中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED
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BOC MEDICAL COMPREHENSIVE PROTECTION PLAN (SERIES 1) POLICY

WHEREAS THE POLICYHOLDER by a proposal and declaration, in either verbal or written basis which shall be the basis of this contract and is deemed to be incorporated herein has applied to BANK OF CHINA GROUP INSURANCE COMPANY LIMITED. (hereinafter called "the Company") for the insurance hereinafter contained and has paid the premium as consideration for such insurance.

NOW THIS POLICY witnesses that subject to the terms, exclusions, conditions, limit of liability contained herein, affixed hereto or endorsed herein (all of which are deemed to be incorporated herein and collectively referred to as the Terms of this Policy), the Company agrees to indemnify the Policyholder in respect of any or all the benefit items hereinafter mentioned happening during the Period of Insurance.

Provided always that the truthfulness, accuracy and completeness of all information provided or declared in the proposal and declaration by the Policyholder and the Insured Person, the due observance and fulfillment by the Policyholder and the Insured Person of all the terms and conditions of the Terms of this Policy shall be a condition precedent to any liability on the part of the Company under this Policy.

For the purpose of this Policy and where the context permits, words importing the singular number only also include the plural and vice versa, words importing the masculine gender only also include the feminine and vice versa.

PART I – GENERAL DEFINITIONS

Any of the following words and expressions to which a specific meaning has been attached in this Policy, the Schedule, endorsement and any memoranda shall bear such specific meanings wherever it may appear.

1. **Accident:** means an unforeseen and unexpected event of violent, accidental, external and visible nature, which shall independently of any other cause be the sole cause of bodily Injury.
2. **Annual Overall Limit:** means the maximum aggregate sum of the benefit under PART II Section 1 - Basic Benefit item A for which the Insured Person aged seventy-six (76) or above is covered under this Policy during the twelve (12) months commencing from the effective date of this Policy or, during any twelve (12) months period measured from the anniversary date of this Policy.
3. **Medical Card/ Assistance Card**
   (1) Medical Card means the "BOC Medical Comprehensive Protection Plan (Series 1) Medical Card" issued by the Company to each Insured Person. This Card serves as an identity for the Insured Person to be entitled Out-patient Services by Network Services Providers (only if Part II Section 2 – Optional Benefit D "Out-patient Benefit" is covered & shown on the Schedule of this Policy) and Hotline service provided by "24-Hour Worldwide Emergency Assistance Service".
   (2) Assistance Card means the "BOC Medical Comprehensive Protection Plan (Series 1) Assistance Card" issued by the Company to the Insured. This Card serves as an identity for the Insured Person to be entitled to Hotline service provided by "24-Hour Worldwide Emergency Assistance Service".
4. **Child:** means in respect to a person, his legal child, including step child, adopted child or guardian child.
5. **Chinese Medical Practitioner:** means a listed or registered Chinese medical practitioner under the Chinese Medicine Ordinance of Hong Kong, Cap.549 or duly qualified practitioner of Chinese medicine registered as such under the laws of the country in which the claim arises and where the treatment takes place but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
6. **Congenital Conditions:** means medical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (6) months of birth. They shall include (but not limited to the exclusion of others which may medically be regarded as congenital conditions) Hernias of all types (except caused by a trauma after the effective date of this Policy); Strabismus; Hydrocephalus; Undescended testicle; Hypospadias; Meckel's diverticulum; cleft palate, clubfoot, birthmark, bone or muscle developmental abnormality, cerebral palsy, etc.
7. **Day of Hospital Confinement:** means each continuous twenty-four (24) hours period that the Insured Person is confined as a Resident In-patient in Hospital.
8. **Disability:** means Injury, Sickness and shall include all disabilities arising from the same cause including any and all complications arising therefrom, except that where no further Medical Services for the said disability is required within ninety (90) days following the latest Medical Services, any subsequent disability from the same cause shall be considered a different disability.
9. **Eligible Expenses:** means any expense incurred for Medical Services in respect of a covered Disability, that shall be reimbursed by the Company, but shall not exceed the actual charges incurred and the relevant maximum benefit limits as specified in the Schedule and the Limit of Indemnity Table of this Policy..
10. **Emergency:** means an event or a situation that treatment is needed immediately in order to prevent death or permanent impairment of the Insured Person's health.
11. **Hong Kong:** means the Hong Kong Special Administrative Region of the People's Republic of China.
12. **Hospital:** means a legally constituted establishment operated pursuant to the laws of the country in which it is based, and meeting all of the following requirements in that it:
    (1) operates primarily for the reception and medical care and treatment of sick, ailing or injured persons on an In-patient basis;
    (2) admits In-patient only under the supervision of a Physician or Physicians one of whom is available for consultation at all times;
    (3) maintains organized facilities for medical diagnosis and treatment of such persons, and provides (where appropriate) facilities for major surgery within the confines of the establishment or in facilities controlled by or available to the establishment;
    (4) provides full-time nursing service by and under the supervision of a staff of nurses;
    (5) maintains a legally licensed Physician in residence;
    (6) if in the Mainland China, the establishment has to be above the county level and operates under Western medical practices.

    "Hospital" shall not include the following:
    (1) a mental institution; an institution confined primarily to the treatment of psychiatric disease including sub-normality; the psychiatric department of a Hospital;

(2) a place for the aged; a rest home; a place for drug addicts or alcoholics;
(3) a health hydro or nature cure clinic; a nursing or convalescent home; a special unit of a Hospital used primarily as a place for drug addicts or alcoholics, or as a nursing, convalescent, rehabilitation, extended-care facility or rest home;
(4) establishment operates under Chinese medical practices.

13. **Hospital Confinement:** means confinement in a Hospital which must be for a minimum period of six (6) consecutive hours before any Medical Benefits hereunder are payable, except that no minimum period of hospital confinement is required in respect of any expenses incurred at a Hospital in connection with any Emergency treatment required as a result of (and within twenty four (24) hours following) an Injury or in respect of fees charged by a Registered Medical Practitioner for the performance of a surgical procedure or operation, or in respect of an operation received in a clinic or in a recognized "Day Care Surgical Centre" owned and operated as such by a Hospital.
14. **Injury:** means an abnormal bodily condition caused solely and directly by Accident and independent of any other cause and not therefore due to Sickness or disease.
15. **In-patient:** means the Insured Person confined in a Hospital and occupies a bed for a minimum period of six (6) consecutive hours, except that no minimum period of Hospital Confinement is required in respect of an operation incurred at a clinic or a recognized "Day Care Surgical Centre" owned and operated as such by a Hospital.
16. **Insured:** a legal resident of Hong Kong aged eighteen (18) years old or above who applies for this Policy and in whose name the Policy is issued and appeared as the Insured in the Schedule or endorsement.
17. **Insured Person:** means the insured person(s) named in the Schedule or endorsement and who is a legal resident of Hong Kong and is the Insured's legal spouse; or the Insured's Child.
18. **Insured Plan:** means the insured plan covered by each Insured Person under this Policy and shown in the Schedule.
19. **Intensive Care Unit:** means a section with a Hospital which is designated as an intensive care unit by the Hospital providing one to one nursing care, in which patients undergo specialized resuscitation, monitoring and treatment procedures. The unit must be staffed twenty-four (24) hours a day with highly trained nurses, technicians and doctors, and be equipped with resuscitative equipment and monitoring devices that allow continuous assessment of vital body functions such as heart rate, blood pressure and blood chemistry.
20. **Maternity:** means any condition arising out of or during any one pregnancy, childbirth or miscarriage or any complication arising from the same (but excluding induced abortion and except where it is medically necessary).
21. **Medical Benefits:** means the benefits provided under this Policy in Part II in respect of medical expenses. Such expenses must be incurred by the Insured Person as a result of Injury; Sickness; disease or illness.
22. **Medically Necessary:** means the necessity to have a Medical services which are:
    (1) consistent with the diagnosis and customary medical treatment for the condition; and
    (2) in accordance with standards of good and prudent medical practice; and
    (3) not for the convenience of the Insured, the Insured Person, or any person coming within the meaning of General Definition items 30 and 34 below; and
    (4) performed at a Reasonable and Customary charge on treatment of a covered Disability.
    (5) Performed in the least costly Setting required for treatment of a covered Disability.

    Experimental, screening test and preventive services or supplies are not considered Medically Necessary.
23. Medical Services: means Medically Necessary services, including, as the context requires, Confinement, treatment, procedure, test, examination or other related services for the investigation or treatment of a Disability.
24. **Overseas:** means territories other than Hong Kong Special Administrative Region.
25. **Place of Residence:** means the place whereby the Insured Person will live for at least six (6) months in the same place within Policy Year and as declared in the proposal form or written notice of change.
26. **Policy:** means all the Terms and Conditions contained herein, including the Schedule, endorsements and attachments thereto and, if applicable by stipulation in the Schedule, the Company's Classification Schedule of Surgical Operations ("the Classification Schedule"), as may be supplied with this Policy or as published or notified to the Insured from time to time.
27. **Policy Year:** means each continuous twelve (12) months period starting from the effective date of this Policy.
28. **Pre-existing Medical Conditions:** means
    (1) Sickness or Injury which existed before the effective date of the Policy and/or the benefit cover in respect of the Insured Person and which presented signs or symptoms of which the Insured Person was aware of or should reasonably have been aware of; or
    (2) any of the following and whether or not the Insured Person has any prior knowledge occurring during one (1) year from the effective date of this Policy and/or the benefit cover:
        i. Diseased tonsils requiring surgery;
        ii. Tumors of organs;
        iii. Haemorrhoids;
        iv. Abnormality of nasal septum or turbinates;
        v. Thyroid Disorders;
        vi. Endometriosis;
        vii. Sinus conditions requiring surgery;
        viii. Cataracts;
        ix. Hernia; or
    (3) any of the following and whether or not the Insured Person has any prior knowledge occurring during the first six (6) months from the effective date of this Policy and/or the benefit cover:
        i. Tuberculosis;
        ii. Gall stones;
        iii. Calculi of kidney, urethra or bladder;
        iv. Anal fistulae;
        v. Hypertension, cardiac disease or vascular disease;
        vi. tumors of skin, muscular tissue, bone tumors or malignancies of blood or bone marrow;
        vii. Hallux valgus;
        viii. Gastric or duodenal ulcer;
        ix. Diabetes mellitus.
29. **Qualified Nurse:** means any nurse legally qualified and authorized to render nursing services, having qualifications at least equivalent to "Registered Nurse" or "Enrolled Nurse" of Hong Kong and should a claim and Medical Services occur outside Hong Kong shall mean a nurse who is duly registered as such under the laws of the country in which the claim arises and where Medical Services take place, but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
30. **Reasonable and Customary:** means, in relation to fees, a sum not exceeding a reasonable average of the fees charged under similar conditions by persons of equivalent experience and professional status in the area in which the service was provided; and in relation to material or services, shall mean a sum not exceeding a reasonable average of the charges for similar material or services in equivalent circumstances of quality and economic consideration in the same area as that in which any such material or services were obtained.
31. **Registered Medical Practitioner; Surgeon; Physician; Doctor; Anaesthetist:** means a person duly qualified and legally registered as such to practice western medicine in Hong Kong, and should a claim and Medical Services occur outside Hong Kong, shall mean a practitioner of western medicine who is duly registered as such under the laws of the country in which the claim arises and where Medical Services take place, but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
32. **Schedule:** means this Policy schedule, which is attached to and forms part of this Policy.
33. **Setting:** means a Hospital out-patient department, Hospital accommodation or clinical services as appropriate for

treatment.

34. **Sickness:** means sickness contracted and commenced while the Insured Person whose sickness or diseases is the basis of a claim is covered under this Policy, and shall exclude any Pre-existing Medical Conditions as defined in this Policy. Such sickness must result directly and independently of all other causes in Hospital Confinement of such Insured Person.
35. **Specialist:** means a person who has completed western specialist course and been granted a qualified specialist certificate and is licensed to legally practice as particular medical specialists in Hong Kong, and should a claim and Medical Services occur outside Hong Kong, shall mean a practitioner who has completed western specialist course who is duly registered as such under the laws of the country in which the claim arises and where Medical Services take place, but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
36. **You, Your or Yourself:** means the Insured and/or the Insured Person.

PART II – INSURED BENEFITS

The Company shall pay Medical Benefits for Medically Necessary expenses in accordance with the scope of cover provided herein below but each Insured Person's benefit shall be subject to the maximums (or maximum percentage), the limits, the respective covered benefits of the Insured Plan as applicable and as specified in the Schedule and the "Limit of Indemnity" table of this Policy.

