Group Medical Insurance Policy

Assicurazioni Generali S.p.A. Hong Kong Branch, 21/F, Cityplaza One, 1111 King's Road, Taikoo Shing, Hong Kong. Tel: (852) 2521-0707, Fax: (852) 2521-8018, hereinafter called "the Company". The Company hereby agrees to insure those members as hereinafter provided to the intent that, if any such members while insured hereunder, as a result of accidental bodily injuries, disease or sickness, the Company will upon receipt of proof acceptable to the Company pay the relevant benefits as provided by this Policy (as defined herein).

This Policy is issued in consideration of the application by the Policyholder (as defined herein) and the payment of the premiums computed and payable as provided hereafter.

IN WITNESS WHEREOF, Assicurazioni Generali S.p.A. Hong Kong Branch has caused this Policy to be executed in Hong Kong on the date shown in the Insurance Schedule.

Assicurazioni Generali S.p.A.
Hong Kong Branch

(Authorized Signature)

IMPORTANT – The Policyholder is requested to read this Policy carefully. If any error or mis-description is found, the Policy should be returned to the Company for correction.

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PROVISIONS

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

PART I - DEFINTIONS

1. **"Accident"** shall mean an unforeseen and unexpected event of violent, accidental, external and visible nature, which shall independently of any other cause be the sole cause of bodily Injury, except caused under situations such as riot, civil commotion, subversion and insurgency etc.

2. **"Accidental Death"** shall mean a death which occurs after the date of the relevant Accident and directly and independently results from "Injury" as defined below.

3. "**Age**" shall mean the attained age.

4. "**Annual Limit**" shall mean the maximum aggregate amount of all Benefits payable under Part III Section B Basic Benefit herein for each Insured Member in anyone (1) Policy Year which is stated on the Schedule of Benefits

5. **"Associated Policyholders"** as stated in the front page shall mean the subsidiaries or affiliated companies of the Policyholder whose members shall be insured under this Policy.
   The Policyholder shall act for and on behalf of any and all of such Associated Policyholders in all matters pertaining to this Policy, and every act done by, agreement made with, or notice given to the Policyholder shall be binding on all such Associated Policyholders. For the purpose of this Policy, subsidiaries or affiliated companies of the Policyholder shall mean companies or other legal entities which the Policyholder directly or indirectly controls, is controlled by or is under common control with.

6. **"Benefits" or "Benefit"** shall mean the benefit(s) provided under this Policy in PART III in respect of medical expenses. Such expenses must be incurred by an Insured Member as a result of Injury; Accident; Sickness; Disease or Illness.

7. **"Chinese Medicine Practitioner"** shall mean a Chinese medicine practitioner legally registered in the Chinese Medicine Board under Chinese Medicine Council in Hong Kong pursuant to the Chinese Medicine Ordinance (Cap.591) of the Laws of Hong Kong holding a valid and current practising certificate pursuant to section 76 thereunder; or the equivalent registration authority in any other place where Chinese medicine Treatment takes place; but excluding a Chinese Medicine Practitioner who is the Insured Member , an insurance agent, business partner(s), employer / employee of the Insured Member, his relatives or a member of the Insured Member's immediately family.

8. "**Chiropractor"** shall mean a registered Chiropractor under the Chiropractors Registration Ordinance (Cap. 428) of the Laws of Hong Kong holding a valid and current practising certificate pursuant to section 12 thereunder or a duly qualified practitioner or Chiropractic registered as such under the laws of the country in which the claim arises and where the Treatment takes place, but excluding a Chiropractor who is the Insured Member , an insurance agent, business partner(s), employer / employee of the Insured Member, his relatives or a member of the Insured Member's immediately family.

9. **"Commencement Date"** shall mean the date set out in the Insurance Schedule from which the Plan under this Policy is effective and operative.

10. **"Company"** shall mean Assicurazioni Generali S.p.A. Hong Kong Branch.

11. **"Congenital Conditions"** shall mean any congenital abnormality (a) for which the Insured Member has received medical Treatment or has been attended to by a Registered Medical Practitioner or has been prescribed drugs or (b) the symptoms of which have occurred or have manifested or (c) which have been diagnosed by a Registered Medical Practitioner, before the Insured Member attains the Age of eighteen (18).

12. **"Co-payment"** shall mean a fixed fee or percentage portion of costs (as stated in the Schedule of Benefits and as may be varied by the Company from time to time) the Insured Member must contribute towards the cost of medical services received.

13. **"Day of Hospital Confinement"** shall mean each continuous twenty-four (24) hours period that an Insured Member is confined as a resident "In-patient" in "Hospital" as defined below for a minimum of twenty-four (24) hours.

14. **"Deductible"** shall mean an amount as may be shown in the Schedule of Benefits or any endorsement or attachment to this Policy, to be deductible from any eligible Benefits payable as provided under Part III.

15. **"Dentist"** shall mean a person duly qualified and legally registered as such to practise dentistry in Hong Kong under Dentists Registration Ordinance (Cap. 156) holding a valid and current practising certificate pursuant to section 11A hereunder, and should a claim and Treatment occur outside Hong Kong, the equivalent under the laws of the country in which the claim arises and where the Treatment takes place but excluding a Dentist who is the Insured Member , an insurance agent, business partner(s), employer / employee of the Insured Member, his relatives or a member of the Insured Member's immediately family.

16. "**Developmental Conditions**" shall mean disorders in which there is either an early development or a delay in development compared to what is expected for at the given age level or stage of development. These impairments or Disabilities originate before the age of eighteen (18) may be expected to continue indefinitely,and constitute a substantial impairment. These include disorders with biological and non-biological factors involved. They shall include but not limited to language and learning disorders, autism, mental retardation, hyperactivity, attention deficit disorder, dyslexia, social problems, child development and physical developmental problems.

17. **"Disability" or "Disabilities"** shall mean Injury, Sickness, Disease or Illness and shall include all disabilities arising from the same cause including any and all complications arising therefrom, except that where after ninety (90) calendar days following the last medical Treatment or consultation no further Treatment for the said Disability is required, any subsequent Disability from the same cause shall be considered a separate Disability.

18. **"Effective Date"** shall mean the commencement date of coverage for an Insured Member who has enrolled with and accepted by the Company after the Policy Commencement Date.

19. **"Eligible Expenses**" shall mean only those Medically Necessary expenses incurred in respect of a covered Disability for which the entire Treatment is rendered by a Registered Medical Practitioner or Registered Chinese Medicine Practitioner.

20. **"Eligible Members"** shall mean qualified employees of the Policyholder or their dependants, who are aged from fifteen (15) days and until the day before sixty- five (65) and have completed the required Terms & Conditions as stated in the Insurance Schedule and not otherwise disqualified, are entitled to participate in the respective Plan under this Policy.

21. **"Emergency"** shall mean an event or a situation that Treatment is needed immediately in order to prevent death or permanent impairment of an Insured Member's health.

22. **"Hereditary Conditions"** shall mean the medical condition inherited by a child from his/her parent at birth.

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

24. **"Hospital"** shall mean an establishment recognized, constituted and registered as such under the laws of the territory in which that establishment is situated as a hospital for the care and Treatment of sick and injured persons as paying bed patients, and which (a) has facilities for diagnosis and major surgery; (b) provides twenty-four (24) hours a day nursing services by registered nurses and Qualified Nurses;(c) is under the supervision of Physicians; and (d) is not primarily a clinic, a place of alcoholics or drug addicts, a sanatorium, a nature care clinic, a health hydro, a nursing, rest or convalescent home, rehabilitation centre or home for the aged or similar establishment.

25. **"Hospital Confinement"** shall mean confinement in a Hospital which must be for a minimum period of six (6) consecutive hours before any medical Benefits hereunder are payable, except that no minimum period of Hospital Confinement is required in respect of any expenses incurred at a Hospital in connection with any Emergency Treatment required as a result of (and within twenty four (24) hours following) an Injury or in respect of fees charged by a Registered Medical Practitioner for the performance of a surgical procedure or operation, or in respect of an operation received in a recognized "Day Care Surgical Centre" owned and operated as such by a Hospital or in Doctor's clinics.

26. **"Injury"** shall mean an abnormal bodily condition caused solely and directly by an Accident and independent of any other cause and not therefore due to Sickness or Disease or Illness.

27. "**In-patient**" shall mean an Insured Member confined in a Hospital and occupies a bed for a minimum period of six (6) consecutive hours, except that no minimum period of Hospital Confinement is required in respect of an operation incurred at a recognized "Day Care Centre" owned and operated as such by a Hospital.

28. **"Insurance Schedule"** shall include Schedule of Benefits as attached to the Policy

29. **"Insured Member(s)"** shall mean Eligible Member(s) as defined in the Insurance Schedule who, in accordance with the provisions of PART II hereof, has/have been enrolled and is/are participating in the respective Plan under this Policy.

30. **"Insured Plan" or "Plan"** shall mean the specific plan of coverage and benefit level selected as shown in the Schedule of Benefits and which each Insured Member is covered under this Policy.

31. **"Intensive Care Unit"** shall mean a section with a Hospital which is designated as an intensive care unit by the Hospital providing one to one nursing care**,** in which patients undergo specialized resuscitation, monitoring and Treatment procedures. The unit must be staffed twenty-four (24) hours a day with highly trained Qualified Nurses, technicians and Doctors, and be equipped with resuscitative equipment and monitoring devices that allow continuous assessment of vital body functions such as heart rate, blood pressure and blood chemistry.

32. **"Medically Necessary"** shall mean a condition in which health care services and supplies provided are determined by the Company to be medically appropriate, and all of the following:
    (a) necessary to meet the basic health needs of the Insured Member;
    (b) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the health service;
    (c) consistent in type, frequency and duration of Treatment with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company;
    (d) consistent with the diagnosis and customary medical Treatment for the condition;
    (e) performed at a Reasonable and Customary charge on Treatment of a covered Disability;

(f) required for reasons other than the convenience of the Insured Member or any person coming within the meanings of clauses 45 and 50 below in Part I - Definitions; and

(g) demonstrated through prevailing peer-reviewed medical literature to be either:
   (i) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,
   (ii) safe with promising efficacy,
   (iii) for treating a life threatening Sickness or condition,
   (iv) in a clinically controlled research setting; and
   (v) using a specific research protocol that meets world standards.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for Treatment.)

The fact that a Physician has performed or prescribed a procedure or Treatment or the fact that it may be the only Treatment for a particular Injury, or Sickness does not mean that it is a Medically Necessary covered health service as defined herein. The definition of Medically Necessary used herein relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

33. "**Member(s)**" shall mean [existing and/or future full-time permanent active employees of the Policyholder that may be eligible to become Insured Members if they meet the conditions set out in this herein].

34. "**Mental Illness and Emotional Disorder**" shall mean the Illness or disorder directly or indirectly arising from any insanity, geriatric, psycho-geriatric, psychological or psychiatric condition including but not limited to psychoses, neuroses, depression of any kind, anxiety, anorexia nervosa, bulimia, schizophrenia, insomnia, neurasthenia and other behavioural disorders.

