



Blue Cross 藍十字

Member of BEA Group 東亞銀行集團成員

Blue Cross (Asia-Pacific) Insurance Limited

藍十字(亞太)保險有限公司

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Caring Medical Protection Plus

「摯安心精選」醫療保險計劃

Terms and Conditions

條款及細則

Please read these terms and conditions carefully.
Should you have any queries, please call our Customer Service Hotline.

請詳細閱讀此條款及細則。如有任何查詢，請致電客戶服務熱線。

Head Office & Customer Service Centre 總辦事處及客戶服務中心

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TERMS AND CONDITIONS FOR CARING MEDICAL PROTECTION PLUS

INSURING CLAUSE

The Policyholder and the Company agree that:

1. this Policy and any endorsement attached to this Policy shall be read together as one contract formed between the Policyholder and the Company;
2. the Application and declaration that have been completed and provided to the Company are the basis of this contract and are deemed to be incorporated herein;
3. all statements made by or for an Insured in the Application, and in any questionnaire or amendment shall be treated as representations and not warranties;
4. this Policy comes into force on the Policy Effective Date as specified in the Policy Schedule on the condition that the Policyholder has paid the first premium in full and the Application has been approved by the Company; and
5. the Policyholder shall ensure that every Insured is aware of the content of this Policy and duly complies with these terms and conditions insofar as they are relevant to him.

DEFINITIONS

Unless the context otherwise requires, the definitions below apply to the following words and phrases wherever they appear in these terms and conditions, the Policy Schedule, Schedule of Benefits, Schedule of Insured(s) or any endorsement attached to this Policy:

1. **"Accident"** shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured(s) and caused by violent, external and visible means.
2. **"Active Treatment"** shall mean treatment from a Physician of a disease, illness or injury that leads to recovery, or to restore the Insured to the previous state of health.
3. **"Age"** shall mean the age at the birthday nearest to the commencement date of a Period of Insurance.
4. **"Anaesthetist"** shall mean a Specialist in anaesthesiology.
5. **"Application"** shall mean the application submitted to the Company in respect of this Policy, including but not limited to the application form, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such application.
6. **"Benefit Effective Date"** shall mean, with respect to any addition or upgrade of benefits on or after the Policy Effective Date, the commencement date of such benefit, subject to the respective waiting period (if any). The respective Benefit Effective Date is specified in the Schedule of Insured(s).
7. **"Benefits Provisions"** shall mean the terms and conditions under the Benefits Provisions section of these terms and conditions.

8. **"Cancer Treatment"** shall mean Active Treatment in respect of chemotherapy, targeted therapy, radiotherapy, hormonal therapy, immunotherapy, gamma knife or cyberknife for cancer treatment.
9. **"Child"** shall mean a person who:
 - a) has attained the Age of 12 days;
 - b) has never been married;
 - c) is financially dependent upon an Insured or the Policyholder (as the case may be); and
 - d) is under the Age of 19, or is under the Age of 26 and is in full-time education at a recognised educational institution.
10. **"Chinese Medicine Practitioner"** shall mean a Chinese medicine practitioner who is a) duly registered with the Chinese Medicine Council of Hong Kong pursuant to the Chinese Medicine Ordinance (Cap. 549 of the Laws of Hong Kong) or in relation to jurisdictions outside of Hong Kong, a body of equivalent standing; and b) legally authorised for practising Chinese medicine in the locality where the treatment is provided to an Insured, but in no circumstance shall include the Insured, the Policyholder, an insurance intermediary or an employer, employee, Immediate Family Member or business partner(s) of the Policyholder and/or the Insured(s).
11. **"Chiropractor"** shall mean a person who is a) duly registered with the Chiropractors Council pursuant to the Chiropractors Registration Ordinance (Cap. 428 of the Laws of Hong Kong) or in relation to jurisdictions outside of Hong Kong, a body of equivalent standing; and b) legally authorised for practising chiropractic in the locality where the treatment is provided to an Insured, but in no circumstance shall include the Insured, the Policyholder, an insurance intermediary or an employer, employee, Immediate Family Member or business partner(s) of the Policyholder and/or the Insured(s).
12. **"Company"** shall mean Blue Cross (Asia-Pacific) Insurance Limited.
13. **"Confinement"** or **"Confined"** shall mean an admission of an Insured to a Hospital for a stay as an Inpatient for a period of no less than 6 consecutive hours upon the recommendation of a Physician in writing. For the avoidance of doubt, such recommendation must be obtained prior to the discharge of the Insured. In case where the Insured remains covered by the In-force Group Policy, the minimum 6-hour confinement period mentioned herein shall be waived.
14. **"Congenital Conditions"** shall mean any medical, physical or mental abnormalities existed at the time of birth, whether or not being manifested, diagnosed or known about at birth or any neo-natal abnormalities developed within 6 months of birth.
15. **"Credit Facilities Services"** shall mean the credit facilities services offered by the Company and more particularly set out in the Credit Facilities Services Provisions of this Policy.
16. **"Day Case Procedure"** shall mean a Medically Necessary medical or surgical procedure which is performed by a Physician in an outpatient facility. An outpatient facility may refer to a) a Physician's clinic; or b) a day case centre, a day care centre or an outpatient

department or equivalent facility established and operated by a Hospital.

17. **"Deductible"** shall mean the total deductible amount as specified in the Schedule of Benefits, which shall be the Eligible Expenses borne by the Policyholder or the Insured(s) for each Policy Year before any benefit under Section B of the Benefits Provisions becomes payable.
18. **"Developmental Conditions"** shall mean disorders which manifest signs of delay or impairment in a child's physical, mental, cognitive, motor, language, behavioural, social interaction, learning or other development when compared to the normal healthy state of person at the given age, level or stage of development.
19. **"Disability"** shall mean a Sickness or Disease arising from a pathogenic cause, or an Injury, including any and all complications therefrom. Any subsequent Sickness, Disease or Injury arising after 90 days following the latest discharge from the Hospital, latest medical consultation or laboratory test or completion of a course of Prescribed Medicines and Drugs (whichever is the latest) arising from the same pathogenic cause or Accident shall be considered as a new Disability.
20. **"Discharge"** shall mean the departure of an Insured from a Hospital, following finalisation of all formal procedures within such Hospital to end the Confinement, with no room or bed retained for the Insured at the Hospital. For the avoidance of doubt, if within the same day of the Insured's departure from the Hospital, he is immediately being transferred to another Hospital for the same Disability, such departure shall not be regarded as a Discharge.
21. **"Eligible Expenses"** shall mean Reasonable and Customary expenses for Medically Necessary treatment or services rendered with respect to a Disability. In any event, the amount shall not exceed the actual charges incurred and the relevant maximum benefit limits as specified in the Schedule of Benefits.
22. **"Eligible Public Hospital"** shall mean a public Hospital which is wholly owned or subvented by the government of Hong Kong and operated or supervised by the Hospital Authority.
23. **"First Period of Insurance"** shall mean the initial Period of Insurance before any Renewal has taken place.
24. **"Hong Kong"** shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
25. **"Hospital"** shall mean an establishment duly constituted and registered as a hospital for the care and treatment of sick and injured persons as resident patients and which:
 - a) has facilities for diagnosis and major operations;
 - b) provides 24-hour nursing services by licensed or registered nurses;
 - c) maintains a Physician; and
 - d) is not primarily a clinic, a place for alcoholics or drug addicts, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or a similar establishment.
26. **"Immediate Family Member"** shall mean a person's spouse, children, parents, brothers or sisters, grandparents, grandchildren, legal guardian or parents-in-law.
27. **"In-force Group Policy"** shall mean the group medical insurance policy underwritten and issued by the Company, which (i) covers the Insured and (ii) offers a top-up privilege permitting the Insured to subscribe to this Policy.
28. **"Injury"** shall mean any bodily damage solely caused by an Accident independent of any other causes.
29. **"Inpatient"** shall mean an Insured a) who is registered as a resident bed patient in a Hospital for receiving Medically Necessary treatment of any Sickness, Disease or Injury, which cannot be performed safely in an outpatient setting; and b) whose occupancy of a bed is evidenced by a daily room and board charges invoice issued by a Hospital.
30. **"Insured"** shall mean any person who is insured under this Policy and named as an "Insured" in the Schedule of Insured(s) or the subsequent endorsement to this Policy.
31. **"Insured Effective Date"** shall mean, with respect to any addition of Insured to this Policy on or after the Policy Effective Date, the first day on which an Insured is added to and covered by this Policy. The respective Insured Effective Date is specified in the Schedule of Insured(s).
32. **"Medically Necessary"** shall mean the need to have treatment or service for the purpose of treating a Disability in accordance with the generally accepted standards of medical practice and such treatment or service must:
 - a) require the expertise of a Qualified Medical Practitioner;
 - b) be consistent with the diagnosis and necessary for the treatment of the condition;
 - c) be rendered in accordance with professional and prudent standards of medical practice, and not be rendered primarily for the convenience or the comfort of an Insured, his family members, caretaker or attending Qualified Medical Practitioner; and
 - d) be rendered in the most cost-efficient manner and setting appropriate in the circumstances.
33. **"Period of Insurance"** shall mean the period of time during which this Policy is in force, which is specified as "Period of Insurance" in the Policy Schedule or any subsequent endorsement to this Policy.
34. **"Physician"** shall mean a medical practitioner who is a) duly registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or in relation to jurisdictions outside of Hong Kong, a body of equivalent standing; and b) legally authorised for rendering medical and surgical service as a practitioner of western medicine in the locality where the treatment is provided to an Insured, but in no circumstance shall include the Insured, the Policyholder, an insurance intermediary or an employer, employee, Immediate Family Member or business partner(s) of the Policyholder and/or the Insured(s).
35. **"Physiotherapist"** shall mean a person who is a) duly registered with the Supplementary Medical Professions Council of Hong Kong pursuant to the Supplementary

Medical Professions Ordinance (Cap. 359 of the Laws of Hong Kong) or in relation to jurisdictions outside of Hong Kong, a body of equivalent standing; and b) legally authorised for practising physiotherapy in the locality where the treatment is provided to an Insured, but in no circumstance shall include the Insured, the Policyholder, an insurance intermediary or an employer, employee, Immediate Family Member or business partner(s) of the Policyholder and/or the Insured(s).

