傷***，包括由之而引發的一切併發症。

「***合資格醫療費用***」是指有關***傷病***的***合理及慣常***和***醫療需要***的費用。

「***生效日***」是指***保單附表***中指名的「最初生效日」。

「***緊急情況***」是指需立即接受治療之事件或情況，以防止***受保人***身故、健康遭永久損害或遭受其他嚴重健康後果。

「***緊急治療***」是指因***緊急情況***需接受診症或治療，而***緊急情況***的事件或情形與所需的診症或治療必須在急症事件或情況出現後的合理時間內進行。

「***批註***」是指任何附於本***保單***，並修改本***保單***內現有***條款及細則*** (包括但不限於第八部分保障利益條款) 的文件。

「***到期日***」是指***保單附表***中列明的***保險期***的最後日期。

「***政府***」是指香港特別行政區政府。

「***醫療機構***」是指醫療診所、***日間手術***護理中心或***醫院***。

「***加護病房***」是指***醫院***內專為***住院病人***提供額外的護理和觀察而設的部門。

「***港元***」是指***香港***法定貨幣。

「***香港***」是指中華人民共和國香港特別行政區。

「***醫院***」是指按其所在地的法律合法成立及正式註冊為醫院的機構。該機構須為***不適***及受傷的***住院病人***提供護理及***治療***，並 –

(i) 具備診斷及進行大型手術的設施；

(ii) 由持牌或註冊護士提供二十四 (24) 小時護理服務；

(iii) 由一位或以上***註冊醫生***駐診；及

(iv) 非主要作為診所、戒酒或戒毒中心、自然療養院、水療院、護理或療養院、寧養或紓緩護理中心、復康中心、護老院或同類機構。

「***醫院管理局***」是指根據《醫院管理局條例》(***香港***法例第113 章) 所成立的法定團體。

「***受傷***」是指完全因***意外***而非涉及任何其他原因所引致的身體損害 (包括有或沒有可見傷口)。

「***住院病人***」是指***住院***中的***受保人***。

「***保險業條例***」是指***香港***法例第41章《保險業條例》。

「***受保人***」是指***保單附表***中或隨後附加於本***保單***的***批註***中列為「受保人」的***受供養人***或***保單持有人***。

「***深切治療部***」是指***醫院***內專為***住院病人***提供深切醫療和護理服務而設的部門。

「***終身保障限額***」是指***本公司***在本***保單***生效起向***保單持有人***累計支付的最高賠償限額，不論***保單附表***中所列的個別保障項目是否已經達到其相關項目的賠償限額，或是否已達到該保單年度的***每年保障總限額***。

「***醫療服務***」是指就診斷或治療某一***傷病***而向受保人提供的***醫療需要***的服務，包括按情況所需的***住院***、***治療***、檢測、檢驗或其他相關服務。

「***醫療需要***」是指按照一般公認的醫療做法標準而接受***醫療服務***的需要，而該等***醫療服務***須符合下列條件 –

(a) 需要***註冊醫生***的專業知識或轉介；

(b) 與該***傷病***的診斷一致並是治療該***傷病***所必要的；

(c) 按良好而審慎的醫療做法及主診***註冊醫生***審慎的專業判斷提供，而非主要為對***受保人***、其家庭成員、照顧人員或主診***註冊醫生***帶來方便或舒適而提供；

(d) 在最適合當時情況的環境及按照***醫療服務***的一般公認的醫療做法標準而提供；及

(e) 以最適當的水平提供，而按主診***註冊醫生***審慎的專業判斷，是可向***受保人***安全及有效地提供的。

就本***保單***而言，在不牴觸上述一般條件下，符合***醫療需要***的條件的***住院***包括但不限於以下情況 -

(i) ***受保人***在***緊急情況***下需要在***醫院***接受緊急治療；及 / 或

(ii) 手術是在全身麻醉下進行；及 / 或

(iii) ***醫院***有具備手術或程序所需的設備， 有關程序並不能以***日症病人***的方式進行；及 / 或

(iv) ***受保人***的共病症屬明顯嚴重；及 / 或

(v) 主診***註冊醫生***考慮到***受保人***的個人情況下，經過審慎的專業判斷及考慮***受保人***的安全後，認為所需的治療或服務應在***醫院***內進行；及 / 或

(vi) 經過主診***註冊醫生***審慎的專業判斷，***受保人***的***住院***期長短對治療或服務是合適的；及 / 或

(vii) 如屬***註冊醫生***指定的診斷程序或專職醫療服務，經該***註冊醫生***審慎的專業判斷及考慮***受保人***的安全後，認為所需的程序或服務應在***醫院***內進行。

在上文 (v) 至 (vii) 的情況下，主診***註冊醫生***行使審慎的專業判斷時，應該考慮該***住院***是否 -

1) 符合當地提供治療或服務的良好及審慎的醫療做法標準，並經主診***註冊醫生***審慎的專業判斷，而非主要為對***受保人***、其家庭成員、照顧人員或主診***註冊醫生***帶來方便或舒適；及

2) 在最適合當時情況的環境及就所提供的治療或服務而言符合當地一般公認的醫療做法標準。

「***門診***」是指***受保人***就***傷病***的治療而於***註冊醫生***的辦公室或診所，或於***醫院***內的門診部門或急症室接受***醫療需要***的非手術服務或物料，惟***受保人***並非***住院***。

「***非AXA安盛特選醫療網絡***」是指相關的***醫療服務***是

(i) 由***AXA安盛特選醫療網絡***名單下列明的***註冊醫生***提供的，該***醫療服務***並不是於***AXA安盛特選醫療網絡***名單下列明的***醫療機構***內進行； 或

(ii) 由非***AXA安盛特選醫療網絡***名單下列明的***註冊醫生***提供的，該***醫療服務***是於***AXA安盛特選醫療網絡***名單下列明的***醫療機構***內進行；或

(iii) 由非***AXA安盛特選醫療網絡***名單下列明的***註冊醫生***提供的，該***醫療服務***並不是於***AXA安盛特選醫療網絡***名單下列明的***醫療機構***內進行。

「***每年保障總限額***」是指***本公司***根據本***條款及細則***的第八部分，於任何一個保單年度就適用的計劃項目的***保單附表***列明的須支付之最高累積賠償額。***每年保障總限額***於每一個保單年度會重新計算。

「***保險期***」是指於***保單附表***或隨後附加於本***保單***的***批註***內列為「保險期」的期間。

「***物理治療師***」是指在物理治療的範疇內正式符合資格的治療師，於其執業地區內註冊並獲得合法授權以進行物理治療。下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴（除非事先經***本公司***的書面批准）。

「***保單***」是指由***本公司***核保及簽發的「摯關懷超卓醫療計劃」保單，並作為***保單持有人***與***本公司***之間全部合約，當中包括但不限於本***條款及細則***、***申請***、聲明、***保單附表***及任何附於***保單***的***批註***、附帶的補充材料、附表或其附載的任何附件、***本公司***不時發表或通知***保單持有人***適用於本***保單***的***日間手術列表***。

「***保單持有人***」是指擁有本***保單***的人士，及於***申請***時，其年齡須介乎十八 (18) 至八十 (80) 歲，並於***保單附表***或隨後附加於本***保單***的***批註***內列為***保單持有人***。

「***保單附表***」是指本***保單***的附表，載有保險細節，包括***生效日***、***保單持有人***及***受保人***的姓名和個人資料，以及本***保單***的合資格保障及保費細節。

「**預先批核**」是指***本公司***就***受保人***在進行相關***醫療服務***前的預先批核，及***本公司***已於進行該***醫療服務***前收到及批准該申請。

「***投保前已存在的病症***」是指：

(a) ***受保人***在***生效日***之前已存在的***傷病***，而這類***傷病***已顯露***受保人***已察覺或應合理地察覺的病徵或症狀。

(b) 在不影響 (a) 之下，***生效日***後首年內出現的下列***傷病***（但不排除其他***傷病***）：

(i) 內部器官腫瘤

(ii) 痔瘡

(iii) 需要動手術的扁桃腺病

(iv) 鼻腔隔膜或鼻甲骨病變

(v) 甲狀腺機能亢進

(vi) 白內障

(vii) 需要動手術的竇症

(viii) 拇趾外翻

(c) 在不影響 (a) 及 (b) 之下，***生效日***後六 (6) 個月內出現的下列***傷病***（但不排除其他***傷病***）：

(i) 肺結核

(ii) 肛門瘻管

(iii) 膽結石

(iv) 腎結石、尿道結石或膀胱結石

(v) 高血壓或心臟疾病或血管疾病

(vi) 胃潰瘍、十二指腸潰瘍

(vii) 皮膚和肌肉組織腫瘤、骨腫瘤或血液或骨髓的惡性病

(viii) 糖尿病

「***公立醫院***」是指任何由香港***政府***或***醫院管理局***經營、運作、控制或資助的***醫院***。

「***合理及慣常***」是指就***醫療需要***的***醫療服務***收費而言，不超過在產生收費所在地相關醫療服務供應者，對於同性別和相近***年齡***的人士，就類似***傷病***提供類似***醫療服務***或物料而收取的一般收費範圍的水平，該水平由***本公司***真誠合理地確定。在任何情況下，***合理及慣常***的收費均不得高於實際收費。