Section 1 - Basic Benefits

A. <u>Hospital and Surgical Benefits</u>

1. **Room and Board Fee**
   Benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured Person is registered as an In-patient in a Hospital for the Medical Services of a Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the actual and reasonable charges made by the Hospital in respect of Room and Board during the Insured Person's Hospital Confinement.
2. **Physician's Visits Fee**
   If the Insured Person on any day of a Hospital Confinement shall be necessarily treated by a Registered Medical Practitioner, benefit shall be payable in an amount equal to the charges made in respect of the attending Physician's visit fees.
3. **Hospital Services Fee**
   Hospital Services benefit shall be payable during the time the Insured Person is registered and staying as an In-patient in a Hospital for Medical Services of a Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the normal, proper and actual charges made by the Hospital in respect of Hospital Services during the Insured Person's Hospital Confinement.
   Hospital Services shall include the following, except where deleted or omitted from coverage or specified to the contrary in the Schedule:
   (1) Administration of blood or blood plasma, but not the cost of blood or blood plasma;
   (2) Ambulance services to and/or from the Hospital;
   (3) Anaesthesia and oxygen and their administration;
   (4) Basal metabolism test;
   (5) Dressing, ordinary splints and plaster casts;
   (6) Drugs and medicines consumed during the Hospital Confinement;
   (7) Electrocardiograms;
   (8) Films & X-rays and their interpretation & special diagnostic procedures such as computerized tomography;
   (9) Intravenous infusions;
   (10) Laboratory examinations;
   (11) Physiotherapy.
4. **Surgical Expenses**
   Surgical expenses benefit shall be payable in an amount equal to the surgical fees actually charged by Surgeon for surgical operation(s) performed in respect of a Disability including the fees for two (2) pre-surgical assessments and normal post-surgical care and post surgical Medical Services by registered Chinese Medical Practitioner within six (6) weeks after discharged from Hospital. This benefit would settle the surgical fees first, the charges for pre-surgical and post-surgical consultation would be settled under the balance amount if any.
   Surgical Fees where applicable will be paid in accordance with the Company's "Classification Schedule of Surgical Operations ("the Classification Schedule")" supplied with this Policy or as may be published or notified by the Company to the Insured from time to time. The Company shall have absolute discretion and liberty to revise or amend the Classification Schedule or any part thereof as it may consider appropriate or necessary from time to time. If the operation performed is not shown in the Classification Schedule, the Company shall have absolute discretion to determine the classification or the percentage for such operation and such determination shall be final and binding. An operation of equivalent severity, difficulty and complexity will be used by the Company as a basis for this determination.
   If two or more procedures are performed through a single incision, reimbursement for expenses for all such procedures shall not exceed the amount indicated for the one surgical procedure performed that incurs the largest amount of expenses. If more than one surgical procedure is to be performed at the same surgical session through different incisions, the Company will pay up to 150% fees of the complex operation in accordance with the Classification Schedule. If more than one surgical operation is to be performed during one Hospital Confinement, reimbursement for expenses for all such procedures shall not exceed the amount indicated for the one surgical procedure performed that incurs the largest amount of expenses. If there are two or more operations to be performed in one disability, the amount payable for all such operations will be calculated on the basis of these operations amongst which only the largest surgical operation according to the "Classification Schedule", but the sum amount payable will not exceed the fees actually charged or the maximum limit in the Benefit Schedule provided for the relevant classification of such the largest surgical operation, whichever is the lesser.

   If any alternative procedure including X-ray, radium or any other radioactive substances are used for Medical Services in place of any cutting operation listed in the Classification Schedule, the Company will, subject to all of the other provisions for "Surgical Benefit", pay a benefit which is Reasonable and Customary for such Medical Services up to the amount provided in the Schedule with reference to the Classification Schedule.
   Any Surgical Fees to be reimbursed must be incurred for services rendered by a Registered Medical Practitioner qualified to render the surgical service for which the claim is made and must be Eligible Expenses.
   Payments made under this surgical benefit provision shall be in lieu of all benefits otherwise payable for the same Medical Services under any other benefits provisions of this Policy.
5. **Operating Theatre Fee**
   Benefit shall be payable for the use of the operating theatre for the carrying out of any surgical procedure during the Insured Person's Hospital Confinement.
6. **Anaethetist's Fee**
   Benefit shall be payable in an amount equal to the actual charges made as a result of Insured Person using the service of Anaesthetist for surgical procedure.
7. **Specialist's Fee**
   Benefit shall be payable in an amount equal to the actual charges made by a Specialist to whom the Insured Person has been referred by a Registered Medical Practitioner during the Insured Person's Hospital Confinement.
8. **Intensive Care Fee**
   Benefit shall be payable for the actual Hospital charges incurred as a result of the Insured Person being accommodated in an Intensive Care Unit recommended by the Doctor in charge. Benefit shall be payable in an amount equal to the actual charges made for Medical Services in an Intensive Care Unit. If the Insured Person suffers from infectious disease, need mandatory isolated by government

authority and being confined to Hospital to receive Medical Services in an Intensive Care Unit, the maximum limit of Intensive Care Benefit shall be doubled automatically. Payments made under this provision shall be in lieu of any Room and Board benefits for such Medical Services.

9. **Post-Hospitalisation Treatment Fee**
   Benefit shall be payable for all related follow-up visits that is recommended by the attending Registered Medical Practitioner within six (6) weeks immediately after discharged from Hospital or post-clinical surgery.
10. **Extra Bed Accommodation Fee**
    An extra-bed accommodation benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured Person is registered as an In-patient in a Hospital for the Medical Services of a Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the actual charges made by the Hospital in respective of providing such service.
11. **Accidental Emergency Out-patient Treatment Expenses**
    If the Insured Person sustains Injury and receives outpatient Medical Services in a Hospital within twenty-four (24) hours of the Accident and incurs charges thereof, the Company will pay for the Reasonable and Customary charges made by the Hospital.
12. **Home Nursing Fee**
    Home Nursing Fee shall be payable when the Insured Person incurs Eligible Expenses for services rendered by a Qualified Nurse in respect of nursing care at the Insured Person's home for such period or periods recommended by a Registered Medical Practitioner after discharged from the Hospital. Benefit shall be payable in an amount equal to the actual charges for such services.
    The coverage provided under this item does not apply to charges for:
    (1) a nursing service provided by more than one nurse during any one consecutive twenty-four (24) hours period;
    (2) any nursing service or Medical Services by physical therapy or any medical check-up by X-ray examination or any other means which are purely for diagnostic purposes;
    (3) nursing service rendered for geriatric, psycho-geriatric or psychiatric condition.
13. **Medical Appliances (Specific Items)**
    If the Insured Person is as an Inpatient during Hospital Confinement, the Company shall reimburse the Eligible Expenses incurred up to the maximum benefit limit specified in the Limit of Indemnity Table of this Policy for the following items:
    (1) pace maker;
    (2) stents for Percutaneous Transluminal Coronary Angioplasty;
    (3) intraocular lens;
    (4) artificial cardiac valve;
    (5) metallic or artificial joints for joint replacement;
    (6) prosthetic ligaments for replacement or implantation between bones; and
    (7) prosthetic intervertebral disc.
14. **Chemotherapy/Radiotherapy/Targeted Therapy/Proton Therapy/Immunotherapy/Hormonal Therapy/Gamma Knife/ Cyber Knife/ Renal Dialysis Treatment Expenses**
    This benefit shall be payable for the Eligible Expenses charged on the Radiotherapy, Chemotherapy, Targeted therapy, Proton therapy, Immunotherapy, Hormonal therapy, Gamma knife and Cyber knife performed during Confinement or in a setting for providing Medical Services to a day patient, outpatient consultation by a Specialist in treatment planning, and monitoring of prognosis and development during the course of Radiotherapy, Chemotherapy, Targeted therapy, Immunotherapy and Hormonal Therapy.

    If the Insured Person is suffering from chronic and irreversible renal failure, this benefit shall be payable for the Eligible Expenses incurred for hemodialysis for Inpatient a day patient as recommended in writing by Physician.
15. **Cash Allowance for Health Supplement Food**
    Special daily cash allowance benefit shall be payable from the 8th day onward when, upon recommendation of a Registered Medical Practitioner, the Insured Person is confined in a Hospital and requires surgical operation Medical Services of a Disability and incurs charges thereof.
16. **Special Cash Allowance for Public Hospital in Hong Kong**
    Special daily cash benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured Person is registered as an In-patient in a general ward bed only of public Hospital in Hong Kong (Hong Kong Government Hospital, Hospitals under the supervision of Hospital Authority or a subsidized charity Hospital) for the Medical Services of a Disability and incurs charges thereof. In no event shall the benefit be paid in addition to any other benefits payable under this "PART II Section 1 - Basic Benefit item A" with the exception of item A15 (Cash Allowance for Health Supplement Food) for any one Disability.
17. **Compassionate Death Benefit**
    Benefit shall be payable when the Insured Person is confined to a Hospital as a result of Accident and died during the confinement period. In the absence of beneficiary designation, benefit shall be payable to the Insured Person's legal estate.

Annual Overall Limit for benefit under Hospital and Surgical Benefits

If the Insured Person attained the age of seventy-six (76), upon the coming and all other subsequent renewal Policy Years, maximum benefit payable for the sum total of all the benefits items under PART II Section 1 – Basic Benefit item A "Hospital and Surgical Benefits" shall not exceed the Annual Overall Limit as set forth in the Schedule and the "Limit of Indemnity" table of this Policy.

Plan 4 (Medical top-up plan)

This plan can be renewable up to seventy (70) years old only.

Benefit shall be payable when the Insured Person is registered as an In-patient in a Hospital or in a recognized day care centre owned and operated by a Hospital for the Medical Services of a Disability and incurs Eligible Expenses. The Company shall pay the incurred Eligible Expenses which are unsettled by other valid Hospital & Surgical insurance owned by the Insured Person and the Company shall not return the original documents including but not limited to the hospital bills and receipts for any settled claim.

B. <u>Supplementary Major Medical Benefit</u> (This benefit is applicable if so stated in the Schedule)

This benefit provision serves to act as a supplement to "PART II Section 1 - Basic Benefit item A" above and can be renewable up to seventy-five (75) years old only.

When the Insured Person is registered as an In-patient in a Hospital and incurs Medically Necessary expenses, for each particular basic benefit under "PART II Section 1 - Basic Benefit item A", the Company shall pay supplementary major medical benefit in accordance with the percentage as stated in the Schedule and the "Limit of Indemnity" table of this Policy and only in excess of the benefit payable under "PART II Section 1 - Basic Benefit item A". In the event that the actual Hospital charges for daily Room and Board is higher than the benefit provided under "PART II Section 1 - Basic Benefit item A" in this Policy, calculation of claims payment shall be subject to both the percentage as stated in the Limit of Indemnity Table and the proportion of the maximum daily limit covered under this item in this Policy bears to the actual amount of daily Room and Board charged by the Hospital.

The Formula shall be expressed as follows:

{Eligible Expenses x adjustment factor }

x the percentage as stated in the Limit of Indemnity Table

subject to the maximum benefit per any one disability

An adjustment factor shall apply if the Insured Person's average daily room and board charges incurred during such hospitalization is higher than the daily Room and Board Benefit set forth in the Benefit Schedule. All Eligible expenses payable under this Supplementary Major Medical Benefit shall first be multiplied by the adjustment factor and

then multiplying the percentage as stated in the Limit of Indemnity Table

The adjustment factor shall be as follows:

Daily Room & Board Benefit Set forth in the Benefit Schedule ÷ Average daily room and board charges incurred during Hospitalization

This item is not applicable to:

1. Hospital and Surgical treatment outside Mainland China, Hong Kong (China) and Macau (China) except in the case of Accidents or Emergencies occurring Overseas as certified by a Registered Medical Practitioner or the Company has adjusted the premium in accordance with the Place of Residence.
2. PART II Section 1 - Basic Benefit item A sub-item 1-2, 9-16"; and fees for two pre & post surgical care by Surgeon and Chinese Medical Practitioner as stated in first paragraph of PART II Section 1 - Basic Benefit item A sub-item 4; or
3. any charges not covered under Maternity benefit described in "PART II Section 2 - Optional Benefit item F" below.

C. <u>Hospital Cash Benefit</u> (This benefit is applicable if so stated in the Schedule)

This benefit can be renewable up to sixty (60) years old only.

When Sickness or Injury shall cause the Insured Person's Hospital Confinement and provided that such Hospital Confinement shall commence whilst insurance under this Policy is in effect with respect to such Insured Person, the Company will pay the relevant Hospital Cash Benefit for each Day of Hospital Confinement the Insured Person shall be so confined.