36. **“Policy”** shall mean this “Caring Medical Protection Plus” underwritten and issued by the Company and refers to the entire contract between the Policyholder and the Company including but not limited to these terms and conditions, the Application, declaration, Policy Schedule, Schedule of Benefits, Schedule of Insured(s), and any attachments or endorsements attached thereto, if applicable.
37. **“Policy Effective Date”** shall mean the commencement date of the First Period of Insurance which is specified as “Policy Effective Date” in the Policy Schedule.
38. **“Policy Issue Date”** shall mean the issue date of this Policy which is specified as “Policy Issue Date” in the Policy Schedule.
39. **“Policy Schedule”** shall mean the “Policy Schedule” attached to this Policy which sets out the Policy details and the Period of Insurance.
40. **“Policy Year”** shall mean each 12-calendar month period commencing from the Policy Effective Date or any Renewal Date thereafter.
41. **“Policyholder”** shall mean the person or corporation who owns this Policy and is named as the “Policyholder” in the Policy Schedule or subsequent endorsement to this Policy.
42. **“Preceding Group Policy”** shall mean the group medical insurance policy underwritten and issued by the Company, which (i) ceased to cover the Insured and (ii) offered a conversion privilege permitting the Insured to subscribe to this Policy.
43. **“Pre-existing Conditions”** shall mean, in respect of an Insured, any Sickness, Disease, Injury, physical condition or physiological degradation which:
- a) has existed or has been diagnosed; or
 - b) has manifested signs or symptoms of which the Insured is aware or should have reasonably been aware,
- preceding the Policy Effective Date, Insured Effective Date or Benefit Effective Date (as the case may be).
44. **“Prescribed Medicines and Drugs”** shall mean the western medicines and drugs as prescribed by a Physician for the treatment of a Disability.
45. **“Qualified Medical Practitioner”** shall mean an Anaesthetist, Chinese Medicine Practitioner, Chiropractor, Physician, Physiotherapist, Specialist, Surgeon or any other qualified medical practitioner who is registered or licensed to render treatments or services corresponding to his professional area in the locality where the treatment is provided to an Insured.
46. **“Reasonable and Customary”** shall mean a charge for medical treatments, services or supplies, which does not exceed the general level of charges being charged by

the relevant service providers or suppliers of similar standing in the locality where the charge is incurred for similar treatments, services or supplies to individuals of the same sex and age, for a similar disease or injury. The “Reasonable and Customary” charges shall not in any event exceed the actual charges incurred. In determining whether an expense is “Reasonable and Customary”, the Company may make reference to the following (if applicable):

- a) the gazette issued by the Hong Kong government which sets out the fees for the private patient services in public hospitals in Hong Kong;
 - b) industrial treatment or service fee survey;
 - c) internal claim statistics;
 - d) extent or level of benefit insured; and/or
 - e) other pertinent source of reference in the locality where the treatments, services or supplies are provided.
47. **“Renewal”** or **“Renew”** shall mean this Policy is renewed without any lapse of time upon its expiry.
48. **“Renewal Date”** shall mean each anniversary of the Policy Effective Date upon Renewal of the Policy.
49. **“Schedule of Benefits”** shall mean the “Schedule of Benefits” attached to this Policy which sets out the benefits conditions and maximum benefits covered (as revised from time to time).
50. **“Schedule of Insured(s)”** shall mean the “Schedule of Insured(s)” attached to this Policy which sets out the particulars of each Insured, his eligible benefits and premium details under this Policy.
51. **“Sickness”** or **“Disease”** shall mean a physical or medical condition marked by a pathological deviation from the normal healthy state.
52. **“Specialist”** shall mean any Physician who is a) registered in the Specialist Register of the Medical Council of Hong Kong or in relation to jurisdictions outside of Hong Kong, a body of equivalent standing; and b) legally authorised for practising specialist care according to his qualified specialty in the locality where the treatment is provided to an Insured.
53. **“Surgeon”** shall mean a Specialist who is qualified to perform a surgical procedure or operation.

GENERAL CONDITIONS

Interpretation

- a) Throughout this Policy, where the context so admits, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.
- b) Headings are for convenience only and shall not affect the interpretation of this Policy.
- c) A time of day is a reference to the time in Hong Kong.
- d) Unless otherwise provided in any endorsement attached to this Policy, should there be any conflict between the terms and conditions in this Policy and those contained in any other material produced by the Company, these terms and conditions shall prevail.

- e) Unless otherwise defined, capitalised terms used in this Policy shall have the meanings ascribed to them under the definitions section of these terms and conditions.
- f) The Chinese version of this Policy is for reference only. Should there be any discrepancy between the English and Chinese versions, the English version of this Policy shall apply and prevail.

Addition or Deletion of Insured

The Policyholder may request for addition or deletion of any Insured at Renewal. The addition of an Insured is however subject to the approval of the Company.

Alterations

No alteration to this Policy including any endorsement thereto shall be valid unless the same is duly signed by an authorised representative of the Company.

Cancellation

The Policyholder may cancel this Policy by giving not less than 7 days’ prior written notice to the Company. The Policyholder may be entitled to a refund of part of the premium paid without interest during the First Period of Insurance if the following conditions are fulfilled: a) no claims have been made; b) there is no outstanding annual premium under this Policy; and c) all healthcare cards (if any) and coupons (if any) are not being used and are returned to the Company. Subject to other terms and conditions of this Policy, the premium will then be refunded in accordance with the table below:

Period covered from the Policy Effective Date		Premium to be refunded	
Not exceeding	2 months	75%	of the annual premium
	4 months	55%	
	6 months	35%	
	8 months	15%	
Over 8 months		Nil	

No premium will be refunded to the Policyholder after the end of the 8th month of the First Period of Insurance.

Notwithstanding anything to the contrary, any indebtedness due and owing under this Policy shall be deducted from the premium to be refunded.

Subject to other terms and conditions of this Policy, if cancellation shall take place after this Policy has been Renewed upon the expiry of the First Period of Insurance, no premium will be refunded to the Policyholder.

The Company may cease to provide cover to an Insured if any requirement under this Policy has not been complied with and in such event, the Company may refund the premium to the Policyholder on a pro-rata basis for the unexpired Period of Insurance in respect of that Insured. For the avoidance of doubt, this Policy shall remain effective for the remainder of the Period of Insurance in respect of other Insured(s).

Change of Personal Details

During the Period of Insurance, the Policyholder shall give immediate notice to the Company in respect of any change of address, name or other personal details of the Insured(s) and the Policyholder.

Change of Benefits

Any change of benefits or coverage under this Policy as requested by the Policyholder shall only take effect at Renewal or otherwise subject to the approval by the Company.

If an Insured is suffering from a Disability prior to the benefit upgrade, in respect of such Disability, the Insured shall only be entitled to the benefit level in-force at the time when the Disability commences.

With respect to an Insured of Age 50, 55, 60 or 65 at Renewal, the Policyholder may also apply for lowering the Deductible within 31 days before or after the relevant Renewal without providing the Company with further evidence of the Insured’s health status. This right can only be exercised once during the lifetime of an Insured and is irrevocable. The change shall only take effect on Renewal. (Only applicable to Section B of the Benefits Provisions)

Clerical Error

Any clerical error shall not invalidate insurance otherwise valid nor continue insurance otherwise not valid.

Currency of Payment

All the amounts payable to or by the Company shall be made in the currency specified in the Policy Schedule or in Hong Kong dollars if not specified. The currency exchange rate is solely determined by the Company with reference to the prevailing market rate.

Effective Date of Benefit Coverage

Notwithstanding anything to the contrary, the benefit coverage for an Insured under this Policy shall become effective on the later of the following:

- a) Policy Effective Date;
- b) Insured Effective Date; or
- c) Policy Issue Date of the First Period of Insurance.

If the Insured is still Confined in a Hospital on the day on which his coverage under this Policy would have otherwise become effective, the coverage for such Insured will only become effective on the next day following his discharge from such Confinement.

Governing Law

This Policy is issued in Hong Kong and shall be governed by and construed in accordance with the laws of Hong Kong.

Liability

The due observance of the terms and conditions of this Policy relating to anything to be done or not to be done or to be complied with by the Insured(s) or any other person claiming to be indemnified, and the truth of the contents of the Application, proposal and declaration shall be conditions precedent to any liability of the Company.

Minimum and Maximum Age

Anyone, who (i) is Age of 12 days or above and (ii) has not attained his 66th birthday, is eligible to enrol under this Policy, provided that coverage under the optional benefits is subject to the Age limits, if any, as set out in the Schedule of Benefits.

Misstatement of Age and/or Sex

Without prejudice to the Company's rights in the case of misrepresentation and fraud, if an Insured's Age and/or sex is misstated in the Application or in any subsequent document submitted to the Company, the Company may adjust the premium, in the past or future, on the basis of the correct Age and/or sex. No benefits shall be payable unless the adjusted premium has been paid.

Where an Insured would not have satisfied the insurability requirements on the basis of the correct Age or sex, the Company has the right to declare this Policy void or refuse to provide coverage for the Insured. If a claim has been paid in respect of an Insured who is not insurable according to the Company's requirements, any benefits obtained by the Policyholder and/or the Insured shall become immediately repayable to the Company. The liability of the Company shall be limited to refunding the premium paid for such cover without interest less any benefits paid in respect of the Insured.

Misrepresentation/Fraud

The Company has the right to declare this Policy void, demand repayment of any benefits paid and/or refuse to provide coverage under this Policy in case of any of the following events:

- a) any material fact affecting the risk is incorrectly stated in or omitted from the Application or any statement or declaration made by an Insured at the time of application or any time thereafter;
- b) this Policy or any Renewal thereof is obtained through any misrepresentation or suppression;
- c) any claim submitted is fraudulent or exaggerated; or
- d) any declaration or statement in support of the Application or any claim is untrue.

Notices to Company

All notices which the Company requires the Policyholder and/or the Insured(s) to give must be in writing, addressed to and received by the Company.

Other Insurance or Sources

The Company will only be liable for expenses in excess of any amount payable under other insurance or sources.

The Insured(s) shall declare if he is under any coverage of medical insurance plans provided by other insurance companies, and if so, provide details of such medical insurance plans upon request of the Company. In the event that an Insured is entitled to recover all or part of the expenses from the group medical insurance plans provided by other insurance companies, and/or In-force Group Policy, such expenses shall firstly be reimbursed under such group medical insurance plans, and/or the In-force Group Policy.

Ownership and Discharge under the Policy

The Company shall treat the Policyholder as the absolute owner of this Policy and shall not be bound to recognise any equitable or other interest of any other party in this Policy. The payment of any benefits hereunder to the Policyholder or Insured(s) shall be deemed to be full and effective discharge of the Company's obligations under this Policy.

Rights of Third Parties

Any person or entity who is not a party to this Policy shall have no rights under the Contract (Rights of Third Parties) Ordinance (Cap. 623 of the Laws of Hong Kong) to enforce any terms of this Policy.