本公司須參照以下資料（如適用）以釐定某項收費是否***合理及慣常*** –

(a) 由保險或醫學業界進行的***醫療服務***費用統計及調查；

(b) ***本公司***內部或業界的索償統計；

(c) 政府憲報；及 / 或

(d) 提供***醫療服務***或物料當地的其他相關參考資料。

本公司保留權利就任何及所有被***本公司***的醫療檢測員評為非***合理及慣常***收費的保障賠償作出調整。

「***註冊醫生***」根據文義要求是指符合以下條件的***專科醫生***或外科醫生：

(a) 具有正式資格並已按***香港***法例第161章《醫療註冊條例》在香港醫務委員會註冊，或在***香港***境外的司法管轄區內由***本公司***真誠合理地認為具有同等地位的團體註冊；及

(b) 在***香港***或向受保人提供***醫療服務***於***香港***境外的司法管轄區，獲得法律許可提供相關的西方***醫療服務***，

惟下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴（除非事先經***本公司***的書面批准）。如該醫生並非按***香港***法例或在***香港***以外的司法管轄區具有同等地位的團體註冊（由***本公司***真誠及合理地作出決定），***本公司***將對該醫生是否符合資格和註冊要求作出合理的判斷。

「***續保***」或「***可續保***」是指本***保單***將續保至下一個保單年度，條件是在無任何中斷下適用的保費已按本***條款及細則***全數繳付。

「***續保日***」是指***保險期***第一天起計後十二 (12) 個月後的當天，除非於任何***批註***內另有定明。

「***日間手術列表***」是指附於此***條款及細則***的列表，該列表設定了必需以***日間手術***進行之手術，***本公司***會定期檢閱此列表並不時作出更改。

「**賠償差額欠款**」是指***本公司***因賠償***受保人***產生的非***合資格醫療費用***及 / 或超出於***保單附表***中列明的保障限額及 / 或***每年保障總限額***費用而出現的任何差額。

「***不適***」、「**疾病**」或「**病痛**」是指在病理學上偏離於正常健康狀態的生理或醫學狀況，包括但不限於***受保人***出現的病徵或症狀，亦不論是否已確診。

「***專科醫生***」是指在香港醫務委員會專科登記名冊中註冊的或具有同等資格***註冊醫生***，其符合資格按照有關專科提供專科治療。

「***條款及細則***」是指***本保單***中第一至第十一部分的***條款及細則***：

「***治療***」是指手術程序或***日間手術***（按情況所需），其唯一目的為治癒或減輕***傷病***。

「***AXA安盛特選醫療網絡***」是指 (i) 由***AXA安盛特選醫療網絡***名單上列明的***註冊醫生***所進行的任何***醫療服務***；及 (ii) 該***醫療服務***是於***AXA安盛特選醫療網絡***名單上列明的***醫療機構***內進行的。

「***工作天***」是指***本公司***正常營業的任何工作日。

第二部分

1. 保險條款

在本***保單***生效期間，如***受保人***罹患***傷病***，***本公司***須按本***保單***之***條款及細則***賠償***合資格醫療費用***。

所有保障須按實際產生的***合資格醫療費用***支付予保單持有人或受保人或提供本***保單***承保服務的其他任何服務提供者，並受本***保單***之***條款及細則***及***保單附表***內所列明之***每年保障總限額***所規限。

儘管有上述規定，本***保單***不設***終身保障限額***。

2. 保單

本***保單***是由***保單持有人***與***本公司***所訂立，及***本公司***與每一方均同意 -

(a) 本***保單***由本***條款及細則***、***申請***、***保單附表***及任何附於本***保單***或不時公布或通知***保單持有人***或附加於此***條款及細則***之***批註***、補充、附表或***日間手術列表***所構成。上述文件須一併考慮為***保單持有人***與***本公司***之間的一份完整合約。

(b) 所有對本***條款及細則***之修訂須按本***條款及細則***執行，否則該修訂將不會有效。

(c) 由***受保人***或為***受保人***於***申請***時作出的陳述均被視為申述，而非保證。

(d) 由***受保人***或為***受保人***按照但不限於本***保單***及***申請***而提供的所有信息和作出的所有陳述，須盡其所知所信予以提供。

(e) 當***保單持有人***繳交全數首期保費後，本***保單***將按***保單附表***內所列之***生效日***起生效。

(f) ***本公司***可以在首次簽發***保單***及/或核准保單復效的***申請***時，透過附加在本***條款及細則***的***批註***、補充、附表或附件的方式，對***受保人***於***申請***時知會***本公司***之***投保前已存在的病症***，或其他會影響其可保性的因素，加設***個別不承保項目***。

(g) 若***保單持有人***或***受保人***未有披露有關資料，而該項未作披露之行為已實質性地影響***本公司***的核保決定，***本公司***將有權行使按第三部分第十五及十六節所賦予的權利。

第三部分

一般條件

1. 合約詮釋

(a) 按條款解釋所需，本***保單***內表示男性性別的用詞，其含義將包括女性性別；單數用詞的含義將包括複數，反之亦然。

(b) 所有標題均作方便參考之用，不應影響本***保單***的詮釋。

(c) 本***保單***內所有時間均為***香港***時間。

(d) 除另有列明外，本***保單***內所用的日 / 天均為日曆日。

(e) 除另行釋義外，本***保單***內以斜體標註之詞彙須以第一部分所載含義詮釋。

2. 冷靜期內取消保單之安排

保單持有人可在冷靜期內行使取消本***保單***的權利，並獲全數發還已繳保費，但必須符合以下條件 -

(a) 取消***保單***的要求必須由***保單持有人***簽署，並確保***本公司***於以下兩者的較先者後起計的三十 (30) 日內收到要求 –

(i) 送出***保單***之日；或

(ii) 向***保單持有人***或其代表發出通知，列明***保單***已備妥及冷靜期何時屆滿；及

(b) 若於冷靜期期間曾經獲支付保障賠償或將獲支付保障賠償，將不獲發還保費。

上述權利並不適用於***續保***。

行使此項權利時，***保單持有人***必須 -

(c) 退回***保單***正本；及

(d) 附有***保單持有人***簽署的信件 (或其他***本公司***接受之方式) 要求取消***保單***。

根據***條款及細則***，本***保單***將被取消及已繳保費將被全數發還。在該情況下，本***保單***將自***生效日***起無效，***本公司***亦無須承擔任何賠償。

3. 冷靜期後取消保單之安排

冷靜期過後，***保單持有人***可於***保單續保日***最少十 (10) 個***工作天***前向***本公司***提出不作***續保***以取消***保單***。根據***保單***此節下所取消的***保單***將於***保單***仍然生效的保單年度之***到期日***緊隨的後一天被取消。

4. 保障權益

若***受保人***因接受***醫療服務***而產生***合資格醫療費用***，須按該***合資格醫療費用***產生時適用於此***保單***的***保單附表***及***條款及細則***的相關部分作出賠償。

5. 轉讓

保單持有人在本***條款及細則***下之權利、保障、責任和義務不得轉讓。***本公司***有權不經***保單持有人***及 / 或***受保人***同意而將本***保單***的任何或全部權利和責任轉讓。

6. 文書錯誤

任何文書記錄錯誤，將不會令原應有效之保障失效，或令原應終止之保障繼續生效。

7. 貨幣

受保人任何以外幣索償的***合資格醫療費用***，須按***本公司***不時採用的兑換率轉換成***港元***。

8. 本公司的責任解除

向***受保人***、***保單持有人***，或其指定的香港上海滙豐銀行有限公司的任何賬戶，或向提供本***保單***承保服務的其他任何服務提供者支付賠償，即全面和有效地解除***本公司***根據本***保單***對該賠償的責任。

9. 利息

除在本***保單***內另有列明之情況外，根據本***保單***須付的一切賠償及費用均不會附帶利息。

10. 證明、資料和證據

所有向***本公司***提供一切所需證明、資料和證據涉及的費用，均由***受保人***及 / 或***保單持有人***承擔。

11. 本保單之保費率調整

在每個保單年度開始時，***本公司***有權調整本***保單***或任何補充條款所定的保費率。***本公司***須根據本***條款及細則***第六部分第四節，於***續保日***不少於四十五 (45) 日前以書面通知***保單持有人***有關***續保***之保費調整。

