Cigna Healthcare VitalGuard Critical Illness Plan

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Part I Definition

1.1 Unless otherwise stated, capitalized words or terms that appear in this Policy shall have the meaning as defined below:

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

"Activities of Daily Living" shall mean:
(a) Bathing/Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash oneself satisfactorily by other means;
(b) Dressing: the ability to put on, take off, secure and unfasten all necessary garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
(c) Transferring: the ability to get in and out of a chair, bed or wheelchair;
(d) Mobility: the ability to move indoors from room to room on level surfaces;
(e) Continence: the ability to voluntarily control bowel and bladder functions so as to maintain a satisfactory level of personal hygiene; and
(f) Feeding/Eating: the ability to feed oneself once food has been prepared and made available.

"Age" shall mean the attained age of the Insured Person upon the Policy Effective Date or any Anniversary Date thereafter.

"Anniversary Date" shall mean each anniversary date of the Policy Effective Date.

"Application" shall mean the application (whether written or verbal) submitted to the Company in respect of this Policy, including the application form, questionnaires, evidence of insurability, any documents and information submitted and any statements and declarations made in relation to such application, including any updates of and changes to such requisite information.

"Basic Policy" shall mean this Policy as may be amended by endorsement from time to time, but excluding any additional benefits issued under a rider which are not related to the benefits payable under Part IV of this Policy.

"Benefit Schedule" shall mean a schedule of benefits attached to this Policy which sets out, among others, the benefit items and maximum benefits covered.

"Calendar Month" shall mean the period of time between any day in a month and the day immediately preceding the same day of the next succeeding month or, if there is no corresponding day in the next succeeding month, the last day of the next succeeding month.

"Company", **"we"**, or **"us"** shall mean Cigna Worldwide General Insurance Company Limited.

"Confinement" or **"Confined"** shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition.

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

"Congenital Conditions" shall mean:
(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) Calendar Months of birth.

"Critical Illness" shall mean any of the critical illness(es) listed and defined under Part VI of this Policy.

"Critical Illness Benefit" shall mean the benefit payable under Clause 4.1 of Part IV of this Policy.

"Diagnosis" or **"diagnosed"** means the definitive diagnosis made by a Registered Medical Practitioner, based upon such specific condition(s), as referred to herein in the definition of the particular illness, or in the absence of such specific condition(s), based upon radiological, clinical, histological or laboratory evidence acceptable to the Company. In the event of any dispute or disagreement regarding the appropriateness or correctness of the diagnosis, the Company shall have the right to call for an examination, of either the Insured Person or the evidence used in arriving at such diagnosis, by an independent acknowledged expert in the field of medicine concerned selected by the Company and the opinion of such expert as to such diagnosis shall be binding on both the Insured Person and the Company.

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

"Early Stage Critical Illness" shall mean any of the early stage critical illness(es) listed and defined under Part VII of this Policy.

"Early Stage Critical Illness Benefit" shall mean the benefit payable under Clause 4.2 of Part IV of this Policy.

"Grace Period" shall mean a period of thirty (30) days after any Premium Due Date excluding the Policy Effective Date.

"Hong Kong" shall mean the Hong Kong Special Administrative Region of the People's Republic of China.

"Hospital" shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which meets all of the following requirements:
(a) is for providing Medical Services for sick and injured persons as Inpatients;
(b) has facilities for diagnosis and major operations;
(c) provides twenty-four (24) hours nursing services by Nurses;
(d) has one (1) or more Registered Medical Practitioners; and
(e) 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, a palliative care facility, a Rehabilitation Centre, an elderly home or similar establishment.

Hospitals in the mainland China must be of Tier 3 Class A.

"Indebtedness" shall mean any amounts owed to us in respect of this Policy, including without limitation any outstanding Standard Premium, Premium Loading, and any accrued interest as determined by us.

"Injury" shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.

"Inpatient" shall mean an Insured Person who is Confined.

"Insured Person" shall mean the person, as specified in the Policy Schedule, whose risks are covered by this Policy.

"Medical Services" shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.

"Medically Necessary" shall mean the need to have medical service for the purpose of investigating or treating the relevant Disability 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 Disability;
(c) be rendered in accordance with standards of good and prudent medical practice, and not be rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner;
(d) be rendered in the setting 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 can be safely and effectively provided to the Insured Person.

"Nurse" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who -
(a) is duly qualified and is 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); and
(b) is legally authorised for rendering nursing treatment or service in Hong Kong or the relevant jurisdiction outside Hong Kong where the nursing treatment or service is provided to the Insured Person.

"Period of Cover" shall mean the period, as specified in the Policy Schedule, during which the Policy shall remain in force.

"Policy" shall mean the Application, the Basic Policy, the Policy Schedule, the Benefit Schedule, any endorsement(s) or supplement(s) attached to this policy, and any rider(s) issued to this policy.

"Policy Effective Date" shall mean the date on which the Policy becomes effective and as specified in the Policy Schedule.

"Policy Holder" or **"you"** shall mean the person, as specified in the Policy Schedule, who is a legal holder of this Policy.

"Policy Issuance Date" shall mean the date on which the Policy is issued by the Company and as specified in the Policy Schedule.

"Policy Schedule" shall mean a schedule attached to this Policy, which sets out, among others, the Policy Effective Date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, the premium and other relevant details in respect of this Policy.

"Policy Year" shall mean the period of time during which this Policy is in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Anniversary Date (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year period from each Anniversary Date to the day immediately preceding the next Anniversary Date (both days inclusive).

"Premium Due Date" shall mean the Policy Effective Date, the Anniversary Dates or (in case the payment frequency as specified in the Policy Schedule is not on an annual basis) such other dates which correspond to the payment frequency, when the Standard Premium and the Premium Loading (if any) is due and payable.

"Premium Loading" shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.

"Registered Medical Practitioner" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who -
(a) is a medical practitioner of western medicine;
(b) 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); and
(c) is 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 Person.

"Rehabilitation Centre" shall mean a registered institution (other than a Hospital) which provides physiotherapy, occupational therapy and other rehabilitative treatment for dysfunction or Disability.

"Renewal", **"Renew"**, **"Renewed"** or **"Renewable"** shall mean renewal of this Policy in accordance with Clause 2.7 of Part II of this Policy.

"Renewal Date" shall mean the effective date of Renewal of the Policy. The Renewal Date shall be the date as specified in the renewal notice.

"Sickness" or **"Disease"** shall mean 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 Person and whether or not any diagnosis is confirmed.

"Specialist" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who -
(a) is a medical practitioner of western medicine;
(b) is duly qualified and is registered in the specialist register 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); and
(c) is 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 Person.

"Standard Premium" shall mean the premium for the coverage under the Basic Policy, as charged by the Company to the Policy Holder.

"Sum Insured" shall mean the amount referred to as such in the Policy Schedule.

"Waiting Period" shall mean a period of ninety (90) days from the latest of:
(a) the Policy Issuance Date or the Policy Effective Date (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

In respect of any increase in benefits resulting from a higher Sum Insured under Clause 2.6 of Part II of this Policy, "Waiting Period" shall mean a period of ninety (90) days from the latest of:
(a) the issue date or the effective date of the increase in the Sum Insured (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

1.2 Unless the context otherwise provides, singular words shall include the plural form and masculine words shall include the feminine form and vice versa. General words shall not be given a restrictive meaning by reason of the fact that they are followed by particular examples intended to be embraced by the general words.

1.3 Reference to Clauses refers to clauses of this Policy. Headings are inserted for convenience of reference only and shall not affect the interpretation of this Policy.

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

1.5 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.

Part II General Provisions

2.1 The Policy contract

In consideration of the payment of the Standard Premium and Premium Loading (if any), and on the basis of the Application submitted to the Company, the Company hereby agrees to issue this Policy to cover the Insured Person and provide for benefits in accordance with the terms and conditions of this Policy.

2.2 Governing law and jurisdiction

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

2.3 Policy currency

All dollar amounts referred to in this Policy are expressed in the currency specified in the Policy Schedule.

