中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED
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BOC MEDICAL COMPREHENSIVE PROTECTION PLAN (SERIES 1) POLICY

WHEREAS THE POLICYHOLDER by a proposal and declaration, in either verbal or written basis which shall be the basis of this contract and is deemed to be incorporated herein has applied to BANK OF CHINA GROUP INSURANCE COMPANY LIMITED. (hereinafter called "the Company") for the insurance hereinafter contained and has paid the premium as consideration for such insurance.

NOW THIS POLICY witnesses that subject to the terms, exclusions, conditions, limit of liability contained herein, affixed hereto or endorsed herein (all of which are deemed to be incorporated herein and collectively referred to as the Terms of this Policy), the Company agrees to indemnify the Policyholder in respect of any or all the benefit items hereinafter mentioned happening during the Period of Insurance.

Provided always that the truthfulness, accuracy and completeness of all information provided or declared in the proposal and declaration by the Policyholder and the Insured Person, the due observance and fulfillment by the Policyholder and the Insured Person of all the terms and conditions of the Terms of this Policy shall be a condition precedent to any liability on the part of the Company under this Policy.

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

PART I – GENERAL DEFINITIONS

Any of the following words and expressions to which a specific meaning has been attached in this Policy, the Schedule, endorsement and any memoranda shall bear such specific meanings wherever it may appear.

1. **Accident:** means an unforeseen and unexpected event of violent, accidental, external and visible nature, which shall independently of any other cause be the sole cause of bodily Injury.
2. **Annual Overall Limit:** means the maximum aggregate sum of the benefit under PART II Section 1 - Basic Benefit item A for which the Insured Person aged seventy-six (76) or above is covered under this Policy during the twelve (12) months commencing from the effective date of this Policy or, during any twelve (12) months period measured from the anniversary date of this Policy.
3. **Medical Card/ Assistance Card**
   (1) Medical Card means the "BOC Medical Comprehensive Protection Plan (Series 1) Medical Card" issued by the Company to each Insured Person. This Card serves as an identity for the Insured Person to be entitled Out-patient Services by Network Services Providers (only if Part II Section 2 – Optional Benefit D "Out-patient Benefit" is covered & shown on the Schedule of this Policy) and Hotline service provided by "24-Hour Worldwide Emergency Assistance Service".
   (2) Assistance Card means the "BOC Medical Comprehensive Protection Plan (Series 1) Assistance Card" issued by the Company to the Insured. This Card serves as an identity for the Insured Person to be entitled to Hotline service provided by "24-Hour Worldwide Emergency Assistance Service".
4. **Child:** means in respect to a person, his legal child, including step child, adopted child or guardian child.
5. **Chinese Medical Practitioner:** means a listed or registered Chinese medical practitioner under the Chinese Medicine Ordinance of Hong Kong, Cap.549 or duly qualified practitioner of Chinese medicine registered as such under the laws of the country in which the claim arises and where the treatment takes place but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
6. **Congenital Conditions:** means medical abnormalities existing at the time of birth, as well as neo-natal physical abnormalities developing within six (6) months of birth. They shall include (but not limited to the exclusion of others which may medically be regarded as congenital conditions) Hernias of all types (except caused by a trauma after the effective date of this Policy); Strabismus; Hydrocephalus; Undescended testicle; Hypospadias; Meckel's diverticulum; cleft palate, clubfoot, birthmark, bone or muscle developmental abnormality, cerebral palsy, etc.
7. **Day of Hospital Confinement:** means each continuous twenty-four (24) hours period that the Insured Person is confined as a Resident In-patient in Hospital.
8. **Disability:** means Injury, Sickness and shall include all disabilities arising from the same cause including any and all complications arising therefrom, except that where no further Medical Services for the said disability is required within ninety (90) days following the latest Medical Services, any subsequent disability from the same cause shall be considered a different disability.
9. **Eligible Expenses:** means any expense incurred for Medical Services in respect of a covered Disability, that shall be reimbursed by the Company, but shall not exceed the actual charges incurred and the relevant maximum benefit limits as specified in the Schedule and the Limit of Indemnity Table of this Policy..
10. **Emergency:** means an event or a situation that treatment is needed immediately in order to prevent death or permanent impairment of the Insured Person's health.
11. **Hong Kong:** means the Hong Kong Special Administrative Region of the People's Republic of China.
12. **Hospital:** means a legally constituted establishment operated pursuant to the laws of the country in which it is based, and meeting all of the following requirements in that it:
    (1) operates primarily for the reception and medical care and treatment of sick, ailing or injured persons on an In-patient basis;
    (2) admits In-patient only under the supervision of a Physician or Physicians one of whom is available for consultation at all times;
    (3) maintains organized facilities for medical diagnosis and treatment of such persons, and provides (where appropriate) facilities for major surgery within the confines of the establishment or in facilities controlled by or available to the establishment;
    (4) provides full-time nursing service by and under the supervision of a staff of nurses;
    (5) maintains a legally licensed Physician in residence;
    (6) if in the Mainland China, the establishment has to be above the county level and operates under Western medical practices.

    "Hospital" shall not include the following:
    (1) a mental institution; an institution confined primarily to the treatment of psychiatric disease including sub-normality; the psychiatric department of a Hospital;

(2) a place for the aged; a rest home; a place for drug addicts or alcoholics;
(3) a health hydro or nature cure clinic; a nursing or convalescent home; a special unit of a Hospital used primarily as a place for drug addicts or alcoholics, or as a nursing, convalescent, rehabilitation, extended-care facility or rest home;
(4) establishment operates under Chinese medical practices.

13. **Hospital Confinement:** means confinement in a Hospital which must be for a minimum period of six (6) consecutive hours before any Medical Benefits hereunder are payable, except that no minimum period of hospital confinement is required in respect of any expenses incurred at a Hospital in connection with any Emergency treatment required as a result of (and within twenty four (24) hours following) an Injury or in respect of fees charged by a Registered Medical Practitioner for the performance of a surgical procedure or operation, or in respect of an operation received in a clinic or in a recognized "Day Care Surgical Centre" owned and operated as such by a Hospital.
14. **Injury:** means an abnormal bodily condition caused solely and directly by Accident and independent of any other cause and not therefore due to Sickness or disease.
15. **In-patient:** means the Insured Person confined in a Hospital and occupies a bed for a minimum period of six (6) consecutive hours, except that no minimum period of Hospital Confinement is required in respect of an operation incurred at a clinic or a recognized "Day Care Surgical Centre" owned and operated as such by a Hospital.
16. **Insured:** a legal resident of Hong Kong aged eighteen (18) years old or above who applies for this Policy and in whose name the Policy is issued and appeared as the Insured in the Schedule or endorsement.
17. **Insured Person:** means the insured person(s) named in the Schedule or endorsement and who is a legal resident of Hong Kong and is the Insured's legal spouse; or the Insured's Child.
18. **Insured Plan:** means the insured plan covered by each Insured Person under this Policy and shown in the Schedule.
19. **Intensive Care Unit:** means a section with a Hospital which is designated as an intensive care unit by the Hospital providing one to one nursing care, in which patients undergo specialized resuscitation, monitoring and treatment procedures. The unit must be staffed twenty-four (24) hours a day with highly trained nurses, technicians and doctors, and be equipped with resuscitative equipment and monitoring devices that allow continuous assessment of vital body functions such as heart rate, blood pressure and blood chemistry.
20. **Maternity:** means any condition arising out of or during any one pregnancy, childbirth or miscarriage or any complication arising from the same (but excluding induced abortion and except where it is medically necessary).
21. **Medical Benefits:** means the benefits provided under this Policy in Part II in respect of medical expenses. Such expenses must be incurred by the Insured Person as a result of Injury; Sickness; disease or illness.
22. **Medically Necessary:** means the necessity to have a Medical services which are:
    (1) consistent with the diagnosis and customary medical treatment for the condition; and
    (2) in accordance with standards of good and prudent medical practice; and
    (3) not for the convenience of the Insured, the Insured Person, or any person coming within the meaning of General Definition items 30 and 34 below; and
    (4) performed at a Reasonable and Customary charge on treatment of a covered Disability.
    (5) Performed in the least costly Setting required for treatment of a covered Disability.

    Experimental, screening test and preventive services or supplies are not considered Medically Necessary.
23. Medical Services: means Medically Necessary services, including, as the context requires, Confinement, treatment, procedure, test, examination or other related services for the investigation or treatment of a Disability.
24. **Overseas:** means territories other than Hong Kong Special Administrative Region.
25. **Place of Residence:** means the place whereby the Insured Person will live for at least six (6) months in the same place within Policy Year and as declared in the proposal form or written notice of change.
26. **Policy:** means all the Terms and Conditions contained herein, including the Schedule, endorsements and attachments thereto and, if applicable by stipulation in the Schedule, the Company's Classification Schedule of Surgical Operations ("the Classification Schedule"), as may be supplied with this Policy or as published or notified to the Insured from time to time.
27. **Policy Year:** means each continuous twelve (12) months period starting from the effective date of this Policy.
28. **Pre-existing Medical Conditions:** means
    (1) Sickness or Injury which existed before the effective date of the Policy and/or the benefit cover in respect of the Insured Person and which presented signs or symptoms of which the Insured Person was aware of or should reasonably have been aware of; or
    (2) any of the following and whether or not the Insured Person has any prior knowledge occurring during one (1) year from the effective date of this Policy and/or the benefit cover:
        i. Diseased tonsils requiring surgery;
        ii. Tumors of organs;
        iii. Haemorrhoids;
        iv. Abnormality of nasal septum or turbinates;
        v. Thyroid Disorders;
        vi. Endometriosis;
        vii. Sinus conditions requiring surgery;
        viii. Cataracts;
        ix. Hernia; or
    (3) any of the following and whether or not the Insured Person has any prior knowledge occurring during the first six (6) months from the effective date of this Policy and/or the benefit cover:
        i. Tuberculosis;
        ii. Gall stones;
        iii. Calculi of kidney, urethra or bladder;
        iv. Anal fistulae;
        v. Hypertension, cardiac disease or vascular disease;
        vi. tumors of skin, muscular tissue, bone tumors or malignancies of blood or bone marrow;
        vii. Hallux valgus;
        viii. Gastric or duodenal ulcer;
        ix. Diabetes mellitus.
29. **Qualified Nurse:** means any nurse legally qualified and authorized to render nursing services, having qualifications at least equivalent to "Registered Nurse" or "Enrolled Nurse" of Hong Kong and should a claim and Medical Services occur outside Hong Kong shall mean a nurse who is duly registered as such under the laws of the country in which the claim arises and where Medical Services take place, but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
30. **Reasonable and Customary:** means, in relation to fees, a sum not exceeding a reasonable average of the fees charged under similar conditions by persons of equivalent experience and professional status in the area in which the service was provided; and in relation to material or services, shall mean a sum not exceeding a reasonable average of the charges for similar material or services in equivalent circumstances of quality and economic consideration in the same area as that in which any such material or services were obtained.
31. **Registered Medical Practitioner; Surgeon; Physician; Doctor; Anaesthetist:** means a person duly qualified and legally registered as such to practice western medicine in Hong Kong, and should a claim and Medical Services occur outside Hong Kong, shall mean a practitioner of western medicine who is duly registered as such under the laws of the country in which the claim arises and where Medical Services take place, but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
32. **Schedule:** means this Policy schedule, which is attached to and forms part of this Policy.
33. **Setting:** means a Hospital out-patient department, Hospital accommodation or clinical services as appropriate for

treatment.

34. **Sickness:** means sickness contracted and commenced while the Insured Person whose sickness or diseases is the basis of a claim is covered under this Policy, and shall exclude any Pre-existing Medical Conditions as defined in this Policy. Such sickness must result directly and independently of all other causes in Hospital Confinement of such Insured Person.
35. **Specialist:** means a person who has completed western specialist course and been granted a qualified specialist certificate and is licensed to legally practice as particular medical specialists in Hong Kong, and should a claim and Medical Services occur outside Hong Kong, shall mean a practitioner who has completed western specialist course who is duly registered as such under the laws of the country in which the claim arises and where Medical Services take place, but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
36. **You, Your or Yourself:** means the Insured and/or the Insured Person.

PART II – INSURED BENEFITS

The Company shall pay Medical Benefits for Medically Necessary expenses in accordance with the scope of cover provided herein below but each Insured Person's benefit shall be subject to the maximums (or maximum percentage), the limits, the respective covered benefits of the Insured Plan as applicable and as specified in the Schedule and the "Limit of Indemnity" table of this Policy.

Section 1 - Basic Benefits

A. <u>Hospital and Surgical Benefits</u>

1. **Room and Board Fee**
   Benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured Person is registered as an In-patient in a Hospital for the Medical Services of a Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the actual and reasonable charges made by the Hospital in respect of Room and Board during the Insured Person's Hospital Confinement.
2. **Physician's Visits Fee**
   If the Insured Person on any day of a Hospital Confinement shall be necessarily treated by a Registered Medical Practitioner, benefit shall be payable in an amount equal to the charges made in respect of the attending Physician's visit fees.
3. **Hospital Services Fee**
   Hospital Services benefit shall be payable during the time the Insured Person is registered and staying as an In-patient in a Hospital for Medical Services of a Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the normal, proper and actual charges made by the Hospital in respect of Hospital Services during the Insured Person's Hospital Confinement.
   Hospital Services shall include the following, except where deleted or omitted from coverage or specified to the contrary in the Schedule:
   (1) Administration of blood or blood plasma, but not the cost of blood or blood plasma;
   (2) Ambulance services to and/or from the Hospital;
   (3) Anaesthesia and oxygen and their administration;
   (4) Basal metabolism test;
   (5) Dressing, ordinary splints and plaster casts;
   (6) Drugs and medicines consumed during the Hospital Confinement;
   (7) Electrocardiograms;
   (8) Films & X-rays and their interpretation & special diagnostic procedures such as computerized tomography;
   (9) Intravenous infusions;
   (10) Laboratory examinations;
   (11) Physiotherapy.
4. **Surgical Expenses**
   Surgical expenses benefit shall be payable in an amount equal to the surgical fees actually charged by Surgeon for surgical operation(s) performed in respect of a Disability including the fees for two (2) pre-surgical assessments and normal post-surgical care and post surgical Medical Services by registered Chinese Medical Practitioner within six (6) weeks after discharged from Hospital. This benefit would settle the surgical fees first, the charges for pre-surgical and post-surgical consultation would be settled under the balance amount if any.
   Surgical Fees where applicable will be paid in accordance with the Company's "Classification Schedule of Surgical Operations ("the Classification Schedule")" supplied with this Policy or as may be published or notified by the Company to the Insured from time to time. The Company shall have absolute discretion and liberty to revise or amend the Classification Schedule or any part thereof as it may consider appropriate or necessary from time to time. If the operation performed is not shown in the Classification Schedule, the Company shall have absolute discretion to determine the classification or the percentage for such operation and such determination shall be final and binding. An operation of equivalent severity, difficulty and complexity will be used by the Company as a basis for this determination.
   If two or more procedures are performed through a single incision, reimbursement for expenses for all such procedures shall not exceed the amount indicated for the one surgical procedure performed that incurs the largest amount of expenses. If more than one surgical procedure is to be performed at the same surgical session through different incisions, the Company will pay up to 150% fees of the complex operation in accordance with the Classification Schedule. If more than one surgical operation is to be performed during one Hospital Confinement, reimbursement for expenses for all such procedures shall not exceed the amount indicated for the one surgical procedure performed that incurs the largest amount of expenses. If there are two or more operations to be performed in one disability, the amount payable for all such operations will be calculated on the basis of these operations amongst which only the largest surgical operation according to the "Classification Schedule", but the sum amount payable will not exceed the fees actually charged or the maximum limit in the Benefit Schedule provided for the relevant classification of such the largest surgical operation, whichever is the lesser.

   If any alternative procedure including X-ray, radium or any other radioactive substances are used for Medical Services in place of any cutting operation listed in the Classification Schedule, the Company will, subject to all of the other provisions for "Surgical Benefit", pay a benefit which is Reasonable and Customary for such Medical Services up to the amount provided in the Schedule with reference to the Classification Schedule.
   Any Surgical Fees to be reimbursed must be incurred for services rendered by a Registered Medical Practitioner qualified to render the surgical service for which the claim is made and must be Eligible Expenses.
   Payments made under this surgical benefit provision shall be in lieu of all benefits otherwise payable for the same Medical Services under any other benefits provisions of this Policy.
5. **Operating Theatre Fee**
   Benefit shall be payable for the use of the operating theatre for the carrying out of any surgical procedure during the Insured Person's Hospital Confinement.
6. **Anaethetist's Fee**
   Benefit shall be payable in an amount equal to the actual charges made as a result of Insured Person using the service of Anaesthetist for surgical procedure.
7. **Specialist's Fee**
   Benefit shall be payable in an amount equal to the actual charges made by a Specialist to whom the Insured Person has been referred by a Registered Medical Practitioner during the Insured Person's Hospital Confinement.
8. **Intensive Care Fee**
   Benefit shall be payable for the actual Hospital charges incurred as a result of the Insured Person being accommodated in an Intensive Care Unit recommended by the Doctor in charge. Benefit shall be payable in an amount equal to the actual charges made for Medical Services in an Intensive Care Unit. If the Insured Person suffers from infectious disease, need mandatory isolated by government

authority and being confined to Hospital to receive Medical Services in an Intensive Care Unit, the maximum limit of Intensive Care Benefit shall be doubled automatically. Payments made under this provision shall be in lieu of any Room and Board benefits for such Medical Services.

9. **Post-Hospitalisation Treatment Fee**
   Benefit shall be payable for all related follow-up visits that is recommended by the attending Registered Medical Practitioner within six (6) weeks immediately after discharged from Hospital or post-clinical surgery.
10. **Extra Bed Accommodation Fee**
    An extra-bed accommodation benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured Person is registered as an In-patient in a Hospital for the Medical Services of a Disability and incurs charges thereof. Benefit shall be payable in an amount equal to the actual charges made by the Hospital in respective of providing such service.
11. **Accidental Emergency Out-patient Treatment Expenses**
    If the Insured Person sustains Injury and receives outpatient Medical Services in a Hospital within twenty-four (24) hours of the Accident and incurs charges thereof, the Company will pay for the Reasonable and Customary charges made by the Hospital.
12. **Home Nursing Fee**
    Home Nursing Fee shall be payable when the Insured Person incurs Eligible Expenses for services rendered by a Qualified Nurse in respect of nursing care at the Insured Person's home for such period or periods recommended by a Registered Medical Practitioner after discharged from the Hospital. Benefit shall be payable in an amount equal to the actual charges for such services.
    The coverage provided under this item does not apply to charges for:
    (1) a nursing service provided by more than one nurse during any one consecutive twenty-four (24) hours period;
    (2) any nursing service or Medical Services by physical therapy or any medical check-up by X-ray examination or any other means which are purely for diagnostic purposes;
    (3) nursing service rendered for geriatric, psycho-geriatric or psychiatric condition.
13. **Medical Appliances (Specific Items)**
    If the Insured Person is as an Inpatient during Hospital Confinement, the Company shall reimburse the Eligible Expenses incurred up to the maximum benefit limit specified in the Limit of Indemnity Table of this Policy for the following items:
    (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 intervertebral disc.
14. **Chemotherapy/Radiotherapy/Targeted Therapy/Proton Therapy/Immunotherapy/Hormonal Therapy/Gamma Knife/ Cyber Knife/ Renal Dialysis Treatment Expenses**
    This benefit shall be payable for the Eligible Expenses charged on the Radiotherapy, Chemotherapy, Targeted therapy, Proton therapy, Immunotherapy, Hormonal therapy, Gamma knife and Cyber knife 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 Radiotherapy, Chemotherapy, Targeted therapy, Immunotherapy and Hormonal Therapy.

    If the Insured Person is suffering from chronic and irreversible renal failure, this benefit shall be payable for the Eligible Expenses incurred for hemodialysis for Inpatient a day patient as recommended in writing by Physician.
15. **Cash Allowance for Health Supplement Food**
    Special daily cash allowance benefit shall be payable from the 8th day onward when, upon recommendation of a Registered Medical Practitioner, the Insured Person is confined in a Hospital and requires surgical operation Medical Services of a Disability and incurs charges thereof.
16. **Special Cash Allowance for Public Hospital in Hong Kong**
    Special daily cash benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured Person is registered as an In-patient in a general ward bed only of public Hospital in Hong Kong (Hong Kong Government Hospital, Hospitals under the supervision of Hospital Authority or a subsidized charity Hospital) for the Medical Services of a Disability and incurs charges thereof. In no event shall the benefit be paid in addition to any other benefits payable under this "PART II Section 1 - Basic Benefit item A" with the exception of item A15 (Cash Allowance for Health Supplement Food) for any one Disability.
17. **Compassionate Death Benefit**
    Benefit shall be payable when the Insured Person is confined to a Hospital as a result of Accident and died during the confinement period. In the absence of beneficiary designation, benefit shall be payable to the Insured Person's legal estate.

Annual Overall Limit for benefit under Hospital and Surgical Benefits

If the Insured Person attained the age of seventy-six (76), upon the coming and all other subsequent renewal Policy Years, maximum benefit payable for the sum total of all the benefits items under PART II Section 1 – Basic Benefit item A "Hospital and Surgical Benefits" shall not exceed the Annual Overall Limit as set forth in the Schedule and the "Limit of Indemnity" table of this Policy.

Plan 4 (Medical top-up plan)

This plan can be renewable up to seventy (70) years old only.

Benefit shall be payable when the Insured Person is registered as an In-patient in a Hospital or in a recognized day care centre owned and operated by a Hospital for the Medical Services of a Disability and incurs Eligible Expenses. The Company shall pay the incurred Eligible Expenses which are unsettled by other valid Hospital & Surgical insurance owned by the Insured Person and the Company shall not return the original documents including but not limited to the hospital bills and receipts for any settled claim.

B. <u>Supplementary Major Medical Benefit</u> (This benefit is applicable if so stated in the Schedule)

This benefit provision serves to act as a supplement to "PART II Section 1 - Basic Benefit item A" above and can be renewable up to seventy-five (75) years old only.