12. 規管法律

本***保單***在***香港***簽發，受***香港***法律管轄及按***香港***法律闡釋。***本公司***及***保單持有人***均同意遵從***香港***法院之司法裁判權。

13. 排解糾紛

本公司和***保單持有人***須盡力以友善方式解決就本***保單***產生之糾紛、爭議及分歧，包括與本***保單***的有效性、無效性、條款違反或終止相關之事宜。如果未能解決，雙方可以 (但無責任) 透過各種方式之替代訴訟糾紛排解程序處理，包括但不限於在向***香港***法院提出訴訟前，以雙方同意的調解或仲裁方式進行。

14. 責任

除非***保單持有人***及***受保人***妥為遵守本***保單***的***條款及細則***訂明須做的事或不得做的事，而且***保單持有人***及 / 或***受保人***作出及 / 或提供的資料、申述及聲明均為正確，否則***本公司***將不會承擔任何此***保單***下的責任。

15. 錯誤申報個人資料

在無損***本公司***按本第三部分第十六節所賦予之權利，即因健康資料之失實陳述或因欺詐的情況宣告本***保單*** (全部或部分) 無效下，若***保單持有人***或***受保人***在***申請***時或其後就***申請***而提交予***本公司***的任何文件中錯誤申報***受保人***的非健康相關資料 (包括但不限於***年齡***、性別或其他個人資料)，從而可能影響***本公司***作出的風險評估，***本公司***可按正確資料調整包括過去、現在或未來保單年度之保費。若***保單持有人***因此須補交額外保費，在補交該額外保費前，***本公司***將不會支付任何賠償。如***保單持有人***在***本公司***通知的保費到期日後三十 (30) 日的寬限期內仍未補交保費，***本公司***將有權行使本第三部分第十七節賦予的權利，從相關的保費到期日開始終止本***保單***。若***保單持有人***多繳保費，***本公司***則須予以退還。

若按***受保人***的正確資料和***本公司***的核保指引，***本公司***認為***受保人***的***申請***本應被拒絕時，***本公司***有權在本***保單生效日***起或第四部分第四節指明的***保單復效日***起宣告本***保單***無效，並通知***保單持有人***，本***保單***將不會為***受保人***提供保障。在該情況下，若本***保單***曾經為***受保人***支付賠償，***本公司***將 -

(a) 有權追討已支付的賠償；及

(b) 有責任退還已收取的保費，

兩者均適用於現保單年度和過往當***保單***有效時的所有保單年度，***本公司***亦有權收取合理的行政費用。此外，上述退款安排須與本第三部分第十六節一致。

16. 失實陳述或欺詐

本公司有權在下列情況宣告本***保單*** (全部或部分) 從***生效日***起或第四部分第四節指明的***保單復效日***起失效，並拒絕提供任何關於本***保單***之保障 -

(a) 在***申請*** (包括保單復效的***申請***) 時，對***受保人***的健康狀況的重要事實有任何失實聲明或遺漏，而該項重要事實可能影響***本公司***對***受保人***的風險評估。一項事實被視為「重要」的情況，包括但不限於在提交***申請***時披露該項事實將會影響***本公司***的核保決定，而***本公司***會因此施加***個別不承保項目***或拒絕***申請***。為免存疑，本 (a) 段並不適用於***受保人***的非健康相關資料，該等資料受本第三部分第十五節管轄；或

(b) 在***申請***或索償時，涉及欺詐或作出有欺詐成分之申述。

在 (a) 的情況下，***本公司***將 -

(i) 有權追討已支付的賠償；及

(ii) 有責任退還已收取的保費，

兩者均適用於現保單年度和過往當***保單***有效時的所有保單年度，***本公司***亦有權收取合埋的行政費用。

在 (b) 的情況下，***本公司***將 -

(iii) 有權追討已支付的賠償；及

(iv) 有權不退還已收取的保費。

17. 終止保單

本***保單***將在以下情況發生時自動終止，以最先者為準 -

(a) 按本第三部分第十五節及第五部分第三節規定，在寬限期屆滿後仍未繳交保費；或

(b) 當收到***本公司***的***賠償差額欠款***通知後的十五 (15) 日內沒有清還***賠償差額欠款***；或

(c) 當本***保單***所有***受保人***身故；或

(d) 按***《保險業條例》***，***本公司***已不再獲准承保或繼續承保本***保單***。

如***保單***是按本第十七節終止，將以終止生效日的00:00時起計失效。

當本***保單***終止時，本***保單***內所有保險保障亦即告終止。除非另有說明，否則現保單年度及過往所有保單年度已繳交的保費，將不獲退還。

若***保單***是按 (a) 終止，終止生效日期為未付保費的原到期日。

若***保單***是按 (b) 終止，終止生效日期為收到***本公司***的***賠償差額欠款***通知後十五 (15) 日。

若***保單***是按 (c) 或 (d) 終止，則***本公司***須按日數比例退還現保單年度已支付的相關保費。

若***保單持有人***根據第三部分第三節或第六部分第一節的任何情況以書面通知***本公司***決定不再為本***保單續保***，本***保單***亦應被終止。倘若***保單***按本第三部分第三節終止，或按第六部分第一節不予以***續保***，則有關終止將於本***保單***仍在生效時的保單年度的***到期日***後隨即生效。

18. 致本公司的通知

本公司要求***保單持有人***作出的所有通知均須以書面方式作出，或以其他獲得***本公司***認可的方式作出，並以***本公司***為收件人。

19. 由本公司發出的通知

本公司根據本***保單***發出的通知須以郵寄方式寄到***保單持有人***通知***本公司***的最新地址，或透過電子郵件傳送到***保單持有人***通知***本公司***的最新電郵地址。在下列情況下，***保單持有人***將被視為正式收到通知 -

(a) 郵寄後四 (4) 個***工作天***；或

(b) 電子郵件的發出日期和時間。

20. 其他保險

若***受保人***受到本***保單***以外的其他***保單***所保障，***保單持有人***應有權決定向該等保單或本***保單***進行索償。然而，若***保單持有人***或***受保人***已從任何其他保單索償全部或部分費用，則***本公司***只會對未被該等其他保單賠償的***合格資醫療費用*** (如有) 作出賠償。

21. 更改保單持有人

保單持有人可填妥***本公司***指定的表格以轉移本***保單***的擁有權，表格須遞交至***本公司***，並須經由***本公司***酌情批核。轉移***保單***擁有權須經***本公司***向原***保單持有人***及其承繼人發出書面通知批准後方為生效。由擁有權轉移生效日起，承繼人將被視為***保單持有人***，並須負責繳交保費 (包括任何到期未付保費)。

本公司不可否決***保單持有人***轉移***保單***擁有權至下列人士的***申請*** -

(a) 年滿十八 (18) 歲的***受保人***；或

(b) ***受保人***的家長或監護人 (若***受保人***未滿十八 (18) 歲)。

若***保單持有人***身故，本***保單***的擁有權將轉移至 -

(c) 年滿十八 (18) 歲的***受保人***；或

(d) ***保單持有人***之遺產管理人或執行人 (如***受保人***未滿十八 (18) 歲)。

上段所述的***保單***擁有權的轉移須在***本公司***獲得***保單持有人***身故的充分證據後方可進行。

22. 第三者的權利

任何非本***保單***合約一方的人士或實體，將不能按《合約 (第三者權利) 條例》(***香港***法例第623章) 強制執行本***保單***的任何條款。

23. 代位追討權

在***本公司***支付本***保單***規定的賠償後，***本公司***有權以***保單持有人***及 / 或***受保人***的名義，對可能須就導致本***保單***作出賠償的事故負責之第三者進行追討。討回的款項亦歸***本公司***所有，但以***本公司***已就本***保單***支付的賠償金額為限。在追索訴訟中，***保單持有人***及 / 或***受保人***須提供其管有或已知的第三者過失全部詳情及充分地與***本公司***合作。為免存疑，上述代位追討權只適用於當第三者不是***保單持有人***或***受保人***之情況。

24. 對第三者之訴訟

本***保單***中的任何內容均沒有規定***本公司***須參與***保單持有人***或***受保人***對任何***註冊醫生***、***麻醉師***、***醫療機構***或其他醫療服務提供者，因任何原因或理由所提出的損害賠償訴訟或替代訴訟糾紛排解程序，或就其作出回應或辯護（或支付其相關之費用）。此類訴訟或替代訴訟糾紛排解程序包括但不限於根據此***保單***的***條款及細則***下對***受保人***的的***傷病***作出任何醫學檢查或***醫療服務***而涉及或產生的疏忽、失職、專業失當行為或其他原因的訴訟或程序。