Provisions:

1. Benefit shall be payable for each Day of Hospital Confinement only when the Insured Person is under the regular care and attendance of a Physician.
   Benefit shall be payable from the first Day of Hospital Confinement for a period not exceeding the number of days as set forth in the "Limit of Indemnity" table of this Policy as in total for all Hospital Confinements both in and outside Hong Kong consequence upon any one or all Sickness or Injuries together. Hospital Confinement outside Hong Kong will be limited to the number of days as set forth in the "Limit of Indemnity" table of this Policy for each Policy Year.
2. If Hospital Confinement incurs in the Mainland China, Insured Person will only be entitled to half of the amount of the Hospital Cash Benefit.
3. Recurrent Hospital Confinement
   (1) Hospital Confinement of the Insured Person, commencing while insurance under this Policy and/or this benefit cover is in effect with respect to such Insured Person, resulting from causes which are the same as, or related to, the causes of a prior Hospital Confinement for which Hospital cash benefit(s) has been payable and not separated from such prior Hospital Confinement by a period of at least six (6) months, shall be considered a continuation of the prior Hospital Confinement. Such Hospital Confinements shall be considered to have occurred during the same period of Sickness or to have resulted from the same Injury for the purpose of determining the relevant Hospital cash benefit period and the maximum Hospital cash benefit payable under this Policy except as provided in provision 5 below.
   (2) Hospital Confinements separated by a period of six (6) months or more shall be considered to be separated Hospital Confinements and shall not be considered to have occurred during the same period of Sickness or to have resulted from the same Injury for the purpose of determining the relevant Hospital cash benefit period and the maximum Hospital cash benefit payable under this Policy.
   (3) For the purpose of above paragraph (1) to (2) in this provision 3, the six (6) months period shall start counting from the next day following the Insured Person being discharged from Hospital Confinement for which Hospital cash benefit has been payable.
4. Except as provided in "Part VII - Section 1", Hospital cash benefit under this Policy shall be paid in addition to any other insurance benefit to which the Insured Person may be entitled.
5. Notwithstanding the foregoing, in the event of
   (1) Insured Person is confined in the Intensive Care Unit (maximum benefit payable up to ninety (90) days);
   (2) Insured Person has received major organ transplant surgery including heart, heart and lung, liver, pancreas, kidney or bone marrow or first diagnosed with cancer disease in the Hospital;
   (3) Insured Person is suffered from the following defined infectious diseases including malaria, cholera, meningococcal infection, dengue fever, tetanus or atypical pneumonia but not limited to COVID-19 and require Hospital Confinement (maximum benefit payable up to thirty (30) days for each infectious disease);
   (4) Insured Person temporary leaving Hong Kong not exceeding sixty (60) days and require Hospital Confinement during this period (excluding Hospital Confinement in the Mainland China or Macau (China) (maximum benefit payable up to thirty (30) days);
   (5) the Insured Person and insured legal spouse are hospitalised at the same time as a result of the same Accident;

   double Hospital cash benefit will be payable. Double Hospital cash benefit in respect of any one Day of Hospital Confinement shall not exceed twice the Hospital cash benefit and in any case shall not exceed the number of days as set in this benefit in total for all Hospital Confinements in and outside Hong Kong (China).

Section 2 - Optional Benefits (each of the below benefit is operative if so stated in the Schedule)

D. <u>Out-Patient Benefit</u>

Benefit will be payable in accordance with the below provisions if Medically Necessary, the Insured Person requires the below Out-patient Services from Network or Non-network Services Provider.

Out-patient Services includes:

1. General Practitioner Consultation

Registered Medical Practitioner consultations for treatment of covered Disabilities rendered by the Network Services Provider or Non-network Services Provider shall be covered unless otherwise restricted by this Policy. The benefits covered shall include consultations and maximum of three (3) days' prescribed basic medication from the Registered Medical Practitioner for treatment provided that no more than one (1) visit or one (1) call per day is incurred. A Co-payment may be required to be paid to the Provider directly by the Insured Person at the time of treatment.

2. Specialist Consultation

Specialist Fees for treatment of covered Disability rendered by Network Service Provider or Non-network Services Provider which have been referred in advance and in writing by a Registered Medical Practitioner shall be covered provided that no more than one (1) Specialist treatment, visit or consultation per day shall be incurred. The benefits covered shall include consultations and maximum of five (5) days' prescribed basic medication from the Specialist for treatment. A Co-payment may be required to be paid to the Provider directly by the Insured Person at the time of treatment.

3. Chinese Medical Practitioner Consultation

Chinese medical consultation, bone-setting and acupuncture treatment of covered Disability rendered by Network Services Provider or Non-network Services Provider shall be covered unless otherwise restricted by this benefit cover provided that no more than one (1) treatment, visit or consultation per day shall be covered. The benefits covered shall include

consultations and prescribed medicines or drugs from the Chinese Medical Practitioner for treatment. A Co-payment may be required to be paid to the Provider directly by the Insured Person at the time of treatment.

4. **Physiotherapy and Chiropractic Treatment**
   Physiotherapy and chiropractic treatment directly administered by Physiotherapist and / or Chiropractor of covered Disability rendered by Network Services Provider or Non-network Services Provider which have been referred in advance by a Registered Medical Practitioner in writing shall be covered provided that no more than one (1) treatment, visit or consultation per day shall be incurred.
5. **Diagnostic X-ray and Laboratory Tests**
   Diagnostic X-ray and laboratory tests rendered by Network Services Provider or Non-network Services Provider shall be covered when recommended by a Registered Medical Practitioner in writing in respect of a covered Disability. This service shall include X-rays, electrocardiographs (ECG) and simple diagnostic tests.

Provisions:

1. **Network Services Providers**
   (1) The Insured Person may elect for the Network Services Providers to obtain Out-patient Services. Details of the Network Services Providers have been supplied to the Insured Person together with the Policy at the Policy or such cover commencement date.
   (2) It will be the Company's responsibility to pay the fees and charges of the Out-patient Services rendered by the Network Services Provider for the Insured Person. The Insured Person shall be required to pay the Network Services Providers any fee or charge of the Out-patient Services that exceeds the maximum Benefit Limits stated in the Schedule, and the Co-payment.
   (3) The Company shall not be responsible for any fee paid by the Insured Person to the Network Services Providers unless otherwise specified.
   (4) The Company shall issue a Medical Card to the Insured Person. Such Medical Card shall be used solely by the cardholder to identify himself for receiving the Out-patient Services at the Network Services Provider.
   (5) To use Network Service the Insured Person shall
      i. make appointment with the Network Services Provider in advance; and
      ii. present his valid Medical Card to the Network Services Provider upon registration at the place of services; and
      iii. arrange consultations during the Network Services Provider's clinical hours;
   (6) It is recognized and agreed that in the event the Insured Person elects for Network Services, such election is made freely and of the own accord of the Insured Person making the election. No representation whatsoever as to the suitability, availability or ability of the Network Services Provider is made by or may be implied on the part of the Company and the Company shall bear no responsibility or obligation, whether contractual or otherwise, in respect of any services or benefits rendered by, or any act, omission, default or negligence on the part of such Network Services Providers, their servants or agents. It is accepted and agreed by the Insured and/or Insured Person that such Network Services Providers shall be rendering services or benefits as independent contractors and not as servants or agents of the Company.
   (7) Unless otherwise specified, any medication other than basic medication, for example expensive medication including but not limited to certain specific treatments, anti-viral agents, treatment or medication for Chronic Illness , are not covered.
2. **Non-network Services Providers**
   (1) If the Out-patient Services are provided by the Non-network Services Providers, the Insured Person shall pay the fees and charges of the Out-patient Services rendered by the Non-network Services Providers first and shall submit his claim for reimbursement to the Company within ninety (90) days after the date of treatment for the Disability for which the claim is being made.

Definition under this "Optional Benefit D - Out-patient Benefit"

1. **Chiropractor:** means a registered Chiropractor under the "Chiropractors Registration Ordinance" of Hong Kong or duly qualified practitioner of Chiropractor registered as such under the laws of the country in which the claim arises and where the treatment takes place but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
2. **Co-payment:** means a fixed fee or percentage portion of costs (as stated in the Schedule and the "Limit of Indemnity" table of this Policy and as may be varied by the Company from time to time) the Insured Person must contribute towards the cost of medical services received.
3. **Long Term Repeat Medication:** means medication prescribed to the Insured Person required for at least fourteen (14) days period.
4. **Network Doctor Directory:** as case may be, shall contain lists of Network Services Providers. The Company reserves the right to update this directory at its own discretion without prior notice.
5. **Network Services:** means the clinics of the health care services Providers listed in Network Doctor Directory.
6. **Non-network Services:** means the clinics of the health care services Providers not listed in Network Doctor Directory.
7. **Out-patient Services:** means those services listed in PART II Section 2 - Optional Benefits D "Out-patient Benefit" of this Policy.
8. **Physiotherapist:** means a person duly qualified and legally registered as such to practice Physiotherapy treatment in Hong Kong or a duly qualified Physiotherapist registered as such under the laws of the country in which the claim arises and where the treatment takes place but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
9. **Provider:** means, wherever the content admits, any Doctor, Registered Medical Practitioner, Qualified Nurse, Specialist and Chinese Medical Practitioner as defined under Part 1 - General Definition in this Policy.
10. **Specialized Investigations:** means those X-ray investigations, using contrast media such as Ba Meal, intravenous pyelogram etc. Advanced imaging including but not limited to computerised axial tomography scan, magnetic resonance imagingscan, positron emission tomography scan, investigations involving radioactive substance.
11. **Chronic Illness:** means any diseases and disorders, with or without signs and symptoms, that persists more than three (3) months and which require regular medical attention, including but not limited to
    - AIDS
    - Allergic Rhinitis
    - Alzheimer's Disease
    - Arthritis
    - Asthma
    - Cancer
    - Chronic Bronchitis
    - Chronic Eczema
    - Chronic Hepatitis
    - Coronary Heart Disease
    - Diabetes Mellitus
    - Gout
    - Heart Disease
    - Heart Failure
    - Hyperlipoidema
    - Hypertension
    - Hyperthyroidism
    - Hypothyroidism
    - Mental Illness & Psychiatric Disorder
    - Onychomycosis
    - Parkinson's Disease
    - Psoriasis
    - Renal Failure
    - Systemic Lupus Erythematosus

Exclusions under this "Optional Benefit D - Out-patient Benefit"

Cover will not be provided for any Out-patient Services directly or indirectly caused by or arising from or in connection with

1. any Long Term Repeat Medication;
2. any medication only on request by the Insured Person including but not limited to medication supply for visiting a malarial area;
3. Specialized Investigations;
4. minor surgical procedures;
5. Chronic Illness.

E. Dental Benefit

The Company will reimburse necessary expenses incurred if the Insured Person requires services from the below Dental Benefits**.**

Dental Benefit includes:

1. Intra-oral small film radiograph
2. Scaling, polishing and prophylaxis
3. Fillings or extraction
4. Drainage of abscess
5. Root canal fillings

Definitions under this "Optional Benefit E – Dental Benefit"

1. **Dental Abnormalities or Conditions:** means a dental condition marked by a pathological deviation from the normal healthy state.
2. **Dental Benefit:** means the benefits provided under this benefit item in respect of dental expenses. Such expenses must be incurred by the Insured Person as a result of Injury, Dental Abnormalities or Conditions.
3. **Dentist:** mean a person duly qualified and legally registered as such in Hong Kong and should a claim and dental treatment occur out of Hong Kong, the term shall mean a practitioner of dentistry who is duly registered as such under the laws of the country in which the claim arises and where dental treatment takes place; but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.

Exclusions under this "Optional Benefit E – Dental Benefit"

Cover will not be provided for any dental expenses directly or indirectly caused by or arising from or in connection with the following:

1. Filling for cosmetic reasons or non-decayed cases of trauma, erosion, attrition, abrasion and others;
2. Dislodged fillings/replacement not due to decay;
3. Treatment for orthodontics reason.

F. Maternity Benefit

This benefit is applicable for the Insured Person above eighteen (18) years old and can be renewable up to fifty (50) years old only.

Upon receipt by the Company of proof acceptable to the Company that the Insured Person has been confined in a Hospital by reason of Maternity and at the same time this benefit is provided or kept in force, the Company shall pay the following benefits:

1. **Caesarean Section**
   In so far as expenses are incurred for Medically Necessary services, the "Maternity Benefit" payable for Hospital Confinement by reason of Maternity requiring an abdominal cutting operation, such as "Caesarean Section or Extra-Uterine Pregnancy", shall be equal to the actual, Reasonable and Customary charges charged by the Hospital for Room and Board and Hospital Services, and any obstetrician's fee, excluding charges in relation to the newborn.
2. **Normal Delivery**
   For Hospital Confinement by reason of Maternity that do not require an abdominal cutting operation, the "Maternity Benefit" payable shall be equal to the actual, Reasonable and Customary charges charged by the Hospital for Room and Board and Hospital Services, and any obstetrician's fee, excluding charges in relation to the newborn.
3. **Miscarriage**
   In case of any miscarriage, the "Maternity Benefit" payable shall be equal to the actual, Reasonable and Customary charges charged by a Registered Medical Practitioner or Qualified Nurse involved in such miscarriage.

In calculating the amount of benefits payable herein above, all expenses during the pre-natal and post-natal periods relating to the same pregnancy shall be included. If the Insured Person becomes pregnant or gives birth to a Child within nine (9) months from the effective or reinstatement date of this benefit, whichever is the later, no "Maternity Benefit" shall be payable in respect of such pregnancy.

G. Critical Illness Benefit

This benefit is applicable for the Insured Person above eighteen (18) years old and can be renewable up to sixty (60) years old only**.**

Benefit will be payable if upon receipt of due proof and approval, the Insured Person is first diagnosed by a Registered Medical Practitioner as suffering from a Critical Illness. Notwithstanding that the Insured Person may suffer from more than one Critical Illness, the Critical Illness benefit and Systemic Lupus Erythematosus (SLE) will only be paid once in respect of each Insured Person.

