

Liberty Flex (GHS) Provision Revamp Summary

The Liberty Flex (GHS) product provision is refreshed to clarify definitions and expand benefits for policyholders and insured members. The changes are designed to provide clearer guidance for members flexibility and offer comprehensive protection when they need care.

Key updates as following:

Hospitalization & Surgical

- **Re-define hospital confinement:** the previous 6-hours confinement requirement is removed, inpatient is now re-defined as occupies a bed which incur a Room and Board charges. This makes eligibility for inpatient benefits clearer and aligns with common clinical practice.
- **Cover day case treatment:** relax and cover day case treatment under Hospital Special Services, Anaesthetist Fee, Operating Theatre, Surgical Fee, Pre Hospitalization Treatment, Post Hospitalization Treatment, Additional Accident Treatment, Renal Dialysis and Oncology Treatment, to provide greater flexibility to members for shorter treatment and procedure that do not require overnight stays.
- **Expand coverage of Hospital Special Services:** extend to cover Renal Dialysis, Chemotherapy for cancer treatment and Advanced Diagnostic Imaging (MRI, CT Scan, PET Scan).
- **Cost containment options:** Renal Dialysis, Oncology Treatment, Day Case Treatment, Day Surgery for Gastroscopy/ Colonoscopy, and Day Case Treatment for Viral Warts & Skin Lesions are now included among the services as cost containment options. This broadens options to manage long-term affordability while maintaining access to appropriate care.
- **Medical necessary requirement:** treatment and procedure must be recommended in writing by a Physician as medically necessary. Reimbursement will be based on usual, reasonable and customary charges.

Supplementary Major Medical (SMM)

- **Follow market trend and offer comprehensive SMM protection:** cover charges exceed the limits under Room and Board, Hospital Special Services, Anesthetist Fee, Operating Theatre, Surgical Fee, In-Hospital Doctor Consultation, In-Hospital Specialist Consultation, Intensive Care Unit and Surgical Appliances to reduce exposure for major or complex inpatient claims.
- **Alter adjustment factor:** alter the adjustment factor formula to align with current market practice and standard.

Dental

- **Extend to cover dental hygienist service:** extend to cover oral examination and polishing performed by dental hygienist, improving routine dental care access for insured members.



Please note this document highlights the principal changes but does not show the full text of the revised provision, please review the complete Liberty Flex provision specimen for full terms and conditions. For any enquiry, please contact your designated account handler.

Attachment: GHS Group Medical Insurance Revamp_final.pdf





Liberty International Insurance Limited
Suites 2601-04 & 2607-16 26/F
1111 King's Road, Taikoo Shing
Hong Kong
Tel: (852) 2892 3888
Fax: (852) 2577 9578
libertyinternational.com/hk

Liberty Flex (GHS) Provision Revamp Comparison

The Liberty Flex (GHS) product provision is refreshed to clarify definitions and expand benefits for policyholders and insured members. The changes are designed to provide clearer guidance for members flexibility and comprehensive protection when they need care.

Please note this document is confidential, for intermediaries' reference only, compares the previous and existing provision but may not show the full text of provision, please review the complete Liberty Flex (GHS) provision specimen for full terms and conditions.

Introduction & Administration

Previous Provision	Existing Provision
DATA REQUIRED The Policyholder shall furnish the Company with all information and proofs which the Company may reasonably require with regard to any matters pertaining to the Policy. All documents furnished to the Policyholder by a Member in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be open for inspection by the Company at all reasonable times.	INTRODUCTION Welcome to Liberty Flex – a bespoke group medical insurance product of Liberty International Insurance Limited (“ Plan ”) tailored to the specific needs of the Group . IMPORTANT – Please read this Policy carefully to see that it meets Policyholder and Insured Member requirements. Any non-disclosure and/or misrepresentation, deliberate or negligent, of a material fact (i.e. facts relevant to an insurer’s decision to provide or continue to provide coverage or for a certain amount/ premium) and/or breach of any warranty(is) or condition(s) of this Policy will render this Policy voidable. Policyholder and Insured Member duties of disclosure remain throughout each Policy Year . Insured Member has a duty to tell Us or Policyholder anything it knows, or could reasonably be expected to know (such as but not limited to changes to information provided to Us), which may affect Our decision to insure and on what terms and whether to accept, renew, extend, vary or reinstate this Policy . Policyholder and Insured Member confirm they have read, or on their behalf have read, the Personal Information Collection Statement set out herein and on the website at https://www.libertyinsurance.com.hk/personal-information-collection-statement (“ Statement ”) and understand and consent to the continued collection, holding, processing, use and/or transfer of personal data for purposes stated under Statement until termination or expiry of Policy . In this Policy , the words We, Us, Our, Insurer, Company means Liberty International Insurance Limited.
GENERAL PROVISIONS THE CONTRACT	The Policy



a) All statements made by the Policyholder, or by the Members insured shall, in the absence of fraud, be deemed representations and not warranties, and no statement shall void the insurance, or be used in defence of a claim under it, unless it is in writing. b) The rights of the Policyholder or of any insured Member or of any beneficiary under the Policy shall not be affected by any provision other than those contained in this Policy or in the copy of the Policyholder's application attached hereto, or in the individual enrolment form of an insured Member, or in any other document which constitute part of the entire contract. c) No agent is authorized to alter or amend this Policy, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by this Policy, or to extend the date before which any such notice or proof must be submitted. No change in this Policy shall be valid unless evidenced by endorsement hereon, or by amendment hereto signed and approved by the Company's President and initialed by the Company's Examiner. d) This Policy provides insurance on the non-contributory basis. Contributory insurance is insurance for which a member contributes towards the cost. Non-Contributory insurance is insurance for which a member does not contribute towards the cost.	The Master Policy is a legally binding contract between Liberty International Insurance Limited and Policyholder. The information provided by Policyholder, Plan Sponsor, and/or Insured Member, or on Policyholder and Insured Member behalf, under forms, declarations, quotations, electronic mail, mobile, web applications, other forms of electronic transmission or otherwise supplied to Us, the Schedule, Statement of Insured Members, and any notices, memoranda or Endorsements will together form evidence of an agreement with the Company. Together, it shall be considered one legally binding contract ("Policy"). Insured Member and Policyholder duty to read all parts of the Policy and inform Us immediately when and if there are changes to information provided to Us. Any capitalized and/or bolded word or expression used in any of the parts of the Policy but not otherwise defined shall bear such meanings under the Definitions section herein. This Policy is an annual contract with the Company and shall be issued for one (1) year period. At the end of each one (1) year period, it may be renewed as determined by the Company in accordance with the terms and conditions of this Policy and subject to the availability of the Plan. Policy application and payment of Premium shall conduct in Hong Kong.
	The Cover Policyholder, Plan Sponsor or Insured Member have, or on Policyholder and Insured Member behalf have, applied to Company for coverage or renewal of coverage per the Plan and Policyholder have paid, or agreed to pay, the Premium. In consideration of Policyholder agreement to and/or the payment of the Premium, and subject to due observance and fulfillment of the terms, conditions and exclusions of this Policy insofar as they relate to anything to be done, or not done, and complied with, We will provide coverage to the extent and in the manner set forth herein, subject always to all stated terms, conditions and exclusions and provided always; a) liability of Insurer shall not exceed the limits set out in this Policy for each section of cover relevant to Insured Member during any one Policy Year; and b) Policy shall become effective as of 00:01 a.m., Hong Kong Time on first day of the original Policy Year at, (or such Date of Entry if an Insured Member is added to the Policy later) For avoidance of doubt, any Optional Plan Covers stated herein will only be part of an Insured Member's coverage if such Optional Plan Covers are also listed under the Insured Member's Schedule as part of its coverage and Insured Member, OR on Insured Member behalf, paid, or agreed to pay, any and all additional Premium. Pronouns used in this Policy shall, when applicable, apply to either gender. Singular shall include the plural. Headings adopted are for ease of reference only, do not



	constitute a part of this Policy , and shall not be deemed to limit or affect any of the provisions hereof. The base currency for the Plan is HK\$.
ENROLMENT The Policyholder shall furnish to the Company individual enrolment form for each insured Member in the form prescribed by the Company. PARTICIPATION - Members already eligible on the Effective Date shall be eligible at such Effective Date. - New Members shall become eligible on the day following their completion of the Probationary Period specified in the Policy Schedule with the Policyholder. - Members whose insurance has been terminated due to termination of membership and who re-apply for membership shall be considered as new Members. - Any Member who is not Actively at Work on the date he would otherwise become eligible for insurance hereunder shall not be eligible until the date he returns to full-time active service in good health. - Any Member shall not have Sanctioned Countries as their Home Country or Country of Residence. - Every Member who fulfils the conditions necessary to participate as set forth in (1) to (5) above must elect to do so in writing within 31 days from the date he becomes eligible. Otherwise, he shall be able to start participating only after he shall have furnished, at his own expense, evidence of his insurability satisfactory to the Company. - Each eligible Member shall be insured hereunder on the first day on which he becomes eligible provided the duly completed enrolment form has been received by the Company from the Policyholder and the conditions set forth in Paragraph (6) of this Section has been satisfied. - If dependent's insurance is provided under the plan as specified in the Benefit Schedule, each person who is a Dependent on the Effective Date shall be eligible at such Effective Date or on the date such person becomes a Dependent. - Any Dependent who fulfils the conditions as set forth in Paragraph (8) of this Section shall become insured on the date the Member makes written application to insure his Dependents. - If written application to the Policyholder for Dependents' insurance is not made within 31 days from the date the Dependent becomes eligible, or if an insured Member re-applies for insurance after a Dependent's insurance has terminated for any reason whatsoever, the insured Member shall be required to furnish, without expense to the Company, evidence of insurability satisfactory to the Company for such	Eligibility To be eligible to apply for Cover and continued Coverage under this Policy, an Insured Member is one as defined under this Policy and must always: - be an age between fifteen (15) days after date of birth or discharge from Hospital where birth took place (whichever is later) to age sixty-nine (69) (inclusive) on date of first application for Coverage; AND - not have USA as both Home Country and Country of Residence; AND - not have Sanctioned Countries as their Home Country or Country of Residence or listed as a Sanctioned Individual; AND - provide satisfactory evidence of good health upon Insurer's request. A Dependent must have the same Plan Coverage as an Insured Member (except for maternity related Optional Plan Cover) and subject to acceptance by the Company. Coverage for Minors shall be subject to the Age of Majority (Related Provisions) Ordinance (Cap 410 of the laws of Hong Kong) and all other related laws. For avoidance of doubt, Parent/ Guardian undertakes to comply with this Policy on behalf of a Minor Insured Member and consents to continued collection, holding, processing, use and/or transfer of Minor's personal data for purposes stated under Statement. Mainland China citizens with Mainland China as their Home Country will not be covered unless they: - hold a current Hong Kong Identity Card; OR - are employed under Hong Kong employment contract; OR - hold a valid Hong Kong working permit



Dependent before the Dependent's participation shall become effective. 11. Any Dependent who is confined in the hospital on the date he would otherwise become eligible for insurance shall not be eligible until the date he is fully recovered and discharged from the hospital. 12. For Group size of less than 6 insured Members upon Policy inception or thereafter upon each Policy anniversary, new Member shall be required to furnish, at his own expense, evidence of insurability satisfactory to the Company before the application of insurance shall become effective. The requirement shall remain applicable throughout the Policy Year regardless of mid- year case size growth, for which review of case size shall be made upon next following renewal date or Policy anniversary.	
TERMINATION The insurance hereunder of any Member and if Dependent's insurance is provided, any Dependent shall automatically cease on the earliest of the following dates: - The date the Policy is terminated. - The date of the expiration of the period for which the last premium payment is made on account of the Member's insurance. - The date on which the Member enters full-time military, naval or air service. - The end of the Policy Year during which the Member and Dependent spouse if applicable attains the age of 65 years; and in case of Dependent child, the end of the Policy Year during which the child attains the age of 19 years or 23 years in full-time-student. - The date communicated to the Policyholder by the Company by virtue of war, act of war, where such date shall be at the discretion of the Company. - The date on which the Member's membership in the class or classes of Members insured hereunder is terminated. Cessation of Active Work by a Member (or cessation of membership in good standing in the case of associations) shall be deemed to constitute the termination of his membership, except that while a Member is temporarily on part-time employment or is absent on account of sickness or injury, membership shall be deemed to continue until premium payments for such Member's insurance are discontinued.	Automatic Termination Coverage shall automatically terminate on the earliest of the following: - Date on which Insurer determine the Dependent, or Employee ceases to meet any one of the eligibility criteria for Coverage or definition of an Insured Member; - Date the Master Policy terminates; - Date the Policy terminates for all Insured Members; - Date Insurer is informed Policy terminates for Insured Member; - Date of an Employee's termination of Active Employment; - First Due Date following the Employee's 70th birthday; - Subject to any applicable Grace Period, the date of expiration of a Policy Year period for which the last Premium payment was made for Dependent, or Employee; - Date on which Insurer determines there was a breach of the Policy; - If Insured Member is a Dependent, in addition to the above, date the Insured Member ceases to meet the definition of a Dependent as defined in the Policy or date the relevant Employee cease to be an Insured Member.
SANCTION LIMITATION & EXCLUSION The Company reserves the right not to accept application for cover OR to cease providing cover if the Company's so doing will in the Company's opinion expose the Company to risk of any breach of any applicable laws or regulations, as well as international economic sanctions, laws or regulations. For avoidance of doubt, the Company shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose Us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union ("EU"), United Kingdom	Sanction Limitation & Exclusion We reserve the right not to accept application for Cover OR to cease providing Cover if Our so doing will in Our opinion expose Us to risk of any breach of any applicable laws or regulations, as well as international economic sanctions, laws or regulations. For avoidance of doubt, We shall not be deemed to provide cover and shall not be liable to pay any claim or provide any Benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such Benefit would expose Us to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions,