2.4 Policy changes

2.4.1 The Company reserves the right to revise, amend or modify the terms and conditions of this Policy at any time whilst this Policy is in force, as considered necessary by the Company to comply with any applicable legislation and/or regulatory requirements effective at the Policy Effective Date or during the term of this Policy.

2.4.2 No change in the terms and conditions of this Policy shall be valid unless recorded in an endorsement to this Policy and issued by the Company.

2.5 Change of details

The Insured Person and the Policy Holder shall give immediate notice to the Company of any change in any of their personal particulars in a form prescribed by us, including but not limited to, names, occupation, resident country or territory and addresses. Such change is valid only if recorded in a written notice effecting such change last issued by the Company.

2.6 Change of Sum Insured

2.6.1 While this Policy is in force and during the lifetime of the Insured Person, provided that no benefit claim has been submitted under the Basic Policy, the Policy Holder may request in a form prescribed by the Company to increase the Sum Insured subject to medical underwriting or decrease the Sum Insured without any medical underwriting.

2.6.2 Subject to the terms and conditions of this Policy and the Company's approval (if recorded in a Policy Schedule last issued by the Company), the new Sum Insured and the corresponding premium will be effective from the Renewal Date following the approval of such request provided that the request is received by the Company at least before thirty (30) days prior to that Renewal Date.

2.6.3 Any increase in benefits resulting from a higher Sum Insured under Clause 2.6 of Part II of this Policy shall only be applicable to any Critical Illness or Early Stage Critical Illness which has been diagnosed for the first time after the Waiting Period from the issue date or the effective date of the increase in the Sum Insured (whichever is the later).

2.7 Renewal

2.7.1 Subject to Clause 2.15 of Part II of this Policy, the Basic Policy shall be effective for the Period of Cover and thereafter guaranteed to be automatically Renewable for each subsequent Period of Cover, provided that the Standard Premium and Premium Loading (if any) is paid on or before each Premium Due Date and that we continue to issue new policy(ies) under the Basic Policy.

2.7.2 The Company reserves the right to revise the terms and conditions and/or the Benefit Schedule of this Policy upon each Renewal.

2.7.3 If the Basic Policy is not Renewed by the Company, we will send a written notice to you, at least before thirty (30) days prior to the next Renewal Date, to notify you that this Policy will not be Renewed.

2.8 Misstatement of personal information

2.8.1 Without prejudice to the Company's right to declare this Policy void as provided in Clause 2.9 of Part II of this Policy, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or smoking habit) is misstated in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information, the Company may adjust the Standard Premium and Premium Loading (if applicable), for the past, current or future Policy Years, on the basis of the correct information. Where additional premium is required, no benefits shall be payable unless the additional premium has been paid. If the additional required premium is not paid within thirty (30) days after the due date as notified by the Company to the Policy Holder, the Company shall have the right to terminate this Policy with effect from such due date. Where there has been an overpayment of premium by the Policy Holder, the Company shall refund the overpaid premium less any Indebtedness.

2.8.2 Where the Company, based on the correct information of the Insured Person and the Company's underwriting guidelines, considers that the application of the Insured Person should have been rejected, the Company shall have the right to declare this Policy void as from the Policy Effective Date and no cover shall be provided for the Insured Person. The Company shall, for the current and all previous Policy Years, have:

(a) the right to demand refund of the benefits previously paid;
(b) the obligation to refund the premium paid after deducting the benefits previously paid, any Indebtedness and a reasonable administration charge payable to the Company; and
(c) the obligation to refund the insurance levy paid.

2.9 Misrepresentation or fraud

The Company has the right to declare this Policy void as from the Policy Effective Date and no cover shall be provided for the Insured Person in case of any of the following events:

(a) any material fact relating to the health related information of the Insured Person which may impact the risk assessment by the Company is incorrectly stated in, or omitted from, the Application or any statement or declaration made for or by the Insured Person in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information. The circumstances that a fact shall be considered "material" include, but not limited to, the situation where the disclosure of such fact as required by the Company would have affected the underwriting decision of the Company, such that the Company would have imposed Premium Loading, included exclusion(s), or rejected the application; or

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

In the event of (a), the Company shall, for the current and all previous Policy Years, have:

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

(ii) the obligation to refund the premium paid after deducting the benefits previously paid, any Indebtedness and a reasonable administration charge payable to the Company; and

(iii) the obligation to refund the insurance levy paid.

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

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

(ii) the right not to refund the premium and the insurance levy paid.

2.10 Subrogation

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

2.11 Notification and proof of claims

2.11.1 Notification of claim

A fully completed claim form prescribed by the Company must be given to the Company during the lifetime of the Insured Person and within sixty (60) days (a) after the date of the event giving rise to the claim or (b) after the first Diagnosis of Critical Illness or Early Stage Critical Illness (whichever is the earlier). Such form shall include information sufficient to identify the Insured Person and the nature of the claim.

2.11.2 Proof of claim

(a) Proof of claim must be given to the Company during the lifetime of the Insured Person and within one hundred and eighty (180) days (a) after the date of the event giving rise to the claim or (b) after the first Diagnosis of Critical Illness or Early Stage Critical Illness (whichever is the earlier). If proof of claim is not given within the prescribed period, it must be shown that proof of claim has been given as soon as reasonably possible; otherwise, the Company shall have the right not to pay the claim.

(b) All information and documents (including but not limited to a copy of the Insured Person's medical records and reports, the original receipts for all expenses and the documentary proof of Age of the Insured Person) that we need to process the claim shall be submitted to the Company, at the Policy Holder's, the Insured Person's and/or any relevant claimant's own expense. The Policy Holder, the Insured Person and/or any relevant claimant shall sign all authorization forms necessary to authorize the Company to obtain a full and complete medical history of the Insured Person.

(c) The Company reserves the right to require that the Insured Person be examined by Registered Medical Practitioner(s) and/or Specialist(s) of our choice, at the Policy Holder's, the Insured Person's and/or any relevant claimant's own expense.

(d) It is a condition precedent to the Company's liability to make any payment under this Policy that the Policy Holder, the Insured Person and any relevant claimant fully comply with the terms and conditions of this Policy.

2.11.3 Deduction of claim payment

The Company shall have the right to deduct any Indebtedness from any benefit payable under this Policy.

2.12 Payment

2.12.1 We shall pay any benefit payable under this Policy to the Policy Holder or if the Policy Holder is not living at the time of payment, to the Policy Holder's estate.

2.12.2 Notwithstanding any provision in this Policy, all payments under this Policy shall be conditional upon production of valid documents verifying the identity of the Policy Holder and/or the personal representative(s) of the Policy Holder's estate and/or the Insured Person (as the case may be) to our satisfaction. For the purpose of Clause 2.12 of Part II of this Policy, "personal representative" shall have the meaning as defined under the Probate and Administration Ordinance (Cap.10 of the Laws of Hong Kong).

2.12.3 The payment of benefits under this Policy in the manner pursuant to Clauses 2.12.1 to 2.12.2 of Part II of this Policy shall be deemed as a full and final discharge of all liabilities of the Company under this Policy.

2.13 Interest

Unless otherwise expressly provided in this Policy, all amounts payable by the Company under this Policy shall not carry any interest.

2.14 Cooling-off period

2.14.1 The Policy Holder may during the cooling-off period exercise the right to cancel this Policy and obtain a refund of the Standard Premium and Premium Loading (if any) and insurance levy paid. In such event, this Policy shall be deemed to have been void from the Policy Effective Date and the Company shall not be liable to pay any benefit.

2.14.2 The cancellation right is subject to the following conditions –

(a) the request to cancel must be made by the Policy Holder in a form prescribed by the Company and received directly by the Company within the cooling-off period. The cooling-off period is the period of thirty (30) days immediately following the day of the delivery of this Policy or the cooling-off notice (whichever is the earlier), to the Policy Holder or the nominated representative of the Policy Holder. For the avoidance of doubt, the day of delivery of this Policy or the cooling-off notice is not included for the calculation of the thirty (30) day period. However, if the last day of the thirty (30) day period is not a working day, the period shall include the next working day;
(b) no refund can be made if a benefit payment has been made, is to be made or pending; and
(c) the above cancellation right shall not apply at Renewal.