35. **"Period of Insurance"** shall mean the period set out in the Insurance Schedule during which the Plan under this Policy is effective. It shall begin at 0:00 and end at 24:00 Hong Kong time.

36. **"Physiotherapy"** shall mean a person qualified and registered pursuant to Supplementary Medical Professions ordinance (Cap.359) of the Laws of Hong Kong holding a valid and current practising certificate pursuant to section 16 thereunder or the equivalent in other place where medical expenses are incurred to render assessment and Treatment service on physical disabilities by means of remedial exercises, manual therapy and mechanical, thermal or electrical energy but excluding a Physiotherapist who is the Insured Member , an insurance agent, business partner(s), employer/employee of the Insured Member, his relatives or a member of the Insured Member's immediate family.

37. **"Policy"** shall mean this agreement, any supplementary contract, endorsements or attachments therein, any amendments thereto signed by the Company, and the application attached hereto of the Policyholder, and, if applicable by stipulation in the , Insurance Schedule and Schedule of Operations, as may be supplied with this Policy or as published or notified to the Policyholder from time to time, which together constitute the entire contract between the parties.

38. **"Policyholder"** shall mean the employer or otherwise defined as the legal entity to whom the Policy is issued.

39. **"Policy Anniversary"** shall mean the anniversary of the Policy Commencement Date or the date otherwise specified in the Insurance Schedule.

40. **"Policy Year"** shall mean every twelve (12) consecutive months period beginning from the Policy Commencement Date to the next Policy Anniversary.

41. **"Prescribed Medicines and Drugs"** shall mean such medicines and drugs which may not be procured legally without the prescriptions of a Physician and which have been prescribed by the Physician specifically for the Treatment of a covered Disability, and should be purchased through

the control of a registered pharmacist holding a valid and current practising certificate under s.10A of the Pharmacy and Poisons Ordinance (Cap. 138) of the laws of Hong Kong or other jurisdiction where the medicines are purchased, and which is not a Doctor's clinic. A registered pharmacist shall exclude Insured Member, an insurance agent, business partner(s), employer/employee of the Insured Member, his relative or a member of the Insured Member's immediate family.

42. **"Qualified Nurse"** shall mean nurse (exclude the Insured Member, an insurance agent, business partner(s), employer/employee of the Insured Member, his relatives or a member of the Insured Member's immediate family) legally qualified in Hong Kong or any other place where medical expenses are incurred to render nursing services for the patient and having qualifications at least equivalent to those of a nurse registered or enrolled pursuant to the Nurses Registration Ordinance of Hong Kong and "nursing" shall be construed accordingly.

43. **"Reasonable and Customary"** shall mean in relation to fees, a sum not exceeding a reasonable average amount of the fees charged under similar conditions by persons of equivalent experience and professional status in the area in which the service was provided; and in relation to material or services, shall mean a sum not exceeding a reasonable average amount of the charges for similar material or services in equivalent circumstances of quality and economic consideration in the same area as that in which any such material or services were contained.

44. **"Registered Medical Practitioner; Surgeon; Physician; Doctor; Anaesthetist"** shall mean a person duly qualified and legally registered as such to practise western medicine, surgery or any branch of medicine in Hong Kong under Medical Registration Ordinance (Cap. 161) holding a valid and current practising certificate pursuant to section 20A thereunder, and should a claim and Treatment occur outside Hong Kong, the equivalent under the laws of the country in which the claim arises and where Treatment takes place, but excluding Insured Member, an insurance agent, business partner(s), employer/employee of the Insured Member, his relatives or a member of the Insured Member's immediate family.

45. **"Referral letter"** shall mean any covered Injury/Sickness/Disease/Illness of which the Insured Person receives Treatment continuously for the same or closely related Injury / Sickness / Disease / Illness, and such continuous Treatment is not interrupted for a period of more than ninety (90) consecutive days, then the concurrent due proof of referral by a Registered Medical Practitioner for that Treatment shall be regarded as a continuous and concurrent referral as from the date of last Treatment of the same or closely related Injury / Sickness / Disease / Illness.

46. "**Schedule of Benefits**" shall mean the benefit schedule to this Policy as amended from time to time in which the benefits clauses and amount of the Benefits are set forth, and schedule of benefits issued at the date of the Policy and any other schedule thereafter varied in accordance with the terms and conditions of this Policy.

47. **"Setting"** shall mean a Hospital out-patient department, Hospital accommodation or clinical services as appropriate for Treatment.

48. **"Sickness", "Disease" or "Illness"** shall mean a physical condition marked by a pathological deviation from the normal healthy state.

49. "**Specialist"** shall mean a person who has completed western specialist course and been granted a qualified specialist certificate and is licensed to legally practice as particular medical specialists in Hong Kong, and should a claim and Treatment occur outside Hong Kong, shall mean a practitioner who has completed western specialist course who is duly registered as such under the laws of the country in which the claim arises and where Treatment takes place, but excluding Insured Member, an insurance agent, business partner(s), employer/employee of the Insured Member, his relatives or a member of the Insured Member's immediate family.

50. **"Shortfall"** shall mean all those expenses which are not Eligible Expenses, of which exceed the Benefit coverage of this Policy incurred by an Insured Member and paid to the provider by the Company on behalf of the Insured Member.

51. **"Treatment"** shall mean surgical or medical procedures, the sole purpose of which is the cure or relief of Injury, Accident, Sickness, Disease or Illness.

PART II – INDIVIDUAL PARTICIPATION AND TERMINATION

Section A – Participation

1. Members already eligible on the Policy Commencement Date shall, subject to clause 4 below of this Section A, be eligible at such Commencement Date.

2. New Insured Members shall become eligible for insurance on the day following the completion of the required Terms of Conditions, if any, as specified in the Insurance Schedule.

3. Members whose insurance has been terminated due to termination of membership and who re-apply for membership shall be considered as new Members.

4. The date of eligibility of a Member shall be a date on which the Member is actually performing his duties full time of at least thirty (30) hours per week. Any Member who may be on vacation, sick or absent from work for any other cause on the date on which, if present, he would have become eligible to participate, shall become eligible to do so immediately following his return to full-time active performance of his duties.

5. Every Member who fulfils the conditions necessary to participate as set forth in clauses 1 to 4 above must elect to do so in writing within thirty-one (31) calendar days from the date he becomes eligible. Otherwise, he shall be able to start participation only after he shall have furnished, at his own expense, evidence of his insurability satisfactory to the Company.

6. Each Eligible Member shall be insured on the first day on which he becomes eligible provided written notification from the Policyholder has been received and approved by the Company and the condition set forth in clause 5 above has been satisfied.

7. Participation of Members of the Associated Policyholders, if any, shall fulfil the conditions as set forth in clauses 1 to 6 above.

Section B – Termination

The insurance of any Insured Member shall automatically cease on the earliest of the following dates:

1. The date the Policy and any of the supplementary contracts are terminated, provided that for the avoidance of doubt termination of the Policy shall automatically terminate all of the supplementary contracts.

2. The date of the expiration of the period for which the last premium payment is made on account of the Insured Member's insurance.

3. The date on which the Insured Member enters full-time military, naval or air service.

4. The end of the Period of Insurance during which the Insured Member attains the age of seventy (70) years.

5. 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.

6. Cessation of active work by an Insured Member (or cessation of membership in good standing in the case of association) shall be deemed to constitute the termination of his membership, except that while an Insured 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 Insured Member's insurance are discontinued. "Part-time" employment shall mean an Insured Member performs his duties less than thirty (30) hours per week.

7. The date on which his membership in the class or classes of Insured Members is terminated.

8. The date on which active membership with the Policyholder is terminated, except that the Policyholder may elect to consider Insured Members temporarily laid-off, given leave of absence or temporarily disabled, as remaining in active membership for purpose of this Policy, membership shall be deemed to continue until premium payments for such Insured Member's insurance are discontinued.

9. The date specified by the Company on which the Insured Member has failed to settle any Shortfall amount in full within the period of time as specified in the relevant written notice to the Insured Member or Policyholder by the Company.

PART III - BENEFITS

Section A – Extent of Benefits

1. The Company shall pay the Benefits for Medically Necessary expenses in accordance with the scope of cover provided herein below but each Insured Member's Benefit shall be subject to the maximums (or maximum percentages), the limits, the respective covered Benefits and the Insured Plan as applicable and as specified in the Schedule of Benefits.

2. The Benefits set out in the following sections are applicable to the following areas of cover:

   i) Depending on the Plan of each Insured Member, Hospital & Surgical Benefits are applicable to worldwide cover subject to the maximum limits as set out in the Schedule of Benefits; or applicable to worldwide cover excluding the United States of America (USA), in which case:

      a): full payment for elective surgery or Treatment in Hong Kong shall still be covered; and
      b): Co-payment for elective surgery or Treatment outside Hong Kong shall also be covered

      subject to the maximum limits set out in the Schedule of Benefits of the specific Plan.

   ii) Optional Outpatient Benefits are applicable without geographical limitations except otherwise stated.

   iii) Optional Dental Benefits are applicable without geographical limitations except otherwise stated.

   iv) Accident Benefits are applicable without geographical limitations except otherwise stated.

3. Benefits entitled by an Insured Member are subject to the members classification as stated in the Insurance Schedule.

4. All Benefits included hereinafter are subject to a maximum limit which is calculated on a per disability basis and/or per Policy Year basis and/or Annual Limit, whichever is applicable. In the event an Insured Member's Effective Date of insurance is other than the Policy Commencement Date/renewal date or an Insured Member's termination date is earlier than the end of Period of Insurance, as stated in the Insurance Schedule, his/her actual entitlement to the Benefits with a per policy year maximum limit shall be calculated on a pro rata basis, i.e. number of days of coverage being divided by number of days of the Period of Insurance and multiplied by the per policy year maximum limit.

5. Co-payment for certain Benefits in the form of percentage of reimbursement or costs and / or Deductible can be selected by the Policyholder for Insured Member to share a portion of medical expenses with the Company in Benefits payment. For a Benefit with a percentage of reimbursement, the Company shall pay an amount equal to the medical expenses incurred multiplied by that percentage of reimbursement as stated in the Schedule of Benefits. For a Benefit with a Deductible amount, the Company shall pay the balance of the Eligible Expenses over the Deductible amount as stated in the Schedule of Benefits.

6. All Benefits applicable to the Insured Member, are subject to the limitations and exclusions specified in PART IV of this Policy.

7. If there is any Benefit change effective after an Insured Member has been hospitalized, the Company shall pay the Benefits in accordance with the Schedule of Benefits effective on the first day he is admitted to the Hospital.

8. In the event of any subsequent Plan changes to Benefit amounts, reimbursement for any claims incurred after such a Plan change shall be based on the new Benefit amounts. However, if the

Insured Member continues to be treated for a previous condition which had been treated within ninety (90) calendar days preceding the effective date of such a change, claims payable for such a previous condition shall be based on the Benefit amounts applicable prior to such change if such change is a benefit upgrade. If, however, after the effective date of such change and the previous condition has not required any Treatment for a continuous period of ninety (90) calendar days, reimbursement for such a condition shall be based on the new Benefit amounts after the change in Plan.