25. 寬免

任何一方寬免追究另外一方違反本***保單***條款的情況，將不會被視為日後違反本***保單***的該條款或任何其他條款的寬免。任何一方不行使或延遲行使本***保單***下任何權利時，亦不會被釋義為該權利的寬免。任何寬免須經***本公司***及***保單持有人***雙方明示同意方可生效，而且除已被寬免的權利和義務外，***本公司***和***保單持有人***在本***保單***下的權利和義務維持全面有效。

26. 遵守法律

若本***保單***在適用於***保單持有人***或***受保人***的法律下是或成為不合法，***本公司***有權宣告本***保單***從其成為不合法之日開始失效，而且***本公司***須按比例退還其就本***保單***失效期間已收到的保費。

27. 個人資料私隱

本公司須遵守《個人資料（私隱）條例》（***香港***法例第486章）及有關守則、指引及通函。

第四部分

受保資格及參與保障條件

1. 增加及刪減受保人

在遵守本***保單***的***條款及細則***的前提下，***保單持有人***可填妥***本公司***規定的表格，並遞交至***本公司***以按以下段落的規定增加或減少本***保單***的***受保人***：

(a) 就增加***受保人***而言，增加***受保人***之申請可於保單年度內任何時候遞交。經***本公司***批准，***保單持有人***須就新增的受保人繳付保費，金額按***本公司***核准增加之日起按日數比例計算。對該新增***受保人***的保障視為在該增加之日生效。

(b) 就刪減***受保人***而言，***保單持有人***應在***續保日***前最少十 (10) 個***工作天***遞交表格至***本公司***。經***本公司***批准，該項刪減將於***續保***時生效。

若***本公司***沒有或無須就擬於該保單年度刪減的***受保人***支付賠償，則刪減該名***受保人***之申請可於保單年度內的任何時間遞交，該項刪減將於***本公司***核准有關申請當日生效。在***本公司***已經就該保單年度收到全部年度保費的條件下，***本公司***將按下表列的規定就該名遭刪減***受保人***作出保費退還：

受保期間	退還保費 （已收年繳保費總額的百分比）
少於或最高4個月	50%
多於4個月或最高5個月	40%
多於5個月或最高6個月	30%
多於6個月或最高8個月	20%
8個月以上	無

2. 重複申請

受保人不得受保於超過一份***本公司***簽發之「摯關懷超卓醫療計劃」保單。若***受保人***受保於多於一份該***保單***。***本公司***將以其中最高賠償額的保單作為***受保人***的保障。如各保單的賠償額相同，則就支付賠償而言，本公司只會考慮由本公司最先發出之保單。***本公司***將會發還由該名***受保人***或其代表人作出的任何重複保險的保費付款。

3. 接保其他醫療保單會員

在***本公司***的書面批准及符合本***保單***的***條款及細則***的前提下，若本***保單***於前保單終止後即時開始生效，而***本公司***在生效日之前接獲前保單的副本，則下列條文將適用：

(a) 若***受保人***已患有某種***傷病***並已在***生效日***向***本公司***披露，而倘前保單仍然有效，***受保人***本可按前保單規定取得賠償，則該名***受保人***將繼續按本***保單***的***條款及細則***，就該現有***傷病***享有保障，但賠償額不會超過前保單或本***保單***規定的最高賠償限額（以較低額為準）。在前保單生效期內發生的已有***傷病***將不會列為不保事項；及

(b) 本***保單***第一部分「***投保前已存在的病症***」的定義中，有關「***生效日***」的所有提述應視作「前保單的生效日」；及

(c) 本***保單***批註規定的其他***條款及細則***（如有）。

4. 保單復效

若本***保單***基於任何原因而終止，***保單持有人***可於本***保單***失效後兩 (2) 個月內以***本公司***指定的表格向***本公司***申請將本***保單***復效，經***本公司***接納及核准後，本***保單***將於該接納及核准日復效（「***保單復效日***」），條件是***保單持有人***須於***保單復效日***前繳付所有逾期的保費及利息（該利息將由***本公司***釐定）。經復效的***保單***僅承保在***保單復效日***後開始出現之***傷病***所引致的醫療費用。

5. 更改計劃項目

就任何計劃項目更改，***保單持有人***可在每個***續保日***前最少十 (10) 個***工作天***向***本公司***作出書面申請。該申請須以***本公司***指定的表格作出，而只有更改至更高級別的計劃項目才需經重新核保。經***本公司***批核後，有關更改計劃項目將於***續保日***生效。

第五部分

保費條款

1. 應付保費

就本***條款及細則***的保障而應繳付的本***保單***保費，是指***本公司***採用的當時保費表列明的須付年度保費，而***本公司***可不時更改該保費表，無須預先通知。

2. 繳交保費

應付之保費金額已載於***保單附表***或本***保單***所附的任何***批註***內。每年之保費必須根據***條款及細則***於保費到期日前繳交，***本公司***才會支付任何賠償。

除非在本***條款及細則***中另有說明，否則保費一經繳交將不獲退還。

保費到期日、***續保日***及保單年度均由***本公司***參照***保單附表***內所載之***生效日***而釐定。第一期保費將於***生效日***到期，隨後之保費將於每一個***續保日***到期。

3. 寬限期

本公司給予***保單持有人***三十 (30) 日繳交保費的寬限期，由每期保費到期日起計。本***保單***於寬限期內仍然生效，惟在收到保費前，***本公司***於該期間內將不會支付任何保障利益，直至保費已獲繳清。如在寬限期屆滿後保費仍未繳交，本***保單***即於保費原本的到期日起當日失效。

第六部分

續保條款

1. 續保

本***保單***自***生效日***起生效（須已繳清所需保費），若***本公司***仍然提供此***保單***，本***保單***將可根據本第六部分的***條款及細則***每年***續保***，並於每個***保單續保日***自動***續保***（須根據***續保***時適用的已調整的保費率、***條款及細則***及***保單附表***）。

除本第六部分第五節所述之情況外，***續保***時無須重新核保本***保單***。

2. 修訂

本公司有權於***續保***時修訂本***條款及細則***及***保單附表***，該修訂將自動適用於***保單***。

3. 保費

不論***本公司***在***續保***時有否修訂本***保單***之***條款及細則***或***保單附表***，***本公司***將有權按當時***本公司***採用的保費表調整保費。

除本第六部分第五節所述之情況外，在每個保單年度及在***續保***時，***本公司***將不會因***受保人***之健康狀況變化而增加***受保人***的***個別不承保項目***。

4. 續保通知

不論***本公司***在***續保***時有否修訂本***保單***之***條款及細則***或***保單附表***，***本公司***須在***續保日***前不少於四十五（45）日向***保單持有人***發出書面通知。

該書面通知須列出已調整的***續保***保費和***續保日***。若***本公司***在***續保***時修改了***條款及細則***，***本公司***在發出書面通知時，須備妥本***保單***最新的***條款及細則***以供***保單持有人***參閱。經修訂之***條款及細則***及***續保***保費將於***續保日***時生效。

5. 除指定情況外不作重新核保

本***保單***的保障範圍如有任何改動，而該改動是適用於所有具備相同***條款及細則***和***保單附表***的保單的，則無須重新核保。這適用於包括但不限於任何保障的升降或增刪，不論該改動是以***批註***或其他方式作出。

儘管如此，***本公司***需要在下列情況下作出重新核保 -

(a) 當***保單持有人***要求***保單***復效時；

(b) 當***保單持有人***根據本***條款及細則***的許可，要求轉換至本***保單***其他提供較高或額外保障的計劃項目時。

  (i) 然而，在任何時候，當***保單持有人***根據本***條款及細則***的許可，要求轉換至本***保單***其他提供較低或較少保障的計劃項目時，則無須重新核保本***保單***，惟***本公司***有酌情權按現行處理類似的要求之慣常做法接受或拒絕該要求；

  (ii) 如***本公司***拒絕上述要求或***保單持有人***不接受重新核保的結果，***本公司***將無權終止或不***續保***本***保單***；

本公司和***保單持有人***均確認 -

(a) 若***本公司***按本第六部分的***條款及細則***有權或必須按某些因素在***續保***時重新核保本***保單***，***本公司***須按本第六部分的***條款及細則***及當時的核保指引，在重新核保時只考慮該等有關因素；及

(b) 重新核保後，***本公司***可終止本***保單***及 / 或增加***個別不承保項目***。

第七部分

索償條款

1. 索償申請提交

所有索償申請須於***受保人***出院後或（當沒有***住院***時）進行及完成相關***醫療服務***後九十（90）日內提交予***本公司***。就此目的而言，除非提交索償時具備以下各項，否則有關索償將被視為無效或不完整，而***本公司***亦不會給予賠償 -

(a) 遞交***本公司***滿意的所有收據正本及 / 或分項賬單正本連同診斷、所獲提供***醫療服務***的種類的證明；

(b) ***本公司***合理要求的所有相關資料、證明書、報告、證據、轉介信及其他數據或資料，均須提供給本公司用以處理該項索償，所有費用均由***保單持有人***支付；及

