TaxVantage Prestige Medical Plan

Terms and Conditions

Contents

TERMS AND CONDITIONS

Part 1 Insuring Clause and The Policy

Insuring Clause

These Terms and Conditions together with the Benefit Schedule (including the Schedule of Surgical Procedures) and any related Supplement(s) as certified by the Government (hereafter "Terms and Benefits") apply to the following Certified Plan under the Voluntary Health Insurance Scheme (hereafter "VHIS") offered by the Company –

Type of the Certified Plan - Flexi Plan
Name of the Certified Plan - TaxVantage Prestige Medical Plan

During the period of time these Terms and Benefits are in force, if the Insured Person suffers from a Disability, the Company shall pay the Eligible Expenses accordingly.

All benefits payable to the Policy Holder shall be on a reimbursement basis of the actual amounts of Eligible Expenses incurred and are subject to the maximum limits and cost-sharing arrangement (if any) as stated in these Terms and Benefits and the Policy Schedule.

The Policy

The Policy Holder and the Company agree that –

1. No alteration to these Terms and Benefits shall be valid unless it is made in accordance with these Terms and Conditions.

2. All statements made by or for the Insured Person in the Application shall be treated as representations and not warranties.

3. All information provided and all statements made by or for the Insured Person as required under this Policy and the Application shall be provided to the best of his knowledge and in his utmost good faith.

4. These Terms and Benefits come into force on the Policy Effective Date as specified in the Policy Schedule on the condition that the Policy Holder has paid the first premium in full.

5. At the inception of these Terms and Benefits and at each Renewal, in the event of any inconsistency between –

   (a) the terms and benefits of this Policy; and

   (b) the Standard Plan Terms and Benefits of such version as may be determined by the Government and is referred to in Sections 1 (a) to (c) of Part 4,

then –

(i) so far as the scope of Standard Plan Terms and Benefits is concerned, the terms and benefits which are more favourable to the Policy Holder or the Insured Person shall prevail to the extent of such inconsistency; and

(ii) so far as the scope of Standard Plan Terms and Benefits is concerned, the terms and benefits which impose additional restrictions or limitations to the Policy Holder or the Insured Person shall become ineffective.

Both (i) and (ii) shall not apply to the exceptions in Section 7 of this Part 1, Sections 1(b) and 5 of Part 6 and any other exception as may be approved by the Government from time to time.

If the relevant terms and benefits in the Standard Plan Terms and Benefits prevail, such terms and benefits shall be deemed to be incorporated into these terms and benefits of this Policy. For the avoidance of doubt, the rights, powers, benefits or entitlements of the Policy Holder or the Insured Person under the terms and benefits of this Policy shall not be less favourable than those under the Standard Plan Terms and Benefits (had it been issued to the Policy Holder in respect of the Insured Person), save for the exceptions in Section 7 of this Part 1, Sections 1(b) and 5 of Part 6 and any other exception as may be approved by the Government from time to time.

6. At the inception of these Terms and Benefits and at each Renewal, if this Policy covers any benefits that exceed the Standard Plan Terms and Benefits and the terms and benefits applicable to such benefits differ from the terms and benefits applicable to the Standard Plan Terms and Benefits, the difference shall not amount to an inconsistency contemplated under Section 5 of this Part 1.

7. At the time these Terms and Benefits are first issued, the Company may apply Case-based Exclusion(s) due to a Pre-existing Condition or other factor that affects the insurability of the Insured Person notified to the Company in the Application.

8. The Company acknowledges that, as part of the underwriting process, it is the obligation of the Company to ask the Policy Holder and the Insured Person in the Application all requisite information for the Company to make the underwriting decision. If the Company requires the Policy Holder and/or the Insured Person to disclose any updates of or changes to such requisite information after the time of submission of Application and before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Company must make such a request prominently to the Policy Holder and the Insured Person (including without limitation in the application form), in which case the Policy Holder and/or the Insured Person shall have the obligation to inform the Company on such updates and changes. Each of the Policy Holder and the Insured Person shall have the obligation to respond to the questions, and to disclose such material facts as requested in the questions. The Company agrees that if any such questions are not included in the Application, the Company shall be deemed to have waived the disclosure obligation of the Policy Holder and the Insured Person in respect of the information that was not requested.

9. All questions and required information included in the Application must be sufficiently specific and unambiguous, and consistent with the rules and regulations of the VHIS, so as to allow the Policy Holder and the Insured Person (as the case may be) to understand the information being requested and to provide clear and unequivocal responses. In case of dispute, the burden of proving that the questions are sufficiently specific and unambiguous shall rest with the Company.

10. If the Policy Holder or the Insured Person fails to make the relevant disclosures under Section 8 or 9 of this Part 1, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right as provided in Sections 13 and 14 of Part 2.

Part 2 General Conditions

1. Interpretation

(a) Throughout these Terms and Benefits, where the context so requires, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.

(b) Headings are for convenience only and shall not affect the interpretation of these Terms and Benefits.

(c) A time of day is a reference to the time in Hong Kong.

(d) Unless otherwise defined, capitalised terms used in these Terms and Benefits shall have the meanings ascribed to them under Part 8.

These Terms and Benefits have been prepared in both English and Chinese. Both English and Chinese versions are official versions and neither one shall prevail over the other. Any inconsistency shall be interpreted in favour of the Policy Holder.

So far as the same benefit coverage is concerned, any inconsistency in terms and amounts of benefits within this Policy shall be interpreted in favour of the Policy Holder and any restrictions or limitations imposed on these Terms and Benefits shall become ineffective, save for the exceptions in Section 7 of this Part 1, Sections 1(b) and 5 of Part 6 and any other exception as may be approved by the Government from time to time.

2. Cancellation within cooling-off period

The Policy Holder may exercise the right of cancellation of these Terms and Benefits with full refund of paid premium during the cooling-off period. The cancellation right is subject to the following conditions –

(a) The request to cancel must be signed by the Policy Holder and received directly by the Company within the cooling-off period. The cooling-off period is the period of twenty-one (21) days immediately following the day of the Delivery to the Policy Holder or the nominated representative of the Policy Holder, of –

(i) these Terms and Benefits and the Policy Schedule; or

(ii) the cooling-off notice;

whichever is the earlier. For the avoidance of doubt, the day of Delivery of these Terms and Benefits and the Policy Schedule or the cooling-off notice is not included for the calculation of the twenty-one (21) days period. However, if the last day of the twenty-one (21) days period is not a working day, the period shall include the next working day; and

(b) no refund can be made if a benefit payment has been made, is to be made or impending.

The above cancellation right shall not apply at Renewal.

To exercise this cancellation right, the Policy Holder must –

(c) return the original of these Terms and Benefits and the Policy Schedule; and

(d) attach a letter, signed by the Policy Holder, requesting cancellation or in other forms acceptable by the Company.

These Terms and Benefits shall then be cancelled and the premium paid shall be fully refunded. In such event, these Terms and Benefits shall be deemed to have been void from the Policy Effective Date and the Company shall not be liable to pay any benefit.

3. Cancellation

After the cooling-off period, the Policy Holder can request cancellation of these Terms and Benefits by giving fourteen (14) days prior written notice to the Company, provided that there has been no benefit payment under these Terms and Benefits during the relevant Policy Year.

The cancellation right under this Section shall also apply after these Terms and Benefits have been Renewed upon expiry of its first (or subsequent) Policy Year.

4. Benefit entitlement

If Eligible Expenses are incurred for Medical Services provided to the Insured Person, the Terms and Benefits applicable shall be those prevailing at the time that such Eligible Expenses are incurred. However, if this Policy has been terminated but Eligible Expenses incurred within a period of thirty (30) days after termination are covered pursuant to Section 15 of this Part 2, the Terms and Benefits applicable shall be those prevailing as at the day immediately preceding the date of termination of this Policy.

5. Assignment

The rights, benefits, obligations and duties of the Policy Holder under these Terms and Benefits shall not be assignable and the Policy Holder warrants that any amounts payable under these Terms and Benefits shall not be subject to any trust, lien or charge.

6. Clerical error

Clerical errors in keeping the records shall neither invalidate coverage which is validly in force nor justify continuation of coverage which has been validly terminated.

7. Currency

Any claim for Eligible Expenses made by the Insured Person in any foreign currency shall be converted to HKD at the opening indicative counter exchange selling rate published by The Hong Kong Association of Banks in respect of that foreign currency for the date on which the claim is settled by the Company. If such rate is not available on the date concerned, reference shall be made to the rate as soon as it is available afterwards. If no such rate exists, the Company shall convert

the foreign currency at the rate certified as appropriate by the Company's bankers which shall be deemed to be final and binding.

8. Interest

Save as otherwise specified, no benefit and expenses payable under these Terms and Benefits shall carry interest.

9. Company's obligation

The Company shall at all times perform its obligations in this Policy in utmost good faith and comply with the rules and regulations of VHIS, the relevant guidelines issued by the Insurance Authority, and all applicable laws and regulations.

10. Governing law

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

11. Dispute resolution

If any dispute, controversy or disagreement arises out of this Policy, including matters relating to the validity, invalidity, breach or termination of this Policy, the Company and Policy Holder shall use their endeavours to resolve it amicably, failing which, the matter may (but is not obliged to) be referred to any form of alternative dispute resolution, including but not limited to mediation or arbitration, as may be agreed between the Company and the Policy Holder, before it is referred to a Hong Kong court.

Each party shall bear its own costs of using services under alternative dispute resolution.

12. Liability

The Company shall not accept any liability under this Policy unless the terms of this Policy relating to anything to be done or not to be done are duly observed and complied with by the Policy Holder and the Insured Person, and the information and representations made in the Application and declaration are correct. Notwithstanding the above, the Company shall not disclaim liability unless any non-observance or non-compliance with the terms of this Policy, or the inaccuracy of the information and representations made in the Application and declaration, shall materially and adversely affect the interests of the Company.

13. Misstatement of personal information

Without prejudice to the Company's right to declare this Policy void in the case of misrepresentation on health related information or fraud as provided in Section 14 of this Part 2, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or smoking habit) is misstated in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1), the Company may adjust the premium, for the past, current or future Policy Years, on the basis of the correct information. Where additional premium is required, no benefits shall be payable unless the additional premium has been paid. If the additional required premium is not paid within a grace period of thirty-one (31) days after the due date as notified by the Company to the Policy Holder, the Company shall have the right to terminate this Policy with effect from such due date, in which case Section 15 of this Part 2 shall apply. Where there has been an overpayment of premium by the Policy Holder, the Company shall refund the overpaid premium.

Where the Company, based on the correct information of the Insured Person and the Company's underwriting guidelines, considered that the application of the Insured Person should have been rejected, the Company shall have the right to declare this Policy void as from the Policy Effective Date and notify the Policy Holder that no cover shall be provided for the Insured Person. In such circumstances, the Company shall have –

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

(b) the obligation to refund the premium received,

in each case for the current Policy Year and the previous Policy Years in which this Policy was in force, subject to a reasonable administration charge payable to the Company. This refund arrangement shall be the same as that in Section 14 of this Part 2.

14. Misrepresentation or fraud

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

(a) any material fact relating to the health related information of the Insured Person which may impact the risk assessment by the Company is incorrectly stated in, or omitted from, the Application or any statement or declaration made for or by the Insured Person in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1). The circumstances that a fact shall be considered "material" include, but not limited to, the situation where the disclosure of such fact as required by the Company would have affected the underwriting decision of the Company, such that the Company would have imposed Premium Loading, included Case-based Exclusion(s), or rejected the application. For the avoidance of doubt, this paragraph (a) shall not apply to non-health related information of the Insured Person, which shall be governed by Section 13 of this Part 2; or

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

The burden of proving (a) and (b) shall rest with the Company. The Company shall have the duty to make all necessary inquiries on all facts which are material to the Company for underwriting purpose as provided in Section 8 or 9 of Part 1.

In the event of (a), the Company shall have -

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

(ii) the obligation to refund the premium received,

in each case for the current Policy Year and the previous Policy Years in which this Policy was in force, subject to a reasonable administration charge payable to the Company.

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

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

(iv) the right not to refund the premium received.

15. Termination of Policy

This Policy shall be automatically terminated on the earliest of the followings –

(a) where this Policy is terminated due to non-payment of premiums after the grace period as specified in Section 13 of this Part 2 or Section 3 of Part 3;

(b) the day immediately following the death of the Insured Person; or

(c) the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write or continue to write this Policy;

If this Policy is terminated pursuant to this Section 15, the termination shall be effective at 00:00 hours of the effective date of termination.

Immediately following the termination of this Policy, insurance coverage under this Policy shall cease to be in force. No premium paid for the current Policy Year and previous Policy Years shall be refunded, unless specified otherwise.

Where this Policy is terminated pursuant to (a), the effective date of termination shall be the date that the unpaid premium is first due.

Where this Policy is terminated pursuant to (b) or (c), the Company shall refund the relevant premium paid for the current Policy Year on a pro rata basis.

This Policy shall also be terminated if the Policy Holder decides to cancel this Policy or not to renew this Policy in accordance with Section 3 of this Part 2 or Section 1 of Part 4, as the case may be, by giving the requisite written notice to the Company. If this Policy is terminated under Section 3 of this Part 2, the effective date of termination shall be the date as stated in the cancellation notice given by the Policy Holder. However, such date shall not be within or earlier than the notice period as required by Section 3 of this Part 2 for the cancellation. If this Policy is not renewed under Section 1 of Part 4, the effective date of termination shall be the renewal date immediately following the expiry of the Policy Year during which this Policy remains valid.

If this Policy is terminated under (a) or (c) of this Section 15, in the case where the Insured Person is being Confined or is undergoing Prescribed Non-surgical Cancer Treatment for a Disability suffered before such termination, then, with respect to the Confinement or treatment in relation to the same Disability, Eligible Expenses incurred shall continue to be covered under this Policy until (i) the Insured Person is discharged or the treatment is completed or (ii) thirty (30) days after the termination of this Policy, whichever is the earlier. The Terms and Benefits applicable shall be those prevailing as at the day immediately preceding the date of termination of this Policy. The Company shall have the right to deduct any outstanding premium under Section 13 of this Part 2 from any benefit payment.

For the avoidance of doubt, where this Policy includes other additional benefits beyond those under the Terms and Benefits of this Certified Plan, removal or downgrading of any such other additional benefits by the Company shall not adversely affect –

(d) the Terms and Benefits of this Certified Plan which shall continue to be in full force and effect; and

(e) the continuity of these Terms and Benefits, and shall not adversely affect the Company's compliance with the licensing requirement in order to continue to write these Terms and Benefits.

16. Notices to Company

All notices which the Company requires the Policy Holder to give shall be in writing, or in other forms acceptable by the Company, addressed to the Company.

17. Notices from Company

Any notice to be given under this Policy shall be sent by post to the latest address of the Policy Holder as notified to the Company, or sent by email to the latest email address of the Policy Holder as notified to the Company. Any notice so served shall be deemed to have been duly received by the Policy Holder as follows –

(a) if sent by post, two (2) working days after posting; or

(b) if sent by email, on the date and time transmitted.

18. Other insurance coverage

If the Policy Holder has taken out other insurance coverage besides this Certified Plan, the Policy Holder shall have the right to claim under any such other insurance coverage or this Certified Plan. However, if the Policy Holder or the Insured Person has already recovered all or part of the expenses from any such other insurance coverage, the Company shall only be liable for such amount of Eligible Expense, if any, which is not compensated by any such other insurance coverage.

19. Ownership and discharge under this Policy

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

20. Change of ownership of the Policy

Subject to the approval of the Company at its discretion, the Policy Holder may transfer the ownership of this Policy by completing the prescribed form and sending it to the Company. The Company shall consider application of transfer of ownership at the time of Policy renewal without any administration charge on the Policy Holder or transferee. The change of ownership shall not be effective until the Company has approved the change and notified in writing to the Policy Holder and transferee. From the effective date of the change of ownership, the transferee shall be treated as the Policy Holder, and the absolute owner of this Policy as described in Section 19 of this Part 2 and be responsible for the payment of the premiums, including any outstanding premiums.

The Company shall not reject any application by the Policy Holder for the transfer of ownership to –

(a) the Insured Person if he has reached the Age of eighteen (18) years;

(b) the parent or the Guardian of the Insured Person if he is a Minor; or

(c) any person whose familial relationship with the Insured Person is accepted by the Company according to its prevailing underwriting practices which are readily accessible by the Policy Holder.

21. Death of Policy Holder

The Policy Holder may nominate a person to be the successive Policy Holder of this Policy in the event of his death. If the Policy Holder dies, but has not named a successive Policy Holder for this Policy or the named successive Policy Holder refuses the transfer, the ownership of this Policy shall be transferred to –

(a) the Insured Person if he has reached the Age of eighteen (18) years; or

(b) the parent or the Guardian if the Insured Person is a Minor. If the parent or the Guardian refuses the transfer, the ownership of this Policy shall be transferred to the administrator or executor of the Policy Holder's estate.

The transfer of ownership of this Policy in accordance with the above paragraph shall be conditional upon the Company having received satisfactory evidence of the Policy Holder's death.

22. Rights of third parties

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.

23. Subrogation

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

24. Suits against third parties

Nothing in this Policy shall oblige the Company to join, respond to or defend (or indemnify in respect of the costs for) any suit or alternative dispute resolution process for damages for any cause or reason which may be instituted by the Policy Holder or the Insured Person against any Registered Medical Practitioner, Hospital or healthcare services provider, including but not limited to any suit or alternative dispute resolution process for negligence, malpractice or professional misconduct or any other causes in relation to or arising out of the medical investigation or treatment of the Disability of the Insured Person under the terms of this Policy.

25. Waiver

No waiver by any party of any breach by any other party of any provisions of this Policy shall be deemed to be a waiver of any subsequent breach of that or any other provision of this Policy, and any forbearance or delay by any party in exercising any of its rights under this Policy shall not be construed as a waiver of such rights. Any waiver shall not take effect unless it is expressly agreed, and the rights and obligations of the Company and Policy Holder under this Policy shall remain in full force and effect except and only to the extent that they are waived.

26. Compliance with law

If this Policy is or becomes illegal under the law applicable to the Policy Holder or the Insured Person, the Company shall have the right to terminate this Policy from the date it becomes illegal and the Company shall refund the relevant premium paid for the Policy Year in which this Policy is terminated, on a pro rata basis.

27. Personal data privacy

The Company shall comply with the Personal Data (Privacy) Ordinance (Cap. 486 of the Laws of Hong Kong) and the related codes, guidelines and circulars.

Part 3 Premium Provisions

1. Premium payable

The premium payable for these Terms and Benefits shall only include –

(a) the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company; and

(b) the Premium Loading, if applicable.

2. Payment of premiums

The amount of premium payable is specified in the Policy Schedule and/or the notification of Renewal as specified in Section 3 of Part 4. The premium, whether paid for a Policy Year or by instalment as agreed by the Company, shall be paid in advance when due before any benefits shall be paid. Premium once paid shall not be refundable, unless otherwise specified in this Policy.

Premium due dates, Renewal Dates and Policy Years are determined with reference to the Policy Effective Date as stated in the Policy Schedule and/or the notification of Renewal as specified in Section 3 of Part 4. The first premium is due on the Policy Effective Date.

3. Grace period

The Company shall allow a grace period of thirty-one (31) days after the premium due date for payment of each premium. This Policy shall continue to be in effect during the grace period but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, this Policy shall be terminated immediately on the date on which the unpaid premium is first due.

Part 4 Renewal Provisions

These Terms and Benefits shall be effective from the Policy Effective Date in consideration of the payment of premium and is Renewable for each Policy Year in accordance with the terms of this Part 4. Renewal is guaranteed up to the Age of one hundred (100) years of the Insured Person.

1. Renewal

The Company shall Renew these Terms and Benefits in accordance with (a) to (c) below –

(a) Unless the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write these Terms and Benefits, or has ceased to maintain its registration with the Government as a VHIS provider, or the Policy Holder decides not to Renew these Terms and Benefits by giving the Company not less than fourteen (14) days prior notice in writing in accordance with Section 3 of Part 2, Renewal shall be arranged automatically with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time of Renewal, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.

(b) At the time of Renewal, if the Company shall cease or has ceased to maintain its registration with the Government as a VHIS provider while maintaining the requisite authorisation under the Insurance Ordinance to write these Terms and Benefits, Renewal shall be arranged automatically with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time when the Company ceased to maintain its registration as a VHIS provider, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.

(c) After the Company has ceased to maintain its registration with the Government, if the Company subsequently re-registers with the Government as a VHIS provider, then at the Renewal Date coinciding with or immediately following such re-registration, these Terms and Benefits shall be Renewed with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time of the Renewal, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.

At the time of Renewal under (a) to (c) above (as the case may be), any other revision of these Terms and Benefits by the Company shall be made on an overall Portfolio basis and shall not have the effect of contravening (a), (b) or (c) above (as applicable) or reducing the benefit limits or increasing the Coinsurance or Deductible of these Terms and Benefits which are applicable prior to Renewal.

2. Adjustment of premium

Irrespective of whether the Company revises these Terms and Benefits upon Renewal, the Company shall have the right to adjust the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company on an overall Portfolio basis. For the avoidance of doubt, if the Premium Loading is set as a percentage of the Standard Premium (i.e. rate of Premium Loading), the

amount of Premium Loading payable shall be automatically adjusted according to the change in Standard Premium.

During each Policy Year and upon Renewal, the Company shall not impose any additional rate of Premium Loading (or any additional amount of Premium Loading if the Premium Loading is set in monetary terms rather than as a percentage of the Standard Premium) or Case-based Exclusion(s) on the Insured Person by reason of any change in the Insured Person's health conditions.

3. Notification of Renewal

Irrespective of whether the Company revises these Terms and Benefits upon Renewal, the Company shall in accordance with the terms of this Section 3 give the Policy Holder a written notice of the revised Terms and Benefits to the Policy Holder of not less than thirty (30) days prior to the Renewal Date.

The written notice shall specify the premium for Renewal and Renewal Date. If the Company revises these Terms and Benefits upon Renewal, the Company shall make available the revised Terms and Benefits to the Policy Holder together with the written notice. The revised Terms and Benefits and premium for Renewal shall take effect on the Renewal Date.

4. No re-underwriting except in limited circumstances

While these Terms and Benefits are in force, the Company shall not have the right to re-underwrite these Terms and Benefits irrespective of any change in health conditions of the Insured Person after the Policy Issuance Date or the Policy Effective Date, whichever is the earlier.

The Company shall not have the right to re-underwrite these Terms and Benefits irrespective of any change in these Terms and Benefits (as permitted under Section 1 of this Part 4). This restriction applies to any change including but not limited to where there is any upgrade or downgrade of any benefits, or any addition or removal of any benefits, as permitted under these Terms and Benefits, regardless of where they are set out in these Terms and Benefits.

The Company shall have the right to re-underwrite these Terms and Benefits only under the following circumstances –

(a) Where the Policy Holder requests the Company to re-underwrite these Terms and Benefits at the time of Renewal for reduction in Premium Loading or removal of Case-based Exclusion(s) according to the Company's underwriting practices. For the avoidance of doubt, the Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;

(b) At any time where the Policy Holder requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits (in which cases the re-underwriting shall be limited to such upgrade or additional benefits).

(i) However, at any time where the Policy Holder requests to unsubscribe the additional benefits (if any) in these Terms and Benefits, or switch to another insurance plan which provides downgrade or reduction of benefits, the Company shall not have the right to re-underwrite

these Terms and Benefits but shall have the discretion to accept or reject the request according to its prevailing practices in handling similar requests; and

(ii) The Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;

(c) Where there is change in the Place of Residence of the Insured Person

At Renewal, the Company shall have the right to re-underwrite these Terms and Benefits due to a change in the Place of Residence of the Insured Person provided that –

(i) The Company has taken into account the Place of Residence of the Insured Person in underwriting these Terms and Benefits before its inception;

(ii) The Company has specifically informed the Policy Holder of the consideration at the time of submission of Application of these Terms and Benefits and that any change in the Place of Residence could lead to re-underwriting upon Renewal;

(iii) The Company has maintained underwriting practices which show unambiguously how changes in the Place of Residence will affect the underwriting result, and the underwriting practices are readily accessible by the Policy Holder;

(iv) The Company shall carry out the re-underwriting solely in respect of the said changes (i.e. the change in the Place of Residence of the Insured Person); and

(v) The re-underwriting result may be more advantageous or adverse to the Policy Holder and the Insured Person.

For the purpose of this paragraph (c), the Company shall have the obligation to request the Policy Holder to inform the Company of any change in the Place of Residence of the Insured Person, which means that as at the Renewal Date his Place of Residence differs from that as at the last Renewal Date (or the Policy Effective Date in the event of first Renewal). After receiving the request, the Policy Holder shall have the obligation to inform the Company of such a change.

(d) Where there is change in the occupation of the Insured Person

At Renewal, the Company shall have the right to re-underwrite these Terms and Benefits due to a change in the occupation of the Insured Person provided that –

(i) The Company has taken into account the occupation of the Insured Person in underwriting these Terms and Benefits before its inception;

(ii) The Company has specifically informed the Policy Holder of the consideration at the time of submission of Application of these Terms and Benefits and that any change in the occupation could lead to re-underwriting upon Renewal;

(iii) The Company has maintained underwriting practices which show unambiguously how changes in the occupation will affect the underwriting result, and the underwriting practices are readily accessible by the Policy Holder;

(iv) The Company shall carry out the re-underwriting solely in respect of the said change (i.e. the change in the occupation of the Insured Person); and

(v) The re-underwriting result may be more advantageous or adverse to the Policy Holder and the Insured Person.

For the purpose of this paragraph (d), the Company shall have the obligation to request the Policy Holder to inform the Company of any change in occupation of the Insured Person, which means that as at the Renewal Date his occupation differs from that as at the last Renewal Date (or the Policy Effective Date in the event of first Renewal). After receiving the request, the Policy Holder shall have the obligation to inform the Company of such a change.

The Company and Policy Holder acknowledge that –

(e) if under the terms of this Part 4, the Company has the right, or is required, to re-underwrite these Terms and Benefits based on certain factors at Renewal, the Company shall, in accordance with the terms of this Part 4 and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and

(f) as a result of re-underwriting, these Terms and Benefits may be terminated, new Premium Loading may be applied, existing Premium Loading may be adjusted upwards or downwards, new Case-based Exclusion(s) may be applied, and existing Case-based Exclusion(s) may be revised or removed.

Part 5 Claim Provisions

1. Submission of claims

All claims incurred in respect of these Terms and Benefits shall be submitted to the Company within ninety (90) days after the date on which the Insured Person is discharged from the Hospital, or (where there is no Confinement) the date on which the relevant Medical Service is performed and completed. For this purpose, a claim shall be deemed not valid or complete and benefit shall not be payable unless –

(a) all original receipts and/or original itemised bills together with the diagnosis, type of treatment, procedure, test or service provided shall have been submitted to the Company; and

(b) all relevant information, certificates, reports, evidence, referral letter and other data or materials as reasonably required by the Company shall have been furnished to the Company for processing of such claim.

The Policy Holder shall notify the Company if claims cannot be submitted within the above timeframe, otherwise the Company shall have the right to reject claims submitted after the above timeframe.

All certificates, information and evidence that are reasonably required by the Company and which can be reasonably provided by the Policy Holder shall be furnished at the expenses of the Policy Holder. The Company shall bear all expenses incurred in obtaining further certificates, information and evidence for the purposes of verification of the claim after the Policy Holder has submitted all required information pursuant to (a) and (b) above.

2. Claimable amount estimate

Before the Insured Person receives a Medical Service, the Policy Holder may request the Company to provide an estimate on the amount that may be claimed under these Terms and Benefits. The Policy Holder shall provide the Company with the estimated fees to be incurred as furnished by the Hospital and/or attending Registered Medical Practitioner as required by the laws and regulations regulating the private healthcare facilities in Hong Kong at the time of request. Upon receiving the request, the Company shall inform the Policy Holder of the claimable amount estimate under these Terms and Benefits based on the estimation furnished by the Hospital and/or attending Registered Medical Practitioner. The Company's estimate is for reference only, and the actual amount claimable by the Policy Holder shall be subject to the final expenses as evidenced in (a) and (b) of Section 1 of this Part 5.

3. Legal action

No legal action shall be brought by the Policy Holder to recover any claim amount payable under these Terms and Benefits within the first sixty (60) days from which all proof of claims as required by these Terms and Benefits has been received by the Company.

4. Medical examination

Where a claim occurs, the Company shall have the right to require the Insured Person to be examined by a Registered Medical Practitioner appointed by the Company at the Company's cost.

Part 6 Benefit Provisions

1. General

(a) **Territorial scope of cover**

Except for the psychiatric treatment as stated in Section 3(l) of this Part 6, room level downgrade cash benefit in Hong Kong and death benefit as stated in Section 1(b) and 1(c) of Other Benefits Supplement, all benefits described in these Terms and Benefits are subject to the geographical limitation for benefit coverage as stated in Section 1 of Part 1 in the Limitations of Benefits Supplement and the Benefit Schedule of these Terms and Benefits.

The above restriction shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

(b) **Lifetime Benefit Limit**

Except for the death benefit as stated in Section 1(c) of Other Benefits Supplement, all benefits described in these Terms and Benefits are subject to the Lifetime Benefit Limit as stated in the Benefit Schedule of these Terms and Benefits.

(c) **Choice of healthcare services providers**

Except for the room level downgrade cash benefit in Hong Kong as stated in Section 1(b) of Other Benefits Supplement, the benefits described in these Terms and Benefits are not subject to any restriction in the choice of healthcare services providers, including but not limited to Registered Medical Practitioner and Hospital.

The above restriction shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

(d) **Choice of ward class**

The benefits described in these Terms and Benefits are subject to the restriction in the choice of ward class as stated in Section 2 of Part 1 of the Limitations of Benefits Supplement and the Benefit Schedule of these Terms and Benefits.

The above restriction shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

2. Coverage of Confinement and non-Confinement services

Subject to these Terms and Benefits, if during the period while these Terms and Benefits are in force, the Insured Person, as a result of a Disability and upon the recommendation of a Registered Medical Practitioner,

(a) is Confined in a Hospital; or

(b) undergoes any Day Case Procedure, Prescribed Diagnostic Imaging Test, Prescribed Non-surgical Cancer Treatment, renal dialysis, Emergency outpatient treatment or Emergency dental treatment,

the Company shall reimburse the Eligible Expenses which are Reasonable and Customary in accordance with benefit items under Section 3 of this Part 6 and Section 1 of the Enhanced Benefits Supplement.

For the avoidance of doubt, where an Insured Person is Confined in a Hospital but the Confinement is considered not Medically Necessary, the expenses incurred as a result of such Confinement shall not be regarded as Eligible Expenses for the purpose of (a) above. However, the Policy Holder shall still have the right to claim for the relevant Eligible Expenses incurred during such Confinement on Medical Services under (b) above.

The amount of Eligible Expenses payable under these Terms and Benefits shall not exceed the actual costs for Medical Services provided to the Insured Person, subject to the limits as stated in the Benefit Schedule.

For the avoidance of doubt, the benefits covered under these Terms and Benefits shall only be payable for Eligible Expenses incurred for Medical Services provided to the Insured Person. Expenses incurred for Medical Services provided to persons other than the Insured Person shall not be covered, unless otherwise specified.

3. Benefits covered

Eligible Expenses covered under Section 2 of this Part 6 shall be payable according to the following benefit items –

(a) Room and board

This benefit shall be payable for the Eligible Expenses charged by the Hospital on the cost of accommodation and meals where the Insured Person is Confined in a Hospital or undergoes any Day Case Procedure or Prescribed Non-surgical Cancer Treatment.

(b) Miscellaneous charges

This benefit shall be payable for the Eligible Expenses charged on miscellaneous charges where the Insured Person is Confined in a Hospital or on the day he undergoes any Day Case Procedure for receiving Medical Services. These charges shall cover the followings –

(i) Road ambulance service to and/or from the Hospital;

(ii) Anaesthetic and oxygen administration;

(iii) Administration charges for blood transfusion;

(iv) Dressing and plaster casts;

(v) Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;

(vi) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;

(vii) Additional surgical appliances, equipment and devices other than those inclusively paid under Section 3(h) of this Part 6, and implants, disposables and consumables used during surgical procedure;

(viii) Medical disposables, consumables, equipment and devices;

(ix) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Section 3(i) of this Part 6;

(x) Intravenous ("IV") infusions including IV fluids;

(xi) Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;

(xii) Rental of walking aids and wheelchair for Inpatients; and

(xiii) Physiotherapy, occupational therapy and speech therapy during Confinement.

(c) Attending doctor's visit fee

If on any day of Confinement, the Insured Person is treated by a Registered Medical Practitioner, this benefit shall be payable for the Eligible Expenses charged by the attending Registered Medical Practitioner for such visit or consultation.