9. The Benefits payable for any claim that is covered by this Policy in respect of any Insured Member shall immediately cease on the date of termination of insurance of such Insured Member.

Section B – Basic Benefits

1. Hospitalization and Surgical Benefits

Hospital and Surgical Benefits shall be available only if the Insured Member is registered and staying as an In-patient in a Hospital; and they are for Reasonable and Customary and Medically Necessary for Treatment of a covered Disability, except minor operation, day case surgery and outpatient renal dialysis / chemotherapy / radiotherapy Treatment performed at a clinic or day case unit of a Hospital, if eligible, that shall be paid hereunder.

All laboratory examinations and diagnostic tests which could have been done in an out-patient facilities without the need to be admitted to Hospital as an In-patient are not considered payable under Hospital & Surgical Benefits when admitted to Hospital as an In-patient. Such expenses shall be payable on out-patient Benefits where applicable.

Hospitalization and Surgical Benefits shall be subject to maximum limits (i.e. percentage, maximum Benefits and the overall Annual Limit) as specified in the Schedule of Benefits.

If the Insured Member is confined in a higher level of Hospital facilities and services during such Hospital Confinement other than that he / she is entitled to under this Policy, the reimbursement percentage shall be reduced as follows.

Entitled Level of Accommodation	Incurred Level of Accommodation	Reimbursement Percentage
Ward	Semi-private	50%
Ward	Private	25%
Semi-private	Private	50%

Hospital accommodation level higher than a regular private room (e.g. VIP, suite or deluxe suite and the like) are not covered.

(a) Daily Room and Board

Benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, an Insured Member is registered as an In-patient in a Hospital for Treatment of a covered Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the actual charges made by the Hospital in respect of Room and Board during the Insured Member's Hospital Confinement subject to the respective maximum limits as specified in the Schedule of Benefits.

(b) Hospital Special Services (Hospital Expenses)

Benefit shall be payable during the time an Insured Member is registered and staying as an In-patient in a Hospital for Treatment of a covered Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the Reasonable and Customary, Medically Necessary, normal, proper and actual charges made by the Hospital in respect of Hospital Services during the Insured

Member's Hospital confinement subject to the maximum Annual Limit as set forth in the Schedule of Benefits.

Hospital Services shall include the following, except where deleted or omitted from coverage or specified to the contrary in the Schedule herein:

- Administration of blood or blood plasma, but not the cost of blood or blood plasma unless in connection with a surgical operation recommended and performed by a Registered Medical Practitioner;
- Ambulance services to and/or from the Hospital;
- Anaesthesia and oxygen and their administration;
- Basal metabolism test;
- Dressing, ordinary splints and plaster casts;
- Drugs and medicines consumed during the Hospital Confinement;
- Electrocardiograms;
- Films & X-rays and their interpretation;
- Intravenous infusions;
- Laboratory examinations;
- Physiotherapy; and
- Magnetic resonance imaging, computerised tomography scan, positron emission tomography scan performed in an in-patient or out-patient setting and recommended by a Registered Medical Practitioner.

(c) Intensive Care Unit

Benefit shall be payable for the actual charges incurred as a result of the Insured Member being accommodated in an Intensive Care Unit recommended by the Doctor in charge. Benefit shall be payable in an amount equal to the actual charges made for Treatment in an Intensive Care Unit subject to the maximum limits as set forth in the Schedule of Benefits. Payments made under this provision shall be in lieu of any Room and Board Benefits for such Treatment.

(d) Surgical Benefit

The Company shall reimburse the Reasonable and Customary charges for any Medically Necessary surgical procedures performed on the Insured Member for a covered Disability in a Hospital, regardless if the Insured Member has been confined or not subject to the respective maximum limits as set forth in the Schedule of Benefits.

The Maximum Limit payable for different surgeries (as per "Schedule of Operations in Section B point 2 of Part II" below) is stated in the Schedule of Benefits or any endorsement attached thereto. The Company shall have absolute discretion and liberty to revise or amend the Schedule of Operations as it may consider appropriate or necessary from time to time. If an operation performed is not listed in the Schedule, the Company shall pay an amount which would be payable for a scheduled operation of equivalent gravity. For this purpose, the Company shall have the sole right to assess such an amount, which shall be binding and final.

No Benefit will be payable under this Basic Benefits in respect of more than one procedure resulting directly or indirectly from the same Disability. If more than one procedure is performed resulting directly or indirectly from the same Disability or during the course of a single operation through the same incision, only the largest Benefit amount indicated for one of the procedures is payable, subject to the maximum limits as set forth in the Schedule of Benefits.

If any alternative procedure including X-ray, radium or any other radioactive substance are used for Treatment in place of any cutting operation listed in the Schedule of Operations, the Company will, subject to all of the other provisions of Surgical Benefit, reimburse the Reasonable and Customary charges for such treatment up to the amount provided by the Schedule of Operations for the replaced cutting operation.

(e) Operation Theatre

If a Benefit is payable under Surgical Benefit as specified in Part III Section B clause (d) in respect of a procedure and the operating room, Treatment room, materials and/or equipment has been used in respect of the procedure, the Company shall reimburse the Reasonable and Customary and Medically Necessary charge made by the Hospital for such use of operating theatre, Treatment room, materials and/or equipment, subject to the maximum limits as indicated in the Schedule of Benefits.

(f) Anaesthetist's Fee

If a benefit is payable under Surgical Benefit as specified in Part III Section B clause (d) in respect of a procedure and an Anaesthetist has provided his services to the Insured Member during the procedure, the Company will reimburse the Reasonable and Customary and Medically Necessary charge made by the Anaesthetist for providing such services subject to the maximum limits as indicated in the Schedule of Benefits.

(g) In-Hospital Doctor Visits

If an Insured Member on any day of Hospital Confinement shall be necessarily treated by a Registered Medical Practitioner, Benefits shall be payable in an amount equal to the charges made in respect of the Physician's visit fees subject to the maximum limits as specified in the Schedule of Benefits.

(h) In-Hospital Specialist Consultation

Benefit shall be payable in an amount equal to the actual charges made by a Specialist who has provided Treatment to the Insured Member and was referred by a Registered Medical Practitioner during an Insured Member's Hospital confinement subject to the maximum limits as specified in the Schedule of Benefits.

(i) Parent Accommodation

If an Insured Member is under Eighteen (18) years old and confined as a bed patient in a Hospital as a result of bodily injury or sickness and has incurred companion bed charges for a parent or legal guardian. The amount of the said benefit shall be equal to the actual charges made by the Hospital during the Insured Member's confinement subject to the maximum limits as set forth in the Schedule of Benefits.

(j) Outpatient Renal/Kidney Dialysis

Benefits shall be payable when an Insured Member is in a recognized day care center owned and operated by a Hospital or at a Doctor's clinic for the Treatment of a covered Disability and incurs Eligible Expenses for renal dialysis Treatment recommended by a Registered Medical Practitioner, subject to the maximum limits as set forth in the Schedule of Benefits.

(k) Outpatient Cancer Treatment

Benefits shall be payable when an Insured Member is in a recognized day care center owned and operated by a Hospital or at a Doctor's clinic for the Treatment of a covered Disability and incurs Eligible Expenses for chemotherapy or radiotherapy or target therapy Treatment recommended by a Registered Medical Practitioner, subject to the maximum limits as set forth in the Schedule of Benefits.

(l) Pre and Post Natal Complication Treatment

If the Insured Member, receives a surgical procedure and/or other medical Treatment performed as an In-patient due to the pregnancy complications that are covered by this Policy, the Company shall reimburse the Eligible Expenses of the Reasonable, Customary and Medically Necessary charges actually incurred subject to the maximum limits as set forth in the Schedule of Benefits. The covered pregnancy complications are only limited to:

i) Ectopic pregnancy;
ii) Molar pregnancy;
iii) Disseminated intravascular coagulopathy;
iv) Pre-eclampsia;
v) Threatened abortion;
vi) Fetal death;
vii) Postpartum haemorrhage requiring hysterectomy; and
viii) Eclampsia, amniotic fluid embolism and pulmonary embolism of pregnancy.

(m) Organ Transplant

If the Insured Member requires organ transplant of heart, kidney, liver, lung or bone marrow as a recipient for a Covered Illness or Injury, the Company shall reimburse the Eligible Expenses of the actual charges incurred for the surgical costs of procedures performed on the Insured Member as a recipient subject to the maximum limits as set forth in the Schedule of Benefits.

The cost of the organ, surgical costs associated with or as a donor shall not be covered under the Policy.

(n) Special Nursing

A nursing Benefit shall be paid when, upon recommendation of a Registered Medical Practitioner, an Insured Member incurs expenses for services rendered by a Qualified Nurse during hospitalization. The amount of such Benefit shall be equal to the sum actually charged for such services but in no event shall exceed the maximum limits as set forth in the Schedule of Benefits.

If, as written requirement of the attending Registered Medical Practitioners following an operation done in a Hospital for which Benefits are payable under Surgical Benefit above, this Benefit is extended to cover services rendered by a Qualified Nurse at home which shall be the Insured Member's usual residence and not a nursing or convalescent home.

(o) Pre-hospitalization and Post-hospitalization Benefit

The Company shall reimburse one (1) visit made by the attending in-hospital Physician for the outpatient Treatment (including X-ray/ laboratory test) within thirty (30) calendar days before admission to Hospital and the outpatient follow-up Treatment (including physiotherapy and X-ray/ laboratory test) within six (6) calendar weeks immediately following the discharge from Hospital, provided that such Treatment is directly related to and a result of the Disability arising from the same cause (including any and all complications thereof) necessitating such Hospital Confinement subject to the respective maximum limits as set forth in the Schedule of Benefits.

(p) Hospital Cash Benefits for Government Ward or Room Level Downgrade

A daily cash Benefit shall be paid for each Day of Hospital Confinement when an Insured Member being a permanent resident of Hong Kong is confined at a public ward accommodation in Government Hospital of Hong Kong for Treatment of a covered Disability subject to the maximum limits as indicated in the Schedule of Benefits. Payments shall be in addition to any Room and Board Benefits as described in Section B of Part III for such Treatment.

If Insured Member opts for room level lower than the eligible room level as stated in the Plan, the Company shall pay the Insured Member the Hospital Cash Benefit for each Day of Hospital Confinement he/she is confined for the purposes of receiving in-patient Treatment, subject to the respective maximum limits as set forth in the Schedule of Benefits. Payment shall be in addition to any Benefits as described in Section B of Part III for such Treatment.

(q) Hospital Income Benefit

If an Insured Member is confined in a Hospital for more than two (2) consecutive days under professional care of a Physician, as a result of Injury or Sickness covered by the Policy, the Company agrees to pay a daily cash Benefit for each Day of Hospital Confinement up to the maximum limits as set forth in the Schedule of Benefits in addition to any Benefits as described in Section B of Part III for such Treatment.