Extended Benefits:

1. **Medical Expenses for Critical Illness**
   If the Insured Person incurs Medical Expenses directly and solely resulting from 1) Cancer 2) Stroke or 3) Cardiomyopathy after the first diagnosis of such Critical Illness (if such Critical Illness is not a surgery) or after completion of the surgery constituting such Critical Illness (if such Critical Illness is a surgery), the Company will reimburse the Insured Person for the actual amount paid for the Medical Expenses before PART II Section 1- Basic Benefits, up to the maximum benefit limit specified in the Limit of Indemnity Table of this Policy provided that
   (1) such Critical Illness benefit has been paid or become payable ; and
   (2) the medical expenses are reasonable and Medically Necessary in that they were incurred for services, supplies or Medical Services usually recommended by a Registered Medical Practitioner or Chinese Medical Practitioner, or are customarily received in the area where Medical Services is provided, for such Critical Illness.
2. **Diagnosed with 5 Types of Female Critical Illness or Serious Disease**
   Additional lump sum payment will be granted if an female Insured Person is first diagnosed with "Breast Cancer; Cervix Uteri Cancer; Ovarian Cancer; Uterine Cancer. A lump sum payment will be granted if a female Insured Person is first diagnosed with Systemic Lupus Erythematosus ".
3. **Diagnosed with 5 Types of Male Critical Illness**
   Additional lump sum payment will be granted if a male Insured Person is first diagnosed with "Lung Cancer; Liver Cancer; Colon Cancer; Prostate Cancer or Cardiomyopathy".

Provisions:

1. Critical Illness or Systemic Lupus Erythematosus (SLE) will be payable only if
   (1) the Policy and such covered benefit was in force at the date of onset of such illness; and
   (2) the Insured Person has survived for not less than thirty (30) days following the diagnosis of such illness(not applicable to SLE); and
   (3) the date of onset of such illness occurred before the expiry of the Policy Year at which the Insured Person's age is sixty (60) and such covered benefit was in force.
2. Upon payment under Critical Illness Benefit, including payment for Critical Illness or Systemic Lupus Erythematosus under Extended Benefits, the Company will be relieved from all further liability under this optional benefit "item G." for that Insured Person and such Insured Person's Critical Illness Benefit under this benefit "item G" will be immediately terminated.
3. No benefit is payable for any Critical Illness or Systemic Lupus Erythematosus
   (1) resulting (directly or indirectly) from, or related to, or caused or contributed by (in whole or in part), any of the followings:
      i. AIDS or HIV (except for the benefit defined under Critical Illness – HIV through blood transfusion; or
      ii. any Congenital Conditions; or
      iii. a self-inflicted Injury or attempted suicide while sane or insane; or
      iv. any Pre-existing Condition; or
      v. intoxication by alcohol or drugs not prescribed by a

Registered Medical Practitioner; or

vi. violation or attempted violation of the law or resistance to arrest or participation in any criminal act; or

vii. travel in any aircraft, except as a fare paying passenger in a commercial aircraft.

For the purposes of provision (1) iv. above, Pre-existing Condition means any condition or illness

i. which existed or was existing; or

ii. where its direct cause existed or was existing; or

iii. where the Insured Person had knowledge, signs or symptoms of the condition or illness; or

iv. where any laboratory test or investigation showed the likely presence of the condition or illness prior to the Policy effective date or the effective date of last reinstatement of the Policy, whichever is later.

(2) where the signs or symptoms of which or the diagnosis of which first occurred within the ninety (90) days immediately following the benefit cover effective date or the effective date of last reinstatement of the Policy, whichever is later.

(3) for which the Insured Person has been diagnosed prior to the benefit cover effective date, whether or not the earlier diagnosis is related to such illness giving rise to the claim. For example, no Critical Illness benefit resulting from "Cancer" can be claimed under this Policy and in this covered item if the Insured Person has been diagnosed with any "Cancer" prior to the benefit cover effective date or the last reinstatement date.

Definitions of Critical Illness and SLE

Critical Illness means one of the following:

1. Alzheimer's Disease

Deterioration or loss of intellectual capacity or abnormal behavior as evidenced by the clinical state and accepted standardized questionnaires or tests arising from "Alzheimer's Disease" or irreversible organic degenerative brain disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. The diagnosis must be clinically confirmed by an appropriate consultant.

2. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring Medical Services with at least one of the following:

(1) blood product transfusion;

(2) marrow stimulating agents;

(3) immunosuppressive agents;

(4) bone marrow transplantation.

The diagnosis must be confirmed by a Specialist haematologist.

3. Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit persisting for at least one hundred and eighty-three (183) days. The diagnosis must be confirmed by a Specialist neurologist.

4. Benign Brain Tumor

A non-cancerous tumor in the brain which either requires surgical excision or causes significant permanent neurological deficit persisting for at least one hundred and eighty-three (183) consecutive days. Cysts, granulomas, malformations in, or of the arteries or veins of the brain, haematomas and tumors in the pituitary gland or spine are not covered.

5. Blindness

The total and irrecoverable loss of sight of both eyes due to traumatic Injury or disease. The diagnosis must be clinically confirmed by a Specialist ophthalmologist.

6. Brain Damage

Irrecoverable impairment or total loss of intellectual capacity as a result of brain damage sustained in an Accident, such that permanent supervision or assistance is required to maintain survival.

7. Cancer

Cancer is the presence of uncontrolled growth and spread of malignant cells and invasion of tissue.

Incontrovertible evidence of the invasion of tissue of definite histology of a malignant growth must be produced. The term "cancer" also includes leukemia, lymphomas and "Hodgkin's disease".

Excluded are non-invasive carcinomas in situ, any skin cancer except malignant melanomas, localized non-invasive tumors showing only early malignant changes and tumors in the presence of any Human-immunodeficiency virus.

8. Cardiomyopathy

Condition of impaired ventricular function (of variable aetiology) resulting in permanent and irreversible physical impairment of at least "Class IV" on the "New York Heart Association (NYHA)" classification of cardiac impairment. The diagnosis of cardiomyopathy must be confirmed by a Specialist cardiologist. Cardiomyopathy includes dilated, hypertrophic and restrictive cardiomyopathy. Cardiomyopathy secondary to alcohol or drug abuse is excluded.

9. Coma

A state of unconsciousness with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems for a period of at least ninety-six (96) hours, resulting in permanent neurological deficit and in the opinion of a Specialist neurologist.

10. Coronary Artery Bypass Grafting

Open heart surgery to correct narrowing or blockage of two or more coronary arteries by the use of saphenous veingrafts or internal mammary grafting, but excluding all non-surgical procedures such as balloon angioplasty or lasertechniques. Angiographic evidence of the underlying disease must be provided.

11. Elephantiasis

The result and complication of filariasis, characterized by massive swelling in the tissues of obstructed circulation in lymphatic vessels. Unequivocal diagnosis of elephantiasis must be clinically confirmed by an appropriate Specialist including laboratory confirmation of microfilaria. The benefit does not cover "Lymphedema" caused by infection with a sexually transmitted disease, trauma, postoperative scarring congestive heart failure, or congenital lymphatic system abnormalities.

12. Encephalitis

Severe inflammation of brain substance which results in significant and permanent neurological deficit persisting for at least one hundred and eighty-three (183) days as certified by a Specialist neurologist.

13. End Stage Lung Disease

Either of the following conditions must be fulfilled

(1) all of the following

- proof of necessary and permanent oxygen therapy for at least 8 hours/day and
- "FEV1" test results of less than 1 litre

or

(2) all of the following

- "FEV1" test results of less than 1 litre and
- increase of resistance in the respiratory tracts to at least "0.5 kPa/l/s" and
- residual volume greater than 60% of "TLC (total lung capacity)" and
- increase of the intrathoracic gas volume to more than 170 (in percentage of the basic value).

14. Fulminant Viral Hepatitis

A submassive to massive necrosis of the liver caused by the hepatitis virus, leading precipitously to liver failure excluding alcohol and drug abuse as certified by a Registered Medical Practitioner. The diagnostic criteria to be met are

(1) a rapidly decreasing liver size;

(2) necrosis involving entire lobules, leaving only a collagen reticular framework;

(3) rapidly degenerating liver function tests;

(4) deepening jaundice.

15. Heart Attack

Heart attack is the death of a portion of the heart muscle as a result of abrupt interruption of adequate blood supply to the area. The diagnosis should be based upon all of the following criteria:

(1) a history of typical chest pain,

(2) new electrocardiographic changes characteristic of myocardial infarction;

(3) an elevation in cardiac enzyme levels.

16. Heart Valve Replacement

The actual undergoing of the replacement of one or more heart valves with artificial valves due to stenosis or incompetence. Heart valve repair and valvotomy are specifically excluded.

17. HIV Through Blood Transfusion

The Insured Person being infected by "Human Immunodeficiency Virus" provided that:

(1) the infection is due to a blood transfusion received after the effective or the reinstatement date of this benefit, whichever is later; and

(2) the institution which provided the transfusion admits liability or there is a final court verdict that cannot be appealed indicating such liability; and

(3) the infected Insured Person is not a haemophiliac.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus.

18. Kidney Failure

End stage renal failure due to chronic irreversible failure of both kidneys to function. This must be evidenced by the Insured Person undergoing regular renal dialysis or having had renal transplantation.

19. Liver Failure

End stage liver failure with permanent jaundice that in general medical opinion will not improve in future and resulting in either ascites and encephalopathy.

20. Loss of Hearing

Total and irreversible loss of hearing for all sounds as a result of traumatic Injury or disease. Medical evidence is to be supplied by a Specialist otohinolaryngologist and to include audiometric and sound-threshold test.

21. Loss of Independent Existence

Confirmation by a consultant Physician of the loss of independent existence, resulting in a permanent inability to perform any three (3) of the Activities of Daily Living. Activities of Daily Living are defined as:

(1) Dressing – the ability to put on and take off clothing without assistance;

(2) Toileting – the ability to use the toilet, including getting on and off without assistance;

(3) Mobility – the ability to get in and out of bed and a chair without assistance;

(4) Continence – the ability to control bowel and bladder function;

(5) Feeding – the ability to get food from a plate into the mouth without assistance;

(6) Bathing and showering – the ability to bathe and shower without assistance.

22. Loss of Limbs

The irreversible severance from the body of two or more limbs where severance is above the knee or elbow.

23. Loss of Speech

Total and irrecoverable loss of the ability to speak which must be established for a continuous period for three hundred and sixty-five (365) days. Medical evidence is to be supplied by a Specialist otohinolaryngologist and to confirm Injury or disease to the vocal chords. All psychiatric related causes are excluded.

24. Major Burns

Third degree burns resulting in full thickness skin destruction of at least 20% of the total skin area.

25. Major Organ Transplant

The actual undergoing of a transplant of heart, lung, liver, kidney, pancreas or bone marrow as a recipient.

26. Motor Neurone Disease

Unequivocal diagnosis of "Motor Neurone Disease" by a Specialist neurologist supported by definitive evidence of appropriate and relevant neurological signs.

27. Multiple Sclerosis

Unequivocal diagnosis by a Specialist neurologist and confirmed by image scanning investigation indicating more than one episode of well-defined neurological symptoms with persistent signs of involvement of the optic nerves, brain stem and spinal cord together with impairment of coordination and motor and sensory function.

28. Muscular Dystrophy

The diagnosis of muscular dystrophy will require confirmation by a Specialist neurologist and will have to be based on all of the following

(1) family history of other affected individuals;

(2) clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid, mild tendon reflex reduction;

(3) characteristic electromyogram;

(4) clinical suspicion confirmed by muscle biopsy and which in the opinion of the Company confirms the diagnosis of muscular dystrophy;

(5) results in the inability of the Insured Person to perform without assistance three (3) or more Activities of Daily Living (same definitions applies as in the above item 21).

29. Paraplegia/Paralysis

The complete and permanent loss of use of two or more limbs through paralysis.

30. Parkinson's Disease

Unequivocal diagnosis of "Parkinson's Disease" by a Specialist neurologist where the condition

(1) cannot be controlled with medication;

(2) shows signs of progressive impairment;

(3) results in the inability of the Insured Person to perform without assistance three (3) or more Activities of Daily Living (same definitions applies as in the above item 21).

Only idiopathic "Parkinson's Disease" is covered. Drug-induced or toxic causes of "Parkinsonism" are excluded.

31. Poliomyelitis

Unequivocal diagnosis by a Specialist neurologist of infection by the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. Cases not involving paralysis will not be eligible for benefit. Other causes of paralysis are specifically excluded.

32. Progressive Bulbar Palsy

Degenerative wasting of the muscles including the bulbar muscles as diagnosed by a Specialist neurologist.

33. Primary Pulmonary Arterial Hypertension

Primary pulmonary arterial hypertension as established by clinical and laboratory investigations including cardiac catheterization and as diagnosed by a cardiology Specialist. The following diagnostic criteria must be met

(1) dyspnoea and fatigue;

(2) increase in left atrial pressure (by at least 20 units);

(3) pulmonary resistance of at least three units above normal;

(4) pulmonary artery pressures of at least 40 mm Hg;

(5) pulmonary wedge pressure of at least 8 mm Hg;

(6) right ventricular end-diastolic pressure of at least 8 mm Hg;

(7) right ventricular hypertrophy, dilation and signs of right heart failure and decompensation.