("UK"), or United States of America ("USA"). Switzerland ("CH"), Singapore ("SG") or any jurisdiction applicable to the Company."	laws or regulations of the European Union ("EU"), United Kingdom ("UK"), United States of America ("USA"), Switzerland ("CH"), Singapore ("SG") or any jurisdiction applicable to Us.
	Territorial Scope of Policy Coverage Worldwide covering the Insured Member against Bodily Injury, Sickness and Emergency treatments during the Policy Year. See Administration – Change in Country of Residence & USA Coverage for further details if Insured Member has USA as its Home Country.
EXCLUSIONS No benefit shall be paid for the following services, products or conditions:- 1. Pre-existing Conditions a. No benefit shall be payable with respect to injuries or sickness sustained prior to the date the insured Member become insured or covered under this Policy and because of which such person shall have received medical or surgical treatment within three consecutive months immediately preceding such date, unless such charges are incurred after a period of three consecutive months ending after such date during which period no medical expenses on account of such injuries or sickness shall have been incurred b. Regardless of the conditions stated in (a) above, expenses incurred for such disability shall be considered as covered expenses after an Insured Member has joined the scheme for twelve (12) consecutive months under the Policy. 2. Functional disorders of the mind; such as neuroses, anxiety, anorexia, bulimia, depression and insomnia, etc. 3. Rest cures or sanatoria care. 4. Congenital anomalies. 5. Sterilization of either sex. 6. Hospitalization primarily for diagnosis, X-ray examinations, or physical therapy, unless recommended by a Registered Medical Practitioner. 7. Any dental treatment or surgery except dental operation resulting from an injury sustained by the insured Member in an accident except as insured under the Supplementary Dental Benefits Rider. 8. Fitting of glasses, contact lenses or eye refraction error such as myopia, hyperopia and presbyopia, etc. 9. Drugs addiction or alcoholism. 10. Injuries due to insanity or self-infliction. 11. Special nursing care and general physical or medical check-up.	Overall Policy Exclusions The following treatments, conditions, activities, items and their related expenses are excluded from the Plan and the Insurer shall not be liable for: 1. Pre-Existing Medical Conditions as defined herein under Definitions. 2. Treatment of mental illness, behavioral, psychiatric disorders such as, but not limited to, depression, eating disorder or any neuroses and their physiological or psychosomatic manifestations unless otherwise explicitly provided and endorsed in the Schedule. 3. Services or treatment at any institution that is mainly a long-term care facility, spa, hydro-clinic, or sanatorium and/or that provides only incidental or limited Hospital services or non- Medically Necessary treatments, or experimental, yet to be scientifically proven medical treatments, complementary and alternative treatments unless otherwise explicitly provided and endorsed in the Policy or Schedule. 4. Treatment relating to birth defect, Congenital Conditions and congenital illnesses unless otherwise explicitly provided and endorsed in the Policy or Schedule. Birth defects include, but not limited to, hereditary conditions, treatment for learning problems or speech defects of a Dependent Child and fetal surgery. 5. Tests and treatment relating to infertility, contraception, sterilization or inducing pregnancy. 6. All dental treatment, oral or maxillofacial surgery unless otherwise explicitly provided and endorsed in the Policy or Schedule. 7. Fitting of glasses, contact lenses, or eye refraction errors, such as, myopia, hyperopia and presbyopia, unless otherwise explicitly provided and endorsed in the Schedule. 8. Treatment arising out of addictive conditions/ disorders, including but not limited to, alcoholism, smoking, drug or substance abuse. 9. Treatment for willfully self-inflicted or grossly negligent Bodily Injury, Sickness, Accident, or suicide.



12. Room, board, general nursing care or special hospital services not in accordance with the diagnosis and treatment of the condition for which the hospital confinement is required. 13. Procurement or use of special braces, appliances or equipment. 14. Cosmetic surgery for purposes of beautification or plastic surgery for any pre-existing condition. 15. Injury or sickness arising directly or indirectly from war, declared or undeclared, strike, riot, revolution, or any warlike operation or racing on horse or wheels. 16. Treatment by any person other than a Registered Medical Practitioner. 17. Injury sustained or sickness contracted as a direct result of participation in illegal acts (except traffic and pedestrian offences); such acts include but are not limited to burglary, robbery, failure to obey an order given by an officer of the law, drug abuse, use of explosives or incendiary devices (unless permit has been issued), assault and battery, etc. 18. Vaccination and any preventive treatment. 19. No benefit is payable as a result of confinement in any Hospital where care was provided to the insured Member without charge. 20. No benefit shall be payable with respect to any period of hospital confinement unless the entire confinement and all the special hospital services so rendered and performed are recommended and approved by a Registered Medical Practitioner. 21. No benefit shall be payable if the claim is due to pregnancy which shall include childbirth, miscarriage, abortion, prenatal care as well as postnatal care, and other complications arising therefrom except as insured under the Maternity Benefit Rider. 22. No benefit is payable for non-medical personal services such as radio, telephone and the like. 23. All expensive nutrient herbs and tonic, or drugs that may be purchased without Registered Medical Practitioner's prescription; alternative treatment; experimental and yet to be scientifically proven medical treatment. When the insured Member is entitled to benefits payable under Employees' Compensation Ordinance in other insurance coverage, the benefits payable under this Policy shall be limited to the balance of expenses not covered by benefits payable under the Ordinance and other insurance coverage or that calculated from the Benefit Schedule of this Policy, whichever is lesser.	10. Special nursing care and general physical or medical check-up unless otherwise explicitly provided and endorsed in the Schedule. 11. Procurement and/or use of special braces, appliances and/or equipment unless otherwise explicitly provided and endorsed in the Schedule. 12. Elective cosmetic surgery such as but not limited to treatments related to or arising from the removal of healthy, surplus or fat issue or other treatment undergone for cosmetic or psychological reasons. 13. Treatment for injuries or Sickness arising directly or indirectly from war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion, uprising, military or usurped power, nuclear energy or participating, attempting to commit, or assist in an illegal act, including resultant imprisonment. 14. Racing of any form other than on foot, caving, rock climbing or mountaineering normally involving the use of ropes or guides, parachuting, bungee jumping, martial arts, winter sports, motor-cycling, hunting, polo, football, aviation or aeronautics (other than travelling as a passenger in a licensed aircraft operated by a recognized airline) or any sports undertaken on a professional or competitive basis and all other professional sports. 15. Treatment or care by persons not falling within definition of Physician, Specialist, Chinese Physician, Dentist, Dental Hygienist, Physiotherapist, Chiropractor, Registered Nurse OR not on the recommendation of a Physician OR against the advice of a Physician. 16. Routine medical examinations and preventive treatment (including vaccinations or inoculations) unless otherwise explicitly provided and endorsed in the Policy or Schedule. 17. Any costs where the Insured Member, Policyholder or Insurer are not required to pay. 18. Maternity care. No Benefit shall be payable, unless otherwise explicitly provided and endorsed in the Schedule. 19. Non-medical services, including the issue of medical certificates and attestations and examinations as to suitability or employment or travel. 20. Any expenses for health supplements and specialized Chinese herbs and/or tonic and/or medicine that may be purchased without a Physician or Chinese Physician's prescription and/or not falling under the definition of Chinese Herbal Medicine.
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	21. Charges exceeding the Usual, Reasonable and Customary Charges range or not Medically Necessary expenses. 22. Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive unless otherwise explicitly provided and endorsed in the Schedule. 23. Treatment for Bodily Injury or Sickness incurred while serving as a member of police or as a result of, or related to, engaging in active service in the armed or military forces of any nation.
	Alteration of Risk The Policyholder and/or Plan Sponsor undertakes to give written notice to Us as soon as possible of any alteration in its activities, or if changes or alterations are intended or made which may increase the risk of a claim being made under the Policy. If We agree to the change, We will do so in writing with any additional Premium We may require. If the Policyholder and/or Plan Sponsor or the Insured Member fails to notify Us, for whatsoever reason, of any change in the Policyholder's and/or Plan Sponsor business activities and/or Insured Member's employment activities or occupation or habits or pursuits which may reasonably be viewed as increasing his/her exposure to Bodily Injury and/or Sickness. We reserve the right to act accordingly such as but not limited to ceasing the Coverage provided by Us under this Policy in respect of the Insured Member with effect from the date on which the change took place but shall in no event affect Our obligations to pay Benefits under this Policy accrued prior to the said change. Before each renewal of this Policy, the Policyholder, or on Policyholder's behalf, shall give written notice of any Bodily Injury, Sickness, illness, disease, physical defect or infirmity by which the Insured Member has become affected or which has come to Policyholder, Plan Sponsor and/or Insured Member knowledge or undertake to Us there were no changes in information provided to Us from previous Policy Year. For avoidance of doubt, We reserve the right to alter the Policy, increase Premium, implement premium loadings or cancel Cover for an Insured Member following an Alteration of Risk. Policyholder may direct Plan Sponsor to act on its behalf in respect of obligations under this section and breaches by Plan Sponsor shall be considered breaches by the Policyholder.
	Amendments No insurance intermediary has the authority to amend this Policy, or to waive any provision. No changes in this



	Policy shall be valid unless approved by Us through a signed Endorsement.
	Arbitration Any dispute or difference, arising out of or in connection with this Policy, shall first be referred to mediation. If the mediation is unsuccessful, subject to Jurisdiction and Governing Law and unless otherwise agreed in writing between the parties, all disputes shall be referred to and finally resolved by arbitration administered by the Hong Kong International Arbitration Centre (HKIAC) under the HKIAC Administered Arbitration Rules in force when the Notice of Arbitration is submitted. The law of this arbitration clause shall be Hong Kong law. The seat of arbitration shall be Hong Kong. The number of arbitrators shall be one. The arbitration proceedings shall be conducted in English.
	Assignment This Policy is neither transferable nor assignable to any other person, entity by Insured Member, Plan Sponsor or Policyholder and shall not be subject to any trust or lien or charge or any kind. The Company shall be entitled to, without the consent of the Policyholder, assign any of its rights and duties under this Policy.
DATA REQUIRED The Policyholder shall keep a record with respect to each Member insured under this Policy, showing the Member's name, sex, date of birth, the date insurance became effective, the date insurance terminated and such other data as may be necessary to carry out the terms of the Policy.	Books & Records We shall be permitted to examine the Insured Member's, Plan Sponsor's or the Policyholder's records relating to this Policy at any time during the Policy Year and for three (3) years after termination of this Policy for any reason.
	Breach of Condition If the Policyholder, Plan Sponsor or the Insured Member is in breach of any of the conditions or provisions of the Policy (including a claims condition), We may decline to pay a claim, to the extent permitted by law.
	Change In Country of Residence & Usa Coverage Immediate notice must be provided to Us if an Insured Member has USA as its Home Country and: a) stayed/ will stay in USA in aggregate for longer than 185 days; OR b) needs to change its Country of Residence to USA; OR c) plans to remain/ has remained in USA for a continuous period of twelve (12) weeks or longer; OR d) shall be an Expatriate in USA during the then current Policy Year; OR e) is an Expatriate returning to USA If any one of a) – e) above is applicable at time of incurring covered expenses, all Benefits payable under the Policy which takes place in the USA shall be reduced by at least forty percent (40%) of relevant reimbursable charges unless Insurer has altered the Policy, implemented premium loadings and/or increased the



