POLICY PROVISIONS
OF
GLOBALREACH MEDICAL INSURANCE PLAN

1. DEFINITION

1.1 Interpretation - How should this policy be read and interpreted?

1. In this policy, the words "**you**" and "**owner**" mean the owner named in the Policy Applications until changed according to the provisions of this policy. The expression "**your**" and "**yours**" should be construed accordingly. The owner may or may not be the Insured.

2. "**We**" and the "**Company**" mean AXA China Region Insurance Company (Bermuda) Limited (incorporated in Bermuda with limited liability). The expression "**us**", "**our**" and "**ours**" should be construed accordingly.

3. The meaning of the terms shown in this "Definition" Provision and all other terms defined in this policy shall apply to the relevant defined terms throughout this policy (unless the context otherwise requires).

4. Unless otherwise stated, the provisions of the Basic Plan also apply to:

   (a) any endorsements which are attached to this policy or expressly indicate that they form part of this policy; and

   (b) any supplements which are attached to the Basic Plan.

5. Where the context permits:

   (a) singular words used in this policy shall include the plural (vice versa);

   (b) any references to the male gender shall include the female gender (vice versa);

   (c) any references to a "person" shall include an individual, body corporate, unincorporated association, partnership, firm, joint venture, trust and its successors and assigns;

   (d) any references to the word "include" or "including" shall mean include without limitation; and

   (e) any references to a clause shall mean the relevant clause of these policy provisions.

6. Reference to any statute, enactment, ordinance, order, regulation or other similar instrument shall be construed to include a reference to the statute, enactment, ordinance, order, regulation or instrument as from time to time amended, extended, re-enacted or consolidated.

7. All headings and sub-headings are for ease of reference only and will not affect the construction or interpretation of this policy.

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8. The phrase first appearing in the left hand column of each provision and sub-provision shall be construed as the title of the relevant provision and sub-provision respectively. Such construction shall apply throughout this policy, unless the context specifies otherwise. By way of example only, Clause 1 shall be referred to as the "Definition" Provision and this Clause 1.1 shall be referred to as the "Interpretation" Provision.

1.2 Defined Terms - What is the meaning of the specifically defined terms below?

Accident: This means a sudden and unforeseen event occurring entirely beyond the control of the Insured and caused by violent, external and visible means.

Active Cancer Treatment: This means Medically Necessary treatment intended to shrink, stabilise or slow the spread of cancer, or related to the diagnosis of cancer, received as an In-patient, Day Patient or Out-patient including but not limited to radiotherapy, chemotherapy, target therapy, immunotherapy or hormonal therapy. It does not include any treatment that is provided solely to prevent or relieve symptoms or Palliative Care and Treatment.

Age: This means the age of the relevant person on his last birthday (and the expression "Aged" shall be construed accordingly).

Annual Benefit Limit: This means the maximum amount of benefits paid by the Company to you in a Policy Year irrespective of whether any limits of any benefit items stated in the Benefit Schedule have been reached.

The Annual Benefit Limit is counted afresh in a new Policy Year.

Application Procedures: This means you must make the relevant application to us in writing (in such form as specified by us and manner satisfactory to us) and send it to us at the Company's Office. Such application must be (i) accepted by us; and (ii) in compliance with applicable laws, regulations and regulatory requirements and the administrative rules, underwriting and any other requirements of the Company in effect from time to time. Your application will be subject to our approval at our discretion.

Area of Cover: This means one of the following, as specified in the Policy Specifications:

(a) **Worldwide**: worldwide; or

(b) **Worldwide excluding USA**: worldwide excluding the USA; or

(c) **Asia**: Australia, Bangladesh, Bhutan, Brunei, Mainland China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Nepal, New Zealand, Philippines, Singapore, South Korea, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, Vietnam.

Basic Plan: This means the Basic Plan as shown in the Policy Specifications.

Beneficiary: This means a person named in our records to receive the Death Proceeds and other applicable benefits under this policy at the Insured's death.

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Benefit Level: This means the Benefit Level applicable to this Basic Plan which is shown in the Policy Specifications.

Benefit Schedule: This means schedule of benefits attached to this Basic Plan which sets out, among others, the benefit items and maximum benefits covered.

Chinese Medical Practitioner: This means a duly qualified practitioner of Chinese medicine registered and legally authorised by the government of the geographical area of his practice to practise Chinese medicine and to render acupuncture treatment but in no circumstance shall include the following persons - the Insured, the owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the owner and/or the Insured (unless approved in advance by the Company in writing).

Company's Office: It is the Company's customer services office in Hong Kong. We can determine the location of the Company's Office from time to time and provide the address to you upon request.

Compassionate Death Benefit: This means the Compassionate Death Benefit which will be paid out under this Basic Plan in accordance with the Benefit 4.1 "Compassionate Death Benefit" under the "Benefit" Provision.

Confinement or Confined: This means an admission of the Insured to a Hospital that is recommended by a Registered Medical Practitioner for Medical Services and as an In-patient as a result of a Medically Necessary condition.

Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured must stay in the Hospital continuously for the entire period of Confinement.

Congenital Condition(s): This means (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.

Contingent Owner: This means the "Contingent Owner" described in the "Contingent Owner" Provision.

Day Patient: This means an Insured receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured is not in Confinement.

Daycare Treatment: This means a Medically Necessary surgical procedure for investigation or treatment to the Insured performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.

Death Proceeds: This means the total amount payable under the Basic Plan and any attached supplement(s) if the Insured dies while this policy is in effect.

Deductible: This means a fixed amount of Eligible Expenses that, in a Policy Year, you must pay before the Company shall reimburse the remaining Eligible Expenses.

Designated Cancer: This means, for the purpose of Benefit 3.9 "Experimental Drugs" under the "Benefit" Provision, malignant cancer which:

(a) has been classified as Stage III or Stage IV malignant tumour pursuant to the American Joint Committee on Cancer (AJCC) cancer staging system or its equivalent; or

(b) is a haematological malignancy and is confirmed incurable with existing non-experimental treatment by a Specialist in haematology services,

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but will specifically exclude any of the following:

(i) All Central Nervous System (CNS) tumours which are histologically classified as Grade III or below according to the World Health Organization (WHO) Classification of Tumours of the Central Nervous System; and

(ii) All chronic lymphocytic leukaemia classified as less than RAI stage III.

The Designated Cancer must be confirmed by the Insured's attending Specialist in writing and supported by clinical, radiological, histological or laboratory evidence reasonably acceptable to the Company.

Designated Major Illness: This means any of the Designated Major Illnesses as specified in the "Definition of Designated Major Illnesses" Provision as set out in **Appendix 1** attached to this Basic Plan and excludes all other illnesses.

For the definition of each Major Illness, please refer to the "Definition of Designated Major Illnesses" Provision as set out in **Appendix 1** attached to the Basic Plan.

Disease: This means a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured and whether or not any diagnosis is confirmed.

Eligible Expenses: This means Reasonable and Customary expenses incurred for Medical Services rendered with respect to a Medical Condition.

Emergency: This means an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured's health.

Emergency Treatment: This means Medical Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.

Experimental Drug: This means, for the purpose of Benefit 3.9 "Experimental Drugs" under the "Benefit" Provision, a substance or medicinal product that:

(a) is intended to treat a disease, or to restore, correct or modify physiological functions by exerting a pharmacological, immunological or metabolic action;

(b) has been tested in the laboratory and has been approved by one of the following regulatory bodies for undergoing phase 3 of a clinical trial for testing and/or treatment in humans for the treatment of the Designated Cancer, including United States Food and Drug Administration (FDA), European Medicines Agency (EMA), National Medical Products Administration (NMPA) of China, Department of Health of Hong Kong or Health Bureau of Macau; and

(c) at the time of prescription to the Insured, such substance or medicinal product must be undergoing phase 3 of a clinical trial that is approved by the relevant institutional review board in the location where the drug is administered, as being an effective treatment for such Designated Cancer upon preliminary review by such board.

General Ward: This means a room categorised as a general ward or standard room by a Hospital in Hong Kong, or a room with more than double occupancy in a Hospital outside Hong Kong with a shared bath or shower room but excluding any Semi-private Room or above. For the

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avoidance of doubt, any room equipped with kitchen, dining and/or sitting room(s) shall be excluded.

Grace Period: This means the "Grace Period" described in the "Grace Period" Provision.

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

Hospital: This means an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as In-patients, and which:

(a) has facilities for diagnosis and major operations, or is a public hospital as defined in the Hospital Authority Ordinance (Cap. 113 of the Laws of Hong Kong) or a hospital for which a licence is issued under the Private Healthcare Facilities Ordinance (Cap. 633 of the Laws of Hong Kong);

(b) provides twenty-four (24) hours nursing services by Qualified Nurses;

(c) has one (1) or more Registered Medical Practitioners; and

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

In-patient: This means the Insured who is Confined.

In-patient Treatment: This means the treatment received by the Insured in a Hospital during the Insured's Confinement.

Injury: This means any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.

Insured: This means the Insured named in the Policy Specifications.

Intensive Care Unit: This means that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for In-patients.

Issue Date: This means the date we issued this policy (which is stated in the Policy Specifications), or in the case of any attached supplement or endorsement, this means the date we issue such supplement or endorsement (which is stated in the supplement or endorsement, as the case may be).

Macau: This means the Macau Special Administrative Region of the People's Republic of China.

Manifested Congenital Condition: This means a Congenital Condition that was known, manifested or diagnosed before the Policy Date.

Mainland China: This means the People's Republic of China (excluding Hong Kong, Macau and Taiwan).

Medical Condition: This means any Disease, illness or Injury, including any and all complications arising therefrom.

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Medical Services: This means Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Medical Condition or Palliative Care and Treatment.

Medically Necessary: This means the need to have medical services for the purpose of investigating or treating the relevant Medical Condition in accordance with the generally accepted standards of medical practice and such medical service must:

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

(b) be consistent with the diagnosis and necessary for the investigation and treatment of the Medical Condition;

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

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

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

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

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

(ii) surgical procedures are performed under general anaesthesia;

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

(iv) there is significantly severe co-morbidity of the Insured;

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

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

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

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

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

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

Non-manifested Congenital Condition: This means a Congenital Condition that was unknown and not manifested nor diagnosed before the Policy Date.

Out-patient Treatment: This means treatment received by the Insured as an Out-patient.

Out-patient: This means the Insured who attends a Hospital, consulting room or out-patient clinic and is not admitted as a Day Patient or In-patient.

Palliative Care and Treatment: This means palliative care and treatment of the Insured diagnosed with a Terminal Medical Condition, when the primary purpose is to offer the Insured with pain controlling relief, alleviate the Insured's symptoms and if any treatment is given, it no longer attempts to alter the Medical Condition's growth or progression that achieves remission or cure.

Palliative Care and Treatment includes accommodation, palliative care, nursing care, prescribed drugs, psychological and social support (medical and paramedical) for the Insured during the last stage of life.

Policy Anniversary: This means, after the Policy Date, the month and day in each year which is the same as the month and day of the Policy Date.

Policy Applications: This means applications for the Basic Plan and supplements (if any) (including any subsequent amendments, declarations and statements made by the owner and/or the Insured).

Policy Currency: This means the currency in which this policy is denominated. The amounts in the Policy Specifications are shown in such currency.

Policy Date: This means the Policy Date as shown in the Policy Specifications.

Policy Specifications: This means the policy specifications which are attached to these policy provisions.

Policy Year: This means the period from a Policy Anniversary (including such date) to the next subsequent Policy Anniversary (excluding such date). The period from the Policy Date (including such date) to the first Policy Anniversary (excluding such date) is deemed to be the first Policy Year.

Pre-existing Condition(s): This means the "Pre-existing Condition" described in the "Pre-existing Condition" Provision.

Premium Payment Term: This means the period(s) for which premiums shall be payable to us under the Basic Plan and/or any supplements of this policy.

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Prescriptions: This means out-patient drugs and dressings as prescribed by a Registered Medical Practitioner for the treatment of a Medical Condition covered by this policy.

Principal Country of Residence: This means the country where the Insured lives or intends to live for most of the Policy Year being one hundred eighty-five (185) days or more and which will be shown as the place of residence in our records. Hong Kong, Macau and Taiwan are respectively considered as country for the purposes of this policy.

Qualified Nurse: This means a nurse who is,

(a) duly qualified and registered with the Nursing Council of Hong Kong pursuant to the Nurses Registration Ordinance (Cap. 164 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and

(b) legally authorised for rendering relevant nursing service in Hong Kong or the relevant jurisdiction outside Hong Kong where the nursing service is provided to the Insured,

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

Reasonable and Customary: This means, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar Age, for a similar Medical Condition, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred.

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

(a) treatment or service fee statistics and surveys in the insurance or medical industry;

(b) internal or industry claim statistics;

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

(d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.

Registered Dentist: This means a dentist who is,

(a) duly qualified and registered with the Dental Council of Hong Kong pursuant to the Dentists Registration Ordinance (Cap. 156 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and

(b) legally authorised for rendering relevant dental service in Hong Kong or the relevant jurisdiction outside Hong Kong where the dental service is provided to the Insured,

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

Recognised Hospital:

This means any Hospital(s) formally assessed and rated by the Mainland Government Ministry of Health of Mainland China as a "third level first class" [三級甲等] Hospital and/or Hospital(s) approved or designated by the Company.

The Company reserves the right to review and reasonably revise the definition of Recognised Hospital in the event that the relevant authority in Mainland China cancels or amends the criteria for rating hospitals and/or where the Company deems necessary.

Registered Medical Practitioner, Specialist, Surgeon and Anaesthetist:

This means a medical practitioner of western medicine,

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

(b) legally authorised for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured,

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

Semi-private Room:

This means a room categorised as a semi-private or second class room by a Hospital in Hong Kong, or a single or double occupancy room in a Hospital outside Hong Kong with a shared bath or shower room but excluding any Standard Private Room or above. For the avoidance of doubt, any room equipped with kitchen, dining and/or sitting room(s) shall be excluded.

Standard Private Room:

This means a room categorised as a single, private or first class room by a Hospital in Hong Kong, or a basic single occupancy room in a Hospital outside Hong Kong with a private bath or shower room. For the avoidance of doubt, any room equipped with kitchen, dining and/or sitting room(s) shall be excluded.

Terminal Medical Condition:

This means the conclusive prognosis of a Medical Condition that is expected to result in the death of the Insured within twelve (12) months. This prognosis must be supported by a Specialist. Terminal Medical Condition in the presence of Human Immunodeficiency Virus infection is excluded.

Termination Date:

If the Policy Anniversary falls on the same month and day as the Insured's birthday, this means the Policy Anniversary on the Insured's one hundredth (100th) birthday. If otherwise, this means the Policy Anniversary immediately following the Insured's one hundredth (100th) birthday.

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Trouble Free: This means when the Insured:

(a) has not required or had any medical opinion (which includes but not limited to follow-up consultation, regular check-up) from a Registered Medical Practitioner including general practitioners (GPs), Specialists or other health professionals;

(b) has not taken any medication (including over the counter drugs) or followed a special diet;

(c) has not had any medical treatment; and

(d) has not had any symptoms;

for the Medical Condition or any associated Medical Condition.

If the Insured suffers from any Pre-existing Condition or any of its associated Medical Condition and does not meet any of the criteria above, the Insured will not be considered as Trouble Free.

USA: This means the United States of America and US Minor Outlying Islands.

Visit: This means each separate occasion that the Insured meets with a Registered Medical Practitioner, Chinese Medical Practitioner, chiropractor, acupuncturist, homeopath, osteopath, or physiotherapist and receives a consultation and/or Out-patient Treatment for a Medical Condition.

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2. GENERAL PROVISION

2.1 Contract - What does this policy consist of?

This policy is a legal contract between you and us. This policy takes effect on the Policy Date. The entire contract of this policy ("**this policy**") consists of the following items:

(a) these policy provisions;

(b) the Policy Applications;

(c) the Policy Specifications;

(d) any endorsements which are attached to this policy or expressly indicate that they form part of this policy; and

(e) any supplements which are attached to the Basic Plan.

Unless we specifically agree in writing (which must be (i) in the form specified by us and (ii) acknowledged and/or approved by our duly authorised representative), any changes to this policy or waiver of our rights and requirements under this policy will not be effective.

We reserve the right to change the provisions of this policy at any time in accordance with the provisions of this policy or if we consider it necessary to comply with any applicable laws, regulations and regulatory requirements or where there is any misstatement of information by you or the claimant under this policy. We have the right to correct any clerical errors or mistakes in the issue of this policy by notifying you.

No failure or delay in exercising any right under this policy by the Company shall operate as a waiver of any such right by the Company.

Any notices or communications required to be given by us under this policy may be given by such means specified by us and in such form satisfactory to us, subject to the administrative rules of the Company in effect from time to time.

2.2 Policy Type - Is this a participating policy?

This policy is a non-participating policy and is not entitled to participate in the distribution of distributable surplus by the Company. This policy has no cash value, loan value, account value or option on non-payment.

2.3 Contestability - Why is it important for you to provide accurate and complete information to us?

We rely on the information you gave us in the Policy Applications to decide whether to accept your application. You shall be responsible for giving us complete and accurate information of the owner, the Insured, the Beneficiary, as well as all material facts required to be disclosed in the Policy Applications or in our specific request(s) which may affect our underwriting decision.

If (i) the issuance of this policy has been procured by fraud or by misrepresentation; or (ii) any of the information provided by you is incomplete or inaccurate or you do not comply with any conditions of this policy; or (iii) there is non-payment of premium, we may at all times contest:

(a) the validity of this policy;

(b) any benefits under this policy; and/or

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(c) insurability of the Insured;

and may determine that this policy shall be void from inception (in which case we reserve the right in our sole and absolute discretion not to refund any premium), refuse to pay any benefit(s), apply different terms of cover and/or premium increase at any time we consider appropriate in our absolute discretion.

2.4 Misstatement of Age or Sex or Smoking Status or Principal Country of Residence - What if the Age or sex or smoking status or Principal Country of Residence of the Insured has been misstated?

If the Age, sex, smoking status and/or Principal Country of Residence (where relevant for underwriting) of the Insured has been misstated (in the Policy Applications or otherwise), we have the right to (but are not obliged to) re-determine the premiums payable under this policy and you shall pay us any additional amounts determined by us to keep this policy in effect. We may also re-calculate the Death Proceeds and other benefits payable under this policy based on the correct Age and sex and actual smoking status and Principal Country of Residence (where relevant for underwriting) and the premiums paid.

If, at the correct Age, sex, smoking status and/or Principal Country of Residence (where relevant for underwriting), the Insured was not insurable according to the Company's requirements, this policy (including any attached endorsement(s) and supplement(s)) will be voided from the Policy Date.

If a claim has been paid in respect of the Insured who was not insurable according to our requirements, you are required to immediately repay to us the amount of that claim and we shall have the right to deduct the amount of such claim from any amounts payable to you under this policy. All our rights under this clause shall survive the termination of this policy and we reserve all our rights to contest in the case of fraud and non-payment of premium.

2.5 Currency of Policy and Payment - What is the currency of this policy?

All amounts which are (a) payable by you to us or (b) payable by us to you will be paid in the Policy Currency. The payment of such amounts is subject to applicable laws, regulations and regulatory requirements and the administrative rules of the Company in force from time to time.

However, we shall have the discretion to accept payment under this policy in another currency, and also have the reasonable discretion to make payments under this policy in another currency.

Conversion between currencies shall be calculated at the prevailing currency exchange rate. We shall have discretion to determine such exchange rate from time to time upon payment. Any rounding difference shall be accrued to the Company.

The Policy Currency of this policy cannot be changed after this policy has been issued.