(d) Specialist's fee

If on any day of Confinement, the Insured Person is treated by a Specialist (not being the attending Registered Medical Practitioner under Section 3(c) of this Part 6) as recommended in writing by the attending Registered Medical Practitioner, this benefit shall be payable for the Eligible Expenses charged by the Specialist for such visit or consultation.

(e) Intensive care

If on any day of Confinement, the Insured Person is admitted to an Intensive Care Unit, this benefit shall be payable for the Eligible Expenses charged on the intensive care services.

For the avoidance of doubt, the Eligible Expenses so incurred and payable under this benefit shall not be payable under Section 3(a) of this Part 6.

(f) Surgeon's fee

This benefit shall be payable for the Eligible Expenses charged by the attending Surgeon on a surgical procedure performed during Confinement or in a setting for providing Medical Services to a Day Patient.

This benefit shall be payable according to the relevant surgical category and the categorisation of such surgical procedure under the Schedule of Surgical Procedures as categorised and reviewed from time to time by the Government. If a surgical procedure performed is not included in the Schedule of Surgical Procedures, the Company may reasonably determine its surgical category according to the gazette published by the Government or any other relevant publication or information including but not limited to the schedule of fees recognised by the government,

relevant authorities and medical association in the locality where the surgical procedure is performed.

(g) Anaesthetist's fee

If Surgeon's fee is payable under Section 3(f) of this Part 6, this benefit shall be payable for the Eligible Expenses charged by the Anaesthetist in relation to the surgical procedure.

(h) Operating theatre charges

If Surgeon's fee is payable under Section 3(f) of this Part 6, this benefit shall be payable for the Eligible Expenses charged for the use of operating theatre (including but not limited to a treatment room and a recovery room) during the surgical procedure.

For the avoidance of doubt, the Eligible Expenses for any additional surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be payable under Section 3(b) of this Part 6.

(i) Prescribed Diagnostic Imaging Tests

This benefit shall be payable for the Eligible Expenses charged on Prescribed Diagnostic Imaging Test performed during Confinement or in a setting for providing Medical Services to a Day Patient recommended in writing by the attending Registered Medical Practitioner for the investigation or treatment of a Disability, subject to the Coinsurance as specified in Section 5 of this Part 6 and the Benefit Schedule.

(j) Prescribed Non-surgical Cancer Treatments

This benefit shall be payable for the Eligible Expenses charged on the Prescribed Non-surgical Cancer Treatment performed during Confinement or in a setting for providing Medical Services to a Day Patient, outpatient consultation by a Specialist in treatment planning, and monitoring of prognosis and development during the course of Prescribed Non-surgical Cancer Treatment.

For the avoidance of doubt, the Eligible Expenses for the Prescribed Diagnostic Imaging Tests shall be payable under Section 3(i) of this Part 6.

(k) Pre- and post-Confinement/Day Case Procedure outpatient care

This benefit shall be payable for the Eligible Expenses for –

(i) outpatient visit or Emergency consultation resulting in a Confinement or Day Case Procedure (including but not limited to consultation, western medication prescribed or diagnostic test); and

(ii) follow-up outpatient visit (including but not limited to consultation, western medication prescribed, dressings, physiotherapy, occupational therapy, speech therapy or diagnostic test) to, or recommended in writing by, the attending Registered Medical Practitioner, within the period stated in the Benefit Schedule after discharge from Hospital or the date of Day Case Procedure, provided that such outpatient visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

For the purpose of (i) and (ii) above, Prescribed Diagnostic Imaging Tests and Prescribed Non-surgical Cancer Treatments shall be payable under Sections 3(i) and 3(j) of this Part 6 respectively.

(l) Psychiatric treatments

This benefit shall be payable for the Eligible Expenses charged on the psychiatric treatments during Confinement in Hong Kong as recommended by a Specialist.

This benefit shall be payable in lieu of other benefit items under Sections 3(a) to (k) of this Part 6. For the avoidance of doubt, where a Confinement is not solely for the purpose of psychiatric treatments, this benefit shall only be payable for the Eligible Expenses charged on the Medical Services related to psychiatric treatments. Where the Eligible Expenses involve both psychiatric and non-psychiatric treatments and apportionment of the expenses is not available, the expenses in entirety shall be payable under this benefit if the Confinement is initially for the purpose of psychiatric treatments. If the Confinement initially is not for the purpose of psychiatric treatment, the expenses in entirety shall be payable under Sections 3(a) to (k) above.

4. Pre-existing Condition(s)

Eligible Expenses arising from Pre-existing Condition(s) that are notified to the Company in the Application and subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1), subject to the Case-based Exclusion(s) (if any), shall be payable in accordance with these Terms and Benefits. The Company may impose Case-based Exclusion(s) to these Terms and Benefits by reason of a Pre-existing Condition or other factor that affects the insurability of the Insured Person notified to the Company in the Application and any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1). After the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Company shall not have the right to impose any additional Case-based Exclusion(s), save for the limited circumstances stated in Section 4 of Part 4.

Eligible Expenses arising from Pre-existing Condition(s) that the Policy Holder and/or Insured Person was not aware and would not reasonably have been aware of at the time of submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 8 of Part 1), shall be payable in accordance with these Terms and Benefits.

For the avoidance of doubt, the Company shall not have the right to re-underwrite or terminate these Terms and Benefits where the Policy Holder and/or Insured Person was not aware and would not reasonably have been aware of the Pre-existing Condition(s) at the time of submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 8 of Part 1).

If the Policy Holder or the Insured Person is requested but fails to disclose to the Company upon submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 8 of Part 1), that the Insured Person is suffering from a Pre-existing Condition, and such Pre-existing Condition has been treated or diagnosed or has manifested signs or symptoms of which the Policy Holder or the Insured Person is aware or should have reasonably been aware of at the time of submission of Application, including any updates of and

changes to the required information (if so requested by the Company under Section 8 of Part 1), the Company has the right to declare these Terms and Benefits void, demand repayment of any benefits paid and/or refuse to provide coverage under these Terms and Benefits. In such event, the Company shall refund the premium in accordance with Section 14 of Part 2. The burden of proving the above shall rest with the Company.

5. Cost-sharing requirement

The Policy Holder is required to pay Coinsurance and/or Deductible as stated in these Terms and Benefits and the Policy Schedule. For the avoidance of doubt, Coinsurance and Deductible do not refer to any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits under these Terms and Benefits.

Part 7 General Exclusions

Under these Terms and Benefits, the Company shall not pay any benefits in relation to or arising from the following expenses.

1. Expenses incurred for treatments, procedures, medications, tests or services which are not Medically Necessary.

2. Expenses incurred for the whole or part of the Confinement solely for the purpose of diagnostic procedures or allied health services, including but not limited to physiotherapy, occupational therapy and speech therapy, unless such procedure or service is recommended by a Registered Medical Practitioner for Medically Necessary investigation or treatment of a Disability which cannot be effectively performed in a setting for providing Medical Services to a Day Patient.

3. Expenses arising from Human Immunodeficiency Virus ("HIV") and its related Disability, which is contracted or occurs before the Policy Effective Date. Irrespective of whether it is known or unknown to the Policy Holder or the Insured Person at the time of submission of Application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1) such Disability shall be generally excluded from any coverage of these Terms and Benefits if it exists before the Policy Effective Date. If evidence of proof as to the time at which such Disability is first contracted or occurs is not available, manifestation of such Disability within the first five (5) years after the Policy Effective Date shall be presumed to be contracted or occur before the Policy Effective Date, while manifestation after such five (5) years shall be presumed to be contracted or occur after the Policy Effective Date.

   However, the exclusion under this entire Section 3 shall not apply where HIV and its related Disability is caused by sexual assault, medical assistance, organ transplant, blood transfusions or blood donation, or infection at birth, and in such cases the other terms of these Terms and Benefits shall apply.

4. Expenses incurred for Medical Services as a result of Disability arising from or consequential upon the dependence, overdose or influence of drugs, alcohol, narcotics or similar drugs or agents, self-inflicted injuries or attempted suicide or illegal activity.

5. Any charges in respect of services for –

   (a) beautification or cosmetic purposes, unless necessitated by Injury caused by an Accident and the Insured Person receives the Medical Services within ninety (90) days of the Accident, or to the extent covered by the reconstructive surgery benefit payable under Section 1(e) of Enhanced Benefits Supplement; or

   (b) correcting visual acuity or refractive errors that can be corrected by fitting of spectacles or contact lens, including but not limited to eye refractive therapy, LASIK and any related tests, procedures and services.

6. Expenses incurred for prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests, screening procedures for asymptomatic conditions, screening or surveillance procedures based on the health history of the Insured Person and/or his family members, Hair Mineral Analysis (HMA), immunisation or health supplements. For the avoidance of doubt, this Section 6 does not apply to –

   (a) treatments, monitoring, investigation or procedures with the purpose of avoiding complications arising from any other Medical Services provided;

(b) removal of pre-malignant conditions; and

(c) treatment for prevention of recurrence or complication of a previous Disability.

7. Expenses incurred for dental treatment and oral and maxillofacial procedures performed by a dentist except for Emergency Treatment and surgery during Confinement arising from an Accident, or to the extent covered by emergency dental benefit payable under Section 1(m) of Enhanced Benefits Supplement. Follow-up dental treatment or oral surgery after discharge from Hospital shall not be covered.

8. Expenses incurred for Medical Services and counselling services relating to maternity conditions and its complications, including but not limited to diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction or pre-mature ejaculation, regardless of cause; except to the extent covered by the pregnancy complications benefit payable under Section 1(f) of Enhanced Benefits Supplement

9. Expenses incurred for the purchase of durable medical equipment or appliances including but not limited to wheelchairs, beds and furniture, airway pressure machines and masks, portable oxygen and oxygen therapy devices, dialysis machines, exercise equipment, spectacles, hearing aids, special braces, walking aids, over-the-counter drugs, air purifiers or conditioners and heat appliances for home use. For the avoidance of doubt, this exclusion shall not apply to rental of medical equipment or appliances during Confinement or on the day of the Day Case Procedure.

10. Expenses incurred for traditional Chinese medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na, and other forms of alternative treatment including but not limited to hypnotism, qigong, massage therapy, aromatherapy, naturopathy, hydropathy, homeotherapy and other similar treatments; except to the extent covered by the ancillary service payable under Section 1(j) of Enhanced Benefits Supplement.

11. Expenses incurred for experimental or unproven medical technology or procedure in accordance with the common standard, or not approved by the recognised authority, in the locality where the treatment, procedure, test or service is received.

12. Expenses incurred for Medical Services provided as a result of Congenital Condition(s) which have manifested or been diagnosed before the Insured Person attained the Age of eight (8) years.

13. Eligible Expenses which have been reimbursed under any law, or medical program or insurance policy provided by any government, company or other third party.

14. Expenses incurred for treatment for Disability arising from war (declared or undeclared), civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power.

Part 8 Definitions

Under these Terms and Benefits, words and expressions used shall have the following meanings -

"Accident"	shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured Person and caused by violent, external and visible means.
"Age"	shall mean the attained age of the Insured Person
"Annual Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder in a Policy Year irrespective of whether any limits of any benefit items stated in the Benefit Schedule have been reached. The Annual Benefit Limit is counted afresh in a new Policy Year.
"Application"	shall mean the application submitted to the Company in respect of this Certified Plan, including the application form, questionnaires, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1).
"Benefit Schedule"	shall mean a schedule of benefits attached to these Terms and Benefits which sets out, among others, the benefit items and maximum benefits covered.
"Case-based Exclusion"	shall mean the exclusion of a particular Sickness or Disease from the coverage of these Terms and Benefits that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person
"Certified Plan"	shall mean all the terms and benefits (including any Supplement(s)) that form an insurance plan certified by the Government to be compliant with the requirements of the VHIS. This Certified Plan comprises these Terms and Conditions and the Benefit Schedule and the followings: (a) Enhanced Benefits Supplement; (b) Other Benefits Supplement; (c) No Claim Premium Discount Supplement; (d) Change of Deductible Supplement; (e) Limitations of Benefits Supplement; (f) Waiver of Deductible for Designated Critical Illnesses Supplement; and (g) Inclusion of VAT and GST as Eligible Expenses Supplement.
"Coinsurance"	shall mean a percentage of Eligible Expenses the Policy Holder must contribute after paying the Deductible (if any) in a Policy Year. For the avoidance of doubt,

	Coinsurance does not refer to any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits under these Terms and Benefits.
"Company"	shall mean YF Life Insurance International Limited.
"Confinement" or "Confined"	shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition for a period of no less than six (6) consecutive hours. No minimum period is required for Confinement in connection with any Emergency Treatment in a Hospital as a result of an Emergency for the performance of a surgical procedure or other Medical Service in a Hospital. Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured Person must stay in the Hospital continuously for the entire period of Confinement.
"Congenital Condition(s)"	shall mean (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.
"Deductible"	shall mean a fixed amount of Eligible Expenses that, in a Policy Year, the Policy Holder must pay before the Company shall reimburse the remaining Eligible Expenses.
"Delivery"	shall mean the delivery of these Terms and Benefits and the Policy Schedule or the cooling-off notice as stated in Section 2(a) of Part 2 to the Policy Holder, or to nominated representative of the Policy Holder, by any the following means: (a) by hand; (b) by post (including registered post); or (c) by electronic means. Regardless of the means of delivery is used, it is the responsibility of the Company, to have sufficient proof of delivery and the timing of delivery.
"Disability"	shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.
"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Disability.

"Emergency"	shall mean an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.
"Emergency Treatment"	shall mean Medical Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.
"Flexi Plan"	shall mean any individual indemnity hospital insurance plan under the VHIS framework with enhancement(s) to any or all of the protections or terms and benefits that the Standard Plan provides to the Policy Holder and the Insured Person, subject to certification by the Government. Such plan shall not contain terms and benefits which are less favourable than those in the Standard Plan, save for the exception as may be approved by the Government from time to time.
"Government"	shall mean the Hong Kong Special Administrative Region Government.
"Guardian"	in respect of a Minor shall mean the person(s) appointed as the guardian(s) under or acting by virtue of the Guardianship of Minors Ordinance (Cap 13. of the Laws of Hong Kong).
"HKD"	shall mean Hong Kong dollars.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which - (a) has facilities for diagnosis and major operations; (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Injury"	shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.
"Inpatient"	shall mean an Insured Person who is Confined.
"Insurance Authority"	shall mean the Insurance Authority of Hong Kong established pursuant to section 4AAA of the Insurance Ordinance.
"Insurance Ordinance"	shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).

"Insured Person"	shall mean any person whose risks are covered by these Terms and Benefits, and named as the "Insured Person" in the Policy Schedule.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
"Lifetime Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder cumulatively since the inception of these Terms and Benefits, irrespective whether any limits of any benefit items stated in the Benefit Schedule have been reached or whether the Annual Benefit Limit in a Policy Year has been reached.
"Medical Services"	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.
"Medically Necessary"	shall mean the need to have medical service for the purpose of investigating or treating the relevant Disability in accordance with the generally accepted standards of medical practice and such medical service must –

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

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

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

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

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

For the purpose of these Terms and Benefits, without prejudice to the generality of the foregoing, circumstances where a Confinement is considered Medically Necessary include, but not limited to -

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

(ii) surgical procedures are performed under general anaesthesia;

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

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

(v) taking into account the individual circumstances of the Insured Person, the attending Registered Medical Practitioner has exercised his prudent

professional judgment and is of the view that for the safety of the Insured Person, the medical service should be conducted in Hospital;

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

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

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

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

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

"Minor" shall mean a person below the Age of eighteen (18) years.

"Place(s) of Residence" shall mean the jurisdiction(s) in which a person legally has the right of abode. A change in the Place(s) of Residence refers to the situation where a person has been granted the right of abode of additional jurisdiction(s), or has ceased to have the right of abode of existing jurisdiction(s). The above definition of "Place(s) of Residence" is used solely for the purpose of these Terms and Benefits. For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, shall not be treated as a Place of Residence.

"Policy" shall mean this policy underwritten and issued by the Company, which is the contract between the Policy Holder(s) and the Company in respect of this Certified Plan including but not limited to these Terms and Conditions, Benefit Schedule, Application, declarations, Policy Schedule and any Supplement(s) attached to this policy, if applicable. Where this Policy contains additional terms and benefits other than those of this Certified Plan, the meaning of Policy shall also cover such additional terms and benefits.

"Policy Effective Date" shall mean the commencement date of these Terms and Benefits which is specified as "Policy Effective Date" in the Policy Schedule.

"Policy Holder" shall mean the person who is a legal holder of this Policy and is named as the “Policy Holder” in the Policy Schedule.

"Policy Issuance Date"	shall mean the date of first issuance of these Terms and Benefits.
"Policy Schedule"	shall mean a schedule attached to these Terms and Benefits, which sets out, among others, the Policy Effective Date, Renewal Date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, premium and other relevant details in respect of these Terms and Benefits.
"Policy Year"	shall mean the period of time these Terms and Benefits are in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Renewal Date as specified in the Policy Schedule (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year period from each Renewal Date.
"Portfolio"	shall mean all policies of the same terms and conditions and the benefit schedule as certified by the Government as a Certified Plan under VHIS.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where - (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.
"Prescribed Diagnostic Imaging Tests"	shall mean computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.
"Prescribed Non-surgical Cancer Treatments"	shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.
"Reasonable and Customary"	shall mean, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar Age, for a similar Disability, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred. In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable) -

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

(b) internal or industry claim statistics;

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

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

"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"

shall mean a medical practitioner of western medicine,

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

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

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

"Renewal", "Renew", "Renewed" or "Renewable"

shall mean renewal of these Terms and Benefits in accordance with their terms without any discontinuance.

"Renewal Date"

shall mean the effective date of Renewal. The first Renewal Date shall be the date as specified in the Policy Schedule (which shall not be later than the first anniversary of the Policy Effective Date) and the subsequent Renewal Date(s) shall be the anniversary(ies) of the first Renewal Date. The relevant Renewal Date shall be specified in the notification of Renewal in accordance with Section 3 of Part 4.

"Schedule of Surgical Procedures"

shall mean the list of surgical procedures attached to the Benefit Schedule which sets out the surgical category of different surgical procedures according to their relative degree of complexity, which is from time to time published and subject to regular review by the Government.

"Sickness" or "Disease"

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

"Standard Plan"	shall mean the insurance plan with terms and conditions and the benefit schedule equivalent to the minimum compliant product requirements of VHIS, which are from time to time published and subject to regular review by the Government.
"Standard Plan Terms and Benefits"	shall mean the terms and conditions and the benefit schedule of the Standard Plan, which are from time to time published and subject to regular review by the Government https://www.vhis.gov.hk/doc/en/information_centre/e_standard_plan_template.pdf.
"Standard Premium"	shall mean the basic premium for the coverage under this Certified Plan, as charged by the Company to the Policy Holder on an overall Portfolio basis, which may be adjusted in accordance with the Age, gender and/or lifestyle factors of the Insured Person.
"Supplement(s)"	shall mean any document which may add, delete, amend or replace the terms and benefits of this Policy. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Policy.
"Terms and Benefits"	shall mean the Terms and Conditions together with the Benefit Schedule (including the Schedule of Surgical Procedures) and any related Supplement(s) as certified by the Government under this Certified Plan.
"Terms and Conditions"	shall mean Part 1 to Part 8 of this Certified Plan.

Enhanced Benefits Supplement

This is to supplement Part 6 Benefit Provisions of the Terms and Benefits.

1. Benefits covered

(a) Private nurse's fee

If room and board is payable under Section 3(a) of Part 6 of the Terms and Benefits, in addition to the general nursing services provided by the Hospital to the Insured Person during Confinement, this benefit shall be payable for the Eligible Expenses the Insured Person incurred for private nursing service provided by a Qualified Nurse recommended in writing by the attending Registered Medical Practitioner and arranged by the Hospital, following a surgical procedure for which Surgeon's fee is payable under Section 3(f) of Part 6 of the Terms and Benefits or following the Insured Person's discharge from the Intensive Care Unit for which intensive care is payable under Section 3(e) of Part 6 of the Terms and Benefits.

This benefit is restricted to nursing services during the Confinement provided by a maximum of one (1) Qualified Nurse during any given time slot, up to a maximum number of days per Policy Year shown in the Benefit Schedule. For the avoidance of doubt, regardless of
(i) whether nursing services are provided for all or part of one (1) days on a particular day; and
(ii) number of time slots on the same day,
that day shall be counted as one (1) day for the purpose of counting the maximum number of days per Policy Year allowed for this benefit.

(b) Home nursing

If room and board is payable under Section 3(a) of Part 6 of the Terms and Benefits where the Insured Person is Confined in a Hospital, and the Insured Person will require services of a Qualified Nurse at home (which shall be the Insured Person's usual residence, not being a nursing or convalescent home) within sixty (60) days upon discharge from Hospital, which is recommended in writing by the attending Registered Medical Practitioner following a surgical procedure performed in a Hospital for which Surgeon's fee is payable under Section 3(f) of Part 6 of the Terms and Benefits or following the Insured Person's discharge from the Intensive Care Unit for which intensive care is payable under Section 3(e) of Part 6 of the Terms and Benefits, this benefit shall be payable for the Eligible Expenses charged by the Qualified Nurse for services rendered.

This benefit is restricted to nursing services provided by a maximum of one (1) Qualified Nurse during any given time slot, up to a maximum number of days per Policy Year shown in the Benefit Schedule. For the avoidance of doubt, regardless of
(i) whether nursing services are provided for all or part of one (1) days on a particular day; and
(ii) number of time slots on the same day,
that day shall be counted as one (1) day for the purpose of counting the maximum number of days per Policy Year allowed for this benefit.

(c) Hospital companion bed

If room and board under Section 3(a) or intersive care under Section 3(e) of Part 6 of the Terms and Benefits is payable, this benefit shall be payable for the expenses charged on one (1) extra bed for one (1) person who accompanies the Insured Person in the Hospital during the Confinement.

(d) Renal dialysis

This benefit shall be payable for the Eligible Expenses charged for renal dialysis performed on the Insured Person as a Day Patient under the recommendation of the attending Registered Medical Practitioner in writing, providing that the Insured Person is suffering from Kidney Failure.

(e) Reconstructive surgery benefit

This benefit shall be payable for the Eligible Expenses charged for reconstructive surgery performed on the Insured Person that are:

(i) charged by the attending Surgeon in respect of a surgical procedure which is performed during Confinement or in a setting for providing Medical Services to a Day Patient;

(ii) charged by the Anaesthetist in relation to the surgical procedure; and

(iii) charged for the use of operating theatre (including but not limited to a treatment room and a recovery room) in relation to the surgical procedure,

up to the maximum limit per Accident / mastectomy as stated in the Benefit Schedule under (iv) or (v) below:

(iv) the Insured Person sustains an Injury and the reconstructive surgery is
   (1) carried out to restore the function of a body part or the appearance of the Insured Person;
   (2) performed within twelve (12) months from the date of Accident; and
   (3) recommended by a Registered Medical Practitioner.

   For the avoidance of doubt, Eligible Expenses charged on the reconstructive surgery which is necessitated by Injury caused by an Accident, provided that the Insured Person receives the relevant Medical Services within ninety (90) days from the date of Accident, shall be payable under Section 3 of Part 6 of these Terms and Benefits.

(v) the Insured Person sustains a Sickness or Disease and undergoes mastectomy (one or both sides) and the reconstructive surgery is
   (1) carried out to restore the breast of the Insured Person for beautification or cosmetic purpose; and
   (2) performed at the same time or within twelve (12) months from the date of the mastectomy.

(f) Pregnancy complications benefit

This benefit shall be payable for the Eligible Expenses arising from the Insured Person's Confinement and/or surgical procedure performed by a Surgeon in a Hospital due to the Covered Pregnancy Complications which is recommended in writing by the attending Registered Medical

Practitioner, provided that the date of first diagnosis of such Covered Pregnancy Complications must be after the Policy has been effective continuously for three hundred (300) days counting from and including the Policy Effective Date.

(g) Medical appliances

If Surgeon's fee is payable under Section 3(f) of Part 6 of the Terms and Benefits, this benefit shall be payable for the Eligible Expenses charged for the following items:

(i) Designated medical appliances

The following medical appliances implanted inside the Insured Person's body during the surgery and/or used in replacement procedures which is required to perform the surgery:

(1) pace maker;
(2) stents for percutaneous transluminal coronary angioplasty;
(3) intraocular lens;
(4) artificial cardiac valve;
(5) metallic or artificial joints for joint replacement;
(6) prosthetic ligaments for replacement or implantation between bones; and
(7) prosthetic intervertebtral disc.

(ii) Other medical appliances

Other medical appliances not mentioned in Section 1(g)(i) above that are implanted inside the Insured Person's body during the surgery and/or used in replacement procedures which is required to perform the surgery, and are subject to the maximum limit per Policy Year as stated in the Benefit Schedule.

Where the Eligible Expenses incurred and payable under this benefit shall not be payable under Section 3(b) of Part 6 of the Terms and Benefits. The use of artificial limb(s), artificial ear(s), and/or artificial eye(s) recommended by a Registered Medical Practitioner, with the Medically Necessary indication of replacing missing limb(s)/ear(s)/eye(s) that were removed or amputated during a surgery are covered as other medical appliances and subject to the maximum limit per Policy Year for this benefit as stated in the Benefit Schedule. For the avoidance of doubt, any cost related to (i) handling fee of providing / fitting of or maintenance fee of artificial limb, ear or eye ball, or (ii) replacement of artificial limb, ear or eye ball which is / are lost or stolen, is not covered.

(h) Transplantation surgery expenses for Living Donor

Notwithstanding the last paragraph of Section 2 of Part 6 of the Terms and Benefits, this benefit shall be payable for the expenses incurred by the Living Donor in respect of the Living Donor Surgery performed in a Hospital, that are:

(i) charged by the Surgeon and Anaesthetist for the Living Donor Surgery of the Living Donor; and
(ii) charged for the use of operating theatre during the Living Donor Surgery,

provided that the Living Donor is Confined in a Standard Semi-private Room or a room of room level below Standard Semi-private Room.

For the avoidance of doubt, the following costs shall not be payable under this benefit:

(1) the cost of the bone marrow, haemopoeitic stem cell or organ;
(2) the cost incurred by the Living Donor due to any complications arising from the Living Donor Surgery;
(3) the cost of handling and preparation of any harvested organ, marrow or stem cells following removal from the Living Donor;
(4) the cost incurred in connection with identifying and procuring a replacement organ; and
(5) any costs incurred by the Living Donor for Living Donor Surgery if the Living Donor is Confined in a room of a room level higher than Standard Semi-private Room.

The benefit limit of this benefit shall be an amount equal to thirty percent (30%) of the sum of the following:
(iii) the surgical expenses charged for the Living Donor Surgery; and
(iv) the Eligible Expenses of the organ transplant procedure performed on the Insured Person as a recipient payable in accordance with the Terms and Benefits.

If the Living Donor Surgery is performed in Hospitals located in mainland China, the cost to the Living Donor for the Living Donor Surgery as stated in (i) and (ii) above shall be payable only if the surgical procedures for the Living Donor Surgery are conducted in local organ transplant accredited institutions by organ transplant accredited surgeons and the organ procurement is in accordance with local medical and legal regulations.

For the avoidance of doubt, the Eligible Expenses of surgical procedures performed on the Insured Person as recipient of the organ or bone marrow shall be payable under Section 3 of Part 6 of these Terms and Benefits.

(i) Rehabilitation Centre & related treatment

This benefit shall be payable for the Eligible Expenses incurred for the Stay in the Rehabilitation Centre and for Medically Necessary rehabilitation treatment provided to the Insured Person during the Stay following the Insured Person's discharge from Hospital, provided that such Stay and the rehabilitation treatment are directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement.

Such Stay and rehabilitation treatment shall be recommended in writing by the attending Registered Medical Practitioner. Regardless of the number of Disabilities suffered by the Insured, this benefit is restricted to charges incurred in respect of up to the maximum number of days of Stay in a Rehabilitation Centre per Policy Year and the maximum limit per Policy Year as shown in the Benefit Schedule.

For the avoidance of doubt, when Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Benefits, such Eligible Expenses shall not be payable under this benefit.

(j) Ancillary service

This benefit shall be payable for the Eligible Expenses incurred for any of the following rehabilitation treatments performed on the Insured Person for the same Disability for which the Insured has been Confined in Hospital or undergone Day Case Procedures, and which takes place within ninety (90) days immediately after the Insured Person's discharge from the Hospital or the surgical procedures performed, subject to the maximum limit per visit, maximum number of days per Policy Year, and maximum aggregate limit per Policy Year as shown in the Benefit Schedule:

(i) consultation with and/or treatment performed on the Insured Person by a Chiropractor, Physiotherapist, Speech Therapist, or Occupational Therapist, which is recommended in writing by the attending Registered Medical Practitioner; and

(ii) consultation with, medical treatment performed and/or medicines prescribed by a Chinese Medicine Practitioner.

This benefit is subject to a maximum of one (1) visit for each day. For the avoidance of doubt, only the visit with the highest Eligible Expenses shall be payable in the event that the Insured Person has received more than one (1) visit on that day.

The Eligible Expenses so incurred as described above which are also covered under Section 3(k) of Part 6 of the Terms and Benefits shall first be paid under Section 3(k) of Part 6 of the Terms and Benefits, and this benefit shall be payable only if the limit on the number of visits under Section 3(k) of Part 6 of the Terms and Benefits as stated in the Benefit Schedule is exhausted.

(k) Hospice care

This benefit shall be payable for the Eligible Expenses and other expenses the Insured Person incurred for a stay in a registered hospice and for such care and nursing services provided by the registered hospice if the Insured Person is diagnosed with a Terminal Illness, which in the opinion of the attending Registered Medical Practitioner that the advent of death of the Insured Person is highly likely within twelve (12) months.

This benefit must be recommended in writing and certified by the attending Registered Medical Practitioner and the Insured Person's admission to the registered hospice must commence within ninety (90) days after the Insured Person's discharge from a Hospital at the end of a Confinement for a Disability which is directly related to such Terminal Illness.

For the avoidance of doubt, when Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Benefits, such Eligible Expenses shall not be payable under this benefit.

(l) Emergency outpatient treatment benefit

If the Insured Person sustains an Injury as a result of an Accident and receives outpatient treatment in the outpatient department of a Hospital within twenty-four (24) hours of the Accident resulting in such Injury, this benefit shall be payable for the Eligible Expenses charged for such treatment.

For the avoidance of doubt, when Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Benefits, such Eligible Expenses shall not be payable under this benefit.

(m) Emergency dental benefit

If the Insured Person sustains an Injury as a result of an Accident and receives Emergency Treatment within two (2) weeks of the Accident, which is necessitated to tooth / teeth which was sound natural right before the Accident, this benefit shall be payable for the Eligible Expenses charged for the dental treatment by a registered dentist (who is not a member of the Insured Person's Immediate Family Member or living regularly with the Insured Person) performed in a legally registered dental clinic or Hospital including consultation, staunch bleeding, x-ray, tooth extraction and root canal work.

This benefit shall not be payable for any restorative treatment, the use of any precious metals and

orthodontic treatment. It shall not cover any treatment for Injury caused by eating or drinking; damage caused by normal wear and tear; or damage caused by tooth brushing or any other oral hygiene procedure.

For the avoidance of doubt, when Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Benefits, such Eligible Expenses shall not be payable under this benefit.

2. Definitions

Under this Enhanced Benefits Supplement, words and expressions used shall have the following meanings –

"Chinese Medicine Practitioner"	shall mean an herbalist, a bonesetter or an acupuncturist registered with the Chinese Medicine Council of Hong Kong according to the Chinese Medicine Ordinance or with the local medical authorities at the place of treatment if such treatment is received outside Hong Kong, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, Immediate Family Member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing).
"Chiropractor"	shall mean a person, who is legally authorized by the government in the geographical area of his practice to render chiropractic services, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, Immediate Family Member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing).
"Covered Pregnancy Complications"	shall only be restricted to ectopic pregnancy, molar pregnancy, disseminated intravascular coagulopathy, pre-eclampsia, miscarriage, threatened abortion, medically prescribed induced abortion, foetal death, postpartum hemorrhage requiring hysterectomy, eclampsia, amniotic fluid embolism and pulmonary embolism of pregnancy.
"Immediate Family Member"	shall mean the legally married spouse, child(ren), siblings and parents of the Insured Person.
"Kidney Failure"	shall mean the end stage renal failure due to chronic irreversible failure of both kidneys to function. This must be evidenced by the Insured Person undergoing regular renal dialysis or have had renal transplantation.
"Living Donor"	shall mean a living donor on which a Living Donor Surgery has been performed.