2.15 Termination

2.15.1 This Policy shall terminate upon the occurrence of the earliest of the following events:

(a) the death of the Insured Person;
(b) the cancellation of this Policy by the Policy Holder pursuant to Clause 2.14 of Part II of this Policy;
(c) the cancellation of this Policy by the Policy Holder pursuant to Clause 2.15.3 of Part II of this Policy;
(d) the cancellation of this Policy by the Company pursuant to Clause 2.15.4 of Part II of this Policy;
(e) when this Policy is not Renewed pursuant to Clause 2.7 of Part II of this Policy;
(f) the lapse of this Policy pursuant to Clause 3.3.2 of Part III of this Policy;
(g) upon payment of the Critical Illness Benefit pursuant to Clause 4.1 of Part IV of this Policy;
(h) when the aggregate amount of the Early Stage Critical Illness Benefit paid pursuant to Clause 4.2 of Part IV of this Policy reaches one hundred percent (100%) of the Sum Insured; or
(i) on the Anniversary Date immediately after the Insured Person reaches Age eighty-five (85).

2.15.2 Termination of this Policy shall be without prejudice to any claim arising prior to such termination unless otherwise stated in this Policy. The payment to or acceptance by the Company of any Standard Premium and Premium Loading (if any) hereunder subsequent to the termination of this Policy shall not create any liability but the Company shall refund any such premium paid less any Indebtedness.

2.15.3 Cancellation by the Policy Holder

(a) The Policy Holder may cancel this Policy by giving not less than thirty (30) days notice to us in a form prescribed by the Company.
(b) Termination of this Policy caused by such cancellation shall become effective on the date specified in such form or the date approved by us, whichever is the later.
(c) Where this Policy is terminated by such cancellation, there shall be no refund of the Standard Premium, the Premium Loading (if any) and insurance levy paid. The Company reserves the right to charge the Standard Premium and the Premium Loading (if any) calculated until the end of such Policy Year during which the termination of this Policy becomes effective.

2.15.4 Cancellation by the Company

(a) The Company shall be entitled to terminate this Policy pursuant to Clause 2.8.1 of Part II of this Policy.
(b) The Company shall be entitled to declare this Policy void as from the Policy Effective Date pursuant to Clauses 2.8.2, 2.9 and/or 3.3.1 of Part II and/or Part III of this Policy.

2.16 Clerical error

Clerical errors by the Company shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force, and this Policy shall be construed as if any such clerical errors have not been committed.

2.17 Limitations

No action at law shall be brought against the Company for the recovery of any claim under this Policy within the first sixty (60) days from the date on which proof of claim has been submitted to the Company in accordance with Clause 2.11.2 of Part II of this Policy or after two (2) years from the date of the Company's final decision in respect of such claim.

2.18 Policy ownership

While this Policy is in force, the Policy Holder can exercise all rights, privileges and options provided under this Policy. The Policy Holder may, during the lifetime of the Insured Person, request to change the ownership of this Policy in a form prescribed by us. Such change is valid only if recorded in a Policy Schedule effecting such change last issued by the Company.

2.19 Rights of third parties

Other than the Company and the Policy Holder, any person or entity who is not a party to this Policy (including but not limited to the Insured Person) shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap.623 of the Laws of Hong Kong) to enforce any terms of this Policy.

2.20 Compliance with sanctions rules

2.20.1 It is the Company's global corporate policy to comply with the economic sanctions rules related to individuals, entities, and countries applicable to its global business operations, including but not limited to those imposed by the United Nations, the European Commission, the United States, and Canada. Therefore, the Company will not offer coverage or pay benefits to or on behalf of, any Policy Holder and/or Insured Person and/or beneficiary and/or otherwise any relevant individual if doing so would violate these sanctions rules. In the event the Company learns that a sanctioned individual is enrolled under this Policy, or that a Policy Holder or Insured Person becomes sanctioned, the Company will take all appropriate action, which could include blocking, reporting, and terminating coverage. The Company is under no obligation to notify the Insured Person or Policy Holder or the beneficiary or otherwise any individual who may be affected in advance of taking these actions, or to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws.

2.20.2 In addition, restrictions will apply to claims incurred in sanctioned countries where there is no relevant, approved license from the U.S. Office of Foreign Assets Control. Among the restrictions, the Company will not cover: (1) elective or pre-scheduled treatment in sanctioned countries; or (2) Insured Person or Policy Holder considered "ordinarily resident" in a sanctioned country. Insured Person or Policy Holder are considered ordinarily resident if they visit a sanctioned country for a period of longer than six (6) weeks over the course of any twelve (12) month period.

Part III Premium Provisions

3.1 Premium payable under this Policy

For the Basic Policy, you are required to pay the Standard Premium and the Premium Loading (if any) regularly on the Premium Due Date.

3.2 Premium payment frequency

Any Standard Premium and Premium Loading (if any) payable under this Policy shall be paid in accordance with the payment frequency as specified in the Policy Schedule. You may request to change the payment frequency in a form prescribed by the Company during the term of this Policy. Such change is valid only if recorded in a Policy Schedule effecting such change last issued by the Company.

3.3 Premium payment

3.3.1 If you fail to pay the initial premium in full for the Policy on or before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Policy shall be deemed to be void as from the Policy Effective Date for all purposes. Accordingly, we shall not be liable to pay any benefit under the Policy.

3.3.2 Except for the initial premium payment, a Grace Period after any Premium Due Date will be allowed for payment of premium or any part thereof. The coverage of this Policy will remain in force during this Grace Period, but the Company shall have the right to deduct at its discretion any due premium payment from the benefit payable under this Policy if there is any benefit payable during the Grace Period. If the Standard Premium and Premium Loading (if any) of the Basic Policy or any part thereof remains unpaid at the end of the Grace Period, the Policy shall terminate on the Premium Due Date on which the unpaid Standard Premium and Premium Loading (if any) was first due.

3.3.3 The Company reserves the right to revise the Standard Premium of this Policy on each Anniversary Date at its sole discretion by taking into account such factors as the Company determines to be relevant for the purpose of revising the Standard Premium. If the Premium Loading is set as a percentage of the Standard Premium, the amount of Premium Loading will be adjusted automatically according to the change in the Standard Premium.

3.3.4 Unless otherwise expressly provided in the Policy, where this Policy is terminated, there shall be no refund of the Standard Premium, the Premium Loading (if any) and insurance levy paid.

3.4 Reinstatement

3.4.1 If the Policy lapses due to non-payment of the Standard Premium and the Premium Loading (if any) under Clause 3.3.2 of Part III of this Policy, the Policy may be reinstated within three (3) Calendar Months from the Premium Due Date on which the unpaid Standard Premium and Premium Loading (if any) was first due subject to all of the following and the approval of the Company:

(a) submission of an application for reinstatement in a form prescribed by the Company;
(b) submission of evidence of insurability of the Insured Person to the satisfaction of the Company; and
(c) receipt of the payment of all outstanding Standard Premium, Premium Loading and other Indebtedness (if any).

3.4.2 The Company will consider reinstatement by redating subject to our rules and regulations, including but not limited to the requirement that all claims for benefits under this Policy prior to the effective date of reinstatement be carried forward and included for purposes of applying any benefit limits as specified in the Benefit Schedule to the benefits payable under the reinstated Policy.

3.4.3 Subject to any provisions endorsed hereon or attached to this Policy in connection with the reinstatement, the Policy Holder shall have the same rights under this Policy as existing immediately before the date of termination of the Policy.

3.4.4 For the avoidance of doubt, the Company shall not be liable to pay any benefits for any Critical Illness or Early Stage Critical Illness which has been diagnosed for the first time on or after the date of termination of the Policy and prior to the effective date of reinstatement of the Policy, and during the Waiting Period from the effective date of reinstatement of the Policy.