2.6 No Interest - Will you be entitled to any interest on amounts payable under this policy?

Unless explicitly stated, we will not pay any interest on any benefit payable or refund to be made under this policy, irrespective of when it is payable. If it is explicitly stated under this policy that interest will be payable by us on the relevant amount, the rate of interest will (unless explicitly stated) be declared by us and is not guaranteed. We have the discretion to determine, review and adjust such rate of interest from time to time.

2.7 Tax Obligations - What are the owner's tax obligations?

The owner acknowledges that he is aware that benefits or other payments under this policy may be liable to estate duty or other tax under applicable tax laws and he is aware that he should seek the advice of his legal or tax advisers if he has any doubts regarding the tax implications in respect of any proceeds under this policy.

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2.8 Governing Law - What is the governing law of this contract and which court has jurisdiction over disputes arising from this policy?

This policy is governed by and shall be construed in accordance with the laws of Hong Kong and is subject to the non-exclusive jurisdiction of the Hong Kong courts.

2.9 Severability - What if a court declares that part of this policy is invalid?

If any provision of this policy is determined by a court of competent jurisdiction to be illegal, invalid or unenforceable, that provision shall not affect the legality, validity or enforceability of any other provision of this policy.

3. OWNERSHIP RIGHTS OF THIRD PARTIES, ASSIGNMENT AND BENEFICIARY PROVISION

3.1 Owner - What are the rights of the owner of this policy? Can the owner of this policy be changed?

You are the only person entitled to exercise all policy rights under this policy while the Insured is living without the consent of any revocable Beneficiary.

During the lifetime of the Insured and while this policy is in effect, subject to the approval of the Company at its sole and absolute discretion and any applicable laws, regulations and guidelines, you may apply to us to change the owner of this policy in accordance with the Application Procedures.

Such change is valid only if your application is satisfactorily accepted and recorded by us in writing during the lifetime of the Insured while this policy is in effect. We will not be responsible for any payment we make or other action we take before we satisfactorily accept and record the change.

3.2 Rights of Third Parties - Can a non-party to this policy enforce the terms of this policy?

Any person or entity which is not a party to this policy shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Chapter 623 of the Laws of Hong Kong) to enforce any terms of this policy.

3.3 Assignment - Can this policy be assigned as collateral or security?

You are not allowed to assign this policy as collateral or security.

3.4 Beneficiary - Can you change the Beneficiary of this policy?

While this policy is in effect, you may nominate or change the Beneficiary of this policy by sending written notice (in such form and manner satisfactory to us) to us at the Company's Office in accordance with the Application Procedures. Such change is valid only if the notice is satisfactorily accepted and recorded by us in writing during the lifetime of the Insured while this policy is in effect. We will not be responsible for any payment we make or other action we take before we accept and record the notice.

We will pay the Death Proceeds under this policy to the Beneficiary named in our records in accordance with the provisions of this policy.

For benefits which are payable to the Beneficiary according to the provisions of this policy, if there is more than one Beneficiary, we will pay such benefits to the Beneficiaries in the proportion as specified by you. If you have not specified such proportion or all the proportions do not add up to a figure of 100%, we shall have the discretion to pay such benefits to all the Beneficiaries in equal shares or in such proportion as determined in our reasonable discretion.

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We will pay the benefits payable to the Beneficiary in accordance with the provisions of this policy to you or your estate where:

(a) no Beneficiary is named in our records;

(b) the Beneficiary dies before the Insured's death; or

(c) the Beneficiary dies at the same time or within ten (10) days from the Insured's death.

If we produce (i) a receipt for any sum payable under this policy which is signed by the owner or the Beneficiary (or their executor(s) or administrator(s)); or (ii) other documentary proof evidencing that payment of any sum payable under this policy was made in accordance with the provisions of this policy, we will be fully discharged from the obligations to pay such sum. Such receipt and/or documentary proof will be final and conclusive evidence that such sum has been duly received by the person entitled to it and that all claims and demands whatsoever against us in respect of such sum have been fully satisfied.

If an irrevocable Beneficiary has been named, the Company may require the consent of the irrevocable Beneficiary for any change or transaction in respect of this policy as the Company may consider necessary at its sole and absolute discretion.

4. PREMIUM PROVISION

4.1 Premium - When should you pay the premiums?

The Policy Specifications shows the applicable premiums payable by you under the Basic Plan and attached supplement(s) (if any). This information is shown as of the Issue Date only and may change according to the policy provisions.

You shall pay all premiums to us on or before each premium due date during the Premium Payment Term of the Basic Plan and attached supplement(s) (if any). Annual premiums are due on the Policy Anniversaries.

Unless otherwise specified, premiums shall be paid to us annually.

Premiums of the Basic Plan are not guaranteed and the Company reserves the right to review and adjust the premium on each Policy Anniversary.

The Premium Payment Term of the Basic Plan and attached supplement(s) (if any) cannot be changed.

4.2 Grace Period - Will there be a grace period for late payments of premiums?

After the first premium payment, you are allowed a Grace Period of thirty-one (31) days after the due date for payment of each premium for this policy. This policy will continue to be in effect during this Grace Period.

If a premium is still unpaid at the end of the Grace Period, the premium is in default and this policy will lapse and terminate.

Any outstanding premium will be deducted from any monies payable by us under this policy. Our right of deduction shall survive the termination of this policy.

4.3 Reinstatement - Can this policy be reinstated

This policy cannot be reinstated after it is no longer in effect.

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after it is no longer in effect?

5. OTHER PROVISION

5.1 Notice and Proof - How and when should claims be made under this policy?

We must receive due proof that Medical Service has been given to the Insured while the coverage of this Basic Plan was in effect resulting (directly and independently of all other causes) from a Medical Condition before any benefit is payable. Due proof should be furnished (in the form specified by us and in such manner satisfactory to us) within ninety (90) days after the date on which the Insured is discharged from the Confinement or, where there is no Confinement, the date on which the relevant Medical Service is performed. Proof, including without limitation medical reports required by us, shall be furnished at your expense. If we do not receive due proof within such timeframe, you or the claimant must show to our satisfaction that due proof was submitted to us as soon as practicable, or we will not pay any benefit.

In respect of death,

(a) we must be notified in writing (in the form specified by us and in such manner satisfactory to us) of the Insured's death within thirty (30) days from the date of death; and

(b) we must also receive due proof of the Insured's death (in the form specified by us and in such manner satisfactory to us) within ninety (90) days from the date of death of the Insured. We shall have the right to request you or the claimant to provide, at your or the claimant's expense, further evidence that is acceptable to us and shall have the right to conduct an autopsy where it is not forbidden by law.

If we do not receive notification or due proof within such timeframe, you or the claimant must show to our satisfaction that such notice or due proof was submitted to us as soon as practicable, or we will not pay the relevant benefit.

5.2 Medical Examination - Are medical examinations required when there is a claim?

When a claim occurs, we may require that the Insured be examined by a Registered Medical Practitioner and/or a Specialist of our choice and may require the Insured to undergo relevant laboratory investigations and/or other investigations.

5.3 Pre-Existing Condition - Are pre-existing conditions covered under this policy?

"Pre-existing Condition" means a Medical Condition which during the five (5) years preceding the Policy Date:

(a) has been diagnosed; or

(b) for which the Insured has received medication, advice or treatment; or

(c) which the Insured reasonably has known about based on the Company's appointed medical doctor's opinion; or

(d) for which the Insured has experienced symptoms even if the Insured has not consulted a Registered Medical Practitioner.

We will assess a Medical Condition associated with a Pre-existing Condition as a Pre-existing Condition.

We will determine that a Medical Condition is associated with a Pre-existing Condition when this Pre-existing Condition is recognised either by your attending Registered

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Medical Practitioner or the Company's appointed Registered Medical Practitioner in the concerned medical area, as a risk factor, or if it is directly or indirectly related to such Medical Condition. While we will not unreasonably refuse to pay benefit, we will reserve the right to determine whether a Medical Condition is associated with a Pre-existing Condition or not.

Benefit for any Medical Condition associated with a Pre-existing Condition will be paid for under the Benefit 3.2 "Pre-existing Conditions" under the "Benefit" Provision if allowed for by your Benefit Level.

During the first two (2) years of consecutive cover you will not be covered for Pre-existing Conditions unless your Benefit Level provides for a Benefit 3.2 "Pre-existing Conditions" under the "Benefit" Provision.

Once the Insured has been covered under this policy for two (2) consecutive years from the Policy Date, the Insured may be able to claim for Eligible Expenses arising from Pre-existing Conditions including associated Medical Conditions as long as the Insured has had a Trouble Free period of two (2) consecutive years immediately before such Eligible Expenses have been incurred.

Some Pre-existing Conditions may continue or keep recurring and hence the Insured may never be able to have a two (2) consecutive years Trouble Free period. This also includes any related or associated Medical Conditions. In such cases the Insured could claim under Benefit 3.2 "Pre-existing Conditions" under the "Benefit" Provision if such benefit is included in the Insured's Benefit Level. If not, the Insured would not be able to claim for them.

5.4 Exclusion - What is not covered under this policy?

We will not pay any benefit (other than Death Proceeds for this Basic Plan) under this Basic Plan in respect of the following tests, investigations, treatments, items, conditions, activities and their related or consequential expenses:

(1) Any Pre-existing Conditions including associated Medical Conditions unless covered in accordance with "Pre-existing Condition" Provision of this policy;

(2) Pregnancy or childbirth (delivery), unless this is specifically included in Benefit Schedule of this Basic Plan. For the avoidance of doubt, under Benefit 3.10 "Pre- and Post-natal Complications" under the "Benefit" Provision of Prestige and Comprehensive Benefit Levels, we will pay for Medical Services of complications which is due to and occurs during the pregnancy prior to the delivery or after the delivery except if the pregnancy was a result of any form of assisted conception, fertility treatment by either parent or pregnancy via a surrogate, or through non-Medically Necessary caesarean section;

(3) Treatment begun, or for which the need had arisen, during the first ninety (90) days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination;

(4) Foetal surgery, surgery on a child while in the mother's womb;

(5) Termination of pregnancy or any consequences of it, except where eligible under Benefit 3.10 "Pre- and Post-natal Complications" under the "Benefit" Provision (applicable to Prestige and Comprehensive Benefit Levels only);

(6) Investigations into and treatment of infertility, contraception, assisted reproduction, sterilization (or its reversal), varicocele, treatment to prevent future

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miscarriage, investigations into miscarriages or any consequence of any of them or of any treatment for them;

(7) Treatment of impotence, sexual dysfunction or sexual problems or any consequence of any of them;

(8) Treatment of sexually transmitted diseases;

(9) Gender dysphoria, gender re-assignment or gender confirmation, including treatment, psychotherapy or similar services which arise from or is directly or indirectly made necessary by a gender dysphoria, gender re-assignment or gender confirmation;

(10) Medical Services which arises in any way from Human Immunodeficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS) unless specified in Benefit 3.17 "HIV/AIDS Treatment" under the "Benefit" Provision;

(11) Treatment of obesity, the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons;

(12) The charges relating to acquiring the organs for transplant surgery, any related administration costs, transport costs, cost of finding a donor and other donor expenses or if the Insured choosing to donate his tissue or organ as a live donor;

(13) Medical Services which arise from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide;

(14) Medical Services which arise from or is in any way connected with alcohol abuse or drug or substance abuse, the consumption of alcohol, drugs or solvents impairing the Insured's physical ability or judgment and results in the Insured putting himself at needless risk;

(15) Treatment to correct long or short-sightedness or astigmatism;

(16) Treatment directed towards developmental delay whether physical or psychological or learning difficulties;

(17) Preventive (i.e.: prophylactic) treatment;

(18) Vaccinations and routine or preventative medical examinations, including routine follow-up consultations, unless allowed for by the Benefit Schedule of this Basic Plan and accepted by us in writing;

(19) The costs of providing or fitting any orthosis, appliance or durable medical equipment unless otherwise agreed by the Company;

(20) Over-the-counter, non-prescription drugs, items which can be purchased at a local pharmacy such as but not limited to drugs to prevent allergies, tobacco dependency patches, toiletries, sunscreens, cosmetic drugs/products even if ordered for non-cosmetic purposes, vitamins, organic substances, health or dietary/nutritional supplements, infant formula, medical alcohol, cotton wool, dental hygiene products, toothpastes, mouthwash, lotions, moisturizers, creams, cleansers, shower gels, shampoos, soaps, proprietary headache and cold cures, nasal spray, artificial tear drops, suppositories, medical supplies – support garments, etc. These shall be excluded even if prescribed by the Registered

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Medical Practitioner unless specified in Benefit 1.1 “Hospital Charges” under the “Benefit” Provision. We do not pay for telephone charges;

(21) Orthodontics, periodontics, endodontics, preventative dentistry and general dental care including fillings, no matter who gives the treatment unless provided for by this Basic Plan and agreed, in writing, by us;

(22) Claims in respect of Medical Services received outside the Area of Cover except as allowed for by the “Outside Area of Cover” section under the “Benefit” Provision or if the Insured travelled against medical advice even inside the Area of Cover;

(23) Treatment of injuries sustained from playing professional sports (including as a result of training) or from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than ten (10) metres, trekking to a height of over two thousand and five hundred (2,500) metres, bungee jumping, canyoning, hang gliding, hot air balloon, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste;

(24) Any treatment specifically excluded by the terms shown on an endorsement or any documents forming part of this policy;

(25) Any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with treatment;

(26) Any charges from health hydros, spas, nature cure clinics (or practitioners) or any similar place, even if it is registered as a Hospital;

(27) Any claim or part of a claim in respect of which you have to pay a Deductible or co-insurance. In this case we will only pay the balance of the claim after we have deducted the Deductible or co-insurance amount;

(28) Any charges made by Registered Medical Practitioner, Hospital, laboratory or any such medical services which are not Reasonable and Customary charges;

(29) Any charges for Medical Services related to and/or the correction of Manifested Congenital Conditions or Non-manifested Congenital Conditions and/or deformities which have manifested or been diagnosed before the Insured attained the Age of eight (8) unless specifically indicated in the Benefit Schedule of the Benefit Level of this Basic Plan;

(30) Any charges for items not listed in the Benefit Schedule applicable to this Basic Plan;

(31) Charges incurred during a period for which the premium has not been paid;

(32) Genetic screening tests and counselling for the purposes of, inter alia, checking whether:

(a) the Insured has a Medical Condition when there are no symptoms;

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(b) the Insured has a genetic risk of developing a Medical Condition in the future;

(c) there is a genetic risk of the Insured passing on a Medical Condition; or

(d) that such genetic tests themselves are not conventional treatment or where they are used to direct treatment that is not established as being effective or is unproven.

(33) Treatment required as result of engaging in criminal activities;

(34) Treatment for all types of sleep disorders including for insomnia, snoring;

(35) Cryopreservation or harvesting or storage of stem cells as a preventative measure against possible future disease, illness or injury;

(36) Implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor unless this has been agreed by us in writing before the start of the treatment. Some examples of such treatment we may cover are organ transplantation, skin grafts, bone grafts, blood transfusions provided it was not due to a Pre-existing Condition or related to a Pre-existing Condition (unless covered in accordance with the "Pre-existing Condition" Provision of this policy);

(37) Any claims arising where the Insured is required to quarantine but have no medical need for treatment or care as an In-patient. This includes state mandated quarantine even if it takes place in a Hospital;

(38) Any loss, damage, liability or claims arising from or in connection with acts or omission of any third-party service providers, including without limitation those providing second medical opinion services and international emergency medical assistance and all other services available to you or the Insured under this policy.

Special terms apply in the following cases.

(1) The following tests, investigations, treatments, items, conditions, activities and their related or consequential expenses are excluded from the Basic Plan and the Company shall not be liable for:

(a) cosmetic (aesthetic) surgery or treatment;

(b) any treatment which relates to or is needed because of previous cosmetic (aesthetic) surgery or treatment. However we will pay for initial treatment plan for reconstructive surgery if:

(i) it is carried out to restore function after an Accident or following surgery for a Medical Condition, provided that the Insured has been continuously covered under this policy since before the Accident or surgery happened; and

(ii) it is done at a medically appropriate stage after the Accident or surgery; and

(iii) we agree the cost of the treatment in writing before it is done;

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(c) any dental procedure unless provided for by this Basic Plan. However, under Prestige and Comprehensive Benefit Levels, we will pay for some surgical procedures which need to be carried out by an oral and maxillofacial Surgeon;

(d) hormone replacement therapy, except when it is medically indicated (rather than for the relief of physiological symptoms), when we will pay for the consultations and for the cost of the implants or patches (but not tablets). We will only pay benefits for a maximum of eighteen (18) months from the date of the first consultation;

(e) treatment which, in our opinion, has not been established as being effective or is experimental or is in trial stage unless (i) such treatment is recognised as appropriate by a local public authority and we have agreed, before such treatment begins, in writing with the attending Registered Medical Practitioner, what the fees will be; or (ii) specified in Benefit 3.9 "Experimental Drugs Benefit" under the "Benefit" Provision.

(2) We will not pay for any Medical Services if they are rendered as a result of nuclear contamination, biological contamination or chemical contamination, or as a result of the Insured's participation in war (whether declared or not), terrorist act, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed. This includes any treatment needed as a result of the Insured exposing himself to needless peril, such as going to a place of unrest as an active onlooker or a spectator.

5.5 Suicide Exclusion - What will be payable if the insured commits suicide?

If the Insured, whether sane or insane, commits suicide within one (1) year from the Policy Date, the Death Proceeds will be limited to a refund of the premiums paid (without interest). The amount of premiums to be refunded will be calculated from the Policy Date.

5.6 Other Insurance or Sources - Will the benefits payable to you be affected by other insurance or coverage?

If you or the Insured is entitled to a reimbursement of all or part of the expenses incurred from any other insurance or sources, the Company will only be liable for such amount in excess of the amount payable under such other insurance or sources, but the amount which the Company is liable to pay shall not exceed the relevant limits as set out in the applicable Benefit Schedule under this Basic Plan.

5.7 Subrogation - What should be done if a third party can be claimed for the relevant expenses?

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

This clause shall not affect the application of the "Other Insurance or Sources" Provision.

5.8 Payment of Benefit - How will benefits be paid?

Unless the context specifies otherwise, the followings shall apply:

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(a) In respect of benefits (except the Compassionate Death Benefit) payable under the Basic Plan:

(i) Subject to Clause 5.8 (a)(ii), if the owner is living at the time of payment, we will pay the owner the benefits in accordance with the provisions of this policy.

(ii) If the owner is certified to be a mentally incapacitated person by at least one (1) Registered Medical Practitioner, the benefits will be paid to the Beneficiary where there is a Beneficiary named in our records.

(iii) If the owner is not living at the time of payment, we will pay the relevant benefit to the Beneficiary.

(b) In respect of the Compassionate Death Benefit payable under the Basic Plan:

We will pay the Beneficiary the Compassionate Death Benefit in accordance with the provisions of this Basic Plan when we receive due proof that the Insured died while this Basic Plan was in effect.

No money will be paid if the amount payable is smaller than zero.

6. RENEWAL AND CHANGES OF BENEFIT PROVISION

6.1 Renewal - How will this policy be renewed?

Subject to the provisions of this policy, you have a guaranteed right to renew this policy by paying in advance the prevailing premium at the time of renewal on each Policy Anniversary. We will notify you reasonably in advance of the Policy Anniversary of the amount of the prevailing premium for the purposes of the renewal. Cover under this policy will cease on the Policy Anniversary if we do not receive the premium due within thirty-one (31) days from the Policy Anniversary. This will happen whether or not written notice of cancellation has been given by us to you.