When the Insured Person is registered as an In-patient in a Hospital and incurs Medically Necessary expenses, for each particular basic benefit under "PART II Section 1 - Basic Benefit item A", the Company shall pay supplementary major medical benefit in accordance with the percentage as stated in the Schedule and the "Limit of Indemnity" table of this Policy and only in excess of the benefit payable under "PART II Section 1 - Basic Benefit item A". In the event that the actual Hospital charges for daily Room and Board is higher than the benefit provided under "PART II Section 1 - Basic Benefit item A" in this Policy, calculation of claims payment shall be subject to both the percentage as stated in the Limit of Indemnity Table and the proportion of the maximum daily limit covered under this item in this Policy bears to the actual amount of daily Room and Board charged by the Hospital.

The Formula shall be expressed as follows:

{Eligible Expenses x adjustment factor }

x the percentage as stated in the Limit of Indemnity Table

subject to the maximum benefit per any one disability

An adjustment factor shall apply if the Insured Person's average daily room and board charges incurred during such hospitalization is higher than the daily Room and Board Benefit set forth in the Benefit Schedule. All Eligible expenses payable under this Supplementary Major Medical Benefit shall first be multiplied by the adjustment factor and

then multiplying the percentage as stated in the Limit of Indemnity Table

The adjustment factor shall be as follows:

Daily Room & Board Benefit Set forth in the Benefit Schedule ÷ Average daily room and board charges incurred during Hospitalization

This item is not applicable to:

1. Hospital and Surgical treatment outside Mainland China, Hong Kong (China) and Macau (China) except in the case of Accidents or Emergencies occurring Overseas as certified by a Registered Medical Practitioner or the Company has adjusted the premium in accordance with the Place of Residence.
2. PART II Section 1 - Basic Benefit item A sub-item 1-2, 9-16"; and fees for two pre & post surgical care by Surgeon and Chinese Medical Practitioner as stated in first paragraph of PART II Section 1 - Basic Benefit item A sub-item 4; or
3. any charges not covered under Maternity benefit described in "PART II Section 2 - Optional Benefit item F" below.

C. <u>Hospital Cash Benefit</u> (This benefit is applicable if so stated in the Schedule)

This benefit can be renewable up to sixty (60) years old only.

When Sickness or Injury shall cause the Insured Person's Hospital Confinement and provided that such Hospital Confinement shall commence whilst insurance under this Policy is in effect with respect to such Insured Person, the Company will pay the relevant Hospital Cash Benefit for each Day of Hospital Confinement the Insured Person shall be so confined.

Provisions:

1. Benefit shall be payable for each Day of Hospital Confinement only when the Insured Person is under the regular care and attendance of a Physician.
   Benefit shall be payable from the first Day of Hospital Confinement for a period not exceeding the number of days as set forth in the "Limit of Indemnity" table of this Policy as in total for all Hospital Confinements both in and outside Hong Kong consequence upon any one or all Sickness or Injuries together. Hospital Confinement outside Hong Kong will be limited to the number of days as set forth in the "Limit of Indemnity" table of this Policy for each Policy Year.
2. If Hospital Confinement incurs in the Mainland China, Insured Person will only be entitled to half of the amount of the Hospital Cash Benefit.
3. Recurrent Hospital Confinement
   (1) Hospital Confinement of the Insured Person, commencing while insurance under this Policy and/or this benefit cover is in effect with respect to such Insured Person, resulting from causes which are the same as, or related to, the causes of a prior Hospital Confinement for which Hospital cash benefit(s) has been payable and not separated from such prior Hospital Confinement by a period of at least six (6) months, shall be considered a continuation of the prior Hospital Confinement. Such Hospital Confinements shall be considered to have occurred during the same period of Sickness or to have resulted from the same Injury for the purpose of determining the relevant Hospital cash benefit period and the maximum Hospital cash benefit payable under this Policy except as provided in provision 5 below.
   (2) Hospital Confinements separated by a period of six (6) months or more shall be considered to be separated Hospital Confinements and shall not be considered to have occurred during the same period of Sickness or to have resulted from the same Injury for the purpose of determining the relevant Hospital cash benefit period and the maximum Hospital cash benefit payable under this Policy.
   (3) For the purpose of above paragraph (1) to (2) in this provision 3, the six (6) months period shall start counting from the next day following the Insured Person being discharged from Hospital Confinement for which Hospital cash benefit has been payable.
4. Except as provided in "Part VII - Section 1", Hospital cash benefit under this Policy shall be paid in addition to any other insurance benefit to which the Insured Person may be entitled.
5. Notwithstanding the foregoing, in the event of
   (1) Insured Person is confined in the Intensive Care Unit (maximum benefit payable up to ninety (90) days);
   (2) Insured Person has received major organ transplant surgery including heart, heart and lung, liver, pancreas, kidney or bone marrow or first diagnosed with cancer disease in the Hospital;
   (3) Insured Person is suffered from the following defined infectious diseases including malaria, cholera, meningococcal infection, dengue fever, tetanus or atypical pneumonia but not limited to COVID-19 and require Hospital Confinement (maximum benefit payable up to thirty (30) days for each infectious disease);
   (4) Insured Person temporary leaving Hong Kong not exceeding sixty (60) days and require Hospital Confinement during this period (excluding Hospital Confinement in the Mainland China or Macau (China) (maximum benefit payable up to thirty (30) days);
   (5) the Insured Person and insured legal spouse are hospitalised at the same time as a result of the same Accident;

   double Hospital cash benefit will be payable. Double Hospital cash benefit in respect of any one Day of Hospital Confinement shall not exceed twice the Hospital cash benefit and in any case shall not exceed the number of days as set in this benefit in total for all Hospital Confinements in and outside Hong Kong (China).

Section 2 - Optional Benefits (each of the below benefit is operative if so stated in the Schedule)

D. <u>Out-Patient Benefit</u>

Benefit will be payable in accordance with the below provisions if Medically Necessary, the Insured Person requires the below Out-patient Services from Network or Non-network Services Provider.

Out-patient Services includes:

1. General Practitioner Consultation

Registered Medical Practitioner consultations for treatment of covered Disabilities rendered by the Network Services Provider or Non-network Services Provider shall be covered unless otherwise restricted by this Policy. The benefits covered shall include consultations and maximum of three (3) days' prescribed basic medication from the Registered Medical Practitioner for treatment provided that no more than one (1) visit or one (1) call per day is incurred. A Co-payment may be required to be paid to the Provider directly by the Insured Person at the time of treatment.

2. Specialist Consultation

Specialist Fees for treatment of covered Disability rendered by Network Service Provider or Non-network Services Provider which have been referred in advance and in writing by a Registered Medical Practitioner shall be covered provided that no more than one (1) Specialist treatment, visit or consultation per day shall be incurred. The benefits covered shall include consultations and maximum of five (5) days' prescribed basic medication from the Specialist for treatment. A Co-payment may be required to be paid to the Provider directly by the Insured Person at the time of treatment.

3. Chinese Medical Practitioner Consultation

Chinese medical consultation, bone-setting and acupuncture treatment of covered Disability rendered by Network Services Provider or Non-network Services Provider shall be covered unless otherwise restricted by this benefit cover provided that no more than one (1) treatment, visit or consultation per day shall be covered. The benefits covered shall include

consultations and prescribed medicines or drugs from the Chinese Medical Practitioner for treatment. A Co-payment may be required to be paid to the Provider directly by the Insured Person at the time of treatment.

4. **Physiotherapy and Chiropractic Treatment**
   Physiotherapy and chiropractic treatment directly administered by Physiotherapist and / or Chiropractor of covered Disability rendered by Network Services Provider or Non-network Services Provider which have been referred in advance by a Registered Medical Practitioner in writing shall be covered provided that no more than one (1) treatment, visit or consultation per day shall be incurred.
5. **Diagnostic X-ray and Laboratory Tests**
   Diagnostic X-ray and laboratory tests rendered by Network Services Provider or Non-network Services Provider shall be covered when recommended by a Registered Medical Practitioner in writing in respect of a covered Disability. This service shall include X-rays, electrocardiographs (ECG) and simple diagnostic tests.

Provisions:

1. **Network Services Providers**
   (1) The Insured Person may elect for the Network Services Providers to obtain Out-patient Services. Details of the Network Services Providers have been supplied to the Insured Person together with the Policy at the Policy or such cover commencement date.
   (2) It will be the Company's responsibility to pay the fees and charges of the Out-patient Services rendered by the Network Services Provider for the Insured Person. The Insured Person shall be required to pay the Network Services Providers any fee or charge of the Out-patient Services that exceeds the maximum Benefit Limits stated in the Schedule, and the Co-payment.
   (3) The Company shall not be responsible for any fee paid by the Insured Person to the Network Services Providers unless otherwise specified.
   (4) The Company shall issue a Medical Card to the Insured Person. Such Medical Card shall be used solely by the cardholder to identify himself for receiving the Out-patient Services at the Network Services Provider.
   (5) To use Network Service the Insured Person shall
      i. make appointment with the Network Services Provider in advance; and
      ii. present his valid Medical Card to the Network Services Provider upon registration at the place of services; and
      iii. arrange consultations during the Network Services Provider's clinical hours;
   (6) It is recognized and agreed that in the event the Insured Person elects for Network Services, such election is made freely and of the own accord of the Insured Person making the election. No representation whatsoever as to the suitability, availability or ability of the Network Services Provider is made by or may be implied on the part of the Company and the Company shall bear no responsibility or obligation, whether contractual or otherwise, in respect of any services or benefits rendered by, or any act, omission, default or negligence on the part of such Network Services Providers, their servants or agents. It is accepted and agreed by the Insured and/or Insured Person that such Network Services Providers shall be rendering services or benefits as independent contractors and not as servants or agents of the Company.
   (7) Unless otherwise specified, any medication other than basic medication, for example expensive medication including but not limited to certain specific treatments, anti-viral agents, treatment or medication for Chronic Illness , are not covered.
2. **Non-network Services Providers**
   (1) If the Out-patient Services are provided by the Non-network Services Providers, the Insured Person shall pay the fees and charges of the Out-patient Services rendered by the Non-network Services Providers first and shall submit his claim for reimbursement to the Company within ninety (90) days after the date of treatment for the Disability for which the claim is being made.

Definition under this "Optional Benefit D - Out-patient Benefit"

1. **Chiropractor:** means a registered Chiropractor under the "Chiropractors Registration Ordinance" of Hong Kong or duly qualified practitioner of Chiropractor registered as such under the laws of the country in which the claim arises and where the treatment takes place but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
2. **Co-payment:** means a fixed fee or percentage portion of costs (as stated in the Schedule and the "Limit of Indemnity" table of this Policy and as may be varied by the Company from time to time) the Insured Person must contribute towards the cost of medical services received.
3. **Long Term Repeat Medication:** means medication prescribed to the Insured Person required for at least fourteen (14) days period.
4. **Network Doctor Directory:** as case may be, shall contain lists of Network Services Providers. The Company reserves the right to update this directory at its own discretion without prior notice.
5. **Network Services:** means the clinics of the health care services Providers listed in Network Doctor Directory.
6. **Non-network Services:** means the clinics of the health care services Providers not listed in Network Doctor Directory.
7. **Out-patient Services:** means those services listed in PART II Section 2 - Optional Benefits D "Out-patient Benefit" of this Policy.
8. **Physiotherapist:** means a person duly qualified and legally registered as such to practice Physiotherapy treatment in Hong Kong or a duly qualified Physiotherapist registered as such under the laws of the country in which the claim arises and where the treatment takes place but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.
9. **Provider:** means, wherever the content admits, any Doctor, Registered Medical Practitioner, Qualified Nurse, Specialist and Chinese Medical Practitioner as defined under Part 1 - General Definition in this Policy.
10. **Specialized Investigations:** means those X-ray investigations, using contrast media such as Ba Meal, intravenous pyelogram etc. Advanced imaging including but not limited to computerised axial tomography scan, magnetic resonance imagingscan, positron emission tomography scan, investigations involving radioactive substance.
11. **Chronic Illness:** means any diseases and disorders, with or without signs and symptoms, that persists more than three (3) months and which require regular medical attention, including but not limited to
    - AIDS
    - Allergic Rhinitis
    - Alzheimer's Disease
    - Arthritis
    - Asthma
    - Cancer
    - Chronic Bronchitis
    - Chronic Eczema
    - Chronic Hepatitis
    - Coronary Heart Disease
    - Diabetes Mellitus
    - Gout
    - Heart Disease
    - Heart Failure
    - Hyperlipoidema
    - Hypertension
    - Hyperthyroidism
    - Hypothyroidism
    - Mental Illness & Psychiatric Disorder
    - Onychomycosis
    - Parkinson's Disease
    - Psoriasis
    - Renal Failure
    - Systemic Lupus Erythematosus

Exclusions under this "Optional Benefit D - Out-patient Benefit"

Cover will not be provided for any Out-patient Services directly or indirectly caused by or arising from or in connection with

1. any Long Term Repeat Medication;
2. any medication only on request by the Insured Person including but not limited to medication supply for visiting a malarial area;
3. Specialized Investigations;
4. minor surgical procedures;
5. Chronic Illness.

E. Dental Benefit

The Company will reimburse necessary expenses incurred if the Insured Person requires services from the below Dental Benefits**.**

Dental Benefit includes:

1. Intra-oral small film radiograph
2. Scaling, polishing and prophylaxis
3. Fillings or extraction
4. Drainage of abscess
5. Root canal fillings

Definitions under this "Optional Benefit E – Dental Benefit"

1. **Dental Abnormalities or Conditions:** means a dental condition marked by a pathological deviation from the normal healthy state.
2. **Dental Benefit:** means the benefits provided under this benefit item in respect of dental expenses. Such expenses must be incurred by the Insured Person as a result of Injury, Dental Abnormalities or Conditions.
3. **Dentist:** mean a person duly qualified and legally registered as such in Hong Kong and should a claim and dental treatment occur out of Hong Kong, the term shall mean a practitioner of dentistry who is duly registered as such under the laws of the country in which the claim arises and where dental treatment takes place; but excluding the Insured, the Insured Person, relatives or business partners of the Insured and/or the Insured Person.

Exclusions under this "Optional Benefit E – Dental Benefit"

Cover will not be provided for any dental expenses directly or indirectly caused by or arising from or in connection with the following:

1. Filling for cosmetic reasons or non-decayed cases of trauma, erosion, attrition, abrasion and others;
2. Dislodged fillings/replacement not due to decay;
3. Treatment for orthodontics reason.

F. Maternity Benefit

This benefit is applicable for the Insured Person above eighteen (18) years old and can be renewable up to fifty (50) years old only.

Upon receipt by the Company of proof acceptable to the Company that the Insured Person has been confined in a Hospital by reason of Maternity and at the same time this benefit is provided or kept in force, the Company shall pay the following benefits:

1. **Caesarean Section**
   In so far as expenses are incurred for Medically Necessary services, the "Maternity Benefit" payable for Hospital Confinement by reason of Maternity requiring an abdominal cutting operation, such as "Caesarean Section or Extra-Uterine Pregnancy", shall be equal to the actual, Reasonable and Customary charges charged by the Hospital for Room and Board and Hospital Services, and any obstetrician's fee, excluding charges in relation to the newborn.
2. **Normal Delivery**
   For Hospital Confinement by reason of Maternity that do not require an abdominal cutting operation, the "Maternity Benefit" payable shall be equal to the actual, Reasonable and Customary charges charged by the Hospital for Room and Board and Hospital Services, and any obstetrician's fee, excluding charges in relation to the newborn.
3. **Miscarriage**
   In case of any miscarriage, the "Maternity Benefit" payable shall be equal to the actual, Reasonable and Customary charges charged by a Registered Medical Practitioner or Qualified Nurse involved in such miscarriage.

In calculating the amount of benefits payable herein above, all expenses during the pre-natal and post-natal periods relating to the same pregnancy shall be included. If the Insured Person becomes pregnant or gives birth to a Child within nine (9) months from the effective or reinstatement date of this benefit, whichever is the later, no "Maternity Benefit" shall be payable in respect of such pregnancy.

G. Critical Illness Benefit

This benefit is applicable for the Insured Person above eighteen (18) years old and can be renewable up to sixty (60) years old only**.**

Benefit will be payable if upon receipt of due proof and approval, the Insured Person is first diagnosed by a Registered Medical Practitioner as suffering from a Critical Illness. Notwithstanding that the Insured Person may suffer from more than one Critical Illness, the Critical Illness benefit and Systemic Lupus Erythematosus (SLE) will only be paid once in respect of each Insured Person.

Extended Benefits:

1. **Medical Expenses for Critical Illness**
   If the Insured Person incurs Medical Expenses directly and solely resulting from 1) Cancer 2) Stroke or 3) Cardiomyopathy after the first diagnosis of such Critical Illness (if such Critical Illness is not a surgery) or after completion of the surgery constituting such Critical Illness (if such Critical Illness is a surgery), the Company will reimburse the Insured Person for the actual amount paid for the Medical Expenses before PART II Section 1- Basic Benefits, up to the maximum benefit limit specified in the Limit of Indemnity Table of this Policy provided that
   (1) such Critical Illness benefit has been paid or become payable ; and
   (2) the medical expenses are reasonable and Medically Necessary in that they were incurred for services, supplies or Medical Services usually recommended by a Registered Medical Practitioner or Chinese Medical Practitioner, or are customarily received in the area where Medical Services is provided, for such Critical Illness.
2. **Diagnosed with 5 Types of Female Critical Illness or Serious Disease**
   Additional lump sum payment will be granted if an female Insured Person is first diagnosed with "Breast Cancer; Cervix Uteri Cancer; Ovarian Cancer; Uterine Cancer. A lump sum payment will be granted if a female Insured Person is first diagnosed with Systemic Lupus Erythematosus ".
3. **Diagnosed with 5 Types of Male Critical Illness**
   Additional lump sum payment will be granted if a male Insured Person is first diagnosed with "Lung Cancer; Liver Cancer; Colon Cancer; Prostate Cancer or Cardiomyopathy".

Provisions:

1. Critical Illness or Systemic Lupus Erythematosus (SLE) will be payable only if
   (1) the Policy and such covered benefit was in force at the date of onset of such illness; and
   (2) the Insured Person has survived for not less than thirty (30) days following the diagnosis of such illness(not applicable to SLE); and
   (3) the date of onset of such illness occurred before the expiry of the Policy Year at which the Insured Person's age is sixty (60) and such covered benefit was in force.
2. Upon payment under Critical Illness Benefit, including payment for Critical Illness or Systemic Lupus Erythematosus under Extended Benefits, the Company will be relieved from all further liability under this optional benefit "item G." for that Insured Person and such Insured Person's Critical Illness Benefit under this benefit "item G" will be immediately terminated.
3. No benefit is payable for any Critical Illness or Systemic Lupus Erythematosus
   (1) resulting (directly or indirectly) from, or related to, or caused or contributed by (in whole or in part), any of the followings:
      i. AIDS or HIV (except for the benefit defined under Critical Illness – HIV through blood transfusion; or
      ii. any Congenital Conditions; or
      iii. a self-inflicted Injury or attempted suicide while sane or insane; or
      iv. any Pre-existing Condition; or
      v. intoxication by alcohol or drugs not prescribed by a

Registered Medical Practitioner; or

vi. violation or attempted violation of the law or resistance to arrest or participation in any criminal act; or

vii. travel in any aircraft, except as a fare paying passenger in a commercial aircraft.

For the purposes of provision (1) iv. above, Pre-existing Condition means any condition or illness

i. which existed or was existing; or

ii. where its direct cause existed or was existing; or

iii. where the Insured Person had knowledge, signs or symptoms of the condition or illness; or

iv. where any laboratory test or investigation showed the likely presence of the condition or illness prior to the Policy effective date or the effective date of last reinstatement of the Policy, whichever is later.

(2) where the signs or symptoms of which or the diagnosis of which first occurred within the ninety (90) days immediately following the benefit cover effective date or the effective date of last reinstatement of the Policy, whichever is later.

(3) for which the Insured Person has been diagnosed prior to the benefit cover effective date, whether or not the earlier diagnosis is related to such illness giving rise to the claim. For example, no Critical Illness benefit resulting from "Cancer" can be claimed under this Policy and in this covered item if the Insured Person has been diagnosed with any "Cancer" prior to the benefit cover effective date or the last reinstatement date.

Definitions of Critical Illness and SLE

Critical Illness means one of the following:

1. Alzheimer's Disease

Deterioration or loss of intellectual capacity or abnormal behavior as evidenced by the clinical state and accepted standardized questionnaires or tests arising from "Alzheimer's Disease" or irreversible organic degenerative brain disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. The diagnosis must be clinically confirmed by an appropriate consultant.

2. Aplastic Anaemia

Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring Medical Services with at least one of the following:

(1) blood product transfusion;

(2) marrow stimulating agents;

(3) immunosuppressive agents;

(4) bone marrow transplantation.

The diagnosis must be confirmed by a Specialist haematologist.

3. Bacterial Meningitis

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit persisting for at least one hundred and eighty-three (183) days. The diagnosis must be confirmed by a Specialist neurologist.

4. Benign Brain Tumor

A non-cancerous tumor in the brain which either requires surgical excision or causes significant permanent neurological deficit persisting for at least one hundred and eighty-three (183) consecutive days. Cysts, granulomas, malformations in, or of the arteries or veins of the brain, haematomas and tumors in the pituitary gland or spine are not covered.

5. Blindness

The total and irrecoverable loss of sight of both eyes due to traumatic Injury or disease. The diagnosis must be clinically confirmed by a Specialist ophthalmologist.

6. Brain Damage

Irrecoverable impairment or total loss of intellectual capacity as a result of brain damage sustained in an Accident, such that permanent supervision or assistance is required to maintain survival.

7. Cancer

Cancer is the presence of uncontrolled growth and spread of malignant cells and invasion of tissue.

Incontrovertible evidence of the invasion of tissue of definite histology of a malignant growth must be produced. The term "cancer" also includes leukemia, lymphomas and "Hodgkin's disease".

Excluded are non-invasive carcinomas in situ, any skin cancer except malignant melanomas, localized non-invasive tumors showing only early malignant changes and tumors in the presence of any Human-immunodeficiency virus.

