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.
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.
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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 Terms 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; 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:

<table>
<thead>
<tr>
<th>Period covered</th>
<th>Premium refund (%) of the total annual premium received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or up to 4 months</td>
<td>50%</td>
</tr>
<tr>
<td>More than 4 or up to 5 months</td>
<td>40%</td>
</tr>
<tr>
<td>More than 5 or up to 6 months</td>
<td>30%</td>
</tr>
<tr>
<td>More than 6 or up to 8 months</td>
<td>20%</td>
</tr>
<tr>
<td>Over 8 months</td>
<td>Nil</td>
</tr>
</tbody>
</table>

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.

   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;

   (i) 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 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:

<table>
<thead>
<tr>
<th>Entitlement</th>
<th>Incurred Room Type</th>
<th>Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Ward</td>
<td>Semi-Private Room</td>
<td>50%</td>
</tr>
<tr>
<td>General Ward</td>
<td>Standard Private Room</td>
<td>25%</td>
</tr>
<tr>
<td>Semi-Private Room</td>
<td>Standard Private Room</td>
<td>50%</td>
</tr>
</tbody>
</table>

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.


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 Anaesthetist 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.

<table>
<thead>
<tr>
<th>Procedure / Surgery</th>
<th>ABDOMINAL AND DIGESTIVE SYSTEM</th>
<th>BRAIN AND NERVOUS SYSTEM</th>
<th>ENDOCRINE SYSTEM</th>
<th>EAR/ NOSE / THROAT / RESPIRATORY SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oesophageal / stomach /duodenum</td>
<td>Oesophagogastroduodenoscopy (OGD) with / without biopsy and/or polypectomy</td>
<td>Brain</td>
<td>Thyroid Gland</td>
<td>Respiratory system</td>
</tr>
<tr>
<td></td>
<td>OGD with removal of foreign body</td>
<td>Spine</td>
<td>Fine needle aspiration (FNA) of thyroid gland with / without imaging guidance</td>
<td>Arytenoid subluxation – laryngoscopic reduction</td>
</tr>
<tr>
<td>Jejunum, ileum and large intestine</td>
<td>Anal fissurectomy</td>
<td><strong>Liver</strong></td>
<td>Fine needle aspiration (FNA) biopsy of liver</td>
<td>Bronchoscopy with/without biopsy</td>
</tr>
<tr>
<td></td>
<td>Incision &amp; drainage of perianal abscess</td>
<td></td>
<td></td>
<td>Bronchoscopy with foreign body removal</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy with / without biopsy</td>
<td></td>
<td></td>
<td>Laryngoscopy with/without biopsy</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy with polypectomy</td>
<td></td>
<td></td>
<td>Micro laryngoscopy with/without Biopsy with/without excision of nodule / polyp / Reinke’s edema</td>
</tr>
<tr>
<td></td>
<td>Sigmoidoscopy</td>
<td></td>
<td></td>
<td>Injection for vocal cord paralysis</td>
</tr>
<tr>
<td></td>
<td>Injection / banding of haemorrhoid</td>
<td></td>
<td></td>
<td>Tracheoesophageal puncture for voice rehabilitation</td>
</tr>
<tr>
<td>Liver</td>
<td>Fine needle aspiration (FNA) biopsy of liver</td>
<td></td>
<td></td>
<td>Vocal cord operation, including use of laser (excluding carcinoma)</td>
</tr>
</tbody>
</table>
## Procedure / Surgery

### EYE

<table>
<thead>
<tr>
<th>Eye</th>
<th>Excision / curettage / cryotherapy of lesion of eyelid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blepharorrhaphy / tarsorrhaphy</td>
</tr>
<tr>
<td></td>
<td>Cataract surgery</td>
</tr>
<tr>
<td></td>
<td>Repair of entropion or ectropion with/without wedge resection</td>
</tr>
<tr>
<td></td>
<td>Excision / destruction of lesion of conjunctiva</td>
</tr>
<tr>
<td></td>
<td>Excision of pterygium</td>
</tr>
<tr>
<td></td>
<td>Removal of corneal foreign body</td>
</tr>
<tr>
<td></td>
<td>Diagnostic aspiration of vitreous</td>
</tr>
<tr>
<td></td>
<td>Biopsy of iris</td>
</tr>
<tr>
<td></td>
<td>Biopsy of extraocular muscle or tendon</td>
</tr>
<tr>
<td></td>
<td>Excision of lacrimal sac and passage</td>
</tr>
<tr>
<td></td>
<td>Probing with/without syringing of lacrimal canaliculi / nasolacrimal duct</td>
</tr>
</tbody>
</table>