Part IV Benefit Provisions

4.1 Critical Illness Benefit

4.1.1 Subject to the terms and conditions of this Policy, while this Policy is in force and after the Waiting Period, if the Insured Person is first diagnosed to be suffering from a Critical Illness, the Company shall pay the Critical Illness Benefit to the Policy Holder in one (1) lump sum calculated in accordance with the formula as follows:

Critical Illness Benefit payable	One hundred percent (100%) of the Sum Insured **LESS (-)** Any Early Stage Critical Illness Benefit paid and/or payable **LESS (-)** Indebtedness (if any)

4.1.2 For the avoidance of doubt, this Policy shall terminate and cease to provide any coverage upon payment of the Critical Illness Benefit.

4.2 Early Stage Critical Illness Benefit

4.2.1 Subject to the terms and conditions of this Policy, while this Policy is in force and after the Waiting Period, if the Insured Person is first diagnosed to be suffering from an Early Stage Critical Illness, the Company shall pay the Early Stage Critical Illness Benefit to the Policy Holder calculated in accordance with the formula as follows:

Early Stage Critical Illness Benefit payable (for each Early Stage Critical Illness)	The lesser of: a) Twenty percent (20%) of the Sum Insured; or b) Four hundred thousand (400,000) Hong Kong dollars less the total amount of benefits paid and/or payable in respect of the same Early Stage Critical Illness under all other policies of "Cigna Healthcare VitalGuard Critical Illness Plan" for the same Insured Person issued by the Company **LESS (-)** Indebtedness (if any)

4.2.2 The Early Stage Critical Illness Benefit can be claimed for each Early Stage Critical Illness once only under this Policy.

4.2.3 Notwithstanding Clause 4.2.2 of Part IV of this Policy, the Early Stage Critical Illness Benefit can be claimed in respect of "Carcinoma-in-situ" for up to two (2) times, provided that the two (2) claims must be in respect of "Carcinoma-in-situ" occurring in two (2) different organ(s). In this regard, once "Carcinoma-in-situ" is diagnosed in one (1) covered organ, that organ is excluded for purposes of a second claim for "Carcinoma-in-situ" under the Early Stage Critical Illness Benefit. If the relevant organ has both a left and a right component (such as, but not limited to, the lungs or breasts), the left side and right side of the organ shall be considered as one (1) and the same organ.

4.2.4 If the Insured Person is insured under more than one (1) policy of "Cigna Healthcare VitalGuard Critical Illness Plan" issued by the Company, the total amount of benefits paid and/or payable in respect of each and the same Early Stage Critical Illness under all such policies shall not exceed four hundred thousand (400,000) Hong Kong dollars.

4.2.5 Notwithstanding Clause 4.2.4 of Part IV of this Policy, if the Insured Person is insured under more than one (1) policy of "Cigna Healthcare VitalGuard Critical Illness Plan" issued by the Company:

(a) the total amount of benefits paid and/or payable in respect of each claim for "Carcinoma-in-situ" under all such policies shall not exceed four hundred thousand (400,000) Hong Kong dollars; and
(b) the total amount of benefits paid and/or payable in respect of the two (2) claims for "Carcinoma-in-situ" under all such policies shall not exceed eight hundred thousand (800,000) Hong Kong dollars.

4.2.6 The Early Stage Critical Illness Benefit can be claimed multiple times and the aggregate amount of the Early Stage Critical Illness Benefit paid and/or payable under this Policy shall not exceed one hundred percent (100%) of the Sum Insured.

4.2.7 For the avoidance of doubt, this Policy shall terminate and cease to provide any coverage when the aggregate amount of the Early Stage Critical Illness Benefit paid reaches one hundred percent (100%) of the Sum Insured.

Part V Exclusion Provisions

5.1 Exclusions

Under this Policy, the Company shall not pay any benefits in relation to or arising from the following:

(a) any Disability other than a Diagnosis of Critical Illness or Early Stage Critical Illness;
(b) any Disability the signs or symptoms of which, or any surgery the cause or triggering condition of which, first occurred prior to the Policy Issuance Date or the Policy Effective Date (whichever is the later);
(c) any Disability the signs or symptoms of which, or any surgery the cause or triggering condition of which, first occurred during the Waiting Period;
(d) "Fulminant Viral Hepatitis" or Cancer suffered by the Insured Person, where in our opinion such disease was directly or indirectly due to AIDS or HIV Infection (except for "AIDS/HIV due to Blood Transfusion", "Occupational Acquired HIV", "HIV Infection due to Organ Transplant", and "Medically Acquired HIV Infection");
(e) any Disability or surgery caused by suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane;
(f) any Disability or surgery directly or indirectly caused by the taking of drugs (except under the direction of a doctor), the consumption of poison or alcohol;
(g) any Disability resulting from a physical or mental condition which existed before the Policy Issuance Date or the Policy Effective Date (whichever is the later) and which was not disclosed in the Application;
(h) violation or attempted violation of the law or participation in fight or affray or resistance to arrest;
(i) war, whether declared or undeclared, revolution or any warlike operations;
(j) engaging in services in armed forces in times of declared or undeclared war or while under orders for warlike operations or restoration of public order;
(k) operating, being transported, or in any way engaging in air travel except as a fare paying passenger or cabin crew in any aircraft operated by a commercial passenger airline on a regular scheduled passenger trip over its established passenger route; and
(l) any Congenital Conditions.

Part VI Critical Illnesses Definitions

6.1 "Major Cancer"

(a) Any malignant tumour positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue; or
(b) Any occurrence of histologically confirmed leukemia, lymphoma or sarcoma.

Irrespective of the above, for purposes of the definition of "Critical Illness", Major Cancer does not include any of the following:
(i) any cancer which is histologically classified as pre-malignant, non-invasive, or carcinoma in situ, or as having either borderline malignancy or low malignant potential;
(ii) any tumour of the thyroid histologically classified as T1N0M0 or a lower stage according to the TNM classification system;
(iii) any tumour of the prostate histologically classified as T1a or T1b or T1c or a lower stage according to the TNM classification system;
(iv) chronic lymphocytic leukemia classified as less than Binet Stage B or RAI Stage III;
(v) any cancer where HIV Infection is also present;
(vi) any skin cancer, other than stage 2 or above malignant melanoma;
(vii) Cervical Intra-epithelial Neoplasia (CIN I, CIN II, or CIN III) or Cervical Squamous Intra-epithelial Lesion;
(viii) Gastrointestinal stromal tumour (GIST) that is histologically classified as stage I, IA or less;
(ix) Thymic epithelial tumour that is malignant and histologically classified as stage I or less; and
(x) Neuroendocrine tumour or neoplasm (NET and NEN) including carcinoid tumours that are histologically classified as Stage I or less.

6.2 "Open Surgery to Aorta"

The actual undergoing of open surgery through a surgical opening of the chest (thoracotomy) or abdomen (laparotomy) to remove, replace, repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta as a result of a Disease. The term aorta includes the thoracic and abdominal aorta but not its branches. The procedure must be considered Medically Necessary by a registered cardiothoracic or vascular surgeon.

The following are specifically excluded:
(i) All percutaneous trans-vascular catheter-based procedures where the chest or abdominal cavity has not been opened.
(ii) Traumatic injury of the aorta.

6.3 "Coronary Artery By-Pass Surgery"

The actual undergoing of a open-chest heart surgery (full sternotomy or partial sternotomy) to correct narrowing or blockage of one (1) or more coronary arteries with bypass grafts. The surgery must be determined to be Medically Necessary by a registered cardiologist or a cardiac surgeon and supported by corresponding coronary angiogram findings to prove significant coronary artery obstruction.

The following are specifically excluded:
(i) Angioplasty;
(ii) Intra-arterial procedures;
(iii) Laser techniques;
(iv) Other non-surgical techniques;
(v) "Keyhole" procedures.