8. Cardiomyopathy

Condition of impaired ventricular function (of variable aetiology) resulting in permanent and irreversible physical impairment of at least "Class IV" on the "New York Heart Association (NYHA)" classification of cardiac impairment. The diagnosis of cardiomyopathy must be confirmed by a Specialist cardiologist. Cardiomyopathy includes dilated, hypertrophic and restrictive cardiomyopathy. Cardiomyopathy secondary to alcohol or drug abuse is excluded.

9. Coma

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

10. Coronary Artery Bypass Grafting

Open heart surgery to correct narrowing or blockage of two or more coronary arteries by the use of saphenous veingrafts or internal mammary grafting, but excluding all non-surgical procedures such as balloon angioplasty or lasertechniques. Angiographic evidence of the underlying disease must be provided.

11. Elephantiasis

The result and complication of filariasis, characterized by massive swelling in the tissues of obstructed circulation in lymphatic vessels. Unequivocal diagnosis of elephantiasis must be clinically confirmed by an appropriate Specialist including laboratory confirmation of microfilaria. The benefit does not cover "Lymphedema" caused by infection with a sexually transmitted disease, trauma, postoperative scarring congestive heart failure, or congenital lymphatic system abnormalities.

12. Encephalitis

Severe inflammation of brain substance which results in significant and permanent neurological deficit persisting for at least one hundred and eighty-three (183) days as certified by a Specialist neurologist.

13. End Stage Lung Disease

Either of the following conditions must be fulfilled

(1) all of the following

- proof of necessary and permanent oxygen therapy for at least 8 hours/day and
- "FEV1" test results of less than 1 litre

or

(2) all of the following

- "FEV1" test results of less than 1 litre and
- increase of resistance in the respiratory tracts to at least "0.5 kPa/l/s" and
- residual volume greater than 60% of "TLC (total lung capacity)" and
- increase of the intrathoracic gas volume to more than 170 (in percentage of the basic value).

14. Fulminant Viral Hepatitis

A submassive to massive necrosis of the liver caused by the hepatitis virus, leading precipitously to liver failure excluding alcohol and drug abuse as certified by a Registered Medical Practitioner. The diagnostic criteria to be 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;

(4) deepening jaundice.

15. Heart Attack

Heart attack is the death of a portion of the heart muscle as a result of abrupt interruption of adequate blood supply to the area. The diagnosis should be based upon all of the following criteria:

(1) a history of typical chest pain,

(2) new electrocardiographic changes characteristic of myocardial infarction;

(3) an elevation in cardiac enzyme levels.

16. Heart Valve Replacement

The actual undergoing of the replacement of one or more heart valves with artificial valves due to stenosis or incompetence. Heart valve repair and valvotomy are specifically excluded.

17. HIV Through Blood Transfusion

The Insured Person being infected by "Human Immunodeficiency Virus" provided that:

(1) the infection is due to a blood transfusion received after the effective or the reinstatement date of this benefit, whichever is later; and

(2) the institution which provided the transfusion admits liability or there is a final court verdict that cannot be appealed indicating such liability; and

(3) the infected Insured Person is not a haemophiliac.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus.

18. Kidney Failure

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 having had renal transplantation.

19. Liver Failure

End stage liver failure with permanent jaundice that in general medical opinion will not improve in future and resulting in either ascites and encephalopathy.

20. Loss of Hearing

Total and irreversible loss of hearing for all sounds as a result of traumatic Injury or disease. Medical evidence is to be supplied by a Specialist otohinolaryngologist and to include audiometric and sound-threshold test.

21. Loss of Independent Existence

Confirmation by a consultant Physician of the loss of independent existence, resulting in a permanent inability to perform any three (3) of the Activities of Daily Living. Activities of Daily Living are defined as:

(1) Dressing – the ability to put on and take off clothing without assistance;

(2) Toileting – the ability to use the toilet, including getting on and off without assistance;

(3) Mobility – the ability to get in and out of bed and a chair without assistance;

(4) Continence – the ability to control bowel and bladder function;

(5) Feeding – the ability to get food from a plate into the mouth without assistance;

(6) Bathing and showering – the ability to bathe and shower without assistance.

22. Loss of Limbs

The irreversible severance from the body of two or more limbs where severance is above the knee or elbow.

23. Loss of Speech

Total and irrecoverable loss of the ability to speak which must be established for a continuous period for three hundred and sixty-five (365) days. Medical evidence is to be supplied by a Specialist otohinolaryngologist and to confirm Injury or disease to the vocal chords. All psychiatric related causes are excluded.

24. Major Burns

Third degree burns resulting in full thickness skin destruction of at least 20% of the total skin area.

25. Major Organ Transplant

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

26. Motor Neurone Disease

Unequivocal diagnosis of "Motor Neurone Disease" by a Specialist neurologist supported by definitive evidence of appropriate and relevant neurological signs.

27. Multiple Sclerosis

Unequivocal diagnosis by a Specialist neurologist and confirmed by image scanning investigation indicating more than one episode of well-defined neurological symptoms with persistent signs of involvement of the optic nerves, brain stem and spinal cord together with impairment of coordination and motor and sensory function.

28. Muscular Dystrophy

The diagnosis of muscular dystrophy will require confirmation by a Specialist neurologist and will have to be based on all of the following

(1) family history of other affected individuals;

(2) clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid, mild tendon reflex reduction;

(3) characteristic electromyogram;

(4) clinical suspicion confirmed by muscle biopsy and which in the opinion of the Company confirms the diagnosis of muscular dystrophy;

(5) results in the inability of the Insured Person to perform without assistance three (3) or more Activities of Daily Living (same definitions applies as in the above item 21).

29. Paraplegia/Paralysis

The complete and permanent loss of use of two or more limbs through paralysis.

30. Parkinson's Disease

Unequivocal diagnosis of "Parkinson's Disease" by a Specialist neurologist where the condition

(1) cannot be controlled with medication;

(2) shows signs of progressive impairment;

(3) results in the inability of the Insured Person to perform without assistance three (3) or more Activities of Daily Living (same definitions applies as in the above item 21).

Only idiopathic "Parkinson's Disease" is covered. Drug-induced or toxic causes of "Parkinsonism" are excluded.

31. Poliomyelitis

Unequivocal diagnosis by a Specialist neurologist of infection by the polio virus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. Cases not involving paralysis will not be eligible for benefit. Other causes of paralysis are specifically excluded.

32. Progressive Bulbar Palsy

Degenerative wasting of the muscles including the bulbar muscles as diagnosed by a Specialist neurologist.

33. Primary Pulmonary Arterial Hypertension

Primary pulmonary arterial hypertension as established by clinical and laboratory investigations including cardiac catheterization and as diagnosed by a cardiology Specialist. The following diagnostic criteria must be met

(1) dyspnoea and fatigue;

(2) increase in left atrial pressure (by at least 20 units);

(3) pulmonary resistance of at least three units above normal;

(4) pulmonary artery pressures 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;

(7) right ventricular hypertrophy, dilation and signs of right heart failure and decompensation.

34. Severe Rheumatoid Arthritis

Widespread joint destruction with major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, cervical spine, knees, ankles, metatarsophalangeal joints in the feet. The Insured Person is then completely unable to engage in any gainful occupation or employment for the remainder of his life. Diagnosis should be confirmed by Specialist rheumatologist with evidence of the following:

(1) morning stiffness in and around joints lasting at least 1 hour before maximal improvement;

(2) symmetric arthritis;

(3) subcutaneous rheumatoid nodules observed by a Physician;

(4) serum rheumatoid factor positive;

(5) radiographic changes of erosions or unequivocal bony decalcification localized in or most marked adjacent to the involved joints.

35. Stroke

Any cerebrovascular incident (or Accident) producing neurological sequelae lasting more than 24 hours and permanent neurological deficit as confirmed by Specialist neurologist, including:

(1) infarction of brain tissue,

(2) haemorrhage from an intracranial vessel and

(3) embolisation from an extracranial source.

36. Surgery To Aorta

The actual undergoing of open heart surgery for 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.

37. Terminal Illness

The Insured Person must be suffering from a disease which in the opinion of a medical Specialist and supported by a Registered Medical Practitioner specified by us, is likely to lead to death within three hundred and sixty-five (365) days from the date of notification.

38. Total And Permanent Disability

After twelve (12) calendar months of continuous total disability which has resulted from Accidental Injury or Sickness the Insured Person is completely unable to engage in any gainful occupation or employment for the remainder of his life.

39. Tuberculous Meningitis

Inflammation of the membranes of the brain or spinal cord by "TB" infection resulting in significant neurological deficit which leads to the permanent inability to perform at least three (3) out of the six (6) Activities of Daily Living (same definitions applies as in the above item 21) without the assistance of another person.

40. Vegetative State (persistent)

A clinical state of unconsciousness with no cerebral cortical function, no reaction or response to external stimuli or internal needs, but with remaining function of the brainstem, persisting continuously with the use of life support system for a period of at least thirty (30) days. Permanent neurological deficit, as certified by a Specialist neurologist, must be present.

Systemic Lupus Erythematosus (SLE) means:

An chronic autoimmune illness in which tissues and cells are damaged by deposition of pathogenic and autoantibodies immune complexes.

The diagnosis of SLE will be based on the following conditions:

(1) There must be at least four (4) out of the following clinical presentations:
   a. Maral rash or discoid rash or photosensitivity;
   b. Pericarditis, or pleuritis;
   c. Kidney disorder with proteinuria and other specific urine abnormalities;
   d. Neurologic disorder with seizures or psychosis;
   e. Blood disorder, including hemolytic anemia or leucopenia or thrombocytopenia or lymphopenia;

AND

(2) Immune disorder confirmed by blood tests which include at least three (3) of the followings:
   a. Positive anti-DNA test;
   b. Positive anti-SM antibody Test;
   c. Positive anti-ds DNA Test;
   d. Positive anti-ENA Test;
   e. Positive ANA Test.

The Company reserves the right to change any definition of a Critical Illness or Systemic Lupus Erythematosus as found in the above from time to time to reflect advancement in medical technology associated with the diagnosis or Medical Services of that illness.

PART III – GENERAL EXCLUSIONS

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

1. expenses payable under PART II that are recoverable from a third party including but not limited to medical services rendered or compensation in connection with any Injury or Disability claimable under Employees' Compensation Ordinance, Cap. 282, or any amendments thereto.
2. expense covered by any other existing insurance; or directly or indirectly arising from health care services provided by Government facilities or by Medical Practitioners employed by Government facilities except for the statutory charges required to be paid for treatment.
3. any claims in respect of expenses incurred for organ tissue, cornea, artificial organ, or organ transplant or bone marrow transplant, or services or supplies which are experimental or investigative in nature, including the treatment procedure, facility, equipment, drugs, drug usage, devices or supplies which have not been recognized as accepted medical practice shall not be covered. Without prejudice to the generality of the foregoing, treatments that have not been proven to be safe, scientifically established therapies or found to have a demonstrable benefit for a particular Sickness shall not be covered.
4. cosmetic or plastic surgery or any treatment solely for the purpose of beautification.
5. dental oral or oro-surgical care and treatment of any kind including orthodontic, endodontic, and periodontic services; and restorative services such as bonding, crowns, bridges, spacing devices, and dentures (except covered in PART II Section 2 - Optional Benefit "E. Dental" of this Policy and as specified in the Schedule). The only services related to dental treatment which shall be covered under this Policy are
   (1) medical care immediately following an Accident which causes Injury to the mouth and teeth, any following treatment thereof shall not be covered;
   (2) oral surgery when properly referred for reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant neoplasm of the jaw;
6. eye or hearing tests, eyesight correction treatment (save and except where the medical treatment is directly caused by an Accident); fitting of glasses or contact lenses, procurement or use of special braces including but not limited to stent, pacemaker, appliances, hearing aids, wheelchairs, crutches, artificial limb or any other similar equipment costs (except as otherwise provided in PART II Section 1 - Basic Benefits item A13 "Medical Appliances (Specific Items)";
7. any Room and Board, companion, special nursing, extended bed (except as provided in PART II), non medical related personal services or any other special expenses which are not directly necessitated by the diagnosed treatment including but not limited to vitamins, antibacterial soaps and detergents, allergenic extracts, nutrient herbs or tonic (including but not limited to Birds' Nest, Ginseng and Lingzhi) or pre-packaged commercial health supplement;
8. Congenital Conditions, heredity condition, developmental condition, Pre-existing Medical Conditions or any complications arising therefrom;
9. expenses directly or indirectly arising from venereal diseases or Human Immunodeficiency Virus (HIV) related disease, including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutation, derivations or variations thereof, which proceeds from an HIV infection occurring prior to the effective date of the benefit cover. For purposes of this exclusion, an HIV related disease emerging within five (5) years of the benefit cover effective date will be conclusively presumed to proceed from an HIV infection occurring prior to the effective date of coverage, in the absence of clear and convincing evidence to the contrary;
10. Maternity, pregnancy, childbirth (including diagnostic tests for pregnancy, sex determination or and surgical delivery), miscarriage, abortion and pre-natal or post-natal care, surgical mechanical or chemical contraceptive methods of birth control or treatment pertaining to infertility or in-vitro fertilization, or sterilization or any complications arising therefrom or all related treatments (except as covered in PART II Section 2 - Optional Benefit F "Maternity Benefit" in this Policy and as specified in the Schedule);
11. female hormonal tests or assays and female hormonal replacement therapy unless resulting from a disease, routine or general check ups or routine blood tests, health examinations, check ups or tests not incidental to treatment or diagnosis of a covered Sickness or Injury, inoculation, medication or vaccination for immunization or quarantine purposes, rehabilitation treatment convalescent treatment;
12. all Hospital expenses incurred primarily for investigations (such as diagnostic scanning, X-ray examinations, laboratory tests, etc.) and/or physical therapy;
13. charges for accommodation and nursing in any establishment, which for any reason is or has effectively become the place of domicile or permanent abode;
14. treatment for mental illness and emotional disorders including treatment directly or indirectly arising from any insanity,

geriatric, psychyco-geriatric or psychiatric condition including but not confined to psychoses, neuroses, depression of any kind, anxiety, anorexia nervosa, bulimia, schizophrenia, Insomnia or other behavioral disorders, etc;

15. Sickness or Injury directly or indirectly resulting from or consequent upon:
    (1) medicines and drugs which are not consumed in a Hospital or prescribed by a Doctor;
    (2) contraceptives or contraceptive devices, vaccines, appetite stimulants or depressants, unless specifically covered;
    (3) prescription drugs used in connection with drug addiction, alcoholism, weight reduction, smoking cessation and treatment of baldness and experimental drugs;
    (4) venereal diseases or willful misuse of drugs or alcohol, attempted suicide or intentional self-inflicted injury or participating in an illegal activity, attempted or committed any unlawful or illegal act or having more than the legally permitted level of alcohol in the blood whilst driving any kind of vehicle;
    (5) high risk activities or occupations:
        i. engaging in or taking part in disciplinary, naval, military or air force service or operations;
        ii. engaging in or practicing in or taking part in training peculiar to: aqualung diving, rafting; mountaineering, rock-climbing, or trekking necessitating the use of ropes or guides; potholing, parachuting, bungee jumping, hang-gliding, stunts or daring feats; skiing, tobogganing, sledding and ice skating, including ice hockey and other sports requiring snow or ice for play; professional sports such as car racing, horse racing; motor cycling; engaging in aviation other than as a fare-paying passenger in an aircraft provided by and operated by an airline or air charter company which is duly licensed for the regular transportation of fare-paying;
    (6) war or any act of war, declared or undeclared, invasion, act of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military or usurped power or act of terrorism, strike, riot, engaging military force;
    (7) nuclear radioactive contamination;
16. Sickness or Injury contracted during any journey taken by the Insured Person which is
    (1) against the advice of a Physician;
    (2) for the purpose of or in connection with emigration or studying Overseas;
    (3) for the purpose of or in connection with obtaining or seeking any medical advice or surgical treatment outside Hong Kong;
17. all inguinal hernias and all hydroceles (or their complications) presenting from birth to the age of 15 years;
18. trans-sexual surgery, circumcision unless Medically Necessary, occupational therapy and speech therapy services; hospice service;
19. alternative treatment including but not limited to acupressure, Tui Nai, massage therapy, naturopathy, hydropathy, chiropractic, podiatry, biofeedback, hypnosis, pain clinics, homeopathy, ear reflexology, moxibustion, cupping and scraping unless otherwise specified;
20. treatment arising from sexual dysfunction including but not limited to impotence, erectile dysfunction, pre-mature ejaculation, regardless of cause;
21. Sickness and/or Hospital Confinement commences during sixty (60) days from the reinstatement date of the Insured Plan, except Hospital Confinement due to Accident and / or Injury.

PART IV – PREMIUM

1. This Policy shall become effective after the Insured has paid the premium.
2. Premiums for each Insured Person is based upon the attained age on the effective date of this Policy and the first (1st) day of each subsequent renewal Policy Year.
3. All advanced premium is not refundable unless the Policy is cancelled within the fifteen (15) days waiting period of the receipt of the Policy and no claim has arisen or paid during the period.
4. Premium shall be paid in accordance with the amount stated in the Schedule, endorsement and any memoranda and shall be paid on the commencement date of this Policy and upon the Policy expiry date of each subsequent Policy Year for premium settled in each year.
5. If change of premium payment mode is required, the Insured shall give notice in writing to the Company at least thirty (30) days before the coming Policy year's expiry date and such changes shall become effective only on the first (1st) day of the earliest coming renewal Policy Year.
6. Except for the first year's premium, the Company will provide the Insured one (1) month (not exceeding 31 days) grace period for premium payment for each renewal Policy Year. If the required renewal premium is paid by the Insured within the grace period, this Policy shall continue to be in effect. If payment is not made within the grace period, this Policy shall become invalid from the Policy expiry date that provides for the said grace period.
7. The Company reserves the right to adjust premium, Maximum Limit of Indemnity and/or Terms of this Policy in respect of like categories of Insured Person(s), such as age or health conditions for all the Insured Plans in the "BOC Medical Comprehensive Protection Plan (Series 1) Policy". The rates or premiums and any rates of premium discounts or surcharges shall be prescribed from time to time by the Company.

PART V – RENEWAL

Subject to Part IV of this Policy,

1. payment of the required renewal premium by the Insured upon each renewal Policy Year for payment made in each year, will continue this Policy to be in force until the expiry date of that Policy Year.
2. this Policy will be automatically renewed upon premium payment by the Insured unless written notice of changes in Policy terms and conditions or cancellation has been given by the Company prior to the renewal date of the Policy Year.
3. Subject to item 7 of Part IV of this Policy, Hospital and Surgical, Out-patient and Dental benefits are guaranteed renewable for lifetime. Regardless of the Insured Person's health or claims condition, the Company shall not impose any additional premium or terms on the Insured Person after the inception date of the cover.
4. the Company reserves the right to cease offering this plan, revise the benefits, premiums and other terms and conditions of this Policy upon expiry date of the anniversary renewal. If the Company decides to cease offering this plan, the Company shall provide alternative insurance option to the Insured Person at the same time.
5. Revision of Benefit Structure
   The Company reserves the right to revise the benefit structure under this Policy. The Company shall give the Policyholder a written notice no less than thirty (30) days prior to the end of a Period of Insurance of such revision specifying the revised Schedule and the Limit of Indemnity Table, the new premium and its effective date. The revised Schedule and the Limit of Indemnity Table and new premium shall take effect on the date specified unless the Policyholder declines in writing in which case this Policy shall automatically terminate on the next premium due date following the date of such written notification. Following each revision, an endorsement shall be issued together with the revised Schedule and the Limit of Indemnity Table.

PART VI – NO CLAIM RENEWAL PREMIUM DISCOUNT

15% premium discount on Part II Section 1 - Basic Benefit will be offered to each Insured Person at renewal provided no claim is payable within the three (3) consecutive years immediately preceding the renewed Policy Year.

If during any of the above renewal period a claim arise or will be payable to one of the Insured Person, all accumulating total "no claim renewal premium discount" for that Insured Person will be cancelled and will restart the accumulation from the first (1st) day of the coming renewal Policy Year and all other Insured Person's no claim renewal discount entitlement will not be affected.

In the event of receiving valid claim documents which falls within the period where "no claim renewal premium discount" has been payable, the Insured shall return the full amount of the discounted premium to the Company. If the Insured fails to comply, the Company shall have the right to delay the claim payment or deduct the full amount of the discounted premium from the amount of the claim.

PART VII – DUPLICATE APPLICATION, COMMENCEMENT DATE, ADDITIONS AND TERMINATION

Section 1 – Duplicate Application

The Insured Person shall not be covered under more than one "BOC Medical Comprehensive Protection Plan (Series 1) Policy" issued by the Company. In the event that the Insured Person is covered under more than one such Policy, the Company will consider that person to be insured under the Policy that provides the greatest amount of benefit. Where the benefit under each such Policy is identical, the Company will consider that person to be insured under the Policy first issued. The Company will refund any duplicated insurance premium payment that may have been made by or on behalf of that person and the duplicated Policy shall be void in respect of such particular Insured Person.

Section 2 - Policy Commencement Date

This Policy shall become effective and commence on the date specified in the Schedule.

Section 3 – Additions

1. If there is only one Insured Person covered under this Policy, the Insured may include himself or legal spouse and/or Child by submitting a written application to the Company thirty (30) days before next renewal Policy Year, specifying the name, sex and age and health conditions of the additional person(s) to be insured.
2. Subject to the approval by the Company with a duly signed endorsement, insurance for such additional Insured Person(s) will only become effective and commence on the first (1st) day of the earliest coming renewal Policy Year and thereby the relevant additional premium will be charged to the Insured.

Section 4 – Termination

1. Termination by the Insured

(1) If thirty (30) days before the coming Policy Year's expiry date the Insured gives written notice to terminate this Policy or one of the Insured Persons in this Policy, such termination shall become effective upon the expiry of that Policy Year. Full annual premium shall be collected and no refund shall be made.

(2) If the Insured gives written notice to terminate this Policy or one of the Insured Persons in this Policy, such termination shall become effective upon the coming Policy Year's expiry date or the date of the Company's receipt of the relevant notice, whichever is earlier. Full annual premium shall be collected and no refund shall be made.

