FirstCare Plus Medical Insurance

The Policy

Please read this policy carefully

Your right to change your mind

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

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

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

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

AXA General Insurance Hong Kong Limited

P.O. Box No. 90852 Tsim Sha Tsui Post Office, Kowloon, Hong Kong
5/F, AXA Southside, 38 Wong Chuk Hang Road, Wong Chuk Hang, Hong Kong
Customer Care Hotline: (852) 2867 8678

Personal Information Collection Statement

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

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

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

1. offering, providing and marketing to you the products/services of the Company, other companies of the AXA Group ("**our affiliates**") or our business partners (see "**Use and provision of personal data in direct marketing**" below), and administering, maintaining, managing and operating such products/services;
2. processing and evaluating any applications or requests made by you for products/services offered by the Company and our affiliates;
3. providing subsequent services to you, including but not limited to administering the policies issued;
4. any purposes in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates, including investigation of claims;
5. detecting and preventing fraud (whether or not relating to the products/services provided by the Company and/or our affiliates);
6. evaluating your financial needs;
7. designing products/services for customers;
8. conducting market research for statistical or other purposes;
9. matching any data held which relates to you from time to time for any of the purposes listed herein;
10. 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;
11. conducting identity and/or credit checks and/or debt collection;
12. complying with the laws of any applicable jurisdiction;
13. carrying out other services in connection with the operation of the Company's business; and
14. 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.
8. the following persons who may collect and use the data only as reasonably necessary to carry out any of the purposes described in paragraphs nos. 2, 3, 4 and 5 of the Purposes specified above: insurance adjusters, agents and brokers, employers, health care professionals, hospitals, accountants, financial advisors, solicitors, organisations that consolidate claims and underwriting information for the insurance industry, fraud prevention organisations, other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check data provided against existing data.

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
5/F, AXA Southside, 38 Wong Chuk Hang Road, Wong Chuk Hang, Hong Kong

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

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

Contents

Terms and Conditions

Part 1

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Non-melanoma skin cancer

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

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

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

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

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

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

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

(iv) undescended testicle; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"**Hong Kong**" shall mean the Hong Kong Special Administrative Region of the mainland 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

The Policyholder may exercise the right of cancellation with refund of premium (if any) after the cooling-off period pursuant to the paragraphs below:

(a) The Policyholder can request to cancel the Policy by giving at least ten (10) Working Days written notice to the Company immediately before the Policy Renewal Date. Cancellation of the Policy will take effect on the day immediately after the Expiry Date of the policy year during which the Policy remains valid.

(b) For other post-cooling off cancellation situations, in the event that no claims have been paid or are payable by the Company in that policy year, the Policyholder can request to cancel the Policy anytime during that policy year by submitting the written request of cancellation to the Company. Such cancellation 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 this Policy to be cancelled in accordance with the table below:

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

4. Benefit entitlement

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

5. Assignment

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

6. Clerical error

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

7. Currency

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

8. Discharge of Company's Liability

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

9. Interest

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

10. Certification, information and evidence

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

11. Adjustment of the premium rate of this Policy

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

12. Governing law

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

13. Dispute resolution

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

14. Liability

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

15. Misstatement of personal information

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

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

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

(b) the obligation to refund the premium received,

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

16. Misrepresentation or fraud

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

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

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

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

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

(ii) the obligation to refund the premium received,

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

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

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

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

17. Termination of Policy

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

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

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

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

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

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

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

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

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

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

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

18. Notices to Company

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

19. Notices from Company

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

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

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

20. Other insurance

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

21. Change of Policyholder

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

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

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

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

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

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

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

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

22. Rights of third parties

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

23. Subrogation

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

24. Suits against third parties

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

25. Waiver

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

26. Compliance with Law

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

27. Personal data privacy

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

Part 4

Conditions for Eligibility and Participation

1. Additions and Deletions of Insured Person(s)

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

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

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

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

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

2. Duplicate Application

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

3. Take-over Membership

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

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

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

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

4. Reinstatement

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

5. Change of plan options

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

Part 5

Premium Provisions

1. Premium payable

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

2. Payment of premiums

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

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

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

3. Grace period

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

Part 6

Renewal Provisions

1. Renewal

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

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

2. Revision

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

3. Premium

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

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

4. Notification of Renewal

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

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

5. No re-underwriting except in limited circumstances

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

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

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

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

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

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

The Company and Policyholder acknowledge that -

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

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

Part 7

Claim Provisions

1. Submission of claims

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

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

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

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

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

2. Legal action

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

3. Medical examination

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

Part 8

Benefit Provisions

1. Territorial scope of cover

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

2. Benefits covered

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

(i) Within AXA Signature Network Benefit

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

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

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

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

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

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

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

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

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

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

For the avoidance of doubt:

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

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

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

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

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

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

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

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

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

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

(v) Accident and Emergency

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

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

For the avoidance of doubt,

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

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

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

3. Room and board

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

4. Miscellaneous charges

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

(a) Anaesthetic and oxygen administration;

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

(c) Dressing and plaster casts;

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

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

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

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

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

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

(j) Physiotherapy during Confinement.

5. Specified Medical Implants

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

(a) pace maker;

(b) stents for Percutaneous Transluminal Coronary Angioplasty;

(c) monofocal intraocular lens;

(d) artificial cardiac valve;

(e) metallic or artificial joints for joint replacement;

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

(g) prosthetic intervertebral disc.

6. Attending doctor's visit fee

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

7. Specialist's fee

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

8. Intensive care

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

9. Surgeon's fee

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

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

10. Anaesthetist's fee

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

11. Operating theatre charges

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

12. Advanced Diagnostic Imaging Tests

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

13. Cancer Treatments

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

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

14. Pre-Confinement/Day Case Procedure outpatient care

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

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

15. Post-Confinement/Day Case Procedure outpatient care

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

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

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

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

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

17. Companion Bed

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

18. Renal Dialysis

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

19. Local Ambulance between Hospitals

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

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

20. Emergency Outpatient Treatment

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

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

21. Maternity Benefit

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

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

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

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

22. Maternity Complications

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

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

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

23. Adjustment Factor

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

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

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

24. Limitations of Benefit

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

Part 9

Exclusions

The Company shall not cover the following -

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

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

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

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

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

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

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

8. Congenital Conditions and Pre-existing Conditions.

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

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

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

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

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

14. Circumcision unless Medically Necessary.

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

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

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

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

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

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

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

22. Occupational therapy and speech therapy services.

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

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

25. Hospice services.

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

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

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

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

30. Sanction Limitation and Exclusion Clause

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

Part 10

Conditions for the use of the Firstcare Plus Medical Card

1. Cancellation or termination of Policy

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

2. Claims Disputes

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

3. Cost exceeding Benefits

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

4. Ineligible Medical Services

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

5. Renewal of Policy

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

6. Replacement Charge of Cards

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

7. Termination of Coverage

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

8. Theft or Loss of Card

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

9. Use of Cards

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

10. Withdrawal of Cards

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

Part 11

Value-added Services Provision

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

Schedule of Surgical Procedure for Day Case Procedure

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

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

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

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

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

Important Notes:
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