Subrogation

The Company has the right to proceed at its own expense in the name of the Policyholder and/or the Insured(s) against any third party who may be responsible for any occurrence giving rise to a claim under this Policy and any amount so recovered from any third party shall belong to the Company. The Policyholder and/or the Insured(s) shall fully cooperate with the Company in the recovery action.

Suits Against Third Parties

Nothing in this Policy shall render the Company liable to indemnify, join, respond to or defend any suit for damages for any cause or reason which may be instituted by the Policyholder or the Insured(s) against any Qualified Medical Practitioner or Hospital nominated under this Policy, including without limitation to any suit for negligence, malpractice or professional misconduct or any other causes in relation to or arising out of the treatment or examination of the Insured(s) under the terms of this Policy.

Termination of Benefits

Unless renewed by the Company, the benefits under this Policy shall be terminated at the expiry of the Period of Insurance. If an Insured is Confined in a Hospital for a Disability at the time before such termination, then the benefits for that Disability under this Policy shall be terminated at the time when the Insured is discharged from the Hospital for that Disability or the Insured's benefits for that Disability or that Policy Year (as the case may be) have been exhausted, whichever is earlier.

Termination of Policy

This Policy shall automatically terminate on the earliest of the following:

- a) the last day of the Period of Insurance in which all Insureds have attained the Age of 100;
- b) when the Policyholder cancels this Policy, or this Policy is cancelled due to non-payment of premiums or any circumstance as set out in the "Misstatement of Age and/or Sex" Clause or "Misrepresentation/Fraud" Clause of the General Conditions of these terms and conditions (as the case may be); or
- c) the date of death of the last remaining life insured under this Policy.

Immediately following the termination of this Policy, insurance coverage under this Policy shall cease to be in force. No unearned premium paid for the Period of Insurance of this Policy shall be refunded, unless specified otherwise.

Territorial Scope of Cover

All benefits described in this Policy are applicable worldwide except where otherwise stated.

Waiver

No waiver by any party of any breach by any other party of any provision hereof shall be deemed to be a waiver of any subsequent breach of that or any other provision hereof and any forbearance or delay by any party in exercising any of its rights hereunder shall not be construed as a waiver thereof, and the provisions of this Policy insofar as the same

shall not have been performed as of the date of this Policy shall remain in full force and effect.

TAKE-OVER PROVISIONS

With respect to any Pre-existing Condition which was covered under the Preceding Group Policy or has been covered under the In-force Group Policy, it shall remain covered by this Policy, unless otherwise excluded.

PREMIUM PROVISIONS

Grace Period

The Company shall allow a grace period of 30 days after the premium due date for payment of each premium. This Policy will continue to be in effect during the grace period but no benefits shall be payable unless the premium is paid. If the premium remains unpaid at the expiration of the grace period, this Policy shall lapse as from the premium due date.

Payment of Premiums

The amount of premium payable is specified in the Schedule of Insured(s) or any endorsement attached to this Policy. The premium, whether paid annually or by instalment as agreed by the Company, shall be paid in advance when due before any benefits under this Policy shall be paid. Where applicable and agreed by the Company, premium for less than one full Policy Year will be calculated on a daily pro-rata basis and the number of days or visits specified as the maximum benefit limits in the Schedule of Benefits (if any) will be adjusted accordingly.

Premium due dates, Renewal Dates and Policy Years are determined with reference to the Policy Effective Date as shown in the Policy Schedule. The first premium is due on the Policy Effective Date.

RENEWAL PROVISIONS

Renewal

This Policy, subject to the payment of premiums, shall be in force for one Policy Year, from the Policy Effective Date to the day before the first anniversary of the Policy Effective Date.

At the expiry of this Policy, subject to the right of the Company to terminate this Policy as provided herein, this Policy shall be automatically Renewed for another Period of Insurance subject to the successful collection of premium at such rate or on such terms as the Company may determine depending on the benefits and the scope of coverage at the time of each Renewal.

In the event that the Policyholder disagrees with the Renewal, he may give a written notice to the Company within 30 days from the Renewal Date of this Policy ("**Cooling-off Period**") to cancel such Renewal. This Policy shall then be terminated at the expiry of the Period of Insurance immediately prior to such Renewal. The Policyholder will be entitled to a full refund of the premium paid for such Renewal, provided that (a) no claim* has been made within such Cooling-off Period and (b) all healthcare cards (if any), and coupons which are issued to the Insured(s) for such Renewal (if any), are not being used within the Cooling-off Period and are returned to the Company.

* except claims made within the Cooling-off Period seeking reimbursement of Eligible Expenses:

- a) incurred before the termination of this Policy; or
- b) arising from the Confinement of an Insured within the Cooling-off Period as a result of a Disability on conditions that (i) such Confinement occasioned by the Disability shall commence before the termination of this Policy, and (ii) the benefits of the Insured for that Disability or that Policy Year (as the case may be) have not yet been exhausted.

Subject to other terms and conditions of this Policy, the Policyholder has a guaranteed right to Renew the insurance coverage for an Insured under this Policy until the Insured reaches the Age of 100. The Company reserves the right to cease offering or suspend this plan, revise the benefits, premiums, terms and conditions, and to make changes to this Policy. If the Company decides to cease offering or suspend this plan, the Company will endeavour to transfer the Insured(s) to another available medical insurance plan.

Revision of Benefit Structure

The Company reserves the right to revise the benefit structure under this Policy. The Company will give the Policyholder a written notice of not less than 30 days prior to the expiry of the Period of Insurance specifying the revised Schedule of Benefits, the new premium and its effective date. The revised Schedule of Benefits and new premium shall take effect on the Renewal Date or any other date as specified in the notice. This Policy shall automatically terminate on the next premium due date unless the Policyholder accepts the revised terms of the written notice and pays the premium. Following each revision, the revised Schedule of Benefits shall be issued together with an endorsement (if applicable).

CLAIM PROVISIONS

Abandoned Claims

If the Company disclaims liability for any claim under this Policy, and such claim has not been referred by the Policyholder and/or Insured to arbitration as described below within 12 calendar months from the date of such disclaimer, then the claim shall for all purposes be considered abandoned and not recoverable.

Arbitration

Any disputes or differences arising out of or in connection with this Policy shall be referred to and determined by arbitration in accordance with the Arbitration Ordinance (Cap. 609 of the Laws of Hong Kong). If the parties fail to agree on the choice of an arbitrator, the Chairperson of Hong Kong International Arbitration Centre shall appoint one.

Claim Procedures

Within 90 days after clinical visit or discharge from Confinement, any related claim must be notified and submitted to the Company using the prescribed form, together with all necessary original documents. Failure to give notice or submit a claim within the specified time period will result in rejection of such claim.

The Company may require further submission of information, certificates, evidence, medical reports, data or other materials for claims assessment purpose. The Company shall not accept liability for any claim if the

required information is not received within 60 days from the issue date of any written request(s) unless otherwise agreed and approved by the Company.

The Company reserves the right to appoint a Physician to examine the Insured(s).

The Company reserves the right to deduct any unpaid premium for the relevant Period of Insurance from any amount payable by the Company under this Policy.

Payment of a claim by the Company shall not be regarded as precedent for payment of subsequent claims. If a claim, which is not payable according to the terms and conditions of this Policy, has been paid, the Policyholder and the Insured shall upon written demand of the Company be liable to reimburse the Company immediately for the amount so paid, including all ineligible or excessive expenses incurred.

No arbitration shall be commenced within the first 60 days from the date when all proof of claims as required by this Policy has been received by the Company.

BENEFITS PROVISIONS

All benefits payable to an Insured pursuant to (i) Section A – Basic Hospital and Surgical Benefits (Benefit Sub-limit) (Items 1-12); (ii) Section B – Basic Hospital and Surgical Benefits (Lump Sum); and (iii) Section C – Optional Outpatient Benefits (Items 1-7) below are subject to the maximum benefit limits, Deductible (if applicable), reimbursement percentage and benefits conditions applicable to the selected plan level and benefit level code as stated in the Schedule of Benefits, as well as the terms and conditions and exclusions of this Policy. For sections or items indicated with an asterisk (*), benefits in such sections or items are available only if the Policyholder or Insured has opted for those benefits under this Policy.

With respect to Pre-existing Conditions, the Insured shall retain coverage provided by the Preceding Group Policy under this Policy, i.e. the benefits payable to the Insured under Section A and Section B below will be equivalent to 100% of the Eligible Expenses for any claim, subject to the applicable maximum benefit limits and other terms and conditions of this Policy.

In case where the Insured remains covered by the In-force Group Policy, if he is suffering from a Disability which is a Pre-existing Condition covered under the In-force Group Policy, the benefits payable to the Insured under Section A and Section B below will be equivalent to 100% of the Eligible Expenses, subject to the applicable maximum benefit limits and other terms and conditions of this Policy. Notwithstanding the aforesaid, during the First Period of Insurance, the Company shall only pay 50% of the Eligible Expenses under Section A and Section B below, subject to the applicable maximum benefit limits and other terms and conditions of this Policy.

The Company is not liable for any claim for Disability which is a Pre-existing Condition that is not covered under the Preceding Group Policy or In-force Group Policy.

BASIC BENEFITS

A. Basic Hospital and Surgical Benefits (Benefit Sub-limit)*

If during the Period of Insurance, an Insured, as a result of a Disability, is Confined in a Hospital or treated in a clinic or the outpatient department of a Hospital as an outpatient or day patient (as the case may be), Eligible Expenses shall be payable in respect of the following:

1. **Room and Board** – hospital room charges including meals incurred by an Insured during Confinement.
 2. **Miscellaneous Hospital Charges** – charges incurred by an Insured as an Inpatient for receiving treatment of a Disability, and include, without limitation, the following as well as charges for items p & q below incurred by the Insured as an outpatient:
 - a) Road ambulance service to and/or from the Hospital;
 - b) Anaesthetic and oxygen administration;
 - c) Blood transfusion, except charges for blood and blood plasma;
 - d) Dressing and plaster casts;
 - e) Prescribed Medicines and Drugs consumed and general nursing services rendered during Confinement;
 - f) Medical and surgical appliances, implants and devices except artificial limbs and prosthetic devices;
 - g) Medical and surgical disposables and consumables used in a ward;
 - h) Films, imaging and X-ray and their interpretation;
 - i) Intravenous infusions including IV fluids;
 - j) Laboratory examinations;
 - k) Radioactive isotope, radiotherapy and related tests;
 - l) Computerised Tomography Scan (“**CT Scan**”), Magnetic Resonance Imaging (“**MRI**”) and Positron Emission Tomography Scan (“**PET Scan**”) services;
 - m) Inpatient rental of walking aids and wheelchair;
 - n) Anaesthetist’s fees and operating theatre charges (if these benefits are not separately listed in the Schedule of Benefits), and charges incurred for the consumables and equipment used during the surgical procedure or operation;
 - o) Physiotherapy;
 - p) Cancer Treatment upon the written recommendation of the attending Physician; and
 - q) Regular haemodialysis or peritoneal dialysis for the treatment of chronic and irreversible kidney failure upon the written recommendation of the attending Physician.
- Note: Charges for physiotherapy and advanced imaging services such as MRI, CT Scan and PET Scan which could have been done in an outpatient facility without the need to be admitted to a Hospital as an Inpatient are not payable under Section A.2 of the Benefits Provisions above.
3. **Surgeon’s Fees** – the fees payable for a surgical procedure or operation performed on an Insured by a Surgeon during a Confinement or Day Case Procedure

upon the written recommendation of his attending Physician.