(3) If the Insured Person is covered under "Insured Plan 4 - Medical Top-up Plan" and gives written notice to terminate this Policy for reason of termination of service with his Company, such termination shall become effective on the date of the Company's receipt of the relevant notice or the date specified in the notice, whichever is later.

If any claim has arisen or paid under "Part II Section 1 – Basic Benefit" of this Policy during the Policy Year, the Insured is required to pay 100% of annual premium as the minimum premium required by the Company.

In the event premium has been paid for any period beyond the Policy cancellation date and provided no claim has arisen or paid under this Policy during the Policy Year, the Insured shall be entitled to the following refund of premium:

Period covered (not exceeding)	Premium refund
4 months	50%
5 months	40%
6 months	30%
7 months	20%
8 months	20%
Over 8 months	0%

2. Termination by the Company

(1) The Company shall be entitled at any time to terminate this Policy, or to subject this Policy to different terms, if the Insured Person has at any time failed to observe the Terms of this Policy or failed to act with utmost good faith. The Company may terminate this Policy by giving seven (7) days notice in writing to the Insured and such notice shall be delivered to the Insured or sent by letter to the Insured at his last known address and such cancellation shall become effective from the seventh (7th) day after such notice has been issued for payment made in each year. For payment made in each year, the Insured shall be entitled to the return of a proportionate part of the premium (in accordance with the refund table shown in Section 4 – Termination item 1(3) above) for the unexpired period of coverage provided no claim has arisen or paid under the Policy during the Policy Year.

(2) This Policy shall terminate forthwith upon the death of the Insured Person. Benefit for any Insured Person under the Policy shall terminate forthwith upon the death of that Insured Person without affecting benefit for other Insured Person under the Policy. For payment made in each year, the Insured shall be entitled to the return of a proportionate part of the premium (in accordance with the refund table shown in Section 4 – Termination item 1(3) above) for the unexpired period of coverage provided no claim has arisen or paid under the Policy during the Policy Year.

(3) Provided one or more premiums charged to the Insured's nominated account have been paid, non-payment of any subsequent premiums shall terminate insurance under this Policy as from that Policy expiry date. Full annual premium for the Policy Year shall be collected from the Insured and no refund shall be made.

PART VIII – CHANGE INSURED PLAN

1. Thirty (30) days before the expiry date of each Policy Year, the Insured can give written notice to the Company for change of Insured Plan. Subject to the approval by the Company, the new Insured Plan and premium will be effective only on the first (1st) day of the earliest coming renewal Policy Year.
2. If such Insured Person(s) shall have been afflicted with a covered Sickness or Injury before the said written notice was received by the Company the benefits payable in respect of such Sickness or Injury shall not exceed the limit(s) or maximum(s) of benefits, whichever is lower, applicable prior to the date the written notice was received by the Company.
3. If the Insured Person covered under Plan 4 "Medical top-up plan" gives a written notice for policy termination within the policy period due to the cancellation of Company Medical insurance, he/she will be entitled to the refund of the paid annual premium on a designated percentage upon submission of the documentary proof. Besides, the Insured Person can request to convert his/her Insured Plan 1, 2 or 3 (if Plan 3 is selected, Insured Person should submit the documentary proof showing that his/her previous company medical insurance coverage is equivalent to or better than that of Plan 3 before the conversion). The Company would charge the new Insured Plan premium on daily pro-rata basis by the number of insured day.

PART IX – CHANGE OF RISK

During the period of insurance, the Insured shall give immediate notice in writing to the Company of any change of risk of the

Insured Person (including change of identity of the residence, the occupation, Place of Residence, etc) which may prejudice the insurance cover. The Company reserves the right to adjust the premium for any period, whether past or future, affected by such change of risk. Accordingly, the Insured shall pay any additional premium as required. The Company reserves the right in the Company's sole and absolute discretion to treat this Policy (including any attached endorsement and supplement) as termination from the inception date of the change of risk. The Company will not refund any premiums paid and reserves right to require repayment of the paid claims. If the change of risk is only found at any claims stage without prior declaration, no claim will be paid.

PART X – CONDITIONS FOR THE USE OF THE MEDICAL CARD

1. **Use of Medical Card**
   In all matters concerning the use of Medical Card, the Company shall deal solely with the Insured and not with individual Insured Person. The Insured shall be fully responsible for controlling and monitoring the use of the Medical Card by the Insured Person in accordance with the provisions of this Policy.
2. **Cancellation, termination or non-renewal of Policy**
   If, for any reason, this Policy and the Out-patient benefit cover is cancelled, terminated or not renewed, the Insured shall collect all Medical Cards issued to all the Insured Person and return immediately the same to the Company from the date of such cancellation or termination. The Insured shall indemnify the Company against all claims, losses, damages, actions, proceedings, costs and expenses which may be brought against the Company or incurred by the Company arising from the use of those Medical Card whilst this Policy and the Out-patient benefit cover is no longer in force, whether or not the Insured ultimately returns all the Medical Cards to the Company. This clause shall survive termination or cancellation of this Policy.
3. **Termination of coverage**
   In the event of the coverage of the Insured Person under this Policy shall be terminated or cancelled for any reason, the Insured agrees to obtain the Medical Card from that Insured Person and the Medical Card will be returned immediately to the Company from the date of termination or cancellation. Should a former Insured Person use the Medical Card to obtain benefits after termination or cancellation, the Insured will be liable to reimburse in full the amount paid by the Company whether or not the Medical Card shall have been subsequently returned to the Company. This clause shall survive termination or cancellation of this Policy.
4. **Claims disputes**
   Should any medical expenses or claim arising from the use of the Medical Card be the subject of a dispute the Insured agrees to immediately reimburse the amount already paid by the Company pending the decision as to whether those medical expenses are payable under the terms of this Policy. This clause shall survive termination or cancellation of this Policy.
5. **Cost exceeding benefits**
   In the event of the costs incurred by any Insured Person using the Medical Card exceeding the benefit payable in respect of that Insured Person, the Insured agrees to reimburse the Company immediately the charge back amount upon receipt the payment notice for any difference or shortfall. This clause shall survive termination or cancellation of this Policy.
6. **Ineligible Treatment**
   If any Insured Person uses the Medical Card for treatment that is not eligible for a benefit under the terms of this Policy, the Insured shall reimburse the Company in full for the costs of such ineligible treatment. This clause shall survive termination or cancellation of this Policy.
7. **Replacement Medical Card charge**
   A charge will be levied for each replacement Medical Card issued and shown on the Medical Card. The Company reserves the right to revise the replacement charge at its sole discretion without prior notice. In the event of Medical Card replacement, the Insured should complete the "Replacement Cards" form and return to the Company and such form shall be provided by the Company upon request.
8. **Theft or loss of Medical Card**
   In the event of loss or theft of the Medical Card, the Insured agrees to notify the Company in writing immediately from the date of such loss or theft of the full details thereof. The Insured is fully responsible for any transactions involving use of a lost or stolen Medical Card issued to any Insured Person until such theft or loss is reported by submitting a written notice to the Company.
9. **Withdrawal of Medical Cards**
   The Company reserves the right to withdraw the use of any or all Medical Cards at any time without prior notice. Any and all such Medical Cards issued under this Policy shall at all times remain the absolute and sole property of the Company.
10. **Outstanding charge back amount**
    Upon receipt of written notice from the Company, the Insured shall reimburse the Company immediately for any outstanding charge back amount shown on the notice. The Company reserves the right to charge the Insured interest at the prevailing prime interest rate per month on any amounts which remain not reimbursed to the Company from the thirty (30) days following the receipt of the written notice from the Company advising any amounts due.
11. **Withhold claims payment**
    The Company reserves the right to withhold claims payment and any medical services provided by Non-network Services Provider to Insured Person at any time by giving an advance notice in writing to the Insured if outstanding charge back amount remain not reimbursed to the Company.

PART XI – GENERAL CONDITIONS

1. **Interpretation**
   This Policy and the Schedule, memoranda and endorsements hereto shall be read together and any word or expression to which a specific meaning has been attached in any part of the Policy, Schedule, memoranda or endorsements hereto shall bear such meaning wherever it may appear. Should there be any discrepancy between the Chinese and English versions, the English version shall prevail.
2. **Consideration**
   This Policy is issued in consideration of the declaration contained in the proposal form and the Insured's payment of premium when due.
3. **Geographical Limits**
   Benefits provided under Part II of this Policy are applicable worldwide subject to the following limitations as appropriate:
   (1) Supplementary Major Medical Benefit: limited to Medical Services incurred solely as the result of an Accident or Emergency situation occurring Overseas;
   (2) Hospital Cash Benefit: limited to ninety (90) Day of Hospital Confinement per Policy Year;
   (3) Out-patient Benefit: limited to Plan 3.
4. **Terms and Conditions**
   All claims payment under this Policy is subject to all definitions, terms and conditions of this Policy.
5. **Non-contribution Clause**
   This Policy is not to be called upon in contribution and is only to pay any expenses under "PART II – INSURED BENEFITS" to the relevant Insured Person if and so far as not recoverable under any other insurance. In the event that a benefit covered or payable under any other contract or plan and/or extension benefits provisions is less than the amount payable under this Policy, the Company will only be liable to pay benefits in an amount equal to the difference between the amount covered or payable under this Policy and that other contract or plan. A copy of all such other contract(s) or plan(s) and, if applicable, the extension benefits provisions shall be provided by the Insured to the Company.
6. **Entire Contract and Changes**
   This Policy, including the Schedule, endorsements, "the Classification Schedule", appendix and amendments (if any), will constitute the entire contract between the parties. Any change in this Policy is not valid unless evidenced by the Company's endorsement or amendment.
   The Company reserves the right to underwrite, amend the

terms and/or adjust the premium and maximum limit for coverage under this policy.

7. Right to Return Policy

In the event the Insured is not satisfied with this Policy for whatsoever reason, the full set of Policy including the Medical Card should be returned to the Company within fifteen (15) days from the effective date of this Policy. If no claim has been made or paid during this period, all premium paid to the Company will be refunded. In such event, this Policy shall be deemed to have been void from the effective date of this Policy and the Company shall not be liable to pay any benefit.

8. Misrepresentation or Fraud

The information and declaration made by the Insured and/or Insured Person in the proposal form and the information contained in the endorsement (if any) have formed the basis of this Policy. Any misrepresentation or untrue information will render this Policy void ab initio. Any fraudulent act concerning any claim shall entitle the Company to repudiate liability under this Policy.

9. Subrogation

The Company has the right to proceed at its own expense in the name of the Insured Person against third parties who may be responsible for an occurrence give rise to a claim under this Policy.

10. Notice of Claim (not applicable to PART II Section 2 - Optional Benefits D and E "Out-patient and Dental Benefits")

It is a condition precedent to the Company's liability that written notice of claim must be given to the Company by or on behalf of the Insured within fourteen (14) days from the commencement of Hospital Confinement or the date of which the Critical Illness is diagnosed. Notice given by or on behalf of the Insured to the Company with information sufficient to identify the Insured Person shall be deemed valid notice.

Failure to give notice in the time prescribed shall not invalidate a claim if it can be shown to the Company's satisfaction that notice had been provided as soon as reasonably practicable, and in any event within sixty (60) days from date of commencement of such Hospital Confinement.

11. Physical Examination

The Company at its own expense shall have the right and opportunity to examine the Insured Person when and so often as it may reasonably require pending the outcome of a claim under this Policy.

12. Claims Procedure

(1) Applicable to PART II except Section 2 - Optional Benefit D and E "Out-patient and Dental Benefits"

When Sickness or Injury shall cause any Insured Person's Hospital Confinement, the Insured Person or his personal representative shall complete the following forms and provide the relevant supporting documents and proof of loss receipts to the Company no later than thirty (30) days from the discharge date of the Hospital or the date of which the Critical Illness is diagnosed.

i. Hospitalisation & surgical or Critical Illness claim form; and
ii. "Attending Physician's Statement"; and
iii. All original copy of Hospital receipts and itemized Hospital charges; and
iv. Death certificate and coroner's report (only applicable to Compassionate Death Benefit).

Failure to provide the above documents will entitle the Company to reject the claim. If the Insured Person or his personal representative is unable to provide the "Attending Physician's Statement" as stated in item (ii) above, the Company can assist to collect such information provided that the expenses in relation to such provision is to be borne by the Insured or his personal representative and the Company is being authorized by the Insured Person or his personal representative to do so.

(2) Applicable to PART II Section 2 - Optional Benefit D and E "Out-patient (Non-network Services) and Dental Benefits"

Insured Person shall pay the fees and charges of the Out-patient Services rendered by the Non-network Services Providers first and shall submit his claim for reimbursement to the Company within ninety (90) days after the date of treatment for the Disability for which the claim is being made. For this purpose, a claim shall be deemed not to be valid or complete and no reimbursement will be made by the Company to the Insured Person unless the following forms and relevant supporting documents and proof of loss receipts have been submitted to the Company:

i. all original receipts with attending Registered Medical Practitioner's and / or Chinese Medical Practitioner's signature (the receipt should have the patient's name, diagnosis, treatment date and breakdown of charges), and/or
ii. referral letter written by a Registered Medical Practitioner (applicable only for diagnostic X-ray and laboratory tests, Specialist (non-surgical) consultation, Physiotherapy and chiropractic treatment), and/or
iii. original copy of prescription sheet, Chinese Medical Practitioner's name, his signature and registration number. (applicable only for Chinese Medical Practitioner consultation)
iv. fully completed Out-patient Benefit or Dental Benefit claim form

Any variation or waiver of the foregoing shall be at the Company's sole discretion and must be evidenced in writing.

Referral letter issued by the qualified attending Physician shall be valid for six (6) months from the issue date of the referral letter.

Medical reports and all proof of loss documents as required by the Company shall be furnished at the expense of the Insured and shall be in such form and of such nature as the Company may prescribe.

It is a condition precedent to the Company's liability that the Insured and/or the Insured Person shall render all necessary assistance and co-operations in assisting the Company to obtain from other party(ies) medical history or claims record of the Insured Person. The Company shall, in the event of the death of the Insured Person to whom a claim is made, be entitled to have a post-mortem examination at its own expense where it is not prohibited by law.

13. Claims Documents

All claims documents and proof of loss receipts in connection with any claim under a Policy Year shall be furnished to the Company within ninety (90) days from the expiry date of that Policy Year, failure in compliance will cause the claim to be abandoned, the Insured Person thereafter cannot be entitled to any benefit payment in such respect. Besides, during the process of benefit payment, the Insured and/or Insured Person shall provide all other relevant evidence of proof documents as required by the Company apart from item 12 above. If the Insured and/or Insured Person fails to provide all other required evidence of proof documents, the Company shall have the right to delay benefit payment until all such documents are obtained. The Company would not return any original receipts for fully reimbursement case.

14. Claims Investigation

Within ninety (90) days from the date of receipt of the claim form from the Insured, the Company has the right to investigate whether the Company's liability is attached. During this period, no arbitration can be brought to the Company by the Insured. If the Company has rejected the claim in accordance with the terms or conditions of this Policy, arbitration can be brought to the Company by the Insured within one (1) year from the date of claim rejection.

15. Payment of Benefits

Benefits payable under this Policy shall be paid to the Insured or Insured Person or his personal representative. In the absence of any such written direction, accrued benefits unpaid at the time of the Insured Person's death shall be paid to the estate of the Insured Person. Any receipt which the Insured, or any third party to whom the Insured has directed that payment to be made, may give to the Company for any benefits paid under this Policy in respect of any one period of covered Hospital Confinement, shall be deemed a final and complete discharge of all liability of the Company in respect of such period of Hospital Confinement. Benefit under this Policy will be paid upon termination of the relevant period of covered Hospital Confinement.

16. Currency

Premium and benefits payable under this Policy shall be in the currency of Hong Kong. Any claim for reimbursement or expenses by the Insured Person in any foreign currency shall be converted to Hong Kong dollars at the official buying rate of such currency for Hong Kong dollars in effect in Hong Kong at the time the payment of such expenses were paid by the Insured Person, or if no such official rate exists, at the rate certified as appropriate by the Company's bankers which shall be deemed to be final band binding.

17. Interest

No benefit and expenses payable under this Policy shall carry interest.

18. Unpaid Premium

Upon the payment of a claim to the Insured under this Policy, any unpaid premium may be deducted from such claim payment.

19. Reinstatement

If this Policy is terminated for any reason, subsequent proposal form for reinstatement should be submitted for Company's acceptance and approval within ninety (90) days from the premium due date. The reinstated Policy shall cover only Hospital Confinement caused by Injury sustained after the date of reinstatement and Sickness commencing sixty (60) days after the date of reinstatement.

20. Errors and Omissions

Clerical errors in keeping the records shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated. If the age or date of birth or other relevant facts relating to the Insured Person shall be found to have been inadvertently misstated, and if such misstatement affects the scale of benefits or has anything to do with the coverage or any provisions or terms under this Policy, the true age and facts shall be used in determining whether benefits are secured under the terms of this Policy, and if so, in what amount, and an adjustment of premium shall be made by the Company in its absolute discretion in the event it considers benefits are payable under this Policy.

21. Contracts (Rights of Third Parties) Ordinance

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.

22. Sanctions Limitation and Exclusion Clause (LMA 3100)

No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

23. Prohibition on Trust or Assignment

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

24. Proper Law and Jurisdiction

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

24. Arbitration

All difference arising out of this Policy shall be determined by arbitration in accordance with the Arbitration Ordinance as amended from time to time. If the parties fail to agree upon the choice of the arbitrators, then the choice shall be referred to the Chairman for the time being of the Hong Kong International Arbitration Centre. It is expressly stipulated that it shall be a condition precedent to any right of action or suit upon this Policy that an arbitration award shall be first obtained. If the Company shall disclaim liability to the Insured Person for any claim hereunder and such claim shall not within twelve (12) calendar months from the date of such disclaimer have been referred to arbitration under the provisions herein contained then the claim shall for all purposes be deemed to have been abandoned and shall not hereafter be recoverable hereunder.

24-Hour Worldwide Emergency Assistance Service Hotline (852) 2861 9235

The Company has arranged the twenty-four (24) hours assistance services with Inter Partner Assistance Hong Kong Ltd (hereinafter referred to as "IPA") to provide the following hotline services to the Insured Person during the effective period of the Policy:

1. <u>Emergency Assistance Service</u>

If the Insured Person shall suffer serious Injury, sudden Sickness or death, or require legal advice, unexpected return to Hong Kong during his journey outside Hong Kong, provided that the trip is not undertaken:

- against the advice of the Physician, and/or
- for the purpose of obtaining or seeking any medical or surgical treatment abroad

the following Emergency assistance services are available directly from IPA upon specific verbal notification by the Insured Person or his personal representative to any of the specified 24-hour alarm centre.

(1) Medical Advice, Evaluation and Referral Appointment

When medical advice is needed, the Insured Person or his personal representative may telephone IPA's alarm centre for medical advice and evaluation from the attending Physician. However, it shall be stressed that telephone conversation cannot establish a diagnosis and shall be considered as an advice only. If consultation becomes necessary, the Insured Person shall be referred to another Physician or to a medical Specialist for personal assessment and IPA will assist the Insured Person in making the medical appointment. All Physician's fees and related charges shall be borne entirely and directly by the Insured Person without any reimbursement from IPA.

(2) Medical Monitoring

In the event of the Insured Person being Hospitalised outside Hong Kong, IPA's medical team will monitor the Insured Person's condition as closely as possible with the attending Physician.

(3) Travel Information

The Insured Person may contact IPA to obtain the following information and services before starting or during his journey.

- Update immunisations and vaccinations requirement and needs
- Weather information worldwide
- Airport taxes
- Customs requirements
- Passport and Visa requirements
- Consulate and embassies addresses and contact numbers
- Exchange rates
- Banking days
- Language Information / Arrangement of interpreter services
- Arrangement of child escort
- Transmission of urgent messages for medical reasons

(4) Luggage Retrieval

In the event of loss or misrouting of the Insured Person's luggage by a common carrier, IPA will liaise with the relevant entities such as but not limited to airline companies, customs officials, and will organize the dispatch of such luggage, if recovered, to such place as the Insured Person may direct.

(5) Emergency Rerouting Arrangements

IPA will assist the Insured Person in reorganizing his flight schedule should an emergency oblige him to alter his original plan.

(6) Assistance on Loss of Travelling Document

In case of loss or theft of essential documents or personal identification documents (e.g. passport, entry visa, etc.), IPA will provide the Insured Person with the necessary

information regarding the formalities to be fulfilled with the appropriate local authorities or entities, in order to obtain the replacement of such lost or stolen documents.

(7) Legal Referral

Upon the request of the Insured Person, IPA can provide the names, addressees, telephone numbers of lawyers and solicitors firms to the Insured Person.

(8) Compassionate Visit

In the event of the Insured Person suffering from serious Injury or sudden Sickness resulting in Hospital Confinement outside Hong Kong, at the Insured Person's cost IPA will arrange a relative or designated person of the Insured Person to travel to the Insured Person's bedside.

(9) Return of Unattended Minor Child to Hong Kong

If the Insured Person's travelling dependent Child under eighteen (18) years of age is left unattended by reason of the Insured Person's Injury or sudden Sickness resulting in Hospital Confinement outside Hong Kong or the death of the Insured Person, at the Insured Person's cost IPA will organize for such Child to return to Hong Kong, including a qualified attendant to accompany any such dependent Child for return journey if necessary.

(10) Deposit Guaranteeing of Hospital Admission

In case of Hospital admission duly approved by both the attending Physician and IPA's alarm centre doctor and the Insured Person is without means of payment of the required Hospital admission deposit, IPA will issue the guarantee or provide such payment up to HKD40,000. Prior to arranging the above service, IPA shall obtain the credit guarantee from the Insured Person.

(11) Hotel Room Accommodation for Convalescence

IPA will arrange and at the Insured Person's cost for an ordinary room accommodation for the sole purpose of Insured Person's convalescence immediately following his discharge from the Hospital.

(12) Unexpected Return to Hong Kong

IPA will arrange and at the Insured Person's cost for a scheduled airline ticket for the return of the Insured Person.