	Premium payable for the Insured Member prior to Insured Member incurring the covered expenses, subject always to this Policy's terms and conditions, but in no event shall such reimbursement exceed the limits stated in the Schedule. The 185 days will be counted on an aggregate annual basis and will be restored for every Policy Year. Insurer does not confirm the Policy conforms with the regulations set forth in the USA Patient Protection and Affordable Care Act (ACA) and does not declare the Policy is ACA-compliant. Policyholder and/or Insured Member are liable for and shall ascertain whether the Policy is suitable for any Insured Member who may require insurance coverage in compliance with ACA or other relevant USA laws.
DATA REQUIRED Clerical error in keeping the records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated, but upon the discovery of such error, an equitable adjustment of premiums shall be made.	Clerical Errors Clerical errors by Us shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force.
GRACE PERIOD - DISCONTINUANCE OF POLICY A grace period of 31 days following the due date shall be allowed the Policyholder for the payment of each premium after the first. If any premium is not paid before the expiration of the grace period, this Policy shall automatically discontinue at the expiration of the grace period, except that if the Policyholder shall have given the Company written notice in advance of an earlier date of discontinuance, this Policy shall discontinue as of such earlier date. The Policyholder shall be liable to the Company for the premiums for the time the Policy was in force during the grace period. If this Policy provides insurance on the Contributory basis, then as to the Contributory insurance, the Company reserves the right to discontinue this Policy on any premium due date when there are less than seventy-five percent of the eligible members are insured hereunder, provided that the Company shall give the Policyholder at least thirty-one (31) days' notice of its intent to discontinue. If this Policy provides insurance on the Non-contributory basis, then as to the Non-Contributory insurance, the Company reserves the right to discontinue this Policy on any premium due date when there are less than the total number of Members then eligible for insurance are insured hereunder, provided that the Company shall give the Policyholder at least thirty-one (31) days notice of its intent of discontinue.	Commencement & Premiums Insurance shall commence from the date specified on the Schedule. Cover and renewals subject to declarations and information submitted by Plan Sponsor, Policyholder, and/or or on behalf of Insured Member, Plan Sponsor, Policyholder, for all proposed individuals that may be eligible for Cover on the Commencement Date or renewal of Policy. See Administration - Condition Precedent to Liability. For avoidance of doubt, We maintain our discretion to accept or not accept applications for Cover or renewals and are not obliged to provide Cover, approve or reject applications even where we have previously provided Cover, approved or rejected such, or similar, applications. Insurer shall have the right to pursue against the Plan Sponsor in lieu of, or together with the Policyholder, for any sections of the Policy which Policyholder has designated Plan Sponsor to act on its behalf in respect of its obligations under such sections. Any Employee or Dependent not enrolled on Commencement Date of Policy or the Commencement Date of subsequent renewals may be subject to individual underwriting and shall furnished, at their own expenses, evidence of insurability satisfactory to the Insurer, and will upon confirmation by Insurer be added to the Policy on its Date of Entry. See Introduction - Eligibility section of the Policy for additional details. Premiums are payable on or before the Due Date subject to any applicable Grace Periods. This Policy will continue



	to be in effect during any applicable Grace Period. If a Premium is still unpaid at the end of a Grace Period, this Policy is no longer in effect from the Due Date. Plan Sponsor and/or Policyholder shall be liable to pay the Company all such Shortfall incurred during the Grace Period if the Policy has lapsed. See Administration - Reinstatement for further Details. Premiums are payable annually by any method which the Company makes available. Premium rates are not guaranteed and may be changed by the Company at its discretion. For an Insured Member who's Country of Residence is a high risk area as assessed by the Company or shall become an Expatriate in a high risk area during Coverage under the then current Policy Year, and based on information provided to the Company by Insured Member, Plan Sponsor or Policyholder, Company shall assess the current, future or developing risk exposures of Insured Members located in the high risk areas during Coverage and will notify the Policyholder of any actions, limitations, exclusions or premium loadings required to ensure on going Cover for the Insured Member.
	Condition Precedent To Liability The truth of any statement or declaration made by a Policyholder, Plan Sponsor and Insured Members and the due observance and the fulfilment of the terms, conditions and provisions of this Policy by the Policyholder, Plan Sponsor and Insured Members and in so far as they relate to anything to be done, or complied with, by the Policyholder, Plan Sponsor and Insured Members shall be conditions precedent to any liability of Ours. See Administration – Misrepresentation / Fraud / Non-Disclosure for further details. Additionally, the Policyholder, Plan Sponsor, Insured Member and/or their representatives, upon making a claim, shall co-operate fully with Us, and will fully and faithfully disclose all material facts and matters and shall, upon request, execute any document to empower Us to obtain relevant information from, including but not limited to, any doctors, Hospitals, third party administrators or other sources. We maintain the right to ask Insured Members to provide proof of eligibility at any time during Cover, such as but not limited to proof of Age, Dependent and/or full-time student status and/or state of health.
	Co-Ordination of Benefits/ Other Insurance If the Insured Member or Policyholder is entitled to reimbursement of all or part of any coverable expenses incurred from any other insurance or sources, We will only be liable for such amounts in excess of the amount payable under such other insurance or sources. In the event of a claim, the Policyholder, Plan Sponsor and/or Insured Member must advise Us as to any other insurance policies that may be available to pay or partially



	pay that claim. Additionally and for avoidance of doubt, if at the time of any claim under this Policy there is any other insurance or source indemnifying any person or the Insured Member or Policyholder who are entitled to be indemnified under this Policy, this Policy is not to be called upon in contribution and, subject to the Policy limit of indemnity, is only to pay any amount if and so far so not recoverable under such other insurance or source.
	Examination We shall have the right and opportunity through Our medical representatives to examine any Insured Member whenever and as often as may be reasonably required within the duration of any claim. In addition, We shall have the right to require an autopsy in the case of death, where this is not forbidden by law or religious belief.
CHANGE IN CLASSIFICATION If this Policy provides insurance on the Contributory basis, and there is a change in the Insured Member's classification, the Member's benefits shall, unless otherwise stated herein, be adjusted automatically to conform to the new classification on the first day of the month concurrent with or next following the date of such change provided that on such adjusted date the Member is both Actively at Work on full time and makes a contribution applicable to the new classification. If this Policy provides insurance on the Non- Contributory basis, and there is a change in the insured Member's classification, the Member's benefits shall, unless otherwise stated herein, be adjusted automatically to conform to the new classification on the first day of the month coincident with or next following the date of such change provided that on such adjusted date the Member is actually at work on full time. CHANGE IN BENEFITS If the eligible benefits for any insured Member under the terms of this Policy are upgraded to another benefit level while this Policy is in force, benefit payable for sickness/injury sustained prior to effective date of change of benefits shall be reimbursed in accordance with the original insurance schedule and provisions for which the member was then insured.	Group Plan Benefit Levels Insured Members may have varying Benefits based on the Group Plan Benefit levels designated by the Policyholder or Plan Sponsor and informed Us. Enrolment under a specific Group Plan Benefit level is based on the Insured Member's ability to fall within the classification requirements imposed by the Policyholder or Plan Sponsor for each Group Plan Benefit level. Insurer is not liable for such decisions by Policyholder/Plan Sponsor. Should an Insured Member be eligible for a different Group Plan Benefit level after Date of Entry, Insurer must be informed by Policyholder or Plan Sponsor at least one (1) month prior to the proposed date for such changes to be implemented with satisfactory proof of such eligibility. If We agree to the change, We will do so in writing and the Policyholder must pay Us any additional Premium We may require. If individual contributions to the additional Premium by Insured Members are required for changes to be implemented. For avoidance of doubt, Policyholder or Plan Sponsor shall remain liable for such amounts owed by Insured Member until payment is made to Insurer. See Administration – Shortfall. For avoidance of doubt and subject to applicable Waiting Periods or exclusions under the Policy, an Employee not actively employed by the Employer shall only be eligible for Cover under the changed Group Plan Benefit level upon resuming or starting Active Employment.
APPLICABLE LAW This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of the country in which the Policy was issued.	Jurisdiction & Governing Law Any disputes or claims arising out of, or in connection with this Policy, its subject matter or formation, shall be governed by and constructed in accordance with the laws of the Hong Kong Special Administrative Region ("Hong Kong"). Unless otherwise stated under Arbitration and



	Mediation or otherwise agreed in writing between the parties, contracting parties of this Policy irrevocably submit to the exclusive jurisdiction of the Hong Kong courts.
	Language The English language version of the Policy shall be controlling in all respects and shall prevail in cases of inconsistencies with translated versions, if any.
LEGAL PROCEEDINGS No action in law or in equity shall be brought to recover on this Policy prior to the expiration of sixty days after proof of claim has been filed in accordance with the requirements, of this Policy, nor shall such action be brought at all unless brought within two years from the expiration of time within which proof of claim is required by this Policy. Any person or entity who is not a party to this Policy shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap 623 of the Laws of Hong Kong) to enforce any terms of this Policy.	Limitation Period for Bringing Action No action at law or in equity shall be brought to recover on this Policy: - prior to the expiration of sixty (60) days after proof of claim/ loss has been filed in accordance with the requirements of this Policy; - after two (2) years from the expiration of the time within which proof of claim/ loss is required by this Policy; or - after the Company rejects liability for any claim and no action was submitted within twelve (12) months from the date of such rejection to the Hong Kong Courts for adjudication. Any action falling within (b) – (c) shall be deemed to have been irrevocably abandoned and shall not be recoverable.
	Mediation Any difference in respect of a Physician's medical opinion in connection with the treatment of an Accident or Sickness shall be settled between two medical experts appointed in writing by the parties to the dispute. Any difference of opinion between the two medical experts shall be referred to a mediator who shall be appointed in writing by the two medical experts at the outset ("Appointed Mediator"). The Appointed Mediator shall be registered under the Insurance Complaints Bureau (ICB) List of Mediators and/or has obtained a certificate on healthcare mediation. Should the two medical experts fail to agree despite the mediation by the Appointed Mediator, the decision of the Appointed Mediator shall be final and binding.
MISSTATEMENT - If the age or date of birth or other relevant facts relating to a Member shall be found to have been misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this Policy, the true age and facts shall be used in determining whether insurance is in force under the terms of this Policy and the benefits payable therefrom, and an equitable adjustment of premiums shall be made. - Where a misstatement of age or other relevant facts has caused a Member to be insured hereunder when he is otherwise ineligible for insurance or where such statement has caused a Member to remain insured when he would otherwise be disqualified for further insurance in accordance with the terms and limitations of this Policy, his insurance shall be void and there shall be a return of premium paid in respect	Misrepresentation/ Fraud/ Non-Disclosure Notwithstanding other terms and conditions, if information or declaration of the Policyholder, Plan Sponsor, or Insured Member is untrue in any respect, or if any material fact affecting the risk are not disclosed or incorrectly stated herein or omitted therefrom, or if this Policy, or any renewal thereof shall have been obtained through any misstatement, misrepresentation or nondisclosure or if any claim shall in any respect be false, exaggerated, or fraudulent or if fraudulent means, statements or devices are used by the Insured Member or anyone acting on his/her behalf to obtain Benefits hereunder, then the Policy shall be cancelled and voided immediately and all benefits and premiums will be forfeited. Insurer's discretion to cancel and void the



of the Member, provided always that when there is fraud on the part of the Policyholder or insured Member, no premiums paid are to be returned.	Policy for all Insured Members or for one or more Insured Members .
	Overall Limits Unless otherwise specified, the total aggregate and overall annual limits of all Benefits that may be claimed overall and/or in any one Policy Year per Insured Member is stated in the Schedule . For avoidance of doubt, limits specific to an Insured Member's Coverage under the chosen Group Plan shall be stated in the Schedule . In no event will Coverage exceed the maximum Benefits limits stated.
	Payment of Claims All Benefits under the Policy shall be payable to the Insured Member unless otherwise specified in the Policy . For avoidance of doubt, We are not obliged to pay ongoing or subsequent costs of continuing, or similar, treatments, even where We have previously paid claims for such type and/or similar type of treatment.
CLAIMS PROCEDURE 1. Notice of any hospital confinement or operation on which a claim may be based must be submitted to the Company within one month after discharge from hospital. 2. Notice given by or on behalf of the claimant to the Company with particulars sufficient to identify the insured Member shall deem to be notice to the Company. Failure to furnish notice within the time provided in the Policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible. 3. Affirmative proof of loss on which claim may be based must be furnished to the Company not later than three months after the date of such loss. 4. All benefits that pertain to any insured Member will be paid by cheque/auto-pay to the order of the Policyholder unless the Policyholder requests otherwise, or the company, in its discretion, consider it preferable to make the payment in another manner. 5. Outpatient medical claim should be submitted within three months together with original receipts and itemized bills with diagnosis certified by attending physician.	Proof of Claim To claim indemnity or reimbursement, the Insured Member must, amongst other requirements under this Policy , be able to produce original receipts for expenses incurred that are covered under this Policy as Benefits . A completed claim form with all original proof of loss documents such as supporting invoices and receipts signed by the treating Physician must be submitted to the Insurer within ninety (90) days from the first date of treatment for which the claim is made. Failure to claim within the time required shall invalidate the claim. Photocopies are not acceptable. We may require the submission at the expense of the claimant of such information, certificates, evidence, medical reports and other data or materials, reasonably required in further support of the claim. Unless otherwise stated, the applicable currency under this Policy shall be HKD (HK\$). Any successful claim for reimbursement of expenses made by an Insured Member in another currency shall be converted to HKD at the rate of exchange quoted on www.oanda.com on the date the Insured Member received treatment. We may appoint independent third-party administrators or service providers to settle claims on Our behalf. All rights reserved by Us in respect of claim procedure equally apply to such third parties acting on Our behalf. If Insured Member makes a claim which is any way dishonest, We reserve the right not to pay any Benefits , or if We have already paid before we discover the dishonesty, We reserve the right to recover those
CLAIMS REIMBURSEMENT Any claim for reimbursement of expenses made by an insured Member in any foreign currency shall be converted to the policy currency. The exchange rate will be according to the Company's prevailing average monthly exchange rates adopted from its banker at the time of the payment of such claim.	