34. Severe Rheumatoid Arthritis

Widespread joint destruction with major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, cervical spine, knees, ankles, metatarsophalangeal joints in the feet. The Insured Person is then completely unable to engage in any gainful occupation or employment for the remainder of his life. Diagnosis should be confirmed by Specialist rheumatologist with evidence of the following:

(1) morning stiffness in and around joints lasting at least 1 hour before maximal improvement;

(2) symmetric arthritis;

(3) subcutaneous rheumatoid nodules observed by a Physician;

(4) serum rheumatoid factor positive;

(5) radiographic changes of erosions or unequivocal bony decalcification localized in or most marked adjacent to the involved joints.

35. Stroke

Any cerebrovascular incident (or Accident) producing neurological sequelae lasting more than 24 hours and permanent neurological deficit as confirmed by Specialist neurologist, including:

(1) infarction of brain tissue,

(2) haemorrhage from an intracranial vessel and

(3) embolisation from an extracranial source.

36. Surgery To Aorta

The actual undergoing of open heart surgery for disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta, but not its branches. Traumatic Injury to the aorta is excluded.

37. Terminal Illness

The Insured Person must be suffering from a disease which in the opinion of a medical Specialist and supported by a Registered Medical Practitioner specified by us, is likely to lead to death within three hundred and sixty-five (365) days from the date of notification.

38. Total And Permanent Disability

After twelve (12) calendar months of continuous total disability which has resulted from Accidental Injury or Sickness the Insured Person is completely unable to engage in any gainful occupation or employment for the remainder of his life.

39. Tuberculous Meningitis

Inflammation of the membranes of the brain or spinal cord by "TB" infection resulting in significant neurological deficit which leads to the permanent inability to perform at least three (3) out of the six (6) Activities of Daily Living (same definitions applies as in the above item 21) without the assistance of another person.

40. Vegetative State (persistent)

A clinical state of unconsciousness with no cerebral cortical function, no reaction or response to external stimuli or internal needs, but with remaining function of the brainstem, persisting continuously with the use of life support system for a period of at least thirty (30) days. Permanent neurological deficit, as certified by a Specialist neurologist, must be present.

Systemic Lupus Erythematosus (SLE) means:

An chronic autoimmune illness in which tissues and cells are damaged by deposition of pathogenic and autoantibodies immune complexes.

The diagnosis of SLE will be based on the following conditions:

(1) There must be at least four (4) out of the following clinical presentations:
   a. Maral rash or discoid rash or photosensitivity;
   b. Pericarditis, or pleuritis;
   c. Kidney disorder with proteinuria and other specific urine abnormalities;
   d. Neurologic disorder with seizures or psychosis;
   e. Blood disorder, including hemolytic anemia or leucopenia or thrombocytopenia or lymphopenia;

AND

(2) Immune disorder confirmed by blood tests which include at least three (3) of the followings:
   a. Positive anti-DNA test;
   b. Positive anti-SM antibody Test;
   c. Positive anti-ds DNA Test;
   d. Positive anti-ENA Test;
   e. Positive ANA Test.

The Company reserves the right to change any definition of a Critical Illness or Systemic Lupus Erythematosus as found in the above from time to time to reflect advancement in medical technology associated with the diagnosis or Medical Services of that illness.

PART III – GENERAL EXCLUSIONS

The Company shall not be liable for any claim in respect of:

1. expenses payable under PART II that are recoverable from a third party including but not limited to medical services rendered or compensation in connection with any Injury or Disability claimable under Employees' Compensation Ordinance, Cap. 282, or any amendments thereto.
2. expense covered by any other existing insurance; or directly or indirectly arising from health care services provided by Government facilities or by Medical Practitioners employed by Government facilities except for the statutory charges required to be paid for treatment.
3. any claims in respect of expenses incurred for organ tissue, cornea, artificial organ, or organ transplant or bone marrow transplant, or services or supplies which are experimental or investigative in nature, including the treatment procedure, facility, equipment, drugs, drug usage, devices or supplies which have not been recognized as accepted medical practice shall not be covered. Without prejudice to the generality of the foregoing, treatments that have not been proven to be safe, scientifically established therapies or found to have a demonstrable benefit for a particular Sickness shall not be covered.
4. cosmetic or plastic surgery or any treatment solely for the purpose of beautification.
5. dental oral or oro-surgical care and treatment of any kind including orthodontic, endodontic, and periodontic services; and restorative services such as bonding, crowns, bridges, spacing devices, and dentures (except covered in PART II Section 2 - Optional Benefit "E. Dental" of this Policy and as specified in the Schedule). The only services related to dental treatment which shall be covered under this Policy are
   (1) medical care immediately following an Accident which causes Injury to the mouth and teeth, any following treatment thereof shall not be covered;
   (2) oral surgery when properly referred for reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant neoplasm of the jaw;
6. eye or hearing tests, eyesight correction treatment (save and except where the medical treatment is directly caused by an Accident); fitting of glasses or contact lenses, procurement or use of special braces including but not limited to stent, pacemaker, appliances, hearing aids, wheelchairs, crutches, artificial limb or any other similar equipment costs (except as otherwise provided in PART II Section 1 - Basic Benefits item A13 "Medical Appliances (Specific Items)";
7. any Room and Board, companion, special nursing, extended bed (except as provided in PART II), non medical related personal services or any other special expenses which are not directly necessitated by the diagnosed treatment including but not limited to vitamins, antibacterial soaps and detergents, allergenic extracts, nutrient herbs or tonic (including but not limited to Birds' Nest, Ginseng and Lingzhi) or pre-packaged commercial health supplement;
8. Congenital Conditions, heredity condition, developmental condition, Pre-existing Medical Conditions or any complications arising therefrom;
9. expenses directly or indirectly arising from venereal diseases or Human Immunodeficiency Virus (HIV) related disease, including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutation, derivations or variations thereof, which proceeds from an HIV infection occurring prior to the effective date of the benefit cover. For purposes of this exclusion, an HIV related disease emerging within five (5) years of the benefit cover effective date will be conclusively presumed to proceed from an HIV infection occurring prior to the effective date of coverage, in the absence of clear and convincing evidence to the contrary;
10. Maternity, pregnancy, childbirth (including diagnostic tests for pregnancy, sex determination or and surgical delivery), miscarriage, abortion and pre-natal or post-natal care, surgical mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility or in-vitro fertilization, or sterilization or any complications arising therefrom or all related treatments (except as covered in PART II Section 2 - Optional Benefit F "Maternity Benefit" in this Policy and as specified in the Schedule);
11. female hormonal tests or assays and female hormonal replacement therapy unless resulting from a disease, routine or general check ups or routine blood tests, health examinations, check ups or tests not incidental to treatment or diagnosis of a covered Sickness or Injury, inoculation, medication or vaccination for immunization or quarantine purposes, rehabilitation treatment convalescent treatment;
12. all Hospital expenses incurred primarily for investigations (such as diagnostic scanning, X-ray examinations, laboratory tests, etc.) and/or physical therapy;
13. charges for accommodation and nursing in any establishment, which for any reason is or has effectively become the place of domicile or permanent abode;
14. treatment for mental illness and emotional disorders including treatment directly or indirectly arising from any insanity,

geriatric, psychyco-geriatric or psychiatric condition including but not confined to psychoses, neuroses, depression of any kind, anxiety, anorexia nervosa, bulimia, schizophrenia, Insomnia or other behavioral disorders, etc;

15. Sickness or Injury directly or indirectly resulting from or consequent upon:
    (1) medicines and drugs which are not consumed in a Hospital or prescribed by a Doctor;
    (2) contraceptives or contraceptive devices, vaccines, appetite stimulants or depressants, unless specifically covered;
    (3) prescription drugs used in connection with drug addiction, alcoholism, weight reduction, smoking cessation and treatment of baldness and experimental drugs;
    (4) venereal diseases or willful misuse of drugs or alcohol, attempted suicide or intentional self-inflicted injury or participating in an illegal activity, attempted or committed any unlawful or illegal act or having more than the legally permitted level of alcohol in the blood whilst driving any kind of vehicle;
    (5) high risk activities or occupations:
        i. engaging in or taking part in disciplinary, naval, military or air force service or operations;
        ii. engaging in or practicing in or taking part in training peculiar to: aqualung diving, rafting; mountaineering, rock-climbing, or trekking necessitating the use of ropes or guides; potholing, parachuting, bungee jumping, hang-gliding, stunts or daring feats; skiing, tobogganing, sledding and ice skating, including ice hockey and other sports requiring snow or ice for play; professional sports such as car racing, horse racing; motor cycling; engaging in aviation other than as a fare-paying passenger in an aircraft provided by and operated by an airline or air charter company which is duly licensed for the regular transportation of fare-paying;
    (6) war or any act of war, declared or undeclared, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military or usurped power or act of terrorism, strike, riot, engaging military force;
    (7) nuclear radioactive contamination;
16. Sickness or Injury contracted during any journey taken by the Insured Person which is
    (1) against the advice of a Physician;
    (2) for the purpose of or in connection with emigration or studying Overseas;
    (3) for the purpose of or in connection with obtaining or seeking any medical advice or surgical treatment outside Hong Kong;
17. all inguinal hernias and all hydroceles (or their complications) presenting from birth to the age of 15 years;
18. trans-sexual surgery, circumcision unless Medically Necessary, occupational therapy and speech therapy services; hospice service;
19. alternative treatment including but not limited to acupressure, Tui Nai, massage therapy, naturopathy, hydropathy, chiropractic, podiatry, biofeedback, hypnosis, pain clinics, homeopathy, ear reflexology, moxibustion, cupping and scraping unless otherwise specified;
20. treatment arising from sexual dysfunction including but not limited to impotence, erectile dysfunction, pre-mature ejaculation, regardless of cause;
21. Sickness and/or Hospital Confinement commences during sixty (60) days from the reinstatement date of the Insured Plan, except Hospital Confinement due to Accident and / or Injury.

PART IV – PREMIUM

1. This Policy shall become effective after the Insured has paid the premium.
2. Premiums for each Insured Person is based upon the attained age on the effective date of this Policy and the first (1st) day of each subsequent renewal Policy Year.
3. All advanced premium is not refundable unless the Policy is cancelled within the fifteen (15) days waiting period of the receipt of the Policy and no claim has arisen or paid during the period.
4. Premium shall be paid in accordance with the amount stated in the Schedule, endorsement and any memoranda and shall be paid on the commencement date of this Policy and upon the Policy expiry date of each subsequent Policy Year for premium settled in each year.
5. If change of premium payment mode is required, the Insured shall give notice in writing to the Company at least thirty (30) days before the coming Policy year's expiry date and such changes shall become effective only on the first (1st) day of the earliest coming renewal Policy Year.
6. Except for the first year's premium, the Company will provide the Insured one (1) month (not exceeding 31 days) grace period for premium payment for each renewal Policy Year. If the required renewal premium is paid by the Insured within the grace period, this Policy shall continue to be in effect. If payment is not made within the grace period, this Policy shall become invalid from the Policy expiry date that provides for the said grace period.
7. The Company reserves the right to adjust premium, Maximum Limit of Indemnity and/or Terms of this Policy in respect of like categories of Insured Person(s), such as age or health conditions for all the Insured Plans in the "BOC Medical Comprehensive Protection Plan (Series 1) Policy". The rates or premiums and any rates of premium discounts or surcharges shall be prescribed from time to time by the Company.

PART V – RENEWAL

Subject to Part IV of this Policy,

1. payment of the required renewal premium by the Insured upon each renewal Policy Year for payment made in each year, will continue this Policy to be in force until the expiry date of that Policy Year.
2. this Policy will be automatically renewed upon premium payment by the Insured unless written notice of changes in Policy terms and conditions or cancellation has been given by the Company prior to the renewal date of the Policy Year.
3. Subject to item 7 of Part IV of this Policy, Hospital and Surgical, Out-patient and Dental benefits are guaranteed renewable for lifetime. Regardless of the Insured Person's health or claims condition, the Company shall not impose any additional premium or terms on the Insured Person after the inception date of the cover.
4. the Company reserves the right to cease offering this plan, revise the benefits, premiums and other terms and conditions of this Policy upon expiry date of the anniversary renewal. If the Company decides to cease offering this plan, the Company shall provide alternative insurance option to the Insured Person at the same time.
5. Revision of Benefit Structure
   The Company reserves the right to revise the benefit structure under this Policy. The Company shall give the Policyholder a written notice no less than thirty (30) days prior to the end of a Period of Insurance of such revision specifying the revised Schedule and the Limit of Indemnity Table, the new premium and its effective date. The revised Schedule and the Limit of Indemnity Table and new premium shall take effect on the date specified unless the Policyholder declines in writing in which case this Policy shall automatically terminate on the next premium due date following the date of such written notification. Following each revision, an endorsement shall be issued together with the revised Schedule and the Limit of Indemnity Table.

PART VI – NO CLAIM RENEWAL PREMIUM DISCOUNT

15% premium discount on Part II Section 1 - Basic Benefit will be offered to each Insured Person at renewal provided no claim is payable within the three (3) consecutive years immediately preceding the renewed Policy Year.

If during any of the above renewal period a claim arise or will be payable to one of the Insured Person, all accumulating total "no claim renewal premium discount" for that Insured Person will be cancelled and will restart the accumulation from the first (1st) day of the coming renewal Policy Year and all other Insured Person's no claim renewal discount entitlement will not be affected.

