Worldwide Elite Medical Plan

The Policy

AXA redefining / standards

HSBC

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 of receipt of your policy.
- No refund can be made if a claim has already been paid.

Should you have any queries or need further explanation, you may contact Worldwide Elite Customer Service Hotline on (852) 2867 8611 (please note that tele-conversations may be recorded to ensure service quality) or write to us.

AXA General Insurance Hong Kong Limited

Mailing Address: P.O. Box No. 90852 Tsim Sha Tsui Post Office, Kowloon, Hong Kong
Office Address: 23/F, One Kowloon, 1 Wang Yuen Street, Kowloon Bay, Hong Kong
Worldwide Elite Customer Service Hotline: (852) 2867 8611

Personal information collection statement

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

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

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

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

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

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

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

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

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

1. use your name, contact details, products and services portfolio information, transaction pattern and behaviour, financial background and demographic data held by the Company from time to time for direct marketing;
2. conduct direct marketing (including but not limited to providing reward, loyalty or privileges programmes) in relation to the following classes of products and services that the Company, our affiliates, our co-branding partners and our business partners may offer:
   a) insurance, banking, provident fund or scheme, financial services, securities and related products and services;
   b) products and services on health, wellness and medical, food and beverage, sporting activities and membership, entertainment, spa and similar relaxation activities, travel and transportation, household, apparel, education, social networking, media and high-end consumer products;

3. the above products and services may be provided by the Company and/or:
   a) any of our affiliates;
   b) third party financial institutions;
   c) the business partners or co-branding partners of the Company and/or affiliates providing the products and services set out in (2) above;
   d) third party reward, loyalty or privileges programme providers supporting the Company or any of the above listed entities
4. in addition to marketing the above products and services, the Company also intends to provide the data described in (1) above to all or any of the persons described in (3) above for use by them in marketing those products and services, and the Company requires your written consent (which includes an indication of no objection) for that purpose;

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

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

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

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

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

Data Privacy Officer
AXA General Insurance Hong Kong Limited,
23/F, One Kowloon, 1 Wang Yuen Street, Kowloon Bay, Kowloon, 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.

Attach Policy Schedule

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Worldwide Elite Medical Plan

Welcome to your AXA General Insurance Hong Kong Limited's Worldwide Elite Medical Plan.

Your Policy consists of
the application form,
the policy wording in this contract, and
the Policy Schedule.

Your Policy Schedule shows
the details of your cover,
the Period of Insurance, and
any special terms that may apply to your Policy.

IMPORTANT NOTICE

1. Before we provide cover, you must fully and faithfully tell us everything you know (or could reasonably be expected to know) that is relevant to our decision to give you the insurance, otherwise you may receive no benefit from this Policy.

2. Please read your Policy carefully to make sure you know what cover is provided. The insurance cover under this Policy is based on the information submitted to us, as set out in the accompanying documents. If any information in this Policy is incorrect, please notify us immediately, otherwise you may receive no benefit in the event of a valid claim. If the information, which you subsequently provide us, differs materially from the information set out in the form, we may offer cover on different terms or decline it altogether. If we do not hear from you within thirty (30) days of receipt of this Policy, we will take it that the information is complete and correct.

3. We give you a period of fifteen (15) days to review the Policy. If you then decide that this Policy does not suit your needs, you may notify us for cancellation by written request. Such request must be received directly by our Customer Service at 23/F, One Kowloon, 1 Wang Yuen Street, Kowloon Bay, Kowloon, Hong Kong before the cooling-off period expires fifteen (15) days after the receipt of this Policy. Provided that no claims have been made during this period, we will then cancel this Policy and refund any premium you have paid. Otherwise, we will assume you have accepted this Policy subject to its terms and conditions.

Whereas the Policyholder by an application and declaration which shall be the basis of this Policy and is deemed to be incorporated herein has applied to the Company for the insurance hereinafter contained and has paid or agreed to pay the premium stated in the Policy Schedule as consideration for such insurance for the period stated therein. This Policy shall become effective on the Original Commencement Date and continue for the Period of Insurance, ending at the time 23:59 on the last date of Period of Insurance.

Now this Policy witnesses that during the Period of Insurance following payment of the premium stated in the Policy Schedule, the Company will subject to the terms, conditions, provisions and exclusions of and/or endorsed on this Policy, pay the benefit to the Policyholder or his/her legal personal representatives as described in this Policy.

Provided always that

(a) The liability of the Company shall not exceed the benefit limits as set out in the Policy for any one Period of Insurance.

(b) The Policy shall become effective as of the Original Commencement Date (or Entry Date if an Insured Person is added to the Policy later). This Policy is an annual contract and shall be issued for one (1) year. At the end of each Period of Insurance it is guaranteed renewable and is automatically renewed at a premium as determined by the Company for another year up to the Insured Person's lifetime in accordance with the terms and conditions of the Policy subject to the availability of the Plan.

DEFINITIONS

In this Policy, the words you, your, yours and Policyholder mean the applicant named in the application form until changed. The Policyholder may be someone other than the Insured Person.

We, us, our, ours and the Company mean AXA General Insurance Hong Kong Limited, which is authorised to carry on insurance business and having its head office in Hong Kong.

Accident: Any sudden, unforeseen, unexpected, external, violent and visible event occurring whilst this Policy is in effect (and the expression **"Accidental"** shall be construed accordingly).

Age: Age on last birthday (and the expression **"Aged"** shall be construed accordingly)

Basic Plan: The Basic Plan (In-patient and Day-patient Treatment) in the Policy.

Benefit Details: The Benefit Details contained in the Policy Schedule, which shows the benefits applicable to this Policy and the maximum benefits we will cover for the Insured Person.

Child(ren): Any biological child, stepchild, legally adopted child or foster child of the Policyholder who is between the Age of fourteen (14) days and Age of seventeen (17), or up to Age of twenty-three (23) if he is unmarried, financially solely dependent upon the Policyholder and registered as a full-time student at school, college or university with written proof from the educational institute where he is enrolled, except as otherwise mentioned in this Policy.

Chinese Medical Practitioner: A duly qualified practitioner of Chinese medicine registered and legally authorised in the geographical area of his practice to render Chinese medicine and/or to render bonesetting and acupuncture Treatment, but excludes the Insured Person, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Congenital Condition: A genetic physical or biochemical defect, malformation or anomaly, present at birth and whether or not manifest, diagnosed or known about at birth.

Day-patient: A patient who is admitted to a Hospital or Day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

Deductible: The level of deductible applicable to this Policy in each Period of Insurance, which shall be borne by the Insured Person, as explained in details in the Description of Benefits Provision of this Policy, and is shown in the Policy Schedule.

Dependents: Spouse and/or unmarried Children of the Policyholder. All dependents must be named as Insured Persons in the Policy Schedule.

Dietician: A duly qualified health professional in the field of nutrition and dietetics registered and legally authorised in the geographical area of his practice to render dietician consultation services, but excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Dental Practitioner: A duly qualified practitioner of dentistry registered and legally authorised in the geographical area of his practice to render dental Treatment, but excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Drugs and Dressings: Essential prescription drugs, dressings and medicines administered by a Medical Practitioner or Specialist needed to relieve or cure a Medical Condition.

Emergency: A sudden, unexpected acute Medical Condition which constitutes a serious or life threatening emergency which will require immediate surgical or medical attention to avoid death or permanent and irreversible total loss of function.

Entry Date: The date on which an Insured Person was included in the Policy and on which his coverage takes effect and such date for each Insured Person is specified in the Policy Schedule.

Evacuation: Moving the Insured Person to a Hospital which has the necessary In-patient and Day-patient medical facilities in the country where the Insured Person is taken ill or in another nearby country.

Global Directory of Hospitals: A document we maintain in which those Hospitals with which we have direct billing facilities are shown and subject to change from time to time. We will settle the bills for eligible In-patient Treatment directly with the Hospital listed in this document, provided you have informed us of the Treatment in advance in accordance with our procedures and requirements (where applicable).

Grace Period: The period we permit limited to thirty (30) days after the due date for payment, in accordance with these Policy terms and conditions, for premium payment after its due date.

Hong Kong: Hong Kong Special Administrative Region of the People's Republic of China.

Hospital: An establishment recognised, constituted and registered as such under the laws of the territory in which that establishment is situated as a hospital for the care and Treatment of sick and injured persons as paying bed patients, and which (i) has facilities for diagnosis and major surgery, (ii) provides twenty-four (24) hours a day nursing services by Nurses, (iii) is under the supervision of Medical Practitioners; and (iv) is not primarily a clinic, a place of alcoholics or drug addicts, a sanatorium, a nature care clinic, a health hydro, a nursing, rest or convalescent home or home for the aged or similar establishment.

Hospital Accommodation: Refers to Standard Single Room or a lower class room. Deluxe room, executive room and suite are not covered under the Plan.

In-patient: A patient who is admitted to Hospital and who occupies a bed overnight or longer, for medical Treatment.

Intensive Care Unit: A section within a Hospital which is designated as an Intensive Care Unit by the Hospital and which is maintained on a twenty-four (24) hours basis solely for Treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.

Insured Person: The Insured Person is the person named as such in the Policy Schedule.

LOG: letter of guarantee, which has the meaning assigned to it under the Letter of Guarantee and Shortfall Policy Conditions provisions of this Policy.

Medical Condition: Any disease, illness or injury, including psychiatric illness.

Medically Necessary: In respect of Treatment, procedure, supplies or other medical services, Medically Necessary means such Treatment, procedure, supplies or other medical services which:

- are required for the diagnosis or direct Treatment of the Insured Person's Medical Condition; and
- are appropriate and consistent with the symptoms and findings or diagnosis and direct Treatment of the Insured Person's Medical Condition; and
- are in accordance with generally accepted medical practice; and
- are not associated with Treatment, procedure, supplies or other medical services of an experimental or investigative nature; and
- cannot have been omitted without adversely affecting the Insured Person's Medical Condition

and the expression **"Medically Necessitating"** shall be construed accordingly.

Medical Practitioner: A duly qualified practitioner in the field of western medicine registered and legally authorised in the geographical area of his practice to render western medical or surgical services but excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons. For the avoidance of doubt, a Medical Practitioner does not include a Dental Practitioner.

Nurse: A qualified nurse who is registered to practice as such where the Treatment is given but excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Ophthalmologist: A duly qualified practitioner in the field of practice ophthalmology registered and legally authorised in the geographical area of his practice to render eye Treatment, but excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Optional Plan: Any of the Optional Out-patient Plan, Optional Maternity Plan, Optional Dental Plan and/or Optional Optical Plan as described in the Benefits Provisions of this Policy.

Original Commencement Date: The Original Commencement Date specified in the Policy Schedule. It is the earliest date the Policy issued to the Policyholder, regardless of the number of Insured Persons covered under this Policy, takes effect.

Out-patient: A patient who attends a Hospital, consulting room, or out-patient clinic and is not admitted as a Day-patient or an In-patient.

Period of Insurance: The period for which this Policy in respect of an Insured Person is effective as stated in the Policy Schedule. The first day of the Period of Insurance is the coverage effective date in that Period of Insurance whereas the last day of the Period of Insurance is the day on which the coverage in that Period of Insurance terminates.

Physiotherapist: 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 excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Plan: Worldwide Elite Medical Plan as specified in the Policy Schedule, with terms, conditions and exclusions stated in the provisions of this Policy.

Policy Anniversary: The same day and month in each Period of Insurance as the Original Commencement Date.

Policy Currency: The Policy Currency is the currency in which this Policy is denominated, as shown in the Policy Schedule.

Policy Schedule: The Policy Schedule is the Policy specifications to which these Policy terms are attached.

Policyholder User Guide: A user guide as provided to the Policyholder by the Company which sets out details of the valued added services, claims handling and other administrative matters in relation to the use of the benefits by the Policyholder/Insured Person(s) under the Policy. The Company reserves the right to revise or update the Policyholder User Guide from time to time. The Company will notify the Policyholder within a reasonable period of time if there is any material change in the content of the Policyholder User Guide.