"Living Donor Surgery"	shall mean the below surgical procedure performed on a Living Donor, where bone marrow, haemopoeitic stem cells, heart, kidney, pancreas, liver, lung or cornea removed will be used in the Medically Necessary organ transplant procedure with the Insured Person as a recipient: (a) a surgical procedure to collect bone marrow, stem cells derived from the bone marrow or haemopoeitic stem cells derived from the peripheral blood on the Living Donor, for the Insured Person's treatment following the total bone marrow ablation; or (b) a surgical procedure to harvest a whole or a part of an organ (heart, kidney, pancreas, liver, lung or cornea) of the Living Donor for the purposes of transplantation into the relevant organ of the Insured Person where the Insured Person has an organ failure as a direct result of a Disability or where an organ of the Insured Person has to be removed as a direct result of a Disability in such organ of the Insured. For the avoidance of doubt, other stem cell collection for transplantation (including cord blood collection) and islet cell collection for transplantation which are not mentioned above, and any transplant required for the repair or replacement of an organ not directly caused by the Disability mentioned in (b) shall not be treated as Living Donor Surgery.
"Occupational Therapist"	shall mean a person, who is legally authorized by the government in the geographical area of his practice to perform occupational therapy, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, Immediate Family Member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing).
"Physiotherapist"	shall mean a person, who is legally authorized by the government in the geographical area of his practice to render physiotherapy services, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, Immediate Family Member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing).
"Qualified Nurse"	shall mean a nurse legally qualified to render nursing services, having qualifications at least equivalent to a government registered or government enrolled nurse, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, Immediate Family Member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the nurse is not duly qualified and registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith), the

	Company shall exercise reasonable judgment to determine whether such nurse shall nonetheless be considered qualified.
"Rehabilitation Centre"	shall mean a registered institution (other than a Hospital) which provides physiotherapy, occupational therapy and other rehabilitative treatment for physical injury, dysfunction or disability.
"Speech Therapist"	shall mean a person, who is legally authorized by the government in the geographical area of his practice to perform speech therapy, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, Immediate Family Member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing).
"Standard Semi-private Room"	shall mean a single or two-bedded room (not including any companion bed) with a shared bathroom / toilet in a Hospital.
"Stay"	shall mean an admission of the Insured Person to a Rehabilitation Centre that is recommended by a Registered Medical Practitioner for Medical Service as a result of a Medically Necessary condition for a period of no less than six (6) consecutive hours.
"Terminal Illness"	shall mean the Sickness, which in the opinion of a Registered Medical Practitioner, is highly likely to lead to the Insured Person's death within twelve (12) months of such diagnosis.

Other Benefits Supplement

This is to supplement Part 6 Benefit Provisions of the Terms and Benefits.

1. Benefits covered

(a) Day surgery cash benefit

In an event that an Insured Person undergoes a Day Case Procedure which is payable in accordance to these Terms and Benefits, this benefit shall be payable in the amount as specified in the Benefit Schedule irrespective of the amount of Eligible Expenses reimbursed under any other benefit items of the Terms and Benefits, subject to the limits as specified in the Benefit Schedule.

(b) Room level downgrade cash benefit in Hong Kong

If room and board is payable under Section 3(a) of Part 6 of the Terms and Benefits, in addition to such Eligible Expenses, this benefit shall be payable for each day of Confinement which the Insured Person is Confined in a private Hospital in Hong Kong and in a room of a class lower than the covered room level as stated in the Benefit Schedule and subject to the limits as specified in the Benefit Schedule.

For the avoidance of doubt, this benefit shall not be payable for Confinement in Hong Kong's public Hospitals.

(c) Death benefit

Subject to these Terms and Benefits, if during the period while these Terms and Benefits are in force, the Insured Person dies due to any cause other than suicide committed within one (1) year from the Policy Effective Date, the death benefit as stated in the Benefit Schedule shall be payable to the Beneficiary regardless of the geographical location of death.

If the Insured Person commits suicide, whether sane or insane, within one (1) year from the Policy Effective Date, no death benefit will be payable.

If this Policy is terminated under Section 15(a) of Part 2 of the Terms and Benefits, in the case where the Insured Person dies within the grace period of this Policy, the death benefit as stated in the prevailing Benefit Schedule as at the day immediately preceding the date of termination of this Policy, after deducting any outstanding premium under Section 13 of Part 2 of the Terms and Benefits, shall be payable to the Beneficiary.

If the Policy Holder names more than one (1) person in each category of Beneficiaries, such living Beneficiaries in that category will share the death benefit equally unless the Policy Holder has directed otherwise in writing in advance.

If there is no named Beneficiary when the Insured Person dies, the death benefit will be payable to the Policy Holder or the Policy Holder's estate.

Unless specifically provided otherwise, the interest of any Beneficiary who predeceases the Insured Person shall vest in the Policy Holder.

If any Beneficiary dies simultaneously with the Insured Person, the death benefit shall be paid as if the younger person survived the older person.

The Policy Holder may change any Beneficiary during the Insured Person's lifetime. The Company does not limit the number of changes that may be made. To make a change, the Company must receive a written request satisfactory to the Company. Once the Company receives the written request, any such change will take effect as of the date the request is signed, even if the Insured Person dies before the Company receives the written request. However, each change and the entitlement of the new Beneficiary will be subject to any payment the Company made before receiving the written request.

2. Definitions

Under this Other Benefits Supplement, words and expressions used shall have the following meanings –

"Beneficiary"	shall mean the person named by the Policy Holder in the Company's records to receive the death benefit after the Insured Person dies. The Beneficiary named in the Application will receive the death benefit unless changed. There may be different categories of Beneficiaries such as primary and contingent. These categories set the order of payment. Any death benefit payable will be paid to the primary Beneficiary if living, otherwise to the contingent Beneficiary.

No Claim Premium Discount Supplement

This is to supplement Part 3 Premium Provisions of the Terms and Benefits.

1. No claim premium discount

Subject to these Terms and Benefits, during the period while these Terms and Benefits are in force, a no claim premium discount will be deducted from the amount of the required premium payable for these Terms and Benefits for the Policy Year starting from a Renewal Date if all of the following conditions ("The Requirements") are met for a continuous period immediately preceding to the Renewal Date as specified below:

(a) there are no paid benefits attributed to such period immediately preceding to the Renewal Date under these Terms and Benefits for the Insured Person; and
(b) these Terms and Benefits are in force during such period immediately preceding to the Renewal Date.

The entitlement of no claim premium discount of this Policy will be determined at every Renewal Date, and the no claim premium discount will be equal to the no claim premium discount rate times the required Annual Premium payable for these Terms and Benefits in the Policy Year immediately preceding the Renewal Date. The no claim premium discount rate will be determined in accordance with the following scale:

Period which all "The Requirements" above are met	**No claim premium discount rate**
3 consecutive Policy Years	5%
4 consecutive Policy Years	10%
5 or more consecutive Policy Years	15%

Once the no claim premium discount is determined, it will be deducted proportionately in the same frequency as the premium payment interval from the required premium payable for this Policy for the Policy Year starting from the Renewal Date. If this Policy is terminated, any outstanding no claim premium discount will be forfeited.

For the purpose of determining the no claim premium discount, any benefits paid under these Terms and Benefits shall be attributed to the Policy Year in which
(a) the admission occurred when an Insured Person is Confined; or
(b) the Medical Service is performed to the Insured Person as a Day Patient.

In the event that a benefit in respect of any previous Policy Year becomes payable by the Company after a no claim premium discount has been given, all the no claim premium discounts given will be recalculated such that the Policy Year in which the benefit was paid shall not be taken into account in the no claims period, and any difference between the recalculated amount and the no claim premium discount amount that the Policy Holder actually received will upon demand immediately be repaid in full to the Company.

2. Definitions

Under this No Claim Premium Discount Supplement, words and expressions used shall have the following meanings –

"Annual Premium"	shall mean the premium amount which is specified as "Annual Premium" in the Policy Schedule, Supplement(s) and/or the notification of Renewal as specified in Section 3 of Part 4 of the Terms and Benefits.

Change of Deductible Supplement

This is to supplement Part 6 Benefit Provisions of the Terms and Benefits.

While the Insured Person is living, Policy Holder may submit a written request to the Company within thirty (30) days before the Renewal Date on or immediately following the fiftieth (50^{th}), fifty-fifth (55^{th}), sixtieth (60^{th}), sixty-fifth (65^{th}), seventieth (70^{th}), seventy-fifth (75^{th}), eightieth (80^{th}) or eighty-fifth (85^{th}) birthday of the Insured Person to reduce the Deductible of this Policy from the relevant Renewal Date without the need to provide further evidence of insurability.

This right can only be exercised once during the lifetime of the Insured Person and is irrevocable, subject to the Deductible options available at that time, which must include a zero (0) Deductible option. Upon reduction of the Deductible on the relevant Renewal Date, the premium payable shall include the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company for such Deductible option, and any Premium Loading the Policy Holder has agreed for the Policy. Claims for expenses incurred after such reduction of the Deductible shall be subject to the reduced Deductible from the relevant Renewal Date.

For the avoidance of doubt, the Policy Holder's right to increase the Deductible is not affected. Upon any Renewal Date, the Policy Holder has the right to request the Company to increase the Deductible, without providing further evidence of insurability on the Insured Person.

Limitations of Benefits Supplement

This is to supplement Part 6 Benefit Provisions of the Terms and Benefits, Enhanced Benefits Supplement and Other Benefits Supplement.

Part 1 General

1. Geographical limitation

(a) Unless otherwise provided, all benefits described in these Terms and Benefits shall be applicable in Asia. The final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 3(a)(i) of Part 1 of this Limitations of Benefits Supplement.

(b) The benefits of psychiatric treatments as stated in Section 3(l) of Part 6 of the Terms and Benefits and the room level downgrade cash benefit in Hong Kong as stated in Section 1(b) of Other Benefits Supplement shall only be payable for Confinement in Hong Kong.

(c) For any non-Emergency Treatment received outside Asia, or for any Emergency Treatment received outside Asia where the Insured Person stayed in the place (where the Emergency incident occurs) for more than sixty (60) days in the past three hundred and sixty-five (365) days from the date of incident, the final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 3(a)(ii) of Part 1 of this Limitations of Benefits Supplement, and in so doing,

(i) the amount of benefits under Sections 3(a) to (k) of Part 6 of the Terms and Benefits shall be payable up to the benefit limits as stated in the benefit schedule attached to the Standard Plan Terms and Benefits;

(ii) no benefit shall be payable under Section 3(l) of Part 6 of the Terms and Benefits, Sections 1(a) to (k) of the Enhanced Benefits Supplement and Sections 1(a) to (b) of the Other Benefits Supplement. The amount of benefits under Sections 1(l) to (m) of the Enhanced Benefits Supplement shall be payable up to the benefit limits as stated in the Benefit Schedule of the Terms and Benefits;

(iii) the restriction in the choice of ward class as stated in Section 2 of Part 1 of this Limitations of Benefits Supplement shall not apply; and

(iv) the benefit payable shall further be reduced by the remaining balance of Deductible in the relevant Policy Year (if applicable).

For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4 of the Terms and Benefits.

(d) For any Emergency Treatment received outside Asia where the Insured Person stayed in the place (where the Emergency incident occurs) for no more than sixty (60) days in the past three hundred and sixty-five (365) days from the date of incident, any Eligible Expenses and/or other expenses incurred shall be payable in accordance with these Terms and Benefits. The final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 3(a)(i) of Part 1 of this Limitations of Benefits Supplement. The Company

shall have the right to require the Policy Holder to provide the proof of the Insured Person's period of stay in location outside Asia during any relevant period for processing of such claim.

2. Restriction in the choice of ward class

(a) If on any day of Confinement, the Insured Person is Confined in a room of room level higher than his/her covered room level as specified in the Benefit Schedule, the room level adjustment factor set out below shall be applied to the benefits payable under the Terms and Benefits in relation to such days of Confinement.

Room level adjustment factor

(i) Insured Person's Confinement in Hong Kong, Australia and New Zealand or Confinement outside Asia for Emergency Treatment where the Insured Person stayed in the place (where the Emergency incident occurs) for no more than sixty (60) days in the past three hundred and sixty-five (365) days from the date of incident

Covered room level as specified in the Benefit Schedule	Actual room level occupied by the Insured Person during Confinement	Room level adjustment factor
Standard Semi-private Room	Standard Private Room	50%
Standard Semi-private Room	Above the Standard Private Room	25%

(ii) Insured Person's Confinement in Asia (excluding Hong Kong, Australia and New Zealand)

Covered room level as specified in the Benefit Schedule	Actual room level occupied by the Insured Person during Confinement	Room level adjustment factor
Standard Private Room	Above the Standard Private Room	25%

(b) The room level adjustment factor shall not be applied under the following circumstances:

(i) unavailability of accommodation at the covered room level due to ward or room shortage for Emergency Treatment;

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

(iii) other reasons not involving personal preference of the Policy Holder and/or the Insured Person.

3. Overall benefit limit and benefit payable

(a) The final amount payable under the Terms and Benefits shall be calculated according to the formula below:

(i) Eligible Expenses and/or other expenses incurred in Asia or for any Emergency Treatment outside Asia as stated in Sections 1(a) and 1(d) of Part 1 of this Limitations of Benefits Supplement respectively:

The benefit amount payable

= [	A x C – B , subject to	the remaining balance of the benefit limits (the benefit limits are as stated in the Benefit Schedule, less the benefit amount(s) previously paid)	] –	Any remaining balance of Deductible (if applicable)

Where:

A = Amount of Eligible Expenses and/or other expenses payable in accordance with the Terms and Benefits, after applying exclusion and before applying the benefit limits

B = Amount of Eligible Expenses payable and/or other expenses payable in accordance with the Terms and Benefits already reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of the Terms and Benefits*

C = Room level adjustment factor under Section 2 of Part 1 of this Limitations of Benefits Supplement (if applicable)

* If there are any Eligible Expenses and/or other expenses payable under the Terms and Benefits already reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of the Terms and Benefits, such amount shall be deducted from the remaining balance of Deductible in the relevant Policy Year, if applicable, provided that all the medical reports, certified copy of all the invoices and receipts, and other necessary documents required by the Company are submitted to the Company as the evidence.

(ii) Eligible Expenses incurred outside Asia as stated in Section 1(c) of Part 1 of this Limitations of Benefits Supplement:

The benefit amount payable

= [	A – B , subject to	the remaining balance of the benefit limits (the benefit limits are as stated in the benefit schedule attached to the Standard Plan Terms and Benefits, less the benefit amount(s) previously paid)	] –	Any remaining balance of Deductible (if applicable)

Where:

A = Amount of Eligible Expenses payable in accordance with the benefit schedule attached to the Standard Plan Terms and Benefits, after applying exclusion and before applying the benefit limits

B = Amount of Eligible Expenses payable in accordance with the benefit schedule attached to the Standard Plan Terms and Benefits already reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of the Terms and Benefits#

If there are any Eligible Expenses payable in accordance with the benefit schedule attached to the Standard Plan Terms and Benefits already reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of the Standard Plan Terms and Benefits, such amount shall be deducted from the remaining balance of Deductible in the relevant Policy Year, if applicable, provided that all the medical reports, certified copy of all the invoices and receipts, and other necessary documents required by the Company are submitted to the Company as the evidence.

(b) If the benefits payable according to the formula in Section 3(a)(i) above is less than the benefits payable according to the formula in Section 3(a)(ii) above, the Company shall pay the latter.

(c) Except for day surgery cash benefit, room level downgrade cash benefit in Hong Kong and death benefit as stated in Sections 1(a), (b) and (c) of the Other Benefits Supplement, all the benefits payable in accordance with the Terms and Benefits (including the Standard Plan Terms and Benefits, if applicable) shall be subject to the application of any applicable remaining balance of Deductible in the relevant Policy Year.

(d) The final amount payable (i.e. after the application of any applicable remaining balance of Deductible in the relevant Policy Year) under the Terms and Benefits (including the Standard Plan Terms and Benefits, if applicable) shall be counted towards the benefit limits of applicable benefit items, Annual Benefit Limit of the relevant Policy Year and the Lifetime Limit as specified in the Benefit Schedule.

Part 2 Definitions

Under this Limitations of Benefits Supplement, words and expressions used shall have the following meanings –

"Asia"	shall mean Afghanistan, Australia, Bangladesh, Bhutan, Brunei, Cambodia, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, mainland China, Malaysia, Maldives, Mongolia, Myanmar, Nepal, New Zealand, North Korea, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, and Vietnam.
"Standard Private Room"	shall mean a basic single occupancy room with adjoining bathroom in a Hospital. For the avoidance of doubt, Standard Private Room does not include any room with amenities upgraded beyond a basic single occupancy room with adjoining bathroom in a Hospital.
"Standard Semi-private Room"	shall mean a single or two-bedded room (not including any companion bed) with a shared bathroom / toilet in a Hospital.

Waiver of Deductible for Designated Critical Illnesses Supplement

This is to supplement Part 6 Benefit Provisions of the Terms and Benefits.

1. Waiver of Deductible for designated critical illnesses

The terms and conditions stated in this Waiver of Deductible for Designated Critical Illnesses Supplement are not applicable to this Certified Plan with zero (0) Deductible option shown in the Benefit Schedule.

While this Policy is in force, under the circumstances where the Insured Person suffers the following (a) to (p) designated critical illnesses and, upon the recommendation of the attending Registered Medical Practitioner in writing, receives any Medical Service as a direct result of the designated critical illnesses, in calculation of the final amount payable under the Terms and Benefits according to the formula as stated in Section 3 of Part 1 of the Limitations of Benefits Supplement, the remaining balance of Deductible (if any and if applicable) for such Medical Services shall be reduced to zero (0). The Company shall pay the Eligible Expenses and/or other expenses charged on such Medical Service for designated critical illnesses before the entire Deductible is met. For the avoidance of doubt, the remaining balance of Deductible in the relevant Policy Year, if any and if applicable, shall not be reduced by the amount of Eligible Expenses and/or other expenses incurred for such designated critical illness paid by the Company.

For the avoidance of doubt, the "Waiver of Deductible for designated critical illnesses" under this Waiver of Deductible for Designated Critical Illnesses Supplement shall only be applicable to the Medical Services arising from any designated critical illness defined under Sections 1 and 2 of this Waiver of Deductible for Designated Critical Illnesses Supplement. Where the Eligible Expenses and/or other expenses involve Medical Services for both designated critical illnesses and any Disabilities other than such designated critical illnesses, and apportionment of the expenses is not available, the expenses in entirety shall be regarded as Eligible Expenses and/or other expenses charged on Medical Services for designated critical illnesses.

The designated critical illnesses must be confirmed by the Insured Person’s attending Registered Medical Practitioner in writing and supported by clinical, radiological, histological or laboratory evidence reasonably acceptable to the Company.

Designated critical illnesses shall include:

(a) Cancer
(b) Cardiac Impairment Caused By Cardiomyopathy
(c) Chronic Liver Failure
(d) Coronary Artery Bypass Surgery
(e) End-stage Lung Disease
(f) Fulminant Viral Hepatitis
(g) Heart Attack
(h) Heart Valve Replacement
(i) Kidney Failure
(j) Major Organ Transplantation
(k) Parkinson’s Disease
(l) Pulmonary Arterial Hypertension
(m) Rheumatoid Arthritis
(n) Stroke

(o) Surgery to Aorta
(p) Terminal Illness

The "Waiver of Deductible for designated critical illnesses" under this Waiver of Deductible for Designated Critical Illnesses Supplement shall not be applicable to the Medical Services arising from any designated critical illness that the Policy Holder or Insured Person is aware of, or shall be reasonably aware of within the first sixty (60) days from the Policy Effective Date of the Policy. An ordinary prudent person shall be reasonably aware of a designated critical illness, where–

(a) the designated critical illness has been diagnosed;
(b) the designated critical illness has manifested clear and distinct signs or symptoms; or
(c) medical advice or treatment has been sought, recommended or received for that signs or symptoms.

2. Definitions

Under this Waiver of Deductible for Designated Critical Illnesses Supplement, words and expressions used shall have the following meanings –

"Cancer"	shall mean: 1. the malignant tumour pathologically confirmed characterized by the uncontrolled growth of malignant cells and the invasion of tissue. Incontrovertible evidence of the invasion of tissue or definite histology of a malignant growth must be produced; or 2. includes leukaemia and malignant Disease of the lymphatic system. The following tumours are excluded: 3. non-invasive carcinomas-in-situ; 4. any skin cancer except malignant melanomas; 5. early stage cancer of the prostate classified as T1a or T1b or of a lesser classification according to the TNM staging method; 6. early stage papillary carcinoma of the thyroid described as T1aN0M0 or of a lesser classification according to the TNM staging method; 7. carcinoma-in-situ, intraepithelial lesion, non-infiltrating or non-invasive tumour; and 8. tumours in the presence of Human Immunodeficiency Virus. For the purpose of this definition, TNM staging method above shall be referenced to the latest edition of the TNM staging system established by the American Joint Committee on Cancer (AJCC) or its equivalent.
"Cardiac Impairment Caused By Cardiomyopathy"	shall mean the impaired ventricular function of variable aetiology, resulting in permanent and irreversible physical impairments to the degree of Class IV of the New York Heart Association Classification of Cardiac Impairment. Cardiomyopathy caused by alcohol or drug abuse is specifically excluded. For the avoidance of doubt, Classes III and/or below are excluded. (Class IV: The Insured Person has cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of inadequate cardiac output, pulmonary congestion, systemic congestion, or the anginal syndrome may be present, even at rest. If any physical activity is undertaken, discomfort is increased.)
"Chronic Liver Failure"	shall mean the end stage liver failure with increasing jaundice that in general medical opinion will not improve in future and resulting in either ascites or encephalopathy.

"Coronary Artery Bypass Surgery"	shall mean the undergoing of open-heart surgery to correct narrowing or blockage of at least two (2) or more coronary arteries by the use of by-pass grafts, but excluding all non-surgical procedures such as balloon angioplasty or laser techniques. Angiographic evidence of the relevant disease must be provided.
"End-stage Lung Disease"	shall mean the end-stage lung disease including interstitial lung disease, requiring extensive and permanent oxygen therapy as well as a "Forced expiratory volume in 1 second" test ("FEV1 test") result of less than one (1) litre.
"Fulminant Viral Hepatitis"	shall mean the submassive to massive necrosis of the liver caused by the Hepatitis virus, leading precipitously to liver failure. The diagnostic criteria to be all met are: 1. a rapidly decreasing liver size; 2. necrosis involving entire lobules, leaving only a collagen reticular framework; 3. rapidly degenerating liver function tests; and 4. deepening jaundice.
"Heart Attack"	shall mean the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis made by a Registered Medical Practitioner should be based upon all of the following criteria: 1. a history of typical chest pain; 2. new electrocardiographic changes; and 3. an elevation in cardiac enzyme levels which include the result of the following specified blood tests: (a) Troponin T > 1.0 ng／ml; and (b) AccuTnI > 0.5 ng／ml or equivalent threshold with other Troponin I methods.
"Heart Valve Replacement"	shall mean the actual undergoing of the replacement of one (1) or more heart valves due to stenosis or incompetence. Heart valve repair and valvotomy are specifically excluded.
"Kidney Failure"	shall mean the end stage renal failure due to chronic irreversible failure of both kidneys to function. This must be evidenced by the Insured Person undergoing regular renal dialysis or have had renal transplantation.
"Major Organ Transplantation"	shall mean the actual undergoing, as a recipient, of transplant of a heart, lung, liver, kidney, pancreas (excluding islet cell) or bone marrow.
"Neurologist"	Shall mean a Registered Medical Practitioner specialising in the diagnosis and treatment of Diseases or conditions of the brain and other parts of the nervous system.
"Parkinson's Disease"	shall mean the unequivocal diagnosis of Parkinson's Disease by a consultant Neurologist where the following conditions are all met: 1. cannot be controlled with medication;

2. shows signs of progressive impairments; and
3. activities of daily living assessment confirms the inability of the Insured Person to perform without assistance three (3) or more of the following:
    (a) bathing;
    (b) dressing;
    (c) using the lavatory;
    (d) eating; and
    (e) ability to move in or out of bed or a chair.

"Pulmonary Arterial Hypertension" shall mean the primary pulmonary arterial hypertension as established by clinical examination and investigations including cardiac catheterisation. The following diagnostic criteria must be met:

1. dyspnoea and fatigue;
2. increase left atrial pressure (by at least twenty (20) units);
3. pulmonary resistance of at least three (3) units above normal;
4. pulmonary artery pressure of at least 40 mm Hg;
5. pulmonary wedge pressure of at least 8 mm Hg.
6. right ventricular end-diastolic pressure of at least 8 mm Hg; and
7. right ventricular hypertrophy, dilation and signs of right heart failure and decompensation.

"Rheumatoid Arthritis" shall mean the occurrence of a rheumatoid arthritis where the diagnosis must be confirmed by a specialist in rheumatology and all the following diagnostic criteria must be met:

1. morning stiffness for at least one (1) hour;
2. symmetrical arthritis;
3. widespread chronic progressive joint destruction with major deformity affecting at least three (3) major joint areas, including
    (a) hands (including metacarpophalangeal joints, proximal interphalangeal joints, and/or thumb interphalangeal joints);
    (b) feet (including ankles and/or metatarsophalangeal joints);
    (c) wrists;
    (d) knees;
    (e) hips;
    (f) shoulders;
    (g) elbows; and
    (h) cervical spine,

    with soft tissue swelling or fluid as observed by a specialist in rheumatology;
4. presence of rheumatois nodules;
5. elevated titres of rheumatoid factor;
6. elevated erythrocyte sedimentation rate (ESR) of above fifty-five (55); and
7. radiographic evidence of severe involvement.

The above criteria of 1, 2 and 3 must be present for at least three (3) months before the first diagnosis of the Insured Person is made.

For the purpose of counting the number of affected joint areas to qualify Rheumatoid Arthritis for criteria 3 in the above, if both left and right hands, feet, wrists, knees, shoulders or elbows (as the case may be) are diagnosed with major deformity, the Company shall consider the right side and left side as two (2) joint areas.

"Stroke" shall mean any cerebrovascular incident (or accident) which:

1. is caused by infarction of brain tissue, haemorrhage from an intracranial vessel or embolisation from an extracranial source; and
2. results in neurological sequelae lasting more than twenty-four (24) hours.

There must be evidence of permanent neurological deficit persisting for at least four (4) consecutive weeks.

The following are excluded:

1. cerebral symptoms due to transient ischaemic attacks (TIA);
2. cerebral symptoms due to migraine; and
3. vascular Disease affecting the eye or optic nerve or vestibular functions.

"Surgery to Aorta" shall mean the actual undergoing of surgery for a Disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta, but not its branches. Traumatic injury to the aorta is excluded.

"Terminal Illness" shall mean the Sickness, which in the opinion of a Registered Medical Practitioner, is highly likely to lead to the Insured Person's death within twelve (12) months of such diagnosis.

Inclusion of VAT and GST as Eligible Expenses Supplement

This is to supplement Part 6 Benefit Provisions of the Terms and Benefits and Enhanced Benefits Supplement.

1. VAT and GST

This Supplement shall take effect from 1 March 2022 ("Effective Date").

With effect from the Effective Date, the following terms and conditions shall be applied to the Terms and Benefits –

(a) With respect to any Eligible Expenses incurred on or after the Effective Date, the terms and conditions in this Supplement shall be applicable, and Eligible Expenses shall include the VAT and GST (if any) charged or imposed on the expenses incurred for Medical Services rendered with respect to a Disability.

(b) For the purpose of Section 13 of Part 7 of the Terms and Benefits, any VAT and GST which is refunded to the Policy Holder or Insured Person (as the case may be) shall be excluded pursuant to such Section 13, and shall not be recoverable under the Terms and Benefits.

2. Definition

Under this Inclusion of VAT and GST as Eligible Expenses Supplement, words and expressions used shall have the following meanings –

"VAT and GST"	shall mean value added taxes, goods and services taxes or other taxes, duties or levies of a similar nature, which may be charged or imposed by the relevant tax or similar authorities or governmental departments on the expenses incurred for Medical Services rendered with respect to a Disability.

Inclusion of Public Hospitals and Private Hospitals in Hong Kong in the Definition of Hospital Supplement

This Supplement shall be attached to and form part of the Terms and Benefits. Unless otherwise defined, words and expressions used in the Terms and Benefits shall have the same meanings when they are used in this Supplement.

This Supplement shall take effect from the Policy Effective Date.

With effect from the Policy Effective Date, the definition of "Hospital" in Part 8 "Definition" shall include public hospitals and private hospitals in Hong Kong, as set out below:

Definition

"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which – (a) has facilities for diagnosis and major operations, or is a public hospital as defined in the Hospital Authority Ordinance (Cap. 113 of the Laws of Hong Kong) or a hospital for which a licence is issued under the Private Healthcare Facilities Ordinance (Cap. 633 of the Laws of Hong Kong); (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.

Flexi Plan Benefit Schedule

TaxVantage Prestige Medical Plan

Geographical coverage	Except for psychiatric treatments and room level downgrade cash benefit in Hong Kong (Hong Kong only) – For non-Emergency Treatment: Asia For Emergency Treatment(1): Worldwide
Covered room level	Confinement in Hong Kong, Australia and New Zealand or Confinement outside Asia for Emergency Treatment(1): Standard Semi-private Room Confinement in Asia (excluding Hong Kong, Australia and New Zealand): Standard Private Room
Annual Benefit Limit for (I) Basic benefits items (a) – (l), (II) Enhanced benefits items (a) – (m) and (III) Other benefits items (a) – (b)	HKD 10,000,000 per Policy Year
Lifetime Benefit Limit for (I) Basic benefits items (a) – (l), (II) Enhanced benefits items (a) – (m) and (III) Other benefits items (a) – (b)	HKD 40,000,000 per life
Deductible for (I) Basic benefits items (a) – (l), (II) Enhanced benefits items (a) – (m)	HKD 100,000 per Policy Year

Benefit items(2)	**Benefit limit (in HKD)**
(I) Basic benefits	
(a) Room and board	Full Cover(4)
(b) Miscellaneous charges	Full Cover(4) (subject to benefit limit of benefit item (g) "medical appliances" under (II) Enhanced benefits)
(c) Attending doctor's visit fee	Full Cover(4)
(d) Specialist's fee(3)	Full Cover(4)
(e) Intensive care	Full Cover(4)
(f) Surgeon's fee	Full Cover(4) regardless of the surgical category
(g) Anaesthetist's fee	Full Cover(4)
(h) Operating theatre charges	Full Cover(4)
(i) Prescribed Diagnostic Imaging Tests(3) (5)	Full Cover(4) Coinsurance: 0%
(j) Prescribed Non-surgical Cancer Treatments(6)	Full Cover(4)
(k) Pre- and post-Confinement/Day Case Procedure outpatient care (3)	Full Cover(4) • 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure

	• 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	$40,000 per Policy Year
(II) Enhanced benefits	
(a) Private nurse's fee[3]	Full Cover[4] Maximum 60 days per Policy Year
(b) Home nursing[3]	Full Cover[4] Maximum 60 days per Policy Year
(c) Hospital companion bed	Full Cover[4]
(d) Renal dialysis[3]	Full Cover[4]
(e) Reconstructive surgery benefit[3]	$200,000 per Accident/mastectomy
(f) Pregnancy complications benefit[3]	Full Cover[4]
(g) Medical appliances[3]	• For the designated medical appliances: Full Cover[4] • For any other medical appliances: $100,000 per Policy Year
(h) Transplantation surgery expenses for Living Donor	30% of the sum of surgical expenses for organ transplantation
(i) Rehabilitation Centre and related treatment[3]	$50,000 per Policy Year Maximum 60 days per Policy Year
(j) Ancillary service[3]	$30,000 per Policy Year Maximum 1 visit per day in total (within 90 days after discharge from Hospital or completion of Day Case Procedure) • Consultation with and/or treatment performed by Physiotherapist / Chiropractor / Speech Therapist / Occupational Therapist - $1,000 per day - Maximum 30 days per Policy Year • Consultation with, medical treatment performed and/or medicines prescribed by Chinese Medicine Practitioner - $600 per day - Maximum 15 days per Policy Year
(k) Hospice care[3]	$80,000 per Policy Year
(l) Emergency outpatient treatment benefit	Full Cover[4]
(m) Emergency dental benefit	Full Cover[4]
(III) Other benefits	
(a) Day surgery cash benefit	$1,600 per procedure Maximum 1 procedure per Policy Year
(b) Room level downgrade cash benefit in Hong Kong	$1,000 per day Maximum 60 days per Policy Year
(c) Death benefit	$80,000

Notes –

(1) The benefit payable is subject to the duration of stay of the Insured Person in the place where Emergency Treatment is received as stated in Section 1(c) and 1(d) of Part 1 of Limitations of Benefits Supplement.

(2) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above unless otherwise specified.

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

(4) Full cover shall mean no itemised benefit sublimit. The actual amount of Eligible Expenses and other expenses payable after deducting the remaining Deductible (if any) shall be subject to the benefit limits of applicable benefits items, Annual Benefit Limit and the Lifetime Benefit Limit.