In the event of receiving valid claim documents which falls within the period where "no claim renewal premium discount" has been payable, the Insured shall return the full amount of the discounted premium to the Company. If the Insured fails to comply, the Company shall have the right to delay the claim payment or deduct the full amount of the discounted premium from the amount of the claim.

PART VII – DUPLICATE APPLICATION, COMMENCEMENT DATE, ADDITIONS AND TERMINATION

Section 1 – Duplicate Application

The Insured Person shall not be covered under more than one "BOC Medical Comprehensive Protection Plan (Series 1) Policy" issued by the Company. In the event that the Insured Person is covered under more than one such Policy, the Company will consider that person to be insured under the Policy that provides the greatest amount of benefit. Where the benefit under each such Policy is identical, the Company will consider that person to be insured under the Policy first issued. The Company will refund any duplicated insurance premium payment that may have been made by or on behalf of that person and the duplicated Policy shall be void in respect of such particular Insured Person.

Section 2 - Policy Commencement Date

This Policy shall become effective and commence on the date specified in the Schedule.

Section 3 – Additions

1. If there is only one Insured Person covered under this Policy, the Insured may include himself or legal spouse and/or Child by submitting a written application to the Company thirty (30) days before next renewal Policy Year, specifying the name, sex and age and health conditions of the additional person(s) to be insured.
2. Subject to the approval by the Company with a duly signed endorsement, insurance for such additional Insured Person(s) will only become effective and commence on the first (1st) day of the earliest coming renewal Policy Year and thereby the relevant additional premium will be charged to the Insured.

Section 4 – Termination

1. Termination by the Insured

(1) If thirty (30) days before the coming Policy Year's expiry date the Insured gives written notice to terminate this Policy or one of the Insured Persons in this Policy, such termination shall become effective upon the expiry of that Policy Year. Full annual premium shall be collected and no refund shall be made.

(2) If the Insured gives written notice to terminate this Policy or one of the Insured Persons in this Policy, such termination shall become effective upon the coming Policy Year's expiry date or the date of the Company's receipt of the relevant notice, whichever is earlier. Full annual premium shall be collected and no refund shall be made.

(3) If the Insured Person is covered under "Insured Plan 4 - Medical Top-up Plan" and gives written notice to terminate this Policy for reason of termination of service with his Company, such termination shall become effective on the date of the Company's receipt of the relevant notice or the date specified in the notice, whichever is later.

If any claim has arisen or paid under "Part II Section 1 – Basic Benefit" of this Policy during the Policy Year, the Insured is required to pay 100% of annual premium as the minimum premium required by the Company.

In the event premium has been paid for any period beyond the Policy cancellation date and provided no claim has arisen or paid under this Policy during the Policy Year, the Insured shall be entitled to the following refund of premium:

Period covered (not exceeding)	Premium refund
4 months	50%
5 months	40%
6 months	30%
7 months	20%
8 months	20%
Over 8 months	0%

2. Termination by the Company

(1) The Company shall be entitled at any time to terminate this Policy, or to subject this Policy to different terms, if the Insured Person has at any time failed to observe the Terms of this Policy or failed to act with utmost good faith. The Company may terminate this Policy by giving seven (7) days notice in writing to the Insured and such notice shall be delivered to the Insured or sent by letter to the Insured at his last known address and such cancellation shall become effective from the seventh (7th) day after such notice has been issued for payment made in each year. For payment made in each year, the Insured shall be entitled to the return of a proportionate part of the premium (in accordance with the refund table shown in Section 4 – Termination item 1(3) above) for the unexpired period of coverage provided no claim has arisen or paid under the Policy during the Policy Year.

(2) This Policy shall terminate forthwith upon the death of the Insured Person. Benefit for any Insured Person under the Policy shall terminate forthwith upon the death of that Insured Person without affecting benefit for other Insured Person under the Policy. For payment made in each year, the Insured shall be entitled to the return of a proportionate part of the premium (in accordance with the refund table shown in Section 4 – Termination item 1(3) above) for the unexpired period of coverage provided no claim has arisen or paid under the Policy during the Policy Year.

(3) Provided one or more premiums charged to the Insured's nominated account have been paid, non-payment of any subsequent premiums shall terminate insurance under this Policy as from that Policy expiry date. Full annual premium for the Policy Year shall be collected from the Insured and no refund shall be made.

PART VIII – CHANGE INSURED PLAN

1. Thirty (30) days before the expiry date of each Policy Year, the Insured can give written notice to the Company for change of Insured Plan. Subject to the approval by the Company, the new Insured Plan and premium will be effective only on the first (1st) day of the earliest coming renewal Policy Year.
2. If such Insured Person(s) shall have been afflicted with a covered Sickness or Injury before the said written notice was received by the Company the benefits payable in respect of such Sickness or Injury shall not exceed the limit(s) or maximum(s) of benefits, whichever is lower, applicable prior to the date the written notice was received by the Company.
3. If the Insured Person covered under Plan 4 "Medical top-up plan" gives a written notice for policy termination within the policy period due to the cancellation of Company Medical insurance, he/she will be entitled to the refund of the paid annual premium on a designated percentage upon submission of the documentary proof. Besides, the Insured Person can request to convert his/her Insured Plan 1, 2 or 3 (if Plan 3 is selected, Insured Person should submit the documentary proof showing that his/her previous company medical insurance coverage is equivalent to or better than that of Plan 3 before the conversion). The Company would charge the new Insured Plan premium on daily pro-rata basis by the number of insured day.

PART IX – CHANGE OF RISK

During the period of insurance, the Insured shall give immediate notice in writing to the Company of any change of risk of the

Insured Person (including change of identity of the residence, the occupation, Place of Residence, etc) which may prejudice the insurance cover. The Company reserves the right to adjust the premium for any period, whether past or future, affected by such change of risk. Accordingly, the Insured shall pay any additional premium as required. The Company reserves the right in the Company's sole and absolute discretion to treat this Policy (including any attached endorsement and supplement) as termination from the inception date of the change of risk. The Company will not refund any premiums paid and reserves right to require repayment of the paid claims. If the change of risk is only found at any claims stage without prior declaration, no claim will be paid.

PART X – CONDITIONS FOR THE USE OF THE MEDICAL CARD

1. **Use of Medical Card**
   In all matters concerning the use of Medical Card, the Company shall deal solely with the Insured and not with individual Insured Person. The Insured shall be fully responsible for controlling and monitoring the use of the Medical Card by the Insured Person in accordance with the provisions of this Policy.
2. **Cancellation, termination or non-renewal of Policy**
   If, for any reason, this Policy and the Out-patient benefit cover is cancelled, terminated or not renewed, the Insured shall collect all Medical Cards issued to all the Insured Person and return immediately the same to the Company from the date of such cancellation or termination. The Insured shall indemnify the Company against all claims, losses, damages, actions, proceedings, costs and expenses which may be brought against the Company or incurred by the Company arising from the use of those Medical Card whilst this Policy and the Out-patient benefit cover is no longer in force, whether or not the Insured ultimately returns all the Medical Cards to the Company. This clause shall survive termination or cancellation of this Policy.
3. **Termination of coverage**
   In the event of the coverage of the Insured Person under this Policy shall be terminated or cancelled for any reason, the Insured agrees to obtain the Medical Card from that Insured Person and the Medical Card will be returned immediately to the Company from the date of termination or cancellation. Should a former Insured Person use the Medical Card to obtain benefits after termination or cancellation, the Insured will be liable to reimburse in full the amount paid by the Company whether or not the Medical Card shall have been subsequently returned to the Company. This clause shall survive termination or cancellation of this Policy.
4. **Claims disputes**
   Should any medical expenses or claim arising from the use of the Medical Card be the subject of a dispute the Insured agrees to immediately reimburse the amount already paid by the Company pending the decision as to whether those medical expenses are payable under the terms of this Policy. This clause shall survive termination or cancellation of this Policy.
5. **Cost exceeding benefits**
   In the event of the costs incurred by any Insured Person using the Medical Card exceeding the benefit payable in respect of that Insured Person, the Insured agrees to reimburse the Company immediately the charge back amount upon receipt the payment notice for any difference or shortfall. This clause shall survive termination or cancellation of this Policy.
6. **Ineligible Treatment**
   If any Insured Person uses the Medical Card for treatment that is not eligible for a benefit under the terms of this Policy, the Insured shall reimburse the Company in full for the costs of such ineligible treatment. This clause shall survive termination or cancellation of this Policy.
7. **Replacement Medical Card charge**
   A charge will be levied for each replacement Medical Card issued and shown on the Medical Card. The Company reserves the right to revise the replacement charge at its sole discretion without prior notice. In the event of Medical Card replacement, the Insured should complete the "Replacement Cards" form and return to the Company and such form shall be provided by the Company upon request.
8. **Theft or loss of Medical Card**
   In the event of loss or theft of the Medical Card, the Insured agrees to notify the Company in writing immediately from the date of such loss or theft of the full details thereof. The Insured is fully responsible for any transactions involving use of a lost or stolen Medical Card issued to any Insured Person until such theft or loss is reported by submitting a written notice to the Company.
9. **Withdrawal of Medical Cards**
   The Company reserves the right to withdraw the use of any or all Medical Cards at any time without prior notice. Any and all such Medical Cards issued under this Policy shall at all times remain the absolute and sole property of the Company.
10. **Outstanding charge back amount**
    Upon receipt of written notice from the Company, the Insured shall reimburse the Company immediately for any outstanding charge back amount shown on the notice. The Company reserves the right to charge the Insured interest at the prevailing prime interest rate per month on any amounts which remain not reimbursed to the Company from the thirty (30) days following the receipt of the written notice from the Company advising any amounts due.
11. **Withhold claims payment**
    The Company reserves the right to withhold claims payment and any medical services provided by Non-network Services Provider to Insured Person at any time by giving an advance notice in writing to the Insured if outstanding charge back amount remain not reimbursed to the Company.

PART XI – GENERAL CONDITIONS

1. **Interpretation**
   This Policy and the Schedule, memoranda and endorsements hereto shall be read together and any word or expression to which a specific meaning has been attached in any part of the Policy, Schedule, memoranda or endorsements hereto shall bear such meaning wherever it may appear. Should there be any discrepancy between the Chinese and English versions, the English version shall prevail.
2. **Consideration**
   This Policy is issued in consideration of the declaration contained in the proposal form and the Insured's payment of premium when due.
3. **Geographical Limits**
   Benefits provided under Part II of this Policy are applicable worldwide subject to the following limitations as appropriate:
   (1) Supplementary Major Medical Benefit: limited to Medical Services incurred solely as the result of an Accident or Emergency situation occurring Overseas;
   (2) Hospital Cash Benefit: limited to ninety (90) Day of Hospital Confinement per Policy Year;
   (3) Out-patient Benefit: limited to Plan 3.
4. **Terms and Conditions**
   All claims payment under this Policy is subject to all definitions, terms and conditions of this Policy.
5. **Non-contribution Clause**
   This Policy is not to be called upon in contribution and is only to pay any expenses under "PART II – INSURED BENEFITS" to the relevant Insured Person if and so far as not recoverable under any other insurance. In the event that a benefit covered or payable under any other contract or plan and/or extension benefits provisions is less than the amount payable under this Policy, the Company will only be liable to pay benefits in an amount equal to the difference between the amount covered or payable under this Policy and that other contract or plan. A copy of all such other contract(s) or plan(s) and, if applicable, the extension benefits provisions shall be provided by the Insured to the Company.
6. **Entire Contract and Changes**
   This Policy, including the Schedule, endorsements, "the Classification Schedule", appendix and amendments (if any), will constitute the entire contract between the parties. Any change in this Policy is not valid unless evidenced by the Company's endorsement or amendment.
   The Company reserves the right to underwrite, amend the

terms and/or adjust the premium and maximum limit for coverage under this policy.

7. Right to Return Policy

In the event the Insured is not satisfied with this Policy for whatsoever reason, the full set of Policy including the Medical Card should be returned to the Company within fifteen (15) days from the effective date of this Policy. If no claim has been made or paid during this period, all premium paid to the Company will be refunded. In such event, this Policy shall be deemed to have been void from the effective date of this Policy and the Company shall not be liable to pay any benefit.

8. Misrepresentation or Fraud

The information and declaration made by the Insured and/or Insured Person in the proposal form and the information contained in the endorsement (if any) have formed the basis of this Policy. Any misrepresentation or untrue information will render this Policy void ab initio. Any fraudulent act concerning any claim shall entitle the Company to repudiate liability under this Policy.

9. Subrogation

The Company has the right to proceed at its own expense in the name of the Insured Person against third parties who may be responsible for an occurrence give rise to a claim under this Policy.

10. Notice of Claim (not applicable to PART II Section 2 - Optional Benefits D and E "Out-patient and Dental Benefits")

It is a condition precedent to the Company's liability that written notice of claim must be given to the Company by or on behalf of the Insured within fourteen (14) days from the commencement of Hospital Confinement or the date of which the Critical Illness is diagnosed. Notice given by or on behalf of the Insured to the Company with information sufficient to identify the Insured Person shall be deemed valid notice.