Pre-authorisation: A process whereby an Insured Person seeks approval from us prior to undertaking any Treatment or incurring costs unless waived by the Company (where applicable) in the Policyholder User Guide.

Pre-existing Condition: Any Medical Condition:

(1) which has been diagnosed; or

(2) for which the Insured Person has received medication, advice or Treatment; or

(3) which the Insured Person reasonably have known about based on our appointed medical doctor's opinion; or

(4) for which the Insured Person has experienced symptoms even if the Insured Person has not consulted a Medical Practitioner; or

(5) which is a Congenital Condition,

before the latest of the following dates:

i. the Entry Date of such Insured Person; or

ii. the approval date of reinstatement (if the Policy in respect of such Insured Person has been reinstated); or

iii. the effective date of increase in benefit or upgrade of level of cover (if any benefit or level of cover under this Policy in respect of such Insured Person has been increased or upgraded).

Pregnancy: Refers to the period of time from the date of the first diagnosis of pregnancy until delivery.

Principal Country of Residence: The country where the Insured Person lives or intends to live for most of the Period of Insurance being one hundred eighty-five (185) days or more and which will be shown as the place of residence in our records.

Psychiatric Illness: The mental or nervous disorder that meets the criteria for classification under an international classification system such as Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation.

Psychiatrist: A duly qualified practitioner in the field of psychiatry registered and legally authorised in the geographical area of his practice to render psychiatric consultation or Treatment, but excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Psychologist: A duly qualified practitioner in the field of clinical psychology registered and legally authorised in the geographical area of his practice to render Treatment services to patients with mental and emotional disorders, but excludes the Insured Person himself, Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Reasonable and Customary Charges: The charges for Treatment, procedure, supplies or other medical services which do not exceed the general level of charges at the location for similar Treatment, procedure, supplies or other medical services to individuals of the same sex and comparable age, for a similar disease or injury.

We will base the calculation of Reasonable and Customary Charges on a combination of the following (if applicable):

(a) the gazette issued by the Hong Kong government which sets out the fees for the private patient services in public hospitals in Hong Kong;

(b) statistical information provided by local health authoritative body and information collected from medical specialists and surgeons practicing in the country or area where the Treatment is received;

(c) industrial medical fee survey;

(d) our internal claim statistics and/or our global experience; and

(e) the extent or level of benefit insured.

Rehabilitation: Medically Necessary Treatment in the form of a combination of therapies such as physical, occupational and speech therapy and is aimed at the restoration of a normal form and/or function after an acute illness or injury.

Related Condition: Any injuries, illness or disease are Related Conditions if we, on advice from a Medical Practitioner, determine that one is a result of the other or if each is a result of the same injury, illness or disease.

Sanctioned Countries: countries as listed in the relevant compliance policy of the Company or AXA Group from time to time, which compliance policy prohibits the Company from any activity involving these countries unless the Company has first followed certain procedures set out in the compliance policy.

Shortfall: shall mean any expenses incurred by the Insured Person and/or Policyholder which are not covered by the Policy in respect of such Insured Person.

Specialist: A duly qualified practitioner who is commonly recognised in the medical profession as a specialist in the medical specialty in respect of the Insured Person's Medical Condition registered and legally authorised in the geographical area of his practice to render western medical or surgical services but excludes the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

Standard Single Room: Single occupancy accommodation in a private Hospital which is of the lowest cost in the private Hospital.

Terminal: Following the diagnosis that the condition is terminal and Treatment can no longer be expected to cure the condition with death anticipated within twelve (12) months of diagnosis. The diagnosis must be supported in writing by a Medical Practitioner.

Treatment: Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a Medical Condition.

Unearned Premium: The portion of the premium you have paid which covers the period between the date of termination of insurance coverage for the relevant Insured Person and the last date of the relevant Period of Insurance.

USA: United States of America and United States Minor Outlying Islands.

Visit: Each separate occasion that the Insured Person meets with a Chinese Medical Practitioner, Dietician, Dental Practitioner, Medical Practitioner, Ophthalmologist, Physiotherapist, Psychiatrist, Psychologist, Specialist or other services provider and receives a consultation and/or a Treatment for a Medical Condition.

Waiting Period: A period of time starting from the Entry Date and is specified under the respective benefits provisions of this Policy, during which the Insured Person is not entitled to cover for particular benefits.

Terms defined above and any other terms defined in this Policy shall have the same meaning wherever used in this Policy unless the context otherwise requires. Where the context permits, words in this Policy denoting the singular shall include the plural and vice versa. Words denoting any gender shall include a reference to each other gender and references to the word "include" or "including" are to be construed without limitation. Hong Kong, Macau and Taiwan are respectively considered as country for the purposes of this Policy.

ELIGIBILITY AND SCOPE

Insured Persons eligible to be covered under this Policy must:

(a) be aged from fourteen (14) days to eighty (80) years old (inclusive) on the date of first time application under the Policy; and

(b) not have USA as their Principal Country of Residence; and

(c) not have Japan and/or any Sanctioned Countries as their residence and/or address.

The above clause (a) does not apply to Optional Maternity Plan for which the Insured Person must be aged from eighteen (18) years to forty-four (44) years old (inclusive) on the date of first time application under the Policy. Cover may be renewed up to Insured Person's Age of forty-four (44).

Further, the Policyholder must not have USA as his Principal Country of Residence and not have Japan and/or any Sanctioned Countries as his residence and/or address.

We reserve the right not to accept application for cover or to continue providing cover if our so doing will in our opinion expose us to risk of any breach of any applicable laws or regulations, as well as international economic sanctions, laws or regulations.

POLICY CONDITIONS

This Policy and the Policy Schedule shall be read together as one contract and any words or expressions to which a specific meaning has been attached in any part of this Policy or of the Policy Schedule shall bear such specific meaning wherever it may appear.

Premium

(a) Payment of Premium

Premiums are payable on or before the premium due dates. Premiums are payable annually by any method which the Company makes available. Premium rates are not guaranteed and may be changed by the Company at its discretion at any Policy Anniversary.

(b) Grace Period

You are allowed a Grace Period of thirty (30) days after the due date for payment of each premium after the first payment. This Policy will continue to be in effect during the Grace Period. If a premium is still unpaid at the end of the Grace Period, this Policy is no longer in effect from the premium due date.

Notice

Every notice or communication to the Company shall be in writing and sent to the Company.

Condition Precedent to Liability

The truth of any statement or declaration made by a Policyholder and the due observance and the fulfilment of the terms, conditions and provisions of this Policy by the Policyholder and in so far as they relate to anything to be done, or complied with, by the Policyholder shall be conditions precedent to any liability of the Company. The costs of obtaining any information reasonably required by the Company for verification shall be borne by the Policyholder.

Misrepresentation/Fraud/Non-disclosure

If information or declaration of the Policyholder is untrue in any respect, or if any material fact affecting the risk are not disclosed or incorrectly stated herein or omitted therefrom, or if this Policy, or any renewal thereof shall have been obtained through any misstatement, misrepresentation or nondisclosure or if any claim made shall be fraudulent or exaggerated, or if any false declaration or statement shall be made in support thereof, then in any of these cases, this Policy shall be void.

Misstatement of Age

If the Age of the Insured Person has been misstated and the premium paid as a result thereof is insufficient, any claim payable under this Policy shall be pro-rata based on the ratio of the actual premium paid to the correct premium which should have been charged for that Period of Insurance. Any excess premium, which may have been paid as a result of such misstatement of Age, shall be refunded without interest. If at the correct Age, the Insured Person would not have been eligible for cover under this Policy, no benefit shall be payable and the actual premium paid shall be refunded without interest.

Renewal

This Policy is in effect subject to the terms and conditions of this Policy from the Original Commencement Date to the next Policy Anniversary. Subject to all the terms and conditions of this Policy and the availability of the Plan at the time of renewal, you have a guaranteed right to renew this Policy by advance payment of the appropriate annual premium as determined by the Company on each Policy Anniversary.

We have the right to cease offering or suspend the Plan, revise the benefits, premiums and other terms and conditions of this Policy at each Policy Anniversary upon renewal. The Company shall inform the Policyholder in writing, not less than forty-five (45) days before the Policy Anniversary, of any change.

Nevertheless, in the event that we are required by law to make a change during the Period of Insurance, for example if a new tax is introduced, we may not be able to give not less than forty-five (45) days' notice in writing to the Policyholder of such change before the Policy Anniversary. In such case, we will give the notice to the Policyholder in writing as soon as reasonably practicable.

Notwithstanding any other provisions of this Policy, if at any time after the issuance of this Policy, any Insured Person changes his Principal Country of Residence to USA or changes his residence and/or address to Japan and/or any Sanctioned Countries, the coverage under this Policy in respect of such Insured Person will not be renewed at the next Policy Anniversary following our actual knowledge of the change. For the sake of clarity, the non-renewal of coverage in respect of such Insured Person under this Policy will not affect the continuance of the Policy in respect of other Insured Persons, if any.

Non-renewal of this Policy will not affect any claims arising before the termination of this Policy. The payment to or acceptance by us or our agent of any premium subsequent to the termination of this Policy will not create any liability on our part except that of refunding any such premium.

Change in Country of Residence

You must give immediate notice to the Company if you and/or any Insured Person changes your/his Principal Country of Residence to USA or changes his residence and/or address to Japan or any Sanctioned Countries.

Co-operation

As a condition precedent to the Company's liability, the Policyholder or his/her representatives, upon making a claim, shall co-operate fully with the Company, and will fully and faithfully disclose all material facts and matters which the Insured Person knows or ought to know, and will upon request execute and/or ensure that the Insured Person will execute any document to empower the Company to obtain relevant information from, including but not limited to, any doctors, hospitals, third party administrators or other sources.

The Company may appoint independent third party administrators or service providers to settle claims on its behalf. Consequently all rights reserved by the Company in respect of claim procedure equally apply to such third parties acting on the Company's behalf.

Notification & Proof of Loss

Written notice of illness or disease on which claim may be based and which is covered by this Policy must be given to the Company or its appointed representatives immediately after the occurrence or commencement.

Written proof of loss shall cover the occurrence, character and extent of loss. The proof of loss documents shall include a fully completed claim form supplied by the Company and all original bills and receipts (if applicable) which state full particulars of the event, such as date of Treatment, name of patient and medical attendant as well as a specific Treatment or services rendered from the clinic of a Chinese Medical Practitioner, Dietician, Dental Practitioner, Medical Practitioner, Ophthalmologist, Physiotherapist, Psychiatrist, Psychologist, Specialist or other service providers or the Hospital to which the claim relates at the Policyholder's expenses.

If the supporting documents of a claim are in a language other than Chinese or English, the Policyholder must undertake to obtain a certified translation of the documents in Chinese or English before the claim is submitted to the Company for processing.

Claims Procedures

The Policyholder shall submit written notice and all proof of loss documents to the Company within ninety (90) days immediately after the date of discharge from Hospital or the date of receiving the Treatment for the Medical Condition for which the claim is being made.

The Company may in the case of any claim require the submission at the expense of the claimant of information, certificates, evidence, medical reports and other data or materials, reasonably required by the Company.

The Company shall not accept liability for any claim if the required information is received by the Company after four (4) weeks from the issue date of any written request(s) from the Company requesting such further information, unless otherwise agreed and approved by the Company. Failure to comply within the time required in these rules shall invalidate the claim whereby no benefit shall be payable.

All claims (including but not limited to Pre-authorisation, reimbursements and bill settlement) under this Policy shall be handled in accordance with such terms and conditions as detailed in the Policyholder User Guide as we may from time to time in our absolution discretion specify.

If you/Insured Person makes a claim which is any way dishonest, we reserve the right not to pay any benefits, or if we have already paid benefits before we discover the dishonesty, we reserve the right to recover those benefits from you and/or terminate the Policy as appropriate.

The payment of any claim does not discharge you/Insured Person's obligations on the fulfillment of the terms and conditions under this Policy. We are not obliged to pay the ongoing costs of continuing, or similar, Treatment, even where we have previously paid for this type of or similar Treatment, if it is subsequently noted that this claim is not an eligible Treatment.