(5) Tests covered here only include computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

(6) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.

Schedule of Surgical Procedures

Procedure / Surgery		Category
ABDOMINAL AND DIGESTIVE SYSTEM		
Oesophageal / stomach / duodenum	Excision of oesophageal lesion / destruction of lesion or tissue of oesophagus, cervical approach	Major
	Highly selective vagotomy	Major
	Laparoscopic fundoplication	Major
	Laparoscopic repair of hiatal hernia	Major
	Oesophagogastroduodenoscopy (OGD) +/- biopsy and/or polypectomy	Minor
	OGD with removal of foreign body	Minor
	OGD with ligation / banding of oesophageal/ gastric varices	Intermediate
	Oesophagectomy	Complex
	Total oesophagectomy and interposition of intestine	Complex
	Percutaneous gastrostomy	Minor
	Permanent gastrostomy / gastroenterostomy	Major
	Partial gastrectomy +/- jejunal transposition	Major
	Partial gastrectomy with anastomosis to duodenum / jejunum	Major
	Partial gastrectomy with anastomosis to oesophagus	Complex
	Proximal gastrectomy / radical gastrectomy / total gastrectomy +/- intestinal interposition	Complex
	Suture of laceration of duodenum / patch repair, duodenal ulcer	Major
	Vagotomy and / or pyloroplasty	Major
Jejunum, ileum and large intestine	Appendicectomy, open or laparoscopic	Intermediate
	Anal fissurectomy	Minor
	Anal fistulotomy / fistulectomy	Intermediate
	Incision & drainage of perianal abscess	Minor
	Delorme operation for repair of prolapsed rectum	Major
	Colonoscopy +/- biopsy	Minor
	Colonoscopy with polypectomy	Minor
	Sigmoidoscopy	Minor
	Haemorrhoidectomy, internal or external	Intermediate
	Injection / banding of haemorrhoid	Minor
	Ileostomy or colostomy	Major
	Anterior resection of rectum, open or laparoscopic	Complex
	Abdominoperineal resection, open or laparoscopic	Complex

Procedure / Surgery		Category
	Colectomy, open or laparoscopic	Complex
	Low anterior resection of rectum , open or laparoscopic	Complex
	Reduction of volvulus or intussusception	Intermediate
	Resection of small intestine and anastomosis	Major
Biliary tract	Cholecystectomy, open or laparoscopic	Major
	Endoscopic retrograde cholangio-pancreatography (ERCP)	Intermediate
	ERCP with papilla operation, stone extraction or other associated operation	Intermediate
Liver	Fine needle aspiration (FNA) biopsy of liver	Minor
	Liver transplantation	Complex
	Marsupialization of lesion / cyst of liver or drainage of liver abscess, open approach	Major
	Removal of liver lesion, open or laparoscopic	Major
	Sub-segmentectomy of liver, open or laparoscopic	Major
	Segmentectomy of liver, open or laparoscopic	Complex
	Wedge resection of liver, open or laparoscopic	Major
Pancreas	Closed biopsy of pancreatic duct	Intermediate
	Excision / destruction of lesion of pancreas or pancreatic duct	Major
	Pancreaticoduodenectomy (Whipple's Operation)	Complex
Abdominal wall	Exploratory laparotomy	Major
	Laparoscopy / peritoneoscopy	Intermediate
	Unilateral repair of inguinal hernia, open or laparoscopic	Intermediate
	Bilateral repair of inguinal hernia, open or laparoscopic	Major
	Unilateral herniotomy / herniorrhaphy, open or laparoscopic	Intermediate
	Bilateral herniotomy / herniorrhaphy, open or laparoscopic	Major
BRAIN AND NERVOUS SYSTEM		
Brain	Brain biopsy	Major
	Burr hole(s)	Intermediate
	Craniectomy	Complex
	Cranial nerve decompression	Complex
	Irrigation of cerebroventricular shunt	Minor
	Maintenance removal of cerebroventricular shunt, including revision	Intermediate
	Creation of ventriculoperitoneal shunt or subcutaneous cerebrospinal fluid reservoir	Major
	Clipping of intracranial aneurysm	Complex
	Wrapping of intracranial aneurysm	Complex

Procedure / Surgery		Category
	Excision of arteriovenous malformation, intracranial	Complex
	Excision of acoustic neuroma	Complex
	Excision of brain tumour or brain abscess	Complex
	Excision of cranial nerve tumour	Complex
	Radiofrequency thermocoagulation of trigeminal ganglion	Intermediate
	Closed trigeminal rhizotomy using radiofrequency	Major
	Decompression of trigeminal nerve root/ open trigeminal rhizotomy	Complex
	Excision of brain, including lobectomy	Complex
	Hemispherectomy	Complex
Spine	Lumbar puncture or cisternal puncture	Minor
	Decompression of spinal cord or spinal nerve root	Major
	Cervical sympathectomy	Intermediate
	Thoracoscopic or lumbar sympathectomy	Major
	Excision of intraspinal tumour, extradural or intradural	Complex
CARDIOVASCULAR SYSTEM		
Heart	Cardiac catheterization	Intermediate
	Coronary artery bypass graft (CABG)	Complex
	Cardiac transplantation	Complex
	Insertion of cardiac pacemaker	Intermediate
	Pericardiocentesis	Minor
	Pericardiotomy	Major
	Percutaneous transluminal coronary angioplasty (PTCA) and related procedures, including use of laser, stenting, motor-blade, balloon angioplasty, radiofrequency ablation technique, etc.	Major
	Pulmonary valvotomy, Balloon / Transluminal laser / Transluminal radiofrequency	Major
	Percutaneous valvuloplasty	Major
	Balloon aortic / mitral valvotomy	Major
	Closed heart valvotomy	Complex
	Open heart valvuloplasty	Complex
	Valve replacement	Complex
Vessels	Intra-abdominal venous shunt/ spleno-renal shunt / portal-caval shunt	Complex
	Resection of abdominal vessels with replacement / anastomosis	Complex
ENDOCRINE SYSTEM		
Adrenal Gland	Unilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Major

Procedure / Surgery		Category
	Bilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Complex
Pineal gland	Total excision of pineal gland	Complex
Pituitary Gland	Operation of pituitary tumour	Complex
Thyroid Gland	Fine needle aspiration (FNA) of thyroid gland +/- imaging guidance	Minor
	Hemithyroidectomy / partial thyroidectomy / subtotal thyroidectomy / parathyroidectomy	Major
	Total thyroidectomy / complete parathyroidectomy / robotic-assisted total thyroidectomy	Major
	Excision of thyroglossal cyst	Intermediate
EAR/ NOSE / THROAT / RESPIRATORY SYSTEM		
Ear	Canaloplasty for aural atresia / stenosis	Major
	Excision of preauricular cyst / sinus	Minor
	Haematoma auris, drainage / buttoning / excision	Minor
	Meatoplasty	Intermediate
	Removal of foreign body	Minor
	Excision of middle ear tumour via tympanotomy	Major
	Myringotomy +/- insertion of tube	Minor
	Myringoplasty / tympanoplasty	Major
	Ossiculoplasty	Major
	Labyrinthectomy, total / partial excision	Major
	Mastoidectomy	Major
	Operation on cochlea and / or cochlear implant	Complex
	Operation on endolymphatic sac / decompression of endolymphatic sac	Major
	Repair of round window or oval window fistula	Intermediate
	Tympanosympathectomy	Major
	Vestibular neurectomy	Intermediate
Nose, mouth and pharynx	Antral puncture and lavage	Minor
	Cauterization of nasal mucosa / control of epistaxis	Minor
	Closed reduction for fracture nasal bone	Minor
	Closure of oro-antral fistula	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lesion of nose	Minor
	Nasopharyngoscopy / rhinoscopy +/- including rhinoscopic biopsy +/- removal of foreign body	Minor
	Polypectomy of nose	Minor

Procedure / Surgery		Category
	Caldwell-Luc operation / Maxillary sinusectomy with Caldwell-Luc approach	Intermediate
	Endoscopic sinus surgery on ethmoid / maxillary / frontal / sphenoid sinuses	Intermediate
	Extended endoscopic frontal sinus surgery with trans-septal frontal sinusotomy	Major
	Frontal sinusotomy or ethmoidectomy	Intermediate
	Frontal sinusectomy	Major
	Functional endoscopic sinus surgery (FESS)	Major
	Functional endoscopic sinus surgery (FESS) bilateral	Complex
	Maxillary / sphenopalatine / ethmoid artery ligation	Intermediate
	Other intranasal operation, including use of laser (excluding simple rhinoscopy, biopsy and cauterisation of vessel)	Intermediate
	Rhinoplasty	Intermediate
	Resection of nasopharyngeal tumour	Intermediate
	Sinoscopy +/- biopsy	Minor
	Septoplasty +/- submucous resection of septum	Intermediate
	Submucous resection of nasal septum	Intermediate
	Turbinectomy / submucous turbinectomy	Intermediate
	Adenoidectomy	Minor
	Tonsillectomy +/- adenoidectomy	Intermediate
	Excision of pharyngeal pouch / diverticulum	Intermediate
	Pharyngoplasty	Intermediate
	Sleep related breathing disorder – hyoid suspension, maxilla / mandible / tongue advancement, laser suspension / resection, radiofrequency ablation assisted uvulopalatopharyngoplasty, uvulopalatopharyngoplasty	Intermediate
	Marsupialization / excision of ranula	Intermediate
	Parotid gland removal, superficial	Intermediate
	Parotid gland removal / parotidectomy	Major
	Removal of submandibular salivary gland	Intermediate
	Submandibular duct relocation	Intermediate
	Submandibular gland excision	Intermediate
Respiratory system	Arytenoid subluxation – laryngoscopic reduction	Minor
	Bronchoscopy +/- biopsy	Minor
	Bronchoscopy with foreign body removal	Minor
	Laryngoscopy +/- biopsy	Minor

Procedure / Surgery		Category
	Laryngeal / tracheal stenosis – endolaryngeal / open operation with stenting / reconstruction	Major
	Laryngeal diversion	Intermediate
	Laryngectomy +/- radical neck resection	Complex
	Microlaryngoscopy +/- Biopsy +/- excision of nodule / polyp / Reinke's edema	Minor
	Partial / total resection of laryngeal tumour	Intermediate
	Removal of vallecular cyst	Intermediate
	Repair of laryngeal fracture	Major
	Injection for vocal cord paralysis	Minor
	Tracheoesophageal puncture for voice rehabilitation	Minor
	Thyroplasty for vocal cord paralysis	Intermediate
	Vocal cord operation, including use of laser (excluding carcinoma)	Minor
	Tracheostomy, temporary / permanent / revision	Minor
	Lobectomy of lung / pneumonectomy	Complex
	Pleurectomy	Major
	Segmental resection of lung	Major
	Thoracocentesis / insertion of chest tube for pneumothorax	Minor
	Thoracoscopy +/- biopsy	Intermediate
	Thoracoplasty	Major
	Thymectomy	Major
EYE		
Eye	Excision / curettage / cryotherapy of lesion of eyelid	Minor
	Blepharorrhaphy / tarsorrhaphy	Minor
	Repair of entropion or ectropion +/- wedge resection	Minor
	Reconstruction of eyelid, partial-thickness	Intermediate
	Excision / destruction of lesion of conjunctiva	Minor
	Excision of pterygium	Minor
	Corneal grafting, severe wound repair and keratoplasty, including corneal transplant	Major
	Laser removal / destruction of corneal lesion	Intermediate
	Removal of corneal foreign body	Minor
	Repair of cornea	Intermediate
	Suture / repair of corneal laceration or wound with conjunctival flap	Intermediate
	Aspiration of lens	Intermediate
	Capsulotomy of lens, including use of laser	Intermediate

Procedure / Surgery		Category
	Extracapsular / intracapsular extraction of lens	Intermediate
	Intraocular lens / explant removal	Intermediate
	Chorioretinal lesion operations	Intermediate
	Phacoemulsification and implant of intraocular lens	Intermediate
	Pneumatic retinopexy	Intermediate
	Retinal Photocoagulation	Intermediate
	Repair of retinal detachment / tear	Intermediate
	Repair of retinal tear / detachment with buckle	Major
	Scleral buckling / encircling of retinal detachment	Major
	Cyclodialysis	Intermediate
	Trabeculectomy, including use of laser	Intermediate
	Surgical treatment for glaucoma including insertion of implant	Intermediate
	Diagnostic aspiration of vitreous	Minor
	Injection of vitreous substitute	Intermediate
	Mechanical vitrectomy / removal of vitreous	Major
	Biopsy of iris	Minor
	Excision of lesion of iris / anterior segment of eye / ciliary body	Intermediate
	Excision of prolapsed iris	Intermediate
	Iridotomy	Intermediate
	Iridectomy	Intermediate
	Iridoplasty +/- coreoplasty by laser	Intermediate
	Iridencleisis and iridotasis	Intermediate
	Scleral fistulization +/- iridectomy	Intermediate
	Thermocauterization of sclera +/- iridectomy	Intermediate
	Diminution of ciliary body	Intermediate
	Biopsy of extraocular muscle or tendon	Minor
	Operation on one extraocular muscle	Intermediate
	Eyeball, perforating wound of, with incarceration or prolapse of uveal tissue repair	Major
	Enucleation of eye	Intermediate
	Evisceration of eyeball / ocular contents	Intermediate
	Repair of eyeball or orbit	Intermediate
	Conjunctivocystorhinostomy	Intermediate
	Conjunctivorhinostomy with insertion of tube / stent	Intermediate
	Dacryocystorhinostomy	Intermediate

Procedure / Surgery		Category
	Excision of lacrimal sac and passage	Minor
	Excision of lacrimal gland / dacryoadenectomy	Intermediate
	Probing +/- syringing of lacrimal canaliculi / nasolacrimal duct	Minor
	Repair of canaliculus	Intermediate
	Coreoplasty	Intermediate
FEMALE GENITAL SYSTEM		
Cervix	Amputation of cervix	Intermediate
	Colposcopy +/- biopsy	Minor
	Conization of cervix	Minor
	Destruction of lesion of cervix by excision/ cryosurgery / cauterization / laser	Minor
	Endocervical curettage	Minor
	Loop electrosurgical excision procedure (LEEP)	Minor
	Marsupialization of cervical cyst	Minor
	Repair of cervix	Minor
	Repair of fistula of cervix	Intermediate
	Suture of laceration of cervix / uterus / vagina	Intermediate
Fallopian tubes and ovaries^	Dilatation / insufflation of fallopian tube	Minor
	Excision / destruction of lesion of fallopian tube, open or laparoscopic	Major
	Repair of fallopian tube	Major
	Salpingostomy / salpingotomy	Intermediate
	Total or partial salpingectomy	Intermediate
	Tuboplasty	Intermediate
	Aspiration of ovarian cyst	Minor
	Ovarian cystectomy, open or laparoscopic	Major
	Wedge resection of ovary, open or laparoscopic	Major
	Oophorectomy	Intermediate
	Oophorectomy, laparoscopic	Major
	Salpingo-oophorectomy, open or laparoscopic	Major
	Drainage of tubo-ovarian abscess, open or laparoscopic	Intermediate
	^ *The category applies to both unilateral and bilateral procedures unless otherwise specified.*	
Uterus	Dilatation and curettage of Uterine (D&C)	Minor
	Hysteroscopy +/- biopsy	Minor
	Hysteroscopy with excision or destruction of uterus and supporting structures	Intermediate

Procedure / Surgery		Category
	Hysterotomy	Major
	Laparoscopic assisted vaginal hysterectomy (LAVH)	Major
	Vaginal hysterectomy +/- repair of cystocele and/or rectocele	Major
	Total / subtotal abdominal hysterectomy +/- bilateral salpingo-oophorectomy, open or laparoscopic	Major
	Radical abdominal hysterectomy	Complex
	Myomectomy, open or laparoscopic	Major
	Uterine myomectomy, vaginal or hysteroscopic	Intermediate
	Laparoscopic drainage of female pelvic abscess	Intermediate
	Colposuspension	Major
	Pelvic floor repair	Major
	Pelvic exenteration	Complex
	Uterine suspension	Intermediate
Vagina	Destruction of lesion of vagina by excision / cryosurgery / cauterization / laser	Minor
	Insertion / removal of vaginal supportive pessaries	Minor
	Marsupialization of Bartholin's cyst	Minor
	Vaginal stripping of vaginal cuff	Minor
	Vaginotomy	Intermediate
	Partial vaginectomy	Intermediate
	Vaginectomy, complete	Major
	Radical vaginectomy	Complex
	Anterior colporrhaphy +/- Kelly plication	Intermediate
	Posterior colporrhaphy	Intermediate
	Obliteration of vaginal vault	Intermediate
	Sacrospinous ligament suspension or fixation of the vagina	Intermediate
	Sacral colpopexy	Intermediate
	Vaginal repair of enterocoele	Intermediate
	Closure of urethro-vaginal fistula	Intermediate
	Repair of rectovaginal fistula, vaginal approach	Intermediate
	Repair of rectovaginal fistula, abdominal approach	Major
	Culdocentesis	Minor
	Culdotomy	Minor
	Excision of transverse vaginal septum	Minor
	McCall's culdeplasty / culdoplasty	Intermediate

Procedure / Surgery		Category
	Vaginal reconstruction	Major
Vulva and introitus	Destruction of lesion of vulva by excision / cryosurgery / cauterization / laser	Minor
	Wide local excision of vulva with cold knife or LEEP	Minor
	Excision of vestibular adenitis	Minor
	Excision biopsy of vulva	Minor
	Incision and drainage of vulva and perineum	Minor
	Lysis of vulvar adhesions	Minor
	Repair of fistula of vulva or perineum	Minor
	Suture of lacerations / repair of vulva and/or perineum	Minor
	Vulvectomy	Intermediate
	Radical vulvectomy	Major
HEMIC AND LYMPHATIC SYSTEM		
Lymph Nodes	Drainage of lesion / abscess of lymph node	Minor
	Biopsy / excision of superficial lymph nodes / simple excision of lymphatic structure	Minor
	Incisional biopsy of cervical lymph node / fine needle aspiration (FNA) biopsy of lymph nodes	Minor
	Excision of deep lymph node / lymphangioma / cystic hygroma	Intermediate
	Bilateral inguinal lymphadenectomy	Intermediate
	Cervical lymphadenectomy	Intermediate
	Inguinal and pelvic lymphadenectomy	Major
	Radical groin dissection	Major
	Radical pelvic lymphadenectomy	Major
	Selective / radical / functional neck dissection	Major
	Wide excision of axillary lymph node	Major
Spleen	Splenectomy, open or laparoscopic	Major
MALE GENITAL SYSTEM		
Prostate	External drainage of prostatic abscess	Minor
	Photoselective vaporization of prostate	Major
	Plasma vaporization of prostate	Major
	Prostate biopsy	Minor
	Transurethral microwave therapy	Intermediate
	Transurethral prostatectomy or TURP	Major
	Prostatectomy, open or laparoscopic	Major
	Radical prostatectomy, open or laparoscopic	Complex

Procedure / Surgery		Category
Penis	Circumcision	Minor
	Release of chordee	Major
	Repair of buried / avulsion of penis	Intermediate
Testicles^	Epididymectomy	Intermediate
	Exploration of testis	Intermediate
	Exploration for undescended testis, laparoscopic	Major
	Orchidopexy	Intermediate
	Orchidectomy or orchidopexy, laparoscopic	Major
	Reduction of torsion of testis and fixation	Intermediate
	Testicular biopsy	Minor
	High ligation of hydrocoele	Intermediate
	Tapping of hydrocele	Minor
	Excision of varicocoele and hydrocoele of spermatic cord	Intermediate
	Varicocelectomy (microsurgical)	Major
	^ *The category applies to both unilateral and bilateral procedures unless otherwise specified.*	
Spermatic cord	Vasectomy	Minor
MUSCULOSKELETAL SYSTEM		
Bone	Amputation of finger(s) / toe(s) of one limb	Intermediate
	Amputation of one arm / hand / leg / foot	Intermediate
	Bunionectomy	Intermediate
	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal	Major
	Excision of radial head	Intermediate
	Mandibulectomy for benign disease	Intermediate
	Patellectomy	Major
	Partial ostectomy of facial bone	Intermediate
	Sequestrectomy of facial bone	Intermediate
	Wedge osteotomy of bone of wrist / hand / leg	Major
	Wedge osteotomy of bone of upper arm / lower arm / thigh	Major
	Wedge osteotomy of scapula / clavicle / sternum	Major
Joint	Arthroscopic drainage and debridement	Intermediate
	Arthroscopic removal of loose body from joints	Intermediate
	Arthroscopic examination of joint +/- biopsy	Intermediate
	Arthroscopic assisted ligament reconstruction	Major
	Arthroscopic Bankart repair	Major

Procedure / Surgery		Category
	Arthroscopic repair for superior labral tear from anterior to posterior of shoulder	Major
	Arthroscopic rotator cuff repair	Major
	Acromioplasty	Major
	Arthrodesis of shoulder	Major
	Arthrodesis of Elbow / Triple arthrodesis	Major
	Arthrodesis of knee / hip	Complex
	Arthroplasty of hand / finger / foot / Toe joint with implant	Major
	Fusion of wrist	Major
	Synovectomy of wrist	Intermediate
	Interphalangeal joint fusion of toes	Intermediate
	Interphalangeal fusion of finger	Major
	Excisional arthroplasty shoulder / hemiarthroplasty of shoulder	Major
	Excisional arthroplasty of hip / knee / Wrist / Elbow	Major
	Excisional arthroplasty of hip / knee with local antibiotic delivery	Complex
	Temporomandibular arthroplasty +/- autograft	Major
	Joint aspiration / injection	Minor
	Manipulation of joint under anesthesia	Minor
	Metal femoral head insertion	Major
	Anterior cruciate ligament reconstruction	Major
	Meniscectomy, open or arthroscopic	Major
	Posterior cruciate ligament reconstruction	Major
	Repair of the collateral ligaments	Major
	Repair of the cruciate ligaments	Major
	Suture of capsule or ligament of ankle and foot	Major
	Total shoulder replacement	Complex
	Total knee replacement	Complex
	Total hip replacement	Complex
	Partial hip replacement	Major
Muscle/ Tendon	Achilles tendon repair	Intermediate
	Achillotenotomy	Intermediate
	Change in muscle or tendon length (except hand) / excision of lesion of muscle	Intermediate
	Change in muscle or tendon length of hand	Major
	Excision of lesion of muscle	Intermediate

Procedure / Surgery		Category
	Lengthening of tendon, including tenotomy	Intermediate
	Open biopsy of muscle	Minor
	Release of De Quervain's disease	Minor
	Release of trigger finger	Minor
	Release of tennis elbow	Minor
	Transfer / transplantation / reattachment of muscle	Major
	Tendon repair / Suture of tendon not involving hand	Intermediate
	Tendon repair / Suture of tendon of hand	Major
	Tenosynovectomy / synovectomy	Intermediate
	Transposition of tendon of wrist / hand	Major
	Secondary repair of tendon, including graft, transfer and / or prosthesis	Major
Fracture/ dislocation	Closed reduction of dislocation of temporomandibular / interphalangeal / acromioclavicular joint	Minor
	Closed reduction of dislocation of shoulder / elbow / wrist / ankle	Intermediate
	Closed reduction for Colles' fracture with percutaneous k-wire fixation	Major
	Closed reduction for fracture of arm / leg / patella / pelvis with internal fixation	Major
	Close reduction for mandibular fracture with internal fixation	Intermediate
	Closed reduction for fracture of clavicle / scapula / phalanges / patella without internal fixation	Minor
	Closed reduction for fracture of upper arm / lower arm / wrist / hand / leg / foot bone without internal fixation	Intermediate
	Closed reduction for fracture of clavicle / hand / ankle /foot with internal fixation	Intermediate
	Closed reduction for fracture of femur +/- internal fixation	Major
	Closed / open reduction of fracture of acetabulum with internal fixation	Complex
	Open reduction for mandibular fracture with internal fixation	Major
	Open reduction for clavicle / hand / foot (except carpal / talus / calcaneus) +/- internal fixation	Intermediate
	Open reduction for arm / leg / patella / scapula +/- internal fixation	Major
	Open reduction for femur / calcaneus / talus/ +/- internal fixation	Major
	Operative treatment of compound fracture with external fixator and extensive wound debridement	Intermediate
	Removal of screw, pin and plate, and other metal for old fracture except fracture femur	Minor
Spine	Artificial cervical disc replacement	Complex

Procedure / Surgery		Category
	Anterior spinal fusion, cervical / cervicothoracic/ C4/5 and C5/6 and locking plate	Major
	Anterior spinal fusion (excluding cervical / cervicothoracic/ C4/5 and C5/6 and locking plate)	Complex
	Anterior spinal fusion with instrumentation	Complex
	Laminoplasty for cervical spine	Major
	Laminectomy / diskectomy	Major
	Laminectomy with diskectomy	Complex
	Posterior spinal fusion, thoracic / cervico-thoracic / thoracolumbar / T5 to L1/ atlas-axis	Major
	Posterior spinal fusion, (excluding thoracic / cervico-thoracic / thoracolumbar / T5 to L1 / atlas-axis)	Complex
	Posterior spinal fusion with instrumentation	Complex
	Spinal biopsy	Minor
	Spinal fusion +/- foraminotomy +/- laminectomy +/- diskectomy	Complex
	Spine osteotomy	Complex
	Vertebroplasty / kyphoplasty	Intermediate
Others	Excision of ganglion / bursa	Minor
	Closed/ Percutaneous needle fasciotomy for Dupuytren disease	Minor
	Radical (or total) fasciectomy for Dupuytren disease	Major
	Release of carpal / tarsal tunnel, open or endoscopic	Intermediate
	Release of peripheral nerve	Intermediate
	Transposition of ulnar nerve	Intermediate
	Sliding / reduction genioplasty	Intermediate
SKIN AND BREAST		
Skin	Curettage / cryotherapy / cauterization / laser treatment of lesion of skin	Minor
	Drainage of subungual haematoma or abscess	Minor
	Excision of lipoma	Minor
	Excision of skin for graft	Minor
	Incision and /or drainage of skin abscess	Minor
	Incision and /or removal of foreign body from skin and subcutaneous tissue	Minor
	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue	Minor
	Suture of wound on skin	Minor
	Surgical toilet and suturing	Minor

Procedure / Surgery		Category
	Wedge resection of toenail	Minor
Breast	Breast tumour/ lump excision +/- biopsy	Intermediate
	Fine needle aspiration (FNA) of breast cyst	Minor
	Incisional breast biopsy	Minor
	Modified radical mastectomy	Major
	Partial or simple mastectomy	Intermediate
	Partial or radical mastectomy with axillary lymphadenectomy	Major
	Total or radical mastectomy	Major
	Duct papilloma excision	Intermediate
	Gynaecomastia excision	Intermediate
URINARY SYSTEM		
Kidney	Extracorporeal shock wave lithotripsy for urinary stone (ESWL)	Intermediate
	Nephrolithotomy / pyelolithotomy	Major
	Nephroscopy	Major
	Percutaneous insertion of nephrostomy tube	Minor
	Renal biopsy	Minor
	Nephrectomy, open or laparoscopic or retroperitoneoscopic	Major
	Nephrectomy, partial/ lower pole	Complex
	Kidney transplant	Complex
Bladder, ureter and urethra	Cystoscopy +/- biopsy	Minor
	Cystoscopy with catheterization of ureter/ transurethral bladder clearance	Minor
	Cystoscopy with electro-cauterisation/ laser lithotripsy	Intermediate
	Excision of urethra caruncle	Minor
	Insertion of urethral/ureter stent	Intermediate
	Diverticulectomy of urinary bladder, open or laparoscopic	Major
	Transurethral resection of bladder tumour	Major
	Partial cystectomy, open or laparoscopic	Major
	Radical/ total cystectomy, open or laparoscopic	Complex
	Ureterolithotomy, open or laparoscopic or retroperitoneoscopic	Major
	Closure of urethro-rectal fistula	Major
	Repair of urethral fistula	Major
	Repair of vesicovaginal fistula	Major
	Repair of vesicocolic fistula	Major
	Repair of rupture of urethra	Major

Procedure / Surgery		Category
	Repair of urinary stress incontinence	Major
	Formation of ileal conduit, including ureteric implantation	Complex
	Ileal or colonic replacement of ureter	Major
	Unilateral reimplantation of ureter into bowel or bladder	Major
	Bilateral reimplantation of ureter into bowel or bladder	Major
DENTAL		
	Any kind of dental surgery due to injury caused by an Accident	Minor

「稅」卓越醫療計劃
條款及細則

目錄

條款及細則

第一部分 保險條文及保單

保險條文

本***條款及細則***，連同***保障表***(包括***手術表***)及***政府***認可的相關***補充文件*** (下簡稱「***條款及保障***」)，適用於以下由***本公司***按**自願醫保計劃** (下簡稱「***自願醫保***」) 提供的***認可產品*** –

認可產品類別: ***靈活計劃***
認可產品名稱: ***「稅」卓越醫療計劃***

在本***條款及保障***生效期間，若***受保人***罹患***傷病***，***本公司***必須按本條文賠償***合資格費用***。

所有賠償予***保單持有人***的保障，必須按 ***合資格費用***的實際金額作實報實銷賠償，並受本***條款及保障*** 和***保單資料頁***內列明的最高賠償額及分擔費用安排(如有)所規限。

保單

保單持有人與***本公司***均同意 –

1. 所有對本***條款及保障***的修訂必須按本***條款及細則***執行，否則該修訂不應視為有效。

2. 在***投保申請文件***內所有由***受保人***或為***受保人***作出的陳述均被視為申述，而非保證。

3. 在***投保申請文件***內及按本***保單***所要求，所有由***受保人***或為***受保人***作出的陳述及提供的資料，必須盡其所知所信，絕對真誠地提出。

4. 當***保單持有人***繳交全數首期保費後，本***條款及保障***將按***保單資料頁***內所列的***保單生效日***起生效。

5. 在***本條款及保障***生效及每次***續保***時，當以下兩者 –

   (a) 本***保單***的條款及保障；及
   (b) 按第四部分第 1 (a) – (c)節所述***政府***所訂定***標準計劃條款及保障***的版本，

   有任何互相抵觸或不相符之處時，

   (i) 只要涉及***標準計劃條款及保障***的範圍，將以對***保單持有人***或***受保人***較有利的條款及保障為準；及
   (ii) 只要涉及***標準計劃條款及保障***的範圍，對***保單持有人***或***受保人***加設額外約束或限制的條款及保障應視為無效。

上述 (i) 及 (ii) 項的規定皆不適用於本第一部分第 7 節、第六部分第 1(b)及第 5 節和***政府***可能不時批准的其他豁免事項。

在以***標準計劃條款及保障***相關的條款及保障為準的情況下，有關條款及保障將被視作本***保單***的條款及保障的一部分。為免存疑，除了本第一部分第 7 節、第六部分第 1(b)及第 5 節和***政府***可能不時批准的其他豁免事項外，***保單持有人***或***受保人***在本***保單***的條款及保障下所享有的權利、權力、保障或權益，不得差於其在***標準計劃條款及保障***下可享有的權利、權力、保障或權益(包括若***保單持有人***基於***受保人***獲得該等權利、權力、保障或權益的情況)。

6. 在本***條款及保障***生效或每次***續保***時，若本***保單***的保障範圍超過或有別於***標準計劃條款及保障***的保障範圍，即使涉及的條款及保障與***標準計劃條款及保障***有所不同，亦不會構成本第一部分第 5 節所述有抵觸或不相符的情況。

7. ***本公司***可以在首次簽發本***條款及保障***時，對***受保人***於***投保申請文件***內知會***本公司***的***投保前已有病症***，及其他會影響其投保風險的因素，加設***個別不保項目***。

8. ***本公司***確認，作為核保程序的一部分，***本公司***有責任向***保單持有人***及***受保人***在***投保申請文件***內提問所有影響核保決定的資料。若***本公司***要求***保單持有人***及/或***受保人***披露，在遞交***投保申請文件***後至***保單簽發日*** 或 ***保單生效日*** (以較早日期為準) 前 ，相關資料的更新或改動，***本公司*** 必須明確地向***保單持有人***及***受保人***作出該要求 (包括但不限於列載於投保申請表內) ， 在這情況下，***保單持有人***及/或***受保人***均有責任知會***本公司***相關資料的更新及改動。每位***保單持有人***及***受保人***均有責任回覆問題，並披露問題所要求的重要事實。***本公司***同意，若在***投保申請文件***內未有包括任何相關問題，將被視為***本公司***豁免***保單持有人***及***受保人***披露有關所需資料的責任。

9. ***投保申請文件***中所有問題及要求的資料必須充分具體及明確，並符合***自願醫保***的規則及規例，協助***保單持有人***及***受保人***（按情況而定）理解所需披露的資料，從而提供清晰而明確的回覆。如有爭議，***本公司***必須負舉證責任，證明問題充分具體及明確。