Failure to give notice in the time prescribed shall not invalidate a claim if it can be shown to the Company's satisfaction that notice had been provided as soon as reasonably practicable, and in any event within sixty (60) days from date of commencement of such Hospital Confinement.

11. Physical Examination

The Company at its own expense shall have the right and opportunity to examine the Insured Person when and so often as it may reasonably require pending the outcome of a claim under this Policy.

12. Claims Procedure

(1) Applicable to PART II except Section 2 - Optional Benefit D and E "Out-patient and Dental Benefits"

When Sickness or Injury shall cause any Insured Person's Hospital Confinement, the Insured Person or his personal representative shall complete the following forms and provide the relevant supporting documents and proof of loss receipts to the Company no later than thirty (30) days from the discharge date of the Hospital or the date of which the Critical Illness is diagnosed.

i. Hospitalisation & surgical or Critical Illness claim form; and
ii. "Attending Physician's Statement"; and
iii. All original copy of Hospital receipts and itemized Hospital charges; and
iv. Death certificate and coroner's report (only applicable to Compassionate Death Benefit).

Failure to provide the above documents will entitle the Company to reject the claim. If the Insured Person or his personal representative is unable to provide the "Attending Physician's Statement" as stated in item (ii) above, the Company can assist to collect such information provided that the expenses in relation to such provision is to be borne by the Insured or his personal representative and the Company is being authorized by the Insured Person or his personal representative to do so.

(2) Applicable to PART II Section 2 - Optional Benefit D and E "Out-patient (Non-network Services) and Dental Benefits"

Insured Person shall pay the fees and charges of the Out-patient Services rendered by the Non-network Services Providers first and shall submit his claim for reimbursement to the Company within ninety (90) days after the date of treatment for the Disability for which the claim is being made. For this purpose, a claim shall be deemed not to be valid or complete and no reimbursement will be made by the Company to the Insured Person unless the following forms and relevant supporting documents and proof of loss receipts have been submitted to the Company:

i. all original receipts with attending Registered Medical Practitioner's and / or Chinese Medical Practitioner's signature (the receipt should have the patient's name, diagnosis, treatment date and breakdown of charges), and/or
ii. referral letter written by a Registered Medical Practitioner (applicable only for diagnostic X-ray and laboratory tests, Specialist (non-surgical) consultation, Physiotherapy and chiropractic treatment), and/or
iii. original copy of prescription sheet, Chinese Medical Practitioner's name, his signature and registration number. (applicable only for Chinese Medical Practitioner consultation)
iv. fully completed Out-patient Benefit or Dental Benefit claim form

Any variation or waiver of the foregoing shall be at the Company's sole discretion and must be evidenced in writing.

Referral letter issued by the qualified attending Physician shall be valid for six (6) months from the issue date of the referral letter.

Medical reports and all proof of loss documents as required by the Company shall be furnished at the expense of the Insured and shall be in such form and of such nature as the Company may prescribe.

It is a condition precedent to the Company's liability that the Insured and/or the Insured Person shall render all necessary assistance and co-operations in assisting the Company to obtain from other party(ies) medical history or claims record of the Insured Person. The Company shall, in the event of the death of the Insured Person to whom a claim is made, be entitled to have a post-mortem examination at its own expense where it is not prohibited by law.

13. Claims Documents

All claims documents and proof of loss receipts in connection with any claim under a Policy Year shall be furnished to the Company within ninety (90) days from the expiry date of that Policy Year, failure in compliance will cause the claim to be abandoned, the Insured Person thereafter cannot be entitled to any benefit payment in such respect. Besides, during the process of benefit payment, the Insured and/or Insured Person shall provide all other relevant evidence of proof documents as required by the Company apart from item 12 above. If the Insured and/or Insured Person fails to provide all other required evidence of proof documents, the Company shall have the right to delay benefit payment until all such documents are obtained. The Company would not return any original receipts for fully reimbursement case.

14. Claims Investigation

Within ninety (90) days from the date of receipt of the claim form from the Insured, the Company has the right to investigate whether the Company's liability is attached. During this period, no arbitration can be brought to the Company by the Insured. If the Company has rejected the claim in accordance with the terms or conditions of this Policy, arbitration can be brought to the Company by the Insured within one (1) year from the date of claim rejection.

15. Payment of Benefits

Benefits payable under this Policy shall be paid to the Insured or Insured Person or his personal representative. In the absence of any such written direction, accrued benefits unpaid at the time of the Insured Person's death shall be paid to the estate of the Insured Person. Any receipt which the Insured, or any third party to whom the Insured has directed that payment to be made, may give to the Company for any benefits paid under this Policy in respect of any one period of covered Hospital Confinement, shall be deemed a final and complete discharge of all liability of the Company in respect of such period of Hospital Confinement. Benefit under this Policy will be paid upon termination of the relevant period of covered Hospital Confinement.

16. Currency

Premium and benefits payable under this Policy shall be in the currency of Hong Kong. Any claim for reimbursement or expenses by the Insured Person in any foreign currency shall be converted to Hong Kong dollars at the official buying rate of such currency for Hong Kong dollars in effect in Hong Kong at the time the payment of such expenses were paid by the Insured Person, or if no such official rate exists, at the rate certified as appropriate by the Company's bankers which shall be deemed to be final band binding.

17. Interest

No benefit and expenses payable under this Policy shall carry interest.

18. Unpaid Premium

Upon the payment of a claim to the Insured under this Policy, any unpaid premium may be deducted from such claim payment.

19. Reinstatement

If this Policy is terminated for any reason, subsequent proposal form for reinstatement should be submitted for Company's acceptance and approval within ninety (90) days from the premium due date. The reinstated Policy shall cover only Hospital Confinement caused by Injury sustained after the date of reinstatement and Sickness commencing sixty (60) days after the date of reinstatement.

20. Errors and Omissions

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 the 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 provisions or terms 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.

21. Contracts (Rights of Third Parties) Ordinance

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.

22. Sanctions Limitation and Exclusion Clause (LMA 3100)

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

23. Prohibition on Trust or Assignment

This Policy is not assignable and the Insured warrants that this Policy is not subject to a trust and will not be made subject to a lien or charge and that this Policy will be kept in the Insured's possession throughout the period of insurance.

24. Proper Law and Jurisdiction

This Policy shall in all respects be governed by and construed in accordance with the laws of Hong Kong and the "Courts" of Hong Kong shall have sole and exclusive jurisdiction in relation to any dispute, claim or legal proceedings arising from anything or matter in connection with this Policy.

24. Arbitration

All difference arising out of this Policy shall be determined by arbitration in accordance with the Arbitration Ordinance as amended from time to time. If the parties fail to agree upon the choice of the arbitrators, then the choice shall be referred to the Chairman for the time being of the Hong Kong International Arbitration Centre. It is expressly stipulated that it shall be a condition precedent to any right of action or suit upon this Policy that an arbitration award shall be first obtained. If the Company shall disclaim liability to the Insured Person for any claim hereunder and such claim shall not within twelve (12) calendar months from the date of such disclaimer have been referred to arbitration under the provisions herein contained then the claim shall for all purposes be deemed to have been abandoned and shall not hereafter be recoverable hereunder.

24-Hour Worldwide Emergency Assistance Service Hotline (852) 2861 9235

The Company has arranged the twenty-four (24) hours assistance services with Inter Partner Assistance Hong Kong Ltd (hereinafter referred to as "IPA") to provide the following hotline services to the Insured Person during the effective period of the Policy:

1. <u>Emergency Assistance Service</u>

If the Insured Person shall suffer serious Injury, sudden Sickness or death, or require legal advice, unexpected return to Hong Kong during his journey outside Hong Kong, provided that the trip is not undertaken:

- against the advice of the Physician, and/or
- for the purpose of obtaining or seeking any medical or surgical treatment abroad

the following Emergency assistance services are available directly from IPA upon specific verbal notification by the Insured Person or his personal representative to any of the specified 24-hour alarm centre.

(1) Medical Advice, Evaluation and Referral Appointment

When medical advice is needed, the Insured Person or his personal representative may telephone IPA's alarm centre for medical advice and evaluation from the attending Physician. However, it shall be stressed that telephone conversation cannot establish a diagnosis and shall be considered as an advice only. If consultation becomes necessary, the Insured Person shall be referred to another Physician or to a medical Specialist for personal assessment and IPA will assist the Insured Person in making the medical appointment. All Physician's fees and related charges shall be borne entirely and directly by the Insured Person without any reimbursement from IPA.

(2) Medical Monitoring

In the event of the Insured Person being Hospitalised outside Hong Kong, IPA's medical team will monitor the Insured Person's condition as closely as possible with the attending Physician.

(3) Travel Information

The Insured Person may contact IPA to obtain the following information and services before starting or during his journey.

- Update immunisations and vaccinations requirement and needs
- Weather information worldwide
- Airport taxes
- Customs requirements
- Passport and Visa requirements
- Consulate and embassies addresses and contact numbers
- Exchange rates
- Banking days
- Language Information / Arrangement of interpreter services
- Arrangement of child escort
- Transmission of urgent messages for medical reasons

(4) Luggage Retrieval

In the event of loss or misrouting of the Insured Person's luggage by a common carrier, IPA will liaise with the relevant entities such as but not limited to airline companies, customs officials, and will organize the dispatch of such luggage, if recovered, to such place as the Insured Person may direct.

(5) Emergency Rerouting Arrangements

IPA will assist the Insured Person in reorganizing his flight schedule should an emergency oblige him to alter his original plan.

(6) Assistance on Loss of Travelling Document

In case of loss or theft of essential documents or personal identification documents (e.g. passport, entry visa, etc.), IPA will provide the Insured Person with the necessary

information regarding the formalities to be fulfilled with the appropriate local authorities or entities, in order to obtain the replacement of such lost or stolen documents.

(7) Legal Referral

Upon the request of the Insured Person, IPA can provide the names, addressees, telephone numbers of lawyers and solicitors firms to the Insured Person.

(8) Compassionate Visit

In the event of the Insured Person suffering from serious Injury or sudden Sickness resulting in Hospital Confinement outside Hong Kong, at the Insured Person's cost IPA will arrange a relative or designated person of the Insured Person to travel to the Insured Person's bedside.

(9) Return of Unattended Minor Child to Hong Kong

If the Insured Person's travelling dependent Child under eighteen (18) years of age is left unattended by reason of the Insured Person's Injury or sudden Sickness resulting in Hospital Confinement outside Hong Kong or the death of the Insured Person, at the Insured Person's cost IPA will organize for such Child to return to Hong Kong, including a qualified attendant to accompany any such dependent Child for return journey if necessary.

(10) Deposit Guaranteeing of Hospital Admission

In case of Hospital admission duly approved by both the attending Physician and IPA's alarm centre doctor and the Insured Person is without means of payment of the required Hospital admission deposit, IPA will issue the guarantee or provide such payment up to HKD40,000. Prior to arranging the above service, IPA shall obtain the credit guarantee from the Insured Person.

(11) Hotel Room Accommodation for Convalescence

IPA will arrange and at the Insured Person's cost for an ordinary room accommodation for the sole purpose of Insured Person's convalescence immediately following his discharge from the Hospital.

(12) Unexpected Return to Hong Kong

IPA will arrange and at the Insured Person's cost for a scheduled airline ticket for the return of the Insured Person.

2. <u>Force Majeure</u>

IPA shall not be held responsible for delays or failures in providing assistance caused by any strike, war, invasion, act of foreign enemies, armed hostilities, (regardless of a formal declaration of war), civil war, rebellion, insurrection, terrorism, political coup, riot and civil commotion, administrative or political impediments or radioactivity or acts of God or any other event of Force Majeure which prevents IPA from providing such assistance services.

3. <u>Liability of the Company and IPA</u>

It is understood that the Physicians, Hospitals, clinics, and any kind of professionals to whom the Insured Person will be referred to by IPA are independent contractors responsible for their own acts and are not employees, agents or servants of IPA. Furthermore, the Company and IPA shall not be responsible for any act or failure to act on the part of those professionals such as, and not limited to, Physicians, Hospitals and clinics.

PERSONAL INFORMATION COLLECTION STATEMENT

The information You provide to Bank of China Group Insurance Company Limited ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:

(i) processing and evaluating Your insurance application and any future insurance application You may make;
(ii) administering Your insurance policy and providing services in relation to Your insurance policy;
(iii) analysis or investigating, processing and paying claims made under Your insurance policy;
(iv) invoicing and collecting premiums and outstanding amounts from You;
(v) any alterations, variations, cancellation or renewal of any insurance related product or service;
(vi) contacting You for any of the above purposes;
(vii) exercising any right of subrogation;
(viii) other ancillary purposes which are directly related to the above purposes; and
(ix) complying with applicable laws, regulations or any industry codes or guidelines.

The Company may disclose Your personal data for the above purposes to the following classes of transferees:

(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist the Company to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
(b) in the event of a claim, loss adjudicators, claims investigators and medical advisors;
(c) in the event of default, debt collectors and recovery agents;
(d) insurance reference bureaus or credit reference bureaus;
(e) reinsurers and reinsurance brokers;
(f) Your insurance broker (if You have one);
(g) the Company's legal and professional advisors;
(h) the Company's related companies (as that term is defined in the Companies Ordinance);
(i) any association, federation or similar organization of insurance companies ("Federation") and its members that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation;
(j) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes;
(k) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
(l) the Insurance Claims Complaints Bureau and similar industry bodies; and
(m) government agencies and authorities as required or permitted by law.