	payments from Policyholder, Plan Sponsor or Insured Member and/or terminate, rescind or void the Policy as appropriate. We are not obliged to pay the ongoing or subsequent costs of continuing, or similar, treatments, even where We have previously paid for this type of or similar treatment.
	Reasonable Care The Policyholder, Plan Sponsor or Insured Member should act in a prudent manner and exercise reasonable care to prevent Accidents, injuries or illnesses and to mitigate any damage or loss. Compensation for any Benefit shall not be payable unless the Insured Member as soon as possible after sustaining Bodily Injury, seek and follow proper medical advice from a Physician. Failure to follow proper medical treatment or advice may result in Us reducing or suspending Our liability under the Policy to the extent to which We have suffered any prejudice due to such failure.
RELOCATION Any Premium paid will not be refundable if the cancellation of a Policy coverage for an Insured Member was due to relocation to a Sanctioned Country.	Relocation Any Premium paid will not be refundable if the cancellation of coverage for an Insured Member was due to relocation to a Sanctioned Country.
RENEWAL This Policy is issued for a term of one year and may be renewed from year to year for a further term of one year subject to the consent of the Company at such premium rates as may be determined by the Company. NON REFUND OF PREMIUM The Company shall make no pro-rata premium refund if the Policy is cancelled by the Policyholder in the midst of a Policy Year. PREMIUM CALCULATION During the period of one year from the Effective Date the premium for insurance under this Policy shall be based upon the premium rates shown in the Benefit Schedule. The Company shall have the right to change the rate at which premium shall be calculated, (1) on any Policy anniversary, and (2) on any premium due date provided the rate that is then being charged has been in effect for at least twelve (12) months and provided further that the Company notifies the Policyholder at least thirty-one (31) days in advance of such premium due date. Premium adjustments, if any, shall be made effective on the first day of the Policy month coinciding with or immediately following the effective date of enrolment, or termination of any insured Member, premium adjustments involving return of unearned premiums to the Policyholder shall be limited to the period of twelve months immediately preceding the date of receipt by the Company of evidence that such adjustment should be made.	Renewal & Cancellation Subject to due observance and fulfillment of the terms, conditions and exclusions of this Policy, and written approval by Company of renewals, the Group Plan is an annual contract which may be renewed each year on the Due Date. Company shall provide a notice, at least thirty (30) days prior to Due Date, that the Group Plan shall be renewed on the Due Date, subject to the Policy terms and conditions in force at the time of each renewal and any variations as may be set out in writing by the Insurer. Renewal Premium will increase (such as, but not limited to, if Insured Members enters a new Age as classified in the premium table shown in the then current Plan brochure) or Premiums may be changed as determined by the Insurer based on the Group Plan's pool pricing and other considerations on the date of renewal. Application to vary the terms of Coverage may only be made prior to the Due Date by providing the Company not less than thirty (30) days prior notice in writing. Unless there was full disclosure by Insured Member, Plan Sponsor and/or Policyholder and acceptance in writing by Insurer, higher classes of Benefits shall not be applicable. Cover will cease at the first Due Date following the 70th birthday of the Insured Member. Company shall give the Policyholder at least thirty (30) days notice of its intent to discontinue and/or not renew the Group Plan PROVIDED THAT Company was made aware by Policyholder or Plan Sponsor of changes in enrollment under the Group Plan at least thirty (30) days



	prior to the Due Date, otherwise Company may give immediate notice of intent. No refunds if the then current Policy Year commenced unless Policyholder is in liquidation.
	Rights of Beneficiary & Assignment Consent of the Beneficiary shall not be requisite to surrender or for assignment of this Policy, or to change Beneficiary, or to make any other changes in this Policy. No Beneficiary of this Policy shall be entitled to any payment under this Policy except for the Benefit payable in respect of death. Additionally, it is hereby understood and agreed that any sums payable in respect of death, once paid to the Beneficiary whose receipt shall be a full and final discharge of the Company obligations. If no Beneficiary is designated, or the Beneficiary, or one of the Beneficiary is not living at the time of payment, We shall pay the total death benefit amount to the Estate or the Policyholder, whose receipt shall be a full and final discharge of Our obligations.
	Set Off Any amount that an Insured Member, Plan Sponsor and/or Policyholder may owe to Insurer under this Policy or otherwise, whether it is liquidated, is actual or contingent, such amounts owe may be set off by Insurer during any Policy Year, or Insurer may on demand request Policyholder, Plan Sponsor or Insured Member, whichever is applicable, to pay the amount owed. Any exercise by Insurer of its rights under this clause will not prejudice any other right or remedy available to it, whether under this Policy or otherwise. For avoidance of doubt, Policyholder shall remain liable for such amounts owed by Insured Member until payment is made to Insurer. Policyholder may direct Plan Sponsor to act on its behalf in respect of obligations under this section and breaches by Plan Sponsor shall be consider breaches by the Policyholder.
	Shortfall Policyholder agrees to reimburse Us in full for any Shortfall within thirty-one (31) days of receipt of a Shortfall written notice from Us ("Shortfall Payment Period"). Without prejudice to other rights and remedies, if the Shortfall is not settled within the Shortfall Payment Period, We may, at Our discretion: - charge the Policyholder interest on such Shortfall from date of written notice until date of payment; - terminate coverage in respect of that Insured Member or the entire Policy; - set off any amounts in accordance with the Set Off section of this Policy. Any delay or non-action by Us in respect of the above shall not constitute a waiver of Our rights and remedies. Policyholder may direct Plan Sponsor to act on its behalf



	in respect of obligations under this section and breaches by Plan Sponsor shall be consider breaches by the Policyholder .
	Subrogation We shall have all rights, and such rights shall be assigned to us where applicable, to proceed at Our own expense in the name of the Policyholder and/or the Insured Member against any third parties who may be responsible for any occurrence giving rise to a claim under this Policy and any amount so recovered shall belong to Us .
	Third Party Rights Any person or entity who is not a party to the Master Policy shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap 623 of the Laws of Hong Kong) to enforce any terms of the Master Policy or this Policy .
	Waiver No delay or omission by Us in exercising any right, power or privilege hereunder shall operate to impair such right, power or privilege or be construed as a waiver thereof and any single or partial exercise of any right, power, privilege shall not in any circumstances preclude any other or further exercise thereof or the exercise of any other right, power or privilege.



Definition

Previous Provision	Existing Provision
"Policy" shall mean this agreement, any riders or endorsements therein, any amendments thereto signed by the Company, the application attached thereto of the Policyholder, and the individual enrolment forms which together constitute the entire contract between the parties.	Master Policy Shall mean the full set of documents that forms the binding contractual agreement between Us and the Policyholder. These documents include but are not limited to the Policy, application and enrollment forms, the group formation form, statement of Insured Members, the Schedule, Endorsement(s), member handbooks, and any other supporting or relevant documentation
"Member" shall mean any person over 16 and under 65 years of age (last birthday) employed by the Policyholder in Hong Kong as a regular full-time active employee.	Insured Member(s) Shall mean the Employee(s) or Dependent(s), which meets all the criteria specified for Cover and eligibility under the Policy, who has completed or whose name is included on an application or enrolment form, is stated in the Schedule or Statement of Insured Members as entitled to Benefits under a specific Group Plan and with respect to whom Premium has been paid or agreed to be paid by the Policyholder and for whom Date of Entry has been confirmed by Us, and added to the Statement of Insured Member. They are person that is legally entitled to claim under the Policy subject always to this Policy's terms and conditions but is not a contracting party of the Master Policy
"Dependent" shall be construed to include only each child of an insured Member provided such child is at least two weeks old and is under nineteen years of age and unmarried or up to aged 23 if the child is a full-time student and unmarried or the legal spouse of an insured Member aged below 65.	Dependent(s) Shall mean the Spouse of an Employee (excluding those legally separated) and/or Dependent Children
"Active Work or Actively at Work" shall mean performing normal duties of one's occupation or being available to perform such duties on a permanent full time basis.	Active Employment Shall mean an Employee will be considered in active employment if performing in the customary manner all the regular duties of his or her full-time continuous employment on a daily basis, which shall be confirmed by the Employer to Insurer during initial application and renewals for Cover
"Effective Date" shall mean the date from which the coverage under this Policy becomes effective.	Commencement/ Commencement Date Shall mean dates shown on Schedules, for the overall Group Plan or a particular Insured Member, whichever is applicable, and which sets out when Policy first came into effect, the current Policy Year, subsequent dates of renewals, or first date a Benefit is added to the Policy
"Registered Medical Practitioner" shall mean a registered and legally qualified practitioner of western medicine recognised by the law of the country where treatment is provided and who, in rendering such medical or surgical treatment, is practicing within the scope of his licensing and training. A Registered Medical Practitioner shall not include the insured Member or the insured Member's immediate family.	Physician(s) Shall mean a legally qualified medical practitioner, surgeon or Specialist of western medicine who is registered and licensed to lawfully render medical and/or surgical services under the laws of the country and geographical area in which they practice but excludes the Policyholder, Plan Sponsor, an insurance intermediary, an employer, an employee, a Family Member, or business



	partner of the Policyholder, Plan Sponsor and/or the Insured Member. Physician does not include allied health professionals or paramedical such as but not limited to podiatrist, psychologist, optometrist, physiotherapist and chiropractor, except as endorsed in the Schedule
"Hospital" shall mean any lawfully operating public or private hospital.	Hospital Shall mean a legally constituted establishment operating pursuant to the laws of the country in which it is based, and registered as a hospital with appropriate license (if licensing is required in the state or government jurisdiction), and meets the following requirements: a) operates primarily for the care and treatment of sick, ailing or injured persons; b) provides a 24-hour a day nursing service by Registered Nurses under medical supervision of a Physician; c) always has a staff of one (1) or more Physician(s) available; d) maintains organized facilities for the medical diagnosis and treatment, and provides (where appropriate) facilities for major surgery within the confines of the establishment or in facilities controlled by the establishment; and is not primarily an outpatient medical center, day procedure center, clinic, nursing, rest or convalescent home, psychiatric institution, community Hospital, rehabilitation institution, a place for alcoholics or drug addicts or similar establishment
"Home Country" shall mean the country of which the Insured Member holds a passport. Where the Insured Member holds more than one passport, the Home Country will be taken to mean the country which the Insured Member has declared to the Company. Where Dependants are included under the Policy, the Home Country for Dependants will be the Home Country declared to the Company for this Policy.	Home Country/ Nationality Shall mean the country of which the Insured Member holds a passport. Where the Insured Member holds more than one passport, the Home Country will be taken to mean the country which the Insured Member has declared to Us.
"Country of Residence" shall mean Hong Kong unless otherwise defined during initial application, renewals, in the Schedule or endorsement(s) as the country in which Insured Members is collectively living at commencement date of the Policy, or an Insured Member is usually living at date of entry or intends to live for most of a Policy Year, being at least one hundred and eighty-five (185) days or more. For avoidance of doubt, Policyholder is responsible for ensuring the country each Insured Member is living in for most of each Policy Year is in accordance with the eligibility of this Policy.	Country of Residence Shall mean Hong Kong, unless otherwise defined during initial application, renewals, in the Schedule, Statement of Insured Members or Endorsement(s) as the country in which Insured Members under a Group Plan is collectively living at Commencement Date of the Policy, or an Insured Member is usually living at Date of Entry or Commencement Date of Cover or intends to live for most of a Policy Year, being at least one hundred and eighty-five (185) days or more. For avoidance of doubt, Plan Sponsor and/or Policyholder is responsible for ensuring the country each Insured Member is living in for most of each Policy Year is in accordance with the Eligibility section of this Policy
"Any One Disability" shall mean all disabilities arising from the same cause including any and all complications therefrom as well as concurrent disabilities from different	Any One Disability/ per disability Shall mean all disabilities/ medical conditions arising from the same cause including any and all complications



causes during the same Hospital confinement or confinements, except that after 90 days following the latest discharge from hospital or the latest outpatient treatment, any subsequent disability from the same cause shall be considered as a new disability.	therefrom as well as concurrent disabilities/ medical conditions from different causes, except that after ninety (90) days following the latest treatment, any subsequent disability/ medical condition from the same cause shall be considered as a new disability/ medical condition
“Sanctioned Countries” shall mean Countries as listed in the relevant policies of the Insured from time to time which prohibits the Insurer from any activities involving these countries and which may expose the Company to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the EU, UK or USA, CH, SG or any jurisdiction applicable to the Company.”	Sanctioned Countries/ Individual Shall mean Countries and/or individuals as listed in applicable laws or relevant policies of the Insurer from time to time which prohibits any activities involving these countries and/or individuals and which may expose Insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of Hong Kong, the EU, UK, USA, CH, SG or any jurisdiction applicable to Insurer

Other definitions that are not included in this list, are newly added in the new provision for clearer clarification.