2. <u>Force Majeure</u>

IPA shall not be held responsible for delays or failures in providing assistance caused by any strike, war, invasion, act of foreign enemies, armed hostilities, (regardless of a formal declaration of war), civil war, rebellion, insurrection, terrorism, political coup, riot and civil commotion, administrative or political impediments or radioactivity or acts of God or any other event of Force Majeure which prevents IPA from providing such assistance services.

3. <u>Liability of the Company and IPA</u>

It is understood that the Physicians, Hospitals, clinics, and any kind of professionals to whom the Insured Person will be referred to by IPA are independent contractors responsible for their own acts and are not employees, agents or servants of IPA. Furthermore, the Company and IPA shall not be responsible for any act or failure to act on the part of those professionals such as, and not limited to, Physicians, Hospitals and clinics.

PERSONAL INFORMATION COLLECTION STATEMENT

The information You provide to Bank of China Group Insurance Company Limited ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:

(i) processing and evaluating Your insurance application and any future insurance application You may make;
(ii) administering Your insurance policy and providing services in relation to Your insurance policy;
(iii) analysis or investigating, processing and paying claims made under Your insurance policy;
(iv) invoicing and collecting premiums and outstanding amounts from You;
(v) any alterations, variations, cancellation or renewal of any insurance related product or service;
(vi) contacting You for any of the above purposes;
(vii) exercising any right of subrogation;
(viii) other ancillary purposes which are directly related to the above purposes; and
(ix) complying with applicable laws, regulations or any industry codes or guidelines.

The Company may disclose Your personal data for the above purposes to the following classes of transferees:

(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist the Company to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
(b) in the event of a claim, loss adjudicators, claims investigators and medical advisors;
(c) in the event of default, debt collectors and recovery agents;
(d) insurance reference bureaus or credit reference bureaus;
(e) reinsurers and reinsurance brokers;
(f) Your insurance broker (if You have one);
(g) the Company's legal and professional advisors;
(h) the Company's related companies (as that term is defined in the Companies Ordinance);
(i) any association, federation or similar organization of insurance companies ("Federation") and its members that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation;
(j) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes;
(k) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
(l) the Insurance Claims Complaints Bureau and similar industry bodies; and
(m) government agencies and authorities as required or permitted by law.

The Company is hereby authorized to obtain access to and/or to verify any of Your data with the information collected by the Federation from the insurance industry.

Moreover, the Company may also use and disclose Your personal data otherwise with Your consent.

You have the right to obtain access to and to request correction of any personal information concerning Yourself held by the Company. Requests for such access can be made to the Company's Legal and Compliance Department (Tel: 2867 0888 / Fax: 3906 9939).

USE OF PERSONAL DATA IN DIRECT MARKETING

With Your written consent given for direct marketing purpose (which includes an indication of no objection), the Company intends to use Your data in direct marketing. The Company will only act in accordance with the rules about direct marketing contained in the Ordinance. Please note that:

(1) Your name, contact details, products and services portfolio information and demographic data held by the Company may be used by the Company in direct marketing from time to time;
(2) the following classes of services, products and subjects may be marketed:
  (i) financial, insurance and related services and products;
  (ii) reward, loyalty or privileges programmes and related services and products;
  (iii) services and products offered by the Company's co-branding partners (the names of such co-branding partners can be found in the application form(s) for the relevant services and products, as the case may be); and
  (iv) donations and contributions for charitable and/or non-profit making purposes;
(3) the above services, products and subjects may be provided to or (in the case of donations and contributions) contributed to by the Company and/or:
  (i) the Company or BOC Hong Kong (Holdings) Limited or any of its subsidiaries;
  (ii) third party reward, loyalty, co-branding or privileges programme providers;
  (iii) co-branding partners of the Company and BOC Hong Kong (Holdings) Limited (the names of such co-branding partners can be found on the application form(s) for the relevant services and products, as the case may be); and
  (iv) charitable or non-profit making organisations;
(4) in addition to marketing the above services, products and subjects itself, the Company also intends to provide the data described in paragraph (1) above to all or any of the persons described in paragraph (3) above for use by them in marketing those services, products and subjects, and the Company requires Your written consent (which includes an indication of no objection) for that purpose;

If You do not wish the Company to use or provide to other persons Your data for use in direct marketing as described above, You shall exercise Your opt-out right by notifying the Legal and Compliance Department of the Company (Tel.:2867 0888, Fax no.:3906 9939).

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LIMIT OF INDEMNITY TABLE

I. Basic Benefits (Insured item B and/or C is operative if coverage is so stated in the Schedule)

Insured Items and Coverage		Maximum Limit (HK$) (per Insured Person)			
		Plan 1	**Plan 2**	**Plan 3**	**Plan 4 (Medical Top-up Plan)**
A	**Hospital and Surgical Benefits (per Disability Per Policy Year) – Compulsory items**				
	1. Room and Board Fee (a maximum of 100 days), limit per day	$800	$1,550	$3,000	Overall maximum limit per Policy Year is $250,000 and a maximum of 55% reimbursement per claim and no specified limit per item. **Note:** The Insured Person should hold a valid hospital and surgical insurance upon submission of claims. Otherwise, this benefit will become invalid.
	2. Physician's Visit Fee (a maximum of 100 days), limit per day	$800	$1,550	$3,000	
	3. Hospital Services Fee	$12,000	$18,000	$25,000	
	4. Surgical Expenses (payable in accordance with "Classification Schedule of Surgical Operations" and 2 pre-surgical assessments and the post–surgical case are included)				
	- Complex	$38,000	$50,000	$70,000	
	- Major	$20,000	$30,000	$47,000	
	- Medium	$9,000	$15,000	$19,000	
	- Minor	$5,000	$6,500	$8,000	
	(Fee for post surgical treatment by registered Chinese Medical Practitioner, 1 visit per day, a maximum of 5 visits per Disability), limit per day	$120	$150	$180	
	5. Operating Theatre Fee	Up to 30% of Surgical Expenses in Item A4			
	6. Anaesthetist's Fee	Up to 30% of Surgical Expenses in Item A4			
	7. Specialist's Fee[1]	$4,000	$6,000	$9,000	
	8. Intensive Care Fee (maximum limit will be doubled automatically for compulsory quarantine by the government authority and for intensive care treatment in the Hospital due to the contraction of infectious disease)	$15,000	$20,000	$25,000	
	9. Post-Hospitalisation Treatment Fee (within 6 weeks immediately after discharged from Hospital or post-clinical surgery)	$1,200	$2,500	$4,500	
	10. Extra Bed Accommodation Fee (accompanying the Insured Person for Hospital Confinement; a maximum of 100 days), limit per day	$800	$1,000	$1,200	
	11. Accidental Emergency Out-patient Treatment Expenses	$1,500	$2,000	$2,500	
	12. Home Nursing Fee (a maximum of 100 days), limit per day	$530	$850	$1,150	
	13. Medical Appliances (Specific Items) (Including Pacemaker, Stents for Percutaneous Transluminal, Coronary Angioplasty, Intraocular Lens, Artificial Cardiac Valve, Metallic or Artificial Joints for Joint Replacement, Prosthetic Ligaments for Replacement or Implantation between Bones and Prosthetic Intervertebral Disc)	$10,000	$20,000	$30,000	
	14. Chemotherapy/Radiotherapy/Targeted therapy/Proton Therapy/ Immunotherapy/Hormonal therapy/Gamma Knife/ Cyber Knife/Renal Dialysis Treatment Expenses	$30,000	$50,000	$70,000	
	15. Cash Allowance for Health Supplement Food (payable from the 8th day of Hospital confinement onward after surgical operation, a maximum of 5 days per Disability), limit per day	$200	$300	$500	
	16. Special Cash Allowance for Public Hospital in Hong Kong (for general ward bed only, a maximum of 50 days. This benefit is payable where no other benefits in item A (Hospital and Surgical Benefits) are payable, but except item A15 (Cash Allowance for Health Supplement Food), limit per day	$500	$750	$1,000	
	17. Compassionate Death Benefit Death in the Hospital as a result of Accident	$8,000	$10,000	$12,000	
Annual Overall Limit for each Insured Person aged 76 or above under Item A		**$200,000**	**$400,000**	**$600,000**	

Insured Items and Coverage		Maximum Limit (HK$) (per Insured Person)			
		Plan 1	**Plan 2**	**Plan 3**	**Plan 4 (Medical Top-up Plan)**
B	**Supplementary Major Medical Benefit** [2] **（Per Disability Per Policy Year）**				
	Only applicable after the exhaustion of "Hospital and Surgical Benefits" payable under Basic Benefits Items A3 to A8 (calculation of reimbursement in accordance with the percentage)	$150,000	$300,000	$500,000	N/A
	Reimbursement Percentage	80%	80%	a. 80% or b. 100%	
C	**Hospital Cash Benefit**				
	• Regardless of any basic benefits or plan selected, the sum insured will be covered under Plan 1 only for the insured Child(ren) aged 18 or below. • If the Hospital confinement is in the Mainland China, the maximum limit of this coverage will be reduced by half. For Hospital confinement outside Hong Kong (China), the maximum number of days is 90 per Policy Year for each Insured Person.				
	1. Daily Hospital Cash (a maximum of 365 days per event)	$300	$500	$1,000	$300
	2. Double Indemnity of Daily Hospital Cash due to any one of following Events (a maximum of 365 days per event) i. Confinement in the Intensive Care Unit (a maximum of 90 days per event) ii. Receiving major organ transplant surgery or first diagnosis with cancer disease iii. Suffering from defined infectious disease (a maximum of 30 days for each infectious disease) iv. Temporary leaving Hong Kong (China) but not exceeding 60 days with Hospital confinement required during this period (excluding the Mainland China and Macau (China), a maximum of 30 days per event v. The Insured Person and insured legal spouse are hospitalised at the same time due to the same Accident	$600	$1,000	$2,000	$600
Free Services					
24-hour Worldwide Emergency Assistance Service (a Hospital deposit guarantee of up to HK$40,000 in the event of emergency Hospital confinement outside Hong Kong (China) is applicable)		Please refer to this Policy for details			

II. Optional Benefits (Each insured item(s) is/are operative if coverage is so stated in the Schedule)

	Insured Items and Coverage	Maximum Limit (HK$) (per Insured Person)		
		Plan 1	**Plan 2**	**Plan 3**
D	**Out-Patient Benefit**			
	Network and Non-network Services (80% reimbursement for Non-network Services)	Network Services	Network Services	Network and Non-network Services
	1. General Practitioner Consultation (3 days western medication, 1 visit per day)			
	Maximum limit per visit	-	-	Non-network Services $350
	Maximum number of visits per Policy Year	Unlimited	Unlimited	Unlimited
	Co-payment – Network Services	$30	$10	$0
	Co-payment – Non-network Services	N/A	N/A	20%
	2. Specialist Consultation[1] (referral letter is required, 5 days western medication, 1 visit per day)			
	Maximum limit per visit	-	-	Non-network Services $700
	Maximum number of visits per Policy Year	Unlimited	Unlimited	Unlimited
	Co-payment - Network Services	$50	$30	$20
	Co-payment - Non-network Services	N/A	N/A	20%
	3. Chinese Medical Practitioner Consultation (including bonesetter & acupuncture, 1 visit per day)			
	Maximum limit per visit	N/A	-	$180
	Maximum number of visits per Policy Year		12	12
	Co-payment – Network Services		$0	$0
	Co-payment – Non-network Services		N/A	20%
	4. Physiotherapy and Chiropractic Treatment[1] (referral letter is required, 1 visit per day)			
	Maximum limit per visit	-	-	$340
	Maximum number of visits per Policy Year	10	10	10
	Co-payment – Network Services	$0	$0	$0
	Co-payment – Non-network Services	N/A	N/A	20%
	5. Diagnostic X-ray and Laboratory Tests[1] (referral letter is required)			
	Maximum limit per Policy Year	$2,500	$3,000	$4,000
	Co-payment – Network Services	$0	$0	$0
	Co-payment – Non-network Services	N/A	N/A	20%
E	**Dental Benefit**			
	Reimbursement Percentage:	80%	100%	
	1. Intra-oral small film radiograph (maximum limit per film)	$60	$70	
	2. Scaling, polishing and prophylaxis (maximum limit per visit, maximum number of visits per Policy Year)	$300 (1 visit)	$400 (2 visits)	
	3. Fillings, extraction (maximum limit per tooth)	$300	$400	N/A
	4. Drainage of abscess (maximum limit per tooth)	$200	$300	
	5. Root canal fillings (maximum limit per root)	$600	$1,200	
	Maximum aggregate limit per Policy Year under Item E "Dental Benefit"	$2,000	$3,800	
F	**Maternity Benefit** (per pregnancy including pre-natal and post-natal out-patient expenses; not applicable for pregnancy or birth of a Child within 9 months from the commencement or the reinstatement date of this benefit cover, whichever is later.)			
	1. Caesarean section	$12,000	$15,000	$22,500
	2. Normal delivery	$8,000	$10,000	$15,000
	3. Miscarriage	$6,000	$8,000	$12,000

Insured Items and Coverage		Maximum Limit (HK$) (per Insured Person)		
		Plan 1	Plan 2	Plan 3
G	**Critical Illness Benefit**			
	1. Provide lump sum payment if first diagnosed with one of the covered Critical Illness. Insured person must be alive for at least 30 days after being first diagnosed before a claim becomes payable. **2.** Upon approval of a claim for Critical Illness, the Insured Person's benefit under this item "G" will be terminated immediately. **3.** 90 days waiting period: benefit is not payable where the signs or symptoms of Critical Illness or the diagnosis of which first occurred within 90 days immediately following the benefit cover effective date or the effective date of last reinstatement of the benefit, whichever is later.	$100,000	$200,000	$300,000
	Extended Benefits:			
	1. **Medical Expenses for Critical Illness** (due to ascertained the first diagnosis of Cancer, Stroke or Cardiomyopathy)	$30,000	$45,000	$60,000
	2. **Additional benefit of the diagnosis of 5 Female Critical Illness or Serious Disease** (A lump sum payment will be made payable to female Insured Person in the event of first diagnosis of breast cancer, cervix uteri cancer, ovarian cancer, uterine cancer or Systemic Lupus Erythematosus (SLE) [3]).	$50,000	$80,000	$100,000
	3. **Additional benefit of the diagnosis of 5 male Critical Illness** (A lump sum payment will be made payable to male Insured Person in the event of first diagnosis of lung cancer, liver cancer, colon cancer, prostate cancer or Cardiomyopathy)	$50,000	$80,000	$100,000

All charges incurred must be Reasonable and Customary.

Remarks:
1. Subject to the referral letter issued by the qualified attending Physician. The time lag between the issuance date of referral letter and the relevant consultation date must not exceed six (6) months.
2. If the Insured Person daily maximum limit for Room and Board Fee is less than the actual amount charged for Room and Board Fee by the Hospital for Hospital Confinement. The Company reserves the right to adjust the benefit payable under Supplementary Major Medical Benefit.
3. SLE: Subject to 90 days waiting period and once a claim being made in this benefit, item "G" benefit will be terminated immediately for the Insured Person receiving such claim.

中銀集團保險有限公司
BANK OF CHINA GROUP INSURANCE COMPANY LIMITED
香港中環德輔道中 71 號永安集團大廈 9 樓
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Tel: 3187 5100 Fax: 3906 9906

中 銀 醫 療 綜 合 保 障 計 劃 (系 列 一) 保 單

保單持有人以投保書及聲明向中銀集團保險有限公司（下稱“本公司”）申請下述保險。而該投保書及聲明，無論是以口述或書面之方式作出，均已被納入本合約內，成為本合約之基礎。保單持有人已繳付保費，作為本保險的代價。

茲證明以本保單或批單上所列之條款、不保事項、承保條件、責任限額（以上各項均被當作納入統稱為“本保單條款”之內）為依歸下，本公司同意賠償給保單持有人任何或所有以下所列在保險期內所發生之保障項目。

保單持有人及受保人確保投保書及聲明內所提供或申報的所有資料是真實、準確及完整的，以及保單持有人及受保人完全遵守及履行本保單條款所載的條款及細則，是為本公司在承保本保單的任何責任的先決條件。

在本保單內，可按其目的及在實際情境許可下，只表達單數的字詞亦可包括眾數，反之亦然。只表達男性的字詞亦可包括女性，反之亦然。

第一部份　定義

任何以下具指定意義的字詞或字句，應用於本保單、承保表、批單及備忘錄時，均具有該指定意義。

1. 「意外」
意指無法預見和意料之外的暴力、偶發、外在及可見事件、並不牽涉任何其他因素下，構成身體受傷的唯一原因。
2. 「每年賠償總限額」
意指 76 歲或以上受保人在本保單起保日起 12 個月內，或由本保單滿周年日起計算的 12 個月內，根據本保單規定而在第二部份第一章-項目 A 基本保障享有的賠償總額。
3. 「醫療卡/支援卡」
(1) 醫療卡意指由本公司向每名受保人發出的「中銀醫療綜合保障計劃(系列一)醫療卡」。此卡證明各受保人可享有由網絡服務提供者提供的門診服務(只適用於在第二部份第二章-自選保障 D 項「門診保障」內受保及於本保單的承保表內列明)及「24 小時全球緊急支援」熱線服務。
(2) 支援卡意指由本公司向投保人發出的「中銀醫療綜合保障計劃(系列一)支援卡」。此卡證明受保人可享有「24 小時全球緊急支援熱線服務」。
4. 「子女」
意指就某相關人士而言，其合法子女，包括繼子女、領養子女、或監護兒童。
5. 「中醫」
意指根據《中醫藥條例》香港法例第 549 章註冊之表列中醫或註冊中醫，或根據引起索償及接受治療所在國家的法律，註冊為正式合資格的中醫，但不包括投保人、受保人、以及投保人及／或受保人的親屬或其業務伙伴。
6. 「先天性疾病」
意指出生時存在的疾病，以及出生後 6 個月內出現的新生嬰兒身體疾病。這類疾病包括下列各項（但不排除其他可被診斷為先天性疾病的狀態），如各種疝脫（本保單起保後發生的創傷所造成者除外）、斜視、睪丸未降、尿道下裂、腦積水、梅克耳氏憩室、兔唇、畸形足、胎記、骨或肌肉不正常生長、腦麻痺等。
7. 「住院日」
意指受保人須連續入住醫院（24）小時為一日，而受保人須被確認為住院病人及入院至少（24）小時。
8. 「傷病」
意指受傷、疾病、頑疾或不適，並包括由同一原因造成的傷病及其一切併發症；惟若此傷病在最後一次接受醫療服務或診症九十（90）天內，無需在就有關傷病接受進一步醫療服務，則其後因相同原因引致的傷病，皆會被視為另一傷病。
9. 「合理支出」
意指就受保傷病提供的醫療服務所產生費用，惟不得超過實際產生的費用以及承保表內及本保單賠償限額表載明的所有相關的最高賠償額。
10. 「急症」
意指受保人需要立即接受治療以防止受保人死亡或其健康遭永久損害的事件或情況。
11. 「香港」
意指中華人民共和國香港特別行政區。
12. 「醫院」
意指合法成立及按其所在地法律運作的機構，並符合以下所有要求：
(1) 主要以住院病人形式接待、治療及護理不適、患病或受傷的人士；
(2) 只在可隨時向其諮詢的醫生監管下始能接納住院病人入院；
(3) 為有關人士提供系統化的醫療設施以進行醫療診斷和治療，並在醫院範圍或醫院可使用或控制的設施下提供進行大型手術的設施（如適用）；
(4) 在護理人員的監督下提供全日護理服務；
(5) 維持一名合法註冊的駐院醫生。
(6) 如在中國內地，則指縣級或以上並以西醫診治為依歸的醫院。

「醫院」的含義並不包括：
(1) 精神護理機構，泛指為精神病者包括弱智人士提供護理的機構、醫院精神病部門；
(2) 老人院、療養院、戒毒或戒酒治療所；
(3) 保健或天然療養診所、護理或療養院、醫院特為戒毒或戒酒而設的部門、或護理、療養、復康、特別護理或靜養所；
(4) 以中醫診治為依歸的中醫院。
13. 「住院」
意指入住醫院之內至少連續 6 小時，方可獲得本保單規定的醫療賠償。不過，如受保人因受傷而(於 24 小時內)接受急症治療，並因而引致醫院費用支出，或註冊醫生為受保人因受傷而進行外科手術收取費用，又或在診所或在醫院擁有和經營的認可日間護理手術中心接受手術，則有關最低住院期的規定便不適用。
14. 「受傷」
意指身體純因意外而直接導致不正常狀況，而此不正常狀況並不牽涉任何其他因素及不因疾病或頑疾導致。
15. 「住院病人」
意指佔用病床並至少連續住院 6 小時的受保人，但如在診所或在醫院擁有和經營的認可日間護理手術中心接受手術，

則有關最低住院期的規定便不適用。

16. 「投保人」
意指投保本保單的香港合法居民，年齡為 18 歲或以上，本保單以其姓名簽發，並同時在承保表或批單內註明為投保人的人士。

17. 「受保人」
意指在承保表或批單內註明之受保人，必須為香港合法居民，並且是投保人的 18 歲或以上合法配偶；或投保人的子女。

18. 「保障計劃」
意指列於承保表內本保單所承保每一受保人的保障計劃。

19. 「深切治療部」
意指醫院指定用作深切治療病房之範圍，以便為病人提供一對一之護理服務及進行恢復其知覺、監察及治療等特別程序。該病房必須每日 24 小時均由接受過特別訓練的護士、技術人員、以及醫生留守，並配備復甦儀器及監察器，以便持續監察/評估各種維持生命的重要功能，例如心跳速度、血壓和血液內的化學性質。

20. 「產科」
意指因一次懷孕、分娩或流產或此等有關的任何併發症而引致的狀態(除非為醫療上所必須的，否則不包括人工流產)。

21. 「醫療保障」
意指按本保單第二部份規定就醫療支出所給予的保障。這些支出必須因為受保人的受傷、疾病、頑疾及不適所引致。

22. 「必要的醫療」
意指必須的醫療服務：
(1) 符合病情的診斷及慣常治療；及
(2) 符合良好和謹慎的行醫標準；及
(3) 並非為了方便投保人、受保人或下文定義 30 及 34 所界定的任何人士；及
(4) 以正常及慣常支出之下進行受保傷病的治療；及
(5) 以最低收費環境之下進行受保傷病的治療。
實驗性、普查及屬預防性質的服務及物品均不被視為必要的醫療。