Without affecting this "Renewal and Changes of Benefit" Provision, the "Contestability" Provision and the "Misstatement of Age or Sex or Smoking Status or Principal Country of Residence" Provision, if there is any misrepresentation, non-disclosure or fraud on the part of the Insured, we shall have the right to terminate this policy, or to revise the provisions of this policy. Subject to any provision in this policy to the contrary, non-renewal of this policy will not affect any claims arising before the termination of this policy.

6.2 Automatic Revision of Benefits and Provisions - Can we revise the benefits under this policy?

We may from time to time revise the benefits and provisions under this policy. We will notify you no less than twenty-eight (28) days in advance of the Policy Anniversary effecting such revision, specifying, among others, the revised benefit definition and/or benefits in the Benefit Schedule, the new premium and effective date.

Any such revision will apply to this policy automatically unless the owner supplies the Company with a written notice to cancel this policy within thirty (30) days after the renewal takes effect in which case this policy will be terminated.

6.3 Change in Level of Cover - Can you upgrade or downgrade the level of cover?

For the avoidance of doubt, "downgrade" and "upgrade" of level of cover refer to any change in the Benefit Level or the Area of Cover or the Deductible.

The Company will not allow the Insured to upgrade or downgrade their level of cover except at each Policy Anniversary and only then when requested within one month before and after the Policy Anniversary (that is, the same day of the one month before

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and after the Policy Anniversary), in writing, to do so. Acceptance by the Company of such an upgrade or downgrade must be confirmed in writing by the Company before the upgrade or downgrade can become effective.

Unless otherwise specified, in the event that we do accept a request for an upgrade, cover for Medical Conditions existing at the time of the upgrade shall be restricted to the Benefit Level enjoyed and subject to the level of Deductible and Area of Cover applicable under the original policy before the upgrade. In the event that we do accept a request for a downgrade, cover for Medical Conditions existing at the time of the downgrade shall be subject to the new downgraded Benefit Level, level of Deductible and Area of Cover starting from the relevant Policy Anniversary whereby such downgrade becomes effective.

However, in the case where the owner requests an upgrade of the level of Deductible (in other words a reduction of Deductible) within one month before or after the Policy Anniversary (that is, the same day of the one month before and after the Policy Anniversary) following the Age of 50, 55, 60 or 65 of the Insured, and such request is accepted by the Company in writing, any Medical Condition existing at the time of the upgrade shall be covered in accordance with the level of Deductible applicable under this Basic Plan after the upgrade, provided that (a) the Insured has been continuously covered under this policy for two (2) consecutive years from the Policy Date; and (b) annual premium payable under this policy has been duly paid. Such request for upgraded coverage on Medical Conditions existing at the time of the upgrade can only be made once during the lifetime of the Insured.

In the event that the "Waiver of Deductible for Confinement across Policy Years" and/or "Waiver of Deductible for Major Incidents" under the "Benefit" Provision becomes applicable and in effect during a Policy Year, we will not accept a request for any change in the Deductible for the immediately following Policy Year.

When Benefit 3.2 "Pre-existing Conditions" under the "Benefit" Provision becomes available under the upgraded plan, Eligible Expenses arising after nine (9) months from the upgrade for Pre-existing Conditions will be payable under Benefit 3.2 "Pre-existing Conditions" under the "Benefit" Provision. When Benefit 3.2 "Pre-existing Conditions" under the "Benefit" Provision ceases to apply under the downgraded plan, Treatment arising from the Pre-existing Conditions will not be payable under this policy starting from the relevant Policy Anniversary whereby such downgrade becomes effective.

When benefits related to Out-patient Treatment become available under the upgraded plan, any Out-patient Treatment arising after nine (9) months from the upgrade related to any Medical Condition existing prior to the upgrade will be payable under Benefit 3.2 "Pre-existing Conditions" under the "Benefit" Provision. When the coverage of "Out-patient Treatment" benefits is to be changed under the downgraded plan, any Out-patient Treatment related to any Medical Condition existing prior to the downgrade will be payable in accordance with the downgraded plan starting from the relevant Policy Anniversary whereby such downgrade becomes effective.

The restriction applicable to any Medical Condition existing prior to the upgrade becoming effective will be waived once the Insured has been Trouble Free for two (2) consecutive years immediately before such Eligible Expenses have been incurred and provided the Insured has been covered for two (2) consecutive years from the Policy Date.

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6.4 Change of Principal Country of Residence - What will happen if the Insured changes his Principal Country of Residence?

The owner must inform the Company in writing if the Insured changes his Principal Country of Residence, even if the Insured is staying in the same Area of Cover, provide documentary proof as required by us and obtain our approval. Otherwise, we reserve the right in our sole and absolute discretion to treat this policy (including any attached endorsement) as void from the Policy Date and not to refund any premium paid, and to require repayment of claims that have already been paid. Any change in premium resulting from an approved amendment of Principal Country of Residence shall take effect on the following Policy Anniversary. If at any time after the issuance of this policy, the Insured changes his Principal Country of Residence, the Principal Country of Residence cannot be outside the Area of Cover applicable to your Benefit Level. If Principal Country of Residence is outside the Area of Cover, this policy may not be renewed at the next Policy Anniversary. We also reserve the right to terminate this policy if the change will in our opinion expose us to the risk of breach of any applicable laws or regulations or economic sanctions.

7. BENEFIT PROVISION

7.1 Benefit - What are the benefits and their limits under this policy?

While this policy is in effect and subject to the provisions, exclusions, limitations and restrictions contained in this policy (including any attached endorsements), we will, upon receipt of due proof and approval by the Company, reimburse the Eligible Expenses as set out in this "Benefit" Provision in accordance with the provisions of this policy, provided always that for all benefits payable regarding Medical Services, such Medical Services must be received by the Insured while this policy is in effect.

Overall Limits

Unless otherwise specified, all benefits covered under this Basic Plan are subject to the Area of Cover, Deductibles and limits (including but not limited to the "Annual Benefit Limit") as set out in the Benefit Schedule of the Benefit Level applicable to this Basic Plan.

Outside Area of Cover

Only Medical Services provided in the Area of Cover will be covered under this Basic Plan. If the "Outside Area of Cover" of the Benefit Schedule applicable to this policy shows "Emergency treatment only", then Emergency Treatment which arises suddenly whilst the Insured is outside the Area of Cover of this Basic Plan will also be covered. We will, in consultation with the attending Registered Medical Practitioner, retain the right to determine at our absolute discretion what constitutes Emergency Treatment and whether the Medical Service concerned is eligible to be covered under this Basic Plan. It does not provide cover for Medical Service if the Insured has travelled outside the Area of Cover to get Medical Service (whether or not that was the only reason) or for any Medical Service which was, or may have reasonably been known about, before travel commenced. Under no circumstance will cover be provided for any aspect of pregnancy or childbirth whilst the Insured is outside the Area of Cover of this Basic Plan. All other policy terms, conditions, limitations and exclusions will apply in any event.

Deductible

The Deductible will be collected by whoever provides the Medical Service (in the case of direct billing) or deducted from any reimbursement made to you by us.

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

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Applicable Deductible for a Policy Year will be set-off by:

(a) Eligible Expenses or part thereof borne by the Insured in that Policy Year; and

(b) actual costs of the eligible In-patient Treatment(s) not borne by us.

Waiver of Deductible for Confinement across Policy Years (Not applicable to zero Deductible option)

While the policy is in effect, if:

(a) the Insured is Confined for a Medical Condition in a preceding Policy Year;

(b) Benefit 1.1 "Hospital Charges" is payable in that preceding Policy Year for such Medical Condition;

(c) such Confinement continues to the current Policy Year; and

(d) the remaining Deductible of the preceding Policy Year has been reduced to zero (0),

the Deductible (if any and if applicable) of the current Policy Year for such Medical Condition shall be reduced to zero (0):

(i) for Benefit 1 "In-patient and Daycare Treatment Benefits", up to the date on which the Insured is discharged from the Hospital or the thirtieth (30th) day immediately after the Policy Anniversary of the current Policy Year, whichever is earlier;

(ii) for Benefit 2 "Out-patient Treatment Benefits", in relation to the Eligible Expenses incurred after Confinement which have been or will be reimbursed by us, up to the ninetieth (90th) day immediately after the Policy Anniversary of the current Policy Year.

For the avoidance of doubt, the "Waiver of Deductible for Confinement across Policy Years" under this section is not applicable to policy with zero Deductible option shown in the Policy Specifications.

Waiver of Deductible for Major Incidents (Not applicable to zero Deductible option)

While this policy is in effect, if the Insured is diagnosed with any of the Designated Major Illnesses and, upon the recommendation of the attending Registered Medical Practitioner in writing, receives any Medical Services as a direct result of the Designated Major Illnesses, in calculation of the amount payable under the provisions of this policy, the remaining balance of Deductible (if any and if applicable) for such Medical Services shall be reduced to zero (0) in relation to such Medical Services arising from Designated Major Illnesses.

The total amount of benefits payable as a direct result of Designated Major Illnesses shall be treated as Deductible paid by the owner in the relevant Policy Year and the remaining balance of Deductible for in the relevant Policy Year (if any and if applicable) shall be reduced by such amount accordingly.

For the avoidance of doubt, the "Waiver of Deductible for Major Incidents" is only applicable to Eligible Expenses and/or other expenses incurred for Medical Services arising from any Designated Major Illnesses defined under this Basic Plan. If the

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Eligible Expenses and/or other expenses incurred involve Medical Services of the Insured for both Designated Major Illnesses and any Medical Condition other than such Designated Major Illnesses, and if apportionment of the expenses is not feasible, all of such Eligible Expenses and/or other expenses incurred shall be regarded as expenses incurred for Medical Services arising from Designated Major Illnesses.

The "Waiver of Deductible for Major Incidents" under this section is not applicable to Benefit 3.2 "Pre-existing Conditions" and Benefit 3.3A "Manifested Congenital Conditions" if such benefits are included in the Insured's Benefit Level.

The definition of the Designated Major Illnesses is provided in **Appendix 1** attached to the Basic Plan.

For the avoidance of doubt, the "Waiver of Deductible for Major Incidents" under this section is not applicable to policy with zero Deductible option shown in the Policy Specifications.

7.2 Benefit Adjustment - Can we adjust the benefits under this policy?

If the Insured is Confined in a room of the class which is of a higher class than his entitled ward class as stated in the Benefit Schedule on any day of a Confinement, the Company will reduce the benefit amount payable in respect of Benefits 1, 2 and 3 under this Basic Plan by multiplying the relevant benefit amount payable by the applicable adjustment factor (as shown in the table below).

Entitled ward class	Confined ward class	Adjustment factor
Semi-private Room	Standard Private Room	50%
Semi-private Room or Standard Private Room	Any ward class above Standard Private Room	0%

For the avoidance of doubt, adjustment factor of 0% means we will not pay any benefit in respect of Benefits 1, 2 and 3 under this Basic Plan.

For the avoidance of doubt, the adjustment factor as specified above shall not apply when such Confinement in a room of a class higher than his entitled ward class is due to:

(a) unavailability of entitled ward class for Emergency Treatment as a result of ward or room shortage for Confinement;

(b) isolation reasons that require a specific class of accommodation; or

(c) other reasons not involving personal preference of the owner and/or the Insured.

7.3 Limitation of Benefit for Treatment in USA - Will treatment in USA affect benefit limits under this policy?

Notwithstanding any other provisions of this policy, if at any time after the issuance of this policy, the Insured changes his Principal Country of Residence to USA and the Area of Cover insured for and stated in the Policy Specifications is Worldwide, and the Insured has incurred any Reasonable and Customary charges in respect of Medical Services in USA, the maximum amount of benefits payable of charges incurred in USA in respect of Benefits 1, 2 and 3 under this Basic Plan for any Medical Condition will be capped at 60% of the relevant eligible charges. Except for such capping limit imposed on the benefits payable, the limits stated under the respective Benefit Level, Annual Benefit Limit, Area of Cover and the Deductible shall remain unchanged.

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In the event where the Insured subsequently changes his Principal Country of Residence out of USA, the capping limit of 60% will not apply to such Reasonable and Customary charges in respect of Medical Services in USA from the next Policy Anniversary. The limits under the respective Benefit Level, Annual Benefit Limit, Area of Cover and Deductible shall be as stated in the Benefit Schedule of this Basic Plan.

7.4 Benefit 1: In-patient and Daycare Treatment Benefits

Subject to the provisions of this policy, if during the period while this policy is in effect, the Insured, as a result of a Medical Condition and upon the recommendation of a Registered Medical Practitioner,

(a) is Confined in a Hospital; or

(b) undergoes any Daycare Treatment,

the Company will reimburse the Eligible Expenses in accordance with the terms and conditions under this Benefit 1 "In-patient and Daycare Treatment Benefits" Provision.

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

<u>Benefit 1.1: Hospital Charges</u>

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for eligible In-patient Treatment and Daycare Treatment of the Insured given during Confinement or on the day he undergoes any Daycare Treatment. These charges shall cover the followings:

(a) diagnostic procedures, including but not limited to computerised tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques;

(b) operating theatre charges;

(c) nursing care;

(d) dressings and plaster casts;

(e) medicine and drug prescribed and consumed during Confinement or any Daycare Treatment;

(f) medicine and drug prescribed upon discharge from Confinement or completion of Daycare Treatment for use up to the ensuing four (4) weeks;

(g) surgical appliances used by the Registered Medical Practitioner during surgery, but we will not pay for external prosthesis or orthosis or appliances under this benefit as they will be covered (where applicable) under Benefit 1.6 "Medical Implants";

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(h) Surgeons' and Anaesthetists' charges charged by attending Surgeon and Anaesthetist on a surgical procedure performed during Confinement or in a setting for providing Medical Services to the Insured as Day Patient;

(i) Intensive Care Unit charges;

(j) organ transplantation for the Insured as a recipient, but we will not pay for charges relating to acquiring the organs, any related administration costs, transport costs, cost of finding a donor and other donor expenses or if the Insured choosing to donate his tissue or organ as a live donor;

(k) consultations and physiotherapy during Confinement when such consultations and physiotherapy are directly related to the Medical Condition for which the Insured is Confined;

(l) occupational therapy and speech therapy during Confinement when such occupational therapy and speech therapy are directly related to the Medical Condition for which the Insured is Confined but we will not pay for such occupational therapy and speech therapy when the Insured is Confined as an In-patient if these Medical Services are purely for the convenience of the Insured or the Registered Medical Practitioner or the Specialist, and can be reasonably rendered in an Out-patient setting; and

(m) Active Cancer Treatment but we will not pay for in-patient Palliative Care and Treatment under this benefit as it will be covered under Benefit 3.16 "Palliative Care and Treatment".

Benefit 1.2: Daily Accommodation Charges

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for the Hospital accommodation and meal charges of the Insured during the Confinement.

Benefit 1.3: Hospital Companion Bed

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for an extra bed of one (1) companion staying overnight in the same Hospital room with the Insured during the Confinement of the Insured within the Area of Cover.

For avoidance of doubt, there shall be no benefit payable for any other cost (including meal charge) under this benefit.

Benefit 1.4: Private Nurse

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses for the Medical Services provided by a Qualified Nurse following surgery for the Insured or the Insured's discharge from Intensive Care Unit and while the Insured is still Confined in a Hospital for an eligible In-patient Treatment.

The Insured's attending Registered Medical Practitioner must provide a written referral stating the reasons for which such private nursing services are required during Confinement.

SAMPLE

We will reimburse the Eligible Expenses for the hire of a private nurse when:

(a) we consider it as Medically Necessary and appropriate for the Insured's eligible In-patient Treatment, and it must be pre-authorised by us in writing before the provision of the private nursing services;

(b) the Insured's attending Registered Medical Practitioner has deemed it as part of essential services for medical reasons and for the continued, direct treatment of the Insured's Medical Condition covered by the policy; and

(c) we must make all private nursing service arrangements.

If condition (c) is not met, this benefit will be subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan.

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

Benefit 1.5: In-patient Rehabilitation

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses for in-patient rehabilitation when:

(a) it is an integral part of Medical Services; and

(b) it is carried out by a Registered Medical Practitioner specialising in rehabilitation; and

(c) it is carried out in a rehabilitation Hospital or unit; and

(d) the costs have been agreed and pre-authorised, in writing, by us before the rehabilitation begins.

We will extend in-patient rehabilitation to a maximum of one hundred eighty (180) days per Policy Year for eligible in-patient rehabilitation necessitated by severe central nervous system damage caused by an external trauma.

Benefit 1.6: Medical Implants

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for the following items:

(a) Specified items

For the following medical implants implanted in the Insured during surgery or used in replacement procedures which are Medically Necessary:

SAMPLE

(i) pace maker;

(ii) stents for percutaneous transluminal coronary angioplasty;

(iii) monofocal intraocular lens;

(iv) artificial cardiac valve;

(v) metallic or artificial joints for joint replacement;

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

(vii) prosthetic intervertebral disc,

The amount payable under this benefit is equal to the amount actually incurred for the cost of such specified item, subject to the limit shown in the Benefit Schedule for the Benefit Level of this Basic Plan.

(b) Other items

For any other Medically Necessary prosthetic device implanted inside or on the surface of the Insured's body, the amount payable under this benefit is equal to the amount actually incurred for the cost of such prosthetic device, subject to the limit shown in the Benefit Schedule for the Benefit Level of this Basic Plan.

For the avoidance of doubt, the Eligible Expenses so incurred and payable under this benefit shall not be payable under Benefit 1.1 "Hospital Charges".

<u>Benefit 1.7: Cash Benefit</u>

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will pay a cash benefit if the Insured:

(a) receives an eligible In-patient Treatment within the Area of Cover, provided no other cost is or will be borne by us for that eligible Medical Services; or

(b) is a Hong Kong identity card holder and is Confined in a General Ward of a public Hospital in Hong Kong, where he incurred charges for the In-patient Treatment; or

(c) is a Macau resident identity card holder and is Confined in a General Ward of a public Hospital in Macau, where he incurred charges for the In-patient Treatment; or

(d) is Confined in a public Recognised Hospital in Mainland China, where he incurred charges for the In-patient Treatment; or

(e) is Confined in a ward class below his entitled ward class as stated in the Benefit Schedule of the Benefit Level of this Basic Plan of a private Hospital in Hong Kong or Macau, where he incurred charges for the In-patient Treatment.

The amount payable under this benefit per night is equal to the amount of cash benefit as shown in the Benefit Schedule for the Benefit Level of this Basic Plan for each night of Confinement. When the In-patient Treatment resulted from a Pre-existing Condition, we will pay a cash benefit up to the limit as set out in the Benefit Schedule of the Benefit

SAMPLE

Level of this Basic Plan (if applicable) and the terms and conditions of this Basic Plan in relation to Pre-existing Conditions.

This benefit is not subject to Deductible and shall not be counted towards the applicable Annual Benefit Limit as specified under the Benefit Schedule.

7.5 Benefit 2: Out-patient Treatment Benefits

Benefit 2.1: Computerised Tomography, Magnetic Resonance Imaging, Positron Emission Tomography, X-rays and Gait Scans

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included, we will reimburse the Eligible Expenses actually incurred for computerised tomography, magnetic resonance imaging, positron emission tomography, x-rays and gait scans received by the Insured as stated below:-

Benefit 2.1A: Computerised Tomography, Magnetic Resonance Imaging, Positron Emission Tomography, X-rays and Gait Scans (Available to Prestige and Comprehensive Benefit Levels only)

We will reimburse the Eligible Expenses actually incurred for computerised tomography, magnetic resonance imaging, positron emission tomography, x-rays and gait scans received by the Insured as part of an eligible Out-patient Treatment as recommended in writing by a Registered Medical Practitioner.