The Surgeon's fees shall be paid subject to the maximum benefit limits specified in the Schedule of Benefits with reference to the relevant surgical category and percentage payable for such operation under the surgical schedule. If an operation performed is not included in the surgical schedule, the Company reserves the right to determine its surgical category with reference to the gazette issued by the Hong Kong government, relative value units or any other relevant publication or information such as the schedule of fees recognized by the local government, relevant authorities and medical association.

For all Inpatient surgical procedures or Day Case Procedures, this benefit also covers charges for post-surgical follow up treatments by Chinese Medicine Practitioner, including bone-setting and acupuncture, provided that the treatments are directly related to and as a result of the diagnosis necessitating such surgical procedures or operations.

4. **Anaesthetist's Fees** – charges for services rendered by an Anaesthetist in relation to a surgical procedure or operation performed on an Insured on condition that Surgeon's fees are payable under Section A.3 of the Benefits Provisions.
5. **Operating Theatre Charges** – charges for the use of an operating theatre (including but not limited to a treatment room and recovery room) during a surgical procedure or operation on condition that Surgeon's fees are payable under Section A.3 of the Benefits Provisions.

Note: For Sections A.3, A.4 and A.5 of the Benefits Provisions above, if multiple surgical operations are performed in respect of the same Disability, the Company's liability is limited to pay for the surgical procedure that pays the highest surgical benefits.

6. **Physician's Visit Fees** – charges for attending Physician's visit per day in respect of a Confinement or a Day Case Procedure (as the case may be), or charges for clinic consultation rendered by the attending Physician on the same day of the Day Case Procedure; and charges for professional services rendered by the attending Physician in respect of such Confinement or Day Case Procedure, including but not limited to escort in ambulance, monitoring and interpretation of report.

For all Confinement cases or Day Case Procedures, this benefit also includes charges for one pre-hospitalisation or pre-surgical clinic consultation (including medication and dressings) and all necessary follow up consultations (including medication and dressings) up to a maximum of 6 weeks after discharge from the Hospital or receiving the Day Case Procedure provided that the consultations are directly related to and as a result of the diagnosis necessitating such Confinement, surgical procedures or operations, and are rendered by the attending Physician or other Physicians practising in the same clinic of the Physician.

7. **Specialist's Fees** – charges for Specialist's consultation during a Confinement incurred upon the written recommendation of the attending Physician.

8. **Charges for Intensive Care** – room and board charges for the period during which an Insured is under intensive care.

9. **Registered Private Nurse's Fees** – nursing fees incurred upon the written recommendation of the attending Physician as an Inpatient.

10. **Advanced Diagnostic Imaging (Performed in Outpatient Facility)** – charges for CT Scan, MRI and PET Scan performed on an outpatient basis upon the written recommendation of the attending Physician for diagnostic purposes.

11. **Emergency Outpatient Treatment** – charges for the treatment provided by a Physician at the outpatient or emergency department of a Hospital or in his clinic within 24 hours of an Accident.

12. **Daily Hospital Cash Allowance (For Confinement in general ward of Eligible Public Hospital only)** – The Company shall pay a daily cash benefit in the amount specified in the Schedule of Benefits provided that an Insured is Confined in the general ward of an Eligible Public Hospital.

Note: For Sections A.1, A.6, A.8, A.9 and A.12 of the Benefits Provisions above, the maximum benefit limits specified in the Schedule of Benefits are limited on a daily basis irrespective of whether an Insured is suffering from one or more Disabilities.

B. Basic Hospital and Surgical Benefits (Lump Sum)*

If during the Period of Insurance, an Insured, as a result of a Disability, is Confined in a Hospital or treated in a clinic or the outpatient department of a Hospital as an outpatient or day patient (as the case may be), the Company shall reimburse the Eligible Expenses for items 1 to 11 in Section A of the Benefits Provisions. The total benefits amount reimbursed under this section is subject to the overall maximum benefit limit per Policy Year, Deductible, reimbursement percentage and benefits conditions as specified in the Schedule of Benefits.

In deciding the applicable Deductible,

- a) where a Confinement spans 2 Policy Years or more, the applicable Deductible for such Confinement shall be the Deductible of the Policy Year in which the date of admission falls and it shall be applied to the calculation of the whole amount of benefit payable with respect to such Confinement; and
- b) the Deductible applicable to the pre-hospitalisation or pre-surgical clinic consultation and follow up consultations under item 6 in Section A shall be the Deductible of the Policy Year in which the date of admission of the relevant Confinement or receiving the relevant Day Case Procedure (as the case may be) falls.

In deciding the applicable maximum benefit limit per Policy Year,

- a) where a Confinement spans 2 Policy Years or more, the benefits payable will be apportioned to the respective Policy Years on the basis of the date on which the actual itemised expenses are incurred. In the event that no breakdown of the daily expenses is available, such expenses shall be apportioned on the basis of the percentage of the actual days of Confinement in each respective Policy Year. The expenses so apportioned for the respective Policy Years shall be subject to the

- applicable maximum benefit limit per Policy Year of that Policy Year; and
- b) the maximum benefit limit per Policy Year applicable to the (i) pre-hospitalisation or pre-surgical clinic consultation under item 6 in Section A shall be the maximum benefit limit per Policy Year of the Policy Year in which the date of admission of the relevant Confinement or the date of receiving the relevant Day Case Procedure (as the case may be) falls, and (ii) follow up consultations under item 6 in Section A shall be the maximum benefit limit per Policy Year of the respective Policy Year in which the date of the consultation takes place.

Notwithstanding anything to the contrary, any 2 or more periods of Confinement shall be regarded as one and the same relevant Confinement unless the Insured's departure from a Hospital is regarded as a Discharge under this Policy.

For the avoidance of doubt, if the Insured is Confined in a room of a class higher than his entitled level of accommodation, the reimbursement percentage specified in the Schedule of Benefits will be replaced by the applicable adjustment factors set out below:

Adjustment Factors

Entitled Level of Accommodation	Actual Level of Accommodation	Reimbursement of Eligible Claims (Adjustment Factor)
Ward	Semi-Private	50%
Ward	Private	25%
Ward	Deluxe	12.5%
Semi-Private	Private	50%
Semi-Private	Deluxe	25%
Private	Deluxe	50%

The above adjustment factors only apply to the Basic Hospital and Surgical Benefits (Lump Sum) as set out in the Schedule of Benefits.

OPTIONAL BENEFITS

C. Optional Outpatient Benefits*

If during the Period of Insurance, an Insured, as a result of a Disability, is treated in a clinic or the outpatient department of a Hospital as an outpatient or day patient, Eligible Expenses shall be payable in respect of the following:

- General Practitioner's Consultation** – charges for the consultation rendered by a Physician and charges for medicine dispensed at the clinic or Hospital where the medical consultation takes place.
- Chinese Medicine Practitioner Treatment** – charges for the consultation rendered by a Chinese Medicine Practitioner for Chinese medicine treatment including bone-setting and acupuncture and charges for medicine dispensed at the clinic or Hospital where the medical consultation takes place.
- Specialist's Consultation** – charges for the consultation rendered by a Specialist upon the written recommendation of a Physician and charges for medicine dispensed at the clinic or Hospital where the medical consultation takes place.

- Prescribed Medicines and Drugs** – charges for Prescribed Medicines and Drugs purchased from a registered pharmacy other than the clinic or Hospital where the medical consultation takes place upon the written prescription of a Physician.
- Diagnostic X-rays and Laboratory Tests** – charges for X-rays; ultrasounds; advanced imaging such as MRI, CT Scan, PET Scan; electrocardiogram and laboratory tests upon the written recommendation of a Physician for diagnostic purposes.
- Physiotherapy Services** – charges for the services rendered by a Physiotherapist.
- Chiropractic Services** – charges for the services rendered by a Chiropractor.

CREDIT FACILITIES SERVICES PROVISIONS

Credit Facilities Services may be offered to the Insured subject to the final approval of the Company.

- Healthcare Card**
The usage of the healthcare card (if applicable) should at all times be subject to the terms and conditions for using the healthcare card prescribed by the Company. Such terms and conditions shall form part of this Policy and the Company may amend such terms and conditions from time to time. For an updated version of such terms and conditions, please refer to the "Blue Cross Healthcare Card – User Guide" on the Company's website at <http://www.bluecross.com.hk>.

The Policyholder and the Insured shall also be liable to the Company for any amount incurred as a result of the use of an unreturned, lost or stolen healthcare card. A handling fee will be charged for the replacement of the healthcare card.

The Company reserves the right to withhold payment of any claim if there is any outstanding charge back amount under this Policy.

The Company may withdraw or suspend the Credit Facilities Services anytime upon written notice. All matters and disputes in relation to the Credit Facilities Services will be subject to the final decision of the Company.