(r) Accidental Death Benefit

The Company shall pay to the beneficiary the Accidental Death Benefit as shown on the Schedule of Benefits in case of the death of the Insured Member provided that the death is caused solely and directly by an Accident and proof of the death is furnished to the Company's satisfaction. If the beneficiary no longer lives when the Benefit is paid, the Company will pay such Benefit to the beneficiary's own estate.

(s) Accidental Dental Benefits

If an Insured Member sustains an Injury due to an Accident and receives Treatment performed by a licensed Dentist or Registered Medical Practitioner within 30 days from the date of Accident occasioning the Injury, the Company shall pay the Reasonable and Customary and Medically Necessary charges incurred up to the maximum limits as specified in the Schedule of Benefits.

Additional Exclusions for Accidental Dental Benefits:
1. No Benefits shall be payable for services or materials for cosmetic purposes, or repair of congenital malformation solely for cosmetic purposes.
2. For any dental procedure not initiated and completed while insured for Accidental Dental Benefits, benefit immediately after the termination of the Policy is excluded, even with proper medical proof.
3. For any restorative or remedial work, the use of any precious metals orthodontic Treatment of any kind, or dental surgery performed in a Hospital unless such dental surgery is the only available Treatment for the damaged teeth.
4. This Benefit shall not cover any dental Treatment for:
   • damage caused by eating or drinking;
   • damage caused by normal wear and tear; and
   • damage caused by tooth brushing or any other oral hygiene procedure.

Filing Dental claims:
- The claim form must be completed by the Insured Member; and
- The claim form attached with the Dentist or Registered Medical Practitioner official receipt must be submitted for claim settlement.

Special Terms and Conditions:
- Accidental Dental Benefits will be payable under Inpatient only.
- The Dental coverage due to Accident (means by external factor) and all related expenses due to such Accident including Treatment in Hospital, clinic and follow up within 30 days of Accident shall be covered under Accidental Dental Benefits.
- Surgery in Hospital immediate after an Accident (e.g. fracture / dislocation) shall be covered under Hospitalization and Surgical Benefits subject to Generali's discretion.

(t) Psychiatric Treatment

When the Insured Member is confined in a Mental or Psychiatric Hospital, or the mental or psychiatric unit of a Hospital as an In-patient for Treatment of a covered Illness in the manner of mental, behavioural or psychiatric disorder which causes suffering to the Insured Member, the Company shall reimburse the Eligible Expenses of the actual charges incurred for such confinement, as recommended in writing by his attending Psychiatrist, subject to the maximum limits as shown on the Schedule of Benefits.

Such Benefit only becomes available after the Insured Member has been continuously covered in the Policy and/or under the same benefit level for 12 consecutive months.

(u) Ancillary Equipment

Benefits shall be payable for crutches, wheelchairs, neck, back or leg braces and trusses required in support of eligible medical Treatment after Hospital Confinement and subject to the maximum limits as stated in the Schedule of Benefits.

2. Schedule of Operations

	Classification
ABDOMEN	
Appendectomy	Intermediate
Removal of, or other operation on gall bladder	Major
Gastro-enterostomy	Major
Resection of stomach (partial), bowel or rectum	Major
Excision of Rectum - combined synchronous	Complex
Oesophagogastrostomy	Complex
Any operation on the Pancreas	Complex
Total Gastrectomy	Complex
ABSCESSES - See Tumors	
AMPUTATIONS	
Thigh, leg	Major
Upper arm, forearm, entire hand or foot	Intermediate
Fingers or toes,	
Fewer than three	Minor
Three or more	Intermediate
ARTERIES AND VEINS	
Any operation on the Aorta or iliac Arteries	Complex
Portocaval Anastomosis	Complex
Splenorenal Anastomosis	Complex
BILIARY TRACT	
Hepatoduodenostomy	Complex
Partial Hepatectomy or Resection	Complex
BREAST	
Removal of benign tumor or cyst	Intermediate
Simple amputation	Major
Radical amputation	Major

	Classification
CHEST	
Complete thoracoplasty, transthoracic approach to stomach, diaphragm, esophagus, sympathectomy or laryngectomy	Major
Removal of whole lung	Major
Portion of lung	Intermediate
Bronchoscopy, esophagoscopy	Minor
Induction of artificial pneumothorax, Initial	Minor
refills each (not more than 12)	Minor
CYSTS - See Tumors	
DISLOCATION, Reduction of	
Hip, vertebra, ankle joint, elbow or knee joint (Patella excepted)	Minor
Shoulder	Minor
Lower jaw, collar bone, wrist or patella	Minor
Any dislocation involving an open operation	Intermediate
EXCISION OR FIXATION BY CUTTING	
Shoulder joint, hip joint	Major
Knee joint, semilunar cartilage, elbow, wrist or ankle joint	Intermediate
Removal of diseased portion of bone, including curettage (alveolar processes excepted)	Intermediate
EAR, NOSE OR THROAT	
Fenestration, one or both sides	Major
Mastoidectomy, one or both sides, simple	Major
Mastoidectomy, one or both sides, radical	Major
Tonsillectomy, adenoidectomy, or both	Intermediate
Sinus operation by cutting (puncture of antrum excepted)	Intermediate
Submucous resection of nasal septum	Minor
Tracheotomy	Intermediate
Any operation on the Inner Ear	Complex
Open operation on the Larynx or Pharynx	Complex

	Classification
EYE	
Operation for detached retina	Major
Cataract, removal of	Intermediate
Any other cutting operation into the eyeball (through the cornea or sclera) or cutting operation on eye muscles	Intermediate
Removal of eyeball	Intermediate
FRACTURE Treatment of	
Thigh, vertebra or vertebrae, pelvis (coccyx excepted)	Intermediate
Leg, kneecap, upper arm, ankle (Potts)	Minor
Lower jaw (alveolar process excepted), collar bone, shoulder blade, forearm, wrist (colles), Skull	Minor
Hand, foot	Minor
Fingers or toes, each	Minor
Nose	Minor
Rib or ribs	Minor

NOTE:
In the case of a compound fracture, or an open operation, the Classification will be upgraded from Minor to Intermediate, or from Intermediate to Major as the case may be.

GENITO - URINARY TRACT	
Removal of, or cutting into, kidney	Major
Fixation of kidney	Major
Removal of tumors or stones in ureters or bladder	
by cutting operation	Major
by endoscopic means	Minor
by extracorporeal shock wave lithotripsy	Intermediate
cystoscopy	Minor
Removal of prostate by open operation	Major
Removal of prostate by endoscopic means	Major
Circumcision	Minor
Vesicocele, hydrocele, orchidectomy or	
epididymectomy, single	Intermediate
bilateral	Intermediate
Hysterectomy	Major
Other cutting operations on uterus and its appendages with abdominal approach	Major
Cervix amputation	Major

	Classification
Dilatation and curettage (non-puerperal), cervix cauterization or conization, polypectomy, or any combination of these	Minor
Vaginal plastic, operation for cystocele or rectocele	Intermediate
Total Cystectomy	Complex
Transplantation of ureters	Complex
Transplantation of kidney	Complex
Transplantation of liver	Complex
GOITRE	
Removal of thyroid, subtotal	Intermediate
Removal of adenoma or benign tumor of thyroid	Intermediate
Thyroidectomy, total	Major
HERNIA	
Herniorrhaphy for	
Single hernia	Intermediate
More than one hernia	Major
JOINT	
Incision into, tapping excepted	Minor
Arthroscopic excision of joint structure	Intermediate
LIGAMENTS AND TENDONS	
Cutting or transplant	
single	Intermediate
multiple	Major
Suturing of tendon	
single	Minor
multiple	Intermediate
PARACENTESIS	
Tapping	Minor

	Classification
PILONIDAL CYST OR SINUS	
Removal of	Intermediate
RECTUM	
Hemorrhoidectomy, external	Intermediate
Internal or Internal and external	Intermediate
Cutting operation for fissure	Minor
Cutting operation for thrombosed hemorrhoids	Minor
Cutting operation for fistula in ano, single	Intermediate
multiple	Intermediate
Injections (complete procedure)	Intermediate
SKULL	
Cutting into cranial cavity (trephine excepted)	Major
Trephine	Intermediate
Any operation on Brain and Meninges	Complex
SPINE OR SPINAL CORD	
Operation for spinal cord tumor	Major
Operation with removal of portion of vertebra or vertebrae (except coccyx, transverse or spinous process)	Major
Removal of part or all of coccyx or of transverse or spinous process	Major
Any operation on spinal cord or spinal Meninges	Complex
Rhizotomy	Complex
TUMORS	
Benign or superficial tumors and cysts or abscesses	Minor
Malignant tumors of face, lip or skin	Major
VARICOSE VEINS	
Injection treatment, complete procedure, one or both legs	Minor
Cutting operation, complete procedure, one leg	Major
both legs	Major

Section C – Supplementary Benefits

In consideration of the payment in advance by the Policyholder to the Company of the additional premiums computed in accordance with the additional premium rates for the following benefits(s) stated in the Schedule of Benefits, the Company agrees to cover the Insured Member as provided by and subject to the provisions herein contained.

In addition to the "Limitations and Exclusions" defined in PART IV, the Supplementary Benefits shall further be subject to the respective Additional Exclusions or Limitations, if any, as mentioned under the corresponding provisions.

1. Optional Supplementary Major Medical (SMM) Benefits
(Applicable when these benefits are indicated in the Schedule of Benefits as being covered by the Policy)

This benefit provision serves to act as a supplement to the basic Hospital and Surgical Benefits provisions above and will only be available as an optional supplementary cover if the underlying Hospital and Surgical Benefits under this Policy is provided or remains in force. Where the Policyholder has opted for such supplementary cover, the Supplementary Major Medical Benefits schedule will be incorporated in this Schedule of Benefits or as an endorsement to this Policy.

Supplementary Major Medical Benefits will only be provided where a minimum number of two (2) employees is registered for and participates in, as a group, for coverage under the Supplementary Major Medical Benefits provisions. If for any reason, participation is or is to be reduced to less than this minimum on subsequent anniversary, the Policyholder shall immediately notify the Company of the same in writing and the Company shall in that event have an absolute discretion as it thinks fit to cancel, suspend or continue with coverage under the Optional Supplementary Major Medical Benefits provisions of this Policy.

While the Supplementary Benefits is in force, an Insured Person is registered as an in-patient in a Hospital for Treatment of a covered Disability and incurs Medically Necessary, Reasonable and Customary charges in excess of that covered under clause (a) to (l) of Section B in PART III of this Policy, the Company shall reimburse the Insured Person any such excess less a Deductible amount shown in the Schedule of Benefits and then multiplied by a reimbursement of percentage. This benefit cannot exceed the Maximum Benefit per Disability stated in the Schedule of Benefits attached to this Policy.