Benefit 2.1B: Computerised Tomography, Magnetic Resonance Imaging, Positron Emission Tomography, X-rays and Gait Scans (Available to Standard and Essential Benefit Levels only)

We will reimburse the Eligible Expenses actually incurred for computerised tomography, magnetic resonance imaging, positron emission tomography, x-rays and gait scans received by the Insured as part of an eligible Out-patient Treatment that occurs within ninety (90) days prior to an In-patient Treatment or Daycare Treatment and within ninety (90) days immediately following the date of discharge from Hospital for which the Insured was Confined as an In-patient or the date of the Daycare Treatment. Such treatment must be recommended in writing by the attending Registered Medical Practitioner. For the avoidance of doubt, this is a pre-/post-Confinement or pre-/post-Daycare Treatment benefit.

Benefit 2.2: Pre- and Post- Hospitalisation Out-patient Consultation

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included, we will reimburse the Eligible Expenses actually incurred by the Insured for Pre-Hospitalisation Out-patient Consultation and Post-Hospitalisation Out-patient Consultation as stated below:-

Benefit 2.2A: Pre-Hospitalisation Out-patient Consultation

We will reimburse the Eligible Expenses actually incurred for consultations resulting in In-patient Treatment, Daycare Treatment, and the associated prescribed investigations and treatments by a Registered Medical Practitioner received as an Out-patient within ninety (90) days prior to an In-patient Treatment or Daycare Treatment, where such In-patient Treatment or Daycare Treatment is eligible for cover under this Basic Plan and where the need for such In-patient Treatment or Daycare Treatment has arisen as a direct result of the medical examination(s) and investigation findings drawn

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from such consultation(s). The number of Visits covered by this benefit is limited to once per day.

Benefit 2.2B: Post-Hospitalisation Out-patient Consultation

We will reimburse the Eligible Expenses actually incurred for Out-patient follow-up consultations and treatments following an eligible In-patient Treatment or Daycare Treatment when such consultations and treatments are carried out by the attending Registered Medical Practitioner or a referred Registered Medical Practitioner, and provided such consultations or treatments occur within ninety (90) days immediately following the date of discharge from Hospital for which the Insured was Confined as an In-patient or the date of Daycare Treatment. The number of Visits covered by this benefit is limited to once per day.

Benefit 2.3: Active Cancer Treatment Received as an Out-patient

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for Active Cancer Treatment received by the Insured as part of an eligible Out-patient Treatment. This benefit covers Eligible Expenses directly related to the Insured's course of Active Cancer Treatment from the point of diagnosis to pre- and post-hospitalisation, planning, carrying out Active Cancer Treatment as prescribed by the attending Specialist (including but not limited to oncologist, Surgeon, radiotherapist or haematologist) treating the Insured's cancer which includes tests, imaging, consultations, prescribed medicines, monitoring and follow-ups at a Hospital or specialist cancer unit.

This benefit does not cover any tests, imaging, consultations, prescribed medicine, monitoring or follow-ups after complete remission.

Benefit 2.4: Kidney Dialysis Treatment Received as an Out-patient

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for haemodialysis or peritoneal dialysis received by the Insured as part of kidney failure treatment on an Out-patient basis at a medical facility or at home including regular haemodialysis or peritoneal dialysis and any pre- and post-hospitalisation follow-up and treatment.

The amount payable under this benefit is equal to, subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan: (a) for haemodialysis or peritoneal dialysis at a medical facility, the amount actually charged by the medical facility for such regular haemodialysis or peritoneal dialysis; or (b) for haemodialysis or peritoneal dialysis at home, the amount of expenses actually incurred for the purchase of supplies and/or rental of the dialysis machine for such regular haemodialysis or peritoneal dialysis where such purchase of supplies and/or rental of dialysis machine is/are prescribed in writing by the Insured's attending Registered Medical Practitioner.

Benefit 2.5: Surgical Procedures Received as an Out-patient

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for surgical procedures received by the Insured as part of an Out-patient Treatment.

We will also pay for consultations, associated prescribed investigations, diagnostic procedures and essential medications by a Registered Medical Practitioner received by the Insured as part of an eligible Out-patient Treatment within ninety (90) days prior to

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and within ninety (90) days immediately following the surgical procedures received as an Out-patient. The number of Visits covered by this benefit is limited to once per day.

Benefit 2.6: Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for courses of chiropractic treatment, acupuncture, homeopathy, osteopathy and physiotherapy received by the Insured as stated below:-

Benefit 2.6A: Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy (Available to Prestige and Comprehensive Benefit Levels only)

We will reimburse the Eligible Expenses actually incurred for courses of chiropractic treatment, acupuncture, homeopathy, osteopathy and physiotherapy received by the Insured as part of an Out-patient Treatment at a medical facility.

Such treatment must be given by a qualified practitioner (but in no circumstance shall include the following persons - the Insured, the owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the owner and/or the Insured (unless approved in advance by the Company in writing)) who is registered to practise this where the treatment is given. Treatment given by a chiropractor, acupuncturist, homeopath, osteopath, or physiotherapist must be recommended in writing by the attending Registered Medical Practitioner or Chinese Medical Practitioner (as the case may be).

A referral letter is valid for the same or related Medical Condition for one hundred eighty (180) days from the date it is issued. Another referral letter is required for treatment of a new or unrelated Medical Condition.

Benefit 2.6B: Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy (Available to Standard and Essential Benefit Levels only)

We will reimburse the Eligible Expenses for the courses of chiropractic treatment, acupuncture, homeopathy, osteopathy and physiotherapy received by the Insured on follow-up Out-patient basis following an eligible In-patient Treatment or Daycare Treatment as part of an Out-patient Treatment at a medical facility provided such courses occur within ninety (90) days immediately following the date of discharge from Hospital for which the Insured was Confined as an In-patient or the date of the Daycare Treatment. The number of Visits covered by this benefit is limited to once per day. For the avoidance of doubt, this is a post-Confinement or post-Daycare Treatment benefit.

The benefit covers for a maximum number of Visits each Policy Year and up to the limit per Visit shown for the Benefit Level of this Basic Plan.

For Standard Benefit Level, the maximum number of Visits covered in each Policy Year is counted together with Benefit 2.7B "Traditional Chinese Medicine" and limited to once per day.

Such treatment must be given by a qualified practitioner (but in no circumstance shall include the following persons - the Insured, the owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the owner and/or the Insured (unless approved in advance by the Company in writing)) who is registered

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to practise chiropractic treatment, acupuncture, homeopathy, osteopathy and physiotherapy (as the case may be) where the treatment is given. Treatment given by a chiropractor, acupuncturist, homeopath, osteopath, or physiotherapist must be recommended in writing by the attending Registered Medical Practitioner or Chinese Medical Practitioner (as the case may be).

This benefit excludes any course of Physiotherapy due to Stroke, which is available under Benefit 2.8 "Courses of Physiotherapy due to Stroke".

Benefit 2.7: Traditional Chinese Medicine

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for the Insured's consultation and treatment with a Chinese Medical Practitioner as stated below:-

Benefit 2.7A: Traditional Chinese Medicine (Available to Prestige and, Comprehensive Benefit Levels only)

We will reimburse the Eligible Expenses actually incurred for the Insured's consultation and treatment with a Chinese Medical Practitioner as part of an eligible Out-patient Treatment of an eligible Medical Condition of the Insured. Prescriptions and diagnostic procedures given by the Chinese Medical Practitioner in such consultation are also covered under this benefit.

The benefit covers for a maximum number of Visits each Policy Year and up to the limit per Visit shown for the Benefit Level of this Basic Plan.

Benefit 2.7B: Traditional Chinese Medicine (Available to Standard Benefit Level only)

We will reimburse the Eligible Expenses actually incurred for the Insured's follow-up consultation and treatment with a Chinese Medical Practitioner following an eligible In-patient Treatment or Daycare Treatment as part of an eligible Out-patient Treatment provided such consultation or Treatment occurs within ninety (90) days immediately following the date of discharge from Hospital for which the Insured was Confined as an In-patient or the date of the Daycare Treatment. The number of Visits covered by this benefit is limited to once per day. For the avoidance of doubt, this is a post-Confinement or post-Daycare Treatment benefit.

The benefit covers for a maximum number of Visits each Policy Year and up to the limit per Visit shown for the Benefit Level of this Basic Plan.

The maximum number of Visits covered in each Policy Year is counted together with Benefit 2.6B "Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy".

The Insured is entitled to only one (1) post-hospitalisation or follow-up Visit per day under either Benefit 2.2B "Post-Hospitalisation Out-patient Consultation" or this Benefit 2.7B "Traditional Chinese Medicine".

Benefit 2.8: Courses of Physiotherapy due to Stroke (Available to Standard and Essential Benefit Levels only)

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the

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Eligible Expenses actually incurred for the courses of physiotherapy on an Out-patient basis following an eligible In-patient Treatment due to Stroke provided such physiotherapy treatments occur within ninety (90) days immediately following the date of discharge from Hospital for which the Insured was Confined as an In-patient. The number of Visits covered by this benefit is limited to once per day. For the avoidance of doubt, this is a post-Confinement benefit.

Such treatment must be given by a qualified practitioner (but in no circumstance shall include the following persons - the Insured, the owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the owner and/or the Insured (unless approved in advance by the Company in writing)) who is registered to practise physiotherapy where the treatment is given. Treatment given by a physiotherapist must be recommended in writing by the attending Registered Medical Practitioner.

Benefit 2.9: Courses of Speech Therapy and Occupational Therapy

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for courses of speech therapy and occupational therapy on an Out-patient basis following an eligible In-patient Treatment provided such treatment occurs within ninety (90) days immediately following the date of discharge from Hospital for which the Insured was Confined as an In-patient. The number of Visits covered by this benefit is limited to once per day. For the avoidance of doubt, this is a post-Confinement benefit.

Such treatment must be given by a qualified practitioner (but in no circumstance shall include the following persons - the Insured, the owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the owner and/or the Insured (unless approved in advance by the Company in writing)) who is recognised by us and registered to practise speech therapy or occupational therapy (as the case may be) where the eligible treatment is given. Treatment given by a speech therapist or an occupational therapist must be recommended in writing by the attending Registered Medical Practitioner.

Benefit 2.10: General Practitioner and Specialist Consultation Charges (Available to Prestige and Comprehensive Benefit Levels only)

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included, we will reimburse the Eligible Expenses actually incurred for the Insured's consultation with a Registered Medical Practitioner. For the purpose of this benefit, a consultation is a Visit to any Registered Medical Practitioner for the Out-patient Treatment of an eligible Medical Condition. Prescriptions and diagnostic procedures (other than computerised tomography, magnetic resonance imaging, positron emission tomography, x-rays and gait scans) are also covered under this benefit.

We will pay for a Visit outside a medical facility by a Registered Medical Practitioner, including but not limited to home and office Visit, in the event of an Emergency situation when the medical personal contacted for organising the Visit determines that such Visit is likely to result in the Insured being moved to the Hospital via ambulance even if it does not.

We will not pay for Visit outside a medical facility in any other circumstances.

For the avoidance of doubt, this benefit is an additional Out-patient Treatment coverage to the benefit payable under Benefit 2.2 "Pre- and Post- Hospitalisation Out-patient

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Consultation". The Eligible Expenses so incurred for Pre-Hospitalisation Out-patient Consultation and Post-Hospitalisation Out-patient Consultation shall first be payable under Benefit 2.2 "Pre- and Post- Hospitalisation Out-patient Consultation", and this benefit shall be payable only if:

(a) the limit as stated in the Benefit Schedule of the Benefit Level of this Basic Plan is exhausted; or

(b) the pre-hospitalisation consultation related to an In-patient Treatment or Daycare Treatment occurs more than ninety (90) days prior to an In-patient Treatment or Daycare Treatment; or

(c) the post-hospitalisation consultation or treatment related to an In-patient Treatment or Daycare Treatment occurs more than ninety (90) days after the date of discharge from Hospital for which the Insured was Confined as an In-patient or the date of Daycare Treatment.

7.6 Benefit 3: Other Benefits

"Other benefits", described here below, provide cover for treatment that may be received as an In-patient, Day Patient or Out-patient, thus limitations and restrictions applicable to In-patient and Day Patient (Benefit 1) and Out-patient (Benefit 2) as described here above will also apply to "other benefits" unless otherwise specified.

The aggregate amount of Eligible Expenses actually incurred for In-patient Treatment, Daycare Treatment and Out-patient Treatment is subject to the monetary limit shown for these "other benefits".

<u>Benefit 3.1: Health Screen and Child Development Assessment (Available to Prestige and Comprehensive Benefit Levels only)</u>

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for health screen or, in relation to the Insured under Age of eighteen (18) at the time of assessment, child development assessment received by the Insured. The limit shown includes the cost of any eligible consultation needed as part of the health screen or child development assessment process.

The limit shown in the Benefit Schedule for the Benefit Level of this Basic Plan applies to the cost of any eligible consultation needed as part of the health screening or child development assessment process.

We will only pay for Eligible Expenses incurred after the Insured has been continuously covered under the same Benefit Level for twelve (12) consecutive months and the annual renewal of that Benefit Level for the coming Policy Year has been effected.

This benefit will not automatically be upgraded to a higher Benefit Level. In the case of an upgrade of Benefit Level, this benefit will be restricted to the original Benefit Level until the Insured has been covered under the upgraded Benefit Level for a period of not less than twelve (12) consecutive months and has effected the annual renewal of the upgraded Benefit Level.

This benefit is not subject to Deductible and the limitation under the "Pre-existing Condition" Provision does not apply to this benefit.

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Benefit 3.2: Pre-existing Conditions (Available to Prestige and Comprehensive Benefit Levels only)

Without prejudice to the "Pre-existing Condition" Provision of this policy, provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for treatment of any Pre-existing Conditions (including their associated Medical Conditions) in the following scenarios:

(a) Treatment which the Insured has received in the first two (2) Policy Years of this policy (but after first two hundred and seventy (270) days from the Policy Date); or

(b) Where the Insured has been covered for two (2) consecutive Policy Years from the Policy Date, but the Insured does not have a consecutive two (2) years Trouble Free period immediately before such Eligible Expenses have been incurred.

This benefit is only available after the Insured has been continuously covered under this Benefit Level for two hundred and seventy (270) days from the Policy Date and has duly paid the annual premium.

Benefit 3.2 "Pre-existing Conditions" and Benefit 3.3A "Manifested Congenital Conditions" share the same aggregate annual limit, thus any claims paid under one of those two benefits reduce the remaining annual limit available for both.

Benefit 3.3: Congenital Conditions

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for treatment of Manifested Congenital Conditions and/or Non-manifested Congenital Conditions (as applicable) as stated below:-

Benefit 3.3A: Manifested Congenital Conditions (Available to Prestige and Comprehensive Benefit Levels only)

We will reimburse the Eligible Expenses actually incurred for treatment of Manifested Congenital Conditions whether pre-existing or not.

This benefit is only available after the Insured has been continuously covered under this Benefit Level for two hundred and seventy (270) days from the Policy Date and has duly paid the annual premium.

Benefit 3.2 "Pre-existing Conditions" and Benefit 3.3A "Manifested Congenital Conditions" share the same aggregate annual limit, thus any claims paid under one of those two benefits reduce the remaining annual limit available for both.

The following exclusions still apply in any event:

(a) item (3) under the "Exclusions" Provision regarding "Treatment begun, or for which the need had arisen, during the first ninety (90) days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination"; and

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(b) item (1)(a) of "Special terms" exclusion under the "Exclusions" Provision regarding "cosmetic (aesthetic) surgery or treatment".

Benefit 3.3B: Non-manifested Congenital Conditions

We will reimburse the Eligible Expenses actually incurred for treatment of Non-manifested Congenital Conditions.

This benefit is only available after the Insured has been continuously covered under this Benefit Level for two hundred and seventy (270) days from the Policy Date and has duly paid the annual premium.

The following exclusions still apply in any event:

(a) item (3) under the "Exclusions" Provision regarding "Treatment begun, or for which the need had arisen, during the first ninety (90) days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination"; and

(b) item (1)(a) of "Special terms" exclusion under the "Exclusions" Provision regarding "cosmetic (aesthetic) surgery or treatment".

Benefit 3.4: Oral and Maxillofacial Surgery (Available to Prestige and Comprehensive Benefit Levels only)

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included, we will reimburse the Eligible Expenses actually incurred for the following oral and maxillofacial surgery performed by an oral and maxillofacial Surgeon received by the Insured:-

(a) surgical removal of impacted/un-erupted wisdom teeth and buried teeth which are diseased or causing symptoms;

(b) surgical removal of complicated buried roots which are diseased or causing symptoms;

(c) enucleation (removal) of cysts of the upper and lower jaw;

(d) treatment of cancers (for lesion or lump in the mouth provided not a Pre-existing Condition); and/or

(e) Medically Necessary surgical treatment to Temporal Mandibular Joint (TMJ).

Physiotherapy for TMJ will be covered under Benefit 2.6A "Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy" if it is done as an Out-patient Treatment.

This benefit does not cover:

(i) routine dental care;

(ii) complex or restorative dental treatment;

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(iii) other dental procedures, for example treatment for gingivitis and periodontitis, etc.; or

(iv) costs for treatment that has not yet taken place, even if it is being provided as part of a treatment package.

Benefit 3.5: Home Nurse

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses for the home nursing services provided by a Qualified Nurse following an eligible In-patient Treatment, surgery or the Insured's discharge from Intensive Care Unit, provided that all of the following conditions are met:-

(a) the home nursing services is provided within one hundred and twenty (120) days immediately after the Insured's discharge from Hospital following an eligible In-patient Treatment, surgery or a discharge from the Intensive Care Unit; and

(b) considered by us as Medically Necessary and appropriate, and must be pre-authorised by us in writing before the provision of the home nursing services; and

(c) the attending Registered Medical Practitioner has prescribed the home nursing services as Medically Necessary for the continued treatment of the eligible Medical Condition; and

(d) the home nurse provides essential Medical Services for medical purposes and relates directly to a Medical Condition covered by the policy.

This benefit is restricted to home nursing services provided by a maximum of one (1) Qualified Nurse during any given time slot; and up to two (2) time slots per day.

The maximum of days will be pre-authorised by us on a case-by-case basis, and you will be advised accordingly upon our approval.

For Terminal Medical Condition, the home nursing service is only payable under Benefit 3.16 "Palliative Care and Treatment" and subject to the limitations applicable to that benefit.

Benefit 3.6: Ambulance Transport

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for a road ambulance for Medically Necessary emergency transport to or between Hospitals. The Registered Medical Practitioner of the Insured will determine if this is Medically Necessary to have medical supervision whilst being transported. We reserve the right to ultimately determine whether such transportation and medical supervision during transportation were Medically Necessary and appropriate.

Benefit 3.7: Psychiatric Treatment

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for psychiatric treatment received by the Insured as In-patient Treatment, Daycare Treatment or Out-patient Treatment.

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For Insured on Standard and Essential Benefit Level, this benefit is available where the Insured receives psychiatric treatment as In-patient Treatment or Daycare Treatment.

Treatment given by a psychologist must be referred in writing by a Specialist.

Benefit 3.8: Accidental Damage to Teeth

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, we will reimburse the Eligible Expenses actually incurred for treatment that takes place twenty-eight (28) days following Accidental damage to the Insured's natural teeth caused by an external trauma when that treatment is given by a Registered Medical Practitioner or Registered Dentist.

This benefit covers the initial treatment only; it does not cover any follow-up treatment.

The benefit is not payable if:

(a) the damage was caused by normal wear and tear;

(b) the damage was caused by consumption of food or drink, or any foreign bodies contained in such food or drink;

(c) the injury/accidental damage was caused when the insured participates in sports such as boxing or rugby (except school or tag rugby) without wearing suitable mouth protection; or

(d) the damage was caused by tooth brushing or any other oral hygiene procedure.