### FEMALE GENITAL SYSTEM

<table>
<thead>
<tr>
<th>Cervix</th>
<th>Colposcopy with/without biopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conisation of cervix</td>
</tr>
<tr>
<td></td>
<td>Destruction of lesion of cervix by excision / cryosurgery / cauterisation / laser</td>
</tr>
<tr>
<td></td>
<td>Endocervical curettage</td>
</tr>
<tr>
<td></td>
<td>Loop electrosurgical excision procedure (LEEP)</td>
</tr>
<tr>
<td></td>
<td>Marsupialisation of cervical cyst</td>
</tr>
<tr>
<td></td>
<td>Repair of cervix</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>Uterus</th>
<th>Dilatation and curettage of Uterine (D&amp;C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hysteroscopy with/without biopsy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vagina</th>
<th>Destruction of lesion of vagina by excision / cryosurgery / cauterisation / laser</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insertion / removal of vaginal supportive pessaries</td>
</tr>
<tr>
<td></td>
<td>Marsupialisation of Bartholin’s cyst</td>
</tr>
<tr>
<td></td>
<td>Vaginal stripping of vaginal cuff</td>
</tr>
<tr>
<td></td>
<td>Culdocentesis</td>
</tr>
<tr>
<td></td>
<td>Culdotomy</td>
</tr>
<tr>
<td></td>
<td>Excision of transverse vaginal septum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vulva and introitus</th>
<th>Destruction of lesion of vulva by excision / cryosurgery / cauterisation / laser</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wide local excision of vulva with cold knife or LEEP</td>
</tr>
<tr>
<td></td>
<td>Excision of vestibular adenitis</td>
</tr>
<tr>
<td></td>
<td>Excision biopsy of vulva</td>
</tr>
<tr>
<td></td>
<td>Incision and drainage of vulva and perineum</td>
</tr>
<tr>
<td></td>
<td>Lysis of vulvar adhesions</td>
</tr>
<tr>
<td></td>
<td>Repair of fistula of vulva or perineum</td>
</tr>
<tr>
<td></td>
<td>Suture of lacerations / repair of vulva and/or perineum</td>
</tr>
<tr>
<td>Procedure / Surgery</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>HEMIC AND LYMPHATIC SYSTEM</strong></td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>Drainage of lesion / abscess of lymph node</td>
</tr>
<tr>
<td></td>
<td>Biopsy / excision of superficial lymph nodes / simple excision of lymphatic structure</td>
</tr>
<tr>
<td></td>
<td>Incisional biopsy of cervical lymph node / fine needle aspiration (FNA) biopsy of lymph nodes</td>
</tr>
<tr>
<td><strong>MALE GENITAL SYSTEM</strong></td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td>External drainage of prostatic abscess</td>
</tr>
<tr>
<td></td>
<td>Prostate biopsy</td>
</tr>
<tr>
<td>Penis</td>
<td>Circumcision</td>
</tr>
<tr>
<td>Testicles^</td>
<td>Testicular biopsy</td>
</tr>
<tr>
<td></td>
<td>Tapping of hydrocele</td>
</tr>
<tr>
<td>Spermatic cord</td>
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### Important Notes:
The above policy is underwritten by **AXA General Insurance Hong Kong Limited (“AXA”)**, which is authorised and regulated by the Insurance Authority of the Hong Kong SAR. AXA will be responsible for providing your insurance coverage and handling claims under your policy. The Hongkong and Shanghai Banking Corporation Limited is registered in accordance with the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong) as an insurance agent of AXA for distribution of general insurance products in the Hong Kong SAR.

 Issued by **AXA General Insurance Hong Kong Limited**

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摯關懷超卓醫療計劃

保單
請詳細參閱本保單
您有權改變主意
若您未能完全滿意或此保單之保障範圍與您現有的其他保障有所重複或超出您的需要，請於30天內
退還保單，以便我們取消此份保單及發還任何已付保費。否則，您將被視為接納此保障計劃，並接
受其條款及細則所約束。

行使取消保單權益須遵守以下規定：

• 您須親筆簽署取消保單的通知書，並於安盛保險有限公司寄出保單後30天內將信件直接交予運豐
  各分行或安盛保險有限公司。詳情請參閱以下第三部分第2節。

• 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
香港九龍九龍灣宏圖街1號壹號九龍23樓
電話：（852）3070 5010
客戶服務熱線：（852）2867 8678
收集個人資料的聲明