10. 若***保單持有人***或***受保人***未有按本第一部分第 8 或 9 節披露有關資料，而相關的披露會對***本公司***的核保決定帶來實質影響時，***本公司***有權行使按第二部分第 13 及 14 節所賦予的權利。

第二部分 一般條件

1. 合約詮釋

(a) 按條款解釋所需，本***條款及保障***內表示男性性別的用詞，其含義將包括女性性別；單數用詞的含義將包括複數，反之亦然。
(b) 所有標題均作方便參考之用，不應影響本***條款及保障***的詮釋。
(c) 所列時間均為***香港***時間。
(d) 除另行釋義外，本***條款及保障***內以斜體標註的詞彙需以第八部分所載涵意詮釋。

本***條款及保障***備有中文及英文版本。兩者均為正式版本，具相同效力。若兩者存有歧義，必須以較有利***保單持有人***的詮釋為準。

就相同的保障範圍而言，若本***保單***內任何條款及保障存有歧義，必須以較有利***保單持有人***的詮釋為準。在這情況下，除了本第一部分第7節、第六部分第1(b)及第5節和***政府***可能不時批准的其他豁免事項外，任何對本***條款及保障***的限制將被視為無效 。

2. 冷靜期內取消條款及保障的安排

保單持有人可在冷靜期內行使權利取消本***條款及保障***及獲發還全數已付保費，但行使此項權利時，必須符合以下條件 –

(a) 取消要求必須由***保單持有人***簽署，並確保***本公司***於冷靜期內直接收到該要求。冷靜期為緊接下列文件***交付***予***保單持有人***或***保單持有人***的指定代表之日起計的二十一(21)日的期間–
   (i) 本***條款及保障***和***保單資料頁***； 或
   (ii) 冷靜期通知書；

   以較早者為準。為免生疑問，***交付***本***條款及保障***和***保單資料頁***或冷靜期通知書當天並不包括在計算二十一(21)日的期間內。然而，若第二十一(21)日當天並非工作天，則冷靜期將包括隨後的工作天的一天在內；

   及

(b) 若曾獲賠償或將獲得賠償，則不獲發還保費。

上述取消的權利並不適用於***續保*** 。

行使此項取消的權利時，***保單持有人***必須 –

(c) 退回本***條款及保障***和***保單資料頁***正本；及
(d) 附有***保單持有人***簽署的信件（或以其他***本公司***接受的方式）要求取消本***條款及保障***。

在完成上述程序後，***本公司***將取消本***條款及保障***及全數發還已付保費。在此情況下，本***條款及保障***將被視為由***保單生效日***起無效，***本公司***亦無須承擔任何賠償責任。

3. 取消保單

冷靜期過後，若***保單持有人***在該***保單年度***期間沒有就本***條款及保障***獲得任何賠償，***保單持有人***可以在十四(14)日前以書面方式通知***本公司***要求取消本***條款及保障***。

此權利在首個（及其後的）***保單年度***的***條款及保障續保***後仍然適用。

4. 保障權益

若***受保人***接受***醫療服務***招致***合資格費用***，則需按招致該費用時適用的***條款及保障***作出賠償。不論如何，按本第二部分第 15 節，於本***保單***終止後三十 (30) 日內所招致的***合資格費用***，必須按本***保單***終止生效日的前一日適用的***條款及保障***作出賠償。

5. 轉讓

保單持有人 不得轉讓本***條款及保障***的部分的權利、保障、義務及責任。***保單持有人***必須保證在本***條款及保障***的任何應付款項均不受任何信託、留置權或費用所約束。

6. 文書錯誤

任何文書記錄錯誤，將不會令原應有效的保障失效，或令原應終止的保障繼續生效。

7. 付款貨幣

任何以外幣索償的***合資格費用***，必須按***本公司***支付賠償當日，該貨幣在香港銀行公會發布的貨幣開市參考賣出牌價兌換成***港元***。若當日沒有可參考的兌換率，***本公司***必須參考緊接當日後的最新兌換率。若香港銀行公會沒有該外幣的兌換率，***本公司***會以***本公司***使用的銀行認可兌換率作為最終的安排。

8. 利息

除非另有列明，本***條款及保障***的一切賠償及費用均不會計算利息。

9. 本公司的責任

本公司必須時刻絕對真誠地履行本***保單***中列載的責任，並遵守***自願醫保***的規則及規例、***保險業監管局***頒布的有關指引，以及所有適用的法律及規例。

10. 規管法律

本***保單***必須在***香港***簽發並受***香港***法律管轄及闡釋。***本公司***及***保單持有人***均同意遵從***香港***法院的司法裁判權。

11. 排解糾紛

本公司及***保單持有人***必須盡力以友善方式解決就本***保單***所出現的糾紛、爭議及分歧，包括與本***保單***的有效性、無效性、條款違反或終止相關的事宜。如未能解決，在有關糾紛轉介至***香港***法院前，雙方亦可以（但沒有責任）透過各種另類排解糾紛程序處理，包括但不限於在雙方同意下以調解或仲裁方式進行。

雙方需要自行承擔另類排解糾紛程序的服務費用。

12. 責任

保單持有人及***受保人***必須遵守本***保單***條款的各項，並確定***投保申請文件***及聲明中的資料及申述均為正確，否則***本公司***將無須承擔本***保單***所訂明的任何責任。儘管有上述規定，除非因為***保單持有人***及***受保人***不遵守本***保單***條款，或在***投保申請文件***及聲明中提供失實的資料及申述，導致***本公司***的權益有實質的損失，否則***本公司***不得拒絕承擔本***保單***所訂明的責任。

13. 錯誤申報個人資料

在不損害***本公司***按本第二部分第 14 節中的權利（即因健康資料的失實陳述或欺詐的情況宣告***保單***無效的權利）下，若在***投保申請文件***或任何其後就相關申請（若***本公司***在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動），提交予***本公司***的資料或文件中錯誤申報***受保人***的非健康相關資料（包括但不限於***年齡***、性別或吸煙習慣），從而可能影響***本公司***作出的風險評估，***本公司***可按正確資料調整過去、現在或未來***保單年度***的保費。若***保單持有人***因此需補交額外保費，***本公司***不會在補交前支付任何賠償。若***保單持有人***在***本公司***通知的保費到期日後三十一(31)日的寬限期內仍未補交保費，***本公司***有權行使本第二部分第 15 節賦予的權利，自保費到期日起終止本***保單***。若有多繳保費，***本公司***則必須予以退還。

若按***受保人***的正確資料及***本公司***的核保指引，認為***受保人***的投保申請應當被拒絕時，***本公司***有權宣告本***保單***自***保單生效日***起無效，並通知***保單持有人***，本***保單***不會為***受保人***提供保障。在此情況下，***本公司***將 –

(a) 有權追討已支付的賠償；及
(b) 有責任退還已繳交的保費，

兩者均適用於現***保單年度***及過往所有***保單年度***"，***本公司***亦有權收取合理的行政費用。上述退款安排必須與本第二部分第 14 節一致。

14. 失實陳述或欺詐

本公司有權在下列情況下，宣告本***保單***自***保單生效日***起無效，並通知***保單持有人***，本***保單***不會為***受保人***提供保障 –

(a) 在***投保申請文件***，或在***投保申請文件***或任何其後就相關申請提交予***本公司***的資料或文件，其所作出的陳述或聲明中，就***受保人***健康狀況的重要事實作出失實聲明或遺漏資料（若***本公司***在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動）。「重要事實」包括

但不限於由 ***本公司*** 要求提供、會影響 ***本公司*** 對 ***受保人*** 的核保決定的事實，若披露該事實***本公司***有可能因而徵收***附加保費***，增加***個別不保項目***或拒絕投保申請。為免存疑，本(a)段並不適用於本第二部分第 13 節關於***受保人***非健康相關資料； 或

(b) 在***投保申請文件***中或索償時，作出欺詐或有欺詐成分的申述。

本公司必須負舉證責任證明(a)及(b)為真確。按第一部分第 8 或 9 節，***本公司***有責任查詢所有影響核保決定的重要事實。

在(a)的情況下，***本公司***將 –

(i) 有權追討已支付的賠償；及
(ii) 有責任退還已繳交的保費，

兩者均適用於現***保單年度***及過往所有***保單年度***，***本公司***亦有權收取合理的行政費用。

在(b)的情況下，***本公司***將 –

(iii) 有權追討已支付的賠償；及
(iv) 有權不退還已繳交的保費。

15. *終止*保單

本***保單***將在以下情況時自動終止，以最先者為準 –

(a) 按本第二部分第 13 節或第三部分第 3 節規定，***保單持有人***在寬限期屆滿時仍未繳交保費；或
(b) ***受保人***身故翌日；或
(c) ***本公司***不再獲***《保險業條例》***授權承保或繼續承保本***保單***。

若***保單***按本第 15 節終止，將以終止生效日的 00:00 時起失效。

在本***保單***終止後，本***保單***的保障亦即告終止。除非另有說明，任何現***保單年度***及過往所有***保單年度***已繳交的保費，均不獲退還。

若***保單***是按(a)終止，終止生效日為未付保費的原到期日。

若***保單***是按(b)或(c)終止，則***本公司***必須按比例退還現***保單年度***已支付的相關保費。
若***保單持有人***按本第二部分第 3 節或第四部分第 1 節（視情況而定），決定取消本***保單***或不再續保，本***保單***亦會被終止，惟***保單持有人***必須向***本公司***提供所需的書面通知作實。若本***保單***是按本第二部分第 3 節的規定終止，則終止的生效日為***保單持有人***發出的取消通知中所述的日期，但該日期不得在本第二部分第 3 節要求的通知期開始前或通知期內。若***受保人***未按第四部分第 1 節的規定續保，則終止的生效日為本***保單***最後有效的***保單年度***屆滿後的續保日。

若本***保單***是按本第 15 節 (a) 或 (c) 終止，而***受保人***在***保單***終止前罹患***傷病***並因此***住院***或接受***訂明非手術癌症治療***，則就有關***傷病***的***住院***或治療，所招致的***合資格費用***仍可獲得保障，直至 (i) ***受保人***出院或完成治療或 (ii) 本***保單***終止後的第三十 (30) 日，以較先者為準，並按本***保單***終止生效日前一日適用

的***條款及保障***作出賠償。***本公司***有權從任何保障賠償中扣除按本第二部分第 13 節所指的所有到期未付的保費。

為免存疑，若本***保單***包含***認可產品***以外的其他附加保障，當***本公司***取消或縮減這些附加保障時 –

(d) 本***認可產品***的***條款及保障***會繼續生效，不帶來負面影響；及
(e) 對本***條款及保障***中根據***認可產品***簽發的部分的延續性，以及對***本公司***繼續符合承保本***條款及保障***的牌照要求均不帶來負面影響。

16. 致本公司的通知

本公司要求***保單持有人***必須以書面，或其他獲得***本公司***認可的方式，發出所有致***本公司***的通知，並必須以***本公司***為收件人。

17. 致保單持有人的通知

本公司就本***保單***發出的通知必須以郵寄方式寄到***保單持有人***通知***本公司***的最新地址，或透過電子郵件傳送到***保單持有人***通知***本公司***的最新電郵地址。在下列情況下，***保單持有人***將被視為正式收到通知 —

(a) 郵寄後兩 (2) 個工作日；或
(b) 電子郵件的發出日期及時間。

18. 其他保障

若***保單持有人***擁有本***認可產品***以外的其他保障，***保單持有人***將有權向該等保障或本***認可產品***進行索償。不論如何，若***保單持有人***或***受保人***已從其他保障索償全部或部分費用，則***本公司***只會對未被其他保障賠償的***合資格費用***（如有）作出賠償。

19. 保單擁有權及責任的履行

本公司將以***保單持有人***為本***保單***的絕對擁有人，***本公司***無須確認***保單持有人***外的其他方於本***保單***中的衡平法權益或其他利益。賠償保障利益予***保單持有人***將被視為***本公司***已充分及有效履行本***保單***上的責任。

20. 更改保單擁有權

由***本公司***酌情決定並經批准後，***保單持有人***可透過***本公司***指定的表格，轉移本***保單***的擁有權。表格必須交予***本公司*** ， 並經由***本公司*** 批核。***本公司***必須處理本 ***保單*** 續保時提出的轉移擁有權申請，並不得向***保單持有人***及其承繼人收取行政費用。轉移保單擁有權必須在***本公司***向原***保單持有人***及其承繼人發出書面通知批准後方為生效。自擁有權轉移生效日起，承繼人將被視為***保單持有人***，並按本第二部分第 19 節成為本***保單***的絕對擁有人，同時必須負責繳交保費（包括到期未付的保費）。

本公司不可否決***保單持有人***轉移保單擁有權至下列人士的申請 –

(a) 年滿十八 (18) 歲的***受保人***；
(b) ***受保人***的家長或***監護人***（如***受保人***為***未成年人***）；或
(c) 按***本公司***當時適用的核保的慣常做法下，可接受的***受保人***的親屬。***本公司***必須備妥該等核保慣常做法以供***保單持有人***查閱。

21. 保單持有人身故

保單持有人可預先提名一人，在其身故時成為本***保單***的承繼人。若***保單持有人***生前未有提名任何承繼人，或指定承繼人拒絕接受本***保單***的轉移，本***保單***的擁有權將轉移至 –

(a) 年滿十八 (18) 歲的***受保人***；或
(b) ***受保人***的家長或***監護人***（如***受保人***為***未成年人***）。若家長或***監護人***拒絕接受本***保單***的轉移，本***保單***的擁有權將轉移至***保單持有人***的遺產管理人或執行人。

上段所述***保單***擁有權的轉移必須在***本公司***獲得***保單持有人***身故的充分證據後方可進行。

22. 第三者權利

任何非本***保單***合約一方的人士或法人，不能按《合約（第三者權利）條例》(香港法例第 623 章）強制執行本***保單***的任何條款。

23. 代位追討權

在***本公司***按本***保單***支付賠償後，***本公司***有權以***保單持有人***及 / 或***受保人***的名義，對可能需就導致本***保單***作出賠償的事故負責的第三者進行追討。***本公司*** 需支付所涉及費用，討回的款項亦歸 ***本公司*** 所有，並以***本公司***就本***保單***支付該事故的賠償金額為限。在追討過程中，***保單持有人***及 / 或***受保人***必須提供全部或已知的第三者過失詳情及充分與***本公司***合作。為免存疑，上述代位追討權只適用於當第三者並非***保單持有人***或***受保人***的情況。

24. 對第三者的訴訟

按本***保單***所述，***保單持有人***或***受保人***對任何***註冊醫生***、***醫院***或其他醫療服務提供者，因任何原因或理由所提出的損害進行訴訟或另類排解糾紛程序，***本公司***並無責任參與、就其作出回應或辯護（或支付其相關的費用），當中包括但不限於就以下情況出現的訴訟或另類排解糾紛程序：按本***保單***的條款，因檢查或治療***受保人***的***傷病***，過程中所牽涉及的疏忽、失職、專業失當行為或其他事件。

25. 寬免

任何合約一方寬免合約另外一方違反本***保單***條文的情況，將不會被視為獲得日後違反該條文或任何其他條文的寬免。任何一方不行使或延遲行使本***保單***下任何權利時，亦不會被釋義為該權利的寬免。任何寬免必須經***本公司***及***保單持有人***雙方同意，方可生效，而合約雙方仍須履行寬免範圍外，本***保單***所列的權利及責任。

26. 遵守法律

若本***保單***在適用於***保單持有人***或***受保人***的法律下已經或將會不合法，***本公司***有權從被判定為不合法日期起終止本***保單***，並需要按比例退還本***保單***終止後期間已收取的保費。

27. 個人資料私隱

本公司必須遵守《個人資料（私隱）條例》(香港法例第 486 章)及有關守則、指引及通函。

第三部分 保費條文

1. 應付保費

本***條款及保障***的應支付保費僅包括 –

(a) 按***本公司***現行採用的***標準保費***表內的***標準保費***；及
(b) ***附加保費***（如適用）。

2. 繳交保費

應付的保費金額會在本***保單資料頁***及/或第四部分第 3 節所指的***續保***通知內列明。不論是按每個***保單年度***或經***本公司***同意下以分期方式繳交的保費，均需在保費到期日前繳交，***本公司***才會支付賠償。除非在本***保單***中另有說明，保費一經繳交將不獲退還。

保費到期日、***續保日***及***保單年度***均參照***保單資料頁***及/或第四部分第 3 節所指的***續保***通知內指明的***保單生效日***釐定。第一期保費將於***保單生效日***到期。

3. 寬限期

本公司將給予***保單持有人***三十一(31)日繳交保費的寬限期，由每期保費到期日起計。本***保單***於寬限期內仍然生效，惟在收到保費前，***本公司***於該期間內不會支付任何賠償，直至保費已獲繳清。若在寬限期屆滿後***保單持有人***仍未繳清保費，本***保單***即於保費到期日起當日終止。

第四部分 續保條文

本***條款及保障***會在繳交保費後於 ***保單生效日*** 起生效，並按本第四部分條款在每個 ***保單年度續保*** ，保證***續保受保人***至***年齡***一百（100）歲。

1. 續保

本公司將按下列 (a) - (c) 段***續保***本***條款及保障***:

(a) 除***本公司***不再獲***《保險業條例》***授權承保本***條款及保障***，或終止與***政府***註冊為***自願醫保***的產品提供者，或***保單持有人***按照第二部分第 3 節所述，於十四(14)日前以書面通知***本公司***決定不***續保***本***條款及保障***的情況外，將按以下安排***續保***:本***條款及保障***將按不差於***續保***時由***政府***公布最新版本的***標準計劃條款及保障***(當中第一部分第 7 節、第六部分第 1(b)及第 5 節和***政府***不時批准的其他豁免事項則除外) 自動***續保***。

(b) 若***本公司***於***續保***時將會或已終止與***政府***註冊為***自願醫保***的產品提供者，但仍獲***《保險業條例》***授權承保本***條款及保障***，將按以下安排***續保***: 本***條款及保障***將按不差於***本公司***終止與***政府***註冊為***自願醫保***的產品提供者時由***政府***公布最新版本的***標準計劃條款及保障***(當中第一部分第 7 節、第六部分第 1(b)及第 5 節和***政府***不時批准的其他豁免事項則除外) 自動***續保***。

(c) 若***本公司***在終止與***政府***的註冊後，重新與***政府***註冊為***自願醫保***的產品提供者，於重新註冊生效當日或緊接的***續保日***，將按以下安排***續保***:本***條款及保障***將按不差於***續保***時由***政府***公布最新版本的***標準計劃條款及保障***(當中第一部分第 7 節、第六部分第 1(b)及第 5 節和***政府***不時批准的其他豁免事項除外)自動***續保***。

按以上(a) - (c) 段所述的***續保***情況下，任何其他對***條款及保障***的修訂應適用於所有***同一類別保單***，並且不可與以上(a)，(b) 或 (c) 段（按情況而定）相違背及導致與***續保***前比較時，出現適用於本***條款及保障***的賠償限額被減少或***共同保險***或***自付費***增加的情況出現。

2. 調整保費

不論***本公司***在***續保***時有否修訂本***條款及保障***，***本公司***將有權按當時採用的***標準保費***表向所有***同一類別保單***調整***標準保費***。為免存疑，若***附加保費*** 設定為***標準保費***的某個百分比（即***附加保費***率），應付的 ***附加保費***金額將會按***標準保費***的變動自動調整。

在每個***保單年度***內及***續保***時，***本公司***不得因***受保人***的健康狀況變化而增加附加保費率（或在***附加保費***是以定額而非設定為***標準保費***某個百分比的情況下，增加其***附加保費***的定額），或增加***受保人***的***個別不保項目***。

3. 續保通知

不論***本公司***在***續保***時有否修訂本***條款及保障***，***本公司***應按本第 3 節的條款，在***續保日***前不少於三十(30)日向***保單持有人***發出書面通知。

該書面通知必須指明***續保***保費及***續保日***。若***本公司***在***續保***時，修訂了本***條款及保障***，***本公司***在發出書面通知書時，必須備妥已修訂的***條款及保障***，以供***保單持有人***參閱。經修訂的***條款及保障***及***續保***保費將由***續保日***起生效。

4. 除指定情況外不可重新核保

不論***受保人***的健康狀況自***保單簽發日***或***保單生效日***(以較早日期為準)起發生任何變化，在本***條款及保障***生效期間，***本公司***無權重新核保本***條款及保障***。

不論本***條款及保障***在符合第四部分第 1 節的情況下有任何改動，***本公司***無權重新核保本***條款及保障***。此限制適用於任何改動，包括但不限於本***條款及保障***容許的任何保障的升降或增刪，不論該改動是涉及本***條款及保障***的任何部分。

本公司僅在下列情況下有權重新核保本***條款及保障***–

(a) ***保單持有人***要求***本公司***在***續保***時，按***本公司***的核保慣常做法對本***條款及保障***進行重新核保，藉此減低***附加保費***或取消***個別不保項目***。為免存疑，即使***本公司***拒絕上述要求或***保單持有人***不接受重新核保的結果，***本公司***亦無權終止或不***續保***本***條款及保障***；

(b) 在任何時候，當***保單持有人***要求在本***條款及保障***增加額外保障（如有），或轉換為另一份提供更佳或額外保障的保險計劃（在這種情況下，重新核保的範圍只限於涉及更佳或額外保障的部分）。

(i) 不論如何，在任何時候，***保單持有人***要求取消本***條款及保障***中新增的額外保障（如有），或轉換為另一份較低或較少保障的保險計劃，***本公司***無權重新核保本***條款及保障***，惟可按***本公司***現行處理類似要求的慣常做法接受或拒絕該要求；及

(ii) 即使***本公司***拒絕上述要求或***保單持有人***不接受重新核保的結果，***本公司***亦無權終止或不***續保***本***條款及保障***；

(c) 當***受保人***改變***居住地***；

續保本***條款及保障***時，***本公司***有權因***受保人***的***居住地***改變重新核保本***條款及保障***，前提是–

(i) 在本***條款及保障***生效前，***本公司***進行核保時已考慮***受保人***的***居住地***；

(ii) 在遞交***投保申請文件***時，***本公司***已通知***保單持有人***，***續保***本***條款及保障***時需就***居住地***的改變重新核保；

(iii) ***本公司***需管有相關的核保指引，當中明確地表明***居住地***的改變將如何影響核保結果，並備妥以供***保單持有人***查詢；

(iv) ***本公司***重新核保時僅可考慮上述改變（即***受保人***的***居住地***改變的因素）；及

(v) 重新核保的結果，對***保單持有人***及***受保人***而言，可以是有利或不利。

就本(c)段而言，***本公司***有責任要求***保單持有人***在***續保***時通知***本公司***，***受保人***的***居住地***是否有別於上一個***續保日***（或***保單生效日***，如屬首次***續保***）。***保單持有人***在收到要求後，有責任通知***本公司***相關改變。

(d) 當***受保人***改變職業

續保本***條款及保障***時，***本公司***有權因***受保人***的職業改變重新核保本***條款及保障***，前提是–

(i) 在本***條款及保障***生效前，***本公司***進行核保時已考慮***受保人***的職業；
(ii) 在遞交***投保申請文件***時，***本公司***已通知***保單持有人***，***續保***本***條款及保障***時需就職業的改變重新核保；
(iii) ***本公司***必須管有相關的核保指引，當中明確地表明職業的改變將如何影響核保結果，並備妥以供***保單持有人***查詢；
(iv) ***本公司***重新核保時僅可考慮上述改變（即***受保人***的職業改變的因素）；及
(v) 重新核保的結果，對***保單持有人***及***受保人***而言，可以是有利或不利。

就本(d)段而言，***本公司***有責任要求***保單持有人***在***續保***時通知***本公司***，***受保人***的職業是否有別於上一個 ***續保日***（或***保單生效日***，如屬首次***續保*** ）。***保單持有人*** 在收到要求後有責任通知***本公司***相關改變。

本公司及***保單持有人***均確認 –

(e) 若***本公司***按本第四部分的條款有權或在有需要時，按某些因素在***續保***過程中重新核保本***條款及保障***，***本公司***必須按本第四部分的條款及當時的核保指引，並在重新核保時只考慮相關因素；及
(f) 在重新核保後，***本公司***可終止本***條款及保障***、徵收***附加保費***、調高或降低原有的***附加保費***、增加***個別不保項目***，以及修訂或取消原有的***個別不保項目***。

第五部分 索償條文

1. 提交索償申請

所有就本***條款及保障***作出的索償申請必須於***受保人***出院或進行及完成相關***醫療服務***（當沒有***住院***時）當日起九十(90)日內提交予***本公司***。提交索償申請時必須包括下列文件及資料，否則有關索償申請會被視為無效或不完整，而***本公司***亦不會給予賠償–

(a) 所有收據正本及 / 或分項賬單正本連同診斷、治療類別、治療程序、檢測或服務的證明；及
(b) 所有***本公司***合理要求的相關資料、證明書、報告、證據、轉介信及其他數據或資料。

若***保單持有人***的索償申請未能於上述期限內提交，***保單持有人***必須通知***本公司***，否則***本公司***將有權拒絕其於上述期限後提交的索償申請。

所有在 ***本公司*** 合理要求下，而 ***保單持有人*** 理應能提供的相關證明書、資料及證據，其所需費用必須由***保單持有人***支付。在收到***保單持有人***提交所有(a)及(b)項的資料後，若***本公司***仍需索取更多證書、資料及證據以核實索償，相關費用則必須由***本公司***負責。

2. 可賠償金額估算

受保人在接受***醫療服務***前，***保單持有人***可要求***本公司***按本***條款及保障***估算賠償金額。在提出要求時，必須附上由***醫院***及 / 或主診***註冊醫生***所估算的金額（按當時***香港***適用的規管私營醫療機構相關法律及規例要求提供）。***本公司***收到要求後，必須按***醫院***及 / 或主診***註冊醫生***作出的估算，通知***保單持有人***可賠償金額的估算，而該估算只供參考，最終的賠償金額必須按本第五部分第 1 節(a)及(b)項所提供的實際費用證明而釐定。

3. 法律行動

在***本公司***收到按本***條款及保障***要求的所有索償證據後的首六十(60)日內，***保單持有人***不可就應付的索償金額採取任何法律行動。

4. 醫療檢查

索償時，***本公司***有權要求***受保人***接受由***本公司***指定的***註冊醫生***進行身體檢查，相關費用由***本公司***承擔。

第六部分 保障條文

1. 一般條件

(a) 保障地域範圍

除本第六部分第 3(l) 節的精神科治療及***其他保障補充文件***第 1(b)及 1(c)節的***香港***病房級別下調現金保障及身故保障外，本***條款及保障***內所有保障必須受本***條款及保障***之***賠償限制補充文件***中第一部分第 1 節及***保障表***所列明的地域範圍限制所規限。

上述限制並不適用於在***標準計劃條款及保障***範圍內的條款及保障。為免存疑，適用的***標準計劃條款及保障***，為按第四部分第 1 (a)、(b) 或 (c)節所述的版本。

(b) 終身保障限額

除***其他保障補充文件***第 1(c)節的身故保障外，本***條款及保障***內的保障必須受本***條款及保障***內的***保障表***所列明的***終身保障限額***所規限。

(c) 選擇醫療服務提供者

除***其他保障補充文件***第 1(b)的節***香港***病房級別下調現金保障外，本***條款及保障*** 內的保障均不設選擇醫療服務提供者的限制，包括但不限於***註冊醫生*** 及***醫院***。

上述限制並不適用於在***標準計劃條款及保障***範圍內的條款及保障。為免存疑，適用的***標準計劃條款及保障***，為按第四部分第1 (a)、(b) 或 (c)節所述的版本。

(d) 選擇病房級別

本***條款及保障***內的保障必須受本***條款及保障***的***賠償限制補充文件***第一部分第 2 節及***保障表***列明的病房級別選擇限制所規限。

上述限制並不適用於在***標準計劃條款及保障***範圍內的條款及保障。為免存疑，適用的***標準計劃條款及保障***，為按第四部分第 1 (a)、(b) 或 (c)節所述的版本。

2. 住院及非住院保障

按本***條款及保障***，當***受保人***在本***條款及保障***生效期間因***傷病***，並在***註冊醫生***的建議下 –

(a) ***住院***；或
(b) 接受任何***日間手術***、***訂明診斷成像檢測***、***訂明非手術癌症治療***、洗腎、緊急***意外***門診治療或緊急門診牙科治療，

本公司將按本第六部分第 3 節及***額外保障補充文件***第 1 節所列明的保障項目，賠償***合理及慣常***的***合資格費用***。

為免存疑，當***受保人***接受***住院***治療，但該次***住院***被視為非***醫療所需***，則因該次***住院***所招致的費用不會被視為上述 (a) 段所指的***合資格費用***。不過，***保單持有人***將仍有權就該次***住院***期間，符合上述(b) 段內所列明的***醫療服務***招致的相關***合資格費用***提出索償。

本***條款及保障***可賠償的***合資格費用***不會超過***受保人***所接受***醫療服務***的實際開支，並必須受***保障表***內的保障限額所規限。

為免存疑，本***條款及保障***只會賠償***受保人***接受***醫療服務***的***合資格費用***。除非另有說明，***受保人***以外的人士所接受的***醫療服務***費用均不獲賠償。

3. 保障項目

本第六部分第 2 節所保障的***合資格費用***，必須按下列保障項目作賠償 –

(a) 病房及膳食

本保障將賠償***受保人***在***住院***或接受任何***日間手術***或***訂明非手術癌症治療***期間，***醫院***就其住宿及膳食收取的***合資格費用***。

(b) 雜項開支

本保障將賠償***受保人***於***住院***期間或在接受任何***日間手術***當日，就接受***醫療服務***所收取的雜項開支的***合資格費用***，包括 –

(i) 往返***醫院***的救護車服務；
(ii) 施行麻醉及提供氧氣；
(iii) 輸血行政費；
(iv) 敷料及石膏模；
(v) 在***住院***或任何***日間手術***期間服用的處方藥物；
(vi) 在出院時或完成***日間手術***後處方，以供其後四（4）星期內使用的藥物；
(vii) 於本第六部分第 3(h)節保障以外的額外手術用具、儀器及裝置，以及手術中使用的植入儀器或裝置、即棄用品及消耗品；
(viii) 醫療用即棄用品、消耗品、儀器及裝置；
(ix) 診斷成像服務，包括超聲波及 X 光以及其分析，但不包括本第六部分第 3 (i) 節所列的***訂明診斷成像檢測***；
(x) 靜脈注射，包括注射液；
(xi) 化驗及其報告，包括為***住院***期間的手術或治療程序或***日間手術***所進行的病理學檢驗；
(xii) ***住院病人***租用輔助步行器具及輪椅的費用；及
(xiii) ***住院***期間的物理治療、職業治療及言語治療。

(c) 主診醫生巡房費

若***受保人***在***住院***期間內任何一日接受***註冊醫生***的診治，本保障將賠償由該主診***註冊醫生***就巡房或診症收取的***合資格費用***。

(d) 專科醫生費

若***受保人***在***住院***期間內任何一日，在主診***註冊醫生***的書面建議下接受***專科醫生***（並非本第六部分第3(c)節所指的主診***註冊醫生***）的診治，本保障將賠償由該***專科醫生***就巡房或診症收取的***合資格費用***。

(e) 深切治療

若***受保人***在***住院***期間內任何一日入住***深切治療部***，本保障將賠償就接受深切治療服務所收取的***合資格費用***。

為免存疑，已獲本保障賠償的***合資格費用***，不會再獲本第六部分第3(a)節的賠償。

(f) 外科醫生費

本保障將賠償***受保人***在***住院***期間，或在為***日症病人***提供***醫療服務***的設備下，主診***外科醫生***為其進行手術所收取的***合資格費用***。

本保障將按***手術表***所列相關手術的分類及該手術本身所屬分類作賠償，而***政府***會不時審視***手術表***的內容及分類。若需進行的手術並無列於***手術表***內，***本公司***可按照***政府***刊登的憲報或其他相關出版物或資料，包括但不限於在進行該手術的所在地，其政府、相關監管機構及醫學組織認可的收費表，合理地決定該手術的分類。

(g) 麻醉科醫生費

在按本第六部分第 3(f)節的***外科醫生***費可獲賠償的情況下，本保障將賠償***麻醉科醫生***就相關手術所收取的***合資格費用***。

(h) 手術室費

在按本第六部分第 3(f)節的***外科醫生***費可獲賠償的情況下，本保障將賠償在手術期間使用手術室（包括但不限於治療室及康復室）的***合資格費用***。

為免存疑，在手術室內需個別收費的額外手術用具、儀器及裝置則將按本第六部分第3(b)節賠償。

(i) 訂明診斷成像檢測

本保障將賠償***受保人***在***住院***期間，或在為***日症病人***提供***醫療服務***的設備下，因檢查或治療***傷病***進行***訂明診斷成像檢測***所收取的***合資格費用***，有關檢測必須在主診***註冊醫生***的書面建議下進行。本保障需按本第六部分第 5 節及***保障表***列明的***共同保險***作出賠償。