Plan Benefits – Hospitalization & Surgical Benefits

Previous Provision	Existing Provision
PART I- EXTENT OF BENEFITS 1. Benefits listed are only applicable if respective coverage is specified in the current and valid Benefit Schedule and subsequent amendment(s) issued by the Company to the Policy. 2. Benefits applicable are without geographical limitation subject to the limitation and exclusions specified hereunder.	Benefits listed below are provided on a worldwide basis for Any One Disability and only applicable if it is specified in the Schedule as part of the Insured Member's chosen Group Plan Coverage and recommended in writing by a Physician, subject always to all Policy terms, conditions and exclusions such as but not limited to any applicable Waiting Periods, Benefit limits, Direct Settlement, Deductibles, Copayments and subsequent amendment(s) issued by the Insurer to the Policy. Benefits have been specifically tailored by Policyholder and/or Plan Sponsor for each Insured Member based on certain considerations such as but not limited to the Group Plan classification of the Insured Member provided to Insurer. See Administration – Group Plan Benefit Levels for further details. Check Schedule for details on limits relating to covered procedures/treatments conducted over the course of a Policy Year. In no event shall reimbursements exceed the stated maximum limits that may be applicable such as but not limited to daily limits, per Benefit, per disability or per Policy Year limits and/or lifetime limits. Classification All medical treatments and procedures must be recommended in writing as Medically Necessary by a Physician and the surgical procedures can be found under the Surgical Schedule of Fees attached to this Policy according to the relative degree of difficulty involved: a) Complex b) Major c) Intermediate d) Minor Thereafter, Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred herein for those treatments and procedures in accordance with the classification under Surgical Schedule of Fees. If a particular treatment or procedure is not stated under the Surgical Schedule of Fees and is not excluded by the Policy, Company shall determine the classification. For avoidance of doubt, an operation of equivalent gravity and severity may be used as basis, and the Company reserves the right to determine this with reference to information issued by a Hospital authority or publication recognized by the local government, relevant authorities and medical association in the locality where the treatment or procedure is to be rendered.
PART II - BENEFITS	Eligible Expenses



Each hospital confinement must be for a minimum period of six (6) consecutive hours before any benefits hereunder are payable, except that no minimum period of hospital confinement is required if such confinement is in connection with a surgical operation, accidental emergency treatment or if the Hospital makes a charge for Room and Board.	Unless otherwise stated under an Insured Member's Coverage, all Planned Treatments coverable under Plan Benefit – Hospitalization & Surgical Benefits are subject to a Copayment. The amount payable by an Insured Member as Copayment for any one Policy Year is stated under the Schedule. For avoidance of doubt, Insurer's reimbursement of eligible expenses for covered medical treatments and procedures rendered with respect to the Bodily Injury or Sickness shall be the remaining sum of such eligible expenses after deducting applicable Copayments and/or Deductibles and up to the Benefit limits specified under the Schedule. If Insured Member becomes entitled to a refund or reimbursement of all or part of eligible expenses from any other source, We will only be liable for the additional amount not recoverable from such other source or insurance. For more information see Administration – Coordination of Benefits / Other Insurance.
Room & Board Charges A hospitalization benefit shall be paid when, upon recommendation of a Registered Medical Practitioner, an insured Member is registered as a bed patient in a Hospital. The amount of the said benefit shall be equal to the actual charges made by the Hospital during the Insured Member's confinement; but in no event shall the benefit exceed for any one day the Rate of Daily Benefit set forth in the Benefit Schedule.	Room & Board (RNB) Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for room and board if an Insured Member is admitted as Inpatient in the Hospital for covered treatments.
Hospital Special Services If while this coverage is in force, in addition to the Daily Benefit under Room & Board Charges, Hospital Special Services shall be paid during the time that an insured Member is registered as a bed patient in a Hospital and is furnished or rendered any Hospital Special Services which is regularly given by the Hospital for treatment of that disability. The amount of said benefit shall be equal to the actual charges made by the Hospital during the insured Member's confinement; but in no event shall the benefit exceed the maximum Hospital Special Services benefit set forth in the Benefit Schedule. The Hospital Special Services covered under this Policy include the following: - Drugs and Medicines consumed on premises; - Dressing, Ordinary Splints and Plaster Casts; - Laboratory Examinations; - Electrocardiograms; - Basal Metabolism Tests; - Physical Therapy; - Anaesthesia and Oxygen and their administration; - X-ray Examinations; - Intravenous infusions; - Blood transfusion;	Hospital Special Services (HSS) Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred as Hospital Special Services which were deemed Medically Necessary for covered treatments whilst Insured Member was an Inpatient in the Hospital or during Day Case Treatment. Unless otherwise stated as a separate Benefit or covered under another Benefit and depending on the covered procedures and/or treatments recommended by a Physician, items of Hospital Special Services expenses may include: - Drugs and Medicines consumed on premises; - Dressing, Ordinary Splints and Plaster Casts; - Laboratory Examinations; - Electrocardiograms; - Basal Metabolism Tests; - Physical Therapy; - Anesthesia and Oxygen and their administration; - X-ray Examinations; - Renal Dialysis; - Chemotherapy for cancer treatment; - Advanced Diagnostic Imaging (MRI, CT Scan, PET Scan);



k) Ambulance Service to and/or from the Hospital	l) Intravenous infusions; m) Blood transfusion; n) Ambulance transportation services to and/or from the Hospital. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under other Benefit including Renal Dialysis, Oncology Treatments, Day Case Treatment, Day Surgery for Gastroscopy/ Colonoscopy and Day Case Treatment for Viral Warts & Skin Lesions, these charges shall be exclusively paid thereunder and no charges shall be payable under this Benefit.
Anaesthetist's Fee If while this coverage is in force, in addition to the benefits payable under Room & Board Charges and Hospital Special Services, the Company will pay to the insured an amount equal to the actual charges made by a qualified anaesthetist for the administration of anaesthesia during a surgical operation up to the maximum amount per classification / disability as shown in the Benefit Schedule. If this benefit is not listed in the Benefit Schedule, charges incurred will be payable in Hospital Special Services.	Anesthetist Fee (AF) Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred for the administration of anesthesia by a legally qualified and licensed anesthetist which were deemed Medically Necessary for covered treatments whilst Insured Member was an Inpatient in the Hospital or during Day Case Treatment. If this is not listed as a separate Benefit in the Schedule, charges incurred may be payable as an item under Hospital Special Services. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under any other Benefit including Renal Dialysis, Oncology Treatments, Day Case Treatment, Day Surgery for Gastroscopy/ Colonoscopy and Day Case Treatment for Viral Warts & Skin Lesions, these charges shall be exclusively paid thereunder and no charges shall be payable under this Benefit.
Operating Theatre If while this coverage is in force, in addition to the benefits payable under Room & Board Charges and Hospital Special Services and Anaesthetist's Fee, the Company will pay to the insured an amount equal to the actual charges made by the Hospital for the use of operating theatre up to maximum amount per classification / disability as shown in the Benefit Schedule. If this benefit is not listed in the Benefit Schedule, charges incurred will be payable in Hospital Special Services.	Operating Theatre (OT) Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred for the use of any operating theatres which were deemed Medically Necessary for covered treatments whilst Insured Member was an Inpatient in the Hospital or during Day Case Treatment. If this is not listed as a separate Benefit in the Schedule, charges incurred may be payable as an item under Hospital Special Services. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under any other Benefit including Renal Dialysis, Oncology Treatments, Day Case Treatment, Day Surgery for Gastroscopy/ Colonoscopy and Day Case Treatment for Viral Warts & Skin Lesions, these charges shall be exclusively paid thereunder and no charges shall be payable under this Benefit.
Surgical Fee If while this coverage is in force, in addition to the benefits payable under Room & Board Charges and Hospital Special Services and Anaesthetist's Fee and Operating Theatre, a surgical benefit will be paid in an amount equal to the sum actually charged for such operation, provided	Surgical Fee (SF) Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred for the surgical operations which were deemed Medically Necessary for covered treatments whilst Insured Member was an Inpatient in the Hospital or during Day



however that the maximum benefit for all surgical operations performed shall not exceed the benefit stated in the Surgical Schedule in the Benefit Schedule. If two or more procedures are performed through a single incision or for concurrent disabilities from different courses during the same Hospital confinement, reimbursement for expenses for all such procedures shall not exceed the amount indicated for the one surgical procedure performed for which the largest amount is payable. If X-ray, radium or any other radioactive substances are used for treatment in place of any cutting operation listed in the Surgical Schedule, the Company will, subject to all of the other provisions of Surgical Benefit, pay a benefit which is usual and customary for such treatment up to the amount provided by the Surgical Schedule for the replaced cutting operation.	Case Treatment. For avoidance of doubt, if two or more procedures were performed through a single incision or for concurrent disabilities from different courses during the same Hospital confinement, reimbursement of all expenses incurred shall not exceed the amount indicated under the Schedule for the surgical procedure with the largest amount payable. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under any other Benefit including Renal Dialysis, Oncology Treatments, Day Case Treatment, Day Surgery for Gastroscopy/ Colonoscopy and Day Case Treatment for Viral Warts & Skin Lesions, these charges shall be exclusively paid thereunder and no charges shall be payable under this Benefit.
In-Hospital Doctor Consultation If an Insured Member on any day of hospital confinement shall be necessarily treated by a Registered Medical Practitioner on account of accidental bodily injury or sickness, the Company will pay to the insured an amount equal to the charges made by the physician for visits made for such treatment up to the Maximum Daily Benefit for each day of such confinement as shown in the Benefit Schedule.	In-Hospital Doctor Consultation (HDC) Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred for visitations/consultations of Physician which were deemed Medically Necessary whilst Insured Member was an Inpatient in the Hospital for covered treatments.
In-Hospital Specialist Consultation If while this coverage is in force, in addition to the In-hospital Doctor's consultation benefit, a specialist consultation benefit will be paid in an amount equal to the sum charged by the specialist for in-hospital consultation up to per disability limit as shown in the Benefit Schedule. The term "Specialist" shall mean a specialist/consultant in medication who is a licensed physician or surgeon and must be referred to by a General Medical Practitioner in writing.	In-Hospital Specialist Consultation (HSP) Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred for visitations/consultations of Specialist referred by a Physician, which were deemed Medically Necessary whilst Insured Member was an Inpatient in the Hospital for covered treatments. If this Benefit is not listed as a separate Benefit in the Schedule, charges incurred may be payable as an item under In-Hospital Doctor Consultation.
Special Registered Nursing If while this coverage is in force and upon recommendation of a Registered Medical Practitioner, an insured Member incurs expenses for services rendered by a Registered Nurse in respect of nursing at home or special nursing care received in the Hospital, a nursing benefit shall be in an amount equal to the sum actually charged for such services up to the per day limit as stated in Benefit Schedule and subject to an overall maximum no. of days per disability.	Special Registered Nurse (SRN) If while this Benefit is in force and recommended by a treating Physician as Medically Necessary, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for the private nursing services of a Registered Nurse while Insured Member was an Inpatient in the Hospital, or in the Insured Member's abode.
Intensive Care Unit If while this coverage is in force, any insured Member on any day of hospital confinement shall be necessarily	Intensive Care Unit (ICU) Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for intensive care at



confined in intensive care unit on account of accidental bodily injury or sickness, the Company will pay to the insured an amount equal to the charges for such treatment subject to the maximum amount based on the terms as shown in the Benefit Schedule.	the intensive care unit which was deemed Medically Necessary whilst an Insured Member was an Inpatient in the Hospital for covered treatments. If this Benefit is not listed as a separate Benefit in the Schedule, charges incurred may be payable as an item under Room & Board.
Pre-hospitalization Treatment If while this coverage is in force, an insured Member shall be necessarily treated by the surgeon for pre-admission consultations within the number of days (as shown in the Benefit Schedule) before admit to the hospital for related sickness/surgery, the Company will pay to the insured member an amount equal to the charges made by the doctor for such treatment(s) up to the maximum amount as shown in the Benefit Schedule.	Pre Hospitalization Treatment (PREH) If while this Benefit is in force and deemed Medically Necessary, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for consultations conducted by the treating Specialist or Physician prior to an Insured Member's Day Case Treatment or Hospitalization as an Inpatient for the covered treatments.
Post Hospitalization Treatment If while this coverage is in force an insured Member shall be necessarily treated by the surgeon for stitch off and/or follow up consultations by a physician within the number of days (as shown in the Benefit Schedule) after discharge from the hospital for related sickness/surgery, the Company will pay to the insured member an amount equal to the charges made by the doctor for such treatment(s) up to the maximum amount as shown in the Benefit Schedule.	Post Hospitalization Treatment (PHT) If while this Benefit is in force and deemed Medically Necessary, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for follow-up consultations by the treating Specialist or Physician after an Insured Member's Day Case Treatment or upon Insured Member's discharge from Hospital as an Inpatient for covered treatments.
Additional Accident Treatment If while this coverage is in force, as a result of a non-occupational Accidental Bodily Injury, an insured Member shall require emergency out-patient treatment in the OutPatient Department of a Hospital or at the office of a Registered Medical Practitioner, the Company will pay the amount actually charged by the Hospital or the Office, but not to exceed the maximum Accidental Treatment benefit set forth in the Benefit Schedule.	Additional Accident Treatment (AAT) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for Emergency Day Case Treatment which was deemed Medically Necessary whilst Insured Member requires such treatment as a result of non-occupational Bodily Injury.
Daily Cash - Government Ward If while this coverage is in force, an Insured Member is confined in the general ward of any Hong Kong Government Hospitals for 24 hours or more and under professional care of a Registered Medical Practitioner other than the Insured Member, as a result of accidental injury or sickness covered by this Policy, the Company agrees to pay a daily cash benefit equivalent to the amount and up to a maximum period as specified in the Benefit Schedule. This benefit shall not be applicable should the Insured Member be confined in a room type other than the general ward or such hospitalization requires extra expenses that paid under the other items of this Policy.	Daily Cash - Government Ward (DC) If while this Benefit is in force, Insurer will pay a daily cash benefit, in respect of each day of Hospital confinement with room charges, up to the Benefit limits stated in the Schedule whilst Insured Member is admitted in a government Hospital as an Inpatient in the General Ward Room for covered treatment. This Benefit shall not be payable if the hospitalization requires extra expenses that paid under the other Benefit of this Policy.
Daily Cash for Coordination of Benefits If while this coverage is in force, the hospital income which is equivalent to the amount and up to a maximum period as specified in the Benefit Schedule shall be paid when the Company is the second payer for coordination of benefits. This benefit shall be applicable only if the	Daily Cash - Coordination of Benefits (DCB) If while this Benefit is in force, Insurer will pay a cash benefit, in respect of each day of Hospital confinement with room charges, up to the Benefit limits stated in the Schedule whilst Insured Member is admitted as an Inpatient, after the Insured Member has been reimbursed