Currency and Place of Payment

All amount payable to or by the Company will be payable in the Policy Currency subject to the applicable laws, regulations and guidelines issued by the relevant authorities from time to time, provided always that we shall have the absolute discretion to accept and make payment (including but not limited to accepting premium payment and making any benefit payment) in another currency. Any exchange costs or any bank charges incurred is payable by the Policyholder and will be subtracted from any payment made by us. Conversion between currencies shall be calculated at the prevailing currency exchange as determined by us in our absolute discretion from time to time upon payment. The rounding difference if any shall be accrued to the Company. All amounts due from the Company will be payable at the Hong Kong office of the Company.

Examination

The Company shall have the right and opportunity through our medical representatives to examine the Insured Person whenever and as often as we may reasonably require within the duration of any claim.

Duplicate Application

An Insured Person shall not be covered under more than one policy of the Plan issued by the Company. In the event the Insured Person is covered by more than one such policy, 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 the Policyholder.

Reinstatement

Within sixty (60) days after the end of Grace Period, this Policy may be reinstated at our absolute discretion provided that the Policyholder sends a written application for reinstatement to us and

(1) provides proof satisfactory to us that the Insured Person is still insurable; and

(2) pays all overdue premiums with interest.

Any reinstated policy will only cover loss or claims incurred (whether reported or not) after the date of reinstatement.

Assignment

This Policy is neither transferable nor assignable to any other person by you and shall not be subject to any trust or lien or charge or any kind by you. The Company shall be entitled to without the consent of the Policyholder assign any of its rights and duties under this Policy.

Cancellation

Policyholder may apply for termination of the Policy by giving a written notice to the Company at least thirty (30) days before the Policy Anniversary, otherwise the Policy will be renewed automatically subject to the terms and conditions of the Policy. No pro-rata refund of premium will be made by the Company if the Policy is being terminated by the Policyholder any time during the Period of Insurance.

The Company may cancel cover for any Insured Person for failure to comply with any requirement under this Policy and in such event shall credit the Policyholder with daily pro-rata premium for any cancelled part of the Policy period in respect of which premium has been paid in advance for cover of that Insured Person, provided that no claims have been paid or payable under this Policy in respect of that Insured Person.

Other Insurance or Sources

If the Insured Person or Policyholder is entitled to a reimbursement of all or part of the expenses incurred from any other insurance or sources, the Company will only be liable for such amount in excess of the amount payable under such other insurance or sources.

Subrogation

The Company has the right to proceed at its own expense in the name of the Policyholder and/or the Insured Person against any third parties who may be responsible for any occurrence giving rise to a claim under this Policy and any amount so recovered shall belong to the Company.

Suit against third parties

Nothing in this Policy shall render the Company liable to indemnify, join, respond to or defend any suit for damages for any cause or reason which may be instituted by the Policyholder or an Insured Person against any medical service provider or medical institution nominated under this Policy, including without limitation to any suit for negligence, malpractice or unprofessional conduct or any other causes in relation to or arising out of the Treatment or examination of such Insured Person under the terms of this Policy.

Letter of Guarantee and Shortfall

Subject to the terms and conditions of the Policy, in case of In-patient Treatment or Day-patient Treatment under our Global Directory of Hospitals, once a Pre-authorisation request is approved by us, we or our designated service provider will issue a letter of guarantee for the Insured Person to pay the medical expenses for such In-patient Treatment or Day-patient Treatment after you have paid the applicable Deductible (if any), subject to the acceptance of LOG by the Hospitals. All expenses charged to the Company remain the responsibility of the Policyholder until settlement of eligible expenses has been notified by the Company to the Policyholder. In the event that the Insured Person and/or Policyholder incurs any costs which exceeds the applicable limits in the Policy or is not eligible under the Policy, the Policyholder agrees to reimburse the Company in full for the Shortfall within fifteen (15) days of receipt of a Shortfall written notice from the Company.

Without prejudice to the Company's right to claim for the Shortfall, if the Shortfall is not settled within fifteen (15) days as specified in the relevant written notice to the Policyholder, the Company may at its option:

(a) charge the Policyholder interest on the Shortfall;

(b) terminate the coverage in respect of that Insured Person or the Policy where applicable;

(c) stop or cancel the LOG;

(d) offset any eligible claim amount payable to the Policyholder against any Shortfall outstanding; and

(e) offset any premium refundable to the Policyholder against any Shortfall outstanding.

Where the Shortfall continues not to be settled, any delay by the Company to take action under options (a) to (e) mentioned above shall not constitute a waiver by the Company of its right to take action at a later time.

The Company or the Company's designated service provider in providing the LOG has the absolute right in accepting or rejecting the LOG application based on the information the Insured Person/Policyholder provides.

The giving of LOG or subsequent LOG from the Company or the Company's designated service provider under this clause shall not be deemed as admission of liability to pay and/or reimburse the Policyholder under this Policy or a waiver of any breach of the terms and conditions of the Policy.

We may determine, review and revise at our absolute discretion the scope, terms and conditions and/or provider of the LOG from time to time.

We shall not be liable for any loss, damage, liability or claims arising from or in connection with acts or omission of any third-party service providers who issue the LOG.

Adding Dependents

If subsequently you apply to add a Dependent to your Policy, you must complete and submit to us a form as prescribed by us. Cover will not start until your application has been accepted by us for that Dependent and we have received the relevant premium payment.

Termination of insurance coverage

Insurance coverage of the Insured Person under this Policy shall automatically terminate on the earliest occurrence of any of the following events:

(a) when such Insured Person or the Policyholder dies; or

(b) Optional Maternity Plan, where applicable, in respect of such Insured Person shall automatically terminate on the Policy Anniversary on or immediately following the Insured Person's Age of forty-five (45); or

(c) when any premium in respect of such Insured Person's coverage under this Policy remains unpaid at the end of the Grace Period; or

(d) when the insurance coverage in respect of such Insured Person under this Policy is cancelled by the Policyholder; or

(e) when there is promulgation of any laws or regulations in the relevant jurisdiction whereby the provision of insurance coverage to such Insured Person will become illegal; or

(f) a Policy Anniversary which falls on the same day or immediately following the Insured Person's change of his Principal Country of Residence to USA or change of his residence and/or address to Japan and/or Sanctioned Countries (provided that we have actual knowledge of the same); or

(g) at midnight (Hong Kong time) on the last day of the Period of Insurance in respect of such Insured Person's coverage; or

(h) when any Shortfall is not settled within fifteen (15) days as specified in the relevant written notice to the Policyholder.

In the event described in sub-paragraphs (a) and (f) above, we will refund the Unearned Premium paid after deduction of any claims paid or payable for the Period of Insurance for such Insured Person from it. In all other cases, we will not refund any premium paid for the Period of Insurance for such Insured Person.

Termination of the Policy

This Policy shall automatically terminate on the earliest occurrence of any of the following events:

(a) when the Policyholder dies; or

(b) when any premiums due under the Policy remain unpaid at the end of the Grace Period; or

(c) when the Policy is cancelled by the Policyholder; or

(d) when there is promulgation of any laws or regulations in the relevant jurisdiction whereby the provision of insurance coverage under this Policy will become illegal; or

(e) a Policy Anniversary which falls on the same day or immediately following the Policyholder's change of his Principal Country of Residence to USA or change of his residence and/or address to Japan and/or Sanctioned Countries; or

(f) when the coverage of all Insured Person terminates for whatever reason; or

(g) when any Shortfall is not settled within fifteen (15) days as specified in the relevant written notice to the Policyholder.

Immediately following the termination of this Policy, the coverage of any Insured Person under this Policy shall cease to be in force.

In the event described in sub-paragraphs (a) and (e) above, we will refund the Unearned Premium paid after deduction of any claims paid or payable for the Period of Insurance for such Insured Person from it. In all other cases, we will not refund any premium paid for the Period of Insurance for such Insured Person.

Applicable Law

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed, determined and enforced in accordance with the laws of Hong Kong.

Legal Proceedings

No action at law or in equity shall be brought to recover on this Policy prior to expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirement of this Policy. If the Policyholder shall fail to supply the requisite proof of loss as stipulated by the terms, conditions and provisions of the Policy, the Policyholder may, within a grace period of one (1) calendar year from the time that the written proof of loss to be furnished, submit the relevant proof of loss to the Company with cogent reason(s) for the failure to comply with Policy terms, conditions and provisions. The acceptance of such proof of loss shall be at sole and entire discretion of the Company. After such grace period has expired, the Company will not accept for any reason whatsoever, such written proof of loss.

Arbitration

All differences arising out of this Policy shall be referred to an arbitrator who shall be appointed in writing by the parties in difference. In the event they are unable to agree on who is to be the arbitrator within one (1) calendar month of being required in writing to do so then both parties shall be entitled to appoint an arbitrator each who shall proceed to hear the differences together with an umpire to be appointed by both arbitrators. If both arbitrators cannot decide on the umpire, the appointing authority shall be Hong Kong International Arbitration Centre. The place of arbitration shall be in Hong Kong. Notwithstanding the aforementioned, any disclaimer of liability by the Company for any claim hereunder must be referred to an arbitrator within twelve (12) calendar months from the date of such disclaimer, otherwise the Company shall not be liable for the claim.

Errors and Omission

Clerical errors in keeping the records shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated. If the Age or date of birth or other relevant facts relating to an Insured Person shall be found to have been inadvertently misstated, and if such misstatement affects the scale of benefits or has anything to do with the coverage or any terms, conditions and provisions under this Policy, the true Age and facts shall be used in determining whether benefits are secured under the terms of this Policy, and if so, in what amount, and an adjustment of premium shall be made by the Company in its absolute discretion in the event it considers benefits are payable under this Policy.

Third Party Rights

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 of this Policy.

DESCRIPTION OF BENEFITS PROVISION

While this Policy is in effect and subject to the provisions, exclusions, limitations and restrictions contained in this Policy (including any attached endorsements), we will, upon receipt of due proof and approval by the Company, provide the benefits as set out in the following benefits provisions in accordance with the terms and conditions therein.

All benefits payable hereunder are subject to the following:

(a) they are subject to the limit set out in the respective benefit provisions and Policy Schedule; and

(b) we will only reimburse the Reasonable and Customary Charges actually incurred; and

(c) the Reasonable and Customary Charges must be Medically Necessary; and

(d) for all benefits payable regarding Treatment, the Treatment must be received by the Insured Person while the Policy in respect of such Insured Person is in effect.

Overall Limits

Unless otherwise specified, all benefits covered under this Policy are subject to the Deductibles and limits shown in the Policy Schedule (including but not limited to the "Yearly Maximum" as set out in the Policy Schedule of this Policy).

Yearly Maximum

The maximum total amount of all benefits covered per Period of Insurance by the Company for the Basic Plan (In-Patient and Day-patient Treatment) and Optional Out-Patient Plan (if applicable) in aggregate shall not exceed the yearly maximum amount as shown in the Policy Schedule of this Policy. The maximum total amount of all benefits covered per Period of Insurance for the Optional Dental Plan and Optional Optical Plan shall not exceed their respective yearly maximum amount as shown in the Policy Schedule of this Policy. All benefits covered during each Period of Insurance will be counted against the respective yearly maximum amount unless otherwise specified.

Reasonable and Customary Charges

For the avoidance of doubt when comparing Treatment, we will take into account the complexity of the procedure and the standard of the medical facility where the Treatment is received.

If the charges are higher than Reasonable and Customary Charges, we will only pay the amount which is, in our experience, customarily charged and you will have to pay the rest.

Deductible

The Deductible is the aggregate amount of eligible expenses claimed that you will have to bear each Period of Insurance before any benefits are payable under this Policy. This amount will be collected by the service provider who provides the benefit under this Policy in the case of directly billing; or deducted from any reimbursement made to you by us.

Deductible applies to all benefits unless otherwise stated in the Benefit Details.