EXCLUSIONS

Unless specifically included in the Schedule of Benefits or any endorsement to this Policy, the Company shall not pay any claims, costs or expenses in relation to or arising out of the following:

- Any loss, costs or expenses which are recoverable under any law, medical program, or other insurance policy provided by any government, company, other insurers or any other third party.
- Treatment or test which is not Medically Necessary; or purchase of drugs which are not prescribed by a Physician.
- Confinement solely for the purpose of general checkup, diagnostic X-ray, advanced imaging, laboratory test or physiotherapy unless such test and service is recommended by a Physician for Medically Necessary

- treatment of a Disability which cannot be effectively performed at outpatient settings.
4. Treatment related to Congenital Conditions (except Hernias, Strabismus and Phimosis) or Developmental Conditions or disease of similar kind.
 5. Pre-existing Conditions, unless specified otherwise in the Benefits Provisions.
 6. Expenses directly or indirectly arising from Human Immunodeficiency Virus (“HIV”) and its related Disability, including Acquired Immune Deficiency Syndrome (“AIDS”) and/or any mutations, derivation or variations thereof, consequential upon an HIV infection occurring before the Insured Effective Date. For the purposes of this exclusion, any HIV related Disability emerging within 5 years after the Insured Effective Date will be conclusively presumed to proceed from an HIV infection occurring prior to the Insured Effective Date.
 7. Treatment or Disability directly or indirectly arising from or consequent upon:

the abuse of drugs or alcohol, self-inflicted injuries or attempted suicide, illegal activity, or driving or maneuvering machines whilst exceeding the prescribed alcohol and drug limit, or venereal and sexually transmitted disease or its sequelae.
 8. Any charges in respect of services for beautification, cosmetic purposes or non-medically related conditions; expenses for hearing tests, routine blood tests, general check-ups, prophylaxis treatment, vaccinations or inoculations, Hair Mineral Analysis (HMA), bird's nest, lingzhi, ginseng and other specialised Chinese tonic medicine, health supplements (unless approved by the Company); charges for correcting visual acuity or refractive errors including but not limited to eye refractive therapy, visual tests, fitting of spectacles or lens and any related operational procedures and services.
 9. Treatment of a dental condition and oral surgery (except treatment of an emergency and surgery arising from an Accident received by an Insured during Confinement) as well as follow up treatment of the dental condition or oral surgery whether as an inpatient or outpatient.
 10. All investigation, treatment, surgical procedure and counselling service relating to maternity conditions and its complications, including diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; and sexual dysfunction including but not limited to impotence, erectile dysfunction, pre-mature ejaculation regardless of cause.
 11. Purchase of artificial limbs, body organs and prosthetic devices including those prosthetic devices that are surgically implanted; purchase or rental of durable medical equipment or appliances including but not limited to wheelchairs, beds and furniture, airway pressure machines and masks, portable oxygen and oxygen therapy devices, dialysis machines, exercise equipment, spectacles, hearing aids, special braces, walking aids, over-the-counter drugs, air purifiers or conditioners and heat appliances for home use.
 12. Treatment directly or indirectly arising from any psychotic, psychological, or psychiatric conditions and any physiological or psychosomatic manifestations thereof.
 13. Alternative treatment including but not limited to acupressure, tianjiu, tui na, hypnotism, qigong, massage therapy, aroma therapy and such alike.
 14. Experimental, unproven and/or new medical technology or procedure not yet approved by the Company with reference to the common standard in the locality where the treatment is received.
 15. Non-medical services, including but not limited to guest meals, radio or TV rentals, telephone charges, photocopy charges, medical report charges, taxes and the like.
 16. Treatment or Disability directly or indirectly arising from war (declared or undeclared), civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection or military or usurped power; resulting from taking part in military, air force, naval and other disciplinary services.

「擊安心精選」醫療保險計劃條款及細則

保險條款

保單持有人與本公司均同意：

1. 本保單與本保單附載的任何批註須一併閱讀，並構成一份保單持有人與本公司之間的合約；
2. 已填妥並交回本公司的投保申請文件及聲明為本合約的依據，並視為已納入作本保單的一部分；
3. 受保人或代表受保人於投保申請文件及問卷或修訂內所作出之任何陳述，皆被視為申述，而非保證；
4. 在保單持有人已繳交全數首期保費及本公司已核准其投保申請文件的情況下，本保單將於保單資料頁內所列之保單生效日期起生效；及
5. 保單持有人須確保每名受保人知悉本保單之內容並恰當地遵從與其相關之條款及細則。

釋義

除非文意另有規定，本部分的定義適用於此條款及細則、保單資料頁、保障利益表、受保人附錄或本保單附載的任何批註內出現的下列詞語：

1. 「意外」指因暴力、外在及可見因素引致並且完全非受保人所能預料及控制的突發事故。
2. 「積極治療」指因疾病、病痛或傷患而由醫生進行的治療，以致令受保人康復或回復其先前的健康狀態。
3. 「年齡」指最近受保期起始日的生日當天之年齡。
4. 「麻醉科醫生」指麻醉科專科醫生。
5. 「投保申請文件」指向本公司遞交的保單申請，包括但不限於投保申請表格、投保資格證明、任何向本公司提交的文件或資料，及任何就申請保單作出的陳述和聲明。
6. 「保障生效日期」指於受保人附錄內所列的保障生效日期，並作為於保單生效日期當日或之後任何增加或提升保障之保障起始日，惟必須受限於有關保障之等候期（如有）。
7. 「保障利益條款」指列於本保單條款及細則內之保障利益條款下的條文。
8. 「癌症治療」指為治療癌症而進行屬積極治療的化學治療、標靶治療、放射治療、荷爾蒙治療、免疫治療、數碼導航刀或伽瑪刀。
9. 「兒童」指符合以下各項的人士：
 - a) 年齡已滿 12 天；
 - b) 從未結婚；
 - c) 在經濟上依賴受保人或保單持有人（按情況而定）；及
 - d) 在 19 歲以下；或在 26 歲以下並為就讀於認可教育機構的全日制學生。
10. 「中醫師」指任何 a) 根據《中醫藥條例》（香港法例第 549 章）於香港中醫藥管理委員會妥善註冊或如涉及香港以外地區，於當地擁有同等地位的機構註冊；及 b) 在受保人接受治療當地獲合法授權提供中醫治療的人士，惟在任何情況下不包括受保人、保單持有人、保險中介人或保

單持有人及 / 或受保人的僱主、僱員、直屬家庭成員或業務夥伴。

11. 「脊醫」指任何 a) 根據《脊醫註冊條例》（香港法例第 428 章）於脊醫管理局妥善註冊或如涉及香港以外地區，於當地擁有同等地位的機構註冊；及 b) 在受保人接受治療當地獲合法授權提供脊椎治療的人士，惟在任何情況下不包括受保人、保單持有人、保險中介人或保單持有人及 / 或受保人的僱主、僱員、直屬家庭成員或業務夥伴。
12. 「本公司」指藍十字（亞太）保險有限公司。
13. 「住院」或「留院」指受保人按醫生的書面建議以住院病人身分入住醫院不少於連續 6 小時。為免存疑，受保人必須在出院前取得該建議。在受保人仍然受保於生效之團體保單的情況下，此定義內所述之 6 小時最低住院期限將獲豁免。
14. 「先天性疾患」指任何於出生時已存在的醫學、身體或精神異常，不論該異常狀況是否於出生時已出現、確診或知悉，或任何於出生後 6 個月內出現的新生嬰兒異常。
15. 「免付賬醫療服務」指由本公司提供及載明於本保單之免付賬醫療服務條款內之免付賬醫療服務。
16. 「日症手術」指於門診設施由醫生進行屬醫療必要之醫療或外科程序。門診設施可包括 a) 醫生診所；或 b) 醫院設立及營運之日症中心、日間護理中心、門診部或相等之門診設施。
17. 「自付額」指載明於保障利益表內，保單持有人或受保人於每個保單年度期間，在本公司須支付本保單之保障利益條款 B 部分的保障前，必須自行承擔的符合索償資格的費用之總金額。
18. 「成長障礙狀況」指兒童於特定年齡、發育水平或階段在其身體、精神、認知、運動、語言、行為、社交、學習或其他發展上出現較正常健康狀況遲緩或受損的發育障礙。
19. 「傷病」指由同一致病原因引致的不適、疾病或受傷，包括由此而引發的一切併發症。於最近一次出院或最近一次就該傷病接受診症或化驗測試，或完成處方藥物療程後（以最遲者為準）的 90 天後由同一致病原因或意外引致的任何傷病將視為新的傷病。
20. 「出院」是指受保人在醫院內完成所有終止住院的正式手續後離開該醫院，而該醫院不再為受保人保留病房或病床。為免存疑，如受保人在離開醫院的同一天內，立刻因同一醫療狀況轉往另一間醫院，該情況將不被視為出院。
21. 「符合索償資格的費用」指因醫療必要需就傷病接受治療所招致的合理慣例費用。該費用在任何情況下不得超過實際招致的費用以及保障利益表內載明的相關最高賠償額。
22. 「合格公立醫院」指由香港政府全權擁有或資助，並由醫院管理局營運或監督的公立醫院。
23. 「首個受保期」指最初並未繼續保之受保期。
24. 「香港」指中華人民共和國香港特別行政區。
25. 「醫院」指正式註冊成立作為醫院，提供住院服務以護理及治療傷病人士的機構，同時：
 - a) 具備診斷及進行大型手術的設施；
 - b) 由持牌或註冊護士提供 24 小時看護服務；
 - c) 駐有醫生；及