(c) 所有文件包括但不限於上述（a）及（b）所列者應以中文或英文書寫。任何文書如非中文或英文，均須予以翻譯，而任何翻譯安排的費用將由***保單持有人***支付。

如***保單持有人***的索償申請未能於上述時段內提交至***本公司***，***保單持有人***須以合理理由連同有關證明文件（如有）通知***本公司***，否則***本公司***有權拒絕其於上述時段後提交的索償申請。***本公司***合理要求的而***保單持有人***可以合理提供的所有證明書、資料及證據，均須由***保單持有人***承擔費用提供。

2. 法律訴訟

在***本公司***收到按本***保單***要求的所有索償證據後的首六十（60）日內，***保單持有人***不得提起任何法律訴訟以追討本***保單***下應付的任何索償金額。

3. 醫療檢查

索償時，***本公司***有權要求***受保人***接受由***本公司***指定之***註冊醫生***作出的身體檢查，相關費用將由***本公司***承擔。

第八部分

保障利益條款

1. 保障地域範圍

除非另有說明，本***保單***所有保障均全球適用（美國除外）。

2. 保障範圍

在遵守本***保單***的***條款及細則***的前提下，若***受保人***在本***保單***生效時接受***醫療服務***，***本公司***將會根據本***保單***所設並適用的限額及於計算本第八部分第三至十三節的應付保障時，按以下條件應用以下***合資格醫療費用***之賠償百分比作出賠償：

(i) AXA安盛特選醫療網絡以內

若符合以下要求，將可獲實際***合資格醫療費用***的百分之一百（100%）-

(a) 相關的***醫療服務***是在***AXA安盛特選醫療網絡***以內進行的；

(b) ***受保人***於進行相關***醫療服務***前至少兩（2）個***工作天***，向***AXA安盛特選醫療網絡***名單上列明的***註冊醫生***出示***醫療卡***及身份證明文件以通知***註冊醫生***該***受保人***是受保於本***保單***的；及

(c) ***受保人***於進行相關***醫療服務***前已收到***本公司***批准相關***醫療服務***的確認。惟收到***本公司***的確認並不代表***本公司***接受該相關***醫療服務***的責任及 / 或負責所有費用。

為免存疑，當只符合以上 (a) 的要求，但沒有符合 (b) 及 / 或 (c) 時，則以下本第八部分第2 (iii) 節的***非AXA安盛特選醫療網絡 — 無預先批核***的賠償百分比將適用。

(ii) 非AXA安盛特選醫療網絡 — 經預先批核

若符合以下要求，將可獲實際***合資格醫療費用***的百分之一百（100%）-

(a) 相關的***醫療服務***（不包括於本第八部分以下第2 (iv) 及2 (v) 所列的***醫療服務***）於***非AXA安盛特選醫療網絡***進行；

(b) 於進行相關***醫療服務***前至少五 (5) 個***工作天***已向***本公司***遞交***預先批核***的申請，該申請須由 (i) ***受保人***遞交（若該***醫療服務***是由並非列於***AXA安盛特選醫療網絡***名單下的***註冊醫生***進行的）或 (ii) ***AXA安盛特選醫療網絡***名單下列明的***註冊醫生***遞交（若該***醫療服務***是由該名***註冊醫生***進行的），而***受保人***須於進行相關***醫療服務***前至少五 (5) 個***工作天***出示***醫療卡***及身份證明文件以通知***註冊醫生***該***受保人***是受保於本***保單***的；及

(c) ***受保人***於進行相關***醫療服務***前已收到***本公司***批准相關***醫療服務***的確認。惟收到***本公司***的確認並不代表***本公司***接受該相關***醫療服務***的責任及 / 或負責所有費用。

為免存疑，

(d) 當只符合以上 (a) 的要求，但沒有符合 (b) 及 / 或 (c) 時，則以下本第八部分第2 (iii) 節的***非AXA安盛特選醫療網絡 – 無預先批核***的賠償百分比將適用；及

(e) 若相關***醫療服務***是於***公立醫院***進行的，則以下本第八部分第 (2) (iv) 節的***公立醫院***公眾病房之***住院***的賠償百分比將適用。

(iii) 非AXA安盛特選醫療網絡 — 無預先批核

若符合以下要求，標準計劃、優選計劃及尊尚計劃將可獲實際***合資格醫療費用***的百分之八十 (80%)；或基本計劃及靈活計劃將不會獲得任何實際***合資格醫療費用***的賠償 (0%) -

(a) 相關的***醫療服務***（不包括於本第八部分以下第2 (iv) 及2 (v) 所列的***醫療服務***）於***非AXA安盛特選醫療網絡***進行；及

(b) 沒有於進行相關***醫療服務***前遞交***預先批核***申請或延遲遞交***預先批核***申請；及 / 或

(c) 於進行相關***醫療服務***前***受保人***沒有收到***本公司***的確認。

為免存疑，若相關***醫療服務***是於***公立醫院***進行的，則以下本第八部分第 (2) (iv) 節的***公立醫院***公眾病房之***住院***的賠償百分比將適用。

(iv) 公立醫院公眾病房之住院

若相關***醫療服務***是於***公立醫院***的公眾病房進行的，將可獲實際***合資格醫療費用***的百分之一百 (100%)。為免存疑，除非相關***醫療服務***是於***公立醫院***的公眾病房進行的，否則醫療費用將不獲保障。

(v) 意外與緊急住院

若相關***醫療服務***是因***緊急情況***（包括因***意外***引致的***緊急情況***）引致的，將可獲實際***合資格醫療費用***的百分之一百 (100%)。

為免存疑，若相關***醫療服務***是於***公立醫院***進行的，則以下本第八部分第 (2) (iv) 節的***公立醫院***公眾病房之***住院***的賠償百分比將適用。

為免存疑，

(i) 本***保單***所賠償的***合資格醫療費用***金額將不會超過***受保人***所接受的***醫療服務***之實際開支，並須受***保單附表***所定的適用最高總額（如有）及***保單附表***中列明的計劃項目之***每年保障總限額***所規限。

(ii) ***本公司***將視任何列明於***日間手術列表***下的程序或手術為***日間手術***，本第八部分第六、七、八、十七及十九節之下的保障利益項目將相應地不適用。有關該程序或手術於本第八部分的其他保障利益項目（如有）的***合資格醫療費用***將會相應減少，並根據發生該等費用的當地類似***日間手術***收取的***合理及慣常***收費水平作出賠償。

(iii) 本***保單***只會賠償***受保人***接受***醫療服務***的***合資格醫療費用***。除非另有說明，由***受保人***以外人士遭受或接受***醫療服務***而產生的費用均不獲賠償。

3. 病房及膳食

本公司須賠償***受保人***在***註冊醫生***的建議下***住院***或接受任何***日間手術***或癌症治療，並因此引致***醫院***的病房及膳食收費之實際***合資格醫療費用***，但在任何情況下，有關保障將不得超過於***保單附表***就本節所列明的每保單年度最多日數。

4. 住院雜費

本公司須賠償***受保人***於***住院***期間或在接受任何***日間手術***當日得到的***醫療服務***所涉及的雜項開支之實際***合資格醫療費用***，包括 -

(a) 施行麻醉及氧氣；

(b) 輸血行政費，但不包括血液或血漿；

(c) 敷料及石膏模；

(d) 在***住院***或任何***日間手術***期間服用的處方藥物；

(e) 在出院或完成***日間手術***後處方，以供其後一 (1) 星期內使用的處方藥物；

(f) 醫學即棄用品、消耗品、儀器和裝置，但不包括於本第八部分第五節所保障的任何醫療植入儀器；

(g) 診斷成像服務，包括超聲波和X光以及其分析，但不包括本第八部分第十二節所列的***先進影像診斷檢查***；

(h) 靜脈注射，包括注射液；

(i) 化驗室進行的化驗，包括為***住院***期間的手術或***日間手術***所進行的病理學檢驗；及

(j) ***住院***期間的***物理治療***。

5. 指定醫療裝置

如須按本第八部分第九節賠償外科醫生費，***本公司***須賠償植入醫療裝置的實際***合資格醫療費用***，惟該植入的醫療裝置（不包括替換程序）必須是***醫療需要***的及是手術過程的必需品。此保障包括但不限於以下裝置：

(a) 起搏器；

(b) 經皮冠狀動脈腔內成形術的支架；

(c) 單聚焦眼內人造晶體；

(d) 人工心瓣；

(e) 金屬或人工關節置換；

(f) 用於更換或植入骨間韌帶的人工韌帶；及

(g) 人工椎間盤。

6. 主診醫生巡房費

本公司須賠償***受保人***在***住院***期間的任何一日，基於***醫療需要***的情況接受***註冊醫生***的治療，該主診***註冊醫生***就巡房或診症而實際收取的***合資格醫療費用***。