Benefit 3.9: Experimental Drugs

Subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan, while the policy is in effect, if the Insured is diagnosed with Designated Cancer and if Experimental Drug has been prescribed for the Active Cancer Treatment or Palliative Care and Treatment of such Designated Cancer, this benefit shall be payable for the Reasonable and Customary charges incurred for the following:

(a) Prescription of Experimental Drug to the Insured,

(b) prior to or after the Insured receives treatment of Experimental Drug, any related consultations, laboratory tests, imaging procedures, screening tests or evaluations done or carried out for:

   (i) evaluating the appropriateness of the Prescription of the Experimental Drug to the Insured; or

   (ii) monitoring the Insured's response to treatment with the Experimental Drug; and

(c) the benefit items described in Benefit 1.1 "Hospital Charges" and Benefit 1.2 "Daily Accommodation Charges" under the "Benefit" Provision if the Insured is Confined in a Hospital for the purpose of treatment with Experimental Drug,

provided that

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(aa) such treatment must be assessed and pre-authorised in writing; and

(bb) a medical certificate issued by a Specialist must be provided to the Company to certify that the Experimental Drug is prescribed by and is deemed by the Specialist to be an appropriate or recommended Active Cancer Treatment or Palliative Care and Treatment of the Designated Cancer of the Insured.

Any charges or expenses which are already covered by any other third parties (including sponsorship from the pharmaceutical company, manufacturer and/or marketer of the Experimental Drug) shall be excluded.

In the event of any dispute or disagreement regarding the appropriateness or recommendation of the prescribed Experimental Drug for treatment of the Designated Cancer of the Insured, the Company shall have the right to call for an evaluation wherever the Company deems necessary to ascertain if such Experimental Drug is identified to be an appropriate and recommended Active Cancer Treatment or Palliative Care and Treatment of the Designated Cancer of the Insured, and the evaluation shall be made by a recognised cancer genetic testing expert and/or an acknowledged expert in the field of medicine concerned as reasonably selected by the Company. For the avoidance of doubt, the Company shall reimburse the Reasonable and Customary charges incurred for such evaluation in accordance with (bb) above.

For any Reasonable and Customary charges incurred outside of Hong Kong, Macau and Mainland China which are payable under this benefit, the amount payable under this benefit shall be reduced to sixty percent (60%) of the Reasonable and Customary charges incurred, subject to the limit(s) shown in the Benefit Schedule for the Benefit Level of this Basic Plan and the "Benefit Adjustment" Provision.

If the Reasonable and Customary charges incurred involve both treatment of Designated Cancer with prescription of Experimental Drug and treatment of other Medical Conditions without prescription of Experimental Drug, and apportionment of such charges is not available, then the charges in entirety shall be payable in accordance with Benefit 1 "In-patient and Daycare Treatment Benefits" and Benefit 2 "Out-patient Treatment Benefits" of this Basic Plan.

Benefit 3.10: Pre- and Post- natal Complications (Available to Prestige and Comprehensive Benefit Levels only)

This benefit is only available to the Insured who is a mother and is over the Age of eighteen (18).

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for treatment of pre- and post- natal complications the Insured mother needs for Medical Condition related to her pregnancy and childbirth. The treatment is covered for pre- and post- natal complications of (1) both the Insured and her unborn child(ren) up to the moment of delivery, and (2) the Insured alone after childbirth.

We will only pay for Eligible Expenses incurred after the Insured has been continuously covered under the same Benefit Level for twelve (12) consecutive months and the annual renewal of that Benefit Level for the coming Policy Year has been effected.

This benefit will not automatically be upgraded to a higher Benefit Level. In the case of an upgrade of Benefit Level, this benefit will be restricted to the original Benefit Level until the Insured has been covered under the upgraded Benefit Level for a period

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of not less than twelve (12) consecutive months and has effected the annual renewal of the upgraded Benefit Level.

This benefit does not cover:

(a) the costs of delivery of any child whether such delivery is by normal birth, by caesarean section or by any other assisted means, or

(b) any complication arising from non-Medically Necessary caesarean section birth, or

(c) treatment of any Medical Condition which is due to and occurs during the pregnancy prior to the delivery or after the delivery if the pregnancy was a result of any form of assisted conception, fertility treatment by either parent or pregnancy via a surrogate.

For avoidance of doubt, the benefit shall not be payable if the:

(i) delivery of birth is through non Medically Necessary caesarean birth, and/or

(ii) conception of the child is conceived by artificial means or any form of assisted conception, fertility treatment by either parent or pregnancy via a surrogate.

<u>Benefit 3.11: New Born Accommodation (Available to Prestige and Comprehensive Benefit Levels only)</u>

This benefit is only available to the Insured who is a mother.

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included, we will reimburse the Eligible Expenses actually incurred for the Hospital accommodation of the Insured's new born child who is less than sixteen (16) weeks old if he is required to stay in the Hospital while the Insured is Confined in such Hospital.

This benefit pays for new born nursery accommodation of a standard class, where the new born child only receives nursery care during the stay in the Hospital. This benefit is not payable if the new born child is hospitalised for treatment of any medical condition of the new born child.

<u>Benefit 3.12: Pregnancy and Delivery (Available to Prestige Benefit Level only)</u>

This benefit is only available to the Insured who is a mother and is over the Age of eighteen (18).

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for pre-natal care, delivery and post-natal care of the Insured.

The monetary limit shown in the Benefit Schedule for this benefit is the maximum amount we will pay under this benefit for each:

(a) Policy Year, even if there is more than one pregnancy in that Policy Year;

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(b) pregnancy, even if a pregnancy, which is eligible for benefit, falls across the Policy Anniversary, and provided this policy, including this benefit, has been renewed for the subsequent Policy Year.

We will only pay for Eligible Expenses incurred after the Insured has been continuously covered under the same Benefit Level for twelve (12) consecutive months and the annual renewal of that Benefit Level for the coming Policy Year has been effected.

For the avoidance of doubt, subject to the provisions, exclusions, limitations and restrictions contained in this policy, we will only reimburse Eligible Expenses actually incurred for delivery through Medically Necessary caesarean section, and reimbursement for a caesarean section that is not Medically Necessary will be restricted up to the Reasonable and Customary charges of a vaginal delivery performed in the same Hospital and by the same Registered Medical Practitioner.

Benefit 3.13: Vaccinations (Available to Prestige and Comprehensive Benefit Levels only)

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for necessary vaccinations of the Insured. The limit shown includes the cost of any eligible consultation needed as part of the vaccination process.

The limitation under the “Pre-existing Condition” Provision does not apply to this benefit.

Benefit 3.14: Routine Dental Care (Available to Prestige Benefit Level only)

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for dentist consultation, extraction, composite and amalgam fillings, root canal treatment, scaling/polishing, bridgework, crowns and the treatment of gum disease of the Insured given by a Registered Dentist (but in no circumstance shall include the following persons - the Insured, the owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the owner and/or the Insured (unless approved in advance by the Company in writing)).

We will pay eighty percent (80%) of all eligible dental treatment shown above up to the monetary limit shown in the Benefit Schedule of this Basic Plan.

This benefit is not subject to Deductible and the limitation under the “Pre-existing Condition” Provision does not apply to this benefit.

Benefit 3.15: Routine Optical Care (Available to Prestige Benefit Level only)

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for eye examinations carried out by a qualified and registered ophthalmologist (but in no circumstance shall include the following persons - the Insured, the owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the owner and/or the Insured (unless approved in

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advance by the Company in writing)), the cost of spectacle frames, corrective lenses prescribed by the ophthalmologist for the Insured.

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

This benefit is not subject to Deductible and the limitation under the "Pre-existing Condition" Provision does not apply to this benefit.

Benefit 3.16: Palliative Care and Treatment

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for Palliative Care and Treatment related to an eligible Terminal Medical Condition and its associated Medical Conditions of the Insured during the Insured's admission and stay in a specialist palliative care centre or hospice following diagnosis and written confirmation (including medical evidence) by a Registered Medical Practitioner that the Insured is suffering from an eligible Terminal Medical Condition and its associated Medical Conditions.

We will pay such continued Palliative Care and Treatment recommended in writing by a Registered Medical Practitioner under this benefit administered by either:

(a) a hospice (a facility that provides palliative treatment);

(b) a recognised organisation providing palliative treatment services for patients;

(c) a registered centre for controlling pain and other symptoms; or

(d) a Hospital if none of the above facilities are available in the country or geographical area where such Palliative Care and Treatment takes place.

Once the Insured is admitted to the specialist palliative care centre or hospice, all costs of care and any treatment related to the eligible Terminal Medical Condition and its associated Medical Conditions will be taken from this benefit and may not be claimed from any other benefit applicable to the Insured under this policy. Any eligible Medical Conditions not related to the Insured's Terminal Medical Condition will be covered under the Insured's other benefits of this policy. We reserve the right to determine, on the advice of our appointed Registered Medical Practitioner, whether a Medical Condition is or is not related to the Terminal Medical Condition.

This benefit is payable, up to the monetary limit shown in the Benefit Schedule of the Benefit Level of this Basic Plan, once in the Insured's lifetime, in aggregate for all such conditions. The Insured must maintain the same level of cover throughout the Palliative Care and Treatment. This means that, if the period of Palliative Care and Treatment falls across a Policy Anniversary, the Insured must pay the premium for the same Benefit Level for the subsequent Policy Year, otherwise benefit will cease at the Policy Anniversary. In the event that the costs of the Insured's admission reach the monetary limit shown for this benefit, no further benefit will be payable.

We will only pay for Eligible Expenses incurred after the Insured has been continuously covered under the same Benefit Level for twelve (12) consecutive months and the annual renewal of that Benefit Level for the coming Policy Year has been effected.

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This benefit will not automatically be upgraded to a higher Benefit Level. In the case of an upgrade of Benefit Level, this benefit will be restricted to the original Benefit Level until the Insured has been covered under the upgraded Benefit Level for a period of not less than twelve (12) consecutive months and has effected the annual renewal of the upgraded Benefit Level.

Benefit 3.17: HIV/AIDS Treatment

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for treatment for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) if the signs or symptoms of a Medical Condition associated with the HIV or AIDS occur for the first time after the Insured has been covered under this policy for five (5) consecutive years from the Policy Date if the HIV or AIDS is as a result of occupational Accident or blood transfusion as described below:

(1) Infection with the HIV through a blood transfusion, provided that all of the following conditions are met:

    (a) the blood transfusion was Medically Necessary or given as part of a medical treatment; and

    (b) the blood transfusion was received after the Policy Date,

(2) Infection with HIV which resulted from an Accident occurring after the Policy Date, whilst the Insured was carrying out the normal professional duties of his or her occupation in the Principal Country of Residence, provided that all of the following are proven to our satisfaction:

    (a) proof of the Accident giving rise to the infection must be reported to us within thirty (30) days of the Accident taking place;

    (b) proof that the Accident involved a definite source of the HIV infected fluids;

    (c) proof of sero-conversion from HIV negative to HIV positive occurring during the one hundred and eighty (180) days after the documented Accident. This proof must include a negative HIV antibody test conducted within five (5) days of the Accident; and

    (d) HIV infection resulting from any other means including sexual activity and/or the use of intravenous drugs are excluded.

This benefit is only for In-patient Treatment of HIV/AIDS associated and underlying conditions. This benefit is payable up to the monetary limit shown in the Benefit Schedule of the Benefit Level of this Basic Plan.

Benefit 3.18: Emergency Out-patient Treatment for Accident (Available to Standard and Essential Benefit Levels only)

Provided that the Benefit Schedule of the Benefit Level of this Basic Plan indicates that this benefit is included and subject to the limit(s) shown therein, we will reimburse the Eligible Expenses actually incurred for the eligible treatment of the Insured received in the out-patient unit of the Hospital or clinic if the Insured has suffered an Injury due to

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an Accident and the Insured has been treated of such Injury within twenty-four (24) hours of the occurrence of the Accident.

7.7 Benefit 4: Compassionate Death Benefit

Benefit 4.1: Compassionate Death Benefit

If the Insured dies while this Basic Plan is in effect, we will pay a Compassionate Death Benefit equivalent to the amount of Compassionate Death Benefit stated in the Benefit Schedule of the Benefit Level of this Basic Plan except in the case of a death (excluding Accidental death) within one (1) year from the Policy Date, the paid premium or Compassionate Death Benefit as stated in the Benefit Schedule of the Benefit Level of this Basic Plan, whichever amount is lower, shall be payable.

This benefit is not subject to Deductible and shall not be counted towards the applicable Annual Benefit Limit as specified under the Benefit Schedule.

8. CONTINGENT OWNER PROVISION

8.1 Designation of Contingent Owner - How does it work?

After the end of the first (1st) Policy Year and while this policy is in effect, subject to the approval of the Company at its sole and absolute discretion, you may apply to designate a Contingent Owner provided that you are an individual, the policy is not held on trust and the following conditions are fulfilled:

(a) You are not the Insured.

(b) The Contingent Owner must have attained the Age of eighteen (18) as at the date of application for the designation of the Contingent Owner pursuant to this Clause 8.1.

(c) The designation satisfies such insurable interest requirements as the Company considers applicable.

(d) You and the Contingent Owner must be alive at the time of application and on the date the Company approves the designation of the Contingent Owner.

(e) The Contingent Owner must agree in writing to be the Contingent Owner.

(f) Only one individual person can be designated as the Contingent Owner at any one time.

(g) If an irrevocable Beneficiary has been named, the irrevocable Beneficiary must agree in writing to the designation of the Contingent Owner.

(h) The designation is in compliance with any applicable laws, regulations and guidelines.

(i) The designation fulfils such other conditions as we may set out from time to time in our specified application form.

You must make a written application for the designation of the Contingent Owner in accordance with the Application Procedures and such designation is valid only if (i) the application is in our specified form; and (ii) the application is approved in writing by the Company while you are alive and this policy is in effect.

The owner may apply to revoke the Contingent Owner or replace the Contingent Owner by designating another person to be the Contingent Owner in his place in

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accordance with the Application Procedures and such application is subject to the approval of the Company at its sole and absolute discretion. The designation of any replacement Contingent Owner is subject to the conditions set out in this Clause 8.1.

The designation of the Contingent Owner will be revoked automatically if:

(aa) there is any change of the owner of this policy; or

(bb) the Contingent Owner dies.

8.2 Contingent Owner - What will happen on the death of the owner?

If the owner dies while the Basic Plan is in effect, the Contingent Owner shall replace the deceased owner and become the new owner of this policy subject to the Company's prevailing rules and the satisfaction of the following conditions:

(a) We receive due proof (in the form specified by us and in such manner satisfactory to us) of the death of the owner.

(b) The Contingent Owner is still alive as at the effective date of the replacement of the deceased owner.

(c) The replacement of the deceased owner is in compliance with any applicable laws, regulations and guidelines.

(d) The Company approves the replacement of the deceased owner in accordance with the administrative rules as determined by the Company from time to time.

The Company has sole and absolute discretion to approve or disapprove the replacement of the deceased owner by the Contingent Owner and its decision shall be final and conclusive.

If the Company approves the replacement of the deceased owner by the Contingent Owner:

(aa) The Contingent Owner will become the new owner of this policy and shall assume all the obligations and be entitled to exercise all the rights of the owner under this policy.

(bb) The replacement will be effective from the effective date of the replacement of the owner as specified in the relevant endorsement.

(cc) For all intent and purposes, this policy with the Contingent Owner as the new owner shall be a continuation of the policy with the original owner. Save for the change of owner, all the terms and conditions under the Basic Plan (including without limitation, Policy Date, Policy Anniversaries, Policy Years) will be unaffected as a result of the replacement of the owner.

If the Company at its sole and absolute discretion does not approve the replacement of the deceased owner by the Contingent Owner, the designation of the Contingent Owner will be revoked automatically.

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9. CROSS-BORDER PROVISION

9.1	**Source of Funds; No Money Laundering, No Tax Evasion**	The owner represents, warrants and certifies to the Company that (i) all funds to be invested in this policy, contract or product have been or will be properly declared to relevant tax authorities in the jurisdiction of the owner's tax residence and/or any other jurisdictions as necessary or appropriate in accordance with applicable laws and regulations, and (ii) none of the funds derive, directly or indirectly, from illegal activities or sources and/or tax evasion.
9.2	**Breach of Representations; Company's Right to Rescind and Impose Surrender Charges; Right to Freeze Refund Amount**	The owner acknowledges that in the event of a violation of the foregoing owner representation and warranty, the owner hereby expressly acknowledges and agrees that the Company shall, to the fullest extent permitted by applicable laws and regulations, have the right to (i) terminate this policy, contract or product immediately, (ii) notwithstanding the actual date of termination pursuant to clause (i), impose the maximum surrender and any other charges imposable on the owner under the policy, contract or product as if the policy, contract or product had been surrendered immediately after issuance; (iii) notify relevant governmental authorities and furnish all information deemed necessary or appropriate in the entire discretion of the Company concerning the owner and/or the policy, contract or product; and (iv) if deemed appropriate after consultation with governmental authorities and legal counsel, either (a) refund to the owner premiums and other amounts paid to the Company through the date of such termination less applicable surrender and other charges in accordance with clause (ii) above (the "**Refund Amount**"), or (b) if requested or required to do so by competent governmental authorities, freeze or pay over to relevant governmental authorities all or a portion of the Refund Amount or take such other actions as competent governmental authorities may request or require.
9.3	**Policy of Cooperating with Tax and Other Governmental Authorities; Consent to Disclose Information to Tax and Other Governmental Authorities**	The AXA Group and the Company have a longstanding policy of cooperating with tax and other governmental authorities to combat money laundering, tax evasion or other illegal activities. In cases where the owner is not a tax resident of the jurisdiction in which this policy is issued (a "**Cross-Border Transaction**"), the AXA Group may disclose to the pertinent tax and/or other governmental authorities the identity of the owner and certain information concerning this policy or contract and the owner hereby consents and agrees that the Company may, in its discretion, make such disclosure.

10. TERMINATION PROVISION

10.1	**Termination of this policy - When will this policy terminate?**	This policy will automatically terminate upon the earliest occurrence of any of the following: (a) on the death of the Insured; (b) on the Termination Date; (c) when this policy lapses or is cancelled; (d) at the next Policy Anniversary after a change in Principal Country of Residence which is outside the Area of Cover and we decide at our sole discretion not to renew this policy pursuant to the "Change of Principal Country of Residence" Provision; (e) when the right of policy termination is exercised pursuant to the "Change of

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Principal Country of Residence" Provision; or

(f) when the right of policy termination is exercised pursuant to the "Cross-Border" Provision.

Upon termination under (f) above, if we are not prohibited from or restricted against refunding any amount to you, we shall have the right to deduct from the amount to be refunded to you (if any) any amount paid or payable by us under this policy and any expenses reasonably incurred by us in respect of this policy under the "Cross-Border" Provision.

Once this policy terminates, this Basic Plan shall cease to have any effect provided that (i) Clauses 3.4, 5.5, 5.8 and 7.7 shall survive the termination and continue to be applicable until the payment of the relevant proceeds or benefits; and (ii) the termination shall not extinguish or otherwise affect our rights under this policy if the relevant rights are stated to or are intended to survive the termination of this policy, including without limitation to Clauses 2.4, 4.2 and 5.7. Our decision as to whether the relevant rights shall survive the termination of this policy shall be reasonably determined by us and be final and binding on you and the claimant.

Where the coverage of the Basic Plan or this policy is terminated during a Policy Year, no part of the premium will be refunded, irrespective whether a claim has or has not been made in that Policy Year.