6.4 "Heart Attack"

The death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply to the relevant myocardium, where all of the following criteria are met, to prove the occurrence of a new acute Heart Attack / Myocardial Infarction. The Diagnosis must be definitively confirmed by a registered cardiologist:-
(a) A history of typical chest pain;
(b) New characteristic ECG changes indicating acute myocardial infarction at the time of the relevant cardiac incident; and
(c) Either:
  (i) elevation of cardiac enzymes (CPK-MB) at levels above the generally accepted laboratory levels of normal, or
  (ii) troponins recorded at a level of Troponin I>0.5ng/ml or higher, or cardiac troponin T > 1.0ng/ml

The following are specifically excluded:
(i) Any other acute coronary syndrome such as angina;
(ii) Elevation of cardiac biomarkers (CKMB and cardiac troponin) caused by illnesses other than Heart Attack / Myocardial Infarction (such as elevation following an intra-arterial cardiac procedure such as coronary angiography and coronary angioplasty, cardiac arrhythmias, myocardial injury, or result of another systemic illness);
(iii) Heart Attack / Myocardial Infarction with normal coronary arteries or caused by coronary vasospasm, myocardial bridging or drug use except prescribed by a registered doctor.

6.5 "Heart Valve Replacement or Repair"

The undergoing of open heart surgery to correct valvular and structural abnormalities.

6.6 "Other Serious Coronary Artery Disease"

The narrowing of the lumen of at least three (3) major coronary arteries by a minimum of sixty percent (60%) stenosis in each artery, as proven by a single invasive coronary angiography.

Diagnosis by imaging or non-invasive diagnostic procedures such as Magnetic Resonance Imaging (MRI), Computed Tomography (CT), or other equivalent imaging techniques does not meet the confirmatory status required by the definition.

Major coronary arteries are defined as left main stem, left anterior descending, circumflex and right coronary artery. Coronary arteries branches are excluded.

6.7 "Primary Pulmonary Arterial Hypertension"

Primary pulmonary arterial hypertension as established by clinical and laboratory investigations (including cardiac catheterisation) and as Diagnosed by a Specialist cardiologist. The following diagnostic criteria must be met:
(a) dyspnoea and fatigue; and
(b) increased left atrial pressure (at least twenty (20) units more); and
(c) pulmonary resistance of at least three (3) units above normal; and
(d) pulmonary artery pressure of at least 40mmHg; and
(e) pulmonary wedge pressure of at least 6mmHg; and
(f) right ventricular end-diastolic pressure of at least 8mmHg; and
(g) right ventricular hypertrophy, dilation and signs of right heart failure and
(h) decompensation.

6.8 "Alzheimer's Disease"

Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (Dementia) Progressive deterioration or loss of intellectual capacity or abnormal behaviour as evidenced by all of the following:
(a) clinical state;
(b) Any of a Clinical Dementia Rating (CDR) scale of three (3) or Mini Mental State Examination (MMSE) score of less than ten (10) out of thirty (30) or an equivalent of this score using another standardized, clinically-accepted, cognitive function test.

The condition must result in significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. The Diagnosis must be confirmed by a Specialist geriatrician, Specialist neurologist, Specialist psychiatrist or Specialist geriatrician psychiatrist. The condition must directly result in a total and permanent inability of the Insured Person to perform, by oneself, at least three (3) out of six (6) of the Activities of Daily Living, making the Insured Person require continuous supervision and assistance by another person with Activities of Daily Living.

Alzheimer's disease or other dementia caused by psychiatric illness, any drug / alcoholic use except prescribed by a registered doctor are specifically excluded.

6.9 "Apallic Syndrome"

Universal necrosis of the brain cortex with the brainstem remaining intact. The definite Diagnosis must be confirmed by a Specialist neurologist. This condition must be medically documented by a Specialist neurologist for at least one (1) month.

6.10 "Bacterial Meningitis"

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit. The Diagnosis is to be confirmed by a Specialist neurologist.

6.11 "Benign Brain Tumour"

A non-cancerous tumour in the brain or meninges within the cranium.

This does not cover the following:
(a) cysts;
(b) granulomas;
(c) malformations in, or of, the arteries or veins of the brain;
(d) haematomas; and
(e) tumours in the pituitary gland or spine.

6.12 "Coma"

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

6.13 "Encephalitis"

Severe inflammation of brain substance which results in significant and permanent neurological sequelae as certified by a Specialist neurologist.

6.14 "Major Head Trauma"

Accidental head injuries resulting in residual brain damage to the extent that there is a permanent neurological deficit causing Significant Functional Impairment. "Significant Functional Impairment" means a Specialist neurologist has assessed the Insured Person as scoring five (5) or less on the eight (8) point version of the Glasgow Outcome Scale of Head Injuries or equivalent levels of functional impairment on a similar scale which has been generally accepted in medical literature.

6.15 "Cerebral Arteriovenous Malformation Requiring Surgery"

The undergoing of intracranial surgery via a craniotomy or the undergoing of Gamma Knife radiosurgery to obliterate arteriovenous malformation of one (1) or more of the cerebral arteries. The Diagnosis must be made by a Specialist neurosurgeon with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram.

Procedures not involving craniotomy or Gamma Knife radiosurgery are excluded.

6.16 "Muscular Dystrophy"

Hereditary muscular dystrophy confirmed by a Specialist neurologist resulting in the inability to perform, without assistance, three (3) or more of the Activities of Daily Living.

6.17 "Progressive bulbar palsy"

Characterised by progressive degeneration of the muscle innervated by cranial nerve and corticobulbar tracts leading to difficulty in chewing, swallowing and talking. The Diagnosis must be made by a Specialist neurologist as progressive and resulting in permanent neurological deficit with appropriate neuromuscular testing such as Electromyogram (EMG).

6.18 "Spinal Muscular Atrophy"

Degenerative diseases of the anterior horn cells in the spinal cord and motor nuclei of the brainstem characterized by profound proximal muscular weakness and wasting, primarily in the legs, followed by distal muscle involvement. The damage must result independently of all other causes and directly in the Insured Person's permanent inability to perform, without assistance, three (3) or more of the Activities of Daily Living. The Diagnosis of Spinal Muscular Atrophy must be made by a Specialist with appropriate neuromuscular testing such as Electromyogram (EMG).

6.19 "Amyotrophic Lateral Sclerosis"

Characterised by muscular weakness and atrophy, evidence of anterior horn cell dysfunction, visible muscle fasciculations, spasticity, hyperactive deep tendon reflexes and extensor plantar reflexes, evidence of corticospinal tract involvement, dysarthria and dysphagia. The Diagnosis must be made by a Specialist neurologist with appropriate neuromuscular testing such as Electromyogram (EMG).

6.20 "Primary Lateral Sclerosis"

Progressive degeneration of the corticospinal tracts and anterior horn cells or bulbar efferent neurons resulting in a permanent neurological deficit and including the primary lateral sclerosis. The Diagnosis of motor neurone disease must be confirmed by a Registered Medical Practitioner who is a neurologist.

6.21 "Multiple Sclerosis"

Unequivocal Diagnosis of Multiple Sclerosis by a Specialist neurologist, and which confirms the following:
(a) objective clinical evidence of ≥1 T2 lesion in at least two (2) out of four (4) regions of the central nervous system as mentioned below:
    (i) Periventricular;
    (ii) Juxtacortical;
    (iii) Infratentorial;
    (iv) spinal cord;

and
(b) more than one (1) episode of well-defined neurological symptoms involving the optic nerves, brain stem, spinal cord, coordination or motor function; and
(c) a well-documented history of exacerbations and remissions of neurological symptoms over a period of more than six (6) months.

6.22 "Paralysis of Limbs"

Complete and permanent loss of use of two (2) or more limbs through paralysis due to Accident or Sickness, where such functional loss is considered to be permanent by a Specialist neurologist.

6.23 "Parkinson's Disease"

Slowly progressive degenerative disease of the central nervous system as a result of loss of pigment containing neurones of the brain. Unequivocal Diagnosis of Parkinson's Disease by a Specialist neurologist where the condition:
(a) cannot be controlled with medication; and
(b) shows signs of progressive impairment; and
(c) inability of the Insured Person to perform, without assistance, three (3) or more of the Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered.

This illness does not cover any other forms of Parkinsonism.

6.24 "Poliomyelitis"

Unequivocal Diagnosis by a Specialist neurologist of infection by the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness.