7. 專科醫生費

本公司須賠償***受保人***在***住院***期間的任何一日，在主診***註冊醫生***的書面建議下，接受***專科醫生***（並非本第八部分第六節所指的主診***註冊醫生***）的診治所涉及的巡房或診症而實際收取的***合資格醫療費用***。

8. 深切治療

本公司須賠償***受保人***在***住院***期間的任何一日，在主診***註冊醫生***的建議下入住***深切治療部***或***加護病房***作為***住院病人***，並因此引致***住院***期間病房及膳食收費之實際***合資格醫療費用***。但在任何情況下，有關保障將不得超過於***保單附表***就本節所列明的每保單年度最多日數。為免存疑，根據本節所發生及須付的***合資格醫療費用***將不會再獲本第八部分第三節的賠償。

9. 外科醫生費

本公司須賠償***受保人***在***住院***期間或於為***日症病人***提供***日間手術***的設備環境下進行***醫療需要***的***治療***（包括內窺鏡程序），主診外科醫生收取之實際***合資格醫療費用***。

若***受保人***接受任何取代切割方式進行之程序治療癌症以外疾病，包括放射手術及放射治療，***本公司***須支付就該取代的手術而言屬***合理及慣常***的賠償，而為***癌症治療***而作出的任何程序則須按本第八部分第十三節賠償。

10. 麻醉師費

如須按本第八部分第九節賠償外科醫生費，***本公司***須賠償***受保人***進行有關***治療***期間***麻醉師***所提供***醫療上需要的***服務而收取的實際***合資格醫療費用***。

11. 手術室費

如須按本第八部分第九節賠償外科醫生費，***本公司***須賠償為***受保人***進行有關***治療***期間因***醫療需要***的情況而使用手術室之實際***合資格醫療費用***（包括但不限於***治療***室和康復室）。

12. 先進影像診斷檢查

就***受保人***在***住院***期間或於為***日症病人***提供***日間手術***的設備環境下，並由主診***註冊醫生***的書面建議下為診斷或治療***傷病***而進行***醫療需要***的***先進影像診斷檢查***的實際***合資格醫療費用***。

13. 癌症治療

本公司須賠償***受保人***在主診***註冊醫生***的建議下作為***住院病人***、***日症病人***或於***門診***接受因其所患癌症而對其進行的：(i) 目的為延長***受保人***生命和因癌症及其拼發症（如適用）而進行的電療、化療、標靶治療、荷爾蒙療法及免疫療法， 或 (ii) 須與上述 (i) 癌症治療相關並在治療過程中的診症、處方藥物及 / 或診斷檢查，以致***受保人***發生的實際***合資格醫療費用***。

為免存疑，此保障將不會賠償對***受保人***進行的純粹為監察其健康狀況而作出的診症、處方藥物及 / 或診斷檢查的費用。

14. 入院 / 日間手術前門診護理

本公司須賠償***受保人***的***門診***護理或***緊急情況***診症的實際***合資格醫療費用***，惟於該次***門診***護理或診症後緊隨的三十 (30) 日內必須***住院***或進行***日間手術***。***本公司***於本節下就每次***住院***或***日間手術***最多只賠償一 (1) 次***門診***護理或診症。

本第十四節將不會賠償***先進影像診斷檢查***及***癌症治療***。

15. 出院 / 日間手術後門診護理

本公司須賠償***受保人***在主診***註冊醫生***的建議下，於出院或完成***日間手術***後緊隨的六 (6) 星期內的門診護理所產生的實際***合資格醫療費用***，惟***門診***護理必須與該次***住院***或***日間手術***的同一***傷病***（包括其任何及所有拼發症）直接有關並因之而直接引致。***本公司***就每次***住院***或***日間手術***最多只賠償兩 (2) 次如此的***門診***護理及每次最多七 (7) 日處方藥物。

本節將不會賠償***先進影像診斷檢查***及***癌症治療***。

16. 出院 / 日間手術後門診輔助服務

本節的保障只適用於以下計劃項目：靈活計劃、標準計劃、優選計劃及尊尚計劃。

本公司須賠償***受保人***在主診***註冊醫生***的建議下，於出院或完成***日間手術***後於門診接受由***物理治療師***進行的物理治療所產生的實際***合資格醫療費用***，惟該物理治療必須與引致該次***住院***或***日間手術***的同一***傷病***有直接關係。在任何情況下，***本公司***所作的賠償將不會超過***保單附表***就此節列明的每保單年度最高賠償額。

17. 住院陪床

本公司須賠償於***受保人住院***期間，***醫院***所收取的住院陪床之實際***合資格醫療費用***。此保障並不包括訪客之膳食，並受限於***保單附表***就本節列明的每保單年度之最多日數。

18. 透析治療

若***受保人***因腎臟正在慢性地並且不能復原地喪失功能，***本公司***將賠償就***受保人***作為***住院病人***或***日症病人***因***傷病***進行***醫療需要***的血液透析或腹膜透析所產生的實際***合資格醫療費用***。惟血液透析或腹膜透析需由主診***註冊醫生***指定。

19. 往來各醫院之本地救護車服務

本節的保障只適用於以下計劃項目：標準計劃、優選計劃及尊尚計劃。

本公司須賠償因***受保人***在***醫院住院***或於***醫院***進行任何***日間手術***當日就往來各***醫院***以接受***醫療需要***的***醫療服務***而產生的***醫院***之間救護車服務的實際***合資格醫療費用***。

20. 緊急門診治療

本節的保障只適用於以下計劃項目：優選計劃及尊尚計劃。

本公司須賠償因***受保人受傷***並作為***日症病人***或於***門診***接受***緊急治療***，***醫院***所收取的實際***合資格醫療費用***，惟該***受傷***必須因***意外***引致，而且***受保人***於該***意外***後七十二 (72) 小時內接受治療。

21. 分娩保障

本節的保障只適用於以下計劃項目：尊尚計劃。

此保障只提供予年齡介乎十八 (18) 歲至四十九 (49) 歲的***受保人***。

本公司須賠償***受保人***因自然分娩、正常剖腹生產、流產、因胎兒畸形及嚴重的身體健康危害而終止懷孕、先兆流產及醫療處方的人工流產而***住院***及在***醫院***進行外科手術，以致***受保人***被收取的實際***合資格醫療費用***。此保障只在***受保人***按尊尚計劃連續獲本***保單***保障連續十二 (12) 個月，並已為同一計劃項目的下一個保單年度進行***續保***的情況下才會提供。

為免存疑，即使***受保人***於同一保單年度內懷孕多於一次，***本公司***於每個保單年度支付的保障以***保單附表***就此節列明的最高金額為限。此分娩保障將於***受保人***四十九 (49) 歲生日當天或隨後的***保單續保日***終止。

22. 妊娠併發症

本節的保障只適用於以下計劃項目：優選計劃及尊尚計劃。

本公司須賠償***受保人***在主診***註冊醫生***的建議下，因以下***緊急情況***的妊娠併發症而需***住院***及 / 或於***醫院***接受手術所產生的實際***合資格醫療費用***。

受保的妊娠併發症只限於子宮外孕、葡萄胎、產前出血、瀰漫性血管內凝血、作為導致蛋白尿的主因的子癇前症、胎兒死亡、需切除子宮之產後出血、羊水栓塞及於懷孕期間肺栓塞。此保障只在***受保人***按優選計劃或尊尚計劃獲本***保單***保障連續十二 (12) 個月，並已為本***保單***的優選計劃或尊尚計劃的下一個保單年度進行***續保***的情況下才會提供。

23. 賠償調整

不論是自願或非自願，若***受保人***於任何高於***保單附表***列明的***醫院***病房級別***住院***，於計算本***保單***此第八部分下第三至十三節、第十七至十八節及二十一至二十二節 (「適用節」) 的保障賠償時，下表根據相關病房類別所列的百分比將予以應用。計算適用節的保障賠償時，***合資格醫療費用***應乘以以下所列的賠償調整之百份比：

合資格之病房	實際住宿之病房	賠償調整
普通房	半私家房	50%
普通房	標準私家房	25%
半私家房	標準私家房	50%

為免存疑，任何高於標準私家房以上等級的病房之***住院***，不論是自願或非自願，***本公司***將不會就適用節支付***合資格醫療費用***。

24. 保障限制

由任何法例、醫療計劃或由任何政府、公司或其他保險公司提供的保險單就***醫療服務***支付之賠償或償付，***本公司***將不會對該等***醫療服務***負責，除非該等費用並沒有由該法律、醫療計劃或保險單獲得賠償。