Insured Member is under insured in other insurance companies which are the first payer of the benefits regardless of individual or group medical policies	from any other insurance or sources as first payer for the eligible expenses coverable under this Policy.
Outpatient Endoscopic Procedures Cash Allowance If while this coverage is in force, an Insured Member shall undergo one or more of the following endoscopic procedures of Gastroscopy (including Esophagogastroduodenoscopy), Colonoscopy, Cystoscopy, Arthroscopy, Colposcopy and Bronchoscopy in an outpatient facility in Hong Kong, and provided that the Surgical Fee for the procedure(s) has been paid or is payable under the Policy, the Company shall pay a cash allowance benefit up to the maximum amount as stated in the Benefit Schedule. An outpatient facility shall include a doctor's clinic and a day case centre or outpatient department of a Hospital.	Daily Cash – Day Case Endoscopic Procedure (OCA) If while this Benefit is in force, Insurer will pay a daily cash benefit up to the Benefit limits stated in the Schedule, if Insured Member undergoes one or more of the following endoscopic procedures: Gastroscopy (including Esophagogastroduodenoscopy), Colonoscopy, Cystoscopy, Arthroscopy, Colposcopy, and Bronchoscopy as covered Day Case Treatment.
Final Tribute Costs (FTC) If while this coverage is in force, upon due proof of the death of the Insured Member as a result of a covered medical condition or accident, the Company will pay to the estate of the Insured Member or to the Policyholder an amount equal to the funeral expenses up to the maximum amount as shown in the Benefit Schedule. The acknowledgement receipt of the reimbursement of the funeral expenses by the Policyholder shall be a good discharge to the Company and shall be final and conclusive evidence that such sum has been duly paid to and received by the person or persons lawfully entitled to the same and that all claims and demands whatsoever against the Company in respect thereto have been fully satisfied. Funeral expenses shall include death certificate and related documentation charges, expenses for coffin, funeral home and ceremony, cremation and burial services.	Final Tribute Cost (FTC-1) If while this Benefit is in force, upon due proof of the death of the Insured Member as a result of a covered Serious Medical Condition, Bodily Injury or Sickness, the Insurer will pay to the Beneficiary or to the Policyholder an amount equal to the funeral expenses up to the maximum Benefits stated in the Schedule. For avoidance of doubt, acknowledgement receipt of the reimbursement of the funeral expenses by the Policyholder shall be a good discharge to the Insurer and shall be final and conclusive evidence that such sum has been duly paid to and received by the person or persons lawfully entitled to the same and that all claims and demands whatsoever against the Insurer in respect thereto have been fully satisfied. See Administration – Payment of Claims. Funeral expenses shall include death certificate and related documentation charges, expenses for coffin, funeral home and ceremony, cremation and burial services.
Renal Dialysis If while this coverage is in force, the Company shall pay for the medical expenses actually incurred if the insured Member undergone regular haemodialysis or peritoneal dialysis as a result of chronic and irreversible kidney failure at the office of a Registered Medical Practitioner or daypatient in the Hospital for such treatment. In no event shall the reimbursement exceed the maximum benefits stated in the Benefit Schedule.	Renal Dialysis (RD) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member undergone regular hemodialysis or peritoneal dialysis as an Inpatient or Day Case Treatment which was deemed Medically Necessary for chronic and irreversible kidney failure. If this Benefit is not listed as a separate Benefit in the Schedule, charges incurred may be payable as an item under Hospital Special Services depending on the nature of the treatment. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under another Benefit including Hospital Special Services Benefit, these charges shall be exclusively paid under this



	Benefit and no charges shall be payable under any other Benefits such as Hospital Special Services Benefit.
Oncology Benefit If an insured Member has undergone chemotherapy or radiotherapy for cancer treatment in a physician's office or confined in a hospital for less than 24 hours for such treatment, the company shall pay this Benefit for the actual medical expenses charged by the physician and/or the hospital up to the maximum amount as shown in the Policy Schedule.	Oncology Treatment (OBH) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member undergone the following: a) Chemotherapy; b) Radiotherapy; c) Target therapy; d) Gamma knife; e) Cyberknife; f) Immunotherapy; g) Hormonal therapy; or h) Proton therapy as an Inpatient or Day Case Treatment which was deemed Medically Necessary for cancer treatment. This Benefit shall cover expenses for related supportive treatment, such as antiemetic and hematopoietic agents, monitoring procedures such as Computerized Tomography Scans (CT Scan), Positron Emission Tomography (PET), blood tests, supporting medication such as anti-nausea and anti-dizziness drugs. If this Benefit is not listed as a separate Benefit in the Schedule, charges incurred may be payable as an item under Surgical Fee or Hospital Special Services depending on the nature of the treatment. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under another Benefit including Surgical Fee or Hospital Special Services Benefit, these charges shall be exclusively paid under this Benefit and no charges shall be payable under any other Benefit such as Surgical Fee or Hospital Special Services Benefit.
Home Health Care If while this coverage is in force, a Home Health Care benefit will be payable up to the maximum per disability as stated in Benefit Schedule if an insured Member, as a result of disease, sickness or injury. a) shall be registered as a bed patient in a Hospital for not less than three (3) consecutive days, and as the result Room & Board benefits are payable on any one of those days; and b) subject to the written approval by his/her attending doctor, shall leave the Hospital and then immediately stay in a home suitable for recovery from the sickness or injury; and c) during the stay in a home, shall incur medically necessary, reasonable and customary charges for the following Home Health Care services and supplies which are approved by the Company:- I. nursing services; II. doctor's service;	Home Health Care (HHC) If while this Benefit is in force and recommended as Medically Necessary, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred towards items stated below. Insured Member must have been an Inpatient in a Hospital for at least three (3) consecutive days and was discharged from Hospital with written approval of attending Physician for home health care services and supplies to be provided at Insured Member's abode immediately upon discharge. Home health care services and supplies may include: a) Nursing services; b) Doctor's service; c) Laboratory tests limited to blood, urine and other body fluids tests, electrocardiogram, pathological machine; d) Medication and drugs; e) Dressings, sterile gloves, antiseptics, needles, syringe, sharp boxes, cotton wool, incontinence pad, mattress cover, braces, supports, splints, plaster casts and rental of durable medical equipment limited to hospital



III. laboratory tests limited to blood, urine and other body fluids tests, electrocardiogram, pathological machine; IV. medication and drugs; V. dressings, sterile gloves, antiseptics, needles, syringe, sharp boxes, cotton wool, incontinence pad, mattress cover, braces, supports, splints, plaster casts and rental of durable medical equipments limited to hospital beds, physiotherapy equipments, oxygen administration equipment and intravenous infusion equipment; VI. physiotherapy, speech and occupational therapy; VII. oxygen and its administration; VIII. blood or blood plasma and their administration; IX. ambulance service to and from the hospital.	beds, physiotherapy equipment, oxygen administration equipment and intravenous infusion equipment; f) Physiotherapy, speech and occupational therapy; g) Oxygen and its administration; h) Blood or blood plasma and their administration; i) Ambulance service to and from the Hospital. Above stated home health care services and supplies must be provided by a qualified home health care agency which was approved in writing by the Insurer.
Psychiatric Treatment If while this coverage is in force, and recommended as Medically Necessary, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member undergone psychiatric treatment by a Psychiatrist.	Psychiatric Treatment (MD1) If while this Benefit is in force, and recommended as Medically Necessary, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member undergone psychiatric treatment by a Psychiatrist as an Inpatient.
	Surgical Appliances (SS) If while this Benefit is in force and prescribed by a Physician, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for specific items and non-specific items of surgical appliances up to the Benefit limits stated in the Schedule. For specific items, the Benefit covers the following surgical appliances only which was Medically Necessary and used or implanted by the Physician during surgery except external prosthesis or appliances or corrective devices: a) Pace maker; b) Artificial cardiac valve; c) Metallic or artificial joint for joint replacement; d) Prosthetic ligaments for replacement or implantation between bones; and e) Prosthetic intervertebral disc. For appliances of stents for percutaneous transluminal coronary angioplasty and intraocular lens for cataract surgery, charges are payable as item under Hospital Special Services.
Accidental Dental Treatment In while this coverage is inforce, an Insured Member shall undergo dental treatment necessary to restore or replace sound natural teeth lost or damaged as a result of an accident in a dentist facility within 2 weeks from the event date of the accident, the Company shall pay the amount equal to the charges made for such dental treatment upto the maximum amount as stated in the Benefit Schedule.	Accidental Dental Treatment (ADT) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for dental treatment which were deemed Medically Necessary if an Insured Member undergone such treatment by a Dentist in a dental facility as a result of an Accident, to restore or replace sound natural teeth lost or damaged within fourteen (14) days from the date of Accident.



Day Confinement If while this coverage is in force, an Insured Member is confined in a Hospital as bed patient for less than six (6) hours as a result of sickness or injury and incur the following expenses: a) Room and Board; b) Surgical Fee; c) Anaesthetist's Fee; d) In-Hospital Doctor Consultation; e) Operating Theatre Fee; f) Hospital Special Services All of which will share the same definitions set out in the Insurance Schedule above, the Company shall pay the benefit as stated in the Insurance Schedule to the extent that they are reasonable and customary charges for the services provided by the Hospital during the said confinement.	Day Case Treatment (DAYC) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred during Day Case Treatments which were deemed Medically Necessary for below Benefits: a) Room and Board; b) Hospital Special Services; c) Anesthetist Fee; d) Operating Theatre; e) Surgical Fee; f) Pre Hospitalization Treatment; g) Post Hospitalization Treatment. All of which will share the same definitions as above Benefits. If this Benefit is not listed as a separate Benefit in the Schedule, charges incurred may be payable as above Benefits depending on the nature of the treatment. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under any other Benefit, these charges shall be exclusively paid under this Benefit and no charges shall be payable under any other Benefits.
Organ Transplantation The medical treatment costs incurred in respect of kidney, heart and liver transplants only up to the respective Plan sublimit as shown in the Benefit Schedule. The cost of acquisition of the organ and all costs incurred by the donor are not covered under the Master Policy.	Organ Transplantation (ACO) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges for actual expenses incurred during kidney, heart and liver transplants which were deemed Medically Necessary. The expenses of acquisition of the organ and all expenses incurred by the donor are not payable.
	Parent Accommodation Charges (PAC) If while this Benefit is in force, in addition to the Benefits payable under Room & Board Charges and Hospital Special Services, Insurer will reimburse the Usual, Reasonable and Customary Charges only for actual companion bed charges incurred in Hospital in respect of a Parent/ Guardian staying with the Insured Member, provided Insured Member is under aged thirteen (13), limited to only one Parent/ Guardian each night.
	Day Surgery For Gastroscopy/ Colonoscopy (OGCC1) If while this Benefit is in force and deemed Medically Necessary, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member undergone endoscopic procedures – Gastroscopy/ Colonoscopy during Day Case Treatment. If this Benefit is not listed as a separate Benefit in the Schedule, charges incurred may be payable as item under other Benefit depending on the nature of the treatment. For avoidance of doubt, if the charges incurred under this Benefit are covered and payable under another Benefit, these charges shall be exclusively paid under this Benefit and no charges shall be payable under any other Benefits.
Day Case Treatment for Skin Lesions	Day Case Treatment for Viral Warts & Skin Lesions (DCTFW)



Insured Member will reimburse the Usual, Reasonable and Customary Charges actually incurred as stated in the Schedule up to the Benefit limits if an insured Member underwent treatment for Skin Lesions which was deemed Medically Necessary in a Physician's office or admitted as day-patient in the hospital. For the avoidance of doubt, Skin Lesions treatments can only be payable under this benefit in all cases no matter it is undergone in an inpatient or day-patient setting.

Skin Lesions shall cover the following skin disorders:

- a) Viral Warts;
- b) Skin lesion;
- c) Seborrhoeic keratosis;
- d) Sebaceous cyst;
- e) Epidermoid Cyst;
- f) Lipoma;
- g) Benign lipomatous neoplasm;
- h) Disorder of skin and subcutaneous tissue;
- i) Cutaneous abscess, furuncle and carbuncle

If while this **Benefit** is in force, **Insurer** will reimburse the **Usual, Reasonable and Customary Charges** for actual expenses incurred for treatment if an **Insured Member** undergone procedure for skin lesions which was deemed **Medically Necessary** during **Day Case Treatments**.

Skin lesions shall cover skin disorders, including but not limited to the following:

- a) Viral warts;
- b) Skin lesion;
- c) Seborrheic keratosis;
- d) Sebaceous cyst;
- e) Epidermoid cyst;
- f) Lipoma;
- g) Benign lipomatous neoplasm;
- h) Disorder of skin and subcutaneous tissue;
- i) Cutaneous abscess, furuncle and carbuncle.

If this **Benefit** is not listed as a separate **Benefit** in the **Schedule**, charges incurred may be payable as item under other **Benefit** depending on the nature of the treatment. For avoidance of doubt, if the charges incurred under this **Benefit** are covered and payable under another **Benefit**, these charges shall be exclusively paid under this **Benefit** and no charges shall be payable under any other **Benefits**.