The payment to the Company or acceptance by the Company of any premium under this policy subsequent to the termination of this policy shall not create any liability on the Company except that the Company will refund any such premium.

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APPENDIX 1 – DEFINITION OF DESIGNATED MAJOR ILLNESSES

Definition of Designated Major Illnesses

Designated Major Illness: Designated Major Illness means any of the illnesses specified below from (1) to (17) and excludes all other illnesses. Any diagnosis of a Designated Major Illness must fulfil the meaning together with the terms and conditions stated under the heading of that Designated Major Illness.

Activities of Daily Living (ADLs): ADLs means the following activities:

- dressing – the ability to put on and take off clothing without assistance
- toileting – the ability to use the toilet, including getting on and off without assistance
- mobility – the ability to get in and out of a bed or a chair without assistance
- continence – the ability to control bowel and bladder function
- feeding – the ability to get food from a plate into the mouth without assistance
- bathing and showering – the ability to bathe and shower without assistance

(1) Cancer

The unequivocal diagnosis of any malignant tumour characterised by the uncontrolled growth of malignant cells and invasion of tissue, and positively diagnosed with histological confirmation. The term malignant tumour includes leukaemia, sarcoma and lymphoma except cutaneous lymphoma (lymphoma confined to the skin).

For the avoidance of doubt, the following conditions do not meet the above definition:

- Urinary bladder tumours that have not invaded the muscle layer (Tis and Ta)
- Cervical Intra-epithelial Neoplasia (CIN I, CIN II, or CIN III) or Cervical Squamous Intra-epithelial Lesion
- All tumours which are histologically classified as benign, carcinoma-in-situ, pre-malignant, non-invasive, having borderline malignancy or having low malignant potential
- All tumours in the presence of any human immunodeficiency virus
- All chronic lymphocytic leukaemia classified as less than RAI stage III
- All prostate tumours which are histologically classified as less than T2N0M0 according to the TNM classification system and having a Gleason score below 7
- All thyroid tumours which are histologically classified as T1N0M0 or a lower stage according to the TNM classification system
- All skin tumours except malignant melanoma
- WHO Grade 1 neuroendocrine tumours without lymph node or other organ involvement

(2) Cardiomyopathy

Condition of impaired ventricular function (of variable aetiology) resulting in significant physical impairment of at least Class 4* on the New York Heart Association (NYHA) classification of cardiac impairment. The diagnosis must be made by a Specialist. Cardiomyopathy includes dilated, hypertrophic and restrictive cardiomyopathy. Cardiomyopathy caused directly or indirectly, wholly or partly, by coronary artery disease or alcohol or drug abuse is excluded.

*NYHA Class 4 means that the patient is unable to carry on any physical activity without discomfort and with symptoms of heart failure at rest. If any physical activity is undertaken by the patient, discomfort increases.

(3) Coronary Artery Bypass Surgery

The undergoing of surgery requiring median sternotomy (surgery to divide the breastbone), which is considered Medically Necessary to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

The following are excluded:

- Angioplasty
- Intra-arterial procedures
- Laser techniques

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- Minimally invasive heart bypass surgery
- Other non-surgical techniques

(4) Heart Attack

Death of heart muscle due to inadequate blood supply that has resulted in all of the following evidence of acute myocardial infarction:

(1) New typical ischaemic changes in the electrocardiograph: new ST–T changes or new left bundle branch block or new pathological Q waves; and

(2) The characteristic rise of cardiac biomarkers or Troponins recorded at the following levels or higher:

2.1. Troponin T > 200ng/L (0.2 ng/ml or 0.2 ug/L); or

2.2. AccuTnI > 500ng/L (0.5 ng/ml or 0.5 ug/L)

The following are excluded:
- Other acute coronary syndromes
- Angina without myocardial infarction
- Non-heart attack related causes of elevated cardiac enzymes or biomarkers

(5) Heart Valve Surgery

The occurrence of open heart valve surgery, performed to replace or repair one or more heart valves, as a consequence of defects that cannot be repaired by intra-arterial catheter procedures alone. The surgery must be considered Medically Necessary by a Specialist and supported by appropriate investigations. Catheter-based techniques including but not limited to balloon valvotomy/valvuloplasty are excluded.

(6) Primary Pulmonary Arterial Hypertension

A primary and unexplained increase in pulmonary artery pressure causing signs of right heart strain and failure. There must be permanent irreversible physical impairment to the degree of at least Class 3* of the New York Heart Association (NYHA) classification of cardiac impairment. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, diseases of the left side of the heart and congenital heart disease are specifically excluded. The diagnosis needs to be made by a Specialist and needs to be established by investigations including cardiac catheterisation.

*NYHA Class 3 means that the patient has marked limitation of physical activity. The patient is comfortable at rest but performing less than ordinary activity will cause fatigue, palpitation or dyspnea.

(7) Surgery to Aorta

Undergoing of a laparotomic or thoracotomic surgery to treat a disease of aorta by excision and replacement of a portion of diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches. The surgery must be considered Medically Necessary by a Specialist. Surgery to treat peripheral vascular disease of the aortic branches is excluded even if a portion of aorta is removed during the operative procedure.

(8) Stroke

Stroke means the death of brain tissue caused by haemorrhage, embolism or thrombosis resulting in permanent neurological deficit with persistent clinical symptoms. There must be clear and obvious abnormalities of sensory or motor functions during the physical examination performed by a Specialist in neurology at least 28 days after the onset of stroke. The incident must be demonstrated by Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) or other reliable imaging techniques approved by the Company.

The following are excluded:
- Transient Ischaemic Attacks (TIA)
- Disorders of the blood vessels affecting the eye including infarction of the optic nerve or retina
- Ischaemic disorders of the vestibular system
- Asymptomatic silent stroke found on imaging

(9) Chronic and Irreversible Kidney Failure

Chronic and irreversible kidney failure presented as chronic irreversible failure of both kidneys requiring permanent renal dialysis (peritoneal or haemodialysis) or renal transplantation.

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(10) Chronic Liver Disease
End stage liver failure as evidenced by at least 2 of the following:

(1) Permanent jaundice;
(2) Esophageal varices;
(3) Ascites; or
(4) Encephalopathy.

The diagnosis must be made by a Specialist in gastroenterology or hepatology. Liver disease caused directly or indirectly, wholly or partly, by alcohol or drug abuse is excluded.

(11) End Stage Lung Disease
End stage lung disease including interstitial lung disease requiring extensive and permanent oxygen therapy as well as Forced Expiratory Volume at one second (FEV1) test result of consistently less than 1.2 litre. The diagnosis must be made by a Specialist.

(12) Major Organ or Bone Marrow Transplantation
The actual undergoing as a recipient of a transplant of heart, lung, liver, pancreas, kidney or bone marrow. The transplant must have been Medically Necessary and based on objective confirmation of organ failure. Other stem cell transplants, islet cell transplants and transplants of part of an organ are excluded.

(13) Fulminant Hepatitis
A submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. Evidence of extensive hepatocellular damage, liver becoming tender or rapidly decreasing in size, degenerating liver function tests, and objective signs of portal systemic encephalopathy must be produced. Liver failure caused directly or indirectly, wholly or partly, by attempted suicide, poisoning or drug or alcohol abuse is excluded.

(14) Severe Rheumatoid Arthritis
Severe Rheumatoid Arthritis where all of the following criteria are met:
(1) The diagnostic criteria of the American College of Rheumatology; and
(2) Permanent inability to perform at least 2 ADLs; and
(3) Widespread joint destruction and major clinical deformity of 2 or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and
(4) The condition has been present for at least 180 days.

(15) Parkinson's Disease
Idiopathic Parkinson's disease resulting independently of all other causes and directly in the Insured's permanent inability to perform at least 3 of the ADLs. The diagnosis must be made by a Specialist. All other types of Parkinsonism are excluded.

(16) Terminal Medical Condition
The conclusive prognosis of a Medical Condition that is expected to result in the death of the Insured within twelve (12) months. This prognosis must be supported by a Specialist. Terminal Medical Condition in the presence of Human Immunodeficiency Virus infection is excluded.

(17) Intensive Care
A Qualified ICU Stay with the use of Invasive Life Support both for seventy two (72) or more consecutive hours.

"**Qualified ICU Stay**" shall mean a stay in an ICU where all of the following criteria must be met:
(a) the stay in ICU must be confirmed as Medically Necessary by a Registered Medical Practitioner;
(b) any stay in ICU in the Mainland China must be at a Recognised Hospital;
(c) the stay in ICU must not be related to or must not arise as a direct or indirect result of:
    (i) a cosmetic treatment performed on the Insured unless it is necessitated by Injury and it is performed within 90 days of the Accident;

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(ii) the Insured's pregnancy, surrogacy, childbirth or termination of pregnancy, birth control, infertility or human assisted reproduction, or sterilisation of either sexes;
(iii) mental disorder, psychological or psychiatric conditions, behavioural problems or personality disorder of the Insured;
(iv) primarily for physiotherapy or for the investigation of signs and/or symptoms with diagnostic imaging, laboratory investigation or other diagnostic procedures; or
(v) experimental and/or unconventional medical technology / procedure / therapy performed on the Insured; or novel drugs / medicines / stem cell therapy not yet approved by the government, relevant authorities and recognised medical association in the locality.

"**Invasive Life Support**" shall mean mechanical ventilation through tracheal intubation, the use of left ventricular assist device (LVAD), intra-aortic balloon pump or Extracorporeal Membrane Oxygenation (ECMO), for the purpose of sustaining life. For the avoidance of doubt, ventilation by any non-invasive ventilator such as CPAP, BiPAP or face mask, shall not be considered as Invasive Life Support.

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BENEFIT SCHEDULE OF GLOBALREACH MEDICAL INSURANCE PLAN – PRESTIGE

Benefit coverage [1] [2] [3]	**Benefit limit**
Please note: The benefit amounts indicated below are per person each Policy Year unless otherwise specified and are reduced each time you claim only by the net amount (less any Deductible or co-insurance) we have actually paid. This Benefit Schedule is subject to and shall be read together with the provisions of this policy.	
Area of Cover	Asia / Worldwide excluding USA / Worldwide
Annual Benefit Limit	Up to HKD60,000,000 / USD7,500,000
Annual Deductible Options	Zero Deductible HKD25,000 / USD3,125 HKD50,000 / USD6,250 HKD100,000 / USD12,500
Waiver of Deductible for Major Incidents [4]	Applicable
Waiver of Deductible for Confinement across Policy Years	Applicable
Outside Area of Cover	Emergency Treatment only
Entitled Ward Class	Standard Private Room
Benefit 1: In-patient and Daycare Treatment Benefits	
1.1: Hospital Charges	Paid in full
1.2: Daily Accommodation Charges	Paid in full
1.3: Hospital Companion Bed	Paid in full
1.4: Private Nurse [5]	Paid in full if arrangement is made by us or Up to HKD2,500 / USD310 per day, up to 2 time slots per day and up to 90 days provided by 1 Qualified Nurse per day (Subject to pre-authorisation)
1.5: In-patient Rehabilitation	Paid in full up to 28 days [6]
1.6: Medical Implants	Specified items: Paid in full Other items: Up to HKD200,000 / USD25,000
1.7: Cash Benefit [7] (Annual Deductible and Annual Benefit Limit do not apply to this benefit)	HKD2,200 / USD280 per night
Benefit 2: Out-patient Treatment Benefits [8]	
2.1A: Computerised Tomography, Magnetic Resonance Imaging, Positron Emission Tomography, X-rays and Gait Scans [5]	Paid in full
2.2: Pre- and Post-Hospitalisation Out-patient Consultation: 2.2A: Pre-Hospitalisation Out-patient Consultation	Paid in full if consultations related to the hospitalisation occur within 90 days before In-patient Treatment or Daycare Treatment (1 Visit per day)
2.2: Pre- and Post-Hospitalisation Out-patient Consultation: 2.2B: Post-Hospitalisation Out-patient Consultation	Paid in full if consultations and treatments related to the hospitalisation occur within 90 days after discharge from Hospital as an In-patient or the date of Daycare Treatment (1 Visit per day)
2.3: Active Cancer Treatment Received as an Out-patient [5]	Paid in full
2.4: Kidney Dialysis Treatment Received as an Out-patient [9]	Paid in full
2.5: Surgical Procedures Received as an Out-patient	Paid in full for consultations, associated prescribed investigations, diagnostic procedures and essential medications by a Registered Medical Practitioner received by the Insured as part of an eligible Out-patient Treatment within 90 days prior to and within 90 days immediately following the surgical procedures received as an Out-patient (1 Visit per day)
2.6A: Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy [5] [10]	For chiropractic treatment, acupuncture, homeopathy, osteopathy: Up to HKD9,000 / USD1,150 For physiotherapy: Paid in full
2.7A: Traditional Chinese Medicine	Up to HKD800 / USD100 per Visit and up to 20 Visits
2.8: Courses of Physiotherapy due to Stroke [5]	Covered under Benefit 2.6A Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy

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Benefit	Coverage
2.9: Courses of Speech Therapy and Occupational Therapy [5]	Paid in full if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient (1 Visit per day)
2.10: General Practitioner and Specialist Consultation Charges [11]	Paid in full (including prescriptions and diagnostic procedures)
Benefit 3: Other Benefits [12]	
3.1: Health Screen and Child Development Assessment (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Up to HKD8,000 / USD1,000 Available only after 12 months of continuous cover from the Policy Date [13]
3.2: Pre-existing Conditions [14] [15]	Policy Years 1 & 2: Up to HKD18,000 / USD2,300 Available only after 270 days of continuous cover from the Policy Date [13] Subsequent years: Up to HKD36,000 / USD4,600
3.3A: Manifested Congenital Conditions [14] [16]	
3.3B: Non-manifested Congenital Conditions [16]	Policy Years 1 & 2: Up to HKD18,000 / USD2,300 Available only after 270 days of continuous cover from the Policy Date [13] Subsequent years: Up to HKD100,000 / USD12,500
3.4: Oral and Maxillofacial Surgery [17]	Paid in full
3.5: Home Nurse [5]	Paid in full, up to 2 time slots per day, provided by 1 Qualified Nurse per day (within 120 days immediately following discharge from Hospital as an In-patient, surgery or discharge from Intensive Care Unit) (Subject to pre-authorisation)
3.6: Ambulance Transport	Paid in full
3.7: Psychiatric Treatment [18]	Up to HKD60,000 / USD7,600
3.8: Accidental Damage to Teeth	Paid in full
3.9: Experimental Drugs [19]	Up to HKD2,000,000 / USD250,000 in an Insured's lifetime
3.10: Pre- and Post-natal Complications [20] [21]	Paid in full Available only after 12 months of continuous cover from the Policy Date [13]
3.11: New Born Accommodation [22]	Paid in full
3.12: Pregnancy and Delivery [20]	Up to HKD110,000 / USD13,800 Available only after 12 months of continuous cover from the Policy Date [13]
3.13: Vaccinations (Pre-existing Condition limitation does not apply to this benefit)	Up to HKD5,600 / USD700
3.14: Routine Dental Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	80% of Eligible Expenses incurred up to HKD9,500 / USD1,200
3.15: Routine Optical Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Up to HKD2,200 / USD280
3.16: Palliative Care and Treatment	Up to HKD300,000 / USD38,000 in an Insured's lifetime Available only after 12 months of continuous cover from the Policy Date [13]
3.17: HIV/AIDS Treatment [23]	Up to HKD1,000,000 / USD125,000 Available only after 5 years of continuous cover from the Policy Date [13]
3.18: Emergency Out-patient Treatment for Accident	Covered under Benefit 2.10 General Practitioner and Specialist Consultation Charges
Benefit 4: Compassionate Death Benefit	
4.1: Compassionate Death Benefit [24] (Annual Deductible and Annual Benefit Limit do not apply to this benefit)	HKD80,000 / USD10,000

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Remarks:

(1) Please refer to the policy terms and conditions applying to these benefits. All benefits shall be subject to the provisions of this policy.

(2) Unless otherwise specified in this policy, all the benefits payable are to cover Eligible Expenses only and are subject to the Annual Benefit Limit and other limits (if any) as stated in the terms and conditions of this policy, including those benefits which indicate “Paid in full”.

(3) Notwithstanding any other provisions of this policy, if at any time after the issuance of this policy, the Insured changes his Principal Country of Residence to USA and the Area of Cover is Worldwide, and the Insured has incurred any Reasonable and Customary charges in respect of Medical Services in USA, the maximum amount of benefits payable of charges incurred in USA in respect of Benefits 1, 2 and 3 for any Medical Condition will be capped at 60% of the relevant eligible charges.

(4) Designated Major Illnesses include Cancer, Cardiomyopathy, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Surgery, Primary Pulmonary Arterial Hypertension, Surgery to Aorta, Stroke, Chronic and Irreversible Kidney Failure, Chronic Liver Disease, End Stage Lung Disease, Major Organ or Bone Marrow Transplantation, Fulminant Hepatitis, Severe Rheumatoid Arthritis, Parkinson’s Disease, Terminal Medical Condition, and Intensive Care, and excludes all other illnesses. Please refer to Appendix 1 to this policy for details.

    The “Waiver of Deductible for Major Incidents” is not applicable to Benefit 3.2 “Pre-existing Conditions” and Benefit 3.3A “Manifested Congenital Conditions”.

(5) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending Registered Medical Practitioner.

(6) We will extend in-patient rehabilitation to a maximum of 180 days per Policy Year for eligible in-patient rehabilitation necessitated by severe central nervous system damage caused by an external trauma.

(7) Cash Benefit will be payable if the Insured:

    (a) receives an eligible In-patient Treatment within the Area of Cover, provided no other cost is or will be borne by us for that eligible treatment; or

    (b) is a Hong Kong identity card holder and is Confined in a General Ward of a public Hospital in Hong Kong, where he incurred charges for the In-patient Treatment; or

    (c) is a Macau resident identity card holder and is Confined in a General Ward of a public Hospital in Macau, where he incurred charges for the In-patient Treatment; or

    (d) is Confined in a public Recognised Hospital in Mainland China, where he incurred charges for the In-patient Treatment; or

    (e) is Confined in a ward class below his entitled ward class as stated in the Benefit Schedule of the Benefit Level of this policy of a private Hospital in Hong Kong or Macau, where he incurred charges for the In-patient Treatment.

(8) Please refer to the provisions of this policy in relation to the limitation on the number of Visit(s) per day.

(9) The amount payable under this benefit is equal to:

    (a) for haemodialysis or peritoneal dialysis at a medical facility, the amount actually charged by the medical facility for such regular haemodialysis or peritoneal dialysis; or

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(b) for haemodialysis or peritoneal dialysis at home, the amount of expenses actually incurred for the purchase of supplies and/or rental of the dialysis machine for such regular haemodialysis or peritoneal dialysis where such purchase of supplies and/or rental of dialysis machine is/are prescribed in writing by the Insured's attending Registered Medical Practitioner.

(10) A referral letter is valid for the same or related Medical Condition for 180 days from the date it is issued. Another referral letter is required for treatment of a new or unrelated Medical Condition.

(11) The Eligible Expenses so incurred for Pre-Hospitalisation Out-patient Consultation and Post-Hospitalisation Out-patient Consultation shall first be payable under Benefit 2.2 "Pre- and Post- Hospitalisation Out-patient Consultation", and this benefit shall be payable only if:

(a) the limit as stated in the Benefit Schedule of the Benefit Level of this Basic Plan is exhausted; or

(b) the pre-hospitalisation consultation related to an In-patient Treatment or Daycare Treatment occurs more than 90 days prior to an In-patient Treatment or Daycare Treatment; or

(c) the post-hospitalisation consultation or treatment related to an In-patient Treatment or Daycare Treatment occurs more than 90 days after the date of discharge from Hospital for which the Insured was Confined as an In-patient or the date of Daycare Treatment.