Cases not involving paralysis and other causes of paralysis are not eligible under this illness.

6.25 "Stroke"

Any cerebrovascular accident or incident producing neurological sequelae lasting at least four (4) weeks and which results in a permanent neurological deficit. Infarction of brain tissue, haemorrhage and embolization from an extra-cranial source are included. The Diagnosis of Stroke must be based on changes seen in a CT scan or MRI and must be confirmed by a Registered Medical Practitioner who is a neurologist.

The following are excluded:
(a) Cerebral symptoms due to transient ischaemic attacks;
(b) Any reversible ischaemic neurological deficit;
(c) Cerebral symptoms due to migraine; and
(d) Vascular disease affecting the eye or optic nerve or vestibular functions.

6.26 "Severe Myasthenia Gravis"

An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatigability. All of the following criteria must be met:
(a) presence of permanent muscle weakness categorised as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
(b) the Diagnosis of Myasthenia Gravis and categorisation are confirmed by a Specialist neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:

Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere
Class II: Eye muscle weakness of any severity, mild weakness of other muscles
Class III: Eye muscle weakness of any severity, moderate weakness of other muscles
Class IV: Eye muscle weakness of any severity, severe weakness of other muscles
Class V: Intubation needed to maintain airway

6.27 "Tuberculosis Meningitis"

An infection of the meninges of the brain with tuberculosis bacterium causing severe inflammation and brain dysfunction. The Diagnosis must be confirmed by a Specialist neurologist and supported by analysis of the cerebrospinal fluid or neuro-imaging. There must also be permanent residual neurological deficit with motor weakness or cranial nerve dysfunction that is present for at least three (3) months after the Diagnosis.

6.28 "Progressive Supranuclear Palsy"

Progressive Supranuclear Palsy occurring independently of all other causes and resulting in a permanent neurological deficit, which is directly responsible for a permanent inability to perform at least two (2) of the Activities of Daily Living. The Diagnosis of Progressive Supranuclear Palsy must be confirmed by a Registered Medical Practitioner who is a neurologist.

6.29 "Progressive Muscular Atrophy"

Confirmation of definitive Diagnosis of either Fried-Emery, Kugelberg-Welander, Aran-Duchenne or Vulpian-Bernhardt Muscular Atrophy by a consultant neurologist. The Diagnosis must be supported by muscle biopsy and CPK estimates. The condition must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living. These conditions have to be medically documented for at least three (3) months.

6.30 "Creutzfeldt-Jacob Disease"

The occurrence of Creutzfeld-Jacob Disease or Variant Creutzfeld-Jacob Disease where there is an associated neurological deficit, which is solely responsible for a permanent inability to perform two (2) or more Activities of Daily Living as defined in the Policy.

Disease caused by human growth hormone treatment is excluded.

6.31 "Aplastic Anaemia"

Bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one (1) of the following:
(a) blood product transfusion
(b) marrow stimulating agents
(c) immunosuppressive agents
(d) bone marrow transplantation

6.32 "End-Stage Liver Disease"

End Stage Liver Disease as evidenced by all of the following:
(a) permanent jaundice;
(b) ascites; and
(c) encephalopathy.

This illness does not cover liver disease secondary to alcohol or drug misuse.

6.33 "End-Stage Lung Disease"

End-Stage Lung Disease including interstitial lung disease requiring permanent oxygen therapy as well as a FEV 1 test result of consistently less than one (1) litre.

6.34 "Fulminant Viral Hepatitis"

This involves a submassive to massive necrosis of the liver caused by viral hepatitis leading precipitously to liver failure, excluding drug and alcohol abuse as certified by a Specialist in the relevant field. The diagnostic criteria which is required to be met are:
(a) a rapidly decreasing liver size; and
(b) necrosis involving entire lobules, leaving only a collapsed reticular framework; and
(c) rapidly degenerating liver function tests; and
(d) deepening jaundice.

6.35 "Kidney Failure"

End stage renal disease, due to whatever cause or causes, with the Insured Person undergoing regular peritoneal dialysis or haemodialysis.

6.36 "Medullary Cystic Disease"

Diagnosis of medullary cystic disease by a Specialist in the relevant field and evidenced by end stage renal disease with the Insured Person undergoing regular peritoneal dialysis or haemodialysis.

6.37 "Major Organ Transplant"

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

6.38 "Systemic Lupus Erythematosus (SLE) with Lupus Nephritis"

A chronic remitting relapsing inflammatory multisystem disease in which tissues and cells are damaged by deposition of pathogenic autoantibodies and immune complexes. Diagnosis must be based on the following conditions:
(a) clinically there must be at least four (4) or more of the manifestations as endorsed by the American College of Rheumatology (ACR) are present, either serially or simultaneously, during any interval of observations; and

(b) presence of lupus nephritis, which is characterized as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) based on renal biopsy.

6.39 "Systemic Scleroderma"

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This Diagnosis must be unequivocally supported by biopsy and serological evidence and the disorder must have reached systemic proportions to involve the heart, lung(s) or kidney(s).
The following are excluded:
(i) Localised scleroderma (linear scleroderma or morphea);
(ii) Eosinophilic fascitis; and
(iii) CREST syndrome.

Unequivocal Diagnosis of Systemic Scleroderma must be confirmed by a Specialist rheumatologist.

6.40 "Eisenmenger's Syndrome"

Eisenmenger's Syndrome shall mean the occurrence of a reversed or bidirectional shunt as a result of pulmonary hypertension, caused by a heart disorder. All of the following criteria must be met:
(a) Presence of permanent physical impairment classified as NYHA IV; and
(b) The unequivocal Diagnosis and the level of physical impairment must be confirmed by a Registered Medical Practitioner who is a cardiologist.

6.41 "Necrotising Fasciitis"

The occurrence of necrotising fasciitis where the following conditions are met:
(a) the usual clinical criteria of necrotising fasciitis are met;
(b) the bacteria identified is a known cause of necrotising fasciitis; and
(c) there is widespread destruction of muscle and other soft tissues that results in a total and permanent loss of function of the affected body part.

6.42 "AIDS/HIV due to Blood Transfusion"

The Insured Person being infected by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) provided that:
(a) the infection is due to blood transfusion received after the Policy Issuance Date, Policy Effective Date or the effective date of any reinstatement, whichever is later; and
(b) the blood transfusion is received on the advice of and under the regular care and attention of a Specialist in the relevant field and is received in a legally constituted Hospital; and
(c) the infected Insured Person is not a haemophiliac; and
(d) certification is received from the Specialist in the relevant field performing the relevant blood transfusion and from the legally constituted blood or blood product supplier which supplied the particular blood or blood product for the relevant transfusion confirming that the Insured Person is infected by HIV or AIDS through blood transfusion.

6.43 "Ebola"

Infection with the Ebola virus where the following conditions are met:
(a) presence of the Ebola virus has been confirmed by laboratory testing; and
(b) there are ongoing complications of the infection persisting beyond thirty (30) days from the onset of symptoms; and
(c) the infection does not result in death.

6.44 "Occupational Acquired HIV"

Infection with HIV where it was acquired as a result of an Accident during the course of carrying out normal occupational duties with sero-conversion to Positive HIV antibody occurring within six (6) months of the Accident. Any Accident giving rise to a potential claim must be reported to us within thirty (30) days of the incident and be supported by a negative HIV antibody test taken immediately after the incident. The coverage of this illness shall cease in the event of an efficient and effective vaccine being found for the prevention of HIV/AIDS.

This illness does not cover sexually transmitted HIV infection.

6.45 "Severe Rheumatoid Arthritis"

Severe Rheumatoid Arthritis where all of the following criteria are met:
(a) fulfill the diagnostic criteria of Rheumatoid Arthritis Classification by the American College of Rheumatology (ACR) as confirmed by a Specialist rheumatologist; and
(b) widespread joint destruction with major clinical deformity of three (3) or more of the following areas: hands, wrists, elbows, spine, knees, ankles, feet; and
(c) permanent inability to perform, without assistance, two (2) Activities of Daily Living; and
(d) persistent conditions of at least six (6) months.