23. 「醫療服務」
意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、程序、檢測、檢查或其他相關服務。

24. 「海外」
意指香港特別行政區以外之地區。

25. 「居住地」
意指受保人在保單年度內居住於同一地最少滿六(6)個月，並於投保書或書面更改通知內作出相關聲明。

26. 「保單」
意指本保單所載全部條款及條件，包括承保表、其批單和附件，以及如根據承保表的規定而適用及附於本保險單或不時向投保人公佈或通知的本公司的外科手術分類表「分類表」。

27. 「保單年度」
意指由本保單起保日開始，每一連續 12 個月的時間。

28. 「已存在的病狀」
意指
(1) 受保人在本保單及/或保障起保日之前已存在的疾病或受傷，當中病徵已顯露並為受保人察覺或應合理地察覺；或
(2) 無論受保人預先知悉與否，受保人於本保單及/或保障起保日的首個保單年度內所患之下列病患：
i. 扁桃體切除術；
ii. 器官腫瘤；
iii. 痔瘡；
iv. 鼻中隔或鼻甲之病理異常；
v. 甲狀腺異常；
vi. 子宮內膜異位；
vii. 需動手術之各類竇病症；
viii. 白內障；
ix. 疝；或
(3) 無論受保人預先知悉與否，受保人於保單及/或保障起保日的首個 6 個月內所患之下列病患：
i. 結核病；
ii. 膽結石；
iii. 腎石、尿道或膀胱結石；
iv. 肛門瘻管；
v. 高血壓或心臟疾病或血管疾病；
vi. 皮膚及肌肉組織腫瘤、骨腫瘤或血液或骨髓之惡性癌症；
vii. 拇指外翻；
viii. 胃潰瘍、十二指腸潰瘍；
ix. 糖尿病。

29. 「合資格護士」
意指在法律上有資格和已獲授權提供護理服務的護士，其資歷至少須相當於香港註冊護士或香港登記護士。如在香港以外地方接受醫療服務並提出索償，則有關名詞應指在接受醫療服務並提出索償的國家，依該國法律正式註冊的護士。但不包括投保人、受保人、以及投保人及／或受保人的親屬或其業務伙伴。

30. 「正常及慣常」
意指收費不超過同等經驗或資歷人士在相類似情況及地方下提供服務所收取的平均合理費用；有關物料或服務不超過在同一類別及相同質素及經濟因素考慮及地方下所需的物料或服務所收取的平均合理費用。

31. 「註冊醫生」、「外科醫生」、「醫生」、「麻醉科醫生」
意指具有正式有關資格並在香港依法註冊為上述西醫身份的人士。如在香港以外地方接受醫療服務並提出索償，則有關名詞應指在接受醫療服務並提出索償的國家，依該國法律正式註冊的西醫。但不包括投保人、受保人、以及投保人及／或受保人的親屬或其業務伙伴。

32. 「承保表」
意指附於本保單的承保表，並為本保單的一部份。

33. 「環境」
意指醫院門診部或適合作治療的醫院或門診服務的設施。

34. 「疾病」
意指受保人所感染的疾病，而該疾病為可就本保單索償的基準，惟不包括本保單所列之已存在的病狀。該疾病必須直接而單獨地導致該受保人住院。

35. 「專科醫生」
意指完成西醫專科課程及具有正式有關的西醫專科證書，並在香港依法註冊為專科西醫身份的人士。如在香港以外地方接受醫療服務並提出索償，則有關名詞應指在接受醫療服務並提出索償的國家，依該國法律正式註冊的專科西醫。但不包括投保人、受保人、以及投保人及／或受保人的親屬或其業務伙伴。

36. 「您」
意指投保人及／或受保人。

第二部份　保障範圍

本公司按以下之保障範圍，就必要的醫療支出，提供醫療保障，唯每名受保人的保障必須受承保表及本保單「賠償限額表」內所列最高賠償額(或最高百分比)、限額、適用的受保保障及保障計劃所規限。

第一章 - 基本保障

A. 住院及手術保障

1. 住院膳宿費
若受保人在註冊醫生的建議下，登記為住院病人因傷病接受醫療服務及引致合理費用支出，此保障便可獲賠償。賠償額將相當於受保人在住院期內醫院實際收取病房和膳食的費用。

2. 醫生巡房費
若受保人在住院期內任何一天需要接受註冊醫生的治療，此保障便可獲賠償。賠償額將相當於註冊醫生就這等巡房所收取的費用。

3. 醫院服務費
受保人因傷病接受醫療服務而登記為住院病人及引致費用支出，此住院服務保障便可獲賠償。賠償額將相當於在受保人住院期內，醫院就正常、適當和實際醫院服務向受保

人收取的費用。
除非已被剔除或不列入受保範圍內，或在承保表內對此另有規定，否則醫院服務將包括下列各項：
(1) 血液或血漿的施用，但不包括血液或血漿的費用；
(2) 進出醫院的救護車服務；
(3) 麻醉、氧氣及其施用；
(4) 基礎新陳代謝測試；
(5) 敷料、普通夾板及石膏模；
(6) 住院期間所用的藥物；
(7) 心電圖；
(8) 塗片、X 光檢查及對其檢查結果的解釋，以及特殊診 斷程序，如電腦掃瞄；
(9) 靜脈注射；
(10) 化驗；
(11) 物理治療。

4. 外科手術費

本公司將支付手術費賠償，而賠償額將相當於就外科手術實際收取的手術費，包括手術前兩次的診斷費及手術後的覆診費及出院後 6 個星期內接受合資格中醫治療的覆診費用。此保障將先支付手術費，如有餘額時才賠付上述手術前後的診療費。
手術費的支付(如適用)須符合本公司的外科手術分類表(“分類表”)的規定。該類附表與本保單一併發出，或由本公司向投保人不時公佈或通知。本公司絕對有權在其認為適當或必要時，修改分類表或其任何部份。若有關手術不在分類表之列，則本公司絕對有權為該項手術決定類別。該決定將是最終的並具約束力。本公司將以同等嚴重、難度及複雜性的手術為其決定之基礎。
若在單一次切口手術中進行兩項或以上外科程序，則所有這類外科程序費用的賠償將不超過支出最高的一項外科程序的賠償額。若在同一次手術中通過不同的切口來進行一項以上外科程序，本公司將支付最高不得超過複雜手術所需費用的 150%。倘受保人在同一次住院期內接受超過一項手術，其可獲支付的手術費將按給予最高賠償的一項手術為準。如在每一傷病需接受超過一項以上手術項目，所有手術項目的總賠償額將只根據所接受的各項手術項目當中在『外科手術項目表』內規定賠償額分類最高的該項手術項目計算，而總賠付金額不能超過外科醫生所收取之實際的手術費用或承保表所規定該項分類最高的手術所獲的最高賠償限額為限，兩者以較低數額者為準。
若採用分類表所列切口手術以外的其他程序(包括 X 光、鐳或其他放射性物質)來進行治療，本公司將在不抵觸所有其他有關外科手術賠償的條款下，根據分類表支付正常及慣常治療的一般賠償。
任何提出索償的手術費必須為提供外科手術服務的合格註冊醫生所收取的費用，並須為合理支出，方可獲得賠償。按本條款支付外科手術賠償後，本公司將毋須再就此等治療，支出本保單其他賠償條款所規定的賠償。

5. 手術室費

若受保人在住院期內使用手術室來進行任何外科程序，此保障便可獲賠償。

6. 麻醉師費

若受保人接受外科手術需要麻醉科醫生服務而引致實際支出，此保障便可獲賠償。

7. 專科醫生費

若受保人在住院期間，在註冊醫生轉介下，接受專科醫生服務，此保障便可獲賠償。賠償額將相當於專科醫生實際收取的費用。

8. 深切治療費

若按主診醫生的建議，受保人入住深切治療部，此保障便可獲賠償。若受保人因感染傳染病而遭政府機關強制性隔離及入院接受深切治療，深切治療保障最高賠償額將自動提升一倍。賠償額將相當於在深切治療部接受治療實際收取的費用。按本條款支付賠償後，本公司將毋須再就這類治療支付任何病房和膳食賠償。

9. 出院後覆診費

若按主診醫生的建議，受保人於出院或門診手術後 6 個星期仍須繼續接受所有與住院治療有關之門診費用，此保障便可獲賠償。

10. 住院加床費

若受保人因按主診醫生的建議治療傷病而登記為住院病人及引致費用支出，住院加床保障便可獲賠償。賠償額將相當於醫院對此項服務實際收取的費用。

11. 意外緊急門診費

若受保人因受傷並在意外發生後 24 小時內前往醫院接受門診治療，本公司將按醫院之一般正常及慣常的收費支付賠償。

12. 家居看護費

若受保人按註冊醫生建議出院後，在家中接受合資格護士提供的護理服務，並因此引致合理支出，此家居看護費用保障便可獲賠償。賠償額將相當於就這類服務實際收取的費用。
本條款提供的保障不適用於由下列所引致的費用：
(1) 任何連續 24 小時期內由一名以上護士提供護理服務；
(2) 純粹為診斷目的而提供護理服務或物理治療，或採用 X 光檢查或其他方法來進行任何醫療檢查；
(3) 老人科、老人精神科或精神科護理服務。

13. 醫療裝置 (指定項目)

若受保人以住院病人身份住院，本公司將賠償受保人因以下項目所產生之符合索償條件的費用：
(1) 心臟起搏器；
(2) 經皮冠狀動脈腔內成形術的支架；
(3) 眼內人造晶體；
(4) 人工心瓣；
(5) 關節置換術的金屬或人工關節；
(6) 置換或植入於關節的人工韌帶；以及
(7) 人工椎間盤。

14. 化療/電療/標靶治療/質子治療/免疫治療/荷爾蒙治療/伽馬刀/數碼導航刀/腎透析治療費

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，接受化療、放射性治療、標靶治療、質子治療、免疫治療、荷爾蒙治療、伽馬刀及數碼導航刀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。
若受保人患有不可復原之慢性腎功能衰竭，本保障將賠償受保人經註冊醫生書面建議，為住院病人或日症病人提供醫療服務的方式下進行血液透析治療而引致的合資格費用。

15. 進補現金津貼

若受保人按註冊醫生的建議，入住醫院及需進行外科手術接受醫療服務的傷病，並因此引致費用支出，由住院第 8 天起，此特設的每日現金津貼便可獲賠償。

16. 香港公立醫院特別現金津貼

若受保人按註冊醫生的建議，登記入住香港政府醫院、醫院管理局轄下的醫院或受資助的慈善醫院普通病房接受醫療服務的傷病，並因此引致費用支出，此特別每日現金津貼便可獲賠償。本公司就任何一種傷病按此第二部份第一章-基本保障項目 A(項目 A15「進補現金津貼」除外)支付其他賠償後，無論如何將不再按本條款支付賠償。

17. 身故恩恤金

若受保人因意外住院及於住院期間身故，便可獲此保障賠償。若未有指定受益人，賠償將撥作受保人的合法遺產。

住院及手術保障的每年賠償總限額

如受保人在下個保單年度或其後的保單續保年度年齡屆滿 76 歲，上述第二部份第一章-基本保障項目 A「住院及手術保障」內所有項目合共的每年賠償總限額，按本條款支付的賠償將不會超過承保表及本保單內賠償限額表所定的最高賠償額。

計劃 4 (醫療增值計劃)

此項保障可續保至 70 歲止。
受保人因接受醫療服務的傷病而登記成為住院病人或在醫院擁有和經營的認可日間護理中心按主診醫生的建議接受治療而引致合理支出，本公司將支付受保人持有之其他有效住院及手術保險賠償後之餘額。就已賠付的賠案，其正本索償文件，包括但不限於住院賬單明細表及正式收據，將不作退還。

B. <u>附加重症住院保障</u> (此保障列於承保表內才適用)

此項保障是上述“第二部份第一章-基本保障項目 A”的附加項目，並可續保至 75 歲止。
若受保人登記為住院病人以治療受保傷病，並因此引致第二部份基本保障項目之必要的醫療支出，本公司將支付附

加重症住院保障賠償。有關賠償額相當於扣除按上述"第二部份第一章-基本保障項目 A"條款所支付的所有賠償以後，餘下醫療費用按承保表列明的百分比及本保單賠償限額表賠償，惟若醫院所收取的實際每日病房及膳食費超過本保單"第二部份第一章-基本保障項目A"的保障額，則賠償額除按賠償限額表列明的百分比計算外，還須按本保單"第二部份第一章-基本保障項目A"保障的每日最高限額相對於醫院所收取的實際每日病房費用的比例計算。

計算方式:

合資格費用x調整系數x賠償限額表列明的百分比

以最高賠償額計(每一傷病)

調整因子是以受保人在住院其間，若平均病房及膳食費較保障表的病房及膳食費為高。此保單中的住院合資格費用，將先乘以調整系數，再乘賠償限額表列明的百分比。

調整系數:

保障表列上的病房及膳食費 ÷ 住院其間平均病房及膳食費

本項目不適用於下列情況：

1. 在中國內地、中國香港及中國澳門境外的住院及外科手術治療，但在海外遭遇意外或緊急事故並獲註冊醫生證明者或本公司根據居住地已作保費調整除外；或
2. 第二部份第一章-基本保障"項目 A 1-A2、A9-A16"；及第二部份第一章-基本保障項目 A 4 第一段所述的手術前兩次的診斷費、手術後的覆診費及手術後接受合資格中醫治療的覆診費用；或
3. 不在下述 "第二部份第二章-自選保障項目 F"產科保障承保範圍內的任何費用。

C. 住院現金保障 (此保障列於承保表內才適用)

此項保障可續保至 60 歲止。

受保人因疾病或受傷而需住院，而開始住院時本保單就該受保人所提供的保障亦已生效，則本公司將按照受保人入住醫院的住院日支付有關之住院現金保障。

條文：

1. 於每住院日內受保人須接受醫生的定期診治及護理，此保障便可獲賠償。
   在香港及香港以外，因任何疾病或受傷，均可獲得由住院日首日起計合共不超逾本保單「賠償限額表」所列日數的住院現金保障。至於香港以外住院，則按本保單「賠償限額表」所列每保單年度之日數計算。
2. 如於中國內地住院，受保人只獲住院現金保障額的半數賠償。
3. 重複的住院
   (1) 若受保人在保單及/或本保障仍然生效之時，因以往曾獲住院現金保障賠償的原因或有關的原因住院，而該住院相距不超過(6)個月，將被視為以往住院的延續。在決定本保單的有關住院現金保障期及最高住院現金保障額時，是次住院將被視為在以往疾病的相同時期出現，或因同一項受傷所致（以下條文 5 所述除外）。
   (2) 若受保人在距離以往住院（6）個月或以後再次住院，則被視為另一次住院處理。在決定本保單的有關住院現金保障期及最高住院現金保障額時，是次住院將不會被視為於以往疾病的相同時期出現，或因同一項受傷所致。
   (3) 按此條文 3 之(1)至(2)項，6 個月之相隔期是由受保人獲住院現金保障賠償出院後的翌日起計算。
4. 除第 7 部份第一章外，受保人在獲得本保單的住院現金保障額外，同樣可獲其所享有的任何其他保險賠償。
5. 儘管上述的條文所訂，在下列情況下：
   (1) 受保人入住深切治療病房 (最高賠償為 90 日)；
   (2) 受保人因接受主要器官移植手術包括心臟、心肺、肝臟、胰臟、腎臟或骨髓或首次證實患上癌病而住院；
   (3) 受保人感染下列指定傳染病包括瘧疾、霍亂、腦膜炎、登革熱、破傷風或非典型肺炎包括但不限於 2019 冠狀病毒病而住院 (就每種傳染病最高賠償為 30 日)；
   (4) 受保人在短暫離開中國香港以外不超過 (60)日的期間住院 (不包括在中國內地或中國澳門住院) (最高賠償為 30 日)；
   (5) 受保人及受保合法配偶同時因同一次意外住院；可獲每日住院現金雙倍賠償。

   雙倍住院現金保障不可超逾每日住院現金保障的兩倍；及在任何中國香港及中國香港以外的情況下合共均不可超逾此項保障所訂立的總住院日數。

第二章 - 自選保障 (以下每項保障列於承保表內才適用)

D. 門診保障

本公司將按以下條款，就必要的醫療支出支付受保人所需的網絡或非網絡醫生的醫療費用。

門診服務包括：

1. 普通科門診

除非本保單另有限制，否則本保障承保由網絡服務提供者或非網絡服務提供者就受保傷病提供的註冊醫生門診服務。保障包括診費及由註冊醫生處方最高 3 天的藥物，但只限於每日一次門診。受保人在接受治療時，可能須要直接向服務提供者支付自付費。

2. 專科門診

若受保傷病，經網絡註冊醫生書面轉介接受網絡服務提供者或非網絡服務提供者的專科醫生治療，本公司將支付此等專科醫生費，但只限於每日一次治療、就診或診治。受保服務包括診治及專科醫生處方最高 5 天的藥物。受保人在接受治療時，可能須要直接向服務提供者支付自付費。

3. 中醫門診

除非本保單另有限制，否則本保障承保由網絡服務提供者或非網絡服務提供者就受保傷病提供的中醫、跌打及針灸門診治療，但只限於每日一次的治療、就診或診治。賠償額包括中醫的診費及由中醫師處方的藥物。受保人在接受治療時，可能須要直接向服務提供者支付自付費。

4. 物理及脊椎治療

承保由網絡服務提供者或非網絡服務提供者就受保傷病經註冊醫生書面轉介並直接由物理治療師及/或脊椎治療師主理的物理治療及脊醫治療，但只限於每日一次的治療、就診或診治。

5. X 光診斷及化驗

由網絡服務提供者或非網絡服務提供者就受保傷病經註冊醫生書面建議的門診斷症檢驗服務，包括 X 光檢查、心電圖及簡單的診斷測試。

條款：

1. 網絡服務提供者

(1) 受保人可選用指定網絡服務提供者，以享用門診服務。指定網絡服務提供者的詳情已在保單生效日跟隨本保單附上。
(2) 指定網絡服務提供者為受保人提供的門診服務所涉及的費用與支出，概由本公司承擔。受保人須向指定網絡服務提供者繳交就超過承保表所列最高保額的費用及自付費。
(3) 除本保單具體列明外，任何向網絡服務提供者繳付的費用均為不受保項目，本公司概不負責。
(4) 本公司將向受保人發出醫療卡。在使用網絡服務提供者的門診服務時，該醫療卡只為識別醫療卡持有人的身份。
(5) 若使用網絡服務提供者門診服務，受保人須：
   (i) 預先向網絡服務提供者預約服務；及
   (ii) 在登記時向網絡服務提供者出示其有效醫療卡；及
   (iii) 安排於網絡服務提供者的診症時間內就診；
(6) 受保人確認和同意若受保人選擇網絡服務，這是受保人自由和主動作出的選擇。本公司對網絡服務提供者的適切性、服務供應或能力並無明示或默示任何陳述，而本公司對服務提供者、其僱員或代理提供的任何服務或福利或任何行為、遺漏、失職或疏忽，概不承擔

任何合約或其他形式的責任或義務。投保人及/或受保人接受和同意提供有關服務或福利的服務提供者為獨立承辦者，而非本公司的僱員或代理。

(7) 除本保單具體列明外，指定網絡服務提供者只限提供指定日數之基本醫生處方藥物，其他例如(包括但不限於)昂貴藥物、用作個別治療的抗病毒藥及長期病患所需之藥物等均不受保。

2. 非網絡服務提供者

(1) 若門診服務由非網絡服務提供者提供，受保人須向非網絡服務提供者先行墊付門診服務的費用，然後在完成傷病治療後 90 日內，向本公司遞交索償申請。

於「自選保障 - D.門診保障」內的定義

1. 「脊醫」
意指於香港或引致醫療費用的任何其他地方擁有最少等同香港《脊醫註冊條例》下的脊醫資格並從事藉矯正關節以提供脊骨療養法的具法定資格人士。但不包括投保人、受保人、以及投保人及／或受保人的親屬或其業務伙伴。
2. 「自付費」
意指受保人接受醫療服務後，必須自行承擔的固定費用或醫療服務費用的一個百分比(按承保表及本保單「賠償限額表」內所列，本公司可不時修訂)。
3. 「長期服用藥物」
意指受保人需服用不少於 14 天的處方藥物。
4. 「網絡醫生目錄」
視情況而定，包括指定網絡服務提供者的名單。本公司有權不時修訂此目錄而毋須另行通知。
5. 「網絡服務」
意指列於網絡醫生目錄內提供保健服務的診所。
6. 「非網絡服務」
意指並非列於網絡醫生目錄內提供保健服務的診所。
7. 「門診服務」
意指本保單第二部份第二章-自選保障 D.「門診保障」所列的服務。
8. 「物理治療師」
意指具有正式有關資格並在香港依法註冊為物理治療師身份的人士。如在香港以外地方接受治療並提出索償，則有關名詞應指在接受治療並提出索償的國家，依該國法律正式註冊的物理治療師。但不包括投保人、受保人、以及投保人及／或受保人的親屬或其業務伙伴。
9. 「服務提供者」
意指在文意許可下，本保單第一部份定義的任何醫生、註冊醫生、合資格護士、專科醫生及中醫。
10. 「特別檢查項目」
意指先進類型之造影或專科 X 光檢驗，例如鋇餐造影、腎盂造影等先進影像包括但不限於電腦素描、磁力素描、正離子核磁素描、涉及放射性物質的化驗。
11. 「慢性疾病」
意指無論有病徵與否，任何持續三個月以上之疾病，而患者需要接受的定期醫療診治。包括但不限於：

- 愛滋病
- 鼻敏感性病炎
- 阿耳滋海默氏病
- 關節炎
- 哮喘
- 癌病
- 慢性支氣管炎
- 慢性濕疹
- 慢性肝炎
- 冠心病
- 糖尿病
- 痛風症
- 心臟病
- 心臟衰竭
- 高血脂
- 血壓高
- 甲狀線激素過高
- 甲狀線激素過低
- 精神病及心理病
- 甲黴菌病
- 栢甘遜症
- 乾癬、牛皮癬
- 腎衰竭
- 紅斑性狼瘡