(j) 訂明非手術癌症治療

本保障將賠償***受保人***在***住院***期間，或在為***日症病人***提供***醫療服務***的設備下，接受***訂明非手術癌症治療***所收取的***合資格費用***，包括在接受治療期間就進行治療計劃、監察預後及病況進展的***專科醫生***門診收費。

為免存疑，有關***訂明診斷成像檢測***的***合資格費用***將按本第六部分第 3(i)節賠償。

(k) 入院前或出院後 / 日間手術前後的門診護理

本保障將賠償以下***合資格費用*** –

(i) ***受保人***在***住院***或***日間手術***前所需的門診或***急症***診症（包括但不限於診症、處方西藥或診斷檢測）；及

(ii) ***受保人***在出院或***日間手術***後，由主診***註冊醫生***提供或書面建議的跟進門診（包括但不限於診症、處方西藥、敷藥、物理治療、職業治療、言語治療或診斷檢測）。有關門診必須在***保障表***列明的期間進行，並與需要***住院***或進行***日間手術***的***傷病***（包括其併發症）直接有關。

就上述 (i) 及 (ii) 段的保障而言，***訂明診斷成像檢測***及***訂明非手術癌症治療***將分別按本第六部分第 3(i)及(j)節作出賠償。

(l) 精神科治療

本保障將賠償***受保人***在***專科醫生***建議下，在***香港***境內***住院***接受精神科治療所收取的***合資格費用***。

本保障將取代本第六部分第 3(a)至(k)節的保障項目賠償。為免存疑，若***受保人***並非純粹為接受精神科治療***住院***，則本保障只會賠償與精神科治療相關***醫療服務***的***合資格費用***。在***合資格費用***同時涉及精神科治療與非精神科治療但未能明確分攤費用的情況下，如精神科治療為最初導致***住院***的原因，有關***合資格費用***會全數由本保障賠償；如精神科治療並非最初導致***住院***的原因，則有關***合資格費用***會全數由以上第 3(a)至(k)節的保障項目賠償。

4. 投保前已有病症

所有在***投保申請文件***或任何其後就相關申請提交予***本公司***的資料或文件（若***本公司***在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動）中，向***本公司***披露的***投保前已有病症***，除非受***個別不保項目***（如有）所規限，***本公司***將按本***條款及保障***賠償該病症的***合資格費用***。***本公司***可因應在***投保申請文件***或任何其後就相關申請提交予***本公司***的資料或文件（若***本公司***在第一部分第 8 節提出要求，

則包括相關必需資料的任何更新及改動）中披露的***投保前已有病症***或影響可保性的因素，對本***條款及保障***加設***個別不保項目***。在***保單簽發日*** 或 ***保單生效日***(以較早日期為準)後，除在第四部分第 4 節列明的情況外，***本公司***將無權再加設任何***個別不保項目***。

至於***保單持有人***或***受保人***在遞交***投保申請文件***（若***本公司***在第一部分第 8 節提出要求，則包括相關所需資料的任何更新及改動） 時不察覺，及理應不察覺的***投保前已有病症***，***本公司***將按本***條款及保障***賠償***合資格費用***。

為免存疑，若***保單持有人***或***受保人***在遞交***投保申請文件***（若***本公司***在第一部分第 8 節提出要求，則包括所需資料的任何更新及改動）時不察覺，及理應不察覺該***投保前已有病症***，***本公司***將無權因此重新核保或終止本***條款及保障***。

若***保單持有人***或***受保人***沒有按要求於***投保申請文件***（若***本公司***在第一部分第 8 節提出要求，則包括所需資料的任何更新及改動）中披露***受保人***的***投保前已有病症***，而該***投保前已有病症***在投保前已接受治療或被確診，或***保單持有人***或***受保人***在遞交***投保申請文件***（若***本公司***在第一部分第 8 節提出要求，則包括所需資料的任何更新及改動）時已察覺或理應察覺該病症出現的病徵或症狀，***本公司***有權因而宣告本***條款及保障***無效，並有權追討已支付的賠償及/或拒絕提供本***條款及保障***的保障。在該情況下，***本公司***將按第二部分第 14 節退還已繳交的保費。***本公司***必須就此情況負上舉證的責任。

5. 分擔費用規定

保單持有人必須支付本***條款及保障***和***保單資料頁***內列明的***共同保險***及/或***自付費***。為免存疑，***共同保險***及***自付費***並非指在實際費用超出本***條款及保障***賠償限額的情況下，***保單持有人***需支付的任何差額。

第七部分 一般不保事項

按本***條款及保障***，***本公司***不會賠償與下列項目相關或由其引致的費用–

1. 任何非***醫療所需***治療、治療程序、藥物、檢測或服務的費用。

2. 若純粹為接受診斷程序或專職醫療服務（包括但不限於物理治療、職業治療及言語治療）而***住院***，該***住院***期間所招致的全部或部分費用。惟若該等程序或服務是在***註冊醫生***建議下因而進行***醫療所需***的診斷，或無法以為***日症病人***提供***醫療服務***的方式下有效地進行的***傷病***治療，則不屬此項。

3. 在***保單生效日***前，因感染或出現人體免疫力缺乏病毒 ("HIV") 及其相關的***傷病***所招致的費用。不論***保單持有人***或***受保人***在遞交***投保申請文件***（若***本公司***在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動）時是否知悉，若此***傷病***在***保單生效日***前已存在，本***條款及保障***則不會賠償此***傷病***。若無法證明初次感染或出現此***傷病***的時間，則此***傷病***於***保單生效日***起計五 (5) 年內發病，將被推定為於***保單生效日***前已感染或出現；若在這五 (5) 年後發病，將被推定為於***保單生效日***後感染或出現。

惟本第 3 節的不保事項並不適用於因性侵犯、醫療援助、器官移植、輸血或捐血、或出生時受 HIV 感染所引致的***傷病***，有關賠償將按本***條款及保障***內其他條款處理。

4. 因倚賴或過量服用藥物、酒精、毒品或類似物質（或受其影響）、故意自殘身體或企圖自殺或參與非法活動的***醫療服務***費用。

5. 以下服務的收費–

(a) 以美容或整容為目的的服務，惟***受保人***因***意外***而***受傷***，並於***意外***後九十 (90) 日內接受的必要***醫療服務***，或受保於***額外保障補充文件***第 1(e)節的矯形手術保障則不屬此項；或
(b) 矯正視力或屈光不正的服務，而該等視力問題可透過驗配眼鏡或隱形眼鏡矯正，包括但不限於眼部屈光治療、角膜激光矯視手術 (LASIK) ，以及任何相關的檢測、治療程序及服務。

6. 預防性治療及預防性護理的費用，包括但不限於並無症狀下的一般身體檢查、定期檢測或篩查程序、或僅因***受保人***及/或其家人過往病歷而進行的篩查或監測程序、頭髮重金屬元素分析、接種疫苗或健康補充品。為免存疑，本第 6 節並不適用於–

(a) 為了避免因接受其他***醫療服務***引起的併發症而進行的治療、監測、檢查或治療程序；
(b) 移除癌前病變；及
(c) 為預防過往***傷病***復發或其併發症的治療。

7. 牙科醫生進行的牙科治療及口腔頜面手術的費用，惟***受保人***因***意外***引致在***住院***期間接受的***急症治療***及手術，或受保於***額外保障補充文件***第 1(m)節的緊急門診牙科治療保障則不屬此項。出院後的跟進牙科治療及口腔手術則不會獲得賠償。

8. 下列***醫療服務***及輔導服務的費用 - 產科狀況及其併發症，包括但不限於懷孕、分娩、墮胎或流產的診斷檢測；節育或恢復生育；任何性別的結紮或變性；不育（包括體外受孕或任何其他人工受孕）；以及性機能失常，包括但不限於任何原因導致的陽萎、不舉或早泄。惟受保於***額外保障補充文件***第 1(f)節的妊娠併發症保障則不屬此項。

9. 購買屬耐用品的醫療設備及儀器的費用，包括但不限於輪椅、床及家具、呼吸道壓力機及面罩、可攜式氧氣及氧氣治療儀器、血液透析機、運動設備、眼鏡、助聽器、特殊支架、輔助步行器具、非處方藥物、家居使用的空氣清新機或空調及供熱裝置。為免存疑，***住院***期間或***日間手術***當日所租用的醫療設備及儀器則不屬此項。

10. 傳統中醫治療的費用，包括但不限於中草藥治療、跌打、針灸、穴位按摩及推拿，以及另類治療，包括但不限於催眠治療、氣功、按摩治療、香薰治療、自然療法、水療法、順勢療法及其他類似的治療。惟受保於***額外保障補充文件***第 1(j)節的輔助服務則不屬此項。

11. 按接受治療、治療程序、檢測或服務所在地的普遍標準（或尚未經當地認可機構批准）界定為實驗性或未經證實醫療成效的醫療技術或治療程序的費用。

12. ***受保人***年屆八 (8) 歲前發病或確診的***先天性疾病***所招致的***醫療服務***費用。

13. 已獲任何法律，或由任何政府、僱主或第三方提供的醫療或保險計劃賠償的***合資格費用***。

14. 因戰爭（不論宣戰與否）、內戰、侵略、外敵行動、敵對行動、叛亂、革命、起義、或軍事政變或奪權事故所招致的治療費用。

第八部分 釋義

本***條款及保障***中使用的字詞及表述必須按照以下所述解釋 –

「***意外***」　是指因暴力、外在及可見因素引致的突發事故，並且完全非***受保人***所能預見及控制。

「***年齡***」　是指***受保人***的實際年齡。

「***每年保障限額***」　是指***本公司***在每個***保單年度***內向***保單持有人***支付的最高賠償限額，不論任何在***保障表***中所列的保障項目是否已經達到其相關項目的賠償限額。

每年保障限額在每個新***保單年度***會重新計算。

「***投保申請文件***」　是指向***本公司***就本***認可產品***遞交的投保申請，包括與該投保申請有關的投保申請表格、問卷、可保性的證明、任何已提交的文件或資料，以及已作出的陳述及聲明（若***本公司***在第一部分第8節提出要求，則包括相關必需資料的任何更新及改動）。

「***保障表***」　是指本***條款及保障***所附的保障表，當中必須列明所涵蓋的保障項目及最高賠償限額。

「***個別不保項目***」　是指***本公司***可按***受保人***的***投保前已有病症***或其他影響其可保性的因素，就特定的***不適***或***疾病***而加設的不保承項目，訂明在本***條款及保障***中不保障。

「***認可產品***」　是指經***政府***認可為符合***自願醫保***內相關合規要求的保險產品內所有***條款及保障***(包括任何***補充文件***) 。本***認可產品***內容包括本***條款及細則***和***保障表***及以下文件-

(a) ***額外保障補充文件***；
(b) ***其他保障補充文件***；
(c) ***無索償保費折扣補充文件***；
(d) ***更改自付費補充文件***；
(e) ***賠償限制補充文件***；
(f) ***指定嚴重疾病豁免自付費補充文件***；及
(g) ***增值稅和商品及服務稅納入為合資格費用補充文件***。

「***共同保險***」　是指***保單持有人***在支付每個***保單年度***的***自付費***後(如有)，必須按比率分擔的***合資格費用***。為免存疑，***共同保險***並非指在實際費用超出本***條款及保障***賠償限額的情況下，***保單持有人***需支付的任何差額。

「***本公司***」　是指萬通保險國際有限公司。

「***住院***」　是指***受保人***在***醫療所需***的情況下，按***註冊醫生***的建議以***住院病人***身份入住***醫院***以接受***醫療服務***，***受保人***必須入住***醫院***不少於連續六(6)小時。惟因***急症***在***醫院***進行手術或其他***醫療服務***的***急症治療***時，則沒有最低***住院***時間要求。

住院必須以***醫院***開出的每日病房費單據作證明，***受保人***必須在整個***住院***期間連續留院。

「***先天性疾病***」　是指 (a) 任何於出生時或之前已存在的醫學、生理或精神上的異常，不論於出生時有關異常是否已出現、被確診或獲知悉；或 (b) 任何於出生後六 (6) 個月內出現的新生嬰兒異常。

「***日間手術***」　是指***受保人***作為***日症病人***在具備康復設施的診所、日間手術中心或***醫院***內因檢查或治療而進行***醫療所需***的外科手術。

「***日症病人***」　是指在診所、日間手術中心或***醫院***（非***住院***性質）接受***醫療服務***或治療的***受保人***。

「***自付費***」　是指在***本公司***賠償餘下的***合資格費用***前，***保單持有人***在每個***保單年度***必須分擔的定額***合資格費用***。

「***交付***」　是指於第二部分第 2(a)節所述以下列任何方式將本***條款及保障***及***保單資料頁***或冷靜期通知書交付予***保單持有人***或其指定代表：

(a) 由專人交付；

(b) 以郵遞方式（包括掛號郵遞方式）；或

(c) 電子方式。

不論以何種方式交付，***本公司***有責任就交付的行為及交付的時間備存充分的證據作證明。

「***傷病***」　是指***不適***、***疾病***或***受傷***，包括任何由此而引發的併發症。

「***合資格費用***」　是指就***傷病***接受***醫療服務***所需的費用。

「***急症***」　是指***受保人***需立即接受***醫療服務***的事件或情況，以防止***受保人***身故、健康遭永久損害或遭受其他嚴重健康後果。

「***急症治療***」　是指***急症***所需的***醫療服務***，而所需的***醫療服務***必須在***急症***事件或情況出現後的合理時間內進行。

「***靈活計劃***」　是指在***自願醫保***的框架下，為***保單持有人***及***受保人***提供較***標準計劃***部分或全部更佳條款及保障，並必須經由***政府***認可的個人償款住院保險產品。除***政***

府可能不時批准的豁免事項外，該等產品不得包含較***標準計劃***差的條款及保障。

「***政府***」　是指「香港特別行政區政府」。

「***監護人***」　是指按香港法例第 13 章 《未成年人監護條例》被委任為或憑藉此條例成為***未成年人***的***監護人***的人士。

「***港元***」　是指***香港***法定貨幣。

「***香港***」　是指「中華人民共和國香港特別行政區」。

「***醫院***」　是指按其所在地法律妥為成立及註冊為醫院的機構，為***不適***及***受傷***的 ***住院病人***提供***醫療服務***，並 –

(a) 具備診斷及進行大型手術的設施；
(b) 由持牌或註冊護士提供二十四 (24) 小時護理服務；
(c) 由一(1)位或以上***註冊醫生***駐診；及
(d) 非主要作為診所、戒酒或戒毒中心、自然療養院、水療中心、護理或療養院、寧養或紓緩護理中心、復康中心、護老院或同類機構。

「***受傷***」　是指完全因***意外***而非涉及任何其他原因所引致的身體損害（包括有或沒有可見的傷口）。

「***住院病人***」　是指***住院***中的***受保人***。

「***保險業監管局***」　是指按***《保險業條例》***第 4AAA 條設立的香港保險業監管局。

「***保險業條例***」　是指香港法例第 41 章***《保險業條例》***。

「***受保人***」　是指本***條款及保障***所保障，並在***保單資料頁***中列為「***受保人***」的人士。

「***深切治療部***」　是指***醫院***內專為***住院病人***提供深切醫療及護理服務而設的部門。

「***終身保障限額***」　是指***本公司***由本***條款及保障***生效起向***保單持有人***累計支付的最高賠償限額，不論***保障表***中所列的保障項目是否已經達到其相關項目的賠償限額，或個別***保單年度***的賠償是否已經達到***每年保障限額***。

「***醫療服務***」　是指就診斷或治療***受保人***的***傷病***所提供的***醫療所需***服務，包括按情況所需的***住院***、治療、程序、檢測、檢查或其他相關服務。

「***醫療所需***」　是指按照一般公認的醫療標準，就診斷或治療相關***傷病***接受醫療服務的需要，而醫療服務必須符合下列條件 –

(a) 需要***註冊醫生***的專業知識或轉介；

(b) 符合該***傷病***的診斷及治療所需；
(c) 按良好而審慎的醫學標準及主診***註冊醫生***審慎的專業判斷提供，而非主要為對***受保人***、其家庭成員、照顧人員或主診***註冊醫生***帶來方便或舒適而提供；
(d) 在環境最適當及符合一般公認的醫療標準的設備下，提供醫療服務；及
(e) 按主診***註冊醫生***審慎的專業判斷，以最適當的水平向***受保人***安全及有效地提供。

就本***條款及保障***的釋義而言，在不抵觸上述一般條件下，符合***醫療所需***條件的***住院***情況包括但不限於以下例子 –

(i) ***受保人***因***急症***需要在***醫院***接受緊急治療；
(ii) 手術是在全身麻醉下進行；
(iii) ***醫院***具備手術或治療程序所需的設備，有關手術或治療程序並不能以***日症病人***的方式進行；
(iv) ***受保人***同時發生的傷病屬明顯嚴重；
(v) 主診***註冊醫生***考慮到***受保人***的個人情況下，經過審慎的專業判斷及考慮***受保人***安全後，所需的醫療服務應在***醫院***內進行；
(vi) 經過主診***註冊醫生***審慎的專業判斷，***住院***時間對***受保人***接受的醫療服務是合適的；及 / 或
(vii) 如屬***註冊醫生***認為需要的診斷程序或專職醫療服務，經該***註冊醫生***審慎的專業判斷及考慮***受保人***安全後，所需治療程序或服務應在***醫院***內進行。

在上文(v)至(vii)的情況下，主診***註冊醫生***行使審慎的專業判斷時，應該考慮該***住院***是否 –

(aa) 按照當地良好及審慎的醫療標準提供該醫療服務，而非主要為***受保人***、其家庭成員、照顧人員或主診***註冊醫生***提供方便或舒適的環境；及
(bb) 在環境最適當及符合當地一般公認的醫療標準的設備下，提供該醫療服務。

「***未成年人***」　是指***年齡***未滿十八 (18) 歲的人士

「***居住地***」　是指某人士在法律上擁有居留權的司法管轄區。***居住地***變更包括該人士獲得新增司法管轄區的居留權或停止擁有現有司法管轄區的居留權。上述關於***居住地***解釋僅適用於本***條款及保障***。為免存疑，某人士若對該司法管轄區只有法律上的入境許可，而非居留權（例如留學、工作或旅遊），該司法管轄區並不可被視為該人士的***居住地***。

「***保單***」　是指由***本公司***承保及簽發的本保單，並作為***保單持有人***與***本公司***之間就本***認可產品***的合約，當中包括但不限於本***條款及細則***、***保障表***、***投保申請文件***、聲明、***保單資料頁***及任何附於本***保單***的***補充文件***（如適用）。當本***保***

保單包含有本***認可產品***以外的條款及保障，該等條款及保障亦將被視作本***保單***的一部分。

「***保單生效日***」　是指本***條款及保障***的起始日，即***保單資料頁***內載明的「***保單生效日***」。

「***保單持有人***」　是指在法律上擁有本***保單***，並於***保單資料頁***內列為「***保單持有人***」的人士。

「***保單簽發日***」　是指首次簽發本***條款及保障***的日期。

「***保單資料頁***」　是指本***條款及保障***的附表，當中載有***保單***細節、***保單生效日***、***續保日***、***保單持有人***及***受保人***的姓名及個人資料，以及本***條款及保障***所適用的保障、保費及其他細節。

「***保單年度***」　是指本***條款及保障***的生效期限。首個***保單年度***是指由***保單生效日***起一(1)年內，直至首個***續保日***前一日為止(包括首尾兩日)的期限。至於在繼後的***保單年度***，則由每個***續保日***起計一(1)年。

「***同一類別保單***」　是指所有具備相同***條款及細則***及***保障表***，並在自願醫保下經***政府***認可為***認可產品***的***保單***。

「***投保前已有病症***」　是指***受保人***於***保單簽發日***或***保單生效日***(以較早日期為準)前已存在的任何***不適***、***疾病***、***受傷***、生理、心理或醫療狀況或機能退化，包括***先天性疾病***。在以下情況發生時，一般審慎人士理應已可察覺到***投保前已有病症*** –

(a) 病症已被確診；或
(b) 病症已出現清楚明顯的病徵或症狀；或
(c) 已尋求、獲得或接受病症的醫療建議或治療。

「***附加保費***」　是指***本公司***因承受***受保人***的額外風險向***保單持有人***收取***標準保費***以外的額外保費。

「***訂明診斷成像檢測***」　是指電腦斷層掃描（“CT”掃描）、磁力共振掃描（“MRI”掃描）、正電子放射斷層掃描（“PET”掃描）、PET–CT組合及PET–MRI組合。

「***訂明非手術癌症治療***」　是指治療癌症的放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。

「***合理及慣常***」　是指就***醫療服務***的收費而言，對情況類似的人士 (例如同性別及相近***年齡***)，就類似***傷病***提供類似治療、服務或物料時，不超過當地相關醫療服務供應者收取的一般收費範圍的水平。***合理及慣常***的收費水平由***本公司***合理及絕對真誠地決定，在任何情況下，此收費不得高於實際收費。

本公司必須參照以下資料（如適用）以釐定***合理及慣常***收費 –

(a) 由保險或醫學業界進行的治療或服務費用統計及調查；

(b) 公司內部或業界的賠償統計；
(c) ***政府***憲報；及 / 或
(d) 提供治療、服務或物料當地的其他相關參考資料。

「***註冊醫生***」、「***專科醫生***」、「***外科醫生***」及「***麻醉科醫生***」

是指符合以下資格的西醫 –

(a) 具有正式資格並已按香港法例第161章《醫療註冊條例》在香港醫務委員會註冊，或在***香港***境外的司法管轄區內由***本公司***絕對真誠及合理地認為具有同等效力的團體註冊；及
(b) 在 ***香港*** 或***香港*** 境外的司法管轄區，經當地法例許可提供相關***醫療服務***，

下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴（除非事先經***本公司***的書面批准）。若該醫生未能按***香港***法例或在***香港***以外的司法管轄區具有同等效力的團體註冊(由***本公司***絕對真誠及合理地決定)，***本公司***必須作出合理的判斷，以決定該醫生是否仍被視為符合資格及已註冊。

「***續保***」

是指就按本***條款及保障***不曾中斷地繼續承保。

「***續保日***」

是指***續保***的生效日期。首個***續保日***必須訂明於***保單資料頁***上(並不可遲於***保單生效日***的首個週年日)，至於繼後的***續保日***則為首個***續保日***的週年日。有關***續保日***將在第四部分第 3 節所述的***續保***通知中列明。

「***手術表***」

是指附於本***保障表***的手術列表，表內的手術或治療程序按其複雜程度分類。***政府***將定期審視其內容，並不時公布有關修訂。

「***不適***」或「***疾病***」

是指正常健康狀態因受到病理偏差而出現的生理、心理或醫療狀況，包括但不限於***受保人***有否出現病徵或症狀的情況，亦不論是否已確診。

「***標準計劃***」

是指條款及細則與保障表等同***自願醫保***最低產品規格要求的保險計劃。***政府***將定期審視其內容，並不時公布有關修訂。

「***標準計劃條款及保障***」

是指***標準計劃***的條款及細則和保障表。***政府***將定期審視其內容，並不時公布有關修訂。
https://www.vhis.gov.hk/doc/tc/information_centre/c_standard_plan_template.pdf

「***標準保費***」

是指***本公司***向***保單持有人***就本***認可產品***的保障所收取的基本保費，適用於所有***同一類別保單***。保費可按***受保人***的***年齡***、性別及 / 或生活方式等因素進行調整。

「***補充文件***」

是指任何對本 ***保單*** 的條款及保障作出增刪 、修改或取替的文件。***補充文件***包括但不限於附加於本***保單***並一併簽發的批注、附加契約、附錄或附表。

「***條款及保障***」

是指經***政府***認可後，本***認可產品***的***條款及細則***，以及***保障表***(包括 ***手術表***)和相關的***補充文件***。

「***條款及細則***」　　是指本***認可產品***的第一至第八部分。

額外保障補充文件

此文件為***條款及保障***第六部分保障條文提供補充資料。

1. 保障項目

(a) 私家看護費

如***條款及保障***第六部分第 3(a)節的病房及膳食獲得賠償及***受保人***於接受手術後(該手術可根據***條款及保障***第六部分第 3(f)節的***外科醫生***費獲支付)或被調出***深切治療部***後(並可根據***條款及保障***第六部分第 3(e)節的深切治療獲支付)，除***住院***期間***醫院***提供予***受保人***的一般護理服務外，本保障將賠償***受保人***在***住院***期間由其主診***註冊醫生***以書面方式建議及***醫院***安排的***合資格護士***提供的私家護理服務而所收取的***合資格費用***。

本保障只限於在***住院***任何時段內由最多一(1)位***合資格護士***提供的護理服務，並按***保障表***內註明之每個***保單年度***最高保障日數為限。為免存疑，不論
(i) 該日之護理服務是全日或部份時間提供；及
(ii) 同日有多少個時段，
就計算每個***保單年度***的最高可賠償日數的目的而言，該天會被算作一(1)天。

(b) 家中看護津貼

如***條款及保障***第六部分第 3(a)節的病房及膳食獲得賠償及***受保人住院***並於***醫院***內接受手術後(該手術可根據***條款及保障***第六部分第 3(f)節的***外科醫生***費獲支付)或被調出***深切治療部***後(並可根據***條款及保障***第六部分第 3(e)節的深切治療獲支付)，得其主診***註冊醫生***以書面方式建議***受保人***於出院後六十(60)日內需接受***合資格護士***提供家中看護服務(「家中」指***受保人***的慣常住所而非療養或康復院)，本保障將賠償該***合資格護士***就其服務所收取的***合資格費用***。

本保障只限於在任何時段最多一(1)位***合資格護士***提供的護理服務，並按***保障表***內註明之每個***保單年度***最高保障日數為限。為免存疑，不論
(i) 該日之護理服務是全日或部份時間提供；及
(ii) 同日有多少個時段，
就計算每個***保單年度***的最高可賠償日數的目的而言，該天會被算作一(1)天。

(c) 住院陪床

如***條款及保障***第六部分第 3(a)節的病房及膳食或第六部分第 3(e)節的深切治療獲得賠償，本保障將賠償就***受保人住院***期間在***醫院***陪伴***受保人***的一(1)位人士的一(1)張額外床位所收取的費用。

(d) 洗腎保障

本保障將賠償***受保人***得其主診***註冊醫生***以書面方式建議，以***日症病人***身份接受洗腎所收取的***合資格費用***，惟***受保人***必須是患上***腎衰竭***。

(e) 矯形手術保障

本保障將賠償***受保人***進行矯形手術所收取的***合資格費用***，包括 –

(i) 在***住院***期間，或在為***日症病人***提供***醫療服務***的設備下，主診***外科醫生***為***受保人***進行手術所收取的***合資格費用***；
(ii) ***麻醉科醫生***就相關手術所收取的***合資格費用***；及
(iii) 在手術期間使用手術室（包括但不限於治療室及康復室）的***合資格費用***。

本保障之賠償以***保障表***內列明之每次***意外***/乳房切除術最高保障額為限，並須符合以下 (iv) 及 (v) 的情況：

(iv) ***受保人***因***受傷***而該矯形手術須 –
(1) 為回復***受保人***身體功能或外觀而進行；
(2) 於***意外***日期起計十二(12)個月內進行；及
(3) 獲***註冊醫生***建議。

為免存疑，就因***意外***而導致***受傷***所需之矯形手術，如***受保人***於***意外***發生後九十(90)日內接受相關***醫療服務***，所收取的***合資格費用***將按本***條款及保障***第六部分第3節作出賠償。

(v) ***受保人***因***不適***或患上***疾病***而需進行乳房切除手術(單邊或兩邊乳房)，而該矯形手術須 –
(1) 為重建***受保人***乳房並以美容或整容為目的而進行；及
(2) 於乳房切除手術當日或之後十二(12) 個月內進行。

(f) 妊娠併發症保障

本保障將賠償***受保人***因被確診的***受保妊娠併發症***，且由主診***註冊醫生***以書面建議***住院***及/或於***醫院***由***外科醫生***為其進行手術的***合資格費用***。惟該***受保妊娠併發症***須於本***保單生效日***(包括***保單生效日***當天)起計持續生效三百 (300)天後被確診。

(g) 醫療裝置

如***條款及保障***第六部分第 3(f)節的***外科醫生***費獲得賠償，本保障將賠償就下列項目所收取的***合資格費用***：

(i) 指定醫療裝置

於手術進行期間植入***受保人***體內及/或須通過手術置換的下列醫療裝置：
(1) 起搏器；
(2) 冠狀動脈血管成形術的支架；
(3) 眼內人造晶體；
(4) 人工心瓣；
(5) 金屬或人工關節置換；
(6) 人工韌帶置換或植入；及
(7) 人工椎間盤。

(ii) 其他醫療裝置

沒有於上述第 1(g)(i)節提及並於該手術進行期間植入***受保人***體內及/或須通過手術置換的其他醫療裝置，並以註明於***保障表***內此保障之每個***保單年度***最高保障額為限。

在本保障可獲賠償的***合資格費用***，將不會再於***條款及保障***第六部分第 3(b) 節下獲得賠償。以***醫療所需***為依據，用以代替因在手術過程中被移除的耳/眼球或截肢，並由其主診***註冊醫生***建議使用的外置義肢及人造耳/眼球均視為其他醫療裝置而被受保，並以註明於***保障表***內此保障的之每個***保單年度***最高保障額為限。為免存疑，任何因(i)提供/裝置外置義肢及人造耳/眼球之手續費或相關維修費用或(ii)更換遺失或被盜竊的外置義肢及人造耳/眼球之費用將不受保。

(h) 在生器官捐贈者之移植手術費用

儘管***條款及保障***第六部分第 2 節最後一段有所規定，若***在生器官捐贈者***入住***標準半私家病房***或病房級別低於***標準半私家病房***的病房，本保障將賠償***在生器官捐贈者***於***醫院***進行***在生器官捐贈者手術***所產生的費用，即：

(i) 就***在生器官捐贈者***進行***在生器官捐贈者手術***而被***外科醫生***及***麻醉科醫生***收取的費用；及
(ii) 在該***在生器官捐贈者手術***期間使用手術室的費用。

為免存疑，以下費用均不會在此保障獲支付賠償：

(1) 骨髓、造血幹細胞或器官之費用；
(2) ***在生器官捐贈者***因***在生器官捐贈者手術***導致併發症所招致的費用；
(3) 在***在生器官捐贈者***捐出器官後用作處理及準備任何已摘取的器官、骨髓或幹細胞的費用；
(4) 有關用作識別和獲得更換器官的費用；及
(5) 若***在生器官捐贈者***入住之病房級別高於***標準半私家病房***，任何***在生器官捐贈者***於進行***在生器官捐贈者手術***所產生之費用。

此***在生器官捐贈者***之移植手術費用的賠償限額相等於以下費用總和的百份之三十(30%)的金額：

(iii) ***在生器官捐贈者手術***的手術費用；及
(iv) ***受保人***作為受贈者接受器官移植手術於本***條款及保障***下可獲賠償的***合資格費用***。

若***在生器官捐贈者手術***於中國內地的***醫院***內進行，手術必須由認可之器官移植醫生於當地認可之器官移植機構內進行及獲得器官之程序必須根據當地醫療及法律規管進行，則***在生器官捐贈者***於***在生器官捐贈者手術***所產生之費用（於上文(i)和(ii)所述）方可獲得賠償。

為免存疑，作為器官或骨髓受贈者的***受保人***接受手術的***合資格費用***將根據***條款及保障***第六部分第3節作出賠償。

(i) 復康中心及其相關治療

本保障將賠償***受保人***於***醫院***出院後***逗留復康中心***及在期間進行***醫療所需***的復康治療所收取的***合資格費用***，而有關***逗留***及康復治療須與需要***住院***的***傷病***（包括其併發症） 直接有關。

該***逗留***及復康治療必須由其主診***註冊醫生***以書面建議。不論***受保人***遭遇多少次***傷病***，本保障之賠償以***保障表***內列明之每個***保單年度逗留復康中心***最高保障日數及每個***保單年度***最高保障額為限。

為免存疑，當本保障的***合資格費用***同時可於***條款及保障***中第六部分第 3 節下獲得賠償，有關***合資格費用***將不會在本保障下獲得賠償。

(j) 輔助服務

若***受保人***因***傷病***引致***住院***或進行***日間手術***，本保障將賠償***受保人***於出院或***日間手術***後九十(90)天內因同一***傷病***進行任何以下的輔助服務而引致的***合資格費用***，並以***保障表***內此保障之每次最高保障額、每個***保單年度***最高保障日數及每個***保單年度***最高合計保障額為限：

(i) 經主診***註冊醫生***書面建議並由***脊骨神經科醫生***、***物理治療師***、***言語治療師***或***職業治療師***所進行的診症及/或治療；及