(12) Limitations and restrictions applicable to In-patient and Day Patient (Benefit 1) and Out-patient (Benefit 2) as described here above will also apply to "other benefits" unless otherwise specified. The aggregate amount of Eligible Expenses actually incurred for In-patient Treatment, Daycare Treatment and Out-patient Treatment is subject to the monetary limit shown for these "other benefits".

(13) Please refer to the provisions of this policy for details of the waiting period requirements for each of these benefits.

(14) Both "Pre-existing Conditions" and "Manifested Congenital Conditions" share the same aggregate annual limit, thus any claims paid under one of those two benefits reduce the remaining annual limit available for both.

(15) This benefit is payable in the following scenarios:

(a) Treatment which the Insured has received in the first 2 Policy Years of this policy (but after first 270 days from the Policy Date); or

(b) Where the Insured has been covered for 2 consecutive Policy Years from the Policy Date, but the Insured does not have a consecutive 2 years Trouble Free period immediately before such Eligible Expenses have been incurred.

(16) The following exclusions still apply in any event:

(a) item (3) under the "Exclusions" Provision regarding "Treatment begun, or for which the need had arisen, during the first 90 days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination"; and

(b) item (1)(a) of "Special terms" exclusion under the "Exclusions" Provision regarding "cosmetic (aesthetic) surgery or treatment".

(17) Please refer to the policy terms and conditions for details on covered surgeries and exclusions.

(18) Treatment given by a psychologist must be referred in writing by a Specialist.

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(19) This benefit is applicable if the Insured is diagnosed with Designated Cancer and if Experimental Drug has been prescribed for the Active Cancer Treatment or Palliative Care and Treatment of such Designated Cancer, provided that:

(a) such treatment must be assessed and pre-authorised in writing; and

(b) a medical certificate issued by a Specialist must be provided to the Company to certify that the Experimental Drug is prescribed by and is deemed by the Specialist to be an appropriate or recommended Active Cancer Treatment or Palliative Care and Treatment of the Designated Cancer of the Insured.

For any Reasonable and Customary charges incurred outside of Hong Kong, Macau and Mainland China which are payable under this benefit, the amount payable under this benefit shall be reduced to 60% of the Reasonable and Customary charges incurred, subject to the limit(s) shown above and the "Benefit Adjustment" Provision.

(20) This benefit is only available to the Insured who is a mother and is over the Age of 18.

(21) The benefit shall not be payable if the:

(a) delivery of birth is through non Medically Necessary caesarean birth, and/or

(b) conception of the child is conceived by artificial means or any form of assisted conception, fertility treatment by either parent or pregnancy via a surrogate.

(22) This benefit is only available to the Insured who is a mother.

(23) This benefit is payable if the HIV or AIDS is as a result of occupational Accident or blood transfusion and the conditions stated in the terms and conditions of this policy are all fulfilled.

(24) Within 1st Policy Year, premium paid or Compassionate Death Benefit whichever is lower.

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BENEFIT SCHEDULE OF GLOBALREACH MEDICAL INSURANCE PLAN – COMPREHENSIVE

Benefit coverage [1] [2] [3]	**Benefit limit**
Please note: The benefit amounts indicated below are per person each Policy Year unless otherwise specified and are reduced each time you claim only by the net amount (less any Deductible or co-insurance) we have actually paid. This Benefit Schedule is subject to and shall be read together with the provisions of this policy.	
Area of Cover	Asia / Worldwide excluding USA / Worldwide
Annual Benefit Limit	Up to HKD50,000,000 / USD6,250,000
Annual Deductible Options	Zero Deductible HKD25,000 / USD3,125 HKD50,000 / USD6,250 HKD100,000 / USD12,500
Waiver of Deductible for Major Incidents [4]	Applicable
Waiver of Deductible for Confinement across Policy Years	Applicable
Outside Area of Cover	Emergency Treatment only
Entitled Ward Class	Standard Private Room
Benefit 1: In-patient and Daycare Treatment Benefits	
1.1: Hospital Charges	Paid in full
1.2: Daily Accommodation Charges	Paid in full
1.3: Hospital Companion Bed	Paid in full
1.4: Private Nurse [5]	Paid in full if arrangement is made by us or Up to HKD2,500 / USD310 per day, up to 2 time slots per day and up to 60 days provided by 1 Qualified Nurse per day (Subject to pre-authorisation)
1.5: In-patient Rehabilitation	Paid in full up to 28 days [6]
1.6: Medical Implants	Specified items: Paid in full Other items: Up to HKD200,000 / USD25,000
1.7: Cash Benefit [7] (Annual Deductible and Annual Benefit Limit do not apply to this benefit)	HKD1,500 / USD190 per night
Benefit 2: Out-patient Treatment Benefits [8]	
2.1A: Computerised Tomography, Magnetic Resonance Imaging, Positron Emission Tomography, X-rays and Gait Scans [5]	Paid in full
2.2: Pre- and Post-Hospitalisation Out-patient Consultation: 2.2A: Pre-Hospitalisation Out-patient Consultation	Paid in full if consultations related to the hospitalisation occur within 90 days before In-patient Treatment or Daycare Treatment (1 Visit per day)
2.2: Pre- and Post-Hospitalisation Out-patient Consultation: 2.2B: Post-Hospitalisation Out-patient Consultation	Paid in full if consultations and treatments related to the hospitalisation occur within 90 days after discharge from Hospital as an In-patient or the date of Daycare Treatment (1 Visit per day)
2.3: Active Cancer Treatment Received as an Out-patient [5]	Paid in full
2.4: Kidney Dialysis Treatment Received as an Out-patient [9]	Paid in full
2.5: Surgical Procedures Received as an Out-patient	Paid in full for consultations, associated prescribed investigations, diagnostic procedures and essential medications by a Registered Medical Practitioner received by the Insured as part of an eligible Out-patient Treatment within 90 days prior to and within 90 days immediately following the surgical procedures received as an Out-patient (1 Visit per day)
2.6A: Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy [5] [10]	For chiropractic treatment, acupuncture, homeopathy, osteopathy: Up to HKD9,000 / USD1,150 For physiotherapy: Paid in full
2.7A: Traditional Chinese Medicine	Up to HKD700 / USD90 per Visit and up to 20 Visits
2.8: Courses of Physiotherapy due to Stroke [5]	Covered under Benefit 2.6A Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy

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Benefit	Limit
2.9: Courses of Speech Therapy and Occupational Therapy [5]	Paid in full if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient (1 Visit per day)
2.10: General Practitioner and Specialist Consultation Charges [11]	Paid in full (including prescriptions and diagnostic procedures)
Benefit 3: Other Benefits [12]	
3.1: Health Screen and Child Development Assessment (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Up to HKD2,400 / USD300 Available only after 12 months of continuous cover from the Policy Date [13]
3.2: Pre-existing Conditions [14] [15]	Policy Years 1 & 2: Up to HKD18,000 / USD2,300 Available only after 270 days of continuous cover from the Policy Date [13] Subsequent years: Up to HKD36,000 / USD4,600
3.3A: Manifested Congenital Conditions [14] [16]	
3.3B: Non-manifested Congenital Conditions [16]	Policy Years 1 & 2: Up to HKD18,000 / USD2,300 Available only after 270 days of continuous cover from the Policy Date [13] Subsequent years: Up to HKD100,000 / USD12,500
3.4: Oral and Maxillofacial Surgery [17]	Paid in full
3.5: Home Nurse [5]	Paid in full, up to 2 time slots per day, provided by 1 Qualified Nurse per day (within 120 days immediately following discharge from Hospital as an In-patient, surgery or discharge from Intensive Care Unit) (Subject to pre-authorisation)
3.6: Ambulance Transport	Paid in full
3.7: Psychiatric Treatment [18]	Up to HKD50,000 / USD6,300
3.8: Accidental Damage to Teeth	Paid in full
3.9: Experimental Drugs [19]	Up to HKD1,500,000 / USD187,500 in an Insured's lifetime
3.10: Pre- and Post-natal Complications [20]	Paid in full Available only after 12 months of continuous cover from the Policy Date [13]
3.11: New Born Accommodation [21]	Paid in full
3.12: Pregnancy and Delivery	Not applicable
3.13: Vaccinations (Pre-existing Condition limitation does not apply to this benefit)	Up to HKD2,400 / USD300
3.14: Routine Dental Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.15: Routine Optical Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.16: Palliative Care and Treatment	Up to HKD240,000 / USD30,000 in an Insured's lifetime Available only after 12 months of continuous cover from the Policy Date [13]
3.17: HIV/AIDS Treatment [22]	Up to HKD1,000,000 / USD125,000 Available only after 5 years of continuous cover from the Policy Date [13]
3.18: Emergency Out-patient Treatment for Accident	Covered under Benefit 2.10 General Practitioner and Specialist Consultation Charges
Benefit 4: Compassionate Death Benefit	
4.1: Compassionate Death Benefit [23] (Annual Deductible and Annual Benefit Limit do not apply to this benefit)	HKD80,000 / USD10,000

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Remarks:

(1) Please refer to the policy terms and conditions applying to these benefits. All benefits shall be subject to the provisions of this policy.

(2) Unless otherwise specified in this policy, all the benefits payable are to cover Eligible Expenses only and are subject to the Annual Benefit Limit and other limits (if any) as stated in the terms and conditions of this policy, including those benefits which indicate "Paid in full".

(3) Notwithstanding any other provisions of this policy, if at any time after the issuance of this policy, the Insured changes his Principal Country of Residence to USA and the Area of Cover is Worldwide, and the Insured has incurred any Reasonable and Customary charges in respect of Medical Services in USA, the maximum amount of benefits payable of charges incurred in USA in respect of Benefits 1, 2 and 3 for any Medical Condition will be capped at 60% of the relevant eligible charges.

(4) Designated Major Illnesses include Cancer, Cardiomyopathy, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Surgery, Primary Pulmonary Arterial Hypertension, Surgery to Aorta, Stroke, Chronic and Irreversible Kidney Failure, Chronic Liver Disease, End Stage Lung Disease, Major Organ or Bone Marrow Transplantation, Fulminant Hepatitis, Severe Rheumatoid Arthritis, Parkinson's Disease, Terminal Medical Condition, and Intensive Care, and excludes all other illnesses. Please refer to Appendix 1 to this policy for details.

    The "Waiver of Deductible for Major Incidents" is not applicable to Benefit 3.2 "Pre-existing Conditions" and Benefit 3.3A "Manifested Congenital Conditions".

(5) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending Registered Medical Practitioner.

(6) We will extend in-patient rehabilitation to a maximum of 180 days per Policy Year for eligible in-patient rehabilitation necessitated by severe central nervous system damage caused by an external trauma.

(7) Cash Benefit will be payable if the Insured:

    (a) receives an eligible In-patient Treatment within the Area of Cover, provided no other cost is or will be borne by us for that eligible treatment; or

    (b) is a Hong Kong identity card holder and is Confined in a General Ward of a public Hospital in Hong Kong, where he incurred charges for the In-patient Treatment; or

    (c) is a Macau resident identity card holder and is Confined in a General Ward of a public Hospital in Macau, where he incurred charges for the In-patient Treatment; or

    (d) is Confined in a public Recognised Hospital in Mainland China, where he incurred charges for the In-patient Treatment; or

    (e) is Confined in a ward class below his entitled ward class as stated in the Benefit Schedule of the Benefit Level of this policy of a private Hospital in Hong Kong or Macau, where he incurred charges for the In-patient Treatment.

(8) Please refer to the provisions of this policy in relation to the limitation on the number of Visit(s) per day.

(9) The amount payable under this benefit is equal to:

    (a) for haemodialysis or peritoneal dialysis at a medical facility, the amount actually charged by the medical facility for such regular haemodialysis or peritoneal dialysis; or

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(b) for haemodialysis or peritoneal dialysis at home, the amount of expenses actually incurred for the purchase of supplies and/or rental of the dialysis machine for such regular haemodialysis or peritoneal dialysis where such purchase of supplies and/or rental of dialysis machine is/are prescribed in writing by the Insured's attending Registered Medical Practitioner.

(10) A referral letter is valid for the same or related Medical Condition for 180 days from the date it is issued. Another referral letter is required for treatment of a new or unrelated Medical Condition.

(11) The Eligible Expenses so incurred for Pre-Hospitalisation Out-patient Consultation and Post-Hospitalisation Out-patient Consultation shall first be payable under Benefit 2.2 "Pre- and Post- Hospitalisation Out-patient Consultation", and this benefit shall be payable only if:

(a) the limit as stated in the Benefit Schedule of the Benefit Level of this Basic Plan is exhausted; or

(b) the pre-hospitalisation consultation related to an In-patient Treatment or Daycare Treatment occurs more than 90 days prior to an In-patient Treatment or Daycare Treatment; or

(c) the post-hospitalisation consultation or treatment related to an In-patient Treatment or Daycare Treatment occurs more than 90 days after the date of discharge from Hospital for which the Insured was Confined as an In-patient or the date of Daycare Treatment.

(12) Limitations and restrictions applicable to In-patient and Day Patient (Benefit 1) and Out-patient (Benefit 2) as described here above will also apply to "other benefits" unless otherwise specified. The aggregate amount of Eligible Expenses actually incurred for In-patient Treatment, Daycare Treatment and Out-patient Treatment is subject to the monetary limit shown for these "other benefits".

(13) Please refer to the provisions of this policy for details of the waiting period requirements for each of these benefits.

(14) Both "Pre-existing Conditions" and "Manifested Congenital Conditions" share the same aggregate annual limit, thus any claims paid under one of those two benefits reduce the remaining annual limit available for both.

(15) This benefit is payable in the following scenarios:

(a) Treatment which the Insured has received in the first 2 Policy Years of this policy (but after first 270 days from the Policy Date); or

(b) Where the Insured has been covered for 2 consecutive Policy Years from the Policy Date, but the Insured does not have a consecutive 2 years Trouble Free period immediately before such Eligible Expenses have been incurred.

(16) The following exclusions still apply in any event:

(a) item (3) under the "Exclusions" Provision regarding "Treatment begun, or for which the need had arisen, during the first 90 days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination"; and

(b) item (1)(a) of "Special terms" exclusion under the "Exclusions" Provision regarding "cosmetic (aesthetic) surgery or treatment".

(17) Please refer to the policy terms and conditions for details on covered surgeries and exclusions.

(18) Treatment given by a psychologist must be referred in writing by a Specialist.

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(19) This benefit is applicable if the Insured is diagnosed with Designated Cancer and if Experimental Drug has been prescribed for the Active Cancer Treatment or Palliative Care and Treatment of such Designated Cancer, provided that:

(a) such treatment must be assessed and pre-authorised in writing; and

(b) a medical certificate issued by a Specialist must be provided to the Company to certify that the Experimental Drug is prescribed by and is deemed by the Specialist to be an appropriate or recommended Active Cancer Treatment or Palliative Care and Treatment of the Designated Cancer of the Insured.

For any Reasonable and Customary charges incurred outside of Hong Kong, Macau and Mainland China which are payable under this benefit, the amount payable under this benefit shall be reduced to 60% of the Reasonable and Customary charges incurred, subject to the limit(s) shown above and the "Benefit Adjustment" Provision.

(20) This benefit is only available to the Insured who is a mother and is over the Age of 18. The benefit shall not be payable if the:

(a) delivery of birth is through non Medically Necessary caesarean birth, and/or

(b) conception of the child is conceived by artificial means or any form of assisted conception, fertility treatment by either parent or pregnancy via a surrogate.

(21) This benefit is only available to the Insured who is a mother.

(22) This benefit is payable if the HIV or AIDS is as a result of occupational Accident or blood transfusion and the conditions stated in the terms and conditions of this policy are all fulfilled.

(23) Within 1st Policy Year, premium paid or Compassionate Death Benefit whichever is lower.

SAMPLE

BENEFIT SCHEDULE OF GLOBALREACH MEDICAL INSURANCE PLAN – STANDARD

<table>
<tr><th colspan="2">Benefit coverage [1] [2] [3]</th><th colspan="2">Benefit limit</th></tr>
<tr><td colspan="4">Please note: The benefit amounts indicated below are per person each Policy Year unless otherwise specified and are reduced each time you claim only by the net amount (less any Deductible or co-insurance) we have actually paid. This Benefit Schedule is subject to and shall be read together with the provisions of this policy.</td></tr>
<tr><td colspan="2">Area of Cover</td><td colspan="2">Asia / Worldwide excluding USA / Worldwide</td></tr>
<tr><td colspan="2">Annual Benefit Limit</td><td colspan="2">Up to HKD40,000,000 / USD5,000,000</td></tr>
<tr><td colspan="2">Annual Deductible Options</td><td colspan="2">Zero Deductible
HKD25,000 / USD3,125
HKD50,000 / USD6,250
HKD100,000 / USD12,500</td></tr>
<tr><td colspan="2">Waiver of Deductible for Major Incidents [4]</td><td colspan="2">Applicable</td></tr>
<tr><td colspan="2">Waiver of Deductible for Confinement across Policy Years</td><td colspan="2">Applicable</td></tr>
<tr><td colspan="2">Outside Area of Cover</td><td colspan="2">Emergency Treatment only</td></tr>
<tr><td colspan="2">Entitled Ward Class</td><td colspan="2">Standard Private Room</td></tr>
<tr><th colspan="4">Benefit 1: In-patient and Daycare Treatment Benefits</th></tr>
<tr><td colspan="2">1.1: Hospital Charges</td><td colspan="2">Paid in full</td></tr>
<tr><td colspan="2">1.2: Daily Accommodation Charges</td><td colspan="2">Paid in full</td></tr>
<tr><td colspan="2">1.3: Hospital Companion Bed</td><td colspan="2">Paid in full</td></tr>
<tr><td colspan="2">1.4: Private Nurse [5]</td><td colspan="2">Paid in full if arrangement is made by us or
Up to HKD2,500 / USD310 per day, up to 2 time slots per day and up to 30 days provided by 1 Qualified Nurse per day
(Subject to pre-authorisation)</td></tr>
<tr><td colspan="2">1.5: In-patient Rehabilitation</td><td colspan="2">Paid in full up to 28 days [6]</td></tr>
<tr><td colspan="2">1.6: Medical Implants</td><td colspan="2">Specified items: Paid in full
Other items: Up to HKD200,000 / USD25,000</td></tr>
<tr><td colspan="2">1.7: Cash Benefit [7]
(Annual Deductible and Annual Benefit Limit do not apply to this benefit)</td><td colspan="2">HKD1,000 / USD125 per night</td></tr>
<tr><th colspan="4">Benefit 2: Out-patient Treatment Benefits [8]</th></tr>
<tr><td colspan="2">2.1B: Computerised Tomography, Magnetic Resonance Imaging, Positron Emission Tomography, X-rays and Gait Scans [5]</td><td colspan="2">Paid in full if the treatment occurs within 90 days before In-patient Treatment or Daycare Treatment and within 90 days after discharge from Hospital as an In-patient or the date of Daycare Treatment</td></tr>
<tr><td rowspan="2">2.2: Pre- and Post-Hospitalisation Out-patient Consultation:</td><td>2.2A: Pre-Hospitalisation Out-patient Consultation</td><td colspan="2">Paid in full if consultations related to the hospitalisation occur within 90 days before In-patient Treatment or Daycare Treatment (1 Visit per day)</td></tr>
<tr><td>2.2B: Post-Hospitalisation Out-patient Consultation [9]</td><td colspan="2">Paid in full if consultations and treatments related to the hospitalisation occur within 90 days after discharge from Hospital as an In-patient or the date of Daycare Treatment (1 Visit per day)</td></tr>
<tr><td colspan="2">2.3: Active Cancer Treatment Received as an Out-patient [5]</td><td colspan="2">Paid in full</td></tr>
<tr><td colspan="2">2.4: Kidney Dialysis Treatment Received as an Out-patient [10]</td><td colspan="2">Paid in full</td></tr>
<tr><td colspan="2">2.5: Surgical Procedures Received as an Out-patient</td><td colspan="2">Paid in full for consultations, associated prescribed investigations, diagnostic procedures and essential medications by a Registered Medical Practitioner received by the Insured as part of an eligible Out-patient Treatment within 90 days prior to and within 90 days immediately following the surgical procedures received as an Out-patient (1 Visit per day)</td></tr>
<tr><td colspan="2">2.6B: Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy [5]</td><td>Up to HKD1,600 / USD200 per Visit if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient or the date of Daycare Treatment</td><td rowspan="2">Up to 20 Visits
(1 Visit per day)</td></tr>
<tr><td colspan="2">2.7B: Traditional Chinese Medicine [9]</td><td>Up to HKD600 / USD75 per Visit if the consultation or treatment occurs within 90 days immediately following discharge from Hospital as an In-patient or the date of Daycare Treatment</td></tr>
</table>