The Deductible option for the Basic Plan (including In-patient and Day-patient Treatment) of an Insured Person and the Deductible option for the Optional Out-patient Plan of such Insured Person must be the same.

Change in Level of Coverage and Deductible

The Company will not allow the Policyholder to upgrade or downgrade the level of coverage for the Insured Person except at each Policy Anniversary in respect of such Insured Person's coverage and only then when requested. The Policyholder may apply to the Company in writing for such an upgrade or downgrade upon payment of appropriate premiums. The application shall be made on a form prescribed and submitted to the Company within thirty (30) days before the Policy Anniversary. Acceptance by the Company of such an upgrade or downgrade must be confirmed in writing by the Company before the upgrade or downgrade can become effective. The Company shall have the sole discretion as to whether to accept the request.

In the event that we do accept a request for an upgrade, cover for conditions of the Insured Person existing at the time of the upgrade shall be restricted to the benefits provided to such Insured Person under his coverage before the upgrade, which include but are not limited to the level of Deductible, limit(s) or maximum(s) of benefits applicable.

BENEFITS

BENEFIT 1: BASIC PLAN (IN-PATIENT AND DAY-PATIENT TREATMENT)

All non-Emergency In-patient Treatment and Day-patient Treatment and any benefit which requires Pre-authorisation must be notified to us and approved by us, in writing, prior to Hospital admission. Notification must be done in accordance with such terms, conditions and formalities as we may from time to time in our absolute discretion impose. Failure to comply with these terms, conditions and formalities shall result in you being responsible to pay additional charges or your claim being refused. We reserve the right to recover from you and/or the Insured Person any ineligible expenses.

In-patient direct billing services may be available to eligible In-patient Treatment and Day-patient Treatment rendered within the Global Directory of Hospitals under Benefit 1 subject to such terms and conditions as we may from time to time in our absolute discretion impose for such services.

Hospitalisation and Surgical Benefits

Benefit 1.1: Hospital Charges

We will reimburse the hospital charges actually incurred for eligible In-patient Treatment and Day-patient Treatment of the Insured Person given during the Insured Person's Hospital stay including the following:

(a) charges for accommodation in the Standard Single Room or a lower class room;

(b) Medical Practitioner's charges and Specialist's fee;

(c) nursing care by a Nurse;

(d) Drugs and Dressings prescribed by a Medical Practitioner;

(e) Intensive Care Unit charges;

(f) physiotherapy or complementary therapies while admitted for Treatment of Medical Condition and when such Treatment directly relates to it;

(g) diagnostic tests such as x-rays or blood test; and

(h) advance medical imaging techniques such as computerised tomography, magnetic resonance imaging, PET scan and other such proven medical imaging techniques.

Notwithstanding the foregoing provisions, eye examination, routine health examination, and/or vaccinations are not covered under this benefit. Please refer to Benefits 2.12, 2.14 and 2.15 for details of the coverage if you have taken out Optional Out-patient Plan.

For the avoidance of doubt, any dental Treatment is not covered under this benefit.

Benefit 1.2: Surgical Expense

We will reimburse the surgeon's and anesthetists' fee actually incurred for eligible surgical operations and procedures performed on the Insured Person in a Hospital, daycare unit, the clinic of a Medical Practitioner or the out-patient department of a Hospital including the following:

(a) surgeon's fee;

(b) anesthetist's fee; and

(c) operating theatre's charges for the medical charges actually incurred by the Insured Person for the use of the operating room, Treatment room and equipment during the eligible surgical operations and procedures.

For the avoidance of doubt, dental surgery is not covered under this benefit.

Benefit 1.3: Surgical/Medical Appliance or Prosthesis (Internal)

We will reimburse the costs of the following items actually incurred as prescribed by a Medical Practitioner when used as an integral part of a surgical procedure administered by a Medical Practitioner for eligible In-patient Treatment, Day-patient Treatment or Out-patient Treatment of the Insured Person:

(a) surgical or medical appliance; and/or

(b) implants (including but not limited to stent and pacemaker),

except all external prosthesis, special braces, equipment or appliances. Pre-authorisation by us is required before this benefit can be considered.

We do not pay for any replacement prosthetic devices required in relation to a Pre-existing Condition.

For the avoidance of doubt, dental appliances and prosthesis, including but not limited to crown, bridge, veneer or dental pin and dental screws are not covered under this benefit.

Benefit 1.4: Surgical/Medical Appliance or Prosthesis (External)

We will reimburse the costs of the following items actually incurred as prescribed by a Medical Practitioner: external prosthesis, special braces, equipment or appliances provided that:

(a) the item is a necessary part of the eligible In-patient Treatment and/or Day-patient Treatment of the Insured Person during the Insured Person's Hospital stay immediately following a surgery for as long as it is Medically Necessary; and

(b) Pre-authorisation by us is required before this benefit can be considered.

We do not pay for any replacement prosthetic devices required in relation to a Pre-existing Condition.

For the avoidance of doubt, (i) dental appliances and prosthesis, including but not limited to denture and orthodontics; and (ii) foot orthosis, hearing aids, crutches or wheelchairs, or orthopaedic supports/braces are not covered under this benefit.

Benefit 1.5: In-patient Private Nurse

We will reimburse the charges for the full-time or part-time services of a Nurse following surgery for the Insured Person or the Insured Person's discharge from Intensive Care Unit and while the Insured Person is still confined in a Hospital for an eligible In-patient Treatment, provided that all the following conditions are met:

(a) it is prescribed by the Insured Person's attending Medical Practitioner who has treated the Insured Person and the Medical Practitioner must provide a written referral stating the reasons for which nursing services are required during hospitalisation, and

(b) considered by us that it is Medically Necessary and appropriate, and authorised by us in writing before the provision of the nursing services,

This benefit is restricted to nursing services provided by a maximum of one (1) Nurse during any given time slot, and up to two (2) time slots per day and up to a maximum of thirty (30) days (during which nursing services are provided for all or part of the day) per Period of Insurance regardless of the number of eligible In-patient Treatment. For the avoidance of doubt, where nursing services are provided on a particular day, regardless of the length of time of the nursing services, it should be counted as one (1) day for the purpose of counting the maximum number of days per Period of Insurance allowed for this benefit.

Pre-authorisation by us is required for this benefit and the maximum number of days will be authorised by us on a case by case basis, and you will be advised accordingly upon our approval. The Pre-authorisation is subject to the Company's review.

Benefit 1.6: Organ Transplant

We will reimburse the In-patient and/or Day-patient Treatment costs for and in relation to a human organ transplant of kidney, pancreas, liver, heart, lung, bone marrow, or cornea, in respect of the Insured Person as a recipient.

We only pay for transplants carried out in internationally-accredited institutions by accredited surgeons and where the organ procurement is in accordance with The World Health Organisation guidelines.

We do not pay for the costs incurred in connection with collecting or locating a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.

For the avoidance of doubt, cryopreservation, harvesting and storage of stem cells and living cells/tissue, whether autologous or provided by a donor, as a preventative measure against possible future disease are not covered under this benefit or other benefits.

Benefit 1.7: Parent Accommodation for Admission (for an insured Child under the Age of 18)

We will reimburse the Hospital charges actually incurred in a Hospital for an extra bed in the Hospital for one (1) of the Insured Person's parent staying overnight in the same room of the Insured Person during the admission of the Insured Person's Age under eighteen (18) to the Hospital for eligible In-patient Treatment.

Various expenses such as meals, telephone calls or newspapers are not covered.

Benefit 1.8: Psychiatric and Psychological Treatment

We will reimburse the Treatment costs of Psychiatric Illness of the Insured Person as In-patient or Day-patient provided that all Treatment Medically Necessary must be administered under the direct control of a Psychiatrist in the Hospital. Treatment by a Psychologist in the Hospital shall be made upon a written referral letter from a Psychiatrist in the Hospital who has treated the Insured Person. Pre-authorisation is required for this benefit. The limit in the Benefit Details shown for this Benefit applies to In-patient Treatment and Day-patient Treatment of Psychiatric Illness in aggregate.

This benefit is subject to Waiting Period and only available for costs incurred after the Insured Person has been continuously covered under the Policy for twenty-four (24) consecutive months and has effected the annual renewal of the Policy for the coming Period of Insurance.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover (such as less Deductible) until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than twenty-four (24) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

The aggregate of all Treatment of all Psychiatric Illnesses under this benefit shall not exceed thirty (30) days (during which the Treatment is provided for all or part of the day) per Period of Insurance. For the avoidance of doubt, where Treatment of Psychiatric Illness is provided on a particular day, regardless of the length of time of the Treatment, it should be counted as one (1) day for the purpose of counting the maximum number of days per Period of Insurance for this benefit.

Benefit 1.9: In-patient Cash Benefit

We will pay a Cash Benefit if the Insured Person receives an eligible In-patient Treatment, provided no other cost is borne by us for and/or arising from that eligible Treatment under any benefit of Benefit 1 (except Benefit 1.10 and Benefit 1.24). The amount payable under this benefit per night is equal to the amount of Cash Benefit as shown in the Benefit Details of this Policy for each night of Hospital stay and only if the Insured Person is admitted for an eligible In-patient Treatment before midnight.

No other benefit will be payable in respect of the period for which Cash Benefit has been claimed (except Benefit 1.10 and Benefit 1.24).

Please note that if a Deductible applies to the Policy, as shown in your Policy Schedule, the Deductible will be eroded by the claimable eligible benefit or the amount of Cash Benefit payable, whichever is higher.

Pre-Hospitalisation and Post-Hospitalisation Benefits

Benefit 1.10: Home Nurse

We will reimburse the charges for the full-time or part-time home nursing services of a Nurse after the Insured Person is discharged from Hospital for an eligible In-patient or Day-patient Treatment, provided that all the following conditions are met:

(a) considered by us that it is Medically Necessary and appropriate, and authorised by us in writing before the provision of the home nursing services, and

(b) it is prescribed by the treating Medical Practitioner as Medically Necessary for the continued Treatment for the eligible Medical Condition, and

(c) when such services are essential for medical as distinct from domestic reasons.

This benefit is restricted to nursing services provided by a maximum of one (1) Nurse during any given time slot, up to two (2) time slots per day and up to a maximum of sixty (60) days (during which nursing services are provided for all or part of the day) per Period of Insurance regardless of the number of eligible In-patient or Day-patient Treatment. For the avoidance of doubt, where nursing services are provided on a particular day, regardless of the length of time of the nursing services, it should be counted as one (1) day for the purpose of counting the maximum number of days per Period of Insurance allowed for this benefit.

Pre-authorisation by us is required before this benefit can be considered and the maximum number of days per Period of Insurance will be authorised by us on a case by case basis, and you will be advised accordingly upon our approval. The Pre-authorisation is subject to the Company's review.

This benefit is not applicable to any home nursing services in relation to Terminal illness. For details, please refer to the "Hospice and Palliative Care" benefit (Benefit 1.21) of the Basic Plan.

Benefit 1.11: Pre-hospitalisation Out-patient Consultation

We will reimburse the costs of consultation and the associated prescribed diagnostic tests and essential medications (up to a length of thirty (30) days' prescription and excluding Chinese medicines) by a Medical Practitioner received by the Insured Person as an Out-patient within thirty (30) days prior to an eligible In-patient Treatment, Day-patient Treatment or Out-patient surgical procedure or operation, where: (a) such In-patient Treatment, Day-patient Treatment or Out-patient surgical procedure or operation is eligible for cover under the Policy; (b) the need for such In-patient Treatment, Day-patient Treatment or Out-patient surgical procedure or operation has arisen as a direct result of the medical examination and investigation findings drawn from that consultation; and (c) that consultation is directly related to the same cause of Medical Condition which necessitated such In-patient Treatment, Day-patient Treatment or Out-patient surgical procedure or operation. This benefit is limited to one (1) Visit per day.