The benefits payable under this Benefit shall be determined in accordance with the following formula:

$$\left\{ \left[\text{Amount of Eligible Expenses incurred} - \text{Benefit payable under clause (a) to (l) of Hospital \& Surgical Benefits under Section B of PART III} \right] - \text{Deductible} \right\} \times \text{Reimbursement Percentage stated in Schedule of Benefits}$$

Subject to the Maximum Benefit per Disability.

If the Insured Person is confined in a higher level of Hospital facilities and services during such Hospital Confinement than that he / she is entitled to under this Policy, the reimbursement percentage will be reduced as the followings.

Entitled Level of Accommodation	Incurred Level of Accommodation	Reimbursement Percentage
Ward	Semi-private	50%

Ward	Private	25%
Semi-private	Private	50%

Additional Exclusions:

(a) Hospital accommodation level higher than a regular private room (e.g. VIP, suite or deluxe suite and the like)
(b) Magnetic resonance imaging, computerised tomography scan, positron emission tomography scan performed in out-patient setting
(c) All laboratory examinations and diagnostic tests which could have been done in an outpatient facility without the need to be admitted to Hospital as an in-patient not payable under Hospital Services of Hospital & Surgical Benefits
(d) Any charges in respect of which Benefit is not payable under item clause (a) to (l) of Hospital & Surgical Benefits under Section B of PART III

In respect of a Hospital Confinement, the amount payable under this Benefit will not exceed the Maximum Limit of Supplementary Major Medical Benefit as shown in the Schedule of Benefits.

2. Optional Outpatient Benefits
(Applicable when these Benefits are indicated in the Schedule of Benefits as being covered by the Policy)

These provisions serve to act as a supplement to the Basic Benefits provisions and will only be available as an optional supplementary cover if the underlying Hospitalization and Surgical Benefits insurance under this Policy is provided and remains in force. Where the Policyholder has opted for such supplementary cover, the outpatient Benefits schedule will be incorporated or set forth in the Schedule of Benefits.

Outpatient Benefits will only be provided where a minimum number of two (2) employees, as a group, are registered and participate in coverage under the outpatient Benefits provisions. If for any reason, participation is or is to be reduced to less than this minimum number of employees required thereof on a subsequent anniversary, the Policyholder shall immediately notify the Company of the same in writing and the Company shall in that event have an absolute discretion as it thinks fit to cancel, suspend or continue with coverage under the "Outpatient Benefits" provisions of this Policy.

The following outpatient services will be covered subject to the maximum limits (i.e. percentage, and maximum benefits) for the respective covered Benefits and the Insured Plan as applicable and as specified in the Schedule of Benefits.

(a) Out-patient General Medical Practitioner Consultation and Medication

The Company shall reimburse the Reasonable, Customary and Medically Necessary charges for consultation or services rendered by a Registered Medical Practitioner on an outpatient basis for a covered Disability up to the maximum limits as indicated in the Schedule of Benefits.

(b) Out-patient Specialist Consultation and Medication

The Company shall reimburse the Reasonable, Customary and Medically Necessary charges for consultation or services rendered by a Specialist on an outpatient basis, as referred by a Registered Medical Practitioner in writing unless otherwise specified in the Schedule of Benefits, for a covered Disability up to the maximum limits as indicated in the Schedule of Benefits.

(c) Chinese Herbalist, Bonesetter and Acupuncturist's Treatment

The Company shall reimburse the Reasonable, Customary and Medically Necessary charges for consultation or services and medicine (excluding brewing or preparation of medicine) rendered by a

Chinese Medicine Practitioner on an outpatient basis for a covered Disability up to the maximum limits as indicated in the Schedule of Benefits.

(d) Physiotherapist's or Chiropractor's Visit

The Company shall reimburse the Reasonable, Customary and Medically Necessary charges for Treatment or services rendered by a Physiotherapist or Chiropractor, when referred by a Registered Medical Practitioner in writing, on an outpatient basis for a covered Disability up to the maximum limits as indicated in the Schedule of Benefits.

(e) Out-patient Diagnostic Laboratory Tests

Upon receipt and approval of due proof by a Registered Medical Practitioner that an Insured Member has sustained Sickness, Illness or Injury and as a result of such recommendation to undergo laboratory tests for diagnostic purpose other than routine medical check-ups, the Company shall reimburse the actual expenses incurred for such tests up to the maximum limits as stated in the Schedule of Benefits. The term "Out-patient Diagnostic Laboratory Tests" shall mean X-ray, electrocardiogram, blood test, urinalysis and other laboratory tests recommended by a Registered Medical Practitioner for diagnostic purpose excluding any such test which is taken by the Insured Member during his Hospital Confinement, or an account of bodily Injury or Sickness due to pregnancy, including childbirth or miscarriage.

(f) Prescribed Medicines and Drugs/Prescribed Western Medication

Upon receipt and approval of due proof by a Registered Medical Practitioner that an Insured member as an out-patient in the course of clinical Treatment requires medications by drugs orally or injections as prescribed therefor the Treatment of a covered Disability, and that these medicines and drugs must be purchased outside the Doctor's clinic, the Company shall reimburse an amount equal to the Reasonable, Customary and Medically Necessary charges actually made by the Practitioner or a pharmacy for the drugs up to the maximum limits as set forth in the Schedule of Benefits.

A Doctor's prescription is valid for 90 days from the issue date. The prescribed Western medication shall require and be dispensed by a registered pharmacist as stipulated by applicable laws and exclude over-the-counter drugs and all kinds of supplement.

3. Optional Dental Benefits
(Applicable when these Benefits are indicated in the Schedule of Benefits as being covered by the Policy)

These provisions serve to act as a supplement to the Basic Benefits provisions and will only be available as an optional supplementary cover if the underlying Hospitalization and Surgical Benefits insurance and Outpatient Benefits insurance under this Policy are provided and remain in force. Where the Policyholder has opted for such supplementary cover, the Dental Benefits schedule will be incorporated or set forth in the Schedule of Benefits.

Dental Benefits will only be provided where a minimum number of two (2) employees, as a group, are registered and participate in coverage under the Dental Benefits provisions. If for any reason, participation is or is to be reduced to less than this minimum number of employees required thereof on a subsequent anniversary, the Policyholder shall immediately notify the Company of the same in writing and the Company shall in that event have an absolute discretion as it thinks fit to cancel, suspend or continue with coverage under the Optional Dental Benefits provisions of this Policy.

On receipt by the Company of due proof that, the Insured Member shall receive Treatment made by a Dentist, Benefits shall be paid in an amount equal to the reimbursement percentage payable up to the maximum limits as set forth in the Schedule of Benefits.

Additional Exclusions:

(a) All other dental expenses not listed in the Schedule of Benefits.
(b) Services or materials for cosmetic purposes, or repair of congenital malformation solely for cosmetic purposes, except charges for cosmetic dental procedures performed while Insured Member hereunder and incurred as a result of and within twelve (12) months after an Accident suffered while Insured Member under this part for Dental Benefit.
(c) For any dental procedure not initiated and completed while insured for Dental Benefits under this part, benefit for more than thirty-one (31) calendar days after the termination of the Policy is excluded, even with proper medical proof.
(d) Dental procedures performed by anyone other than a licensed Dentist, except dental prophylaxis performed by a licensed dental hygienist under the supervision and direction of a licensed Dentist.
(e) Replacement of any lost or stolen denture, bridge or other dental appliance.
(f) Expenses incurred for oral hygiene instructions, plague control programs and dietary instructions.
(g) Addition of teeth to an existing partial removable denture or to replace extracted natural teeth, unless the natural teeth to be replaced were extracted while the patient was insured for Dental Benefits under this part.

PART IV – LIMITATIONS, EXCLUSIONS & CLAIMS PROCEDURE

Section A – Limitations

1. When an Insured Member is entitled to benefits payable under the Employee's Compensation Ordinance, any government or public program of medical benefits and other group or individual insurance plans, the Company shall determine the order of benefits payment in accordance with the following criteria:

   (a) An insurance plan with no provision to co-ordinate with other benefits shall be considered to pay benefits before an insurance plan which has such a provision.
   (b) An insurance plan which covers the insured as a member shall be considered to pay its benefits before an insurance plan which covers the insured as a dependant.
   (c) If benefits are payable under Employee's Compensation Ordinance or government or public program of medical benefits, the Company shall pay after benefits payment under the Employee's Compensation Ordinance or is made.

   If an Insured Member has, in accordance with the above criteria, claimed against the Employee's Compensation Ordinance or any government or public program of medical benefits or other insurance plans first, the Benefits payable under this Policy shall be limited to the balance of expenses not covered by Benefits already claimed or that calculated from the Insurance Schedule, whichever is less.

2. No benefit shall be payable under the Policy and the supplementary contracts for pre-existing conditions of an Insured Member. A pre-existing condition shall mean any Disease, or Injury for which an Insured Member received medical Treatment, medical diagnosis, care, consultation, or service, or took prescribed drugs or medicine for a period of time (pre-existing time period) immediately before the Effective Date of insurance for that person.

   The pre-existing time period is ninety (90) calendar days if the Insured Member has a pre-existing condition, the Company shall not pay benefits for any expenses incurred due to that condition until the earliest of the following occurs:

   (a) The completion of ninety (90) consecutive calendar days (while the Insured Member is insured under this Policy). During this time, the Insured Member receives no medical Treatment, incurs no medical expense, and takes no prescribed drugs to that condition; or
   (b) The date the Insured Member has been insured under this Policy for one year.

Section B – General Exclusions

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

1. Any charges for Mental Illness and Emotional Disorders except where specifically included for coverage as specified in the Schedule of Benefits;

2. Rest cures or sanitarian care; special nursing care;

3. Congenital Conditions, Developmental Conditions, Hereditary Conditions and all kinds of birth defects regardless of age;

4. Maternity, pregnancy, childbirth (including diagnostic tests for pregnancy, sex determination or and surgical delivery), miscarriage, abortion and pre-natal or post-natal care, surgical mechanical or chemical contraceptive methods of birth control or Treatment pertaining to infertility or in-vitro fertilization or sterilization or any complications (except as otherwise provided in Part B Item l) arising therefrom or all related Treatments;

5. All Hospital expenses incurred primarily for investigations (such as diagnostic scanning, X-ray examinations, laboratory tests, etc.) and/or physical therapy;

6. Room, board, general nursing care and other hospital services not relating to the diagnosis or Treatment of the condition for which the Hospital Confinement is required; non-medical personal services such as radio, telephone, photocopy, medical report charges, internet service, newspaper, taxi fare, travelling expenses, guest meal, taxes and the like;

7. Cosmetic surgery and/or Treatment for the purpose of beautification; or plastic surgery for any pre-existing condition;

8. Routine or general check-ups or routine blood tests, health examinations, check-ups or tests not incidental to Treatment or diagnosis of a covered Sickness or Injury, inoculation, medication or vaccination for immunization or quarantine purposes, convalescent Treatment except where specifically included for coverage as specified in the Schedule of Benefits;

9. Dental oral or oro-surgical care and Treatment of any kind including orthodontic, endodontic, and periodontic services; and restorative services such as bonding, crowns, bridges, spacing devices, and dentures, except where specifically included for coverage as specified in the Schedule of Benefits;