The Company is hereby authorized to obtain access to and/or to verify any of Your data with the information collected by the Federation from the insurance industry.

Moreover, the Company may also use and disclose Your personal data otherwise with Your consent.

You have the right to obtain access to and to request correction of any personal information concerning Yourself held by the Company. Requests for such access can be made to the Company's Legal and Compliance Department (Tel: 2867 0888 / Fax: 3906 9939).

USE OF PERSONAL DATA IN DIRECT MARKETING

With Your written consent given for direct marketing purpose (which includes an indication of no objection), the Company intends to use Your data in direct marketing. The Company will only act in accordance with the rules about direct marketing contained in the Ordinance. Please note that:

(1) Your name, contact details, products and services portfolio information and demographic data held by the Company may be used by the Company in direct marketing from time to time;
(2) the following classes of services, products and subjects may be marketed:
  (i) financial, insurance and related services and products;
  (ii) reward, loyalty or privileges programmes and related services and products;
  (iii) services and products offered by the Company's co-branding partners (the names of such co-branding partners can be found in the application form(s) for the relevant services and products, as the case may be); and
  (iv) donations and contributions for charitable and/or non-profit making purposes;
(3) the above services, products and subjects may be provided to or (in the case of donations and contributions) contributed to by the Company and/or:
  (i) the Company or BOC Hong Kong (Holdings) Limited or any of its subsidiaries;
  (ii) third party reward, loyalty, co-branding or privileges programme providers;
  (iii) co-branding partners of the Company and BOC Hong Kong (Holdings) Limited (the names of such co-branding partners can be found on the application form(s) for the relevant services and products, as the case may be); and
  (iv) charitable or non-profit making organisations;
(4) in addition to marketing the above services, products and subjects itself, the Company also intends to provide the data described in paragraph (1) above to all or any of the persons described in paragraph (3) above for use by them in marketing those services, products and subjects, and the Company requires Your written consent (which includes an indication of no objection) for that purpose;

If You do not wish the Company to use or provide to other persons Your data for use in direct marketing as described above, You shall exercise Your opt-out right by notifying the Legal and Compliance Department of the Company (Tel.:2867 0888, Fax no.:3906 9939).

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LIMIT OF INDEMNITY TABLE

I. Basic Benefits (Insured item B and/or C is operative if coverage is so stated in the Schedule)

Insured Items and Coverage		Maximum Limit (HK$) (per Insured Person)			
		Plan 1	**Plan 2**	**Plan 3**	**Plan 4 (Medical Top-up Plan)**
A	**Hospital and Surgical Benefits (per Disability Per Policy Year) – Compulsory items**				
	1. Room and Board Fee (a maximum of 100 days), limit per day	$800	$1,550	$3,000	Overall maximum limit per Policy Year is $250,000 and a maximum of 55% reimbursement per claim and no specified limit per item. **Note:** The Insured Person should hold a valid hospital and surgical insurance upon submission of claims. Otherwise, this benefit will become invalid.
	2. Physician's Visit Fee (a maximum of 100 days), limit per day	$800	$1,550	$3,000	
	3. Hospital Services Fee	$12,000	$18,000	$25,000	
	4. Surgical Expenses (payable in accordance with "Classification Schedule of Surgical Operations" and 2 pre-surgical assessments and the post–surgical case are included)				
	- Complex	$38,000	$50,000	$70,000	
	- Major	$20,000	$30,000	$47,000	
	- Medium	$9,000	$15,000	$19,000	
	- Minor	$5,000	$6,500	$8,000	
	(Fee for post surgical treatment by registered Chinese Medical Practitioner, 1 visit per day, a maximum of 5 visits per Disability), limit per day	$120	$150	$180	
	5. Operating Theatre Fee	Up to 30% of Surgical Expenses in Item A4			
	6. Anaesthetist's Fee	Up to 30% of Surgical Expenses in Item A4			
	7. Specialist's Fee[1]	$4,000	$6,000	$9,000	
	8. Intensive Care Fee (maximum limit will be doubled automatically for compulsory quarantine by the government authority and for intensive care treatment in the Hospital due to the contraction of infectious disease)	$15,000	$20,000	$25,000	
	9. Post-Hospitalisation Treatment Fee (within 6 weeks immediately after discharged from Hospital or post-clinical surgery)	$1,200	$2,500	$4,500	
	10. Extra Bed Accommodation Fee (accompanying the Insured Person for Hospital Confinement; a maximum of 100 days), limit per day	$800	$1,000	$1,200	
	11. Accidental Emergency Out-patient Treatment Expenses	$1,500	$2,000	$2,500	
	12. Home Nursing Fee (a maximum of 100 days), limit per day	$530	$850	$1,150	
	13. Medical Appliances (Specific Items) (Including Pacemaker, Stents for Percutaneous Transluminal, Coronary Angioplasty, Intraocular Lens, Artificial Cardiac Valve, Metallic or Artificial Joints for Joint Replacement, Prosthetic Ligaments for Replacement or Implantation between Bones and Prosthetic Intervertebral Disc)	$10,000	$20,000	$30,000	
	14. Chemotherapy/Radiotherapy/Targeted therapy/Proton Therapy/ Immunotherapy/Hormonal therapy/Gamma Knife/ Cyber Knife/Renal Dialysis Treatment Expenses	$30,000	$50,000	$70,000	
	15. Cash Allowance for Health Supplement Food (payable from the 8th day of Hospital confinement onward after surgical operation, a maximum of 5 days per Disability), limit per day	$200	$300	$500	
	16. Special Cash Allowance for Public Hospital in Hong Kong (for general ward bed only, a maximum of 50 days. This benefit is payable where no other benefits in item A (Hospital and Surgical Benefits) are payable, but except item A15 (Cash Allowance for Health Supplement Food), limit per day	$500	$750	$1,000	
	17. Compassionate Death Benefit Death in the Hospital as a result of Accident	$8,000	$10,000	$12,000	
Annual Overall Limit for each Insured Person aged 76 or above under Item A		**$200,000**	**$400,000**	**$600,000**	

Insured Items and Coverage		Maximum Limit (HK$) (per Insured Person)			
		Plan 1	**Plan 2**	**Plan 3**	**Plan 4 (Medical Top-up Plan)**
B	**Supplementary Major Medical Benefit** [2] **（Per Disability Per Policy Year）**				
	Only applicable after the exhaustion of "Hospital and Surgical Benefits" payable under Basic Benefits Items A3 to A8 (calculation of reimbursement in accordance with the percentage)	$150,000	$300,000	$500,000	N/A
	Reimbursement Percentage	80%	80%	a. 80% or b. 100%	
C	**Hospital Cash Benefit**				
	• Regardless of any basic benefits or plan selected, the sum insured will be covered under Plan 1 only for the insured Child(ren) aged 18 or below. • If the Hospital confinement is in the Mainland China, the maximum limit of this coverage will be reduced by half. For Hospital confinement outside Hong Kong (China), the maximum number of days is 90 per Policy Year for each Insured Person.				
	1. Daily Hospital Cash (a maximum of 365 days per event)	$300	$500	$1,000	$300
	2. Double Indemnity of Daily Hospital Cash due to any one of following Events (a maximum of 365 days per event) i. Confinement in the Intensive Care Unit (a maximum of 90 days per event) ii. Receiving major organ transplant surgery or first diagnosis with cancer disease iii. Suffering from defined infectious disease (a maximum of 30 days for each infectious disease) iv. Temporary leaving Hong Kong (China) but not exceeding 60 days with Hospital confinement required during this period (excluding the Mainland China and Macau (China), a maximum of 30 days per event v. The Insured Person and insured legal spouse are hospitalised at the same time due to the same Accident	$600	$1,000	$2,000	$600
Free Services					
24-hour Worldwide Emergency Assistance Service (a Hospital deposit guarantee of up to HK$40,000 in the event of emergency Hospital confinement outside Hong Kong (China) is applicable)		Please refer to this Policy for details			

II. Optional Benefits (Each insured item(s) is/are operative if coverage is so stated in the Schedule)

	Insured Items and Coverage	Maximum Limit (HK$) (per Insured Person)		
		Plan 1	**Plan 2**	**Plan 3**
D	**Out-Patient Benefit**			
	Network and Non-network Services (80% reimbursement for Non-network Services)	Network Services	Network Services	Network and Non-network Services
	1. General Practitioner Consultation (3 days western medication, 1 visit per day)			
	Maximum limit per visit	-	-	Non-network Services $350
	Maximum number of visits per Policy Year	Unlimited	Unlimited	Unlimited
	Co-payment – Network Services	$30	$10	$0
	Co-payment – Non-network Services	N/A	N/A	20%
	2. Specialist Consultation[1] (referral letter is required, 5 days western medication, 1 visit per day)			
	Maximum limit per visit	-	-	Non-network Services $700
	Maximum number of visits per Policy Year	Unlimited	Unlimited	Unlimited
	Co-payment - Network Services	$50	$30	$20
	Co-payment - Non-network Services	N/A	N/A	20%
	3. Chinese Medical Practitioner Consultation (including bonesetter & acupuncture, 1 visit per day)			
	Maximum limit per visit	N/A	-	$180
	Maximum number of visits per Policy Year		12	12
	Co-payment – Network Services		$0	$0
	Co-payment – Non-network Services		N/A	20%
	4. Physiotherapy and Chiropractic Treatment[1] (referral letter is required, 1 visit per day)			
	Maximum limit per visit	-	-	$340
	Maximum number of visits per Policy Year	10	10	10
	Co-payment – Network Services	$0	$0	$0
	Co-payment – Non-network Services	N/A	N/A	20%
	5. Diagnostic X-ray and Laboratory Tests[1] (referral letter is required)			
	Maximum limit per Policy Year	$2,500	$3,000	$4,000
	Co-payment – Network Services	$0	$0	$0
	Co-payment – Non-network Services	N/A	N/A	20%
E	**Dental Benefit**			
	Reimbursement Percentage:	80%	100%	
	1. Intra-oral small film radiograph (maximum limit per film)	$60	$70	
	2. Scaling, polishing and prophylaxis (maximum limit per visit, maximum number of visits per Policy Year)	$300 (1 visit)	$400 (2 visits)	
	3. Fillings, extraction (maximum limit per tooth)	$300	$400	N/A
	4. Drainage of abscess (maximum limit per tooth)	$200	$300	
	5. Root canal fillings (maximum limit per root)	$600	$1,200	
	Maximum aggregate limit per Policy Year under Item E "Dental Benefit"	$2,000	$3,800	
F	**Maternity Benefit** (per pregnancy including pre-natal and post-natal out-patient expenses; not applicable for pregnancy or birth of a Child within 9 months from the commencement or the reinstatement date of this benefit cover, whichever is later.)			
	1. Caesarean section	$12,000	$15,000	$22,500
	2. Normal delivery	$8,000	$10,000	$15,000
	3. Miscarriage	$6,000	$8,000	$12,000

Insured Items and Coverage		Maximum Limit (HK$) (per Insured Person)		
		Plan 1	Plan 2	Plan 3
G	**Critical Illness Benefit**			
	1. Provide lump sum payment if first diagnosed with one of the covered Critical Illness. Insured person must be alive for at least 30 days after being first diagnosed before a claim becomes payable. **2.** Upon approval of a claim for Critical Illness, the Insured Person's benefit under this item "G" will be terminated immediately. **3.** 90 days waiting period: benefit is not payable where the signs or symptoms of Critical Illness or the diagnosis of which first occurred within 90 days immediately following the benefit cover effective date or the effective date of last reinstatement of the benefit, whichever is later.	$100,000	$200,000	$300,000
	Extended Benefits:			
	1. **Medical Expenses for Critical Illness** (due to ascertained the first diagnosis of Cancer, Stroke or Cardiomyopathy)	$30,000	$45,000	$60,000
	2. **Additional benefit of the diagnosis of 5 Female Critical Illness or Serious Disease** (A lump sum payment will be made payable to female Insured Person in the event of first diagnosis of breast cancer, cervix uteri cancer, ovarian cancer, uterine cancer or Systemic Lupus Erythematosus (SLE) [3]).	$50,000	$80,000	$100,000
	3. **Additional benefit of the diagnosis of 5 male Critical Illness** (A lump sum payment will be made payable to male Insured Person in the event of first diagnosis of lung cancer, liver cancer, colon cancer, prostate cancer or Cardiomyopathy)	$50,000	$80,000	$100,000

All charges incurred must be Reasonable and Customary.

Remarks:
1. Subject to the referral letter issued by the qualified attending Physician. The time lag between the issuance date of referral letter and the relevant consultation date must not exceed six (6) months.
2. If the Insured Person daily maximum limit for Room and Board Fee is less than the actual amount charged for Room and Board Fee by the Hospital for Hospital Confinement. The Company reserves the right to adjust the benefit payable under Supplementary Major Medical Benefit.
3. SLE: Subject to 90 days waiting period and once a claim being made in this benefit, item "G" benefit will be terminated immediately for the Insured Person receiving such claim.