Benefit 1.12: Post-hospitalisation Follow-up Consultation

We will reimburse the costs of follow-up consultation and the associated prescribed diagnostic tests and essential medications (up to a length of thirty (30) days' prescription and excluding Chinese medicines) by a Medical Practitioner received by the Insured Person as an Out-patient within thirty (30) days immediately following an eligible In-patient Treatment, Day-patient Treatment or Out-patient surgical procedure or operation, where: (a) the Medical Practitioner is the Insured Person's attending Medical Practitioner who has treated the Insured Person or is recommended in writing by the Insured Person's attending Medical Practitioner; and (b) that consultation is directly related to the same cause of Medical Condition which necessitated such In-patient Treatment, Day-patient Treatment or Out-patient surgical procedure or operation. This benefit is limited to one (1) Visit per day.

Benefit 1.13: Post-hospitalisation Ancillary Services (including physiotherapists, speech-therapists, pathologists, orthoptists or podiatrists)

We will reimburse the amount actually charged for Out-patient Treatment by Physiotherapist, speech therapist, pathologist, orthoptist or podiatrist within thirty (30) days immediately following the Insured Person's discharge from the Hospital for an eligible In-patient Treatment or Day-patient Treatment. That Out-patient Treatment must be directly related to the same cause of Medical Condition which necessitated such In-patient Treatment or Day-patient Treatment. This benefit must be prescribed by the Insured Person's attending Medical Practitioner who has treated the Insured Person and the Medical Practitioner must provide a written referral stating the reasons for which such Out-patient Treatment is required. This benefit is limited one (1) Treatment per day for each kind of Treatment.

There must be a clear Treatment plan from the Physiotherapist, speech therapist, pathologist, orthoptist or podiatrist with an end point and expected outcome.

Pre-authorisation by us is required after ten (10) sessions of each kind of Treatment. Our authorisation for this benefit is subject to our review. Any further Treatment needed after exceeding the limit of the original Treatment plan (this does not refer to the benefit limit per Period of Insurance) needs further written referral by the attending Medical Practitioner.

Speech therapy in this benefit will not cover any therapy whose aim is not to restore impaired speech function after an acute illness or injury. In particular, it will not cover any therapy which:

(a) aims to improve speech skills which are not fully developed;

(b) is educational in nature;

(c) is intended to maintain speech communication;

(d) aims to improve speech or language disorders (such as stammering); or

(e) is as a result of learning difficulties, developmental problems (such as dyslexia), behavioural problems (such as attention-deficit hyperactivity disorder), or autism.

Benefit 1.14: Rehabilitation

We will reimburse the costs actually incurred on the advice of a Specialist as an integral part of Treatment for a Medical Condition necessitating admission to a recognised Rehabilitation unit of a Hospital or in a licensed rehabilitation facility, where the Insured Person was confined to a Hospital or licensed rehabilitation facility as an In-patient for at least three (3) consecutive days, and where a Specialist confirms in writing that Rehabilitation is required, and provided that the admission to a Rehabilitation unit or licensed rehabilitation facility must be made within thirty (30) days of discharge from Hospital. Such Treatment should be under the direct supervision and control of a Specialist and our reimbursement of the Rehabilitation costs would cover:

(a) use of special Treatment rooms

(b) physical therapy fees

(c) speech therapy fees

(d) occupational therapy fees

Payment of this benefit shall be in lieu of all other benefits provided by this Policy in respect of such confinement and Treatment.

Pre-authorisation by us is required for this benefit and subject to the Company's review.

Speech therapy in this benefit will not cover any therapy whose aim is not to restore impaired speech function after an acute illness or injury. In particular, it will not cover any therapy which:

(a) aims to improve speech skills which are not fully developed;

(b) is educational in nature;

(c) is intended to maintain speech communication;

(d) aims to improve speech or language disorders (such as stammering); or

(e) is as a result of learning difficulties, developmental problems (such as dyslexia), behavioural problems (such as attention-deficit hyperactivity disorder), or autism.

Emergency Benefits

Benefit 1.15: Emergency In-patient and Out-patient Dental Treatment for Accident

We will reimburse the charges actually incurred for Emergency restorative dental Treatment required to sound, natural teeth following an Accident which necessitates your admission to Hospital for at least one (1) night or your consultation with a Dental Practitioner in his legally registered dental clinic.

The dental Treatment must be received within fourteen (14) days of the Accident. This Benefit covers all costs incurred for Treatment made necessary by an accidental injury caused by an extra-oral impact. If implants are clinically needed we will pay only the cost which would have been incurred if equivalent bridgework was undertaken instead.

For the avoidance of doubt, this benefit does not cover any costs incurred for replacement of a crown, bridge facing, veneer or denture.

The following Treatment, damage, injury, procedure and their related or consequential expenses are excluded from this benefit and the Company shall not be liable for:

(a) Treatment required as the result of consumption of food or drink or foreign bodies contained in such food or drink;

(b) damage caused by normal wear and tear;

(c) injury was caused by playing boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn;

(d) damage caused by tooth brushing; or

(e) any other oral hygiene procedure.

Benefit 1.16: Private Land Ambulance

We will reimburse the charges actually incurred for Medically Necessary Emergency road ambulance transport costs (a) to and between the Hospital nearest to the Insured Person or (b) to a more distant Hospital.

The treating Medical Practitioner or Specialist of the Insured Person will determine if this is Medically Necessary. We reserve the right to ultimately determine whether such transportation was Medically Necessary and appropriate.

Benefit 1.17: Emergency Treatment for Accident

We will reimburse the costs actually charged by a Hospital for Emergency Treatment if the Insured Person sustains an Injury and is treated as an Out-patient in the out-patient department of a Hospital or emergency department of a Hospital within seventy-two (72) hours of the Accident resulting in such Injury. This means the costs of consultation and the associated prescribed diagnostic tests and essential medications (up to a length of fourteen (14) days' prescription and excluding Chinese medicines) prescribed by a Medical Practitioner.

Extended Benefits

Benefit 1.18: Kidney Dialysis

We will reimburse the charges actually incurred for haemodialysis or peritoneal dialysis received by the Insured Person on an In-patient, Day-patient or Out-patient basis.

Benefit 1.19: Cancer Treatment (including Chemotherapy and Radiotherapy)

We will reimburse the charges actually incurred for chemotherapy and/or radiotherapy Treatment of the Insured Person diagnosed with cancer on an In-patient, Day-patient or Out-patient basis.

Benefit 1.20: Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

We will reimburse medical expenses, which arise from or are in any way related to HIV and/or HIV related illnesses, including AIDS or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, as a result of proven Occupation Accident (as defined below) or Blood Transfusion (as defined below). Expenses are limited to pre and post-diagnosis consultations, routine check-ups for this condition, Drugs and Dressings (except experimental or those unproven), Hospital Accommodation and nursing fees.

"Occupation Accident" means an Accident which fulfills all of the following criteria: (a) an Accident happened to an Insured Person in the course of and arising out of his employment, with such employment being in the emergency services, medical or dental professions, laboratory assistants, pharmacist or being an employee in a medical facility; (b) as a direct result of the Accident, he contracted the HIV infection while carrying out normal duties of his employment; (c) the Accident from which he contracted the HIV infection was reported, investigated and documented according to normal procedures for his employment; (d) a test showing no HIV or antibodies to such a virus was made within five (5) days of the Accident; (e) the Accident and the test must be reported to us within thirty (30) days of the Accident; and (f) a positive HIV test occurred within twelve (12) months of the reported Accident.

"Blood Transfusion" means the blood transfusion received by an Insured Person as an In-patient as part of Medically Necessary Treatment.

This benefit is subject to Waiting Period, and is only available after the Insured Person has been insured in your Policy for twenty-four (24) consecutive months.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with a higher level of cover for a period of not less than twenty-four (24) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Pre-authorisation by us is required for this benefit and subject to the Company's review.

Benefit 1.21: Hospice and Palliative

Upon diagnosis of a Terminal illness, we will reimburse the costs actually incurred for any In-patient, Day-patient or Out-patient Treatment (up to one (1) Visit per day for Out-patient Treatment), of the Insured Person given on the advice of a Medical Practitioner or Specialist for the purpose of offering temporary relief of symptoms. Charges for Hospital, specialist palliative care centre or hospice accommodation, consultation with a Medical Practitioner, nursing care by a Nurse and prescribed Drugs and Dressings are covered.

Once the Insured Person is admitted to Hospital, specialist palliative care centre or hospice, all costs of care and any Treatment related to the Terminal illness and Related Conditions will be taken from this benefit and may not be claimed from any other benefit applicable to the Insured Person under this Policy.

This benefit is payable once in the Insured Person's lifetime up to thirty (30) days, in aggregate for all such conditions. Once the limit of this benefit is reached, no benefit of any kind will be payable in respect of any Medical Condition for which palliative and/or hospice care has been received.

This benefit is subject to Waiting Period and only becomes available for charges incurred after the Insured Person has been continuously covered under the Policy for twelve (12) consecutive months and has effected the annual renewal of the Policy for the coming Period of Insurance.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover (such as less Deductible) until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than twelve (12) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Pre-authorisation by us is required for this benefit and subject to the Company's review.

Benefit 1.22: Treatment for Alcohol or Substance Abuse in the Recognised Centre (including detoxification)

We will reimburse the costs actually incurred for alcohol or substance abuse (including detoxification) In-patient and Day-patient Treatment at a recognised medical facility providing evidence-based Treatment when it is Medically Necessary and recommended by a Medical Practitioner. This benefit is subject

to Waiting Period and only becomes available for charges incurred after the Insured Person has been continuously covered for twenty-four (24) consecutive months under the Policy and has effected the annual renewal for the coming Period of Insurance.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than twenty-four (24) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Pre-authorisation by us is required for this benefit and subject to the Company's review.

Benefit 1.23: Weight Loss Treatment for Morbid Obesity

We will reimburse the medical costs actually incurred for Treatment of obesity (which is defined as Body Mass Index equal to forty (40) and above) in any way including but not limited to the use of gastric banding or stapling, the removal of fat or surplus tissue from any part of the body, slimming classes organised by Dietician and drugs prescribed by a Medical Practitioner. We will only reimburse ninety (90) per cent of the eligible medical costs actually incurred.

Payment of this benefit shall be in lieu of all other benefits provided by this Policy. This benefit is subject to Waiting Period and only becomes available for charges incurred after the Insured Person has been continuously covered for twenty-four (24) consecutive months under the Policy and has effected the annual renewal of the Policy for the coming Period of Insurance.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than twenty-four (24) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Pre-authorisation by us is required for this benefit and subject to the Company's review.

Benefit 1.24: Funeral Expenses

We will reimburse the costs actually incurred for one (1) funeral of the Insured Person provided proof of such death and costs is furnished to the Company. This benefit is payable once per lifetime.

BENEFIT 2: OPTIONAL OUT-PATIENT PLAN

This benefit provision serves to act as a supplement to the Basic Plan (In-patient and Day-patient Treatment) provision above and will only be available as an optional supplementary cover upon payment of adequate premiums if the Basic Plan (In-patient and Day-patient Treatment) is kept in force. Where the Insured Person has opted for such supplementary cover, it will be shown in the Policy Schedule. All Treatment, purchase, consultation, test, examination, and check-up hereunder must not be done in Hospital unless otherwise specified.

Benefit 2.1: Consultation with Medical Practitioner

For the Insured Person's consultation with a Medical Practitioner for the Out-patient Treatment of an eligible Medical Condition, we will reimburse the fees actually charged by the Medical Practitioner including consultations, prescribed Drugs and Dressings (up to a length of thirty (30) days' prescription per Visit) and non-surgical or minor surgical procedures such as dressing and offing of stitches which are Medically Necessary, but excluding any traditional Chinese medicines. This benefit is subject to a maximum of fifteen (15) Visits per month regardless of the number of eligible Medical Condition.

For the avoidance of doubt, Out-patient routine health examination, eye examination or vaccinations are not covered under this benefit.