Add-On Group Plan Cover – Supplementary Major Medical (SMM)

Previous Provision	Existing Provision
	Supplementary Major Medical (SMM) Benefit is supplementary and only available as Optional Plan Cover to Group Plan. SMM Benefit listed below are only applicable if it is specified in the Schedule as part of the Insured Member's chosen Group Plan Coverage subject always to all Policy terms, conditions and exclusions such as but not limited to any applicable Waiting Periods, Benefit limits, Direct Settlement, Deductibles and subsequent amendment(s) issued by the Insurer to the Policy. For avoidance of doubt, if eligible expenses for Any One Disability exceeds the Schedule's stated limits for Benefit items under Plan Benefit – Hospitalization & Surgical Benefits, Insured Member must pay the relevant Deductible for additional reimbursement under a SMM Benefit. Amounts payable as Deductible are stated on the Schedule. Refer to Schedule for details on limits related to covered procedures/ treatments conducted over the course of a Policy Year. In no event shall reimbursements exceed the maximum limits stated in the Schedule. If Insured Member becomes entitled to a refund or reimbursement of all or part of SMM Benefits from any other source, We will only be liable for the additional amount not recoverable from such other source or insurance. For more information, see Administration - Coordination of Benefits / Other Insurance.
SUPPLEMENTARY MAJOR MEDICAL INSURANCE RIDER (SMM-IIDS) PART I – BENEFITS If while this coverage is in force, the benefits provided will be superimposed on the hospitalization benefits as stipulated in the Basic Hospital & Surgical Benefits. The benefits shall cover clinical surgery and hospital confinement of less than six (6) hours. The amount reimbursable will be the portion of actual, necessary and reasonable expenses incurred from medical, surgical and hospital treatment which exceed the amounts covered in the Basic Hospital & Surgical Benefits and any covered expenses specified hereunder on any day. The amount reimbursable shall be the sum obtained by multiplying the reimbursement percentage specified in the Benefit Schedule for the Supplementary Major Medical Benefit after satisfaction of the Deductible.	Supplementary Major Medical (SMM-IID) If while this SMM Benefit is in force and the Usual, Reasonable and Customary Charges incurred for covered Inpatient and/or Day Case Treatments, which were deemed Medically Necessary, exceeds the stated limits under the Schedule, Insurer may, where applicable, additionally reimburse all or part of such Usual, Reasonable and Customary Charges which exceeded the stated limits under Plan Benefit – Hospitalization & Surgical Benefits and/or any other eligible expenses specified below as covered Benefits. Covered Benefits: a) Room and Board; b) Hospital Special Services ; c) Anesthetist Fee; d) Operating Theatre; e) Surgical Fee; f) In-Hospital Doctor Consultation; g) In-Hospital Specialist Consultation; h) Intensive Care Unit;



If the confinement is in an accommodation of one level higher than as stated, the reimbursement percentage of SMM will be reduced to 50% and likewise 25% for two levels higher than as stated.

PART II – COVERED EXPENSES

1. Room and Board charges.
2. Miscellaneous hospital services and supplies including costs of blood and blood plasma.
3. Charges for services rendered by a qualified physician/surgeon.
4. Charges for services rendered by a registered nurse.
5. Diagnostic x-ray and laboratory tests done in the Hospital premises.
6. Charges for radiation therapy and physiotherapy.
7. Local use of ambulance.

i) Surgical Appliances.

Upon payment of the relevant **Deductible** for this particular **SMM Benefit**, amounts reimbursable shall be the sum obtained by multiplying the reimbursement percentage specified in the **Schedule**.

$(\text{SMM-IID eligible expenses} - \text{SMM-IID Deductible}) \times \text{Reimbursement percentage in Schedule}$
= Amounts reimbursable under SMM-IID

For avoidance of doubt, if **Insured Member** is charged Room & Board during covered treatments and is confined in a room type:

- one (1) level higher than room type shown in the **Schedule**, amounts reimbursable under SMM-IID will be further reduced by fifty percent (50%); or
- two (2) levels higher than room type shown in the **Schedule**, amounts reimbursable under SMM-IID will be further reduced by seventy-five percent (75%).

Plan Benefit	Actual Room Confined	Reduction %
General Ward Room	Semi-Private Room	50%
Semi-Private Room	Standard Private Room	50%
Standard Private Room	Non-Standard Private Room	50%
General Ward Room	Standard Private Room	75%
Semi-Private Room	Non-Standard Private Room	75%

$(\text{SMM-IID eligible expenses} - \text{SMM-IID Deductible}) \times \text{Reimbursement percentage in Schedule} \times (1 - \text{Reduction percentage})$
= Amounts reimbursable under SMM-IID

All stated **Policy** terms, conditions and exclusions for **Plan Benefits – Hospitalization & Surgical Benefits** shall also remain and be applicable to this SMM **Benefit** section.



Add-On Group Plan Cover – Outpatient Benefits

Previous Provision	Existing Provision
PART I - EXTENT OF BENEFITS The Company shall pay the expenses incurred by an insured Member for the following benefits in accordance with the Benefit Schedule.	Outpatient Benefits is supplementary and only available as Optional Plan Cover to Group Plans. Outpatient Benefits listed below are for Any One Disability and only applicable if it is specified in the Schedule as part of the Insured Member's chosen Group Plan Coverage which may include the Medically Necessary treatments, purchases, consultation, tests, examinations, check-ups provided or prescribed to the Insured Member outside of a Hospital, unless stated otherwise and subject always to all Policy terms, conditions and exclusions such as but not limited to any applicable Waiting Periods, Benefit limits, Direct Settlement, Deductibles, Copayments and subsequent amendment(s) issued by the Insurer to the Policy. All outpatient treatments/ procedures must be conducted by a Physician, Chinese Physician or Panel Provider without admission into a Hospital. Refer to Schedule for details on limits related to covered procedures/ treatments conducted over the course of a Policy Year. Unless otherwise stated in the Schedule, Insured Member is limited to one (1) visit per day per Benefit item. In no event shall reimbursements exceed the maximum limits stated in the Schedule. If Insured Member becomes entitled to a refund or reimbursement of all or part of Outpatient Benefits from any other source, We will only be liable for the additional amount not recoverable from such other source or insurance. For more information see Administration - Coordination of Benefits/ Other Insurance.
Outpatient Doctor Consultation If, on account of accident, sickness or disease contracted during the term of this Policy, the insured Member shall require treatment by a Registered Medical Practitioner, the Company will pay the actual expenses incurred which include consultation fee and medicine for such treatment and such payment shall not exceed the maximum amount stated in the Benefit Schedule per call at doctor's clinic, limiting to either one call per day up to the maximum number of visits per Policy Year.	General Outpatient Physician Services (GP) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member has undergone treatment by a general Physician or Panel Provider without admission into a Hospital. Benefit includes consultation fee and medicine fee for such treatment.
Outpatient Specialist Consultation If while this coverage is in force and as a result of bodily injury, sickness or disease, the insured Member shall require treatment by a specialist at his clinic, the Company will pay the actual expenses incurred up to the per visit limit as stated in the Benefit Schedule subject to the maximum number of visits per Policy Year. The term "Specialist" as used in this Policy shall mean a specialist/consultant in medication who is a licensed	Outpatient Specialist Services (OSP) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred, upon referral of a Physician in writing, an Insured Member has undergone treatment within six (6) calendar months from the date of written referral, by a Specialist without admission into a Hospital. Benefit includes consultation fee and medicine fee for such treatment.



physician or qualified surgeon. All charges made by such Specialist shall be subject to written recommendation made by attending General Medical Practitioner. The written recommendation shall consist of date of recommendation, patient's name and the name of the Specialist referring to. In the absence of above materials, such claim will be considered as ordinary out-patient doctor's treatment. The validity of any referral shall be valid for three months from the latest treatment of relevant diagnosis.	
Chinese Herbalist and Bonesetter If while this coverage is in force, on account of accident, sickness or disease contracted during the term of this Policy, the insured Member shall require treatment by a Chinese Herbalist and Bonesetter, the Company will pay the actual expenses incurred which include consultation fee and medicine for such treatment and such payment shall not exceed the maximum amount and subject to the maximum number of visits per Policy Year stated in the Benefit Schedule, limiting to either one visit per day. Under the new legislation of Chinese Medicine Practitioner Ordinance, any person who does not qualify for registration and listing as a Chinese Medicine Practitioner shall not be permitted to practice Chinese Medicine Treatment in Hong Kong SAR effective March 1, 2002. The Chinese Herbalist/Bonesetter benefit shall be defined as follows:- - Chinese Herbalist shall mean a registered/listed Chinese Medicine Practitioner in Hong Kong or any Chinese Medicine Practitioner who is being authorized or listed in the geographical area of his practice to render treatment. The Chinese Medicine Practitioner shall not include the insured Member or the insured Member's immediate family. - Herbal Medication shall mean herbal medications prescribed by a registered Chinese Medicine Practitioner in writing commensurate with the diagnosis being treated. - Bonesetter shall mean a Chinese medicine surgical specialist registered/listed in Hong Kong for treatment of musculoskeletal system, joint and soft tissues resulting from accident for internal or external bodily injuries. Note: Any other charges made by persons not defined above shall not be subject to reimbursement.	Chinese Herbalist and Bonesetter (CHBS) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member has undergone treatments by a Chinese Herbalist and/or Chinese Bonesetter. Benefit includes consultation fee and Chinese Herbal Medicine fee for such treatment.
Chinese Herbalist or Bonesetter or Acupuncture If while this coverage is in force, on account of accident, sickness or disease contracted during the term of this Policy, the insured Member shall require treatment by a	Chinese Herbalist, Acupuncturist and Bonesetter (CHBSA) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually



Chinese Herbalist and Bonesetter or Acupuncture, the Company will pay the actual expenses incurred which include consultation fee and medicine for such treatment and such payment shall not exceed the maximum amount and subject to the maximum number of visits per Policy Year stated in the Benefit Schedule, limiting to either one visit per day. Under the new legislation of Chinese Medicine Practitioner Ordinance, any person who does not qualify for registration and listing as a Chinese Medicine Practitioner shall not be permitted to practice Chinese Medicine Treatment in Hong Kong SAR effective March 1, 2002. The Chinese Herbalist/Bonesetter benefit shall be defined as follows:- a) Chinese Herbalist shall mean a registered/listed Chinese Medicine Practitioner in Hong Kong or any Chinese Medicine Practitioner who is being authorized or listed in the geographical area of his practice to render treatment. The Chinese Medicine Practitioner shall not include the insured Member or the insured Member's immediate family. b) Herbal Medication shall mean herbal medications prescribed by a registered Chinese Medicine Practitioner in writing commensurate with the diagnosis being treated. c) Bonesetter shall mean a Chinese medicine surgical specialist registered/listed in Hong Kong for treatment of musculoskeletal system, joint and soft tissues resulting from accident for internal or external bodily injuries. Note: Any other charges made by persons not defined above shall not be subject to reimbursement.	incurred if an Insured Member has undergone treatments by a Chinese Herbalist, Chinese Acupuncturist and/or Chinese Bonesetter. Benefit includes consultation fee and Chinese Herbal Medicine fee for such treatment.
Physiotherapy or Chiropractic Treatment If while this coverage is in force, on account of accident, sickness or disease contracted during the term of this Policy, the insured Member shall require treatment by a Physiotherapy or Chiropractic treatment upon recommendation by attending physician in writing, the Company will pay the actual expenses incurred and such payment shall not exceed the maximum amount and subject to the maximum number of visits per Policy Year stated in the Benefit Schedule, limiting to either one call per day.	Physiotherapy & Chiropractic Treatment (PNC) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred, upon referral of a Physician, in writing, an Insured Member has undergone treatment by a Physiotherapist / Chiropractor, within six (6) calendar months from the date of written referral.
Outpatient Diagnostic Laboratory Test If while this coverage is in force and upon receipt and approval of due proof that the insured Member while covered under this Policy shall have been unwell and is recommended by a Registered Medical Practitioner to undergo laboratory tests for diagnostic purposes other	Outpatient Laboratory And X-Ray Services (LAB) Unless otherwise stated as a separate Benefit or covered under another section of the Policy, if while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for the laboratory testing, such as but not limited to, radiographic blood tests, electrocardiogram, urinalysis and other laboratory



than routine medical check-ups, the Company will reimburse the actual expenses incurred for such tests up to the per Disability / Policy Year limit as stated in the Benefit Schedule. The term "Out-Patient Laboratory Tests" shall mean x-ray, blood test, electrocardiogram, urinalysis and other laboratory tests recommended by a Registered Medical Practitioner for diagnostic purposes excluding any such test which is taken by the insured Member during his confinement in hospital, or on account of bodily injury or sickness due to pregnancy including child birth or miscarriage.	tests recommended by a Physician to diagnose and treat medical conditions. Laboratory and X-Ray Services must be referred by a Physician or Specialist, in writing, undertaken within six (6) calendar months from the date of written referral.
Prescribed Medicines - outside clinic If while this coverage is in force, as a result of a written prescription by a Registered Medical Practitioner, the insured Member shall require to purchase medicine other than provided by the doctor's clinic, the Company will pay the actual expenses incurred subject to conditions as stated in the Benefit Schedule.	Prescribed Medicines – Outside Clinic (PMO) Unless otherwise covered under another section of the Policy, if while this Benefit is in force, and as a result of a written prescription by a Physician, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for the medication the Insured Member requires and which was purchased outside the Physician's clinic. The purchase of medication should be made within six (6) calendar months from the date of written prescription.
Prescribed Medicines – any source If while this coverage is in force, in addition to Outpatient Doctor Consultation or Outpatient Specialist Consultation of the Outpatient Benefit Section, the expenses of medicine or injection for covered sickness/injury will be reimbursable up to the maximum amount as stipulated in the Benefit Schedule. The term "Medicine/ Injection" shall include medicine/ injection provided by attending doctor's clinic and/or medicine purchased in drug store with doctor's prescription. - If doctor's receipt bears separated amount for consultation and medicine/injection, the reimbursement shall be payable under Outpatient Doctor Consultation and Prescribed Medicine - any source accordingly. - If doctor's receipt consists of charges of consultation and medicine/injection but with no breakdown figures, the reimbursement shall be totally made under Outpatient Doctor Consultation or Outpatient Specialist Consultation. - If doctor's receipt consists of charge of consultation only, the reimbursement shall be totally made under Outpatient Doctor Consultation or Outpatient Specialist Consultation.	Prescribed Medicine – Any Source (PMA) Unless otherwise covered under another Section of the Policy, if while this Benefit is in force, and as a result of a written prescription by a Physician, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred for the medication the Insured Member requires and which was purchased outside the Physician's clinic or at the Physician's clinic. The purchase of medication should be made within six (6) calendar months from the date of written prescription.
Hearing Test If while this coverage is in force, an insured Member incurred expenses for hearing examination, the Company will pay for the actual charges subject to maximum amount as stated in the Benefit Schedule.	Hearing Tests (HEAR) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member has undertaken hearing examinations by an audiologist and/or Physician.
Dental Treatment (Oral Examination) If while this coverage is in force, during the term of this Policy, the insured Member shall require an oral examination by a Registered Dentist, the Company will	Outpatient Dental Treatments (DENO) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member undergone oral