(ii) 由***中醫師***所進行的診症及治療，及/或其處方的藥物。

本保障受限於每日最多一(1)次跟進門診。為免存疑，若***受保人***於該日接受多於一(1)次跟進門診，則只賠償當中最高一(1)次***合資格費用***的跟進門診。

按上文所述而產生的***合資格費用***可於***條款及保障***第六部分第 3(k)節下獲得賠償時，應先於***條款及保障***第六部分第 3(k)節作出賠償，並且只有當***條款及保障***第六部分該第 3(k)節的所列次數限額耗盡時，本保障方應予賠償。

(k) 善終院舍護理服務

若***受保人***被診斷患上***末期病症***，按照其主診***註冊醫生***的意見認為***受保人***很大機會於十二(12)個月內死亡，本保障將賠償***受保人***入住註冊善終院舍及該註冊善終院舍提供的照顧和護理服務的***合資格費用***及其他費用。

本保障必須由主診***註冊醫生***以書面建議及證明，而***受保人***必須由直接與該***末期病症***相關的***傷病***引致之***住院***完結後出院當日起計九十(90)日內開始入住註冊善終院舍。

為免存疑，當本保障的***合資格費用***同時可於***條款及保障***中第六部分第 3 節下獲得賠償，有關***合資格費用***將不會在本保障下獲得賠償。

(l) 緊急意外門診治療保障

若***受保人***因***意外***而***受傷***，並於引致該***受傷***的***意外***發生起計二十四(24)小時內在***醫院***門診部就該***傷病***接受治療，本保障將賠償該治療所收取的***合資格費用***。

為免存疑，當本保障的***合資格費用***同時可於***條款及保障***第六部分第 3 節下獲得賠償，有關***合資格費用***將不會在本保障下獲得賠償。

(m) 緊急門診牙科治療保障

若***受保人***因***意外***而***受傷***，並於該***意外***發生後兩(2)星期內接受為其***意外***前屬健全自然的牙齒作出***急症治療***(包括診症、止血、X-光、拔牙及根管治療)，且該治療由註冊牙醫(***受保人***的***直系親屬***或與***受保人***慣常居住的人士除外)於合法註冊牙醫診所或***醫院***內進行，本保障將賠償該治療所收取的***合資格費用***。

本保障不會就任何修復治療、任何貴金屬的使用及矯正治療作出賠償，並且不保障任何由飲食引致的***受傷***、由正常磨損引致的損壞或由刷牙或任何其他口腔衛生護理程序引致的損壞。

為免存疑，當本保障的***合資格費用***同時可於***條款及保障***第六部分第 3 節下獲得賠償，有關***合資格費用***將不會在本保障下獲得賠償。

2. 釋義

本***額外保障補充文件***中使用的字詞及表述必須按照以下所述解釋 –

「***中醫師***」	是指根據《中醫藥條例》於***香港***中醫藥管理委員會註冊或於治療當地的醫療監管機構註冊（若該治療在***香港***境外進行）的中醫師、跌打醫師或針灸師。下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、***直系親屬***或業務夥伴（除非事先經***本公司***的書面批准）。
「***脊骨神經科醫生***」	是指在其執業地區獲當地政府合法授權提供脊骨神經治療的人士，但下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、***直系親屬***或業務夥伴（除非事先經***本公司***的書面批准）。
「***受保妊娠併發症***」	只包括異位妊娠、葡萄胎妊娠、播散性血管內之凝血機制障礙、先兆子癇、流產、先兆流產、醫療需要之人工流產、胎兒夭折、因產後出血切除子宮、子癇、羊水栓塞及妊娠肺栓塞。
「***直系親屬***」	是指***受保人***經合法婚姻的配偶、子女、兄弟姊妹及父母。
「***腎衰竭***」	是指由於兩(2)個腎臟長期不能發揮功能而導致無法復原的末期腎病。***受保人***必須接受定期洗腎或已接受腎臟移植作為佐證。
「***在生器官捐贈者***」	是指一位進行***在生器官捐贈者手術***之在生捐贈者
「***在生器官捐贈者手術***」	是指對***在生器官捐贈者***進行的下列手術，所移除的骨髓、造血幹細胞、心臟、腎臟、胰臟、肝臟、肺或角膜將用於以***受保人***為接受者的***醫療所需***的器官移植手術： (a) 從***在生器官捐贈者***採集骨髓、從骨髓中取得幹細胞，或透過周邊血抽取造血幹細胞的手術，用作治療已接受清除所有骨髓療程的***受保人之傷病***；或 (b) 於***在生器官捐贈者***採集整個或部分器官（心臟、腎臟、胰臟、肝臟、肺或角膜），以用作移植到***受保人***相關器官的手術；而該移植手術須直接因***傷病***而導致***受保人***有關器官功能衰竭，或直接因***受保人***該器官的***傷病***而切除***受保人***有關器官。 為免存疑，上述未有提及的其他用於移植的幹細胞採集（包括臍帶血採集）及用於移植的胰臟細胞採集，及任何與(b)提及的***傷病***無直接關係的器官修補或更換的移植，均不會被視為***在生器官捐贈者手術***。
「***職業治療師***」	是指在其執業地區獲當地政府合法授權提供職業治療的人士，但下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、***直系親屬***或業務夥伴（除非事先經***本公司***的書面批准）。

「***物理治療師***」　是指在其執業地區獲當地政府合法授權提供物理治療的人士，但下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、***直系親屬***或業務夥伴（除非事先經***本公司***的書面批准）。

「***合資格護士***」　是指獲政府認可的註冊護士或登記護士或擁有同等資歷者，以合法資格提供護理服務，但下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、***直系親屬***或業務夥伴（除非事先經***本公司***的書面批准）。若該護士未能按***香港***法例或在***香港***以外的司法管轄區具有同等效力的團體註冊(由***本公司***絕對真誠及合理地決定)，***本公司***必須作出合理的判斷，以決定該護士是否仍被視為符合資格。

「***復康中心***」　是指一所註冊機構(***醫院***除外)，而此機構為身體受傷、功能障礙或殘疾提供物理治療、職業治療及其他復康治療。

「***言語治療師***」　是指在其執業地區獲當地政府合法授權提供言語治療的人士，但下列人士在任何情況下均不得包括在內 – ***受保人***、***保單持有人***、或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、***直系親屬***或業務夥伴（除非事先經***本公司***的書面批准）。

「***標準半私家病房***」　是指在***醫院***內提供一(1)張床或兩(2)張床（不包括住院陪床）並設有共用浴室/洗手間的房間。

「***逗留***」　是指***受保人***在***醫療所需***的情況下，按***註冊醫生***的建議入住***復康中心***以接受***醫療服務***。***受保人***必須入住***復康中心***不少於連六(6)小時。

「***末期病症***」　是指根據***註冊醫生***的意見，***受保人***因患病以致其壽命很可能由被確診當日起計不會多於十二(12)個月。

其他保障補充文件

此文件為***條款及保障***第六部分保障條文提供補充資料。

1. 保障項目

(a) 日間手術現金保障

若***受保人***接受***日間手術***並按本***條款及保障***獲得賠償，不論就本***條款及保障***內任何其他保障項目所獲賠償的***合資格費用***金額多少，本保障將賠償於***保障表***中所列的金額，惟受***保障表***內所列的限額規限。

(b) 香港病房級別下調現金保障

如***條款及保障***第六部分第3(a)節的病房及膳食獲得賠償，當***受保人***在***香港***私家***醫院***入住本***條款及保障***中***保障表***所列的指定病房等級以下的病房，除該病房及膳食相關的***合資格費用***外，本保障將按每日***住院***額外支付賠償，惟受***保障表***內所列的限額規限。

為免存疑，本保障不會賠償於***香港***公立***醫院***之***住院***。

(c) 身故保障

按本***條款及保障***，當***受保人***在本***條款及保障***生效期間身故（於***保單生效日***起計一(1)年內自殺則除外），不論於任何地域內身故，***保障表***內訂明之身故保障將獲賠償至***受益人***。

受保人若在***保單生效日***起計一(1)年內自殺，無論其是否在神智清醒的情況下，將不獲支付任何身故保障賠償。

若本***保單***按***條款及保障***第二部分第15(a)節終止，如***受保人***於本***保單***之寬限期內身故，***受益人***將獲賠償於本***保單***終止日之前一(1)日當時適用的***保障表***內訂明之身故保障，惟需扣除***條款及保障***第二部分第13節所指的所有到期未付的保費。

如***保單持有人***於每一***受益人***類別指明多於一(1)人，除非***保單持有人***另有預先書面指示，否則於該類別之在生***受益人***將平均獲得身故保障。

如在***受保人***身故時，並無指定的***受益人***，身故保障將賠償予***保單持有人***或撥入***保單持有人***的遺產內。

除非特別地指明，否則，在任何***受益人***早於***受保人***身故的情況下，其利益將歸於***保單持有人***的名下。

如任何***受益人***與***受保人***同時身故，身故保障將按當中較年長的人比較年少的人早身故的情況獲賠償。

在***受保人***在生期間，***保單持有人***可轉換***受益人***。***本公司***並不規限更改的次數。如作出更改，必須以符合***本公司***要求的書面方式通知***本公司***。***本公司***一旦收到書面通知，即使***受保人***在***本公司***收到書面通知前已身故，任何該等改變將在作出要求的簽署日期起生效。然而，每一項轉換及新***受益人***的權益將受制於***本公司***收到書面通知前已支付的任何款項。

2. 釋義

本***其他保障補充文件***中使用的字詞及表述必須按照以下所述解釋 –

「**受益人**」	是指於***本公司***的記錄中，***保單持有人***所指定收取於***受保人***身故後而獲得身故保障的人士。除非有所更改，否則，在***投保申請文件***內指明的***受益人***將可獲得該等身故保障。***受益人***亦可分為不同類別，例如第一***受益人***及第二***受益人***。此等類別將釐定賠償的先後次序。如第一***受益人***在生，任何可獲賠償的身故保障將獲賠償至第一***受益人***，否則將獲賠償至第二***受益人***。

無索償保費折扣補充文件

此文件為***條款及保障***第三部分保費條文提供補充資料。

1. 無索償保費折扣

按本***條款及保障***，在本***條款及保障***生效期間，如於緊接一個***續保日***前的一段連續時段符合下列所有條件(「要求」)，於該***續保日***開始的***保單年度***就本***條款及保障***的所需保費可獲扣減無索償保費折扣：

(a) 於緊接該***續保日***前的時段內，並沒有為***受保人***就本***條款及保障***支付賠償；及

(b) 本***條款及保障***於該段緊接***續保日***前的時段內維持生效。

於本***保單***可否獲得無索償保費折扣會於每個***續保日***釐定，無索償保費折扣相等於無索償保費折扣率乘以該***續保日***前的***保單年度***就本***條款及保障***的所需***每年保費***。無索償保費折扣率將根據以下比率釐定：

在已符合上述所有要求的時段	**無索償保費折扣率**
連續三個***保單年度***	5%
連續四個***保單年度***	10%
連續五個***保單年度***或以上	15%

當釐定無索償保費折扣後，在該***續保日***開始的***保單年度***本***保單***的所需保費將根據繳付保費的頻率按比例獲扣減無索償保費折扣。若本***保單***被終止，任何未給付之無索償保費折扣將會作廢。

就釐定無索償保費折扣而言，本***條款及保障***之任何賠償會按以下計算所屬的***保單年度***：

(a) 如***受保人住院***，以該次***住院***的入院日期計算；或

(b) 如***受保人***以***日症病人***身份接受***醫療服務***，以該次接受***醫療服務***的日期計算。

在已給付無索償保費折扣後，如***本公司***就過往任何***保單年度***的索償而支付保障，所有已給付的無索償保費折扣將會被重新計算(有支付保障的***保單年度***將不會被計入無索償時段)，而任何重新計算之金額及***保單持有人***實際所得之無索償保費折扣金額的差額將根據要求立即全額償還給***本公司***。

2. 釋義

本***無索償保費折扣補充文件***中使用的字詞及表述必須按照以下所述解釋 –

「***每年保費***」	是指***保單資料頁***、***補充文件***及/或***條款及保障***第四部分第3節所指的***續保***通知內載明的「***每年保費***」。

更改自付費補充文件

此文件為***條款及保障***第六部分保障條文提供補充資料。

在***受保人***年滿或緊隨五十(50)、五十五(55)、六十(60)、六十五(65)、七十(70)、七十五(75)、八十(80)或八十五(85)歲生日的***續保日***，並需於***受保人***在生期間，***保單持有人***可於該***續保日***前的三十(30)日內以書面向***本公司***申請於相關***續保日***起減低本***保單***之***自付費***而無需提供可保性的證明。

此權利於***受保人***在生時只可行使一次並不可撤銷，惟需視乎屆時可提供的***自付費***選擇（必須包括零(0)***自付費***選擇）。於相關***續保日***減低***自付費***後，應支付保費應包括按***本公司***現行採用就該***自付費***選項的***標準保費***表內的***標準保費***，及***保單持有人***曾就***保單***所接受的任何***附加保費***。就於***自付費***減低後招致的費用所作出之索償，將受限於相關***續保日***開始已調低的***自付費***。

為免存疑，***保單持有人***增加***自付費***權利不會受影響。於任何的***續保日***，***保單持有人***有權無需再提供***受保人***的可保性的證明而向***本公司***要求增加***自付費***。

賠償限制補充文件

此文件為***條款及保障***第六部分保障條文、***額外保障補充文件***及***其他保障補充文件***提供補充資料。

第一部分 一般條件

1. 地域範圍限制

(a) 除非另有規定，所有按***條款及保障***所述的保障將適用於***亞洲***，最終按本***條款及保障***所支付的金額將以本***賠償限制補充文件***的第一部分第 3(a)(i)節的公式計算。

(b) ***條款及保障***第六部分第 3(l)節的精神科治療的保障及***其他保障補充文件***第 1(b)節的***香港***病房級別下調現金保障只會就於***香港***的***住院***作出賠償。

(c) 若於***亞洲***以外的地方接受任何非***急症治療***，或於***亞洲***以外的地方進行任何***急症治療***時，而***受保人***於事發前三百六十五(365)天內於該事發地點已逗留超過六十(60)天，最終按本***條款及保障***所支付的金額將以本***賠償限制補充文件***的第一部分第 3(a)(ii)節的公式並按以下做法計算：

(i) ***條款及保障***第六部分第 3(a) 至 (k)節下的保障金額將會按***標準計劃條款及保障***所附的保障表中所列之賠償限額作出賠償；

(ii) ***條款及保障***第六部分第 3(l)節、***額外保障補充文件***第 1(a) 至 (k)節及***其他保障補充文件***第 1(a) 至 (b)節將不獲賠償。***額外保障補充文件***第 1(l) 至 (m)節的保障金額將會按***條款及保障***所附的***保障表***中所列之賠償限額作出賠償；

(iii) 本***賠償限制補充文件***第一部分第 2 節所註明的選擇病房級別限制將不適用；及

(iv) 應付的保障將再被扣除相關***保單年度***餘下的***自付費***差額（如適用）。

為免存疑，適用的***標準計劃條款及保障***，為按***條款及保障***第四部分第 1 (a)、(b) 或 (c)節所述的版本。

(d) 就於***亞洲***以外的地方進行任何***急症治療***，並且***受保人***於事發前三百六十五(365)天內於該事發地點逗留不超過六十(60)天，任何招致的***合資格費用***及／或其他費用將按本***條款及保障***作出賠償。最終按本***條款及保障***所支付的金額將以本***賠償限制補充文件***的第一部分第 3(a)(i)節的公式計算。於處理索償申請時，***本公司***有權要求***保單持有人***提供***受保人***於任何相關期間在***亞洲***以外逗留期間的證明。

2. 選擇病房級別限制

(a) 若***受保人***於***住院***期間的任何一(1)天入住病房之病房級別高於***保障表***內所示的指定病房級別，以下所示的病房級別調整因子將應用於該相關***住院***日計算***條款及保障***的應付賠償。

病房級別調整因子

(i) ***受保人***於***香港***、澳洲及紐西蘭***住院***或因***急症治療***於***亞洲*** 以外地方***住院***，並且***受保人***於事發前三百六十五(365)天內於該事發地點逗留不超過六十(60)天

於***保障表***內所示的指定病房級別	***受保人***於***住院***期間實際入住的病房級別	病房級別調整因子
標準半私家病房	***標準私家病房***	50%
標準半私家病房	***標準私家病房***以上	25%

(ii) ***受保人***於***亞洲***（***香港***、澳洲及紐西蘭除外）***住院***

於***保障表***內所示的指定病房級別	***受保人***於***住院***期間實際入住的病房級別	病房級別調整因子
標準私家病房	***標準私家病房***以上	25%

(b) 病房級別調整因子將不會應用於以下情況：

(i) 在接受***急症治療***時，因房間短缺而無法入住指定病房級別；

(ii) 因病情需要隔離而入住特定級別的病房；或

(iii) 不涉及***保單持有人***及 / 或***受保人***個人偏好的其他原因。

3. 整體賠償限額及應付賠償

(a) 根據***條款及保障***所獲得最終賠償金額將會按以下公式計算：

(i) 分別在本***賠償限制補充文件***第一部分第 1(a)及 1(d)節所註明的於***亞洲***以內的地方或就***急症治療***於***亞洲***以外所引致的***合資格費用***及／或其他費用：

應支付的保障金額 = [A x C – B，受限於 餘下的賠償限額（即***保障表***上所示的賠償限額，減去先前已賠償的保障金額）] - ***自付費***的任何餘額（如適用）

當中：

A = 於應用不保事項後及賠償限額前，根據***條款及保障***所支付的應付***合資格費用***及／或其他費用的金額

B = 任何根據***條款及保障***所支付的應付***合資格費用***及／或其他費用的金額，已由任何其他保險保障或根據***條款及保障***第七部分第 13 節獲得賠償*

C = 本***賠償限制補充文件***第一部分第 2 節的病房級別調整因子（如適用）

* 如有任何於***條款及保障***下應付的***合資格費用***及/或其他費用，並已由任何其他保險保障或根據***條款及保障***第七部分第 13 節獲得賠償，如所有醫療報告、票據之經核證副本及其他***本公司***所要求的必要文件均遞交予***本公司***作證明，該已獲賠償的金額將用以扣減相關***保單年度***餘下的***自付費***差額（如適用）。

(ii) 在本***賠償限制補充文件***第一部分第 1(c)節所註明的於***亞洲***以外的地方所招致的***合資格費用***：

應支付的保障金額 = [A – B，受限於 餘下的賠償限額（即***標準計劃條款及保障***所附的保障表上所示的賠償限額，減去先前已賠償的保障金額）] - ***自付費***的任何餘額（如適用）

當中：

A = 於應用不保事項後及賠償限額前，根據***標準計劃條款及保障***所附的保障表所支付的應付***合資格費用***

B = 任何根據***標準計劃條款及保障***所附的保障表所支付的應付***合資格費用***的金額，已由任何其他保險保障或根據***條款及保障***第七部分第 13 節獲得賠償#

#如有任何根據***標準計劃條款及保障***所附的保障表所支付的***合資格費用***，已由任何其他保險保障或根據***標準計劃條款及保障***第七部分第 13 節獲得賠償，如所有醫療報告、票據之經核證副本及其他***本公司***所要求的必要文件均遞交予***本公司***作證明，該已獲賠償的金額將用以扣減相關***保單年度***餘下的***自付費***差額（如適用）。

(b) 如按上述 3(a)(i)節的公式計算的應付的保障少於按上述 3(a)(ii)節的公式計算的應付的保障，***本公司***將支付後者。

(c) 所有根據***條款及保障***（包括***標準計劃條款及保障***，如適用）可獲得的賠償（***額外保障補充文件***第 1(a)、(b)及(c)節的日間手術現金保障、***香港***病房級別下調現金保障及身故保障除外），將會扣減任何相關***保單年度***適用的餘下的***自付費***差額。

(d) 根據***條款及保障***（包括***標準計劃條款及保障***，如適用）所獲得的最終賠償金額（即扣減任何相關***保單年度***適用的餘下的***自付費***差額後的相關賠償金額），將計入***保障表***內列明的適用的保障項目賠償限額、相關***保單年度***之***每年保障限額***及***終身保障限額***。

第二部分 釋義

本***賠償限制補充文件***中使用的字詞及表述必須按照以下所述解釋－

「***亞洲***」	是指阿富汗、澳洲、孟加拉、不丹、汶萊、柬埔寨、***香港***、印度、印尼、日本、哈薩克、吉爾吉斯、老撾、澳門、中國內地、馬來西亞、馬爾代夫、蒙古、緬甸、尼泊爾、紐西蘭、北韓、巴基斯坦、菲律賓、新加坡、南韓、斯里蘭卡、台灣、塔吉克、泰國、東帝汶、土庫曼、烏茲別克及越南。
「***標準私家病房***」	是指在***醫院***內連浴室的標準單人房。為免生疑，***標準私家房***並不包括在***醫院***內相比連浴室的標準單人住房較多設施的任何房間。
「***標準半私家病房***」	是指在***醫院***內提供一(1)張床或兩(2)張床（不包括住院陪床）並設有共用浴室/洗手間的房間。

指定嚴重疾病豁免自付費補充文件

此文件為***條款及保障***第六部分保障條文提供補充資料。

1. 指定嚴重疾病豁免自付費

本***指定嚴重疾病豁免自付費補充文件***內的條款及細則不適用於在***保障表***中顯示為零(0)***自付費***選項的本***認可產品***。

在本***保單***生效期間，若***受保人***患上以下(a)至(p)項指定嚴重疾病，並在主診***註冊醫生***的書面建議下直接因該指定嚴重疾病而接受任何***醫療服務***的情況下，於按***賠償限制補充文件***第一部分第 3 節中所列之公式計算本***條款及保障***下之最終賠償金額時，餘下的***自付費***餘額(如有及如適用)將就該***醫療服務***被減少至零(0)。於完全達到***自付費***限額前，本公司將賠償與該指定嚴重疾病有關之***醫療服務***所收取的***合資格費用***及/或其他費用。為免存疑，就相關指定嚴重疾病已招致並獲***本公司***支付的***合資格費用***及／或其他費用金額將不會用以扣減相關***保單年度***的***自付費***餘額（如有及如適用）。

為免存疑，本***指定嚴重疾病豁免自付費補充文件***中的「指定嚴重疾病豁免***自付費***」只適用於由本***指定嚴重疾病豁免自付費補充文件***第 1 及第 2 節中定義的任何指定嚴重疾病所引致的***醫療服務***。在***合資格費用***及/或其他費用同時涉及與指定嚴重疾病及任何指定嚴重疾病以外之其他***傷病***有關的***醫療服務***，但未能明確分攤費用的情況下，則該費用將全數被視為就與指定嚴重疾病相關之***醫療服務***所收取的***合資格費用***及/或其他費用。

指定嚴重疾病必須得到***受保人***的主診***註冊醫生***的書面證實，且具備***本公司***所合理接納之臨床、放射性、組織學或化驗證據。

指定嚴重疾病應包括：

(a) ***癌症***
(b) ***由心肌病所導致的心臟功能受損***
(c) ***慢性肝衰竭***
(d) ***冠狀動脈搭橋手術***
(e) ***末期肺病***
(f) ***暴發性病毒性肝炎***
(g) ***心臟病***
(h) ***心瓣置換***
(i) ***腎衰竭***
(j) ***主要器官移植***
(k) ***柏金遜病***
(l) ***肺動脈高血壓***
(m) ***類風濕性關節炎***
(n) ***中風***
(o) ***主要動脈手術***

(p) ***末期病症***

若***保單持有人***或***受保人***在本***保單***的***保單生效日***起計六十(60)日內已察覺或理應察覺任何指定嚴重疾病。在以下情況發生時，一般審慎人士理應已可察覺到指定嚴重疾病 –

(a) 該指定嚴重疾病已被確診；
(b) 該指定嚴重疾病已出現清楚明顯的病徵或症狀；或
(c) 就該病徵或症狀已尋求、獲得或接受醫療建議或治療。

本***指定嚴重疾病豁免自付費補充文件***中的「指定嚴重疾病豁免***自付費***」將不適用於由該指定嚴重疾病所引致的***醫療服務***。

2. 釋義

本***指定嚴重疾病豁免自付費補充文件***中使用的字詞及表述必須按照以下所述解釋 –

「***癌症***」	是指： 1. 經由病理化驗結果確定的惡性腫瘤不受控制地生長，並侵入身體的機能組織。確鑿無疑的細胞及機能組織的病理化驗證據必須被提供，證明惡性細胞生長及侵入身體的機能組織；或 2. 包括血癌及淋巴系統的惡性***疾病***。 不包括下列腫瘤： 3. 非侵入性在原位的癌病； 4. 任何皮膚癌(惡性黑色素瘤除外)； 5. 根據 TNM 分期方法被界定為 T1a 或 T1b 或較低類別的前列腺之初期癌症； 6. 根據 TNM 分期方法被界定為 T1aN0M0 或較低類別的甲狀腺初期乳頭狀癌症； 7. 原位癌，上皮病變 ，非滲入性或非侵入性腫瘤；及 8. 因人類免疫力缺乏症病毒引致之腫瘤。 就本定義而言，以上 TNM 分期方法應參考由美國癌症聯合委員會（AJCC）所制訂之最新版本的 TNM 分期系統（或同等癌症分期系統）。
「***由心肌病所導致的心臟功能受損***」	是指因不同的病因引致心室功能受損，導致永久及不可逆轉的身體損害程度達到紐約心臟協會的心臟損害評級第IV級。由酗酒或濫用藥物導致的心肌病特定不包括在此定義範圍內。為免存疑，第III級及/或以下不包括在此定義範圍內。 (第IV級：心肌病導致***受保人***不能在沒有感到不適的情況下進行任何身體活動。在靜止時可能出現的徵狀包括心臟輸出量不足、肺充血、系統充血或心絞痛症狀等。如果執行任何身體活動時，不適情況增加。)
「***慢性肝衰竭***」	是指末期肝衰竭伴黃疸加劇，在一般醫學觀點而言沒有好轉機會，該情況導致腹腔積水或肝性腦病。
「***冠狀動脈搭橋手術***」	是指接受開心手術，以搭橋手術，矯正兩(2)條或以上的冠狀動脈狹窄或阻塞的情況，但不包括所有非手術的治療方法，例如氣球血管造形術或激光技術。必須提供有關病症的血管造影報告作為佐證。
「***末期肺病***」	是指末期肺病包括間質性肺病，需作廣泛性及永久性氧氣治療，並且第一秒用力呼氣量(FEV1)測試結果少於一(1)公升。
「***暴發性病毒性肝炎***」	是指病毒性肝炎引起的肝臟次廣泛至廣泛性壞死，並導致肝臟衰竭，其診斷必須符合以下所有標準： 1. 肝臟體積急速地萎縮；

2. 壞死範圍覆蓋整個肝葉，只存留膠原網狀結構；
3. 肝功能檢驗顯示呈現急速衰退；及
4. 呈現嚴重的黃疸情形。

「***心臟病***」　是指因血液供應不足而導致部份心臟肌肉死亡。***註冊醫生***必須根據以下各點作出診斷：
1. 典型胸痛的歷史；
2. 心電圖新近之變化；及
3. 心臟酵素的水平升高，包括下列指定驗血項目的結果：
   (a) Troponin T 超越1.0 ng／ml；及
   (b) AccuTnI 超越0.5 ng／ml 或與其他以Troponin I 方法類同的鑑定標準。

「***心瓣置換***」　是指由於心瓣狹窄或不健全而需更換一(1)片或多於一(1)片的心瓣。心瓣修補或切除手術則不包括在此定義範圍內。

「***腎衰竭***」　是指由於兩(2)個腎臟長期不能發揮功能而導致無法復原的末期腎病。***受保人***必須接受定期洗腎或已接受腎臟移植作為佐證。

「***主要器官移植***」　是指作為接受者，確實接受心臟、肺、肝、腎、胰(胰島細胞除外)或骨髓移植。

「***神經科醫生***」　是指專為診斷及治療腦部及其他神經系統***疾病***及情況的***註冊醫生***。

「***柏金遜病***」　由顧問***神經科醫生***清楚確診為柏金遜病，並符合以下所有情況：
1. 不受藥物控制；
2. 呈現身體漸進式衰竭；及
3. 由日常活動測試證實***受保人***無能力在無人協助下完成下列三(3)項或以上的活動：
   (a) 洗澡；
   (b) 穿衣；
   (c) 如廁；
   (d) 進食；及
   (e) 上牀或下牀、就座或離開座位。

「***肺動脈高血壓***」　是指經由臨床及包括心導管在內的各類檢查而確定原發性肺動脈高血壓，並需符合以下所有診斷標準：
1. 呼吸困難並呈現疲勞；
2.（左）心房壓上升（至少增加二十(20)個單位）；
3. 肺阻力至少高過正常值三(3)個單位；
4. 肺動脈壓至少為40mmHg；
5. 肺的楔壓至少為8mmHg；
6.（右）心室未舒張壓力至少為8mmHg；及
7.（右）心室肥大、擴張及有（右）心臟衰竭的症狀和代償機能衰敗。

「***類風濕性關節炎***」　是指必須經由風濕病科醫生作出診斷，以確定出現類風濕性關節炎，並需符合下列所有診斷標準：

1. 於上午出現持續不少於一(1)小時的關節僵硬；
2. 雙邊性關節炎；
3. 慢性擴散漸進式關節耗損，風濕病科醫生診斷出其最少三(3)個主要關節，包括：
   (a) 手(包括掌指關節、近端指間關節及/或拇指指間關節)；
   (b) 腳(包括腳踝及/或蹠趾關節)；
   (c) 腕；
   (d) 膝；
   (e) 髖；
   (f) 肩；
   (g) 手肘；及
   (h) 頸椎

   的軟組織腫脹或呈流質狀。
4. 出現風濕性小瘤；
5. 類風濕因子的滴定度提升；
6. 紅血球沉降率提升至處於五十五(55)以上；及
7. 放射檢查證明情況嚴重。

在***受保人***首次被診斷前，上述第1、2及3項的病徵必須已出現最少三(3)個月。

就上述第3項計算受影響關節數量以符合***類風濕性關節炎***之準則而言，若左及右手、腳、腕、膝、肩或手肘（視屬何情況而定）均被診斷為嚴重畸形，本公司將視左及右側為兩(2)個關節。

「***中風***」　是指任何腦血管事件（或事故）：

1. 由腦組織梗塞，顱內血管出血及源自頭顱外之栓塞所致；及
2. 引致持續超過二十四(24)小時的神經系統機能失調，

以及持續四(4)個星期或以上出現永久性的神經系統功能缺陷。

以下各項不在定義範圍內：

1. 因短暫性腦缺血引致的腦部症狀；
2. 因偏頭痛引致的腦部症狀；及
3. 對眼或視神經或前庭系統功能造成影響的血管***疾病***。

「***主要動脈手術***」　是指因主要動脈***疾病***而需要接受切除及移植已患病的主要動脈。就本定義而言，主要動脈指胸腔動脈及腹腔大動脈，但不是其支脈。主動脈創傷性受傷不包括在此定義範圍內。

「***末期病症***」　是指根據***註冊醫生***的意見，***受保人***因患病以致其壽命很可能由被確診當日起計不會多於十二(12)個月。

增值稅和商品及服務稅納入為合資格費用補充文件

此文件為***條款及保障***第六部分保障條文及***額外保障補充文件***提供補充資料。

1. 增值稅和商品及服務稅

本***補充文件***將由 2022 年 3 月 1 日起生效（「***生效日期***」）。

由***生效日期***開始，以下條款及細則將應用於***條款及保障***：

(a) 本***補充文件***的條款及細則將適用於在***生效日期***當日或之後所招致的***合資格費用***，***合資格費用***將包括就***傷病***所需的***醫療服務***而徵收的***增值稅和商品及服務稅***（如有）。

(b) 就本***條款及保障***第 7 部分第 13 節而言，任何已退還予***保單持有人***或***受保人***（視情況而定）的***增值稅和商品及服務稅***將根據該第 13 節不受保障，並不得根據本***條款及保障***獲得支付。

2. 釋義

本***增值稅和商品及服務稅納入為合資格費用補充文件***中使用的字詞及表述必須按照以下所述解釋 –

「***增值稅和商品及服務稅***」　是指增值稅、商品和服務稅或其他性質類似的稅項、關稅或徵費，有關費用由相關稅務或類似機構，或政府部門就***傷病***所需的***醫療服務***而招致的費用收取或徵收。

香港公營醫院及私營醫院納入醫院的釋義補充文件

本***補充文件***將附加於本***條款及保障***並構成其一部分。除另行釋義外，在本***條款及保障***和在本***補充文件***中所使用的字詞及表述，具有相同的涵意。