Benefit 2.2: Prescribed Health Supplements

We will reimburse the costs for prescribed health supplement such as vitamins (but excluding any consultation fee and traditional Chinese medicines) provided that:

(a) it must be prescribed in writing by a Medical Practitioner and dispensed within one hundred and eighty (180) days of being prescribed; and

(b) it must be purchased from a licensed or registered health supplement shop, pharmacy, dispensary, clinic or Hospital under the laws of Hong Kong or other jurisdiction; and

(c) each prescription order or refill shall be limited up to a consecutive sixty (60) days' supply, unless limited by the drug manufacturer's packaging; and

(d) where a prescription order provides a certain number of days of supply of health supplement but it is dispensed more than such number of days of supply due to limitation by the drug manufacturer's packaging, any refill can only be made after the elapse of the actual number of days of supply based on the drug manufacturer's packaging.

The costs and/or expense incurred for replacement of such prescribed health supplement due to loss, theft, damage, spoilage or expiry is excluded from this benefit.

Benefit 2.3: Diagnostic Tests

We will reimburse the Out-patient expenses for imaging and laboratory examination(s) for diagnostic purpose as part of an eligible Out-patient Treatment. The imaging and laboratory examination(s) must be consistent with the symptoms and diagnosis of the Insured Person and supported by a written referral letter from a Medical Practitioner who has treated the Insured Person, provided that each referral letter is valid for the same or related Medical Condition for up to ninety (90) days.

Benefit 2.4: Physiotherapy

We will reimburse the Out-patient expenses for Out-patient consultation fee charged by a Physiotherapist for physiotherapy Treatment, provided that:

(a) the Treatment shall be made upon a written referral letter from a Medical Practitioner who has treated the Insured Person, with each referral letter valid for the same or related Medical Condition for up to one hundred and eighty (180) days; and

(b) this benefit is limited to one (1) Treatment per day regardless of the number of eligible Medical Condition; and

(c) this benefit is subject to a maximum of twenty (20) Visits per Period of Insurance regardless of the number of eligible Medical Condition; and

(d) Pre-authorisation by us is required after ten (10) sessions of Treatment and subject to the Company's review. Any further Treatment needed after exceeding the limit of the original Treatment plan (this does not refer to the benefit limit per Period of Insurance) needs further written referral by the treating Medical Practitioner.

Benefit 2.5: Speech Therapy, Oculomotor Therapy and Occupational Therapy

We will reimburse the fees charged by a speech therapist, oculomotor therapist or occupational therapist as part of the Insured Person's Out-patient Treatment at a medical facility, provided that:

(a) such Treatment shall be made upon a written referral letter from a Medical Practitioner who has treated the Insured Person, with each referral letter valid for the same or related Medical Condition for up to one hundred and eighty (180) days; and

(b) this benefit is limited to one (1) Treatment for each kind of therapy per day regardless of the number of eligible Medical Condition; and

(c) the purpose of the Treatment is aimed at restoring the Insured Person to his previous state of health after an acute illness or injury; and

(d) regardless of the number of eligible Medical Condition, this benefit is subject to a maximum of twenty (20) Visits per Period of Insurance, in aggregate for all kinds of therapy; and

(e) Pre-authorisation by us is required after ten (10) sessions of the same kind of therapy and subject to the Company's review. Any further Treatment needed after exceeding the limit of the original Treatment plan (this does not refer to the benefit limit per Period of Insurance) needs further written referral by the treating Medical Practitioner.

Such Treatment must be given by a duly qualified therapist registered and legally authorised in the geographical area of his practice to render Treatment services to patients, but excludes the Insured Person himself, Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

There must be a clear Treatment plan from the speech therapist, oculomotor therapist or occupational therapist with an end point and expected outcome.

Speech therapy in this benefit will not cover any therapy whose aim is not to restore impaired speech function after an acute illness or injury. In particular, it will not cover any therapy which:

(a) aims to improve speech skills which are not fully developed;

(b) is educational in nature;

(c) is intended to maintain speech communication;

(d) aims to improve speech or language disorders (such as stammering); or

(e) is as a result of learning difficulties, developmental problems (such as dyslexia), behavioural problems (such as attention-deficit hyperactivity disorder), or autism.

Benefit 2.6: Traditional Chinese Medicine

We will reimburse the Out-patient consultation fees, bonesetting and acupuncture Treatment and the cost of two (2) days' basic Chinese medicines prescribed per Visit and charged by a Chinese Medical Practitioner.

Chinese tonic medicine, including but not limited to cubilose, ganoderma, ginseng, red ginseng, American ginseng, radix ginseng silvestris, cordyceps, antler, donkeyhide gelatin, hippocampus, antelope horn powder, placenta hominis, agaricus blazei murill, musk and pearl powder are not covered.

This benefit is subject to a maximum of twenty (20) Visits per Period of Insurance regardless of the number of eligible Medical Condition.

Benefit 2.7:Chiropractic, Acupuncturist, Osteopathic and Homeopath

We will reimburse the charges actually incurred for courses of chiropractic Treatment, acupuncture, osteopathy and homeopath received as part of the Insured Person's Out-patient Treatment at a medical facility, provided that:

(a) such Treatment shall be made upon a written referral letter from a Medical Practitioner who has treated the Insured Person, with each referral letter valid for the same or related Medical Condition for up to one hundred and eighty (180) days; and

(b) this benefit is limited to one (1) Visit for each kind of therapy per day regardless of the number of eligible Medical Condition; and

(c) regardless of the number of eligible Medical Condition, this benefit is subject to a maximum of twenty (20) Visits per Period of Insurance, in aggregate for all kinds of therapy; and

(d) Pre-authorisation by us is required after ten (10) sessions of the same kind of therapy and subject to the Company's review. Any further Treatment needed after exceeding the limit of the original Treatment plan (this does not refer to the benefit limit per Period of Insurance) needs further written referral by the treating Medical Practitioner.

Such Treatment must be given by a duly qualified therapist registered and legally authorised in the geographical area of his practice to render Treatment services to patients, but excludes the Insured Person himself, Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

There must be a clear Treatment plan from the practitioner with an end point and expected outcome.

Benefit 2.8: Dietician

We will reimburse the charges actually incurred for the Insured Person's Visit to a Dietician as an Out-patient provided that:

(a) the Visit shall be made upon a written referral letter from a Medical Practitioner who has treated the Insured Person, with each referral letter valid for the same or related Medical Condition for up to one hundred and eighty (180) days; and

(b) regardless of the number of eligible Medical Condition, this benefit is subject to a maximum of twenty (20) Visits per Period of Insurance; and is limited to one (1) Visit per day; and

(c) Pre-authorisation by us is required after ten (10) sessions of Visit and subject to the Company's review. Any further Visit needed after exceeding the limit of the original Treatment plan (this does not refer to the benefit limit per Period of Insurance) needs further written referral by the treating Medical Practitioner.

Benefit 2.9: Psychiatric and Psychological Treatment

We will reimburse the Treatment costs of Psychiatric Illness of the Insured Person as Out-patient provided that all Treatment must be administered under the direct control of a Psychiatrist or Psychologist, provided that:

(a) Treatment by a Psychologist shall be made upon a written referral letter from a Psychiatrist who has treated the Insured Person, with each referral letter valid for the same or related Medical Condition for up to one hundred and eighty (180) days; and

(b) this benefit is limited to one (1) Visit to either a Psychiatrist or a Psychologist or both per day regardless of the number of eligible Medical Condition; and

(c) regardless of the number of eligible Medical Condition, this benefit is subject to a maximum of ten (10) Visits per Period of Insurance, in aggregate for all kinds of Treatment irrespective of whether it is by a Psychiatrist or a Psychologist.

This benefit is subject to Waiting Period and only available for costs incurred after the Insured Person has been continuously covered under the Policy for twenty-four (24) consecutive months and has effected the annual renewal of the Policy for the coming Period of Insurance.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than twenty-four (24) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 2.10: Medical Prosthesis

We will pay for the charges of any instrument, apparatus or device, provided that

(a) it is prescribed by a Medical Practitioner; and

(b) it is an aid to the function or capacity of the Insured Person which means any of the following:

- foot orthosis (which is limited to one pair per Period of Insurance);
- hearing aids;
- speaking aids (electronic larynx);
- crutches or wheelchairs;
- orthopaedic supports/braces.

We will pay for each kind of item mentioned in clause (b) above only once (1) per Period of Insurance.

Pre-authorisation is required for any item whose cost is over HK$3,000

This benefit is subject to Waiting Period and only available for costs incurred after the Insured Person has been continuously covered under the Policy for six (6) consecutive months.

We do not pay for any replacement prosthetic devices required in relation to a Pre-existing Condition.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than six (6) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 2.11: Hormone Replacement Therapy

We will reimburse the costs for Out-patient medically indicated (rather than for the relief of physiological symptoms) hormone replacement therapy, i.e. the Out-patient consultation fee charged by a Medical Practitioner or Specialist including the cost of the prescribed tablets, implants or patches when Treatment of the Insured Person is for the female menopause which has been induced artificially and/or through early onset under the Insured Person's Age of forty (40). We will only pay this benefit for a maximum of eighteen (18) months per lifetime.

Benefit 2.12: Child Annual Eye and Hearing Tests

We will reimburse the charges for routine eye examinations and/or routine ear examinations for the Insured Person who does not exceed the Age of fifteen (15) at the time of the examinations, which means the costs of consultation with a qualified optometrist or ophthalmologist for the eye test and qualified audiologist or otorhinolaryngologist for hearing test as part of the routine examination process on an Out-patient basis. However, the examiner and/or Medical Practitioner shall exclude any person who is the Insured Person himself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

This benefit is limited to one (1) eye test and one (1) hearing test per Period of Insurance.

Benefit 2.13: Child Wellness Tests

Provided that the Insured Person does not exceed the Age of seven (7) at the time of the routine test, consultation and/or preventive care, we will reimburse the cost actually incurred for routine tests of the Insured Person, including the cost of consultation by a Medical Practitioner needed as part of wellness test process at any of the appropriate age intervals, and for a Medical Practitioner to provide preventative care to the Insured Person (up to a total of fifteen (15) Visits per lifetime of the Insured Person), consisting of:

(a) evaluating medical history;

(b) physical examinations;

(c) development assessment; and

(d) appropriate laboratory tests.

For a package of tests, we will only reimburse the cost upon completion of the package. If a package of tests starts during the Period of Insurance and ends beyond the Period of Insurance, this benefit for the package will only be paid subject to the renewal of the Policy in respect of the Insured Person for the subsequent period of insurance; otherwise, the cost for the package will be reimbursed on a pro-rata basis taking into account the number of eligible tests which the Insured Person has received during the Period of Insurance.

Benefit 2.14: Adult Annual Check-Up

We will reimburse the routine tests including the costs of consultation by a Medical Practitioner needed as part of check-up process for the Insured Person who is over the Age of fifteen (15) at the time of the tests, consisting of any of the following:-

urine analysis, blood samples (diabetes, cholesterol, etc.), hearing test, biometric assessment (size, weight, Body Mass Index measurement), sight test, electrocardiogram at rest, treadmill, memory test, lung capacity measurement, gynecological examination (breast and cervical cancer tests), "hemoccult" test and HIV test.

This benefit is limited to one (1) check-up per Period of Insurance.

This benefit is subject to Waiting Period and only available for costs incurred after the Insured Person has been continuously covered under the Policy for six (6) consecutive months.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than six (6) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 2.15: Vaccinations

We will pay for Medically Necessary vaccinations given by a Medical Practitioner to the Insured Person including the costs of consultation needed as part of vaccination process. For a package of vaccinations, we will only reimburse the costs upon completion of the package. If a package of vaccinations starts during the Period of Insurance and ends beyond the Period of Insurance, this benefit for the package will only be paid subject to the renewal of the Policy in respect of the Insured Person for the subsequent period of insurance; otherwise, the cost for the package will be reimbursed on a pro-rata basis taking into account the number of eligible vaccinations which the Insured Person has received during the Period of Insurance.

BENEFIT 3 : OPTIONAL MATERNITY PLAN

This benefit provision serves to act as a supplement to the Basic Plan (In-Patient and Day-patient Treatment) provision above and will only be available as an optional supplementary cover upon payment of adequate premiums if the Basic Plan (In-Patient and Day-patient Treatment) is kept in force. The Insured Person cannot be covered under the Optional Maternity Plan if the Optional Maternity Plan in respect of such Insured Person has been cancelled previously.