安盛保險有限公司（下稱“本公司”）明白其就《個人資料（私隱）條例》（香港法例第486章）（“條例”）收集、持有、處理、使用和／或轉移個人資料所負有的責任。本公司僅將為合法和相關的目的收集個人資料，並將採取一切切實可行的步驟，確保本公司所持個人資料的準確性。本公司將採取一切切實可行的步驟，確保個人資料的安全性，及避免發生未經授權或者因意外而擅自取得、刪除或另行使用個人資料的情況。

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，提供和宣傳本公司、安盛集團的其他公司（“安盛聯繫方”）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other parties”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聯繫方所提供之產品／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／或安盛聯繫方提供的任何產品／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所持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聯繫方、本公司的任何相關聯人士、任何保險公司、索賠調查公司、閣下之保險經紀、財務顧問、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. 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滬豐銀行有限公司（“滬豐”）：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的調查懷恨欠款項；
3. 與就本公司和／或安盛聯繫方提供的任何產品／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／或安盛聯繫方提供行政，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（在出現拖欠償款的情況下）追討欠款公司；
6. 本公司財務或業務的任何實際或建議的承讓人、受讓人、持有人或被轉讓人或財務或業務的任何代理、承包商或第三方；
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。

如有欲了解本公司為促銷目的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以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
後方可以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，閣下有權查閱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
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第一部分

释義

本保單中的字詞及表述均按照以下所述解释。

「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療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」是指當指明的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」是指本保單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「緊急醫療儲備卡」（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、疾病或疾病。

「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、潛在惡性或亦惡性不良的腫瘤；
(ii) 所有與人類免疫缺陷病毒同存的腫瘤；
(iii) 子宮頸上皮內腫瘤（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，於財政上依靠保單持有人，及於申請按保時的年齡介乎十五 (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，按註冊醫生的建議住於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用單據作證明。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。這種缺陷包括下列各項：

(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部疾病及水腫腫（或其併發症）；
(iii) 先天性氣，例如肺积水、腫內疝、先天性胸腹疝或先天性腹膜；
(iv) 喘息未減，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病傷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」是指於接受治療的

「受保病人」是指

「合資格醫療費用」是指

「生效日」是指

「緊急情況」是指

「批註」是指

「到期日」是指

「政府」是指

「醫療機構」是指

「保險期」是指

「醫院」是指

「醫療需要」是指

「受保人」是指

「保險業條例」是指

「住院」是指

「收入」是指

「政府」是指

「香港」是指

「香港」是指

「香港醫療管理局」是指

「受供養人」是指

「合理及慣常」是指

「緊急治療」是指

「終身保障限額」是指

「醫療服務」是指

「醫療需要」是指

(a) 需要

(b) 與該

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(c) 按良好而審慎的醫療做法及主診\textit{註冊醫生}審慎的專業判斷提供，而非主要為對\textit{受保人}、其家庭成員、照顧人員或主診\textit{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\textit{醫療服務}的一般公認的醫療做法標準而提供的；及

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

就本\textit{保單}而言，在不違反上述一般條件下，符合\textit{醫療需要}的條件的\textit{住院}包括但不限於以下情況 -

(i) \textit{受保人在緊急情況}下需要在\textit{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) \textit{醫院}有具備手術或程序所需的設備；有關程序並不能以\textit{日症病人}的方式進行；及 / 或

(iv) \textit{受保人的}共病症狀明顯嚴重；及 / 或

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

(vi) 經過為主診\textit{註冊醫生}審慎的專業判斷，\textit{受保人的}住院期長短對治療或服務是合適的；及 / 或

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

在上文(v) 至 (vii) 的情況下，主診\textit{註冊醫生}行使審慎的專業判斷時，應該考慮該\textit{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\textit{註冊醫生}審慎的專業判斷，而非主要為對\textit{受保人}，其家庭成員、照顧人員或主診\textit{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。

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

\textit{非AXA安盛特選醫療網絡}是指相關的\textit{醫療服務}是

(i) 由\textit{AXA安盛特選醫療網絡}名單非列的\textit{註冊醫生}提供的，該\textit{醫療服務}並非於\textit{AXA安盛特選醫療網絡}名單非列的\textit{醫療機構}內進行；或