6.46 "Severe Ulcerative Colitis"

Severe Ulcerative Colitis shall mean an inflammation of the lining of the large bowel (colon and rectum). There must be biopsy evidence which unequivocally confirms the presence of ulcerative colitis and there must be imaging or endoscopic evidence that the condition involves the entire colon and rectum.
For the purposes of this illness, there must be a requirement for ongoing systemic immunosuppressive therapy or immunomodulatory therapy for a period of at least three (3) months supervised by a Specialist gastroenterologist.

Other forms of inflammatory colitis are specifically excluded. Ulcerative colitis confined to the rectum is specifically excluded.

6.47 "Elephantiasis"

The end-stage lesion of filariasis, characterised by massive swelling in the tissues of the body as a result of obstructed circulation in the blood or lymphatic vessels. Unequivocal Diagnosis of elephantiasis must be:
(a) clinically confirmed by a Registered Medical Practitioner in the appropriate medical specialty;
(b) supported by laboratory confirmation of microfilariae; and
(c) concurred in by the Company's medical director.

Lymphedema caused by infection with any other disease(s), trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded.

6.48 "Chronic Adrenal Insufficiency (Addison's Disease)"

An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life-long glucocorticoid and mineral corticoid replacement therapy. The Diagnosis of Chronic Adrenal Insufficiency (Addison's Disease) must be: i) confirmed by a Registered Medical Practitioner who is an endocrinologist and an independent medical expert appointed by us; and ii) supported by ACTH stimulation tests.

Only chronic adrenal insufficiency caused by an autoimmune disorder is included. All other causes of adrenal insufficiency are excluded.

6.49 "HIV Infection due to Organ Transplant"

The Insured Person being infected by the Human Immunodeficiency Virus (HIV) arising from an organ transplant to the Insured Person performed in Hong Kong. The Insured Person being infected by Human Immunodeficiency Virus (HIV) provided that:

(a) The infection is due to an organ transplant received after the Policy Issuance Date, Policy Effective Date or the effective date of any reinstatement, whichever is the later; and
(b) The organ transplant must be performed in Hong Kong and the medical institution which provided the transplant admits liability or there is a final court verdict that cannot be appealed indicating such liability; and
(c) The infected Insured Person is not a haemophiliac.

HIV infection transmitted by any other means including sexual activity or recreational intravenous drug use is specifically excluded. This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS.

6.50 "Medically Acquired HIV Infection"

The Insured Person being infected by Human Immunodeficiency Virus (HIV) provided that:

(a) The infection is due to an operation or a medical or dental procedure after the Policy Issuance Date, Policy Effective Date or the effective date of any reinstatement, whichever is the later; and
(b) The institution which provided the operation or the medical or dental procedure admits liability or there is a final court verdict that cannot be appealed indicating such liability; and
(c) The infected Insured Person is not a hemophiliac.

The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. Infection in any other manner, including infection as a result of sexual activity or recreational intravenous drug use is excluded.

The insurer must have open access to all blood samples of the Insured Person and reserves the right to obtain independent testing of such blood samples.

6.51 "Blindness"

Total and irrecoverable loss of sight in both eyes.

6.52 "Loss of Hearing"

Total permanent and irreversible loss of hearing in both ears.

6.53 "Loss of One Eye and One Limb"

Irreversible loss of sight in one (1) eye and loss by severance of one (1) limb at or above the wrist or ankle as a result of illness or Injury.
For the purpose of this definition, "loss of sight" refers to meeting any one (1) of the following conditions:

(a) the best corrected visual acuity in one (1) eye must be 2/60 or less using a Snellen Chart or equivalent test; or
(b) the best corrected visual field in one (1) eye must be five (5) degrees or less.

The loss of sight must be confirmed by a Registered Medical Practitioner who is an ophthalmologist.

The blindness must not be correctable by surgical procedures, implants or any other means.

6.54 "Loss of Speech"

Total permanent and irrecoverable loss of the ability to speak due to physical damage to the vocal cords which must be established for a continuous period of twelve (12) months.

6.55 "Major Burns"

Third degree burns covering at least twenty percent (20%) of the surface area of the Insured Person's body.

6.56 "Terminal Illness"

In the opinion of the Specialist involved and subject to the acceptance of our appointed Registered Medical Practitioner the advent of death is highly likely within twelve (12) months.

6.57 "Total Permanent Disability"

The Insured Person has become totally and permanently disabled as a result of Sickness or Injury before Age sixty-five (65).
The Insured Person is considered to be totally and permanently disabled if

(a) he or she is totally and permanently incapable of being engaged in any occupation, business or activity which pays an income or profit. The above disability must have lasted without interruption for at least hundred-eighty (180) consecutive days; or

(b) he or she suffers the following conditions:
  (i) Total and irrecoverable loss of sight in both eyes; or
  (ii) Total and irrecoverable loss of use of two (2) limbs (at or above the wrist or ankle joints); or
  (iii) Total and irrecoverable loss of sight of one (1) eye and total and irrecoverable loss of use of one (1) limb (at or above the wrist or ankle joint).

"Loss of use" means complete and permanent paralysis or actual severance. If the Insured Person is below Age fifteen (15) or is unemployed at the time of becoming totally and permanently disabled, he or she is only considered to be totally and permanently disabled if he or she satisfies the conditions as specified in (b) above. Such disabilities must be certified by a Registered Medical Practitioner acceptable to us.

6.58 "Loss of Independent Existence"

The permanent inability of the Insured Person to perform, without assistance, three (3) or more of the Activities of Daily Living. The coverage of this illness will cease at Age sixty-five (65) of the Insured Person.

This illness does not cover any event caused by a psychiatric condition.

Part VII Early Stage Critical Illnesses Definitions

7.1 "Carcinoma-in-situ"

Carcinoma-in-situ is defined as a focal autonomous new growth of carcinomatous cells which have not yet resulted in the invasion of normal tissue. Invasion means an infiltration and/or active destruction of normal tissue beyond the epithelial basement membrane, or surrounding tissues or stroma.

The Diagnosis must be definitively confirmed by histopathological evidence either by a registered oncologist or a pathologist. Clinical Diagnosis, Diagnosis purely based on Magnetic Resonance Imaging (MRI), Computed Tomography (CT), or other equivalent imaging techniques, or Diagnosis by tumour cells or tumour-associated molecules in the body fluid (such as liquid biopsy) do not meet the definition.

The Carcinoma-in-situ Diagnosis and staging shall follow the latest WHO cancer classification and/or AJCC (American Joint Committee on Cancer) cancer staging manual.

The definition of Carcinoma-in-situ also include:
(a) Cervical intraepithelial neoplasia grade III (CIN III) or carcinoma-in-situ (CIS).
(b) TaN0M0 and TisN0M0 bladder.
(c) Prostatic intraepithelial neoplasia grade III (PIN III) and vulval intraepithelial neoplasia grade III (VIN III).

The following are specifically excluded:
(i) Cervical intraepithelial neoplasia grade II (CIN II) or below;
(ii) Prostatic intraepithelial neoplasia grade II (PIN II) or below;
(iii) Vulval intraepithelial neoplasia grade II (VIN II) or below;
(iv) Any carcinoma-in-situ of the skin, including melanoma in situ;
(v) any gastric MALT lymphoma if the condition can be treated with Helicobacter eradication;
(vi) any pituitary tumours;
(vii) any condition where HIV infection is also present.

7.2 "Early Stage Cancer"

An early cancer is a malignant tumour characterized by the uncontrolled growth of malignant cells with the invasion of normal tissues in early stage.

The Diagnosis must be definitively confirmed by histopathological evidence either by a registered oncologist or a pathologist. Clinical Diagnosis, Diagnosis purely based on Magnetic Resonance Imaging (MRI), Computed Tomography (CT), or other equivalent imaging techniques, or Diagnosis by tumour cells or tumour-associated molecules in the body fluid (such as liquid biopsy) do not meet the definition.

The early cancer Diagnosis and staging shall follow the latest WHO cancer classification and/or AJCC (American Joint Committee on Cancer) cancer staging manual.