Where the Insured Person has opted for such supplementary cover, it will be shown in the Policy Schedule.

Benefit 3.1: Routine Pregnancy

We will reimburse the medical costs for natural delivery and non Medically Necessary caesarian delivery actually incurred during normal Pregnancy and childbirth of the Insured Person, which includes:

(a) Hospital charges, midwife fees (during labour only);

(b) Specialist fees;

(c) costs for the Insured Person's pre-natal care;

(d) costs for the Insured Person's post-natal care up to six (6) weeks following a birth;

(e) paediatrician costs for the first examination/check-up of a newborn baby if the examination is made within twenty-four (24) hours of delivery; and

(f) costs for the newborn's Hospital stay which does not exceed the Insured Person's Hospital stay but excludes nursery care for newborn.

Costs related to complications of Pregnancy or complications of childbirth are not payable under this benefit. In addition, any non-Medically Necessary caesarean sections will be covered up to the costs of a routine delivery in the same Hospital.

If a maternity package starts during the Period of Insurance and ends beyond the Period of Insurance, this benefit for the package will only be paid subject to the renewal of the Policy in respect of the Insured Person for the subsequent period of insurance; otherwise, the costs for the package will be reimbursed on a pro-rata basis as determined by the Company.

This benefit is subject to Waiting Period and only becomes available for charges incurred after the Insured Person has been continuously covered for ten (10) consecutive months under the Policy.

If an application is made, subject to the rules and regulations of the Company, to enrol the newborn under the Plan within fifteen (15) days of the newborn's date of birth and this Optional Maternity Plan in respect of such Insured Person has been in force for a continuous period of ten (10) months or more prior to the newborn's birth, we will not require information about the newborn's health or require any medical examination. Upon successful enrolment of the newborn as Insured Person under the Plan, the newborn will enjoy cover commencing at the time of birth. For the avoidance of doubt, the terms and conditions of Benefit 3.4 shall apply to the newborn's coverage.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than ten (10) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 3.2: Non Elective Caesarean Section, Complicated Pregnancy and Complicated Childbirth

We will reimburse the medical costs for Medically Necessary caesarian delivery, complicated Pregnancy and complicated childbirth actually incurred during Pregnancy and childbirth of the Insured Person, which includes:

(a) Hospital charges, midwife fees (during labour only);

(b) Specialist fees;

(c) costs for the Insured Person's pre-natal care;

(d) costs for the Insured Person's post-natal care up to six (6) weeks following a birth;

(e) paediatrician costs for the first examination/check-up of a newborn baby if the examination is made within twenty-four (24) hours of delivery; and

(f) costs for the newborn's Hospital stay which does not exceed the Insured Person's Hospital stay but excludes nursery care for newborn.

For complicated Pregnancy and complicated childbirth, by way of illustration, we would consider Treatment of the following:

(a) Ectopic Pregnancy (where the foetus is growing outside the womb);

(b) Hydatidiform mole (abnormal cell growth in the womb);

(c) Retained placenta (afterbirth retained in the womb);

(d) Placenta praevia;

(e) Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia);

(f) Diabetes (If the Insured Person has exclusions because of her past medical history which relate to diabetes, then she will not be covered for any Treatment for diabetes during Pregnancy);

(g) Post partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth);

(h) Miscarriage requiring immediate surgical Treatment; and

(i) Failure to progress in labour.

This benefit will, subject to the limitations and exclusions of this Policy, cover Treatment of both the mother and the unborn child up to the moment of delivery. Thereafter cover will be restricted to eligible Treatment for the mother alone.

If an application is made, subject to the rules and regulations of the Company, to enrol the newborn under the Plan within fifteen (15) days of the newborn's date of birth and this Optional Maternity Plan in respect of such Insured Person has been in force for a continuous period of ten (10) months or more prior to the newborn's birth, we will not require information about the newborn's health or require any medical examination. Upon successful enrolment of the newborn as Insured Person under the Plan, the newborn will enjoy cover commencing at the time of birth. For the avoidance of doubt, the terms and conditions of Benefit 3.4 shall apply to the newborn's coverage.

This benefit does not cover the costs of delivery of any child if such delivery is normal, by any other assisted means or by non Medically Necessary caesarean section.

This benefit is subject to Waiting Period and only becomes available for charges incurred after the Insured Person has been continuously covered under the Policy for ten (10) consecutive months.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than ten (10) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 3.3: Infertility Treatment

We will reimburse the Treatment costs related to artificial insemination and in vitro fertilisation for the Insured Person who is under the Age of forty (40) at the time of first Treatment and who attempts to give birth to her first child. This benefit is subject to a maximum of three (3) procedures per lifetime of the Insured Person.

This benefit is subject to Waiting Period and only available for costs incurred after the Insured Person has been continuously covered under the Policy for twenty-four (24) consecutive months and has effected the annual renewal of the Policy for the coming Period of Insurance. Pre-authorisation by us is required for this benefit and subject the Company's review.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than twenty-four (24) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 3.4: Congenital, Hereditary and Birth Abnormality

If an application is made, subject to the rules and regulations of the Company, to enrol a newborn under the Plan within fifteen (15) days of the newborn's date of birth and this Optional Maternity Plan in respect of the Insured Person (who gave birth to the newborn) has been in force for a continuous period of ten (10) months or more prior to the newborn's birth, we will not require information about the newborn's health or require any medical examination. Upon successful enrolment of the newborn as Insured Person under the Plan, the newborn will enjoy cover commencing at the time of birth and all congenital, hereditary and birth abnormality Medical Condition of the newborn will be covered subject to the following:

(a) if the Insured Person has exclusion clauses in the Policy for hereditary conditions such as thalassemia or Christmas disease, the exclusion clauses will be applied to her newborn;

(b) costs of Treatment for congenital, hereditary & birth abnormality Medical Conditions of the newborn will be provided on an In-patient or Day-patient basis only; and

(c) the Insured Person is not surrogate mother of the newborn.

For the avoidance of doubt, Policy Exclusion clause (3) will not apply to such newborn in respect of his congenital, hereditary and birth abnormality Medical Condition except that the provisions in sub-paragraphs (a), (b) and (c) above shall still apply .

BENEFIT 4: OPTIONAL DENTAL PLAN

This benefit provision serves to act as a supplement to the Basic Plan (In-Patient and Day-patient Treatment) provision above and will only be available as an optional supplementary cover upon payment of adequate premiums if both the Basic Plan (In-Patient and Day-patient Treatment) and Optional Out-patient Plan are kept in force. Where the Insured Person has opted for such supplementary cover, it will be shown in the Policy Schedule.

Notwithstanding any other provisions herein below, we will not pay for the cost of supplies including but not limited to toothbrush, dental floss and toothpaste or Treatment for teeth whitening under the Optional Dental Plan in all cases.

Benefit 4.1: Routine and Preventive

We will reimburse the costs of routine dental Treatment, i.e. fees of a Dental Practitioner carrying out dental Treatment in a dental clinic including any of the following:

(a) screening (up to twice per year), i.e. the assessment of diseased, missing and filled teeth, including x-rays where necessary;

(b) preventive scaling, polishing, and sealing (limited to once per year) ;

(c) fillings (standard amalgam or composite fillings) ;

(d) extractions except removal of wisdom tooth or impacted tooth;

(e) inlay and onlays (except gold inlays and onlays) ;

(f) drainage of abscesses ; and

(g) root-canal Treatment (but not the fitting of a crown following root-canal Treatment).

Except the above-mentioned, no other Treatment is covered under the routine dental Treatment.

This benefit is subject to Waiting Period and only available for costs incurred after the Insured Person has been continuously covered under the Policy for six (6) consecutive months.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than six (6) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 4.2: Major Restorative and Implant

We will reimburse the costs of major restorative and implant Treatment, i.e. fees of a Dental Practitioner and associated costs for any of the following procedures in a dental clinic:

(a) apicoectomy done to treat a fractured tooth root, a severely curved tooth root, teeth with caps or posts, cyst or infection which is untreatable with root canal therapy, root perforations;

(b) new or repair of crowns (except golden crowns);

(c) persistent symptoms that do not indicate problems from x-rays; calcification;

(d) damaged root surfaces and surrounding bone requiring surgery;

(e) dental implant;

(f) removal of wisdom tooth or impacted tooth;

(g) new or repair of dentures;

(h) new or repair of bridge work (excluding gold bridge work); and

(i) pins for cusp restoration.

This benefit is subject to Waiting Period and only available for costs incurred after the Insured Person has been continuously covered under the Policy for six (6) consecutive months.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than six (6) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

Benefit 4.3: Orthodontic Treatment for an insured Child Up To Age of Sixteen (16)

We will reimburse fifty (50) per cent of medical costs actually incurred for orthodontic Treatment of the Insured Person who is under the Age of seventeen (17) at the time of the first Treatment provided that all coverage under this benefit shall terminate when the Insured Person reaches the Age of nineteen (19).

This benefit is subject to Waiting Period and is only available for charges incurred after the Insured Person has been continuously covered under the Optional Dental Plan for six (6) consecutive months.

Even if the Insured Person's coverage is upgraded to a higher level of cover, this benefit will not be upgraded to the higher level of cover until such Insured Person has been covered under the upgraded Policy with higher level of cover for a period of not less than six (6) consecutive months and you have effected the annual renewal of the upgraded Policy in respect of such Insured Person.

If an orthodontic Treatment package starts during the Period of Insurance and ends beyond the Period of Insurance, this benefit for the package will only be paid subject to the renewal of the Policy in respect of the Insured Person for the subsequent period of insurance; otherwise, the costs for the package will be reimbursed on a pro-rata basis as determined by the Company.

BENEFIT 5: OPTIONAL OPTICAL PLAN

This benefit provision serves to act as a supplement to the Basic Plan (In-patient and Day-patient Treatment) provision above and will only be available as an optional supplementary cover upon payment of adequate premiums if both the Basic Plan (In-Patient and Day-patient Treatment) and Optional Out-Patient Plan are kept in force. Where the Insured Person has opted for such supplementary cover, it will be shown in the Policy Schedule.

Benefit 5.1: Contact Lenses, Frames & Glasses (excluding sunglasses)

We will reimburse the charges for eye examinations carried out by an Ophthalmologist, the cost of spectacle frames and corrective lenses (whether disposable or not) prescribed by the Ophthalmologist for the Insured Person. This benefit is limited to one (1) Visit to the Ophthalmologist per Period of Insurance.

This benefit does not cover tinted/reactive lenses, sunglasses, non-corrective contact lenses, laser eye surgery and/or similar, whether prescribed or not.

Benefit 5.2: Lasik Surgery and Lens Implants

We will reimburse the charges for surgical operations and procedures performed for the Insured Person in a Hospital, the clinic of a Medical Practitioner, the out-patient department of a Hospital or an eye surgical centre by an Ophthalmologist in respect of Lasik surgery and/or intraocular lens implants, including charges for items incurred for the Lasik surgery such as Ophthalmologist's fee, operation theater fee, anesthetist fee and charges for all consumable items.

VALUE-ADDED SERVICES: WORLDWIDE EMERGENCY ASSISTANCE AND SECOND MEDICAL OPINION

Please refer to the Policyholder User Guide for details, terms and conditions for these services.

We may determine, review and revise at our absolute discretion the scope, terms and conditions and/or provider of these services from time to time.

We shall not be liable for any loss, damage, liability or claims arising from or in connection with acts or omission of any third-party service providers, including without limitation those providing worldwide emergency assistance and second medical opinion and all other services available to you or the Insured Person under this Policy.

POLICY EXCLUSIONS

These are Policy limitations that apply in addition to any personal exclusion detailed in the Insured Person's Policy Schedule.

(1) Act of terrorism, war and illegal acts

We do not pay for treatment of any condition resulting directly or indirectly from, or as a consequence of war, acts of foreign hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, unless the Insured Person is an innocent bystander. "Innocent bystander" means that the Insured Person does not actively take part in any act or incident afore-mentioned.