(ii) 由非\textit{AXA安盛特選醫療網絡}名單非列的\textit{註冊醫生}提供的，該\textit{醫療服務}是於\textit{AXA安盛特選醫療網絡}名單非列的\textit{醫療機構}內進行；或

(iii) 由非\textit{AXA安盛特選醫療網絡}名單非列的\textit{註冊醫生}提供的，該\textit{醫療服務}並非於\textit{AXA安盛特選醫療網絡}名單非列的\textit{醫療機構}內進行。

\textit{每年保障總額限額}是指\textit{本公司}根據本\textit{條款}及\textit{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\textit{保單附表}列明的須支付之最高累積賠償額。\textit{每年保障總額限額}於每個保單年度會重新計算。

\textit{保險期}是指於\textit{保單附表}或隨後附於本\textit{保單}的\textit{批註}內列為「保險期」的期間。

\textit{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 - \textit{受保人}、\textit{保單持有人}，或\textit{保單持有人}及 / 或 \textit{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\textit{本公司}的書面批准）。

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

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

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

\textit{預先批核}是指\textit{本公司}就\textit{受保人}在進行相關\textit{醫療服務}的預先批核，及\textit{本公司}已於進行該\textit{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病症，而该类病症已显示受保人已察觉或应合理地察觉的病徵或症状。

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

(i) 內部器官腫瘤
(ii) 脫癒
(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) 肢肢外翻

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

(i) 腎結核
(ii) 肺門塟管
(iii) 腫結石
(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) 腹瀉癱、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營運、運作、控制或資助的醫院。

「合理及慣常」是指指醫學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，就類似病症提供類似醫療服務或相類取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，合理及慣常的收費不得高於實際收費。

本公司須照以下資料（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) 政府報告及 / 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醫療檢測員評為非合理及慣常收費的保障補償作出調整。

「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》在香港醫療委員會註冊，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理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」是指保單期第一日起計後十二 (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，該列表設定了必須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之註冊醫生，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病痛。

「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額所限。

儘管有上述規定，本保單不設終身保障額度。

2. 保單

本保單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) 本保單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之批註、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，或其它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之核保決定，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) 按條款解讀所需，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) 除另解釋外，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，並確保持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) 返回保單正本；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兌換率轉換成港元。

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细则第六部分第四節，於續保日不少于四十五 (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闢解。本公司及保單持有人同意遵從香港法院之司法裁判權。

13. 排解糾紛
本公司及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喪失遵守本保單的條款及細則或因欺詐的情況宣告本保單（全部或部分）無效，或保單持有人或受保人在申請時或其後就申請而提交予項下的任何文件中錯誤申報受保人的的非健康相關資料 (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。若保單持有人因年齡差額保費，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授予的權利，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之核保指引，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或右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，保單將不會為受保人提供保障。在該情況下，若本公司曾經為受保人支付賠償，本公司將不——
(a) 有權追討已支付的賠償；及
(b) 有責任追還已收取的保費。

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。

15. 錯誤申報個人資料
在獲保本公司按本第三部分第十六節所授予之權利，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，或保單持有人或受保人在申請時或其後就申請而提交予項下的任何文件中錯誤申報受保人的的非健康相關資料 (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。若保單持有人因年齡差額保費，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授予的權利，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之核保指引，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或右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，保單將不會為受保人提供保障。在該情況下，若本公司曾經為受保人支付賠償，本公司將不——
(a) 有權追討已支付的賠償；及
(b) 有責任追還已收取的保費。

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敗，並拒絕提供任何關於本保單之保障。

(a) 在申請時 (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陳述或遺漏，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) 有責任追還已收取的保費。

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。
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

終止保單

(a) 按本第三部分第十節及第五部分第四節規定，在寬限期屆滿後仍未繳交保費；或
(b) 當收到 保單人的 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 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，終止生效日期為未交保費的原到期日。
若 保單 是按 (b) 終止，終止生效日期為收到 本公司 賠償差額欠款通知後十五 (15) 日。
若 保單 是按 (c) (d) 終止，則 本公司 須按日數比例退回現保單年度已支付的相關保費。
若 受保人身故 根據第三部分第三節或第六部分第四節的任何情況以書面通知 本公司 決定不再為本 保單 償償，本 保單 內亦應被終止。
倘若 保單 按本第三部分第三節終止，或按第六部分第四節不予以 償償，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 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 合格資治療費用 (如有) 作出賠償。