- d) 並非一般診所、戒酒或戒毒中心、護理療養中心、寧養或紓緩護理中心、康復中心、護老院或同類機構。
26. 「直屬家庭成員」指某人士之配偶、子女、父母、兄弟姊妹、祖父母、孫、法定監護人或配偶的父母。
27. 「生效之團體保單」指本公司承保及簽發的團體醫療保險保單，而該保單(i)必須提供保障予受保人，並(ii)須授予該受保人投保本保單的增值權益。
28. 「受傷」指完全因意外，而非涉及任何其他原因所引致的身體損害。
29. 「住院病人」指任何受保人 a) 因不適、疾病或受傷所需，於醫院登記為佔用病床之病人以接受醫療必要之治療，而該治療不能透過門診安全地進行；以及 b) 該病床之佔用有醫院發出的每天病房及膳食費用之單據為證。
30. 「受保人」指任何受保於本保單並於受保人附錄或隨後附加於本保單的批註內列為「受保人」的人士。
31. 「受保人生效日期」指就任何於保單生效日期當日或之後新增的受保人而言，其受保於本保單的起始日。「受保人生效日期」載明於受保人附錄。
32. 「醫療必要」指需要就傷病接受治療或服務，而所進行的治療或服務按照一般公認的醫療標準乃屬必要的。被視為「醫療必要」的治療或服務必須符合以下各項：
- 需要合資格醫療人士的專業知識；
 - 與診斷一致，並對醫治該狀況而言屬必需；
 - 根據專業而審慎的醫療標準提供，而並非主要為使受保人、其家庭成員、護理人員或主診的合資格醫療人士帶來方便或感到舒適而提供；及
 - 在該情況下以最具有成本效益的方式和設定提供。
33. 「受保期」指本保單生效的期間。「受保期」載明於保單資料頁或隨後附加於本保單的批註。
34. 「醫生」指任何 a) 根據《醫生註冊條例》(香港法例第161章)於香港醫務委員會妥善註冊或如涉及香港以外地區，於當地擁有同等地位的機構註冊；及 b) 在受保人接受治療當地獲合法授權從事西方醫學的內科及/或外科診療的人士。惟在任何情況下不包括受保人、保單持有人、保險中介人或保單持有人及/或受保人的僱主、僱員、直屬家庭成員或業務夥伴。
35. 「物理治療師」指任何 a) 根據《輔助醫療業條例》(香港法例第359章)於輔助醫療業管理局妥善註冊或如涉及香港以外地區，於當地擁有同等地位的機構註冊；及 b) 在受保人接受治療當地獲合法授權提供物理治療服務的人士。惟在任何情況下不包括受保人、保單持有人、保險中介人或保單持有人及/或受保人的僱主、僱員、直屬家庭成員或業務夥伴。
36. 「保單」指本公司承保及簽發的「摯安心精選」醫療保險計劃，並作為保單持有人與本公司之間的整份保單合約，包括但不限於此條款及細則、投保申請文件、聲明、保單資料頁、保障利益表、受保人附錄及其附載的任何附件或批註，如適用。
37. 「保單生效日期」指首個受保期的起始日。「保單生效日期」載明於保單資料頁。
38. 「保單簽發日期」指本保單的簽發日。「保單簽發日期」載明於保單資料頁。
39. 「保單資料頁」指附載於本保單的「保單資料頁」，並說明保單細節及受保期。
40. 「保單年度」指保單生效日期或其後之任何續保日起計，每12個月之期間。
41. 「保單持有人」指持有本保單的擁有權並於保單資料頁或隨後附加於本保單的批註內列為保單持有人的人士或公司。
42. 「先前之團體保單」指本公司承保及簽發的團體醫療保險保單，而該保單(i)必須不再保障該受保人，並(ii)須授予受保人轉換至本保單的權益。
43. 「已存在的狀況」指任何於保單生效日期、受保人生效日期或保障生效日期(按情況而定)前：
- 已存在或確診；或
 - 受保人當時已知悉或按合理情況下應知悉出現了病徵或症狀，
- 之不適、疾病、受傷、身體狀況或生理退化。
44. 「處方藥物」指由醫生處方用於治療傷病的西方藥物。
45. 「合資格醫療人士」指麻醉科醫生、中醫師、脊醫、醫生、物理治療師、專科醫生、外科醫生或任何其他在受保人接受治療當地獲合法授權或註冊以提供有關其專業範疇之治療或服務的合資格醫療人士。
46. 「合理慣例」指就治療、服務或物料收費而言，不超過在當地由具相若水平的相關服務或物料供應者，為同一性別和年齡的人士針對類似疾病或傷患提供的相類似的治療、服務或物料所收取的收費水平。合理慣例的收費在任何情況下均不應高於所招致的實際收費。本公司會參照以下資料(如適用)以釐定合理慣例的醫療費用：
- 載列於由香港政府發佈之憲報中香港公立醫院向自費病人收取私家住院醫療服務的費用；
 - 由業界進行的治療或服務費用調查；
 - 內部索償數據；
 - 受保程度或水平；及/或
 - 於提供治療、服務或物料當地之其他適當相關參考資料。
47. 「續保」指就本保單而言，緊接保單屆滿時立即續期。
48. 「續保日」指保單續保的日期，並為保單生效日期的每個週年日。
49. 「保障利益表」指附載於本保單的「保障利益表」，當中載列了保障利益的條件及其最高保障額(將不時修定)。
50. 「受保人附錄」指附載於本保單的「受保人附錄」，當中載列了受保人資料、其合資格的保障及保費詳情。
51. 「不適」或「疾病」指正常健康狀態因受到病理偏差的影響而出現的生理及醫療狀況。
52. 「專科醫生」指任何 a) 於香港醫務委員會之專科醫生名冊註冊或如涉及香港以外地區，於當地擁有同等地位的機構註冊；及 b) 在受保人接受治療當地獲合法授權以其專科資格提供專科護理的醫生。
53. 「外科醫生」指合資格進行外科程序或手術的專科醫生。

一般條件

合約註釋

- 在本保單中，表示單一性別的詞包含所有性別；單數詞包括複數含義，反之亦然。
- 所有標題乃為方便而設，不會影響對本保單的闡釋。
- 本保單內所有時間均指香港時間。
- 除非於本保單附載的批註內另有規定，若本保單與本公司其他文件之條款及細則出現任何抵觸，將以此條款及細則為準。
- 除非另有註解，否則本保單內所用之詞語具有此條款及細則之釋義部分所載明的涵義。
- 本保單之中文版本僅作參考。英文版本與中文版本之間如有任何差異，均以英文版本為準。

新增或刪除受保人

保單持有人可於提交續保申請時要求新增或刪除任何受保人，惟新增受保人必須獲得本公司批准。

保單更改

除非由本公司的授權代表正式簽署，否則有關於本保單（包括任何批註）的任何更改均屬無效。

取消保單

保單持有人可以向本公司發出不少於 7 天的書面通知以取消本保單。如於首個受保期內符合以下條件：a) 無任何索償；b) 無尚未繳付之每年保費；及 c) 所有醫療卡（如有）及優惠券（如有）從未被使用及已被退還予本公司，保單持有人可獲無息退還部分已繳保費。除根據本保單的其他條款及細則外，可獲退還之保費金額將按照下表計算：

保單生效期 (由保單生效日期起計)		獲退還之保費	
不多於	2 個月	每年保費之	75%
	4 個月		55%
	6 個月		35%
	8 個月		15%
8 個月以上		無	

在首個受保期的第 8 個月後，保單持有人將不獲退還任何保費。

儘管有任何其他規定，本公司將在應退還之保費內扣除本保單下尚未償還之任何欠款。

除根據本保單的其他條款及細則外，若保單持有人於首個受保期完結並續保後取消本保單，將不獲退還任何保費。

本公司可因任何受保人未能遵從本保單的任何要求而取消其保障。在該情況下，保單持有人可獲按比例退還該受保人剩餘之受保期的保費。為免存疑，就本保單之其他受保人而言，本保單在餘下之受保期仍然繼續生效。

個人詳情變動

保單持有人在受保期內，必須就受保人或保單持有人之地址、姓名或個人詳情的變動即時通知本公司。

保障更改

保單持有人如要求就本保單作出任何保障更改，有關更改將於續保時或經本公司批准後生效。

若受保人於保障提升前已患上任何一種傷病，就該傷病而言，受保人可獲得的保障應以患上該傷病時所生效之保障級別為準。

如受保人於續保時年齡為 50、55、60 或 65 歲，保單持有人亦可於該續保日之前或之後 31 天內要求減低該受保人之自付額，而無須提供該受保人進一步之健康證明。每名受保人終身只限行使此權利 1 次，而且一經行使將不可撤銷。有關更改只會於續保時生效。（只適用於保障利益條款 B 部分）

文書錯誤

任何文書錯誤不會令生效的保單因而失效，或令失效的保單因而生效。

付款貨幣

本公司將按照保單資料頁內所指定的貨幣或如無指定則以港幣收取或繳付所有款項。所適用的貨幣兌換率由本公司參考現行的市場匯率後全權釐定。

保障生效日

儘管有任何其他規定，受保人本保單可享之保障將在下列日期起生效，以較遲者為準：

- 保單生效日期；
- 受保人生效日期；或
- 首個受保期之保單簽發日期。

若受保人在其保障生效當日仍然住院，本保單之保障只會於該受保人出院當日的下一天起生效。

規管法律

本保單於香港簽發，並受香港法律規管並按其詮釋。

責任

受保人及提出索償人士須適當遵守及履行本保單的條款及細則；及其在投保申請文件、投保書及聲明內容的真實性，乃本公司根據本保單承擔賠償責任的先決條件。

最高及最低年齡限制

任何 (i) 年齡為 12 天或以上及 (ii) 未達其 66 歲生日之人士均合資格投保本保單，惟附加保障則須受限於載明於保障利益表內之相關年齡限制。

錯誤申報年齡及 / 或性別

在不損害本公司於失實陳述及欺詐情況下之權利，若受保人在投保申請文件或任何隨後向本公司提交的文件內錯誤申報年齡及 / 或性別，本公司可根據受保人的正確年齡及 / 或性別調整保費（不論過去或未來之保費）。除非已支付調整的保費，本公司將不會支付賠償。

凡受保人之正確年齡或性別未能符合受保的資格，本公司有權宣告本保單無效或拒絕提供保障予受保人。若受保人在未能根據本公司的規定符合受保資格的情況下獲支付賠償，保單持有人及 / 或受保人必須即時償還任何已支付的賠償予本公司。本公司之責任僅限在扣除在本保單下所有就該受保人已支付的保障後無息退還所有就相關保障已繳付之保費。

失實陳述及 / 或欺詐

本公司有權就下列任何一個情況發生而宣告保單為無效，要求償還任何已支付的賠償及 / 或拒絕提供任何本保單下之保障：

- 受保人在投保申請文件或其於投保申請時或其後任何時間所作之陳述或聲明中不正確地陳述或遺漏申報任何影響風險的重要事實；
- 藉任何失實陳述或隱瞞手段而獲得承保或續保；
- 任何索償涉及欺詐或誇大成分；或
- 任何支持投保或索償時所作出之聲明或陳述並非屬實。

向公司呈報

本公司要求保單持有人及 / 或受保人呈報的所有資料須以書面形式致予本公司，並由本公司確定收受。

其他保險或來源

本公司僅須負責支付在扣除根據其他保險或來源應付金額後之費用餘額。

受保人必須按本公司要求就其有否享有其他保險公司提供的醫療保障向本公司作出申報，如有，受保人須提供該等醫療保障的詳細資料。若受保人可因其他保險公司提供的團體醫療保障、及 / 或其生效之團體保單獲賠償全部或部分之費用，該費用應先從該等團體醫療保障、及 / 或其生效之團體保單獲得賠償。

保單權益及責任的解除

本公司將視保單持有人為本保單的絕對權益人，及本公司並無責任確認本保單中任何其他方在衡平法下的利益或其他利益。償付任何下述利益予保單持有人或受保人，將視為本公司已充分及有效履行本保單的責任。

第三者權利

任何不是本保單某一方的人士或實體，不能根據《合約（第三者權利）條例》（香港法例第 623 章）強制執行本保單的任何條款。

代位權

本公司有權以保單持有人及 / 或受保人的名義，對可能須就引致本保單提出索償的事故負上責任的第三者提出訴訟，有關費用將由本公司承擔，而所討回的款項亦歸本公司所有。在訴訟過程中，保單持有人及 / 或受保人須在追討行動中與本公司充分合作。

對第三者的訴訟

本保單中並無任何條款會令致本公司就保單持有人或受保人基於任何原因或理由蒙受損害因而對本保單所提名的合資格醫療人士或醫院提出的訴訟負上責任、或須作出回應或答辯，這包括但不限於受保人根據本保單條款在接受治療或檢查時因疏忽、治療不當、專業失當或其他原因而引致的訴訟。