The Insured Person is not covered for costs arising from taking part in any illegal act.

(2) Self-inflicted injuries or attempted suicide

The Insured Person is not covered for any costs for treatment resulting directly or indirectly from self-inflicted injury, suicide or attempted suicide.

(3) Pre-existing Condition

The Insured Person is not covered for treatment of any Pre-existing Condition.

(4) Administrative and shipping fee

The Insured Person is not covered for any charges made by a Chinese Medical Practitioner, Dietician, Dental Practitioner, Medical Practitioner, Ophthalmologist, Physiotherapist, Psychiatrist, Psychologist, Specialist or other services provider for filling in claim forms or providing medical reports. The Insured Person is not covered for any charges where a police report is required. The Insured Person is not covered for the cost of shipping (including customs duty) on transporting medication.

(5) Non-Medically Necessary service fees

The Insured Person is not covered for any charges for non-Medically Necessary service provided by the Hospital such as television, radio, telephone or other similar facility.

(6) Supplements

We do not pay for vitamins, minerals, baby food, cosmetic medicines and any type of supplements that can be purchased or obtained without prescription, except as covered under the Prescribed Health Supplements benefit (Benefit 2.2) of the Optional Out-patient Plan.

(7) Medical health-check or self-request for admission or for surgery recovery or rehabilitation

The Insured Person is not covered for routine medical examinations including issuing medical certificates, health screening examinations or tests to rule out the existence of a condition for which the Insured Person does not have any symptoms, except as covered under the Child Annual Eye and Hearing Test benefit (Benefit 2.12), Child Wellness Tests benefit (Benefit 2.13) and Adult Annual Check-Up benefit (Benefit 2.14) of the Optional Out-patient Plan.

The Insured Person is not covered for rehabilitation except as covered under the Rehabilitation benefit (Benefit 1.14) of the Basic Plan

(8) Alcohol and drug abuse

The Insured Person is not covered for costs for treatment resulting from dependency on or abuse of alcohol, drugs, or other addictive substances and any illness or injury arising directly or indirectly from such dependency or abuse, except as covered under the Treatment for Alcohol or Substance Abuse in the Recognised Centre (including detoxification) benefit (Benefit 1.22) of the Basic Plan.

(9) Nuclear exposure

The Insured Person is not covered for treatment costs directly or indirectly caused by or contributed to or arising from: ionizing radiations or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel; the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

We do not pay for the treatment of any conditions, or for any claim arising directly or indirectly from contamination by radioactivity from any nuclear material whatsoever, including expenses in any way caused by or contributed to by an act of war or terrorism.

(10) Cosmetic surgery

The Insured Person is not covered for treatment costs relating to cosmetic or aesthetic treatment or any treatment related to previous cosmetic or reconstructive surgery (whether or not for psychological purposes), such as but not limited to acne, teeth whitening, lentigo and alopecia.

(11) Chemical or biological contamination

We do not pay for the treatment of any conditions, or for any claim arising directly or indirectly from chemical or biological contamination, however caused, or asbestosis, including expenses in any way caused by or contributed to by an act of war or terrorism.

(12) Developmental disorders

The Insured Person is not covered for treatment of developmental, behavioral or learning problems such as attention deficit hyperactivity disorder, speech disorders, autism spectrum disorder or dyslexia and physical developmental problems.

(13) Eating disorders

The Insured Person is not covered for costs relating to treatment of eating disorders such as, but not limited to, anorexia nervosa and bulimia, including any required psychiatric treatment where the psychiatric condition is a related condition to the eating disorder, except as covered under the Weight Loss Treatment for Morbid Obesity benefit (Benefit 1.23) of the Basic Plan provided that the Treatment costs under Benefit 1.23 do not cover costs for psychiatric Treatment where the psychiatric condition is a Related Condition to the eating disorder.

(14) Deductible or co-payment

The Insured Person is not covered for the amount of the deductible or co-payment that is shown on the Insured Person's Policy or Policy Schedule.

(15) Experimental treatment and drugs

The Insured Person is not covered for treatment or drugs which have not been established as being effective or which are experimental. For drugs this means they must be licensed for use by the Department of Health of Hong Kong Special Administrative Region, European Medicines Agency or the Medicines and Healthcare products Regulatory Agency and be used within the terms of that license. For established treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced and published by medical journals and/or approved by the National Institute for Health and Clinical Excellence for specific purposes to be considered proven safe and effective therapies.

(16) Eyes and ears

The Insured Person is not covered for routine eyesight or hearing tests or the cost of eyeglasses, contact lenses, hearing aids, except as covered under the Optional Out-patient Plan or Optional Optical Plan. We do not pay for eye surgery to correct vision such as myopia, hyperopia/hypermetropia, astigmatism, presbyopia and strabismus except as covered under the Lasik Surgery and Lens Implants benefit (Benefit 5.2) of the Optional Optical Plan.

(17) Failure to follow medical advice

We do not pay for treatment arising from or related to the Insured Person's unreasonable failure to seek or follow medical advice and/or prescribed treatment, or the Insured Person's unreasonable delay in seeking or following such medical advice and/or prescribed treatment. We do not pay for complications arising from ignoring such advice.

(18) Foetal surgery

We do not cover the costs of surgery on a child while in its mother's womb.

(19) Genetic testing

We do not cover the cost of genetic tests, when those tests are undertaken to establish whether or not the Insured Person may be genetically disposed to the development of a Medical Condition.

(20) Acquired Immune Deficiency Syndrome ("AIDS"), Human Immunodeficiency Virus ("HIV") or sexually transmitted disease

The Insured Person is not covered for treatment for AIDS, AIDS-related Complex Syndrome (ARCS), all diseases caused by or related to HIV (or both), or sexually transmitted disease, except as covered under the Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus benefit (Benefit 1.20) of the Basic Plan.

(21) Morbid Obesity

The Insured Person is not covered for the costs of treatment for, or related to, morbid obesity; and the Insured Person is not covered for costs arising from or relating to removing fat or surplus healthy tissue from any part of the body, except as covered under the Weight Loss Treatment for Morbid Obesity benefit (Benefit 1.23) of the Basic Plan.

(22) Nursing homes, convalescence homes, health hydros, and nature cure clinics

The Insured Person is not covered for treatment received in nursing homes, convalescence homes, health hydros, nature cure clinics or similar establishments.

The Insured Person is not covered for any costs incurred in Hospital accommodation when it is solely or primarily for any of the following purposes: receiving general nursing care or any other services which do not require the Insured Person to be in a Hospital and could be provided in a nursing home or other establishment that is not at hospital; receiving services which would not normally require trained medical professionals (e.g. help in walking and bathing).

(23) Pregnancy or maternity

The Insured Person is not covered for costs relating to normal pregnancy or childbirth, voluntary caesarean section and any means of fertility treatment, except as covered under the Optional Maternity Plan.

Surrogacy is excluded in all cases.

We will not pay for any benefit under the Optional Maternity Plan:

(a) to an Insured person who acts as a surrogate; or

(b) to anyone else acting as a surrogate for an Insured Person.

We will not pay for the cost of treatment by way of the intentional termination of pregnancy, unless the pregnancy endangers the Insured Person's life or mental stability.

(24) Reproductive treatment and drugs

The Insured Person is not covered for costs relating to investigations into or treatment of infertility and fertility, sterilisation (or its reversal) or assisted conception, except as covered under the Infertility Treatment benefit (Benefit 3.3) of the Optional Maternity Plan. The Insured Person is not covered for the costs in connection with contraception.

(25) Professional sports

The Insured Person is not covered for any costs resulting from injuries or illness arising from the Insured Person taking part in any form of professional sport.

(26) Sexual problems and gender re-assignment

The Insured Person is not covered for treatment costs relating to sexual problems including sexual dysfunction or gender re-assignment operations or any other surgical or medical treatment including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment. The Insured Person is not covered for the costs of treating sexually transmitted infections.

(27) Sleep-related disorders

The Insured Person is not covered for treatment costs for sleep-related disorder including but not limited to snoring, insomnia, jet-lag, fatigue or sleep apnoea, except for the Treatment of sleep apnoea which is life-threatening as confirmed by a Specialist and approved by us in advance.

(28) Transportation / accommodation costs

The Insured Person is not covered for transport or accommodation costs the Insured Person incurs during trips made specifically to get medical treatment unless these costs are for an Emergency medical Evacuation that we pre-authorise, except as provided under the Private Land Ambulance benefit (Benefit 1.16) of the Basic Plan. The Insured Person is not covered for any costs of Emergency medical Evacuation or repatriating the Insured Person's body that we did not pre-authorise and arrange.

(29) Travelling against medical advice

The Insured Person is not covered for medical or other costs the Insured Person incurs if the Insured Person travels against the advice given by the Insured Person's treating Medical Practitioner.

(30) Treatment by an immediate family member, Insured Person himself/herself and related enterprise

The Insured Person is not covered for the costs of treatment by the Insured Person himself/herself, the Policyholder, anyone with the same residence as the Insured Person or who is a member of the Insured Person's immediate family or an enterprise owned by one of the above-mentioned persons.

(31) Treatment charges outside of our reasonable and customary range

We will not pay treatment charges when they are above the Reasonable and Customary Charges level.

(32) Circumcision

The Insured Person is not covered for the costs of circumcision and the treatment of any condition resulting directly or indirectly from, or as a consequence of circumcision except for the circumcision arising from Accident or balanitis.

(33) Alternative treatment

The Insured Person is not covered for alternative treatment including but not limited to acupressure, Tui Nai, hypnotism, rolfing, massage therapy, aromatherapy, except as covered under Speech Therapy, Oculomotor Therapy and Occupational Therapy benefit (Benefit 2.5), Traditional Chinese Medicine benefit (Benefit 2.6), Chiropractic, Acupuncturist, Osteopathic, Homeopath benefit (Benefit 2.7) and Dietician benefit (Benefit 2.8) of the Optional Out-patient Plan.

(34) Life support treatment more than ninety (90) days

We will not pay for treatment whilst the Insured Person has been staying in a hospital for more than ninety (90) continuous days if the Insured Person has suffered permanent neurological damage or is in a persistent vegetative state. For the purpose of this paragraph, "persistent vegetative state" means a condition of profound unresponsiveness, with no sign of awareness or consciousness or a functioning mind (even if the Insured Person can open his eyes and breathe unaided), and the Insured Person does not respond to stimuli such as calling his name, or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery.

(35) Smoking cessation

The insured person is not covered for costs for treatment resulting from dependency on nicotine unless it is a Treatment for Alcohol or Substance Abuse in the Recognised Centre (including detoxification) benefits (Benefit 1.22) of the Basic Plan.

(36) Sanctions exclusion provision

We and other service providers will not provide cover or pay claims under this Policy if doing so would expose us or the service provider to a breach of international economic sanctions, laws or regulations, including but not limited to those provided for by the European Union, United Kingdom, USA or under a United Nations resolution.

(37) Mental disorder

The Insured Person is not covered for any costs for treatment resulting directly or indirectly from mental disorder, psychological or psychiatric conditions, behavioral problems or personality disorder, except as covered under Psychiatric and Psychological Treatment benefit (Benefit 1.8) of the Basic Plan and Psychiatric and Psychological Treatment benefit (Benefit 2.9) of the Optional Out-patient Plan.

Levy collected by the Insurance Authority has been imposed on this policy at the applicable rate. For further information, please visit www.axa.com.hk/ia-levy or contact AXA at (852) 2867 8611.

Important Notes:

The above policy is underwritten by **AXA General Insurance Hong Kong Limited ("AXA")**, which is authorised and regulated by the Insurance Authority of the Hong Kong SAR. AXA will be responsible for providing your insurance coverage and handling claims under your policy. The Hongkong and Shanghai Banking Corporation Limited is registered in accordance with the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong) as an insurance agent of AXA for distribution of general insurance products in the Hong Kong SAR. General insurance plans are products of AXA but not HSBC.

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