10. Services or supplies which are experimental or investigative in nature, including the Treatment procedure, facility, equipment, drugs, drug usage, devices or supplies which have not been recognized as accepted medical practice shall not be covered. Without prejudice to the generality of the foregoing, Treatments that have not been proven to be safe, scientifically established therapies or found to have a demonstrable benefit for a particular Sickness/Illness/Disease shall not be covered;

11. Eye or vision test or hearing tests, eye refraction Treatment; fitting of glasses or contact lenses,procurement or use of special braces, appliances, hearing aids, wheelchairs, crutches, artificial limb or any other similar equipment costs (except where specifically included for coverage as specified in the Schedule of Benefits);

12. Sickness or Injury directly or indirectly resulting from or consequent upon:

    (a) medicines and drugs which are not consumed in a Hospital or prescribed by a Doctor;
    (b) prescription drugs used in connection with drug addiction, alcoholism, weight reduction / control, smoking cessation and Treatment of baldness and experimental drugs;
    (c) willful misuse of drugs or alcohol, attempted suicide or intentional self-inflicted injury or participating in an illegal activity (except traffic and pedestrian offenses), attempted or committed any unlawful or illegal act or having more than the legally permitted level of alcohol in the blood whilst driving any kind of vehicle;
    (d) high risk activities or occupations including but not limited to:
        (i) engaging in or taking part in disciplinary, naval, military or air force service or operations;
        (ii) engaging in or practising in or taking part in training peculiar to: aqualung diving, rafting; mountaineering, rock-climbing, or trekking necessitating the use of ropes or guides; potholing, parachuting, bungee jumping, hang-gliding, stunts or daring feats; skiing, tobogganing, sledding and ice skating, including ice hockey and other sports requiring snow or ice for play; professional sports such as car racing, horse racing; motor cycling; engaging in aviation other than as a fare-paying passenger in an aircraft provided by and operated by an airline or air charter company which is duly licensed for the regular transportation of fare-paying passengers;
    (e) war or any act of war, declared or undeclared, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military or usurped power or act of terrorism, strike, riot, engaging military force; or

(f) radioactive contamination including any nuclear radiation or contamination of the use of ionization or combustion of any nuclear weapons, materials energy or power or any nuclear waste;

13. Venereal diseases and their sequelae; Acquired Immune Deficiency Syndrome (AIDS) and ARC (AIDS Related Complex) and their complications;

14. All inguinal hernias, hydroceles and undescended/retractile testes presenting from birth to the age of 15 years and their complications;

15. Trans-sexual surgery, circumcision unless Medically Necessary, podiatry, dietician, occupational therapy and speech therapy services; hospice service;

16. Alternative Treatment including but not limited to acupressure, Tui Nai, massage therapy, naturopathy, hydropathy, podiatry, biofeedback, hypnosis, pain clinics, homeopathy, ear reflexology, moxibustion, Qi Gong, hypnotism, aromatherapy, rolfing, yoga activities, cupping and scraping unless otherwise specified;

17. Any charges in respect of sexual dysfunction including but not limited to impotence, erectile dysfunction, pre-mature ejaculation, regardless of cause;

18. Female hormonal tests or assays and female hormonal replacement therapy unless resulting from a disease; hair mineral analysis (HMA);

19. Vitamins, antibacterial soaps and detergents, vaccines and allergenic extracts, nutrient herbs or tonic (including but not limited to Birds' Nest, Ginseng and Lingzhi) or pre-packaged commercial health supplement, shampoo, minerals, bath, oil/lotion, appetite stimulants or depressants and the like;

20. Any charge in excess of Reasonable, Customary and Medically Necessary charges or

21. Non-Medically Necessary Health Services.

Section C – Notice of Claim

1. Written notice of any Hospital Confinement or operation on which a claim may be based must be submitted to the Company within ninety (90) calendar days after the completion of Treatment or the date of discharge from the Hospital. Claims in respect of Out-patient Benefits, should be submitted to the Company within ninety (90) calendar days from the date of receipts. All claims must be submitted with original copies of receipts and itemized bills with diagnosis certified by the attending registered medical practitioner and a fully completed claim form supplied by the Company.

   All claims must be submitted to the Company within ninety (90) calendar days of completion of the events for which the claims is being made.

2. Notice given by or on behalf of the claimant to the Company with particulars sufficient to identify the Insured Member shall be deemed 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.

Section D – Filing Proof of Loss

Affirmative proof of loss acceptable to the Company, including original copies of receipts and itemized bills, for which claim may be based together with a fully completed claim form supplied by the Company must be furnished by the Policyholder to the Company within ninety (90) calendar days after the termination of the period for which claim is made. Should the submitted documents require verification or other necessary actions, they shall be returned to the Policyholder for such actions and must be re-submitted to the Company within ninety (90) calendar days after the termination of the period for which claim is made.

Section E – Examination

The Company shall have the right and opportunity to examine any Insured Member in respect of whom a claim has been submitted when and so often as it may reasonably require during pendency of a claim, and also the right and opportunity to make or have made an autopsy in case of death where it is not forbidden by law.

Section F – Payment of Claim

All Benefits that pertain to an Insured Member shall be paid by cheque to the order of the Insured Member or by direct reimbursement to the Insured Member's bank account, unless the Policyholder for reasons acceptable to the Company requests otherwise, or the Company, at its discretion, considers it preferable to make the payment in another manner.

If the Policyholder has appointed specific Network Service Provider(s) for providing medical services to the Insured Member, direct payment of any Benefits by the Company in respect of the Insured Member to such Provider(s) shall be a good and full discharge to the Company and shall release the Company of all claims and demands whatsoever in respect thereto.

Settlement of any death proceeds shall be made only after the production to the Company of proof of cause of death and proof of death of the Insured Member in a form satisfactory to the Company and, where applicable, after probate or letters of administration has been submitted to the Company and when the Company is permitted under the laws of Hong Kong to make payment of the death proceeds.

Section G – Subrogation Rights

In the event of any payments for Benefits provided to an Insured Member under the Policy, the Company, to the extent of such payment, shall be subrogated to all rights or recovery such Insured Member has against any person or organization; and the Insured Member shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

PART V – GENERAL CONDITIONS

Section A – Premium

1. During the Period of Insurance, the premium for insurance under this Policy shall be based upon the premium rates shown in the Premium Schedule. The Company shall have the right to change the rate at which premium shall be calculated, (a) on any Policy Renewal Date, and (b) 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) calendar days in advance of such Premium Due Date.

2. Premium adjustments, if any, shall be effective immediately following the Effective Date of enrolment, benefit change or termination of any Insured Member.

3. Premiums are payable by the Policyholder as frequent as specified in Premium Payment Mode of Insurance Schedule in advance to the Company. The first premium shall be payable at or before the Commencement Date and subsequent premiums shall be due and payable on the Premium Due Dates as stated in the Insurance Schedule or renewal invitation document/renewal notice or invoices/debit notes whichever is earlier.

Section B – Termination and Reinstatement of Policy

1. If any premium is not paid in respect of this Policy or any of the supplementary contracts before Premium Due Date, this Policy and the relevant supplementary contracts (if any) shall automatically terminate after such due date, except that if the Policyholder shall have given the Company written notice in advance of an earlier date of termination, this Policy and the relevant supplementary contracts shall terminate as of such earlier date. The Policyholder shall be liable to the Company for the premiums for the time the Policy and any of the supplementary contracts in force.

2. The Company reserves the right to terminate this Policy and any of the supplementary contracts when fewer than the total number of Insured Members then eligible for insurance are insured, provided that the Company shall give the Policyholder at least thirty-one (31) calendar days of its intent to terminate.

3. At any Policy Anniversary, both the Policyholder and the Company may cancel this Policy and any of the supplementary contracts by giving the other party at least thirty-one (31) calendar days' notice before Policy Anniversary of its intent to terminate.

4. Whenever this Policy or any of the supplementary contracts is terminated either by the Policyholder or by the Company, any premiums that are outstanding and unpaid up to the date of termination of this Policy or of any of the supplementary contracts shall be paid by the Policyholder. If this Policy or any of the supplementary contracts is terminated by the Company, unless the termination is due to the number of employees registered or participating decreases for any reason to less than three (3) employees during the duration of this Policy, any premium that have been paid to cover the period after the date of termination of this Policy or of any of the supplementary contracts shall be refunded by the Company to Policyholder after deducting all the claim payments made or to be for that period.

   For the avoidance of doubt, no premium will be refunded if this Policy or any of the supplementary contracts is terminated by the Policyholder, or, if this Policy or any of the supplementary contracts is terminated by the Company due to the number of employees registered or participating decreases for any reason to less than three (3) employees during the duration of this Policy.

5. Termination and non-renewal of this Policy or of any of the supplementary contracts either by the Policyholder or by the Company shall be without prejudice to any valid claim arising prior to the

date of termination but the incurred date of such claim shall be limited to the last day of the Period of Insurance.

6. After termination of the Policy or of any of the supplementary contracts, the Policyholder may apply for reinstatement which shall be subject to the consent of the Company to terms and conditions which the Company may impose including but not limited to the payment of any all premiums due and in arrears together with interest at a rate to be decided upon by the Company.

7. This Policy shall be terminated by the Company, by written notice to the Policyholder, due to the Policyholder's breach of participation rules or material breach of the terms of the Policy.

8. This Policy shall be terminated by the Company, by written notice to the Policyholder, if the Policyholder provided the Company with false information material to the execution of this Policy or to the provision of benefits under this Policy.

9. In the circumstances described it in clauses 7 and 8 above, the Company has the right to rescind this Policy retroactively to the Policy Commencement Date, and collect compensation from the Policyholder for all claims reimbursed under this Policy, plus administrative fees.

10. This Policy shall be terminated by the Company due to fraud or misrepresentation by the Policyholder, or because the Insured Member knowingly provided the Company with false material information, including, but not limited to, false information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind to the Policy from the Effective Date.

Section C – Renewal

This Policy and each of the supplementary contracts (if any) are issued for the Period of Insurance as stated in the Insurance Schedule and at the end of such Period of Insurance may be renewed subject to the consent of the Company at such premium rates as may be determined by the Company.

The Company reserves the right to revise the Benefits, terms and conditions and premiums under this Policy upon policy renewal. Any such revision and adjustment will be applicable from the next renewal of this Policy. The Company shall not be under any obligation to renew the Policy or any part thereof.

The Policyholder can give written notice to the Company at least thirty (30) days before the expiry date of each Policy Year for applying change of Insured Plan upon renewal. Subject to the approval by the Company, the new Insured Plan and premium will be effective only on the first (1st) day of the earliest coming renewal Policy Year.

Section D – Data Required

1. The Policyholder shall keep a record with respect to each Insured Member under this Policy, showing the Insured Member's name, sex, age or 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 this Policy.

2. Clerical error in keeping the records shall not invalidate insurance in force, but upon the discovery of such error, an equitable adjustment shall be made.