This definition covers the following Early Stage Cancers of Specified Severity:
(a) Any thyroid cancer that is histologically classified as stage I.
(b) Any prostate cancer that is histologically classified as T1N0M0.
(c) Malignant melanoma that is histologically classified as stage I.
(d) Chronic lymphocytic leukaemia having progressed to Binet Stage A or RAI stage I or II.
(e) Gastrointestinal stromal tumour (GIST) that is histologically classified as stage I or IA.
(f) Thymic epithelial tumour that is malignant and histologically classified as stage I.
(g) Neuroendocrine tumour or neoplasm (NET and NEN) including carcinoid tumours that are histologically classified as Stage I.

The following are specifically excluded:
(i) Any tumour that is histologically classified as pre-malignant, non-invasive, carcinoma in situ;
(ii) All grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intra-epithelial neoplasia (such as cervical intra-epithelia neoplasia (CIN) 1, 2, and 3, prostatic intra-epithelial neoplasia (PIN) 1, 2, 3);
(iii) Any tumour that is histologically classified as borderline malignancy or low malignant potential;
(iv) Any gastric MALT lymphoma if the condition can be treated with Helicobacter eradication;
(v) Any pituitary tumours;
(vi) Any cancer where HIV infection is also present.

7.3 "Angioplasty and other Invasive Treatments for Coronary Artery"

The actual undergoing of angioplasty with stenting, balloon angioplasty, atherectomy or laser treatment to correct a narrowing (minimum of sixty percent (60%) stenosis) of one (1) or more major coronary arteries. The treatment must be confirmed by a Specialist in the relevant field as Medically Necessary.

Medical evidence shall include all of the following:
(a) Full report from attending cardiologist; and
(b) Angiographic evidence to confirm the location and degree of stenosis of one (1) or more major coronary arteries.

Major coronary arteries are defined as left main stem, left anterior descending, circumflex and right coronary artery.

In the absence of fulfulling the definition of Heart Attack and/or Other Serious Coronary Artery Disease at Part VI of this Policy.

7.4 "Angioplasty or endarterectomy for carotid arteries"

Carotid Endarterectomy and Angioplasty and Stenting for Carotid Arteries Angioplasty and Stenting for Carotid Arteries shall mean the treatment of stenosis of fifty percent (50%) or above in one (1) or more carotid arteries, as proven by angiographic evidence. All of the following criteria must be met:
(a) actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy or endarterectomy to alleviate the symptoms; and
(b) the Diagnosis must be confirmed by a Specialist in the relevant field and the procedure must be considered to be Medically Necessary.

7.5 "Surgery coverage"

The Insured Person undergone any one (1) of the following surgeries.

List of surgery
1. Oesophagectomy
2. Total oesophagectomy and interposition of intestine
3. Partial gastrectomy with anastomosis to oesophagus
4. Proximal gastrectomy / radical gastrectomy / total gastrectomy +/- intestinal interposition
5. Anterior resection of rectum, open or laparoscopic
6. Abdominoperineal resection, open or laparoscopic
7. Colectomy, open or laparoscopic
8. Low anterior resection of rectum , open or laparoscopic
9. Liver transplantation
10. Segmentectomy of liver, open or laparoscopic
11. Pancreaticoduodenectomy (Whipple's Operation)
12. Craniectomy
13. Cranial nerve decompression
14. Clipping of intracranial aneurysm
15. Wrapping of intracranial aneurysm
16. Excision of arteriovenous malformation, intracranial
17. Excision of acoustic neuroma
18. Excision of brain tumour or brain abscess
19. Excision of cranial nerve tumour
20. Decompression of trigeminal nerve root/ open trigeminal rhizotomy
21. Excision of brain, including lobectomy
22. Hemispherectomy
23. Excision of intraspinal tumour, extradural or intradural
24. Coronary artery bypass graft (CABG)
25. Cardiac transplantation
26. Closed heart valvotomy
27. Open heart valvuloplasty
28. Valve replacement
29. Intra-abdominal venous shunt/ spleno-renal shunt / portal-caval shunt
30. Resection of abdominal vessels with replacement / anastomosis
31. Bilateral adrenalectomy, laparoscopic or retroperitoneoscopic
32. Total excision of pineal gland
33. Operation of pituitary tumour
34. Laryngectomy +/- radical neck resection
35. Lobectomy of lung / pneumonectomy
36. Radical abdominal hysterectomy
37. Pelvic exenteration
38. Radical vaginectomy
39. Radical prostatectomy, open or laparoscopic
40. Nephrectomy, partial/ lower pole
41. Kidney transplant
42. Radical/ total cystectomy, open or laparoscopic
43. Formation of ileal conduit, including ureteric implantation

No Early Stage Critical Illness Benefit shall be payable if any of the above surgeries is performed as a direct result of a medical condition already covered under any Early Stage Critical Illness (other than "Surgery coverage") or any Critical Illness in respect of which the Early Stage Critical Illness Benefit or the Critical Illness Benefit is paid and/or payable.

7.6 "Kawasaki Disease"

The occurrence of Kawasaki Disease with heart complications where all of the following conditions are met:

(a) The occurrence of any one (1) of the following conditions in one (1) or more coronary arteries:
  (i) persistent dilation of at least six (6) millimeters in diameter; or
  (ii) aneurysm formation of at least six (6) millimeters in diameter; and
(b) Such dilation or aneurysm in the coronary arteries has persisted for at least six (6) months following initial Diagnosis of this disease by a Registered Medical Practitioner who is a pediatric cardiologist.

7.7 "Intellectual Impairment due to Injury"

An unequivocal Diagnosis by a Registered Medical Practitioner who is a pediatric psychiatrist of intellectual impairment directly resulting from an Injury and independently of any other cause(s), where all of the following conditions are met:

(a) The Insured Person suffers from sub-average general intellectual functioning, mental handicap, or learning disorder, as determined by a Pediatric Neuro-psychological assessment; and the Insured Person's treating pediatric psychiatrist certifies that such condition is caused by the said Injury;
(b) An IQ below seventy (70), as established with either of the standardized IQ tests - "Raven's Progressive Matrices" or "Wechsler Intelligence Scale for Children";
(c) The Insured Person is Age four (4) or above at the time of Diagnosis and the condition has continued without interruption for a period of at least six (6) consecutive months after the Diagnosis; and
(d) There is documented proof of hospitalization of the Insured Person due to Injury resulting in said intellectual impairment.

For the avoidance of doubt, intellectual impairment resulting from any substance abuse is excluded.

7.8 "Hand, Foot, Mouth Disease with Severe Complications"

The unequivocal Diagnosis of Hand, Foot and Mouth Disease with evidence of infection by Coxsackie A16 and Enterovirus 71. Only severe Hand, Foot and Mouth Disease requiring the admission into an Intensive Care Unit (ICU) and associated with either encephalitis and/ or myocarditis will be covered.

Positive isolation of the causative virus to support the unequivocal Diagnosis has to be provided together with documented evidence of the presence of encephalitis and/ or myocarditis. A claim can only be made with evidence of neurological deficit for at least thirty (30) days after the event.

7.9 "Pulmonary Hemorrhage Nephritis Syndrome"

The clinical manifestations of pulmonary haemorrhage and glomerulonephritis appear at the same time. The Diagnosis must be confirmed by Specialist in nephrology with supporting from a biopsy report.

7.10 "Respiratory Diphtheria"

Diphtheria is defined as an acute toxin-mediated disease caused by Corynebacterium diphtheriae. The unequivocal Diagnosis must be certified by a Specialist in pediatrics. All of the following criteria must be met:

(a) upper respiratory tract illness presenting with high fever, pseudomembrane formation (involving pharyngeal walls, tonsils and larynx) and cervical lymphadenopathy;
(b) mechanical ventilation is instituted on an inpatient basis;
(c) bacteriologic cultures of throat swab/pseudo membrane specimen isolate Corynebacterium diphtheriae;
(d) antitoxin is administered;
(e) laboratory confirmation of diphtheria toxin production; and
(f) evidence of inflammation of heart muscle.