21. 更改保單持有人

保單持有人 可接受 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 於批准後，轉移 保單 擁有
權須經本公司 向 保單持有人 及其承保人發出書面通知批准後方為生效。由擁有權轉移生效日起，承保人將被視為 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 擁有權至下列表內的 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（如 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追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

保單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應付保費，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) 就删減受保人而言，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內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被刪減受保人作出保費退還：

<table>
<thead>
<tr>
<th>受保期間</th>
<th>退還保費（已收年缴保費總額的百分比）</th>
</tr>
</thead>
<tbody>
<tr>
<td>少於或最高4個月</td>
<td>50%</td>
</tr>
<tr>
<td>多於4個月或最高5個月</td>
<td>40%</td>
</tr>
<tr>
<td>多於5個月或最高6個月</td>
<td>30%</td>
</tr>
<tr>
<td>多於6個月或最高8個月</td>
<td>20%</td>
</tr>
<tr>
<td>8個月以上</td>
<td>無</td>
</tr>
</tbody>
</table>

2. 重複申請

受保人不得保於超過一份本公司簽發之「擎關懷超卓醫療計劃」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單。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單的保費付款。

3. 接保其他醫療保單會員

在本公司之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額限額（以較低額為準）。在前保單生效期間發生的已有傷病將不會列為不保事項；及

(b) 不保保單第一部份「投保前已存在的病患」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) 不保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敗後（2）個月內以本公司指定的表格向本公司申請本保單復效，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，本公司才有權收取任何賠償。
   除非在本條款及細則中另有規定，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三十一 (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

本保單自生效日生效起生效（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于四十五（45）日向保單持有人發出書面通知。

該書面通知須列明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，須備受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及保單附表的保單的，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申請之慣常做法接受或拒絕該申請；

(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；

本公司和其他保單持有人均確認。

(a) 若本公司按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) 經本公司滿意的所有收據正本及／或分項清單正本連同診斷，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，而任何翻譯開支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根據後的首六十 (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，若保單人在保單生效時接受醫療服務，本公司將會根據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。惟收到本公司之確認并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—無預先批准的賠償百分比將適用。

(ii) 非AXA安盛特選醫療網絡—經預先批准

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准的申請，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上的註冊醫生進行的）或(ii) AXA安盛特選醫療網絡名單上的名單醫生遞交（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。惟收到本公司之確認并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—無預先批准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)節的公立醫院公立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—無預先批准

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准申請或延遲遞交預先批准申請；及／或

(c) 於進行相關醫療服務受保人沒有收到本公司之確認。

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)節的公立醫院公立病房之住院的賠償百分比將適用。

(iv) 公立醫院公立病房之住院

若相關醫療服務是於公立醫院的公立病房進行的，將可獲實際合資格醫療費用的百分之百（100%）。為免存疑，除非相關醫療服務是於公立醫院的公立病房進行的，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)節的公立醫院公立病房之住院的賠償百分比將適用。
為免存疑，
(i) 本保單所指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額所規定。
(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，並因此引致住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任何日間手術的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) 施行麻醉及氣壓；
(b) 輸血行政費，但不包括血液或血漿；
(c) 敷料及石膏膜；
(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－（1）星期內使用的處方藥物；
(f) 醫學新型用品、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查；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，包括主要醫療設備及手術耗材。對於日間手術，本公司須支付受保人的手術費用。

10. 麻醉師費
    本公司須賠償受保人在住院期間接受麻醉師所提供的治療，包括主要醫療設備及手術耗材。對於日間手術，本公司須支付受保人的手術費用。

11. 手術室費
    本公司須賠償受保人在住院期間接受麻醉師所提供的治療，包括主要醫療設備及手術耗材。對於日間手術，本公司須支付受保人的手術費用。

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，由主診註冊醫生書面建議下接受診斷或治療所需進行診斷和治療的護理費，以確定受保人的醫療需要。此外，對於日間手術，本公司須支付受保人的手術費用。

13. 癌症治療
    本公司須賠償受保人在住院期間接受治療，包括主要醫療設備及手術耗材。對於日間手術，本公司須支付受保人的手術費用。

14. 密集治療
    本公司須賠償受保人在住院期間接受治療，包括主要醫療設備及手術耗材。對於日間手術，本公司須支付受保人的手術費用。

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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。

本節須賠償於受保人在醫院住院或於醫院進行任何日間手術（包括日間手術）或於受保人在接受醫療服務（包括日間手術）的醫院之外產生的醫院之間救護車於本地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。