第九部分

不受保項目

本公司不承保下列各項：

1. 非***醫療需要***的***治療***、程序、藥物、檢測或服務。

2. 屬實驗性質或沒有在第八部分具體列明的***醫療服務***、供應品或服務。在不影響上述條款的一般性原則下，任何***醫療服務***若尚未證實為對某種***傷病***是安全、於科學上得到證實的療法或未顯示具有可證明益處的，均不受保。此外，任何有關下列各項所引致的費用的索償均不受理：實驗性質的服務或供應品，包括並未認可為公認醫療常規的治療程序、設施、儀器、藥物、施用藥物、裝置或供應品。

3. (i) 不在***醫院***使用或並非***註冊醫生***處方的藥物（於第八部分另有說明除外）；
   (ii) 維他命、避孕藥或避孕裝置、抗菌肥皂和清潔劑、疫苗及過敏原萃取物、補品/保健產品、刺激或抑制食慾的藥物，但具體列明屬受保者除外；或
   (iii) 與吸毒、酗酒、減輕體重、戒煙及治療禿頭有關的處方藥物及實驗性藥物。

4. 主要為進行診斷掃描、X光檢查或物理治療而***住院***，而該等程序可在***門診***或***日間手術***的環境提供。

5. 血液、血漿的費用及捐血費，包括儲存費。

6. 可向第三方追討的費用，包括但不限於可根據《僱員補償條例》（***香港***法例第282章）或其任何修訂提出索償的***傷病***事件所涉及的***醫療服務***或補償。

7. 美容及 / 或整容手術，及 / 或任何純粹為美容而進行的***醫療服務***。.

8. ***先天性疾病***及在***投保前已存在的病症***。

9. 任何類別的牙科及口腔手術護理和治療，包括牙齒矯形、齒髓及牙周膜服務；以及修復服務，例如補牙、鑲齒冠、牙橋、箍牙及鑲假牙。本***保單***只承保下列與牙科治療有關的服務 ：-
   a. 因***意外***而導致口部和牙齒受傷，需要立即接受醫治。所有其後有關之任何治療則不獲賠償；
   b. 經適當轉介的口腔手術，以治療頜骨或面骨脫位或骨折；切除頜骨良性或惡性腫瘤；

10. 眼折射能力、眼折射手術（放射式角膜切割術）、視力測驗或驗配眼鏡，以及各種形式的斜視治療。

11. 生育管理的外科或化學避孕方法，或不育治療或體外受精，或男性或女性的絕育或性別重置。

12. 婦產、懷孕、分娩（包括驗孕、確定嬰兒性別、外科手術分娩）、流產、墮胎及產前或產後護理，以及生育或不育治療（包括自願絕育後恢復生育能力），不論原因為何，惟分別於第八部分第二十一及第二十二節的分娩保障及 / 或妊娠併發症之下具體指明受保的除外。

13. 變性手術或性機能失常的治療，包括但不限於陽萎、不舉或早泄。

14. 包皮環切手術，惟***醫療需要***的除外。

15. 直接或間接因與人體免疫力缺乏病毒有關的***傷病***而引致的費用，包括後天免疫力缺乏症（愛滋病）及 / 或因愛滋病而產生的任何突變、衍化或變異，並因在***生效日***之前感染人體免疫力缺乏病毒而病發。就本不受保項目而言，若在***生效日***後五 (5) 年內出現與人體免疫力缺乏病毒有關的***傷病***，在沒有明確和具說服力的相反證據之情況下，將不可推翻地推定為因在***生效日***之前感染人體免疫力缺乏病毒而病發。

16. 例行或一般檢查，或與受保***傷病***的治療或診斷無關的例行驗血、健康檢查、體檢或化驗、免疫或檢疫的疫苗接種、藥物或防疫注射，惟具體列為受保服務者除外。

17. 有關手術或非手術美容治療、聽力測試、疫苗注射或接種、頭髮礦物分析、保健品或體重控制、眼折射治療的費用，包括但不限於例行眼科檢查或任何配戴眼鏡或鏡片的費用。

18. 精神病及情緒失調治療，包括直接或間接源自以下各項的治療：精神失常、老人科病、老人心理或精神病變，包括但不限於精神變態、神經官能症、各種抑鬱症、焦慮、厭食症、飢餓症、精神分裂及其他行為失常。

19. 購買或使用特別支架、器械、助聽器、輪椅、丁字形拐杖、持續性正壓呼吸器、靜脈注射裝備及任何其他類似儀器。

20. 購置用於第八部分第五節列明的醫療植入裝置的費用，目的為替換現有醫療裝置。

21. 直接或間接因下列各項而引致的***傷病***，並因此而接受的醫療或其他護理服務：-

    (a) 吸毒、酗酒、性病或蓄意濫用藥物或酒精、企圖自殺或故意自傷身體或參與非法活動。

    (b) 從事或參與高風險職業或活動，包括但不限於以下各項：-

        (i) 海陸空軍服務或行動；

        (ii) 飛行活動，但購票乘搭由正式持牌作定期運輸購票乘客的航空或包機公司所提供和經營的飛機則不在此限；

        (iii) 深海潛水、攀山、水上降傘、危險動作或特技、洞穴探險、賽車或賽馬，或涉及任何危險或帶有污染物質的工作或活動；或

        (iv) 專業體育活動或***受保人***將會或可以從該種體育活動中賺取收入或報酬。

    (c) 戰爭或任何戰爭行為（不論宣戰與否）、侵略、外敵行動、戰事、內戰、叛亂、革命、起義或軍事政變或奪權，或恐怖主義行動；

    (d) 任何核子輻射或污染或任何核子武器、物料、能源或電力或任何核子廢料的電離作用或燃燒。就本不受保項目而言，燃燒包括任何自持核裂變過程。

22. 職業治療及語言治療服務。

23. 其他治療方法包括但不限於按摩治療、自然療法、水療法、脊椎神經科治療、足部治療、生物反饋療法、催眠、鎮痛及順勢療法，但本***保單***另有規定的除外。

24. 傳統中醫治療，包括但不限於中草藥治療、跌打、針灸、穴位按摩及推拿。

25. 善終服務。

26. ***受保人***在駕駛任何種類的汽車時，血液內的酒精含量超過法律上允許的水平，並因此引致***意外***而需要的服務。

27. 任何其他現有保險承保的費用，或直接或間接因***政府***設施或其僱用的***註冊醫生***或***麻醉師***所提供的護理服務而引致的費用，但就***醫療服務***所須支付的法定收費則不在此限。

28. 在任何因故或實際上已成為居留地或長期居留的場所居住和接受護理服務所引致的費用。

29. 就移植手術收集捐贈者器官或組織的費用或所涉及的任何行政費用，即使該等移植手術獲本***保單***的***條款及細則***准許亦然。

30. 制裁除外條文

    保險人不得視為提供任何保險，及不會承擔任何賠償或提供任何利益之責任，若就所提供的保險及支付任何賠償款項或利益責任可能使保險人受到聯合國決議的任何制裁、禁令或限制、或遭受歐盟、英國或美國的貿易或經濟制裁，或違反歐盟、英國或美國的法律或法規。

第十部分

摯關懷超卓醫療卡的使用條件

1. 保單之取消或終止

若本***保單***因故被取消或終止，則***保單持有人***須在取消或終止之日後七 (7) 日內將所有***受保人***的***醫療卡***交還***本公司***。***保單持有人***須就***受保人***在***保單***無效時仍使用***醫療卡***所產生的任何索償、損失、損害、訴訟、程序、費用及支出，全數付還***本公司***，不論該***醫療卡***最終是否已交還***本公司***。本節在本***保單***取消或終止後仍然有效。

2. 索償爭議

若因使用***醫療卡***所產生的醫療費用出現爭議，***保單持有人***同意立即先退還***本公司***已付的款項，再待決定有關醫療費用是否應按本***保單條款及細則***支付。本節在本***保單***取消或終止後仍然有效。

3. 超過賠償額的費用

若任何***受保人***使用***醫療卡***所引致的費用超過該名***受保人***在此***保單***的保障額，***保單持有人***應在收到***本公司***發出的欠款或***賠償差額欠款***的通知書 (連同須付金額的發票) 後，立即向***本公司***償還該項欠款或***賠償差額欠款***。若該欠款或***賠償差額欠款***在通知書日期起計十五 (15) 日內沒有付清，***本公司***將會加收利息，利息將會按照相等於香港上海滙豐銀行有限公司的最優惠利率按月複利計算。本節在本***保單***取消或終止後仍然有效。

4. 不受保醫療服務

若***受保人***利用***醫療卡***接受不在本***保單***的***條款及細則***規定下保障的***醫療服務***，則***保單持有人***須向***本公司***全數付還此等不受保***醫療服務***的費用。本節在本***保單***取消或終止後仍然有效。