reimburse the actual expenses incurred for such dental treatment subject to conditions as stated in the Benefit Schedule.	examination (including scale, polish and prophylaxis) which was rendered by a Dentist or Dental Hygienist .
Routine Physical Check Up If while this coverage is in force, the insured Member undergoes a medical check up, including consultation and other laboratory tests, the Company will reimburse the actual expenses incurred for examination subject to conditions as stated in the Benefit Schedule and the medical check up consultation is performed by a Registered Medical Practitioner.	Routine Physical Check Up (EXAM) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member has undertaken a physical examination for routine medical check up, consultation or tests rendered by a Physician .
Vision Care – Exam Only Benefits will be paid for charges for vision examinations and visual aids for diagnostic purposes only as prescribed by certified optometrist. Covered Services are listed in the Insurance Schedule. Benefits for those services will not exceed the amount allowed by the Schedule for each services. In addition to General Exclusion, no Vision Care Benefit will be paid for "Sunglasses".	Optical Examination (EYEC) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member has undertaken vision examinations and vision aids for diagnostic purpose only as prescribed by certified optometrist or Physician .
Vaccination If while this coverage is in force, the Company will pay the actual expenses incurred for vaccinations and immunizations rendered by a Registered Medical Practitioner upto the limit as stated in the Benefit Schedule.	Outpatient Vaccinations (VACC) If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member has undertaken vaccinations and immunizations rendered by a Physician .
Psychiatric Treatment If while this benefit is in force, the insured Member shall require treatment by a Psychiatrist at his clinic, the Company will pay the actual expenses incurred up to the per visit limit as stated in the Benefit Schedule subject to the reimbursement percentage and maximum number of visits per Policy Year, limiting to either one visit per day.	Outpatient Psychiatric Treatment (OPSY1) Unless otherwise stated as a separate Benefit or covered under another section of the Policy , if while this Benefit is in force, and recommended by a Physician in writing, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member has undergone psychiatric treatment or consultation by a Psychiatrist in his/her office or as Day Case Treatments in the Hospital .
Psychological Counselling Benefit If the Member is treated by a Psychologist at his clinic on the account of psychiatric, psychological, mental, or behavioural conditions (excluding Alzheimer's disease, senile dementia, Parkinson's diseases or any conditions caused by or related to drug abuse or alcoholism) on an outpatient basis and such visit is recommended in writing by the attending Psychiatrist, this Benefit shall be payable under non-panel benefit only for the psychological counselling fee charged by the Psychologist for rendering psychological counselling treatment to the Member. Notwithstanding anything to the contrary contained in the general exclusions, this benefit shall also cover psychiatric, psychological, mental or behavioral conditions arising from Congenital Conditions and maternity conditions (including its complications) but all	Psychological Counselling Benefit (PSYCC) If while this Benefit is in force and recommended by a Physician in writing, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member is treated by a Psychologist on the account of psychiatric, psychological, mental, or behavioral conditions (excluding Alzheimer's disease, senile dementia, Parkinson's diseases or any conditions caused by or related to drug abuse or alcoholism) in Clinic or as Day Case Treatments in the Hospital . Notwithstanding anything to the contrary contained in the general exclusions, this Benefit shall also Cover psychiatric, psychological, mental or behavioral conditions arising from Congenital Conditions and maternity conditions (including its complications), but all conditions caused by or related to drug abuse and alcoholism are expressly excluded.



conditions caused by or related to drug abuse and alcoholism are expressly excluded.



Add-On Group Plan Cover – Dental Benefit

Previous Provision	Existing Provision
	Dental Benefit is supplementary and only available as Optional Plan Cover to Group Plans. Dental Benefits listed below are for Any One Disability and only applicable if it is specified in the Schedule as part of the Insured Member's chosen Group Plan coverage subject always to all Policy terms, conditions and exclusions such as but not limited to any applicable Waiting Periods, Benefit limits, Direct Settlement, Deductions, Copayments and subsequent amendment(s) issued by the Insurer to the Policy. Other than scaling and polishing, all dental procedures/ treatments must be conducted by a Dentist in a licensed dental facility. Refer to Schedule for details on what types of procedures/ treatments may be covered over the course of a Policy Year including its limits. Unless otherwise stated in the Schedule, Insured Member is limited to one (1) visit per day per Benefit item. In no event shall reimbursements exceed the maximum daily, annual and/or overall limits stated in the Schedule. If Insured Member becomes entitled to a refund or reimbursement of all or part of Dental Benefit from any other source, We will only be liable for the additional amount not recoverable from such other source or insurance. For more information see Administration - Coordination of Benefits / Other Insurance.
PART I - COVERED EXPENSES Benefits listed are only applicable if respective coverage is specified in the current and valid Benefit Schedule and subsequent amendment(s) issued by the Company to the Policy. 1. Emergency treatment of dental pain (Palliative) 2. Dental x-rays. 3. Extraction of teeth including postoperative treatments. <i>(Excluding Wisdom Tooth extraction, unless otherwise stated in the Benefit Schedule)</i> 4. Fillings restoration of teeth consisting of silver amalgam, silicate, plastic & composite. 5. Medication/Drugs. 6. Impaction. 7. Root Canal Treatment/Crowning. 8. Oral Examination (Including Scale & Polish & Prophylaxis).	Covered Dental Benefits If while this Benefit is in force, Insurer will reimburse the Usual, Reasonable and Customary Charges actually incurred if an Insured Member undergone specific dental treatments as listed under the Schedule.
PART II - EXCLUSIONS AND LIMITATIONS 1. Charges for treatment made by a person other than a legally qualified dentist. 2. Conditions arising out of congenital dental defects or diseases.	Exclusions For avoidance of doubt, Insurer shall not be liable for: 1. treatments by a person other than a Dentist (except oral examination/ polishing performed by a Dental Hygienist) 2. Conditions arising out of Congenital Conditions.



3. Dental cosmetics including personalization or characterization of dentures. 4. Charges as a result of the member engaging in racing (except foot racing), climbing, winter sports, motor-cycling, hunting, polo, football, aviation or aeronautics (other than travelling as a passenger in a licensed aircraft operated by a recognized airline), or deliberately exposing himself to unnecessary danger. 5. All other dental procedures not mentioned under the Benefit Schedule are excluded.	3. Wisdom tooth extraction. 4. Dental cosmetics and related procedures beyond what are Medically Necessary, including but not limited to bleaching and veneers. 5. All other dental procedures not mentioned under the Covered Dental Expenses.
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Add-On Group Plan Cover – Maternity Benefit

Previous Provision	Existing Provision
PART I - BENEFITS Upon receipt by the Company of due proof that a female employee or a dependent wife of a male employee, while insured under this Policy, has been confined for reasons of maternity, the Company shall pay in lieu of all other benefits payable under the Policy, the Maternity Benefits upto the maximum amount per type of procedure as shown in the Benefit Schedule :-	Maternity Benefit is supplementary and only available as Optional Plan Cover to Group Plans. Maternity Benefits listed below are for Any One Disability and only applicable if it is specified in the Schedule as part of the Insured Member's chosen Group Plan Coverage subject always to all Policy terms, conditions and exclusions such as but not limited to any applicable Waiting Periods, Benefit limits, Direct Settlement, Deductions, Copayments and subsequent amendment(s) issued by the Insurer to the Policy. Check Schedule for details on limits related to covered procedures/ treatments conducted over the course of a Policy Year. In no event shall reimbursements exceed the maximum daily, annual and/or overall limits stated in the Schedule. If Insured Member becomes entitled to a refund or reimbursement of all or part of Maternity Benefit from any other source, We will only be liable for the additional amount not recoverable from such other source or insurance. For more information see Administration - Coordination of Benefits / Other Insurance.
Where the Insured female employee or a dependent wife of a male employee is confined in a hospital, the maternity benefits shall be equal to the actual charges made by the hospital for room, board and general nursing service, any special hospital service including infant's charges for the first 7 days and any obstetrician's fees, subject, however to the limitation that the total amount of such benefit in respect of any one pregnancy shall not exceed the maximum amount indicated in the Benefit Schedule.	Enrollment Requirements In addition to the Eligibility section of the Policy, the following requirements shall be applicable: 1. Policyholder shall advise Insurer in writing to enroll all female Employees and Spouses as of: a) the effective date of this Optional Plan Cover; b) the Date of Entry of the Employee or Spouse; c) date of Marriage whichever of the above is later. 2. If written application for enrollment is not provided to Insurer within thirty-one (31) days from the date mentioned above (1), Policyholder shall ensure such written applications for enrollments are submitted to Insurer for eligible Employees and Spouses on renewal of the Group Plan Policy and within thirty-one (31) days of the renewal date confirmed by Insurer. 3. For avoidance of doubt, no withdrawal of Coverage for the eligible Employees and Spouses shall be permitted unless: a) the employment of the Employee is terminated; OR b) the Spouse ceases to meet the definition of a Dependent as defined in the Policy; OR c) upon prior written notice by Policyholder to the Insurer during renewal of the Policy. Under such circumstances, no re-enrollment of the said Employee or Spouse shall be accepted.



PART II – LIMITATION No maternity benefits shall be payable in respect of the delivery of any child unless the female employee or dependent wife shall have been continuously insured under this Rider for a minimum period of 280 days immediately preceding the delivery of the child, except in case of pre-mature termination of pregnancy, the maternity benefits shall be paid, provided such pregnancy commences after the maternity coverage of a female employee or dependent wife become effective. It is further declared and agreed that the following participation requirements shall be applied to this Maternity Benefits :- 1. All female employees and dependent wife's of male employees shall enroll for maternity coverage on: a) the Effective Date of this Rider, b) the Effective Date of employees insurance under Basic Hospital & Surgical coverage, or c) the date of marriage, whichever is later. 2. If written application for maternity coverage is not made within 31 days from the date as mentioned in (1) above the females shall have a chance to enroll for maternity coverage on each policy anniversary provided a written notice of such enrollment is filed with the Company within thirty-one (31) days after such policy anniversary. 3. For female who is already insured for maternity coverage under this Rider, no withdrawal of coverage shall be allowed unless a) the employee's employment is terminated, b) the dependent wife ceases to fulfil the conditions as a dependent and c) on each policy anniversary with prior notice to the Company. Under such circumstances, no re-enrollment of maternity coverage shall be accepted.	Limitation No maternity benefits shall be payable to an Insured Member unless, upon Date of Entry: a) conception occurs after Waiting Period of 280 days; OR b) expected delivery date or actual delivery occurs after Waiting Period of 280 days; OR c) actual delivery occurred prior to Date of Entry but Insurer accepted Coverage for the post-natal period on Continuous Transfer Terms No maternity benefits shall be payable unless the eligible Employees or Spouses shall have been continuously insured under this Optional Plan Cover for a Waiting Period of 280 days and the expected delivery date or actual delivery occurs after Waiting Period of 280 days, except: a) in the case of miscarriage or pre-mature termination of pregnancy whereas the expected delivery date occurs after Waiting Period of 280 days; OR b) in the case of actual delivery occurred prior to Date of Entry but Insurer accepted Coverage for the post-natal period on Continuous Transfer Terms
In calculating the amount of maximum benefits payable hereunder, all hospitalization and out-patient expenses during the pre-natal and post-natal period relating to the same pregnancy shall be included.	Covered Maternity Expenses If while this Benefit is in force, and upon receipt of a Physician's written report on the Insured Member's pregnancy and expected delivery date, Insurer will, in lieu of all other Benefits payable under the Policy, reimburse the Usual, Reasonable and Customary Charges actually incurred for covered maternity expenses recommended by a Physician in writing as Medically Necessary up to the maximum limits per each type of procedure as shown in the Schedule in respect of the same pregnancy. In calculating the amount payable, all Inpatient, Day Case Treatments and outpatient expenses during the pre-natal and post-natal period relating to the same pregnancy may



	be included depending on the relevant Waiting Period scenarios stated above and the Maternity Benefits shall be equal to the actual charges made by the Hospital for room, board and general nursing service, any special Hospital service including infant's charges for the first 7 days only and any obstetrician's fees. For avoidance of doubt, only expenses occurring prior to a termination of Cover shall be payable. Any expenses occurring after a Cover's termination date shall not be payable.
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Above comparison may not show the full text of existing provision, please review the complete Liberty Flex (GHS) provision specimen for full terms and conditions.

For any enquiry, please contact your designated account handler.