SAMPLE

2.8: Courses of Physiotherapy due to Stroke [5]	Paid in full if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient (1 Visit per day)
2.9: Courses of Speech Therapy and Occupational Therapy [5]	Paid in full if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient (1 Visit per day)
2.10: General Practitioner and Specialist Consultation Charges	Not applicable
Benefit 3: Other Benefits [11]	
3.1: Health Screen and Child Development Assessment (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.2: Pre-existing Conditions	Not applicable
3.3A: Manifested Congenital Conditions	
3.3B: Non-manifested Congenital Conditions [12]	Policy Years 1 & 2: Up to HKD18,000 / USD2,300 Available only after 270 days of continuous cover from the Policy Date [13] Subsequent years: Up to HKD100,000 / USD12,500
3.4: Oral and Maxillofacial Surgery	Not applicable
3.5: Home Nurse [5]	Paid in full, up to 2 time slots per day, provided by 1 Qualified Nurse per day (within 120 days immediately following discharge from Hospital as an In-patient, surgery or discharge from Intensive Care Unit) (Subject to pre-authorisation)
3.6: Ambulance Transport	Paid in full
3.7: Psychiatric Treatment [14]	Up to HKD40,000 / USD5,000
3.8: Accidental Damage to Teeth	Paid in full
3.9: Experimental Drugs [15]	Up to HKD1,000,000 / USD125,000 in an Insured's lifetime
3.10: Pre- and Post-natal Complications	Not applicable
3.11: New Born Accommodation	Not applicable
3.12: Pregnancy and Delivery	Not applicable
3.13: Vaccinations (Pre-existing Condition limitation does not apply to this benefit)	Not applicable
3.14: Routine Dental Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.15: Routine Optical Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.16: Palliative Care and Treatment	Up to HKD80,000 / USD10,000 in an Insured's lifetime Available only after 12 months of continuous cover from the Policy Date [13]
3.17: HIV/AIDS Treatment [16]	Up to HKD1,000,000 / USD125,000 Available only after 5 years of continuous cover from the Policy Date [13]
3.18: Emergency Out-patient Treatment for Accident	Paid in full if treatment occurs within 24 hours after the Accident
Benefit 4: Compassionate Death Benefit	
4.1: Compassionate Death Benefit [17] (Annual Deductible and Annual Benefit Limit do not apply to this benefit)	HKD80,000 / USD10,000

SAMPLE

Remarks:

(1) Please refer to the policy terms and conditions applying to these benefits. All benefits shall be subject to the provisions of this policy.

(2) Unless otherwise specified in this policy, all the benefits payable are to cover Eligible Expenses only and are subject to the Annual Benefit Limit and other limits (if any) as stated in the terms and conditions of this policy, including those benefits which indicate "Paid in full".

(3) Notwithstanding any other provisions of this policy, if at any time after the issuance of this policy, the Insured changes his Principal Country of Residence to USA and the Area of Cover is Worldwide, and the Insured has incurred any Reasonable and Customary charges in respect of Medical Services in USA, the maximum amount of benefits payable of charges incurred in USA in respect of Benefits 1, 2 and 3 for any Medical Condition will be capped at 60% of the relevant eligible charges.

(4) Designated Major Illnesses include Cancer, Cardiomyopathy, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Surgery, Primary Pulmonary Arterial Hypertension, Surgery to Aorta, Stroke, Chronic and Irreversible Kidney Failure, Chronic Liver Disease, End Stage Lung Disease, Major Organ or Bone Marrow Transplantation, Fulminant Hepatitis, Severe Rheumatoid Arthritis, Parkinson's Disease, Terminal Medical Condition, and Intensive Care, and excludes all other illnesses. Please refer to Appendix 1 to this policy for details.

(5) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending Registered Medical Practitioner.

(6) We will extend in-patient rehabilitation to a maximum of 180 days per Policy Year for eligible in-patient rehabilitation necessitated by severe central nervous system damage caused by an external trauma.

(7) Cash Benefit will be payable if the Insured:

    (a) receives an eligible In-patient Treatment within the Area of Cover, provided no other cost is or will be borne by us for that eligible treatment; or

    (b) is a Hong Kong identity card holder and is Confined in a General Ward of a public Hospital in Hong Kong, where he incurred charges for the In-patient Treatment; or

    (c) is a Macau resident identity card holder and is Confined in a General Ward of a public Hospital in Macau, where he incurred charges for the In-patient Treatment; or

    (d) is Confined in a public Recognised Hospital in Mainland China, where he incurred charges for the In-patient Treatment; or

    (e) is Confined in a ward class below his entitled ward class as stated in the Benefit Schedule of the Benefit Level of this policy of a private Hospital in Hong Kong or Macau, where he incurred charges for the In-patient Treatment.

(8) Please refer to the provisions of this policy in relation to the limitation on the number of Visit(s) per day.

(9) The Insured is entitled to only 1 post-hospitalisation consultation or follow-up Visit per day under either Benefit 2.2B "Post-Hospitalisation Out-patient Consultation" or Benefit 2.7B "Traditional Chinese Medicine".

(10) The amount payable under this benefit is equal to:

    (a) for haemodialysis or peritoneal dialysis at a medical facility, the amount actually charged by the medical facility for such regular haemodialysis or peritoneal dialysis; or

SAMPLE

(b) for haemodialysis or peritoneal dialysis at home, the amount of expenses actually incurred for the purchase of supplies and/or rental of the dialysis machine for such regular haemodialysis or peritoneal dialysis where such purchase of supplies and/or rental of dialysis machine is/are prescribed in writing by the Insured's attending Registered Medical Practitioner.

(11) Limitations and restrictions applicable to In-patient and Day Patient (Benefit 1) and Out-patient (Benefit 2) as described here above will also apply to "other benefits" unless otherwise specified. The aggregate amount of Eligible Expenses actually incurred for In-patient Treatment, Daycare Treatment and Out-patient Treatment is subject to the monetary limit shown for these "other benefits".

(12) The following exclusions still apply in any event:

(a) item (3) under the "Exclusions" Provision regarding "Treatment begun, or for which the need had arisen, during the first 90 days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination"; and

(b) item (1)(a) of "Special terms" exclusion under the "Exclusions" Provision regarding "cosmetic (aesthetic) surgery or treatment".

(13) Please refer to the provisions of this policy for details of the waiting period requirements for each of these benefits.

(14) This benefit is available where the Insured receives psychiatric treatment as In-patient Treatment or Daycare Treatment. Treatment given by a psychologist must be referred in writing by a Specialist.

(15) This benefit is applicable if the Insured is diagnosed with Designated Cancer and if Experimental Drug has been prescribed for the Active Cancer Treatment or Palliative Care and Treatment of such Designated Cancer, provided that:

(a) such treatment must be assessed and pre-authorised in writing; and

(b) a medical certificate issued by a Specialist must be provided to the Company to certify that the Experimental Drug is prescribed by and is deemed by the Specialist to be an appropriate or recommended Active Cancer Treatment or Palliative Care and Treatment of the Designated Cancer of the Insured.

For any Reasonable and Customary charges incurred outside of Hong Kong, Macau and Mainland China which are payable under this benefit, the amount payable under this benefit shall be reduced to 60% of the Reasonable and Customary charges incurred, subject to the limit(s) shown above and the "Benefit Adjustment" Provision.

(16) This benefit is payable if the HIV or AIDS is as a result of occupational Accident or blood transfusion and the conditions stated in the terms and conditions of this policy are all fulfilled.

(17) Within 1st Policy Year, premium paid or Compassionate Death Benefit whichever is lower.

SAMPLE

BENEFIT SCHEDULE OF GLOBALREACH MEDICAL INSURANCE PLAN – ESSENTIAL

Benefit coverage (1) (2) (3)	**Benefit limit**
Please note: The benefit amounts indicated below are per person each Policy Year unless otherwise specified and are reduced each time you claim only by the net amount (less any Deductible or co-insurance) we have actually paid. This Benefit Schedule is subject to and shall be read together with the provisions of this policy.	
Area of Cover	Asia / Worldwide excluding USA / Worldwide
Annual Benefit Limit	Up to HKD30,000,000 / USD3,750,000
Annual Deductible Options	Zero Deductible HKD25,000 / USD3,125 HKD50,000 / USD6,250 HKD100,000 / USD12,500
Waiver of Deductible for Major Incidents (4)	Applicable
Waiver of Deductible for Confinement across Policy Years	Applicable
Outside Area of Cover	Emergency Treatment only
Entitled Ward Class	For Confinement in Hong Kong, Macau and Mainland China: Semi-private Room For Confinement outside Hong Kong, Macau and Mainland China: Standard Private Room
Benefit 1: In-patient and Daycare Treatment Benefits	
1.1: Hospital Charges	Paid in full
1.2: Daily Accommodation Charges	Paid in full
1.3: Hospital Companion Bed	Paid in full
1.4: Private Nurse (5)	Paid in full if arrangement is made by us or Up to HKD2,500 / USD310 per day, up to 2 time slots per day and up to 30 days provided by 1 Qualified Nurse per day (Subject to pre-authorisation)
1.5: In-patient Rehabilitation	Paid in full up to 28 days (6)
1.6: Medical Implants	Specified items: Paid in full Other items: Up to HKD200,000 / USD25,000
1.7: Cash Benefit (7) (Annual Deductible and Annual Benefit Limit do not apply to this benefit)	HKD800 / USD100 per night
Benefit 2: Out-patient Treatment Benefits (8)	
2.1B: Computerised Tomography, Magnetic Resonance Imaging, Positron Emission Tomography, X-rays and Gait Scans (5)	Paid in full if the treatment occurs within 90 days before In-patient Treatment or Daycare Treatment and within 90 days after discharge from Hospital as an In-patient or the date of Daycare Treatment
2.2: Pre- and Post-Hospitalisation Out-patient Consultation: 2.2A: Pre-Hospitalisation Out-patient Consultation	Paid in full if consultations related to the hospitalisation occur within 90 days before In-patient Treatment or Daycare Treatment (1 Visit per day)
2.2: Pre- and Post-Hospitalisation Out-patient Consultation: 2.2B: Post-Hospitalisation Out-patient Consultation	Paid in full if consultations and treatments related to the hospitalisation occur within 90 days after discharge from Hospital as an In-patient or the date of Daycare Treatment (1 Visit per day)
2.3: Active Cancer Treatment Received as an Out-patient (5)	Paid in full
2.4: Kidney Dialysis Treatment Received as an Out-patient (9)	Paid in full
2.5: Surgical Procedures Received as an Out-patient	Paid in full for consultations, associated prescribed investigations, diagnostic procedures and essential medications by a Registered Medical Practitioner received by the Insured as part of an eligible Out-patient Treatment within 90 days prior to and within 90 days immediately following the surgical procedures received as an Out-patient (1 Visit per day)
2.6B: Courses of Chiropractic Treatment, Acupuncture, Homeopathy, Osteopathy and Physiotherapy (5)	Up to HKD1,600 / USD200 per Visit and up to 10 Visits if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient or the date of Daycare Treatment (1 Visit per day)
2.7B: Traditional Chinese Medicine	Not applicable

SAMPLE

2.8: Courses of Physiotherapy due to Stroke [5]	Paid in full if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient (1 Visit per day)
2.9: Courses of Speech Therapy and Occupational Therapy [5]	Paid in full if the treatment occurs within 90 days immediately following discharge from Hospital as an In-patient (1 Visit per day)
2.10: General Practitioner and Specialist Consultation Charges	Not applicable
Benefit 3: Other Benefits [10]	
3.1: Health Screen and Child Development Assessment (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.2: Pre-existing Conditions	Not applicable
3.3A: Manifested Congenital Conditions	
3.3B: Non-manifested Congenital Conditions [11]	Policy Years 1 & 2: Up to HKD18,000 / USD2,300 Available only after 270 days of continuous cover from the Policy Date [12] Subsequent years: Up to HKD100,000 / USD12,500
3.4: Oral and Maxillofacial Surgery	Not applicable
3.5: Home Nurse [5]	Paid in full, up to 2 time slots per day, provided by 1 Qualified Nurse per day (within 120 days immediately following discharge from Hospital as an In-patient, surgery or discharge from Intensive Care Unit) (Subject to pre-authorisation)
3.6: Ambulance Transport	Paid in full
3.7: Psychiatric Treatment [13]	Up to HKD30,000 / USD4,000
3.8: Accidental Damage to Teeth	Paid in full
3.9: Experimental Drugs [14]	Up to HKD500,000 / USD62,500 in an Insured's lifetime
3.10: Pre- and Post-natal Complications	Not applicable
3.11: New Born Accommodation	Not applicable
3.12: Pregnancy and Delivery	Not applicable
3.13: Vaccinations (Pre-existing Condition limitation does not apply to this benefit)	Not applicable
3.14: Routine Dental Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.15: Routine Optical Care (Annual Deductible and Pre-existing Condition limitation do not apply to this benefit)	Not applicable
3.16 Palliative Care and Treatment	Up to HKD50,000 / USD6,300 in an Insured's lifetime Available only after 12 months of continuous cover from the Policy Date [12]
3.17 HIV/AIDS Treatment [15]	Up to HKD1,000,000 / USD125,000 Available only after 5 years of continuous cover from the Policy Date [12]
3.18: Emergency Out-patient Treatment for Accident	Paid in full if treatment occurs within 24 hours after the Accident
Benefit 4: Compassionate Death Benefit	
4.1: Compassionate Death Benefit [16] (Annual Deductible and Annual Benefit Limit do not apply to this benefit)	HKD80,000 / USD10,000

SAMPLE

Remarks:

(1) Please refer to the policy terms and conditions applying to these benefits. All benefits shall be subject to the provisions of this policy.

(2) Unless otherwise specified in this policy, all the benefits payable are to cover Eligible Expenses only and are subject to the Annual Benefit Limit and other limits (if any) as stated in the terms and conditions of this policy, including those benefits which indicate "Paid in full".

(3) Notwithstanding any other provisions of this policy, if at any time after the issuance of this policy, the Insured changes his Principal Country of Residence to USA and the Area of Cover is Worldwide, and the Insured has incurred any Reasonable and Customary charges in respect of Medical Services in USA, the maximum amount of benefits payable of charges incurred in USA in respect of Benefits 1, 2 and 3 for any Medical Condition will be capped at 60% of the relevant eligible charges.

(4) Designated Major Illnesses include Cancer, Cardiomyopathy, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Surgery, Primary Pulmonary Arterial Hypertension, Surgery to Aorta, Stroke, Chronic and Irreversible Kidney Failure, Chronic Liver Disease, End Stage Lung Disease, Major Organ or Bone Marrow Transplantation, Fulminant Hepatitis, Severe Rheumatoid Arthritis, Parkinson's Disease, Terminal Medical Condition, and Intensive Care, and excludes all other illnesses. Please refer to Appendix 1 to this policy for details.

(5) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending Registered Medical Practitioner.

(6) We will extend in-patient rehabilitation to a maximum of 180 days per Policy Year for eligible in-patient rehabilitation necessitated by severe central nervous system damage caused by an external trauma.

(7) Cash Benefit will be payable if the Insured:

    (a) receives an eligible In-patient Treatment within the Area of Cover, provided no other cost is or will be borne by us for that eligible treatment; or

    (b) is a Hong Kong identity card holder and is Confined in a General Ward of a public Hospital in Hong Kong, where he incurred charges for the In-patient Treatment; or

    (c) is a Macau resident identity card holder and is Confined in a General Ward of a public Hospital in Macau, where he incurred charges for the In-patient Treatment; or

    (d) is Confined in a public Recognised Hospital in Mainland China, where he incurred charges for the In-patient Treatment; or

    (e) is Confined in a ward class below his entitled ward class as stated in the Benefit Schedule of the Benefit Level of this policy of a private Hospital in Hong Kong or Macau, where he incurred charges for the In-patient Treatment.

(8) Please refer to the provisions of this policy in relation to the limitation on the number of Visit(s) per day.

(9) The amount payable under this benefit is equal to:

    (a) for haemodialysis or peritoneal dialysis at a medical facility, the amount actually charged by the medical facility for such regular haemodialysis or peritoneal dialysis; or

    (b) for haemodialysis or peritoneal dialysis at home, the amount of expenses actually incurred for the purchase of supplies and/or rental of the dialysis machine for such regular haemodialysis or peritoneal dialysis where such purchase of supplies and/or rental of dialysis machine is/are prescribed in writing by the Insured's attending Registered Medical Practitioner.

SAMPLE

(10) Limitations and restrictions applicable to In-patient and Day Patient (Benefit 1) and Out-patient (Benefit 2) as described here above will also apply to "other benefits" unless otherwise specified. The aggregate amount of Eligible Expenses actually incurred for In-patient Treatment, Daycare Treatment and Out-patient Treatment is subject to the monetary limit shown for these "other benefits".

(11) The following exclusions still apply in any event:

(a) item (3) under the "Exclusions" Provision regarding "Treatment begun, or for which the need had arisen, during the first 90 days after birth for any child conceived by artificial means or any form of assisted conception including artificial insemination"; and

(b) item (1)(a) of "Special terms" exclusion under the "Exclusions" Provision regarding "cosmetic (aesthetic) surgery or treatment".

(12) Please refer to the provisions of this policy for details of the waiting period requirements for each of these benefits.

(13) This benefit is available where the Insured receives psychiatric treatment as In-patient Treatment or Daycare Treatment. Treatment given by a psychologist must be referred in writing by a Specialist.

(14) This benefit is applicable if the Insured is diagnosed with Designated Cancer and if Experimental Drug has been prescribed for the Active Cancer Treatment or Palliative Care and Treatment of such Designated Cancer, provided that:

(a) such treatment must be assessed and pre-authorised in writing; and

(b) a medical certificate issued by a Specialist must be provided to the Company to certify that the Experimental Drug is prescribed by and is deemed by the Specialist to be an appropriate or recommended Active Cancer Treatment or Palliative Care and Treatment of the Designated Cancer of the Insured.

For any Reasonable and Customary charges incurred outside of Hong Kong, Macau and Mainland China which are payable under this benefit, the amount payable under this benefit shall be reduced to 60% of the Reasonable and Customary charges incurred, subject to the limit(s) shown above and the "Benefit Adjustment" Provision.

(15) This benefit is payable if the HIV or AIDS is as a result of occupational Accident or blood transfusion and the conditions stated in the terms and conditions of this policy are all fulfilled.

(16) Within 1st Policy Year, premium paid or Compassionate Death Benefit whichever is lower.

SAMPLE