5. 保單續保

若本***保單***因故而未***續保***，則***保單持有人***須於***到期日***後七 (7) 日內立即將所有***受保人***的***醫療卡***交還***本公司***，並須就***受保人***在***保單***無效、有待簽發或沒有***續保***時使用***醫療卡***所產生的費用及付款，全數付還***本公司***。本節在本***保單***取消或終止後仍然有效。

6. 實體醫療卡補領費

每張補發的***醫療卡***均須支付補領費。***本公司***將不時知會***保單持有人***有關的補領費用。

7. 保障之終止

若***受保人***按本***保單***享有的保障因故終止或取消，***保單持有人***同意在有關終止或取消之日或之前，向該名***受保人***收回***醫療卡***，並於***醫療卡***終止或取消之日後二十八 (28) 日內將***醫療卡***交還***本公司***。若該名前***受保人***於終止或取消之日後仍然使用***醫療卡***來獲取賠償，***保單持有人***須負責全數付還***本公司***已付的款項，不論該***醫療卡***最終是否已交還***本公司***。本節在本***保單***取消或終止後仍然有效。

8. 醫療卡被竊或遺失

若***醫療卡***被竊或遺失，***保單持有人***同意在三 (3) 個***工作天***內以書面通知***本公司***有關詳情。***保單持有人***須就任何***受保人***的***醫療卡***被竊或遺失後遭他人使用而造成的任何交易負全責，直至***保單持有人***向***本公司***遞交填妥的「遺失聲明」表格，申報有關***醫療卡***被竊或遺失為止。有關表格可向***本公司***索取。

9. 使用醫療卡

在一切有關***醫療卡***使用的事宜上，***本公司***只與***保單持有人***而非個別***受保人***接洽。根據本***保單***的***條款及細則***的規定，***保單持有人***須負全責控制及監察***受保人***對***醫療卡***的使用。

10. 取消醫療卡

本公司保留可不經事先通知而隨時收回任何***醫療卡***之權利，按本***保單***發出的任何及一切***醫療卡***均為***本公司***絕對專有的財產。

第十一部分

增值服務條款

請參閱***保單***的保單持有人指南以獲取增值服務的詳情。***本公司***有權不時更改保單持有人指南所列明的增值服務，並無須作出預先通知。

日間手術列表

以下列明的所有手術須以***日間手術***進行。這***日間手術列表***僅作參考用途，***本公司***可不時更改此列表，並無須作出預先通知。

程序 / 手術	
腹部及消化系統	
食道、胃及十二指腸	食道胃十二指腸內窺鏡檢查，連或不連活體組織檢查及 / 或息肉切除術
	食道胃十二指腸內窺鏡檢查連異物清除
空腸、迴腸及大腸	肛裂切除術
	肛周膿腫的切除術及引流術
	結腸鏡檢查連或不連活體組織檢查
	結腸鏡檢查，連息肉切除術
	乙狀結腸內窺鏡檢查
	痔瘡的注射療法或綁紮術
肝臟	幼針抽吸肝活體組織檢查
腦部及中樞神經系統	
神經外科手術	腦室引流沖洗術
脊椎手術	腰椎穿刺或小腦延髓池穿刺手術
內分泌系統	
甲狀腺	幼針抽吸甲狀腺活組織檢查連或不連影像導引
耳鼻喉 / 呼吸系統	
耳	耳廓血腫引流 / 裝鈕 / 切除術
	（耳科）異物清除術
	鼓膜切開術連或不連導管插入
鼻、口及咽喉	上頜竇穿刺及沖洗術
	鼻粘膜燒灼術 / 鼻衄控制
	鼻骨折閉合復位術
	鼻病變組織切除術
	鼻咽鏡檢查或鼻鏡檢查連或不連鼻腔活體組織檢查連或不連清除異物
	鼻瘜肉切除術
	竇腔鏡連或不連活體組織檢查
呼吸系統	杓狀軟骨半脫位 – 喉鏡復位術
	支氣管鏡檢查連或不連活體組織檢查
	支氣管鏡檢查連清除異物
	喉鏡檢查連或不連活體組織檢查
	喉顯微鏡檢查連或不連活體組織檢查，連或不連小結 / 息肉 / 聲帶水腫切除術
	治療聲帶麻痺注射法
	氣管食道穿刺術進行語音復建
	聲帶手術包括使用激光技術（惡性腫瘤除外）

程序 / 手術	
眼部	
眼	眼瞼損傷組織切除術 / 刮除術 / 冷凍治療
	眼瞼縫合術 / 眼緣縫合術
	白內障手術
	瞼內翻或瞼外翻修補術連或不連楔型切除術
	結膜損傷組織切除術 / 破壞術
	胬肉切除術
	角膜異物清除術
	玻璃體診斷性抽吸術
	虹膜活體組織檢查
	眼外肌或肌腱活體組織檢查
	淚囊及淚道切除術
	淚小管 / 鼻淚管探查連或不連冲洗
女性生殖系統	
子宮頸	陰道鏡檢查連或不連活體組織檢查
	子宮頸錐形切除術
	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞子宮頸病變組織
	子宮頸內膜刮除術
	子宮頸電環切除術
	子宮頸囊腫袋形縫合術
	子宮頸修補術
輸卵管及卵巢 ^	輸卵管擴張術 / 吹氣術
	卵巢囊腫抽吸術
	^ 除非另有說明，此類別應用於單側或兩側（輸卵管及卵巢）
子宮	子宮頸擴張及刮宮術
	宮腔鏡檢查連或不連活體組織檢查
陰道	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞陰道病變組織
	陰道承托環的嵌入或移除
	巴多林氏腺囊腫袋形縫合術
	陰道剝脫術或陰道斷端術
	後穹窿穿刺術
	子宮直腸凹切開術
	陰道橫隔切除
外陰及入口	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞外陰病變組織
	闊邊局部外陰冷刀切除術或子宮頸電環切除術
	前庭腺炎切除術
	切除外陰活體組織檢查
	外陰及會陰切開術及引流術
	外陰粘連鬆解術
	外陰或會陰瘻管修補術
	外陰及 / 或會陰撕裂縫合術 / 修補術

程序 / 手術	
血液淋巴系統	
淋巴結	淋巴結病變組織 / 膿腫引流術
	表面淋巴結活體組織檢查 / 切除 / 淋巴結構的單純切除術
	頸淋巴結切開活組織檢查 / 幼針抽吸淋巴結活組織檢查
男性生殖系統	
前列腺	前列腺膿腫外部引流術
	前列腺活體組織檢查
陰莖	包皮環切術
睾丸 ^	睾丸活體組織檢查
	睾丸鞘膜積水抽液手術
	^ *如非特別說明，此類別應用於單側或兩側（睾丸）*
輸精管	輸精管結紮手術
肌肉骨骼系統	
關節	關節抽吸術 / 注射
	麻醉下進行關節鬆弛治療
肌肉及肌腱	開放式肌肉活體組織檢查
	橈骨莖突狹窄性腱鞘炎鬆解術
	板機指鬆解術
	網球肘（肱骨外上髁炎）鬆解術
骨折及脱位	顳顎 / 指間骨 / 肩峰關節脱位閉合復位術
	鎖骨 / 肩胛骨 / 指骨 / 髕骨骨折閉合復位術不連內固定術
	拆除因舊骨折而裝上的螺絲、釘、金屬板及其他金屬（股骨除外）
其他	神經節 / 滑囊切除術
	掌腱膜攣縮的閉合式 / 經皮膚刺針筋膜切開術
皮膚及乳房	
皮膚	皮膚或皮下病變組織切除術 / 冷凍術 / 電灼術 / 激光治療
	指甲下血腫或膿腫引流術
	脂瘤切除術
	用於移植的切皮手術
	皮膚膿腫切開術及 / 或引流術
	皮膚及 / 或皮下組織切開術及 / 或異物清除
	皮膚及皮下病變組織的局部切除術或破壞術
	皮膚傷口縫合術
	外科洗滌及縫合術
	趾甲楔形切除術
乳房	幼針抽吸乳房囊腫檢查
	乳房活體組織檢查

程序 / 手術	
泌尿系統	
腎臟	經皮膚插入腎造口管手術
	腎活體組織檢查
膀胱、輸尿管及尿道	膀胱鏡檢查連或不連活體組織檢查
	膀胱鏡連輸尿管導管插入 / 經尿道膀胱清除術
	尿道肉阜切除術
牙科	
	任何因意外受傷而進行的牙科手術

重要事項：
以上保單由**安盛保險有限公司**（「**AXA安盛**」）承保，AXA安盛已獲香港保險業監管局授權並受其監管。AXA安盛將負責按保單條款為您提供保險保障以及處理索償申請。香港上海滙豐銀行有限公司乃根據保險業條例（香港法例第 41 章）註冊為AXA安盛於香港特別行政區分銷一般保險產品之授權保險代理商。

由安盛保險有限公司刊發

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