本節須賠償於受保人因受傷並作為日間病人或於門診接受緊急治療，於接受醫療服務或於日間手術的醫院之外產生的實質合資格醫療費用。惟該受傷必須因意外引致，而且受保人於該意外後二四（24）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。本節須賠償於受保人在主診註冊醫生之建議下，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。

分娩保障於受保人在醫院分娩期間產生的實際合資格醫療費用。

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。

本節須賠償於受保人在醫院住院，因為日間病人或於醫院進行外科手術，以致受保人因受傷而被接收的實際合資格醫療費用。此保障只在受保人因受傷而被接收於醫院住院的醫院之間產生的實際合資格醫療費用。

為免存疑，即使受保人於同一保單年度內受傷多於一次，於同一保單年度支付的保障以保單附表所列之最高金額為限。分娩保障將於受保人於四十九（49）歲生日當天或隨後的保單續保日終止。

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住院病房級別住院，於計算本保單此第八部分第十三至十三節、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，下表根據相關病房級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下列所列的賠償調整之百分比：

<table>
<thead>
<tr>
<th>合資格之病房</th>
<th>實際住院之病房</th>
<th>賠償調整</th>
</tr>
</thead>
<tbody>
<tr>
<td>普通房</td>
<td>半私家房</td>
<td>50%</td>
</tr>
<tr>
<td>普通房</td>
<td>標準私家房</td>
<td>25%</td>
</tr>
<tr>
<td>半私家房</td>
<td>標準私家房</td>
<td>50%</td>
</tr>
</tbody>
</table>

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所附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療病是安全，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) 與吸煙、酗酒、減輕體重、戒菸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、齒顎及牙周膜服務；以及修復服務，例如補牙、鑲金冠、牙橋、箍牙及箍假牙。本保單只承保下列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，以治療頸骨或面骨脫位或骨折；切除頸骨良性或惡性腫瘤；

10. 眼折射能力、眼折射手術（放射性角膜切削術）、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，或男性或女性的睾育或性別重置。

12. 嫁產、懷孕、分娩（包括剖腹、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（包括自體組織移植術後康復服務），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. 直接或間接因與人類免疫缺陷病毒有關的傷病而引致的費用，包括後天免疫缺陷症（愛滋病）及/或因愛滋病而產生的任何突變，衍化或變異，並因在生效日之前染人類免疫缺陷病毒而病發。就本不受保項目而言，若在生效日後五（5）年內出現與人類免疫缺陷病毒有關的傷病，在沒有明確和具說服力的相反證據情況下，將不可推翻地推定為因在生效日之前染人類免疫缺陷病毒而病發。

16. 例行或一般檢查，或與保傷病的治療及診斷無關的例行驗血、健康檢查、體檢或化验、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、頭髮礦土分析、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，包括但不限於精神失常、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 疾病，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買乘客的航空或包機公司所提供之飛機則不在此限；
      (iii) 深海潜水、攀山、水上降落、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來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，但不受 保單 另有規定的除外。

24. 傳統中醫治療，包括但不限於中藥藥治療、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. 就移植手術收集捐赠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，若該所提供的保單及支付任何賠償款項或利益責任可能使保險人受損於總和決議的任何制裁、禁令或限制，或遭受制裁、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

若保單持有人因故被取消或終止，則保單持有人須在取消或終止之後七（7）日內將所有受保人的醫療卡交還本公司。保單持有人須於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通知本公司已付的款項，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於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匯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

若保單因故未續保，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，並另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起十八（18）日內將醫療卡交還本公司。若該名受保人在終止或取消之日後仍然使用醫療卡而獲取賠償，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由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。

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<td>食道、胃及十二指腸</td>
<td>食道胃十二指腸內窺鏡檢查，達或不達活體組織檢查及 / 或息肉切除術</td>
<td>食道胃十二指腸內窺鏡檢查異物清除</td>
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<td>肛裂切除術</td>
<td>肛周膿腫的切除術及引流術</td>
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<td>乙狀結腸內窺鏡檢查</td>
<td>痢疾的注射療法或縫紉術</td>
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<td>腎</td>
<td>幼針抽取腎活體組織檢查</td>
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<td>腦部及中樞神經系統</td>
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<td>神經外科手術</td>
<td>腦室引流沖洗術</td>
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<td>幼針抽取甲狀腺活組織檢查或達不達影像導引</td>
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<td>(耳科) 異物清除術</td>
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**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安盛將根據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