3. The Policyholder shall furnish the Company with all information and proofs with the Company may reasonably require with regards to any matters pertaining to the Policy. All documents furnished to the Policyholder by any Insured 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.

Section E – Misstatement

1. If the age or date of birth or other relevant facts relating to an Insured Member shall be found to have 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.

2. Where a misstatement of age or other relevant facts has caused an Insured Member to be insured hereunder when he is otherwise ineligible for insurance or where such statement has caused a Insured 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 of the Insured Member after deducting any claim paid, provided always that when there is fraud on the part of the Policyholder or Insured Member, no premiums paid are to be returned.

Section F – Prohibition on Trust or Assignment

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

The Company shall be entitled to without the consent of the Policyholder assign any or all of its right and duties under this Policy.

Section G – Proper Law and Jurisdiction

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

Section H – Legal Proceedings

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of ninety (90) calendar 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 (2) years from the expiration of time within which proof of claim is required by this Policy.

Section I – The Contract

1. All statement made by the Policyholder, or by the Insured Member, shall, in the absence of fraud, be deemed representations and not warranties, and no statement avoid the insurance, or be used in defence of a claim under it, unless it is in writing.

2. The rights of the Policyholder or 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 Medical Health Statement, or in any other document which constitutes part of the entire contract.

3. No agent is authorized to alter or amend this Policy, to accept premium in arrears, 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 approved by the Company and evidenced by endorsement hereon, or by amendment hereto signed by the Company.

4. 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.

Section J - Currency and Place of Payment

All premiums to the Company and Benefits payable by the Company shall be payable at the office hours and in the Hong Kong currency. Any claim for reimbursement or expenses by an Insured Member in any foreign currency shall be converted to the currency of Hong Kong at the official buying rate of such currency for Hong Kong dollars in effect in Hong Kong at the time the payment of such expenses were paid by the Insured Member, or if no such official rate exists, at the rate certified as appropriate by the Company's bankers which shall be deemed to be final and binding.

Section K – Interest

No Benefit and Eligible Expenses payable under this Policy shall carry interest.

Section L – Discharge of Company's Liability

Payment of any claim, or a portion of any claim under any part of parts of this Policy is made without prejudice and any payment shall be a full and an effective and complete discharge of the Company's liability for that claim under this Policy.

Section M – Whole Agreement

This Policy contains whole agreement between the parties and the Policyholder acknowledges that the Policyholder has not relied upon any oral or written representation made to the Policyholder by the Company, its employees or agents.

Section N – Suits Against Third Parties

Nothing in this Policy shall render the Company liable in respect of, or liable to prosecute, respond to or defend, any suit for damages which may arise in connection with any negligence, omission, default or malpractice of any prover to provider any services or Treatment or conduct any medical examination of any Insured Member under the terms and conditions of this Policy.

Section O – Conditions Precedent to Liability

Any and all liabilities of the Company to the Policyholder under this Policy shall be wholly dependant upon:

1. The Company being furnished with all the statements and declarations required under this Policy to be provided by the Insured Member (or by a parent or duly appointed guardian if the Insured Member is a child);

2. The truth of all statements, warranties and declarations made by the Policyholder or Insured Member or made in respect to any claim made against the Company under the provisions of this Policy; and

3. The due observance and fulfilment of all the Terms, Provisions and Conditions of this Policy as they relate to anything to be done or complied with by the Policyholder or the Insured Member (whose observance and fulfilment of the same shall be solely the Policyholder's obligation to procure);

All of which shall be conditions precedent to any liability by the Company to pay any benefit under this Policy.

Section P – Registration

A written Application in a form satisfactory to the Company is required for each Eligible Member. A minimum of three (3) employees of the Policyholder for registration and participation, as a group or class, is required for coverage under this Policy and in the event that the number of employees registered or participating decreases for any reason to less than three (3) employees during the duration of this Policy, the Policyholder shall immediately notify the Company of the same in writing and the Company shall have an absolute discretion as it thinks fit to cancel, suspend or continue with coverage under this Policy. Under no circumstances will the Company arrange any premium refund to the Policyholder if the number of employees registered or participating decreases for any reason to less than three (3) employees during the duration of this Policy. Special provisions as to the minimum number of Eligible Members for registration and participation may however apply in respect of certain types of coverage as may be set in PARTIII of this Policy in which event, those special provisions shall override the requirements under this condition as to the minimum number of employees for registration and participation.

Section Q – Sanction Clause

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 the Company to any sanction, prohibition or restriction under United Nations resolutions or the trade, economic or financial sanctions, laws or regulations of, but without limitation, the European Union, United Kingdom, United States of America, Hong Kong or any other applicable country or territory.

This Policy excludes the provision of any insurance service, coverage or any benefit in connection with loss, damage or liability resulting from activities that directly or indirectly, involve or benefit the government of Belarus, Crimea, Democratic People's Republic of Korea, Iran, Syria, Cuba and Venezuela, or persons of entities resident or located in Belarus, Crimea, Democratic People's Republic of Korea, Iran, Syria, Cuba and Venezuela. However, this exclusion shall not apply to activities carried out, or service provided, in an emergency for the purposes of safety and/or security or where the related risk has been notified to the Company and the Company has confirmed cover for the respective risk in writing.

PART VI – EMERGENCY ASSISTANCE PROGRAM

This Emergency Assistance Program is issued and provided by Europ Assistance Worldwide Services Pte Ltd (hereinafter called "Europ Assistance") to the Insured Members who are insured under this Policy with Assicurazioni Generali S.p.A.

Section A – Scope of Services

The Insured Member may call to Europ Assistance at **(852) 8109 2883**, 24 hours a day, 365 days (or 366 days, in a leap year) to request the following services.

1. Medical Assistance

(a) Emergency Medical Evacuation

Europ Assistance will arrange and pay for the reasonable cost(s) of transportation and on-route medical care and supplies necessarily incurred, in the event an Insured Member suffers a Sickness or Accident or Injury overseas, and in the opinion of Europ Assistance's Doctor, it is necessary to evacuate the Insured Member to the nearest Hospital for urgent and necessary medical Treatment.

(b) Emergency Medical Repatriation

Europ Assistance will arrange and pay the cost(s) for a medically supervised repatriation for an Insured Member's return to his/her Country of Residence or Country of Origin by scheduled airline flight as soon as his medical condition allows it if, following a medical emergency, care was provided close to the Insured Member's place of Accident or Injury or Sickness or in a Hospital Europ Assistance evacuated the Insured Member to, but Europ Assistance's Doctor deems the Insured Member unfit to continue his/her trip.

(c) Repatriation of Mortal Remains

Europ Assistance will, in the event of the death of an Insured Member, assist with the necessary formalities and pay for all reasonable and necessary transportation charges directly related to transporting the Insured Member's mortal remains or body from the place of death to his/her Country of Residence or Country of Origin.

(d) Tele-medical Consultation and Evaluation of the Insured Member's Condition (applicable whilst traveling abroad)

In the event an Insured Member needs medical advice while on a trip, the Insured Member may call Europ Assistance's duty Doctor for consultation and evaluation.

The telephone conversation between the Insured Member and the Europ Assistance's duty Doctor cannot establish a diagnosis and must be treated as advice only.

(e) Deposit Guaranteeing of Hospital Admission

If an Insured Member is required while on a trip to be hospitalized, and upon the Insured Member's request, Europ Assistance will guarantee or provide such emergency medical payment to the hospital up to HK$50,000. Europ Assistance must first receive the total amount to be advanced in cash or in the form of guarantees of reimbursement from a person designated by the Insured Member.

2. Personal Assistance

(a) Pre-Trip Travel Information (applicable whilst traveling abroad)

Europ Assistance will provide pre-trip referral and travel information, visa, inoculation, passport or immunization requirements of the country(ies) to which the Insured Member will be traveling.

(b) Return of Dependent Children

If an Insured Member has minor child(ren) (aged 16 or below) who are left unattended as a result of the Insured Member's Injury, Illness, Accident or medical evacuation, Europ Assistance will pay (one-way economy transportation) and assist the Insured Member in making arrangement for the unattended child(ren) to return to his/her home in the Insured Member's Country of Residence or Country of Origin.

(c) Locating Lost Items (applicable whilst traveling abroad)

Europ Assistance will assist the Member as far as is reasonably possible, in the location of lost luggage, documents and personal items, by providing instructions for recovery or replacement, and contacting if necessary, airlines, government authorities, credit card issuers and other relevant organizations.

(d) Referral to Interpreter (applicable whilst traveling abroad)

Europ Assistance will, at the request of the Insured Member, refer the Insured Member to available interpretation services, where the Insured Member is located.

(e) Message Relay in an Emergency (applicable whilst traveling abroad)

Europ Assistance will, in case of an Emergency, use its best efforts to establish a national or international message relay to a designated addressee.

(f) Flight Information (applicable whilst traveling abroad)

The Member may call Europ Assistance for flight information including departure and arrival times for flights.

(g) Visit to bedside by a next-of-kin (Compassionate visit)

If as a result of a medical Emergency, the Insured Member is hospitalized for more than seven (7) consecutive days, and Europ Assistance's Doctor agrees that it is medically necessary for a next-of-kin to be by the Insured Member's bedside provided no travel companion is with the Insured Member, Europ Assistance will arrange and pay for the cost of a round-trip economy transportation from Hong Kong, including the cost of an ordinary room accommodation in any reasonable hotel up to HK$1,200 per day for a maximum period of five (5) consecutive days, but excluding the cost of beverages, meals and other room services/charges.

(h) Convalescence Expense

Europ Assistance will arrange and pay for the cost of an ordinary room accommodation in any reasonable hotel up to HK$1,200 per day for a maximum of five (5) consecutive days, excluding the cost of beverages, meals and other room services/charges, incurred by the Insured Member for the sole purpose of convalescence immediately following his discharge from the hospital, and if deemed medically necessary by both attending Doctor and Europ Assistance's Doctor.

(i) Unexpected Return to Country of Residence

In the event of death of the Insured Member's Immediate Family Member in his/her Country of Residence while the Insured Member is traveling overseas (excluding the case of immigration) necessitating an unexpected return to his Country of Residence, Europ Assistance will arrange and pay for the cost of a one-way economy transportation for the return of the Insured Member.

3. Legal Assistance

(a) Legal Referral (applicable whilst traveling abroad)

Europ Assistance will provide the Insured Members with the names, address, telephone numbers and if requested by an Insured Member and if available, office hours for lawyers or legal practitioners within the area where the Insured Member is then located. These recommendations are based upon the best judgment of Europ Assistance and its knowledge of the local conditions and availability of legal services at the geographical location involved. Europ Assistance does not guarantee the quality of the legal advice nor will Europ Assistance be liable for any consequences arising from the services provided by the lawyer or legal practitioner. The final selection of the lawyer or legal practitioner will be the responsibility of the Insured Member.