保障終結

除非獲本公司續保，否則本保單的保障將於受保期到期時終結。若受保人在保單終結時仍因傷病留院，則本保單就該傷病提供之保障將延至受保人因該傷病康復出院或該傷病或保單年度的保障額（按情況而定）已經用完時終結，以較早者為準。

終止保單

本保單將在下列情況自動終止，以最早者為準：

- 當於受保期內所有受保人的年齡均達至 100 歲，該受保期的最後一天；
- 當保單持有人取消本保單或當本保單因沒有繳付保費或根據此條款及細則一般條件中之錯誤申報年齡及 / 或性別條款或失實陳述及 / 或欺詐條款（按情況而定）所列的情形被取消；或
- 本保單最後一名在生之受保人身故當日。

當本保單在以上情況下終止，本保單內所有受保人的保障亦即告終止。除非已特別註明，任何於保單受保期內已繳付但未滿期的保費，將不獲退還。

保障地域範圍

若無特別聲明，本保單提述的所有保障適用於全球。

寬免

任何一方寬免任何其他一方，允許其違反於此任何條款，不應視為獲得日後違反該條款或任何其他條款的寬免，而任何一方任何延期償付或延遲行使其下文之任何權利亦不應詮釋為相關寬免，再者，本保單內尚未履行的條款亦不應獲得履行寬免。

權益接管條款

除非另有不受保之情況，否則就任何已存在的狀況而言，若該狀況是受先前之團體保單或生效之團體保單所保障，本保單將會繼續保障該狀況。

保費條款

寬限期

本公司給予 30 天繳付保費的寬限期，由每期保費之到期日起計。本保單將於寬限期內仍然生效，惟於該期間內本公司將不會支付任何保障利益（除非已繳清保費）。若在寬限期屆滿後仍未繳付保費，本保單即於保費到期日當天失效。

保費繳付方法

應付之保費金額載於受保人附錄或本保單所附載的批註內。保費必須按年或經本公司同意下以分期付款方式於到期日前繳付，本公司才會支付任何賠償。如適用並在本公司同意的情況下，少於一個保單年度之保費將按照每日比例計算，而保障利益表內列明之最高保障日數或次數（如有）將按比例調整。

保費到期日、續保日及保單年度均由本公司參照保單資料頁內所載之保單生效日期而釐定。第一期保費將於保單生效日期到期。

續保條款

續保

在繳付保費後，保單有效期為一個保單年度（由保單生效日期起計至保單生效日期後首個保單週年日前一天）。

受本公司享有終止本保單權利之條款約束下，於保單期屆滿時，本保單將按本公司因應每次續保時所提供的利益及保障範圍而釐定的保費及施加的條款並在本公司成功收取保費後自動續保至下一個受保期。

受限於本保單其他條款及細則，本公司保證保單持有人有權為受保人續保直至該受保人年齡為 100 歲。

倘若保單持有人不同意續保，他可於本保單續保日當日起計 30 天內（「冷靜期」）向本公司發出書面通知以取消該續保，而本保單將會於緊接該續保前之受保期屆滿時終止。如 a) 本保單於該冷靜期內並無任何索償*及 b) 所有醫療卡（如有）及就該續保向受保人繕發的優惠券（如有）於冷靜期內從未被使用及已被退還予本公司，保單持有人將可獲全數退還就該續保已繳付之保費。

* 除非冷靜期內為符合索償資格的費用賠償所作出的索償是：

- a) 本保單終止前招致；或
- b) 由於受保人冷靜期內因傷病住院，而 (i) 因該傷病引致之住院是於本保單終止前已經開始及 (ii) 受保人就該傷病或保單年度所享有的保障額（按情況而定）尚未用完。

本公司將保留中止提供本計劃或修改保障利益、保費、條款及細則，及對本保單作出更改的權利。若我們決定停止提供或中止本計劃，我們將致力為受保人轉換至另一個可供選擇的醫療保險計劃。

保障利益架構修訂

本公司將保留不時修訂本保單的保障利益架構的權利。本公司會於受保期到期前不少於 30 天以書面形式通知保單持有人有關修訂並列明經修訂的保障利益表、新保費及其生效日期。經修訂的保障利益表及新保費將於續保日或書面通知上所列之日期起生效。除非保單持有人接受該書面通知上所列明之條款並支付保費，否則本保單將於下一個保費到期日自動終止。於每次修訂後，本公司將發出經修訂的保障利益表及有關批註（如適用）。

索償條款

放棄索償

若本公司拒絕就本保單之索償作出賠償，而該項索償並未於拒絕賠償日期後 12 個月內由保單持有人及 / 或受保人根據下文交付仲裁，則該項索償就各方面而言將被視作放棄論，且日後不能再提出索償。

仲裁

由本保單引致之所有糾紛或爭議，均須根據《仲裁條例》（香港法例第 609 章）進行仲裁。若雙方未能就仲裁員的選擇達成協議，則由香港國際仲裁中心當時的主席指派一位仲裁員。

索償程序

就申請任何有關索償，必須於接受門診或出院後 90 天內向本公司作出通知及提交指定表格及所有所需文件的正本。若未能於指定期間內給予通知或遞交索償申請，可導致有關索償遭拒絕。

本公司可能要求額外提交資料、證書、證據、醫療報告、數據或其他文件以作評估索償用途。除非獲本公司同意及批准，否則若本公司於發出書面要求該額外資料的日期後 60 天內仍未接獲所要求的資料，本公司將不會承擔賠償的責任。

本公司保留指定一名醫生為受保人作身體檢查的權利。

本公司保留在支付任何保障時扣除本保單在相關受保期內尚未繳付保費的權利。

任何本公司已付之賠償將不會成為作出其後任何賠償的先例。就某項已付之賠償而言，倘若有關的索償不符合本保單之條款

及細則所載的索償資格，保單持有人及受保人須按本公司之書面要求立即向本公司償還已付之賠償金額，包括所有不符合索償資格或超額之費用。

保單持有人及受保人不得在本公司收到所有根據本保單要求而提交的索償證明當日後的 60 天內就本保單向本公司展開仲裁。

保障利益條款

根據下文 (i) A 部分 – 基本住院及手術保障（分項限額）（第 1 至 12 項）；(ii) B 部分 – 基本住院及手術保障（總額）；及 (iii) C 部分 – 附加門診保障（第 1 至 7 項）向受保人支付的保障利益，須受載列於保障利益表適用於所選之計劃級別及保障級別代碼之最高賠償額、自付額（如適用）、賠償百分比及保障條件，以及本保單的條款、細則及不保事項所限制。就註有星號（*）的部分或項目而言，該等部分或項目的保障利益僅適用於已選擇該保障利益的保單持有人或受保人。

就已存在的狀況而言，若該狀況是受保於先前之團體保單，該狀況於本保單將繼續受到保障，即代表受保人就以下之 A 部分及 B 部分可獲之保障相等於符合索償資格的費用之 100%，惟須受限於本保單適用的最高賠償額及其他條款及細則。

在受保人仍然受保於生效之團體保單的情況下，若受保人患上之傷病為生效之團體保單所保障之已存在的狀況，就該已存在的狀況而言，受保人就以下之 A 部分及 B 部分可獲之相關保障將相等於符合索償資格的費用之 100%，惟須受限於適用的最高賠償額及其他條款及細則。儘管如上文所述，本公司於第一個受保期內就以下之 A 部分及 B 部分將只會支付符合索償資格的費用之 50%，惟須受限於本保單適用的最高賠償額及其他條款及細則。

本公司不會就不受保於先前之團體保單或生效之團體保單的已存在的狀況之傷病作出任何賠償。

基本保障

A. 基本住院及手術保障（分項限額）*

若於受保期內，受保人因傷病留院或需於診所 / 醫院門診部接受門診或日症治療（按情況而定），本公司將根據以下所列項目賠償符合索償資格的費用：

1. **病房費用** – 醫院房間費用包括受保人於留院期間的膳食費用。
2. **醫院雜項費用** – 受保人為住院病人期間，因傷病接受治療所招致之醫院費用，該等費用包括（但不限於）以下各項（就項目 p 及 q 而言，受保人以門診病人身分招致之費用亦包括在內）：
 - a) 往返醫院的救護車服務；
 - b) 施用麻醉藥及氧氣；
 - c) 輸血，不包括血液及血漿費用；
 - d) 敷料及石膏模；
 - e) 住院期間使用的處方藥物及接受的一般護理服務；
 - f) 醫療和外科手術儀器、植入儀器及裝置，不包括義肢及矯型裝置；
 - g) 在病房使用的醫療及外科即棄用品及消耗品；
 - h) 菲林、造影和 X 光，及分析；

- i) 靜脈注射，包括 IV 注射液；
- j) 化驗；
- k) 放射性同位素、放射治療及相關測試；
- l) 電腦掃描、磁力共振造影及正電子掃描；
- m) 於住院期間租用輔助步行器具及輪椅；
- n) 麻醉醫生費用及手術室費用（倘該等保障利益並無另外列於保障利益表內），及於接受外科程序或手術期間使用的消耗品及儀器用具所招致之費用；
- o) 物理治療；
- p) 經主診醫生書面建議下接受癌症治療；及
- q) 經主診醫生書面建議下，因慢性和不可復原之腎功能衰竭接受血液透析治療或腹膜透析治療。

注意：保障利益條款第 A.2 項不會就毋須住院而可在醫院門診部接受的物理治療和先進造影服務，如磁力共振造影、電腦掃描及正電子掃描，所招致之費用作出賠償。

3. **外科醫生費用** – 受保人按其主診醫生書面建議，於住院期間接受由外科醫生進行之外科程序或手術，或接受日症手術所招致之費用。

外科醫生費用將受限於保障利益表內有關外科手術所列的最高限額，並參照外科手術表內所屬之手術類別及百分比支付。若所進行的手術並不載列於該外科手術表內，本公司保留參照由香港政府發佈之憲報、或任何由本地政府、有關當局及醫學協會認可之相對價值單位或其他刊物或資料（如收費表）以釐定該外科手術所屬之手術類別的權利。

就所有住院期間進行的外科手術或日症手術而言，本保障亦包括手術後接受中醫師提供的覆診治療（包括跌打及針灸），惟有關覆診治療必須與該次外科程序或手術之診斷結果有直接關係。