於「自選保障 - D.門診保障」內除外責任

由下述直接或間接引致或產生的醫療費用均不承保：

1. 任何長期服用藥物；
2. 任何只由受保人要求處方的藥物包括但不限於到訪受瘧疾感染地區所需的藥物；
3. 特別檢查項目；
4. 小型手術；
5. 慢性疾病。

E. 牙科保障

本公司將賠償受保人就下列牙科保障引致的必須開支。

牙科保障包括：

1. 口腔 X-光片檢查
2. 洗牙石、牙漬及預防治療
3. 補牙或脫牙
4. 膿瘡排放
5. 牙齦管填補

於「自選保障 - E.牙科保障」內的定義

1. 「牙科之異常狀態或情況」
意指異於正常健康狀態的牙科狀況。

2. 「牙科保障」
意指就牙科開支，根據本保障項目提供的保障。有關開支必須為受保人因受傷、牙科之異常狀態或情況而引致的開支。

3. 「牙醫」
意指在香港依法註冊為牙醫的正式合資格人士。若在香港以外的地方索償及接受牙科治療，「牙醫」則指根據引起索償及接受牙科治療所在國家的法律，正式登記註冊為牙醫的牙科從業員。但不包括投保人、受保人、以及投保人及／或受保人的親屬或其業務伙伴。

於「自選保障 - E.牙科保障」的除外責任

由下述直接或間接引致或產生的醫療費用均不承保：

1. 因美容、創傷、溶蝕、磨牙、磨損及其他非蛀牙而導致的補牙；
2. 不因蛀牙而導致的補牙剝落及重補；
3. 齒科矯正服務。

F. 產科保障

此項保障只適用於 18 歲以上的受保人及可續保至 50 歲止。若本公司收到充分證據，證明受保人曾因產科原因而住院，與此同時此項保障仍然生效，本公司將支付以下賠償：

1. 手術分娩
若住院作產科剖腹手術，如剖腹分娩或宮外孕手術，只要所付費用為必要的醫療支出，則產科保障賠償將相當於醫院實際、正常及慣常收取的病房、膳食及一般護理費用及醫院服務費用，以及任何產科醫生費用(新生嬰兒有關費用除外)。

2. 自然分娩
若受保人因產科原因住院但毋須接受剖腹手術，本公司將支付產科保障的賠償。賠償額相當於醫院實際、正常及慣常收取的病房及膳食費用及醫院服務費用，以及任何產科醫生費用(新生嬰兒有關費用除外)。

3. 流產
若遇上流產的情況，產科保障賠償將相當於註冊醫生或合資格護士就該次流產收取實際、正常及慣常的費用。

在計算上述的賠償額時，將包括同一次懷孕的產前和產後費用。受保人於產科保障生效日或復效日起計 9 個月或內懷孕或分娩，以較後者為準，將不會獲得任何產科保障的賠償。

G. 危疾保障

此項保障只適用於 18 歲以上的受保人及可續保至 60 歲止。若受保人經註冊醫生診斷證實首次患上危疾而在本公司接獲有關索償的合理證明及批核後，此保障便可獲賠償。儘管受保人或會患上超過一種危疾，每受保人只可獲賠一次危疾保障。

伸延保障：

1. 危疾醫療費用

如受保人被診斷證實首次患上 1)癌症 2)中風或 3)心肌疾病危疾(若該危疾並非一項手術）或完成手術後而引發的危疾(若該危疾是一項手術)而直接及獨立地引致醫療費用，本公司將向受保人賠償實際支付的醫療費用，並以不超過承保表之規定為限，餘額於第二部份第一章-基本保障項目賠償。

惟需符合以下條件

(1) 該危疾保障已作出或將作出賠償；及

(2) 有關的醫療費用是合理及醫學上必須的，而且是因註冊醫生或中醫一般建議的服務、用品或醫療服務或是就該危疾而慣常接受的醫療服務所引致。

2. 患上 5 種婦女危疾或嚴重疾病

若女性受保人因初次證實患上乳癌、子宮頸癌、卵巢癌或子宮體癌，將可獲一次性支付額外保障。若女性受保人因初次證實患上紅斑狼瘡症，將可獲一次性支付保障。

3. 患上 5 種男性危疾

若男性受保人因初次證實患上肺癌、肝癌、結腸癌、前列腺癌或心肌疾病，將可獲一次性支付額外保障。

條款：

1. 危疾或紅斑狼瘡症只會在下列情況支付
   (1) 在發病日本保單及此保障仍然生效；及
   (2) 受保人經診斷患上危疾後仍生存不少於 30 日(不適用於紅斑狼瘡症)；及
   (3) 發病日是在受保人之受保年齡達 60 歲的保單年度前發生及此保障仍然生效。
2. 支付危疾保障賠償後，包括危疾或伸延保障中之紅斑狼瘡症，本公司將立即獲解除對受保人於"G.項"危疾保障的其他任何責任，而該受保人於此"G.項"危疾保障便立即終止。
3. 危疾或紅斑狼瘡症不保以下情況
   (1) 因以下任何一項直接或間接引起、與其有關、導致或產生(全部或部分)：
      i 後天免疫力缺乏或愛滋病(AIDS)或人體免疫力缺乏病毒(HIV) (危疾定義下，因輸血而感染人體免疫力缺乏病毒除外)；或
      ii 任何先天缺陷；或
      iii 自我毀傷或企圖自殺 (不論當時神智是否清醒)；或
      iv 任何已存在的傷病；或
      v 酒精或非由註冊醫生處方開列的藥物引致中毒；或
      vi 違反或企圖違反或拒捕或參與任何犯罪活動；或
      vii 乘搭任何飛機 (以購票乘客身份乘搭商務客機除外)。

      在以上不保事項第(1)iv 項，已存在的傷病指任何以下狀況或疾病：
      i. 以前曾存在或一直存在；或
      ii 直接致病因素以前存在或一直存在；或
      iii 受保人知悉該情況、疾病、病徵或病狀；或
      vi 任何化驗室的測試或調查顯示可能有該狀況或疾病的存在而有關情況在保單生效日期或最後保單復效日期前發生，以較遲者為準。

   (2) 保障生效日或保單最後復效日期(以較後者為準)的首 90 日內首次顯現有關徵狀或病徵或任何首次診斷患上的危疾。

   (3) 受保人在保障生效日期前已確診的同類危疾，不論該早期確診是否與現提出索償的危疾有關。例如，若受保人在保障生效日期前已確診患上一種「癌症」，本保單將不會再就任何一種「癌症」作出危疾保障賠償。

危疾及紅斑狼瘡症定義

危疾指下列其中一種疾病：

1. 阿耳滋海默氏症

因患上阿耳滋海默氏症或不可復原的機能變性腦部失調而出現智力退化或喪失智力或不正常的行為，並由臨床狀態及認可的標準問卷或測驗證實，但不包括神經病、精神病及任何與藥物或酒精有關的機能失調，導致精神和社交機能嚴重減少，而受保人需要不斷接受監護。診斷必須由合適的註冊醫生臨床證實。

2. 再生障礙性貧血

慢性及永久性的骨髓衰竭而導致貧血、嗜中性白血球減少及血小板減少之出現，須接受下列最少一項的醫療服務：

(1) 輸血；

(2) 刺激骨髓藥物；

(3) 免疫系統抑制性藥物；

(4) 骨髓移植。

診斷必須經有關血病科專科醫生確認。

3. 細菌性腦膜炎

細菌性腦膜炎引致腦部或脊髓膜炎症，導致最少連續 183 日的永久性腦神經科缺陷，而有關診斷須由腦神經專科醫生證實。

4. 良性腦腫瘤

需要接受切除手術或引致最少連續存在 183 日的嚴重永久性神經科缺陷的腦內非癌症腫瘤。腦動脈或靜脈囊腫、肉芽腫和畸形、腦垂體或脊椎血腫和腫瘤並不在受保範圍內。

5. 失明

由眼專科醫生診斷證實，兩眼的視力因創傷或疾病導致完全和不可復原地喪失。

6. 腦部損傷

因意外產生的腦部損傷而引致不可復原的智力受損或完全喪失，並因此需要永久監護或援助以維持生命。

7. 癌症

癌症指體內存在不受控制地生長和擴散的惡性細胞，而這些細胞會侵襲人體組織。

患者必須提供明確的證據，以確定細胞惡性生長並侵襲人體組織。「癌症」亦包括白血病、淋巴瘤及霍奇金氏病。「癌症」不包括非侵襲性的原位癌瘤、惡性黑瘤以外任何皮膚癌、只出現早期惡性病變的局部非侵襲性腫瘤，以及存在任何人體免疫力缺乏病毒的腫瘤。

8. 心肌疾病

心室功能永久性及不可復原的受損，受損程度達至紐約心臟協會所訂定之最少第四級程度。有關診斷必須獲心臟科專科醫生確認。心肌疾病乃包括擴張性、肥厚或收縮性心肌疾病。如因濫用酒精或藥物所引起之心肌疾病，將不在保障範圍之內。

9. 昏迷

處於不省人事的狀態，對外界刺激或內在需要毫無反應，需要不斷使用生命輔助器不少於 96 小時，引致其患上永久性的腦神經科缺陷並獲腦神經科專科醫生確認。

10. 冠狀動脈搭橋移植手術

利用隱靜脈移植物或內乳移植術，用以矯正兩條或以上收窄或阻塞的冠狀動脈之剖開心臟手術，但一切非外科手術程序，如氣脹血管造形術或激光技術，則不包括在內。必須提供有關疾病的心臟血管造影片。

11. 象皮病

由絲蟲病引起或其併發症，特徵為由於淋巴血管循環阻塞而造成身體組織大範圍腫脹，必須由適當的專家臨床確定診斷為象皮病，包括檢驗證實幼絲蟲屬存在。惟保障不包括由性接觸傳染的疾病、創傷、手術後疤痕、充血性心臟衰竭或先天淋巴系統異常引起的淋巴水腫。

12. 腦炎

由腦神經專科醫生證明腦質嚴重發炎，導致最少連續 183 日的嚴重和永久性神經科缺陷。

13. 末期肺病

必須符合下列兩項標準中的一項：

(1) 符合以下所有條件

- 必需永久吸氧治療，達每天至少 8 小時的證據，及
- 第一秒鐘用力呼氣容積(FEV1)低於 1 公升

或者

(2) 符合以下所有條件

- 第一秒用力呼氣容積(FEV1)低於 1 公升，及
- 氣道內阻力增加，至少達到 0.5 kPa/l/s，及
- 殘氣容積佔肺總量(TLC)的 60%以上，及
- 胸內氣體容積升高，超過 170（基值的百分比）

14. 暴發性病毒性肝炎

由肝炎病毒引致的肝臟次廣泛性至廣泛性壞死，導致突發性肝衰竭，惟保障不包括經註冊醫生證明因濫用酒精或藥物而引致之情況。有關診斷必須符合以下準則：

(1) 肝臟體積急劇縮少；
(2) 整塊肝葉壞死，只剩下膠質網狀支架；
(3) 肝功能測驗急劇惡化；
(4) 黃疸不斷加深。

15. 突發性心臟病

突發性心臟病指某部分心肌因突然供血不足而壞死。病症的診斷必須基於下列所有準則：
(1) 典型的胸痛病歷；
(2) 心電圖出現心肌梗塞特有的新變化；及
(3) 心臟酵素水平上升。

16. 心瓣置換

因心瓣狹窄或關閉不全而實際將一塊或以上心瓣換上人造心瓣的手術，但不包括心瓣修補和切斷手術。

17. 因輸血而感染人體免疫力缺乏病毒

受保人感染上人體免疫力缺乏病毒（HIV）並且符合下列全部條件：
(1) 在保障生效日期或復效日期之後，以較後者為準，受保人因輸血而感染 HIV，而且
(2) 提供輸血治療的機構出示該項輸血感染屬醫療責任事故的報告，或者經法院終審裁定為醫療責任並且不准上訴，而且
(3) 受感染的受保人不是血友病患者。

在任何治癒愛滋病（AIDS）或阻止 HIV 病毒作用的方法被發現以後，本保障將不再予以賠付。

18. 腎衰竭

因兩個腎臟出現不可復原的慢性功能衰竭而導致的末期腎衰竭。受保人必須定期接受腎臟透析治療或已接受腎臟移植手術。

19. 肝衰竭

末期肝衰竭，永久性黃疸，普遍醫學觀點認為不會有好轉的機會，並且導致腹水及肝性腦病。

20. 失聰

因創傷或疾病而導致完全和不可復原地喪失對所有聲音的聽力。患者必須由耳鼻喉科專科醫生提供醫療證據，包括聽力和音域測驗。

21. 喪失獨立生活能力

經主診專科醫生鑑定，受保人證實缺乏獨立處理「每日起居活動」的其中最少三種活動的能力；「每日起居活動」的定義為：
(1) 更衣 － 在毋須協助的情況下，可自己穿衣及脫衣；
(2) 如廁 － 可使用洗手間，包括在毋須協助的情況下自行往返洗手間；
(3) 行動 － 在毋須協助的情況下，可自行往返睡床或座椅；
(4) 自制 － 自我控制大、小便能力；
(5) 進食 － 在毋須協助的情況下自行進食已準備之食物；
(6) 沐浴 － 在毋須協助的情況下沐浴及洗澡方法清潔身體的能力。

22. 喪失肢體

兩條或以上肢體從身體不可復原地分離，而斷肢處在膝部或肘部以上。

23. 喪失語言能力

持續 365 日完全和不可復原地喪失說話的能力。患者必須由耳鼻喉科專科醫生提供醫療證據，以證實聲帶的損傷或疾病。一切與精神有關的因素除外。

24. 嚴重燒傷

3 級程度嚴重燒傷引致皮膚總面積 20%或以上的皮層全部破壞。

25. 主要器官移植

作為受贈者接受心臟、肺、肝臟、腎臟、胰臟或骨髓移植手術。

26. 運動神經元疾病

確實出現適當和有關的神經科病徵，並由神經專科註冊醫生明確診斷為患上運動神經元疾病。

27. 多發性硬化

出現多於一次明顯的神經科徵狀，並持續有跡象顯示涉及視覺神經、腦幹和脊髓，加上共濟、運動和感覺機能受損，及後由神經專科註冊醫生作出明確診斷，並經影像掃描診症報告確實。

28. 肌肉營養不良症

肌肉營養不良症的診斷須由神經專科醫生證實，並須根據下列全部情況作出診斷：
(1) 其他家庭成員有同樣的病歷；
(2) 臨床表現，包括並無感覺失調、腦脊髓液正常、腱反射輕微減少；
(3) 特殊的肌電圖；
(4) 肌肉活組織檢查證實臨床上的懷疑，及本公司認為該項檢查證實患上肌肉營養不良症。
(5) 引致受保人在缺乏援助的情況下，不能進行「每日起居活動」的其中最少三種活動。(有關定義與上述第 21 點相同)

29. 截癱／癱瘓

因癱瘓而引致兩條或以上肢體完全和永久喪失功能。

30. 柏金遜症

因出現下列病情，由神經專科註冊醫生明確診斷為患上柏金遜症：
(1) 不能以藥物控制；
(2) 出現逐步的機能障礙之徵狀；
(3) 引致受保人在缺乏援助的情況下，不能進行「每日起居活動」的其中最少三種活動。(有關定義與上述第 21 點相同)

只受保原發性柏金遜症，由藥物或毒性因素引致的柏金遜症皆不在受保範圍之內。

31. 脊髓灰質炎

由神經專科醫生明確診斷為感染脊髓灰質炎病毒，引致患上令運動機能受損或呼吸衰弱的癱瘓性疾病。不涉及癱瘓的個案將不獲得賠償。因其他原因而引致的癱瘓不在受保範圍之內。

32. 延髓性逐漸癱瘓

由神經專科醫生診斷及確認為退化性肌肉，包括延髓肌肉萎縮。

33. 肺動脈高血壓

臨床和實驗診查，包括心導管插入檢查，由心臟科專科醫生證實患上原發性肺動脈高血壓。

有關診斷必須符合下列準則：
(1) 呼吸困難和疲勞；
(2) 左心房血壓上升（最少 20 個單位）；
(3) 肺阻力比正常水平高出最少三個單位；
(4) 肺動脈血壓最少為 40 mm Hg；
(5) 肺楔壓力最少為 8 mm Hg；
(6) 右心室的終舒張壓最少為 8 mm Hg；
(7) 右心室肥大、擴張及出現右心衰竭和代償機能衰敗的徵狀。

34. 嚴重類風濕性關節炎

下列之關節部位有三個或以上出現廣泛性關節損壞及嚴重臨床變形：手、手腕、手肘、頸椎、膝、足踝及足部；受保人必須是永久及完全喪失從事任何工作的能力。診斷須經下列各項證實並由風濕病科專科醫生確認：
(1) 於關節部份有不少於 1 個小時之清晨僵硬；
(2) 對稱性關節炎；
(3) 經註冊醫生證實之類風濕性小結；
(4) 類風濕因子滴度呈陽性反應並上升；
(5) 放射照相證實關節受損及磨損。

35. 中風

任何腦血管病發事件（或意外），引致持續超過 24 小時的腦神經科後遺症及有永久性之神經功能缺陷，包括：
(1) 腦組織梗塞；
(2) 臚內血管出血；及
(3) 臚外因素引起的栓塞。

36. 主動脈手術

因主動脈疾病而需要接受切除手術並以移植物置換病變的主動脈之剖開心臟手術。就定義而言，主動脈指胸和腹主動脈而非其分支。不包括主動脈創傷。

37. 末期疾病

受保人必須患上經專科醫生及獲本公司指定的註冊醫生確認之疾病，而很可能在通知日期後 365 日內死亡。

38. 永久完全傷殘

受保人因意外或疾病導致的完全傷殘持續十二個曆月後，受保人在餘下的生活期間，完全不能從事任何可賺取收入

的職業或工作。

39. 結核性腦膜炎

因結核桿菌感染造成的覆蓋腦和脊髓的腦脊膜的炎症，引起顯著的神經功能障礙，導致永久無法獨立完成六項「每日起居活動」中的三項或三項以上(有關定義與上述第 21 點相同)。

40. 植物性狀況（持續性）

完全失去知覺及腦皮質功能，對外界刺激或內在需要毫無反應，惟腦幹仍然運作，需要持續性輔助以維持生命最少 30 日。永久性神經系統損傷被有關腦神經科專科醫生確認。

紅斑狼瘡症指

一種慢性自身免疫性疾病，可令身體組織及細胞受到病理性自身抗體及免疫抗體的沉積而被破壞。

系統性紅斑狼瘡症的診斷必須基於以下條件：

(1) 必須出現以下最少四(4)個的臨床表徵：
   a. 臉頰疹或盤狀疹或對光線敏感；
   b. 心包炎或胸膜炎；
   c. 腎功能障礙(由蛋白尿及其他特定的尿液不正常情況證實)；
   d. 引致腦癇發作或精神病的神經系統疾病；
   e. 血液疾病，包括溶血性貧血、白血球減少症或血小板減少症或淋巴細胞減少症；及

(2) 包括以下最少三(3)項經血液測試證實的免疫疾病：
   a. 呈陽性反應的抗脫氧核糖核酸(anti-DNA)測試；
   b. 呈陽性反應的抗史密斯免疫球蛋白自身抗體(anti SM)測試
   c. 呈陽性反應的抗雙縷脫氧核糖核酸(anti-ds DNA)測試；
   d. 呈陽性反應的抗可提取性核抗原(anti-ENA)測試；
   e. 呈陽性反應的抗核抗體(anti-ANA)測試。