本***補充文件***將由***保單生效日***起生效。

由***保單生效日***開始，第八部分「釋義」中「***醫院***」的解釋應包括***香港***的公營醫院及私營醫院，詳情如下：

釋義

「***醫院***」 是指按其所在地法律妥為成立及註冊為醫院的機構，為不適及受傷的***住院病人***提供***醫療服務***，並 –

(a) 具備診斷及進行大型手術的設施，或屬於《醫院管理局條例》（香港法例第 113 章）所界定的公營醫院或是根據《私營醫療機構條例》（香港法例第 633 章）領有牌照的醫院；
(b) 由持牌或註冊護士提供二十四 (24) 小時護理服務；
(c) 由一(1)位或以上***註冊醫生***駐診；及
(d) 非主要作為診所、戒酒或戒毒中心、自然療養院、水療中心、護理或療養院、寧養或紓緩護理中心、復康中心、護老院或同類機構。

靈活計劃保障表

「稅」卓越醫療計劃

保障地域範圍	除精神科治療及***香港***病房級別下調現金保障外(只限***香港***)– 非***急症治療***：***亞洲*** ***急症治療***[1]：全球
指定病房級別	於***香港***、澳洲及紐西蘭***住院***或因***急症治療***[1]於***亞洲*** 以外地方***住院***：***標準半私家病房*** 於***亞洲***（***香港***、澳洲及紐西蘭除外）***住院***：***標準私家病房***
(I)基本保障項目(a) – (l)、(II)額外保障項目(a) – (m)及(III)其他保障項目(a) – (b)的***每年保障限額***	每***保單年度*** 10,000,000 ***港元***
(I)基本保障項目(a) – (l)、(II)額外保障項目(a) – (m)及(III)其他保障項目(a) – (b)的***終身保障限額***	每人 40,000,000 ***港元***
(I)基本保障項目(a) – (l)及(II)額外保障項目(a) – (m)的***自付費***	每***保單年度*** 100,000 ***港元***

保障項目[2]	**賠償限額（港元）**
(I) 基本保障	
(a) 病房及膳食	全數保障[4]
(b) 雜項開支	全數保障[4] （受(II)額外保障下保障項目(g)「醫療裝置」的賠償限額所規限）
(c) 主診醫生巡房費	全數保障[4]
(d) ***專科醫生***費[3]	全數保障[4]
(e) 深切治療	全數保障[4]
(f) ***外科醫生***費	不論手術的分類均全數保障[4]
(g) ***麻醉科醫生***費	全數保障[4]
(h) 手術室費	全數保障[4]
(i) ***訂明診斷成像檢測***[3] [5]	全數保障[4] ***共同保險***：0%
(j) ***訂明非手術癌症治療***[6]	全數保障[4]
(k) 入院前或出院後 / ***日間手術***前後的門診護理[3]	全數保障[4] • ***住院*** / ***日間手術***前最多 1 次門診或***急症***診症 • 出院 / ***日間手術***後 90 日內最多 3 次跟進門診
(l) 精神科治療	每***保單年度*** $40,000
(II) 額外保障	
(a) 私家看護費[3]	全數保障[4] 每***保單年度***最多 60 日
(b) 家中看護津貼[3]	全數保障[4] 每***保單年度***最多 60 日
(c) ***住院***陪床	全數保障[4]

(d) 洗腎保障[3]	全數保障[4]
(e) 矯形手術保障[3]	每次***意外***/乳房切除術$200,000
(f) 妊娠併發症保障[3]	全數保障[4]
(g) 醫療裝置[3]	指定醫療裝置：全數保障[4] 其他醫療裝置：每***保單年度*** $100,000
(h) ***在生器官捐贈者***之移植手術費用	器官移植手術費用總和的 30%
(i) ***復康中心***及其相關治療[3]	每***保單年度*** $50,000 每***保單年度***最多 60 日
(j) 輔助服務[3]	每***保單年度*** $30,000 出院 / ***日間手術***後 90 日內每日合計最多 1 次 • ***物理治療師***/***脊骨神經科醫生***/***言語治療師***/***職業治療師***所進行的診症及/或治療： - 每日 $1,000 - 每***保單年度***最多 30 日 • ***中醫師***所進行的診症及治療，及/或其處方的藥物： - 每日 $600 - 每***保單年度***最多 15 日
(k) 善終院舍護理服務[3]	每***保單年度*** $80,000
(l) 緊急意外門診治療保障	全數保障[4]
(m) 緊急門診牙科治療保障	全數保障[4]
(III) 其他保障	
(a) 日間手術現金保障	每宗手術 $1,600 每***保單年度***最多 1 宗手術
(b) ***香港***病房級別下調現金保障	每日 $1,000 每***保單年度***最多 60 日
(c) 身故保障	$80,000

註解 –

(1) 應付的保障受限於***賠償限制補充文件***第一部分第 1(c)及 1(d)節所註明的***受保人***在進行***急症治療***的地方的逗留日數。

(2) 除非另有註明，同一項目的***合資格費用***不可獲上述表中多於一個保障項目的賠償。

(3) ***本公司***有權要求有關書面建議的證明，例如轉介信或由主診醫生或***註冊醫生***在索償申請表內提供的陳述。

(4) 全數保障是指不設分項賠償限額，應支付的***合資格費用***及其他費用於扣除餘下的***自付費***（如有）後的實際金額，須受適用的保障項目賠償限額、***每年保障限額***及***終身保障限額***所規限。

(5) 檢測只包括電腦斷層掃描（“CT”掃描）、磁力共振掃描（“MRI”掃描）、正電子放射斷層掃描（“PET”掃描）、PET–CT 組合及 PET–MRI 組合。

(6) 治療只包括放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。

手術表

程序 / 手術		分類
腹部及消化系統		
食道、胃及十二指腸	食道病變組織切除術 / 經頸進行食道病變組織或組織破壞術	大型
	高選擇性胃迷走神經切斷術	大型
	腹腔鏡胃底摺疊術	大型
	腹腔鏡式食道裂孔疝氣修補術	大型
	食道胃十二指腸內窺鏡檢查，連或不連活體組織檢查及 / 或息肉切除術	小型
	食道胃十二指腸內窺鏡檢查連異物清除	小型
	食道胃十二指腸內窺鏡連食道 / 胃靜脈曲張結紮 / 綁紮術	中型
	食道切除術	複雜
	食道全切除術及腸插入手術	複雜
	經皮膚進行胃造口術	小型
	永久胃切開術 / 胃腸造口術	大型
	部分胃切除術連或不連空腸移位術	大型
	部分胃切除術連十二指腸 / 空腸接合術	大型
	部分胃切除術連接合食道術	複雜
	近端胃切除術 / 根治性胃切除術 / 全部胃切除術連或不連腸插入術	複雜
	十二指腸撕裂縫合術 / 十二指腸潰瘍修補術	大型
	胃迷走神經切斷術及 / 或幽門成形術	大型
空腸、迴腸及大腸	開放式或腹腔鏡式闌尾炎切除術	中型
	肛裂切除術	小型
	肛瘻管切開術或切除術	中型
	肛周膿腫的切除術及引流術	小型
	修補直腸脫垂的德洛姆手術	大型
	結腸鏡檢查連或不連活體組織檢查	小型
	結腸鏡檢查，連息肉切除術	小型
	乙狀結腸內窺鏡檢查	小型
	外痔或內痔切除術	中型
	痔瘡的注射療法或綁紮術	小型
	迴腸造口術或結腸造口術	大型
	開放式或腹腔鏡式直腸前位切除術	複雜
	開放式或腹腔鏡式經腹部會陰切除術	複雜
	開放式或腹腔鏡式結腸切除術	複雜

程序 / 手術		分類
	開放式或腹腔鏡式直腸低前位切除術	複雜
	腸扭結或腸套疊復位術	中型
	小腸切除術及接合術	大型
膽管	開放式或腹腔鏡式膽囊切除術	大型
	逆行內窺鏡膽胰管造影術	中型
	逆行內窺鏡膽胰管造影術連乳突物手術、膽結石摘取或其他相關手術	中型
肝臟	幼針抽吸肝活體組織檢查	小型
	肝移植手術	複雜
	開放式肝病變組織 / 肝囊腫或肝膿腫袋形縫合術	大型
	開放式或腹腔鏡式移除肝病變組織	大型
	開放式或腹腔鏡式肝次葉切除術	大型
	開放式或腹腔鏡式肝葉切除術	複雜
	開放式或腹腔鏡式肝楔形切除術	大型
胰臟	閉合式胰管活體組織檢查	中型
	胰臟 / 胰管病變組織或組織的切除術或破壞術	大型
	胰臟十二指腸切除術（惠普爾手術）	複雜
腹部	剖腹探查	大型
	腹腔鏡檢查 / 腹膜內窺鏡檢查	中型
	開放式或腹腔鏡式的單側疝切開 / 縫合術	中型
	開放式或腹腔鏡式的兩側疝切開 / 縫合術	大型
	開放式或腹腔鏡式的單側腹腔溝疝修補術	中型
	開放式或腹腔鏡式的兩側腹腔溝疝修補術	大型
腦部及中樞神經系統		
神經外科手術	腦部活體組織檢查	大型
	顱骨鑽孔術	中型
	顱骨切除術	複雜
	顱神經減壓術	複雜
	腦室引流沖洗術	小型
	腦室引流的維修清除術，包括修正術	中型
	建立腦室腹腔引流或皮下腦脊液儲存器	大型
	顱內動脈瘤鉗夾術	複雜
	顱內動脈瘤包裹術	複雜
	顱內動靜脈血管畸型切除手術	複雜
	聽覺神經瘤切除術	複雜
	腦腫瘤或腦膿腫切除術	複雜

程序 / 手術		分類
	顱神經腫瘤切除手術	複雜
	治療三叉神經節氣囊的射頻溫熱凝固術	中型
	使用射頻進行閉合式三叉神經根切斷術	大型
	三叉神經根減壓術 / 開放式三叉神經根切斷術	複雜
	大腦包括腦葉切除手術	複雜
	大腦半球切除術	複雜
脊椎手術	腰椎穿刺或小腦延髓池穿刺手術	小型
	脊髓或脊神經根減壓術	大型
	頸交感神經切除術	中型
	胸腔鏡或腰交感神經切除術	大型
	脊髓管內硬膜內或硬膜外的腫瘤切除術	複雜
心血管系統		
心臟	心臟導管插入	中型
	冠狀動脈分流手術	複雜
	心臟移植	複雜
	心臟起膊器置入	中型
	心包穿刺術	小型
	心包切開術	大型
	經皮刺穿冠狀動脈腔內成形術及有關程序，包括：激光、支架置入、馬達扇頁切割、氣囊擴張或射頻切割技術	大型
	肺動脈瓣切開術、氣囊 / 腔內激光 / 腔內射頻術	大型
	經皮心瓣成形術	大型
	主動脈瓣擴張術 / 二尖瓣切開術	大型
	閉合式心瓣切開術	複雜
	心臟直視心瓣成形術	複雜
	心瓣置換	複雜
血管	腹內動脈 / 脾靜脈腎靜脈 / 門靜脈腔靜脈分流術	複雜
	腹腔血管切除術連置換 / 接合術	複雜
內分泌系統		
腎上腺	腹腔鏡式或腹膜後腔鏡式單側腎上腺切除術	大型
	腹腔鏡式或腹膜後腔鏡式兩側腎上腺切除術	複雜
松果腺	松果腺全切除術	複雜
腦下垂體	腦下垂體腫瘤切除術	複雜
甲狀腺	幼針抽吸甲狀腺活組織檢查連或不連影像導引	小型
	半甲狀腺切除術 / 部分甲狀腺切除術 / 大部分甲狀腺切除術 / 副甲狀腺切除術	大型

程序 / 手術		分類
	甲狀腺全切除術 / 副甲狀旁腺全切除術 / 機械人輔助式甲狀腺全切除術	大型
	甲狀舌管囊腫切除術	中型
耳鼻喉 / 呼吸系統		
耳	耳道閉鎖 / 耳道狹窄的耳道成形術	大型
	耳前囊腫 / 耳前竇切除術	小型
	耳廓血腫引流 / 裝鈕 / 切除術	小型
	耳道成形術	中型
	（耳科）異物清除術	小型
	切開鼓室進行中耳腫瘤切除術	大型
	鼓膜切開術連或不連導管插入	小型
	鼓膜成形術 / 鼓室成形術	大型
	聽小骨成形術	大型
	全部 / 部分迷路切除術	大型
	乳突切除術	大型
	耳蝸手術及 / 或人工耳蝸植入	複雜
	內淋巴囊手術 / 內淋巴囊減壓術	大型
	圓窗或卵圓窗瘻管修補術	中型
	鼓室交感神經切除術	大型
	前庭神經切除術	中型
鼻、口及咽喉	上頜竇穿刺及沖洗術	小型
	鼻粘膜燒灼術 / 鼻衄控制	小型
	鼻骨折閉合復位術	小型
	口竇瘻管閉合術	中型
	淚囊鼻腔造口術	中型
	鼻病變組織切除術	小型
	鼻咽鏡檢查或鼻鏡檢查連或不連鼻腔活體組織檢查連或不連清除異物	小型
	鼻瘜肉切除術	小型
	考一路二氏手術 / 以考一路二氏式進行 / 上頜竇切除術	中型
	篩竇 / 上頜竇 / 額竇 / 蝶竇內窺鏡手術	中型
	延伸性額竇內窺鏡手術連經中隔的額竇切開術	大型
	額竇切開術或篩竇切除術	中型
	額竇切除術	大型
	功能性鼻竇內窺鏡手術	大型
	兩側功能性鼻竇內窺鏡手術	複雜

程序 / 手術		分類
	上頜竇 / 蝶竇 / 篩竇動脈結紮術	中型
	其他鼻內手術，包括激光手術（除了簡易的鼻鏡檢查、活體組織檢查及血管燒灼術）	中型
	鼻成形術	中型
	鼻咽腫瘤切除術	中型
	竇腔鏡連或不連活體組織檢查	小型
	鼻中隔成形術連或不連黏膜下層切除術	中型
	鼻中隔黏膜下層切除術	中型
	鼻甲切除術 / 粘膜下鼻甲切除術	中型
	腺樣體切除術	小型
	扁桃體切除術連或不連腺樣體切除術	中型
	咽囊 / 咽憩室切除術	中型
	咽成形術	中型
	治療睡眠相關呼吸疾病的舌骨懸吊術、上顎 / 下顎 / 舌頭前移術、激光懸吊術 / 切除術、射頻切割輔助垂腭咽成形術、垂腭咽成形術	中型
	治療舌下囊腫的袋形縫合術 / 切除術	中型
	表層腮腺清除術	中型
	腮腺清除術 / 腮腺切除術	大型
	下頜唾腺液清除術	中型
	下頜腺導管移位術	中型
	下頜腺切除術	中型
呼吸系統	杓狀軟骨半脫位 – 喉鏡復位術	小型
	支氣管鏡檢查連或不連活體組織檢查	小型
	支氣管鏡連清除異物	小型
	喉鏡檢查連或不連活體組織檢查	小型
	喉頭 / 氣管狹窄 – 喉內 / 開放式支架置入術 / 重建術	大型
	喉頭分流術	中型
	喉切除術連或不連根治性頸淋巴組織切除術	複雜
	喉顯微鏡檢查連或不連活體組織檢查，連或不連小結 / 息肉 / 聲帶水腫切除術	小型
	喉腫瘤切除術	中型
	會厭窩囊腫清除術	中型
	喉骨折修補術	大型
	治療聲帶麻痺注射法	小型
	氣管食道穿刺術進行語音復建	小型

程序 / 手術		分類
	治療聲帶麻痺的甲狀軟骨成形術	中型
	聲帶手術包括使用激光技術（惡性腫瘤除外）	小型
	氣管造口術 – 臨時性 / 永久性 / 修正術	小型
	肺葉切除術 / 肺切除術	複雜
	胸膜切除術	大型
	肺節段切除術	大型
	治療氣胸的胸腔穿刺術 / 胸管插入術	小型
	胸腔鏡連或不連活體組織檢查	中型
	胸廓成形術	大型
	胸腺切除術	大型
眼部		
眼	眼瞼損傷組織切除術 / 刮除術 / 冷凍治療	小型
	眼瞼縫合術 / 眼緣縫合術	小型
	瞼內翻或瞼外翻修補術連或不連楔型切除術	小型
	部分皮層眼瞼重建術	中型
	結膜損傷組織切除術 / 破壞術	小型
	贅肉切除術	小型
	角膜移植術、嚴重傷口修復及角膜成形術，包括角膜移植	大型
	激光清除術或角膜損傷組織破壞術	中型
	角膜異物清除術	小型
	角膜修復手術	中型
	角膜撕裂或受傷的縫補術 / 修補術連結膜移位	中型
	晶狀體囊抽吸術	中型
	晶狀體囊切開術，包括使用激光	中型
	囊外 / 囊內晶狀體摘除術	中型
	去除眼內晶狀體 / 植入物	中型
	為脈絡膜視網膜損傷組織進行的手術	中型
	白內障超聲乳化手術連人工晶體植入	中型
	氣體視網膜粘結術	中型
	視網膜光凝固療法	中型
	視網膜脫落 / 撕裂的修補手術	中型
	視網膜撕裂 / 脫落的修補術連扣帶術	大型
	視網膜脫落扣帶術 / 環紮術	大型
	睫狀體分離術	中型
	小梁切除術，包括使用激光	中型
	青光眼手術治療包括置入植入物	中型

程序 / 手術		分類
	玻璃體診斷性抽吸術	小型
	注入玻璃體替代物	中型
	玻璃體切除術 / 移除術	大型
	虹膜活體組織檢查	小型
	虹膜 / 眼前半段 / 睫狀體損傷組織切除術	中型
	脫垂虹膜切除術	中型
	虹膜切開術	中型
	虹膜切除術	中型
	激光虹膜成形連或不連瞳孔成形術	中型
	虹膜嵌頓術及虹膜牽張術	中型
	鞏膜造瘻術連或不連虹膜切除術	中型
	鞏膜熱灼術連或不連虹膜切除術	中型
	睫狀體縮減術	中型
	眼外肌或肌腱活體組織檢查	小型
	單一條眼外肌手術	中型
	眼球穿孔傷口連箝閉或眼色素膜脫落修補術	大型
	眼球摘除術	中型
	眼球 / 眼內物摘除術	中型
	眼球或眼眶修補術	中型
	結膜淚囊鼻腔造口術	中型
	結膜淚囊鼻腔造口術連導管或支架插入	中型
	淚囊鼻腔造口術	中型
	淚囊及淚道切除術	小型
	淚腺切除術	中型
	淚小管 / 鼻淚管探查連或不連冲洗	小型
	淚小管修補術	中型
	瞳孔成形術	中型
女性生殖系統		
子宮頸	子宮頸截除術	中型
	陰道鏡檢查連或不連活體組織檢查	小型
	子宮頸錐形切除術	小型
	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞子宮頸病變組織	小型
	子宮頸內膜刮除術	小型
	子宮頸電環切除術	小型
	子宮頸囊腫袋形縫合術	小型
	子宮頸修補術	小型

程序 / 手術		分類
	子宮頸瘻管修補術	中型
	子宮頸 / 子宮 / 陰道撕裂縫合術	中型
輸卵管及卵巢^	輸卵管擴張術 / 吹氣術	小型
	開放式或腹腔鏡式切除 / 破壞輸卵管病變組織	大型
	輸卵管修補術	大型
	輸卵管造口術 / 輸卵管切開術	中型
	全部或部分輸卵管切除術	中型
	輸卵管成形術	中型
	卵巢囊腫抽吸術	小型
	開放式或腹腔鏡式卵巢囊腫切除術	大型
	開放式或腹腔鏡式卵巢楔形切除術	大型
	卵巢切除術	中型
	腹腔鏡式卵巢切除術	大型
	開放式或腹腔鏡式輸卵管卵巢切除術	大型
	開放式或腹腔鏡式輸卵管卵巢膿瘍引流術	中型
	^除非另有說明，此類別應用於單側或兩側（輸卵管及卵巢）	
子宮	子宮頸擴張及刮宮術	小型
	宮腔鏡檢查連或不連活體組織檢查	小型
	宮腔鏡檢查連切除或破壞子宮及承重結構	中型
	子宮切開術	大型
	腹腔鏡輔助的陰道子宮切除術	大型
	經陰道切除子宮連或不連膀胱突出症及 / 或直腸突出症的修補術	大型
	開放式或腹腔鏡式經腹部切除全部 / 大部分子宮連或不連兩側輸卵管卵巢切除術	大型
	經腹部進行根治性子宮切除術	複雜
	開放式或腹腔鏡式子宮肌瘤切除術	大型
	經陰道或宮腔鏡切除子宮肌瘤	中型
	腹腔鏡式盆腔膿腫引流術	中型
	陰道懸吊術	大型
	盆腔底修補術	大型
	盆腔臟器切除術	複雜
	子宮懸吊術	中型
陰道	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞陰道病變組織	小型
	陰道承托環的嵌入或移除	小型
	巴多林氏腺囊腫袋形縫合術	小型

程序 / 手術		分類
	陰道剝脫術或陰道斷端術	小型
	陰道切開術	中型
	陰道部分切除術	中型
	陰道全切除術	大型
	根治性陰道切除術	複雜
	陰道前壁修補術使用或不使用基利氏聯針法	中型
	陰道後壁修補術	中型
	陰道穹窿閉塞術	中型
	骶棘韌帶懸吊或陰道固定術	中型
	骶骨陰道固定術	中型
	經陰道進行腸疝修補術	中型
	尿道陰道瘻管閉合術	中型
	經陰道進行直腸陰道瘻管修補術	中型
	經腹部進行直腸陰道瘻管修補術	大型
	後穹窿穿刺術	小型
	子宮直腸凹切開術	小型
	陰道橫隔切除術	小型
	麥哥氏後穹窿整型術	中型
	陰道重建術	大型
外陰及入口	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞外陰病變組織	小型
	闊邊局部外陰冷刀切除術或子宮頸電環切除術	小型
	前庭腺炎切除術	小型
	切除外陰活體組織檢查	小型
	外陰及會陰切開術及引流術	小型
	外陰粘連鬆解術	小型
	外陰或會陰瘻管修補術	小型
	外陰及 / 或會陰撕裂縫合術 / 修補術	小型
	外陰切除術	中型
	根治性外陰切除術	大型
血液淋巴系統		
淋巴結	淋巴結病變組織 / 膿腫引流術	小型
	表面淋巴結活體組織檢查 / 切除 / 淋巴結構的單純切除術	小型
	頸淋巴結切開活組織檢查 / 幼針抽吸淋巴結活組織檢查	小型
	深淋巴結 / 淋巴管瘤 / 囊狀水瘤切除術	中型
	兩側腹股溝淋巴結切除術	中型
	頸淋巴結切除術	中型

程序 / 手術		分類
	腹股溝及盤骨淋巴結切除術	大型
	根治性腹股溝清掃術	大型
	根治性盤腔淋巴結切除術	大型
	選擇性 / 根治性 / 功能性頸淋巴切除術	大型
	腋淋巴結廣泛性切除術	大型
脾臟	開放式或腹腔鏡式脾切除術	大型
男性生殖系統		
前列腺	前列腺膿腫外部引流術	小型
	激光前列腺氣化術	大型
	等離子激光前列腺氣化術	大型
	前列腺活體組織檢查	小型
	經尿道微波電療法	中型
	經尿道前列腺切除術	大型
	開放式或腹腔鏡式前列腺切除術	大型
	開放式或腹腔鏡式根治性前列腺切除術	複雜
陰莖	包皮環切術	小型
	痛性陰莖勃起鬆解術	大型
	隱藏陰莖修補術 / 陰莖抽出術	中型
睾丸^	附睾切除術	中型
	睾丸探查	中型
	腹腔鏡探查未降睾丸	大型
	睾丸固定術	中型
	腹腔鏡式睾丸切除術或睾丸固定術	大型
	睾丸扭轉復位及固定術	中型
	睾丸活體組織檢查	小型
	睾丸鞘膜積水高位結紮術	中型
	睾丸鞘膜積水抽液手術	小型
	精索靜脈曲張及睾丸鞘膜積液切除術	中型
	精索靜脈曲張切除術（顯微外科）	大型
	^如非特別說明，此類別應用於單側或兩側（睾丸）	
輸精管	輸精管結紮手術	小型
肌肉骨骼系統		
骨	單肢的手指 / 腳趾截肢術	中型
	單臂 / 單手 / 單腿 / 單腳截肢術	中型
	拇趾囊腫切除術	中型
	拇趾囊腫切除術並進行軟組織矯正及第一蹠骨切除術	大型

程序 / 手術		分類
	橈骨頭切除術	中型
	因良性疾病切除下頜骨	中型
	膝蓋骨切除術	大型
	部分面骨骨切除術	中型
	面部死骨切除術	中型
	腕 / 手 / 腿骨的楔形截骨術	大型
	上臂 / 下臂 / 大腿的楔形截骨術	大型
	肩胛骨 / 鎖骨 / 胸骨的楔形截骨術	大型
關節	關節鏡引流及清創手術	中型
	關節鏡移除關節內游離體	中型
	關節鏡檢查連或不連活體組織檢查	中型
	關節鏡輔助進行韌帶重建術	大型
	關節鏡班卡特修補術	大型
	經關節鏡肩關節上盂唇由前往後撕裂的修補術	大型
	關節鏡旋轉套修復術	大型
	肩峰切除術	大型
	肩關節融合術	大型
	肘關節融合術 / 三關節融合術	大型
	膝關節 / 髖關節融合術	複雜
	手 / 手指 / 足 / 足趾的關節置換連植入術	大型
	腕融合術	大型
	腕滑膜切除術	中型
	腳趾指骨間關節融合術	中型
	手指指骨間關節融合術	大型
	肩關節切除術 / 半肩關節置換術	大型
	髖關節 / 膝關節 / 手腕關節 / 肘關節切除術	大型
	髖關節 / 膝關節切除術連局部釋放抗生素	複雜
	顳顎關節成形術連或不連自體移植	大型
	關節抽吸術 / 注射	小型
	麻醉下進行關節鬆弛治療	小型
	金屬股骨頭置入術	大型
	前十字韌帶重建術	大型
	開放式或關節鏡式鏡半月板切除術	大型
	後十字韌帶重建術	大型
	副韌帶修復術	大型

程序 / 手術		分類
	十字韌帶修補術	大型
	踝及足關節囊或韌帶的縫合術	大型
	全肩置換術	複雜
	全膝置換術	複雜
	全髖置換術	複雜
	部分髖關節置換術	大型
肌肉及肌腱	跟腱修補術	中型
	跟腱切斷術	中型
	肌肉或肌腱放鬆或收緊手術（除手部以外）/ 肌肉損傷組織切除術	中型
	手部肌肉或肌腱放鬆或收緊手術	大型
	肌肉損傷組織切除術	中型
	肌腱延長，包括腱切斷術	中型
	開放式肌肉活體組織檢查	小型
	橈骨莖突狹窄性腱鞘炎	小型
	板機指鬆解術	小型
	網球肘（肱骨外上髁炎）鬆解術	小型
	肌肉轉移 / 移植 / 再接合術	大型
	不涉及手部的肌腱修復術 / 縫合術	中型
	手肌腱修復術 / 縫合術	大型
	腱鞘滑膜切除術 / 滑膜切除術	中型
	手腕 / 手肌腱移位術	大型
	二期肌腱修補術，包括移植、轉移及 / 或假體置入	大型
骨折及脫位	顳顎 / 指間骨 / 肩峰關節脫位閉合復位術	小型
	肩膀 / 肘 / 腕 / 踝骨脫位閉合復位術	中型
	科雷氏骨折閉合復位術連經皮膚克氏線固定治療	大型
	手臂 / 腿骨 / 髕骨 / 盤骨骨折閉合復位術連內固定術	大型
	顎骨骨折閉合復位術連內固定術	中型
	肩胛骨 / 鎖骨 / 指骨 / 髕骨骨折閉合復位術不連內固定術	小型
	上臂 / 前臂 / 手腕 / 手 / 腿 / 足骨骨折閉合復位術不連內固定術	中型
	鎖骨 / 手骨 / 踝骨 / 足骨骨折閉合復位術連內固定術	中型
	股骨骨折閉合復位術連或不連內固定術	大型
	關節窩骨折閉合 / 開放復位術連內固定術	複雜
	顎骨骨折開放復位術連內固定術	大型

程序 / 手術		分類
	鎖骨 / 手 / 足骨骨折開放復位術（除腕骨 / 踝骨 / 跟骨外）連或不連內固定術	中型
	手臂 / 腿骨 / 髕骨 / 肩胛骨骨折開放復位術連或不連內固定術	大型
	股骨 / 跟骨 / 踝骨骨折開放復位術連或不連內固定術	大型
	使用外固定支架及徹底傷口清創術的複合性骨折手術治療	中型
	拆除因舊骨折而裝上的螺絲、釘、金屬板及其他金屬 (股骨除外)	小型
脊椎	人造頸椎間盤置換術	複雜
	頸 / 頸胸 / C4/5 及 C5/6 前脊柱融合術連鎖定骨板	大型
	除頸 / 頸胸 / C4/5 及 C5/6 以外的前脊柱融合術連鎖定骨板	複雜
	前脊椎融合術連儀器設置	複雜
	頸椎板成形術	大型
	椎板切除術或椎間盤切除術	大型
	椎板切除術連椎間盤切除術	複雜
	胸 / 頸胸 / 胸腰 / T5 至 L1 / 環 – 樞椎 後脊椎融合術	大型
	（除胸 / 頸胸 / 胸腰 / T5 至 L1 / 環 – 樞椎以外的）後脊椎融合術	複雜
	後脊椎融合術連儀器設置	複雜
	脊椎活體組織檢查	小型
	脊椎融合術，連或不連椎間孔切開術，連或不連椎板切除術，連或不連椎間盤切除術	複雜
	脊椎截骨術	複雜
	椎體成形術 / 椎體矯正術	中型
其他	神經節 / 滑囊切除術	小型
	掌腱膜攣縮的閉合式 / 經皮膚刺針筋膜切開術	小型
	掌腱膜攣縮的根治性或全部筋膜切開術	大型
	開放式或內窺鏡式腕道或踝管鬆解術	中型
	周圍神經鬆解術	中型
	尺神經移位術	中型
	滑動式 / 復位式下巴整形術	中型
皮膚及乳房		
皮膚	皮膚或皮下病變組織切除術 / 冷凍術 / 電灼術 / 激光治療	小型
	指甲下血腫或膿腫引流術	小型
	脂肪瘤切除術	小型
	用於移植的切皮手術	小型
	皮膚膿腫切開術及 / 或引流術	小型

程序 / 手術		分類
	皮膚及 / 或皮下組織切開術及 / 或異物清除	小型
	皮膚及皮下病變組織的局部切除術或破壞術	小型
	皮膚傷口縫合術	小型
	外科洗滌及縫合術	小型
	趾甲楔形切除術	小型
乳房	乳房腫瘤 / 腫塊切除術連或不連活體組織檢查	中型
	幼針抽吸乳房囊腫檢查	小型
	乳房活體組織檢查	小型
	改良式根治性乳房切除術	大型
	部分或簡易乳房切除術	中型
	部分或根治性乳房切除連腋窩淋巴切除術	大型
	全部或根治性乳房切除術	大型
	乳管內乳頭狀瘤切除術	中型
	男性乳腺增生切除術	中型
泌尿系統		
腎臟	因泌尿系統結石進行的體外衝擊波碎石術	中型
	腎石切除術 / 腎盂切開術	大型
	腎內窺鏡	大型
	經皮膚插入腎造口管手術	小型
	腎活體組織檢查	小型
	開放式或使用腹腔鏡或後腹腔鏡的腎切除術	大型
	部分 / 下端腎切除術	複雜
	腎移植手術	複雜
膀胱、輸尿管及尿道	膀胱鏡檢查連或不連活體組織檢查	小型
	膀胱鏡連輸尿管導管插入 / 經尿道膀胱清除術	小型
	膀胱鏡連電灼術 / 激光碎石術	中型
	尿道肉阜切除術	小型
	尿道或尿管支架植入	中型
	開放式或腹腔鏡式膀胱憩室切除術	大型
	經尿道切除膀胱腫瘤	大型
	開放式或腹腔鏡式部分膀胱切除術	大型
	開放式或腹腔鏡式根治性 / 全部膀胱切除術	複雜
	開放式或使用腹腔鏡或後腹腔鏡的尿管切石術	大型
	尿道直腸瘻管閉合術	大型
	尿道瘻管修補術	大型
	膀胱陰道瘻管修補術	大型

程序 / 手術		分類
	結腸膀胱瘻管修補術	大型
	尿道破裂修補術	大型
	應力性尿失禁修補術	大型
	迴腸導管建造，包括輸尿管植入	複雜
	迴腸或結腸代替輸尿管手術	大型
	單邊輸尿管再植入腸或膀胱	大型
	雙邊輸尿管再植入腸或膀胱	大型
牙科		
	任何因意外受傷而進行的牙科手術	小型