4. **麻醉科醫生費用** – 如本公司須就保障利益條款第 A.3 項支付外科醫生費用，本公司亦將賠償受保人在該外科程序或手術期間接受由麻醉科醫生提供的麻醉服務所招致之費用。
5. **手術室費用** – 如本公司須就保障利益條款第 A.3 項支付外科醫生費用，本公司亦將賠償受保人在該外科程序或手術期間使用手術室（包括但不限於治療室及休息室）所招致之費用。

注意：就上述保障利益條款第 A.3、A.4 及 A.5 項而言，若就同一種傷病進行多項外科手術，本公司之責任僅限於按附帶最高保障的一項手術作出賠償。

6. **醫生巡房費用** – 受保人之主診醫生於受保人住院時或接受日症手術後（按情況而定）進行巡房而每日收取的費用，或受保人之主診醫生於受保人接受日症手術當日提供之診所診症的費用；及該主診醫生就受保人住院或接受日症手術而向其提供專業服務（包括但不限於救護車中的醫療護送、醫療監察及報告解讀）所收取的費用。

就所有住院的情況或日症手術而言，此保障亦包括住院或手術前的一次診所診症之費用（包括藥物及敷料）及出院或接受日症手術後 6 星期內的所有必需的覆診費用（包括藥物及敷料），惟有關診症必須與引致該次住院、外科程序或手術之診斷結果有直接關係，而提供診症的醫生必須為受保人之主診醫生或與主診醫生駐診於同一診所的其他醫生。

7. **專科醫生費用** – 受保人於留院期間按其主診醫生的書面建議接受專科醫生診症所招致之費用。
8. **深切治療費用** – 受保人留院接受深切治療期間的病房費用。
9. **註冊私家看護費用** – 受保人按其主診醫生的書面建議於住院期間接受護理服務所產生的費用。
10. **先進診斷掃描（在門診進行）** – 受保人以診斷為目的按其主診醫生的書面建議以門診病人身分接受電腦掃描、磁力共振造影及正電子掃描所招致之費用。
11. **緊急門診治療** – 受保人於意外發生起計 24 小時內於醫院之門診部或急症室或醫生診所接受醫生提供的治療或服務的費用。
12. **每天住院現金津貼（僅適用於入住合格公立醫院普通病房）** – 若受保人於合格公立醫院的普通病房留院治療，本公司將根據保障利益表列明的金額支付每天住院現金津貼。

注意：就上述保障利益條款內第 A.1、A.6、A.8、A.9 及 A.12 項而言，不論受保人患有 1 種或多於 1 種傷病，載列於保障利益表內之最高賠償額僅限於以每天作為基礎計算。

B. 基本住院及手術保障（總額）*

若於受保期內，受保人因傷病留院或需於診所 / 醫院門診部接受門診或日症治療（按情況而定），本公司將賠償保障利益條款 A 部分第 1 至 11 項所招致之符合索償資格的費用。本部分所作出的賠償總額將受限於載列於保障利益表內之每保單年度綜合最高賠償額、自付額、賠償百分比及保障條件。

就決定適用之自付額而言，

- a) 當住院跨越兩個保單年度或以上，適用於該次住院之自付額為按入住醫院之日期所屬之保單年度的自付額，並適用於計算該次住院的整筆相關應支付之賠償；及
- b) 適用於 A 部分第 6 項的住院或手術前的診所診症及覆診之自付額為按相關住院之入住日期或接受相關日症手術之日期（按情況而定）所屬之保單年度的自付額。

就決定適用之每保單年度最高賠償額而言，

- a) 當住院跨越兩個保單年度或以上，應支付之賠償將按各個分項實際招致費用該日之基準上分攤至相應的保單年度。若招致之費用無法按每日分項，該等費用將以實際住院日數按比例分攤至每個相應的保單年度。上述按相應保單年度分攤之費用須受限於該保單年度所適用之每保單年度最高賠償額；及
- b) 適用於 (i) A 部分第 6 項的住院或手術前的診所診症之每保單年度最高賠償額為按相關住院之入住日期或接受相關日症手術之日期（按情況而定）所屬之保單年度的每保單年度最高賠償額，及 (ii) A 部分第 6 項的覆診之每保單年度最高賠償額為按進行相關診症該日之相應的保單年度的每保單年度最高賠償額。

儘管有任何其他規定，除非受保人從醫院之離開被本保單視為出院，否則任何兩次或以上的住院將被視為同一次相關住院。為免存疑，若受保人所入住之病房級別高於其可享用的級別，載列於保障利益表內之賠償百分比將由下表中適用之調整系數所取代：

調整系數

可享有的病房級別	實際入住的病房級別	合格索償賠償 (調整系數)
普通病房	半私家病房	50%
普通病房	私家病房	25%
普通病房	豪華病房	12.5%
半私家病房	私家病房	50%
半私家病房	豪華病房	25%
私家病房	豪華病房	50%

以上之調整系數只適用於保障利益表所列之基本住院及手術保障 (總額)。

附加保障

C. 附加門診保障*

若於受保期內，受保人因傷病而需於診所 / 醫院門診部接受門診或日症治療，本公司將根據以下所列賠償符合索償資格的費用：

1. **普通科醫生診症** – 由醫生進行的診症及於接受診症之診所或醫院配發藥物所招致之費用。
2. **中醫治療** – 由中醫師因進行中醫治療 (包括跌打及針灸) 而提供的診症及於接受診症之診所或醫院配發藥物所招致之費用。
3. **專科醫生診症** – 由醫生以書面轉介並由專科醫生進行的診症及於接受診症之診所或醫院配發藥物所招致之費用。
4. **處方藥物** – 於受保人接受診症之診所或醫院以外之註冊藥房以醫生書面處方購買處方藥物所招致之費用。
5. **X 光診斷及化驗** – 由醫生以書面轉介為作出診斷而進行的 X 光診斷、超聲波、先進造影如磁力共振造影、電腦掃描及正電子掃描、心電圖及化驗所招致之費用。
6. **物理治療服務** – 由物理治療師提供服務所招致之費用。
7. **脊椎治療服務** – 由脊醫提供服務所招致之費用。

免付賬醫療服務條款

受保人可經本公司批核後享用免付賬醫療服務。

1. **醫療卡**
使用醫療卡 (如適用) 須隨時受限於本公司所規定之使用醫療卡的條款及細則，該條款及細則將會構成本保單的一部分，本公司並會不時就該條款及細則作出修訂。最新版本之條款及細則請參閱本公司網頁 (<http://www.bluecross.com.hk>) 內之《藍十字醫療卡 – 使用簡介》。

保單持有人及受保人須承擔任何因使用未退還、已遺失或遭盜竊之醫療卡所引致之費用，而本公司亦會就補發新醫療卡收取服務費用。

若本保單內尚有未償還之款項，本公司將保留拒絕對本保單之其他索償作出賠償的權利。

本公司可隨時發出書面通知以中止或暫停任何免付賬醫療服務，並保留所有與免付賬醫療服務相關事項及爭議的最終決定權。

不保事項

除於保障利益表或隨後附加於本保單的批註內特別列明外，本公司概不支付涉及以下事項或因其引致的任何索償、支出或費用：

1. 根據任何法例、醫療計劃或其他保單，可向任何政府、公司、其他保險公司或任何第三者追討的任何損失、支出或費用。
2. 並非屬醫療必要的治療或測試，或並非經醫生處方購買的藥物。
3. 純粹因接受一般身體檢查、X 光診斷、先進造影、化驗或物理治療而住院，除非該測試或治療服務獲醫生建議為治療某傷病而屬醫療必要，而該測試或治療並無法於門診設施有效地進行。
4. 任何先天性疾患 (疝氣、斜視或包皮開口狹窄除外) 或成長障礙狀況或相類似疾病的相關治療。
5. 已存在的狀況，除非已於保障利益條款內另有註明。
6. 直接或間接因後天免疫力缺乏症病毒 (「HIV 病毒」) 及其有關的傷病而引致的費用，包括愛滋病及 / 或因愛滋病而引發的任何突變、衍生或變異，純因為受保人於受保人生效日期前感染 HIV 病毒所引致。就本不保事項而言，所有於受保人生效日期後 5 年內出現與 HIV 病毒有關的傷病，將推定為受保人於受保人生效日期前已感染 HIV 病毒所引致。
7. 直接或間接由於或因為以下事項所引致的治療或傷病：
濫用藥物或酒精、自我毀傷或企圖自殺、進行不法活動、飲用超過規定水平的酒精或服用超過規定水平的藥物後駕駛或操控機器，或經由性接觸傳染的疾病或其後遺症。
8. 以美容或整形為目的或並非與醫療有關的狀況之任何服務費用；聽力測試、例行血液測試、一般身體檢查、預防性治療、接種疫苗或防疫注射、頭髮重金屬元素分析、服食燕窩、靈芝、人蔘及其他中醫專用補藥、健康補充品 (除非獲本公司批准) 之費用；為矯正視力或屈光不正而引致之費用，包括但不限於眼部屈光治療、視力測試、驗配眼鏡或鏡片，以及任何相關手術程序及服務。
9. 因牙科狀況接受之牙科治療及口腔外科手術 (受保人因意外而需在住院期間接受的緊急牙科治療及手術除外)，及因牙科狀況或於口腔外科手術後不論是以住院病人或門診病人身分接受的覆診治療。
10. 與產科及其併發症有關的檢查、治療、外科程序及諮詢服務，包括驗孕或其後的分娩、墮胎或流產；節育或恢復生育；兩性結紮或變性；不育治療，包括體外受孕或以任何其他人工方法導致懷孕；及性功能失調，包括但不限於任何原因導致的陽萎、不舉、早泄。
11. 購買義肢、身體器官及矯型裝置，包括經由手術植入體內的矯型裝置。購買或租借耐用的醫療設備及儀器，包括但不限於家居使用之輪椅、床及傢俱、呼吸道壓力治療機及面罩、可攜式氧氣及氧氣治療儀器、透析機、運動設備、

眼鏡、助聽器、特別支架、輔助步行器具、非處方藥物、空氣清新機、空調及供熱裝置。

12. 直接或間接由任何精神或心理狀況，以及其生理及心理表現而引致的治療。
13. 另類療法，包括但不限於指壓、天灸、推拿、催眠、氣功、按摩治療、香薰治療及相類似之療法。
14. 未獲本公司於參照進行治療當地之普遍標準後認可的試驗性及 / 或新醫療技術或程序。
15. 非醫療服務，包括但不限於訪客膳食、租用收音機或電視、電話費、影印費、醫療報告費、稅項及相類似項目。
16. 直接或間接因戰爭（不論宣戰與否）、內戰、侵略、外敵行動、敵對行動、叛亂、革命、起義或軍事政變或奪權；或因參與陸軍、空軍、海軍及其他紀律性服務而引致的治療或傷病。