Section B – Costs and Expense to Be Borne By Insured Member

The services stated herein, except services stipulated in Section A Clause 1(a) to Clause 1(c), Clause 2(b), and Clause 2(g) to Clause 2(i), are rendered to the Insured Member solely on referral basis.

Section C – General Provision

1. The following General Provisions apply:

(a) The Insured Member or expatriate on valid work pass must be domiciled in Hong Kong Special Administrative Region ("Hong Kong SAR"), China and must be at least fifteen (15) days old and not more than age seventy (70).

(b) Services and Benefits will be granted to Insured Members whilst traveling abroad outside the Territory of Hong Kong SAR, China.

(c) Any legal actions and claims must be received by Europ Assistance, in writing, within thirty (30) days of the date of the event giving rise to the action or claim.

(d) The Insured Member must take reasonable care to prevent Accident, Injury or Illness.

(e) Fraud, misstatement or concealment in the statements made by or on behalf of the Insured Member prior to or when effecting this Policy, or any fraudulent claim made, will render the Policy null and void and all Benefits will be forfeited.

2. In the case of medical evacuation, repatriation or return of dependant children, if the Insured Member or his/her child holds valid open or modifiable tickets, this shall be put at the disposal of Europ Assistance to make the new travel arrangement on behalf of the Insured Member. If the original return ticket is not valid for the return journey, the Insured Member shall surrender any unused portion of the return ticket to Europ Assistance.

Section D – Other Limitations

1. The legal and/or medical referrals provided by Europ Assistance are not employees or agents of

Europ Assistance and/or its subsidiaries or affiliated companies. Europ Assistance and/or its subsidiaries or affiliated companies cannot be held responsible for the quality or results of any services provided by persons to whom Europ Assistance refers the Insured Member.

2. In no event will Europ Assistance be liable for any incidental, special, consequential or indirect loss, damages, costs, charges, fees or expenses, howsoever caused, including without limitation loss of profits, revenues, business, use, or anticipated savings.

3. In providing Emergency medical evacuation and repatriation services, Europ Assistance reserves the right, at its discretion, to determine whether the Insured Member's medical condition is sufficiently serious to warrant medical evacuation, the location to which the Insured Member will be evacuated and the means or methods by which the repatriation or evacuation will be conducted. In making any arrangements, Europ Assistance may consider all relevant circumstances, including but not limited to the Insured Member's medical condition, the degree of urgency, the Insured Member's fitness to travel, airport availability, weather conditions and travel distance in determining whether transport will be provided by air ambulance, regular air transportation, rail, road or any other appropriate means. All decisions as to the means of transportation and the final destination will be made by Europ Assistance or its authorized representative. If the Insured Member refuses to accept these conclusions, all consequences and expenses arising from the refusal will not be covered by Europ Assistance.

4. Europ Assistance will not be responsible for delay in performing or for failure to perform any obligations arising directly or indirectly from any cause or circumstance whatsoever beyond its control, including but not limited to Acts of God, strikes, flight conditions, or the act of any local, regional or international government, authority or agency.

5. Europ Assistance reserves the right to impose a limit of one (1) Emergency evacuation and/or repatriation attributable to any single medical condition of an Insured Member.

Section E – Exclusions

1. The following Treatment, items, conditions, activities and their related consequential expenses are excluded:

(a) Emergency medical evacuation, repatriation or any other cost(s) not approved in advance and in writing by Europ Assistance and/or not arranged by Europ Assistance. This exclusion will not apply to Emergency medical evacuation from remote or primitive areas, when Europ Assistance cannot be contacted in advance and delay might reasonably be expected to result in loss of life or extreme prejudice to the Insured Member's prospect.

(b) Any expense incurred when the Insured Member is traveling outside Hong Kong:

(i) contrary to the advice of a Medical Practitioner;
(ii) for the purpose of obtaining medical Treatment; or
(iii) for rest and recuperation following any Accident, Injury or Illness, of which Europ Assistance does not render authorization and/or intervention.

(c) Any expense incurred when the Insured Member is not suffering from a serious medical condition and/or in the opinion of Europ Assistance's Doctor, the Insured Member can be adequately treated locally or if the Treatment can be reasonably delayed until the Insured Member returns to Hong Kong.

(d) Europ Assistance will not provide any services in respect of:

(i) declared or undeclared war, invasion, act of foreign enemy, hostilities or war-like operations, civil war, rebellion, revolution, insurrection or military usurped power;

(ii) nuclear weapons material, ionising radiations or contamination by radioactivity from any nuclear fuel or nuclear waste;

(iii) full-time military service with any armed forces of any country or international authority other than peace time reservist training;

(iv) failure by the Insured Member to take reasonable precautions following warnings of any intended strike, riot or civil commotion via the mass media;

(v) intentional self-inflicted injury, insanity, suicide, or attempted suicide, pregnancy, miscarriage, contraception and all related complications sexually transmitted diseases, AIDS, HIV infections and AIDS related condition or disease;

(vi) engaging in or taking part in aeronautics or aviation, other than as a fare paying passenger in a properly licensed commercial or private aircraft;

(vii) engaging as competitor in wagers, horse races, bicycle races, any kind of motorized races, sports exhibitions, aerial sports, bungee jumping, climbing, rafting, speleology, scuba diving, speed competition and all sports practised as a profession and all sports when the Insured Member takes part in them as a competitor;

(viii) committing or attempt to commit any illegal or unlawful act;

(ix) detention, destruction, confiscation by customs or government authorities, breach of government regulations;

(x) any expenses associated with drug abuse, narcotics, derivative products and alcohol;

(xi) any health condition which constitutes one of the reasons to undertake the trip;

(xii) the cost of burial in the Member's home country;

(xiii) all medical / hospital expenses; and

(xiv) the following excluded countries and territories:

- Africa: Algeria, Eritrea, Rwanda, Somalia, Western Sahara and Saint Helena
- Asia: Afghanistan, Iraq, Cocos Islands, East Timor and British Indian Ocean Territories
- Pacific Rim: American Samoa, Bouvet Island, Christmas Island, French Southern Territories, Heard &McDonald, Kiribati, Marshall Islands, Micronesia, Nauru, Niue, Palau, Pitcairn, Solomon Islands, South Georgia and South Sandwich, Tokelau, Tonga, Tuvalu, U.S. Minor Outlying Islands, Vanuatu, Wallis & Futuna.
- Antarctica: Antarctic

This list is subject to change at any time. The Insured Member may call Europ Assistance at any time for an updated list of countries and territories in which the services may not be available.

Section F – Subrogation and Subsidiarity

1. The primary purpose of this supplement is the provision of services to Insured Members when involved in a medical Emergency.

2. If the services provided by Europ Assistance are covered in whole or in part by an insurance policy or other health plans, Europ Assistance will only be responsible for any cost which cannot be recovered by the Insured Member under the insurance.

3. Any portion of an Insured Member's travel ticket, which is unused following the provision of services, is to be surrendered to Europ Assistance.
4. Europ Assistance may at any time and at its own expense, and without prejudice to this supplement, take proceedings in the name of the Insured Member to obtain compensation or secure an indemnity from any third party in respect of any loss or injury, arising from the provision

of services.

Section G – Governing Law

This Agreement shall be governed by and construed in accordance with the laws of Hong Kong. Any disputes arising in connection with the contract which cannot be settled shall be referred to and settled in accordance with the arbitration rules of the Hong Kong International Arbitration Centre then in force.

Section H – Definitions

The following terms and expressions will have the following meanings unless otherwise stated:

"Accident" means any sudden and unexpected violent event which may befall the Insured Member, but excludes any intentionally self-inflicted injury.

"Illness" means any sudden and unexpected deterioration of health as certified by a Medical Practitioner**.**

"Emergency" means a situation which in the opinion of Europ Assistance requires urgent remedial Treatment to avoid death or serious impairment to the Insured Member's immediate or long term health prospects. The severity of the medical condition will be judged by various factors including the context of the Insured Member's geographical location, the nature of the medical emergency and the local availability of appropriate Medical Facility.

"Europ Assistance's Doctor or duty Doctor" means a Medical Practitioner designated by Europ Assistance.

"Hospital, Medical Facility or Local Medical Provider" means any institution which is licensed as a medical or surgical hospital in the country in which it is located and whose main activities are not those of a spa, hydro clinic, sanatorium, nursing home or home for the aged. It must be under the constant supervision of a Medical Practitioner.

"Medical Practitioner" means a person with a degree in western medicine who is authorized to provide medical services by the law of the country where the medical services is provided but excludes:

1. the Insured Member; and
2. a business partner or relative of the Insured Member.

"Insured Member(s)" means the person(s) to whom Europ Assistance has to provide services to.

"Immediate Family Member" means the Insured Member's spouse, father, mother and his/her child(ren).

"Country of Residence" means Hong Kong SAR, China.

"Country of Origin" means the country in which the Insured Member's citizenship was issued. If the Insured Member holds a dual citizenship, he/she will have to elect either one (1) country as his/her Country of Origin.

PART VII – DEPENDANT PROVISIONS

Section A – Dependants

For the purpose of this Policy, the term "Dependant" shall mean the following:

1. An Insured Member's legal spouse aged between sixteen (16) and sixty-five (65) years, who is not a member of the Policy.

2. An Insured Member's unmarried children aged between fifteen (15) calendar days and nineteen (19) years, who are not gainfully employed as a full-time employee or twenty-three (23) years full time student.

If any person defined as a Dependant is also eligible to become an Insured Member, such person shall not be eligible as a Dependant. When both husband and wife are Insured Members, their children are eligible only as Dependants of the husband or of the wife as duly specified by the Policyholder.

Section B - Individual Participation and Termination

1. Participation

(a) All Dependants of an Insured Member shall become eligible for coverage on the date the Insured Member becomes eligible or on the first day immediately following their becoming "Dependants" as defined above, whichever is later.
(b) If a Dependant is disabled by sickness or injury on the date that he would otherwise be eligible, the Dependant's eligibility date shall be deferred to the first day immediately following his complete recovery from such disability.
(c) The insurance of a Dependant of an Insured Member shall take effect on the Dependant's eligibility date provided the Insured Member applies to enroll the Dependant within thirty-one (31) calendar days from the Dependant's eligibility date; otherwise the insurance of the Dependant shall take effect on a date to be specified by the Company after the Insured Member has submitted written notification and has produced satisfactory evidence of insurability of the Dependant which the Company may require at no expense to the Company.

2. Termination

The insurance of a Dependant shall cease on the earliest of the following dates:

(a) The date the Policy is terminated.
(b) The date this supplement is terminated.
(c) The date the Insured Member's insurance under this Policy is terminated.
(d) The date when the Dependant ceases to fulfil the conditions as stated in Section A - Dependants.
(e) The date of expiration of the period for which the last premium payment is made for insurance under this supplement.

Section C - Benefits

Subject to the provisions of the Policy and of this supplement, the Company shall pay the Benefits up to the amount indicated in the Insurance Schedule.

Section D - Terms and Provisions of the Policy

All other terms and provisions of the Policy to which this supplement is attached shall apply to this supplement insofar as they are not inconsistent with this supplement.