本公司保留隨時更改上述危疾及紅斑狼瘡症定義的權利，以反映對有關危疾之診斷或醫療服務在醫療科技方面之發展。

第三部份　一般除外責任

本公司將不予負責任何有關下述的賠償：

1. 可向第三者追討的費用，包括但不限於可根據醫療服務提供者或《僱員補償條例》第 282 章或其任何修訂提出索償的受傷或傷病事件所涉及的醫療服務或補償；
2. 任何其他現有保險承保的費用，或直接或間接因政府設施或其僱用的醫生所提供的醫療護理服務而引致的費用，在政府醫院內接受治療所須支付的法定費用則不在此限；
3. 任何由器官組織、眼角膜、人造器官、器官移植或骨髓移植、或屬試驗或研究性質的服務或供應，包括並未認可為公認醫療常規的治療程序、設施、儀器、藥物、施用藥物、裝置或供應。在不影響上述條款的一般性原則下，尚未證實為安全或屬於科學上確立的治療或明顯對某一種疾病有利的治療均不受保；
4. 美容或整容手術，或任何純粹為美容而進行的治療；
5. 任何類別的牙科及口腔手術護理和治療，包括牙齒矯形、齒髓及牙周膜服務；以及修復服務，例如補牙、鑲齒冠、牙橋、箍牙及鑲假牙（唯在本保單第二部份第二章-自選保障「E.牙科」的承保範圍內及在承保表列明承保除外）。
   本保單只承保下列與牙科治療有關的服務：
   (1) 因意外而導致口部和牙齒受傷，需要立即接受醫治，但所有其後有關之治療則不獲賠償；
   (2) 經適當轉介的口腔手術，以治療頜骨或面骨脫位或骨折；切除頜骨良性或惡性腫瘤；
6. 視力或聽覺測驗、視力矯正（如該項目是因為意外引致除外）；配眼鏡或隱形眼鏡；購買或使用特別支架(包括但不限於心臟支架)、心臟起博器、器械、助聽器、輪椅、丁字形拐杖、義肢或任何其他類似設備的費用(除第二部份第一章-基本保障第 A13 項「醫療裝置(指定項目)」中另有規定外);
7. 與就診病無關之病房和膳食費、陪人費、特別看護費、額外病床 (如包括在第二部份除外)、非醫療性的個人服務或其他特殊費用包括但不限於維他命、抗菌肥皂和清潔劑、及過敏原抽取物、滋養的草本植物或補品/保健產品(包括但不限於燕窩、人參及靈芝)或商業健康補健包；
8. 先天性疾病、遺傳性疾病、發展性疾病、已存在的病狀或其併發症；
9. 直接或間接因性病或與人體免疫力缺乏病毒有關的疾病而引致的費用，包括後天免疫力缺乏症（愛滋病）及/或因愛滋病而產生的任何突變、衍生或變異，並因在保單起保日期之前感染人體免疫力缺乏病毒而病發。就本不受保項目而言，若保障起保日後 5 年內出現與人體免疫力缺乏病毒有關的疾病，在沒有明確和具說服力的相反證據之情況下，將不可推翻地推定為因在保障起保日之前感染人體免疫力缺乏病毒而病發；
10. 婦產、懷孕、分娩（包括診斷懷孕的測驗、決定嬰兒性別或外科手術分娩）、流產、墮胎、產前或產後護理、外科、機械性或化學避孕方法、不育治療或體外受精、絕育或其併發症或一切有關的治療；(惟包括在本保單第二部份第二章-自選保障 F「產科保障」的承保範圍內及在承保表列明承保除外)；
11. 女性荷爾蒙測試或分析及女性荷爾蒙補充治療（惟疾病引致除外）、例行或一般檢查或例行驗血、健康檢查、與受保疾病或受傷的治療或診斷無關的檢查或化驗、為免疫或檢疫而接受的接種、藥物或防疫注射、療養性治療、休養性治療；
12. 主要因檢驗（例：電腦掃瞄、X 光檢查、化驗等）及/或物理治療而住院；
13. 在任何原故或實際上已成為住處或永久居留地的場所居住和接受護理服務所引致的費用；
14. 精神病及情緒病失調治療，包括直接或間接源自以下各項的治療：精神病、老人科病、老人心理或老人精神病、包括但不限於精神變態、神經官能症、抑鬱症、焦慮、厭食症、飢餓症、精神分裂、失眠或其他行為失常等；
15. 直接或間接因下列各項而引致的疾病或受傷：
   (1) 不在醫院使用或並非醫生處方的藥物；
   (2) 避孕藥或避孕器、疫苗、刺激或抑制食慾的藥物，但具體列明屬受保者除外；
   (3) 與吸毒、酗酒、減肥、戒煙及治療禿頭有關的處方藥物及試驗性藥物；
   (4) 性病、蓄意濫用藥物或酒精、企圖自殺或故意自傷身體或參與非法活動、觸犯或參與刑事罪行、或在駕駛任何車輛時血液之含酒精量超出法律所容許之標準；
   (5) 高風險活動或職業：
      i. 參加紀律部隊或海陸空軍服務或行動；
      ii. 參加或就該等活動進行實習或參與特有的訓練：水肺潛水、激流；使用繩索或在嚮導帶領下登山、攀石或攀山；洞穴探險、跳傘、吊索跳崖、懸掛滑翔、特技或危險技巧；滑雪、長橇運動、雪橇滑行或滑冰，包括冰上曲棍球與任何其他在雪地或冰上進行的運動；職業運動如賽車、賽馬；駕駛電單車；參加航空活動，但購票乘搭由正式持牌作定期運輸的航空或包機公司所提供及經營的飛機則不在此限；
   (6) 戰爭或任何戰事（不論宣戰與否）、侵略、外敵行動、敵對行動（不論宣戰與否）、內戰、叛亂、革命、起義或軍事政變或奪權、恐怖主義活動、罷工、暴亂、參加軍警工作；
   (7) 核輻射性污染；
16. 受保人因以下情況於任何旅程中發生的疾病或受傷：
   (1) 不依醫生指示；
   (2) 移民、留學或與移民、留學有關為目的；
   (3) 為於香港境外接受任何醫療意見或手術或與此有關為目的；
17. 由出生至 15 歲期間出現的各種腹股溝疝氣及水囊腫(或其併發症)；
18. 變性手術、包皮環切手術，惟醫療上必須者除外、職業治療及語言治療服務、善終服務；
19. 其他治療方法包括但不限於自然療法、穴位按摩、推拿、按摩治療、水療法、脊椎神經科治療、足部治療、生物反饋療法、催眠、鎮痛、順勢療法、耳窩反射療法、艾灸、拔火罐及刮痧除非本保單另有規定；
20. 不論任何原因的性功能障礙治療，包括但不限於陽萎、勃起障礙及早泄；
21. 保障計劃復效日後首 60 天內發生之疾病及/或住院，因意

外及/或受傷而引致之住院除外。

第四部份　保費

1. 投保人在繳交保費後，本保單方可生效。
2. 每名受保人的保費乃根據在保單起保日當時受保人的投保年齡及任何其後每個續保保單年度的首天起計算。
3. 除非在接獲保單後 15 天等候期內取消保單，而該期間沒有任何索償或賠償記錄，否則所有預繳保費將不獲退還。
4. 保費需按承保表、批單或備忘錄上所列繳付，保費亦需在保單起保日時及其後每個保單年度的保單期滿日時繳交全年保費。
5. 若要求更改保單的保費付款模式，投保人須於保單期滿日前最少 30 天向本公司作出書面通知，有關更改只會在來年續保的保單年度的首天開始生效。
6. 除首年保費外，對每個保單年度續期保費，本公司給予投保人 1 個月（不超過 31 日）的繳費寬限期。投保人所須繳付的續期保費在繳費寬限期內繳交，本保單繼續有效。如超過繳費寬限期仍未繳費者，本保單由給予投保人繳費寬限期日開始即時失效。
7. 本公司保留就受保人之類別，如年齡、性別或健康狀況而調整所有「中銀醫療綜合保障計劃(系列一)」保障計劃內保費、最高賠償額及/或條款的權利。本公司可不時釐定保費率及任何保費折扣率或附加費。

第五部份 續保

根據本保單第四部份，

1. 投保人以每年付款而在每一個續保保單年度，繳交所須的續保保費，本保單將繼續生效，直至該年度的保單期滿日為止。
2. 本保單將於投保人繳付保費時自動續保，除非投保人於保單年度續保前接獲本公司更改保單條款或取消保單的書面通知。
3. 根據本保單第四部份第七項，住院及手術、門診及牙科保障為保證終生續保，而保障生效後本公司不會因受保人的健康或索賠狀況而額外收費或附加條款。
4. 本公司保留於保單每年續保之到期日時終止本計劃或修改本保單之保障、保費及其他條款及細則的權利。若本公司決定停止提供本計劃，本公司將同時為受保人提供另一個可供選擇的保險計劃。
5. 保障利益架構修訂
   本公司將保留不時修訂本保單之保障利益架構的權利。本公司應於保險期完結前不少於三十（30）天以書面形式通知保單持有人有關修訂並列明經修訂的承保表、賠償限額表、新保費及其生效日期。除非保單持有人以書面拒絕有關修訂，否則經修訂的承保表、賠償限額表及新保費應於所定明的日期生效。若保單持有人以書面拒絕有關修訂，本保單會於該通知日期後的第一個保費到期日自動終止。於每次修訂後，本公司應發出有關批單，並附隨經修訂的承保表及賠償限額表一併發出。

第六部份 無索償續保保費折扣

如連續三個保單年度內沒有索償記錄，則每名受保人於續保第二部份第一章-基本保障時可獲百分之十五續保保費折扣優惠。

如在任何上述續保期內有賠償事故發生或對其中一名受保人作出任何賠償，該受保人所累計的「無索償續保保費折扣」將予取消，並在下個保單年度續保的首日起重新開始累計。其他受保人的無索償續保保費折扣則不受影響。

若獲享保費折扣優惠後，收到投保人於此段期間的有效索償文件，投保人需向本公司退回保費折扣額總數。若投保人未能照辦，本公司有權延遲發給賠償，或於其賠償金額內扣除有關的保費折扣額總數。

第七部份　重複投保、起保日、增加受保人及終止保單

第一章　重複投保

受保人不得投保多於一份本公司承保的「中銀醫療綜合保障計劃(系列一)」保單。若受保人投保多於一份相同保險，本公司將視受保人受其中最高保障額的保單所保障。如各保單的保障額相同，本公司將視受保人受最先發出之保單所保障。本公司將向受保人或其代表人發還重複支付的保費，而重複投保的保單則由生效日開始作廢。

第二章　保單起保日

本保單於承保表所列的保單起保日期開始生效。

第三章　增加受保人

1. 若本保單只有一位受保人，投保人可於下個續保保單年度前 30 日向本公司提供書面申請包括其本人或配偶及/或其子女，使其成為本保單附加的受保人。提出申請時須註明有關額外受保人的姓名、性別、年齡及健康狀況。
2. 經本公司同意及加簽批單，有關增加的受保人之保險方能於下一個續保保單年度首日生效，有關額外保費將向投保人收取。

第四章　終止保單

1. 投保人終止保單

(1) 若投保人於保單年度期滿前 30 天以書面通知本公司終止保單或終止保單內其中 1 名受保人，則有關終止生效日為該保單年度的期滿日。本公司將收取該保單年度之年繳保費全數，而已繳的保費不獲退還。

(2) 若投保人以書面通知本公司終止保單或終止保單內其中 1 名受保人，則有關終止生效日為保單年度的期滿日或本公司接獲有關通知當日，以較早者為準。本公司將收取該保單年度之年繳保費全數，而已繳的保費不獲退還。

(3) 若投保「計劃 4-醫療增值計劃」的受保人因離開其任職公司而以書面通知本公司終止保單，則有關終止生效日為本公司接獲有關通知當日或按通知書列明的日子，以較後者為準。

倘若曾在保單年度內就本保單「第二部份第一章-基本保障」提出任何索償，投保人需要向本公司支付 100%的每年保費作為最低保費。

若投保人所繳付的保費超出保單取消日及不曾在本保單年度內提出任何索償，本公司將按以下比例退還有關的保費予投保人：

已受保期（不超過）	退還保費
4 個月	50%
5 個月	40%
6 個月	30%
7 個月	20%
8 個月	20%
超過 8 個月	0%

2. 本公司終止保單

(1) 若受保人在任何時候未能履行本保單的條款或未能本著絕對真誠行事，本公司有權隨時終止本保單或更改本保單的條款。本公司可向投保人以書面發出 7 日通知以終止本保單。該通知將送出或郵寄至投保人最後通知地址。就以每年繳款的保單而言，保單將於該通知書發出後 7 日終止。若投保人以年繳模式，而受保期內沒有任何索償或賠償記錄，可獲得按比例退回尚未屆滿受保期的保費(按上述第四章-終止保單項目 1(3)退費表)。

(2) 本保單將於受保人身故時終止。保單內任何受保人身故，該受保人的保障將立即終止但保單內的其他受保人將不受影響。若投保人以年繳模式而受保期內沒有任何索償或賠償記錄，可獲得按比例退回尚未屆滿受保期的保費(按上述第四章-終止保單項目 1(3)退費表)。

(3) 若從投保人指定的賬戶扣除的一期或以上保費已付訖，其後若未能支付任何保費，則本保單所載保險將於該應付的保單期滿日終止。本公司將收取該保單年度之年繳保費全數，而所有已繳的保費不獲退還。

第八部份　轉換保障計劃

1. 投保人在本保單的每個保單年度保單期滿日 30 日前，可向本公司發出書面申請轉換受保人的保障計劃。經本公司批核後，新保障計劃及保費將於最新的續保保單年度的首

日開始生效。

2. 若本公司收到該書面通知之前，該受保人已患有疾病或受傷，則該疾病或受傷的賠償不會超過本公司收到書面通知之日前適用於該種疾病或受傷的限額或最高賠償額，以最低的賠償限額計算。
3. 若受保人因離職而失去公司醫療保險，且須於保險期內終止計劃 4「醫療增值計劃」的保障，當提供證明文件後，已繳的年繳保費可按指定百分比退回。此外，受保人亦可同時要求轉換投保計劃 1、2 或 3(若選擇計劃 3，須於轉保前提供證明文件以說明前公司的醫療保險曾提供相等或優於計劃 3 的保障額度)。本公司將以受保日數按比例收取新投保計劃的保費。

第九部份　風險變動

風險變動有機會影響本保單的保障，如受保人在保險期內有任何風險變動(包括居留身份、職業、居住地等變動)，投保人必須即時以書面通知本公司。本公司有權就任何風險變動在任何期間作保費調整（不論就過去或未來受風險變動而影響之保費），而投保人必須繳付任何所須的額外保費。本公司有權保留終止保單絕對權（包括所附任何批註及補充文件）。終止保單日期將按自更改風險變動日期起計。本公司不會退還任何已繳保費，亦保留要求受保人償還已付的索賠款項之權利。若未有事先申報，在任何索償階段方發現有關風險變動更改，將無法獲得賠償。

第十部份　醫療卡的使用條件

1. **使用醫療卡**
   在一切有關醫療卡使用的事宜上，本公司只與投保人而非個別受保人接洽。根據本保單的條文規定，投保人須負全責控制及監察受保人對醫療卡的使用。
2. **取消、終止或不續保保單**
   若本保單因故取消、終止或不續保，則投保人須在取消或終止之日立即把所有受保人的醫療卡交還本公司。投保人須就受保人在保單及門診保障無效時仍使用醫療卡所產生的任何索償、損失、損毀、法律行動、訴訟、費用及支出，全數付還本公司，不論該醫療卡事後是否已交還本公司。本條款在本保單及門診保障取消或終止後仍然有效。
3. **終止保障**
   若受保人按本保單享有的保障因故終止或取消，投保人同意在有關終止或取消之日或之前，向該名受保人收回醫療卡，並於終止或取消之日立即把醫療卡交還本公司。若該名受保人於終止或取消之日後仍然使用醫療卡來獲取賠償，投保人須負責全數付還本公司已付的款項，不論該醫療卡事後是否已交還本公司。本條款在本保單取消或終止後仍然有效。
4. **索償爭議**
   若因使用醫療卡所產生的醫療費用出現爭議，投保人同意立即先退還本公司已付的款項，再待決定有關醫療費用是否應按本保單條款支付。本條款在本保單取消或終止後仍然有效。
5. **超越賠償額的費用**
   若任何受保人使用醫療卡所引致的費用超過該名受保人在本保單的保障額，投保人同意退回費用在收到欠款通知書後立即向本公司償還任何差額或不足之數。本條款在本保單取消或終止後仍然有效。
6. **不受保治療**
   若受保人利用醫療卡接受本保單條款規定不可享有賠償的治療，則投保人須向本公司全數付還此等不受保治療費用。本條款在本保單取消或終止後仍然有效。
7. **醫療卡補領費**
   每張補發的醫療卡均須支付補領費。本公司保留不時調整補領費用而毋須另行通知。若補領醫療卡，投保人需填妥「補領醫療卡」表格及交回本公司。有關表格可向本公司索取。
8. **醫療卡被竊或遺失**
   若醫療卡被竊或遺失，投保人需於醫療卡被竊或遺失當日以書面通知本公司有關詳情。投保人須就任何受保人的醫療卡被竊或遺失後遭他人使用而造成的任何交易負全責，直至投保人向本公司遞交填妥的「遺失聲明」表格，申報有關醫療卡被竊或遺失的詳情為止。有關表格可向本公司索取。
9. **取消醫療卡**
   本公司保留可不經事先通知而隨時收回任何醫療卡之權利，按本保單發出的任何及一切醫療卡均為本公司絕對專有的財產。
10. **退回超額費用**
    當接獲本公司書面通知後，投保人需立即向本公司退回通知書上所列的超額費用。若該欠款未能在接獲本公司書面通知日期起計 30 日內付清，本公司保留向客戶按月加收財務費用。
11. **暫停支付賠償**
    若接獲本公司進一步書面通知後仍未付清超額費用，本公司保留暫停向受保人支付賠償及使用非網絡服務提供者提供的任何醫療服務的權利。

第十一部份　一般保單條文

1. **解釋**
   本保單應與其承保表、備忘錄及批單一併閱讀，而本保單、其承保表、備忘錄或批單任何部份內之任何字詞或字句如帶有特定解釋，在任何情況下出現都視作帶有此種解釋。如中、英文版本有任何歧異，概以英文版本為準。
2. **約因**
   本保單是根據投保書所載的聲明，以及投保人繳付保費的情況下而簽發的。
3. **地域限制**
   本保單第二部份所提供的保障適用於全球，惟需受以下限制：
   (1) 住院重症保障：病狀或治療乃完全歸因於在海外發生的意外或緊急情況者為限；
   (2) 住院現金保障：每保單年度以 90 日住院為限；
   (3) 門診保障：以計劃 3 為限。
4. **條款及條件**
   本保單的任何賠償須符合本保單之所有定義、條款及條件所規定。
5. **毋須分攤條款**
   本保單所提供的保障並不會以分攤形式支付，而只會在有關受保人就「第二部份 - 保障範圍」的任何費用並未能從其他保單獲得全數賠償之下，賠償不足之費用。若其他合約或計劃及/或附加賠償條款所提供的賠償，少於受保人按本保單規定可得的賠償，則本公司只會提供賠償額之間的差額。投保人須向本公司提供一切其他保險合約或計劃或附加賠償條款(如適用)的副本。
6. **完整合約及修改**
   本保單包括承保表、批單、「手術分類表」、付錄與修訂（如有），將構成雙方之間的完整合約。除經本公司批准，並得批單和修訂本為證，否則本保單的任何修改均屬無效。
   本公司將保留對所有本保單作核保、修改條款及/或調整保費及最高賠償額的權利。
7. **退回保單的權利**
   倘若投保人基於任何原因不滿意本保單，可在保單起保日起計 15 日內將整套保單包括醫療卡退回本公司。如在此段時間內無任何索償或賠償紀錄，已繳付予本公司的保費將全數退還。在此情況下，本保單將視為由保單起保日即無效，而本公司亦毋須支付任何索償。
8. **失實陳述或欺詐**
   投保人及/或受保人於投保書及批單內容（如有）所提供的資料及聲明將視為本保單的基準。任何失實陳述或資料將促使本保單起保日即失效。有關索償如存有任何欺詐行為，本公司有權拒絕本保單的賠償責任。
9. **代位權**
   本公司有權以受保人的名義，對可能須就引致按本保單提出索償的事故負上責任的第三者提出訴訟，有關費用將由本公司承擔。
10. **索償通知 (不適用於第二部份第二章-自選保障 D 及 E「門診及牙科保障」)**
    本公司承擔賠償責任的先決條件，在於投保人或其代表必須於受保人住院日或診斷患上危疾之日起計 14 日內給予

本公司書面索償通知。若索償人向本公司遞交的通知，內列的資料足以確定受保人的身份，則當作已發出通知論。若未能在上述期限內給予通知，惟能在本公司表示滿意下證明已在合理可行的情況內盡快給予通知，並在住院之日起計 60 日內給予通知，則不會促使有關索償失效。

11. 身體檢驗

本公司在收到索償通知書後，有權隨時合理地要求受保人進行體檢，以決定應否作出賠償。有關費用由本公司支付。

12. 索償手續

(1) 適用於第二部份 (第二章-自選保障 D 及 E「門診及牙科保障」除外)

任何受保人因疾病或意外受傷住院，受保人出院後 30 日內或診斷患上危疾之日內或受保人之遺產代理人須填具下列表格，連同有關文件及帳單等送交本公司：

i. 住院及手術保障索賠申請書或危疾保障索賠申請書；及
ii. 主診醫生證明書；及
iii. 所有住院醫療費用正本單據及帳單明細表正本；及
iv. 死亡證及法醫官報告(只適用於身故恩恤金保障)。

如不具備上述書面文件，本公司將不予受理。如受保人或遺產代理人未能提供上述第（ii）項的醫生證明書，本公司可協助代辦，惟投保人或遺產代理人須承擔向本公司提交所需的醫療報告及所有證明文件的費用及受保人或遺產代理人需辦理授權手續。

(2) 適用於第 2 部份第二章-自選保障 D 及 E 「門診(非網絡服務)及牙科保障」

受保人須向非指定網絡服務提供者先行墊付門診服務的費用，然後在完成傷病治療後 90 日內，向本公司遞交索償申請。為此，受保人須向本公司索取索償表格，並填妥表格，連同收據和分列項目的賬單正本及醫生診斷證明一併交回本公司，否則，索償申請將視為無效或不完整，而本公司亦不會向受保人發放任何賠償。

i. 所有主診註冊醫生及/或中醫師簽署的收據正本(每張收據須顯示病人姓名、疾病名稱、診症日期及收費項目說明及明細)；及/或
ii. 有效註冊西醫轉介信 (適用於 X 光診斷及化驗、專科醫生門診(非手術)、物理治療及脊醫治療)；及/或
iii. 藥物處方正本、中醫名字、簽署及註冊登記號碼(只適用於中醫門診)；
iv. 填妥的門診保障或牙科保障索償申請書。

本公司可自行決定及以書面為證，可酌情免去以上申請手續。

由合資格主診醫生發出的轉介信有效期以轉介信的發出日期起計 6 個月。

投保人須承擔向本公司提交所需的醫療報告及所有證明文件的費用，並依照本公司所述的形式和性質提呈有關文件。

投保人及/或受保人亦需提供所有必須的合作以協助本公司從他人獲取受保人之病歷或索償紀錄，此乃本公司承擔賠償責任的先決條件。如因受保人身故而提出索償，本公司有權自費進行法律許可的驗屍手續。

13. 索償文件

在保單年度內所有索賠文件及單據，須在該保單年度期滿日起 90 日內向本公司提交申請索償，否則作為放棄索賠論，以後受保人將不能獲取任何有關是次之賠償。另外，在辦理支付利益保障時，投保人及/或受保人除上述第 12 項所列文件外，亦須按本公司要求提供其他有關的證明文件。倘投保人及/或受保人未能提供所需證明文件，本公司可延遲發給其應得利益，直至所需證明文件具備為止。已全數賠償的個案本公司將不退回所有正本收據。

14. 索償調查

本公司有權在收到投保人索賠申請書後 90 日內進行調查，決定是否在保單承保責任範圍內，在此期間，投保人不得向本公司採取任何仲裁行為。如本公司依保單規章或條款決定拒賠，投保人可在拒賠後一年內提出仲裁。

15. 支付賠償

本保單的賠償只可支付予投保人或受保人或遺產代理人。若並無書面指示，在受保人身故時，所有未支付的累積賠償，將撥作受保人的遺產。任何由投保人或其指定賠償的第三者就任何住院所收訖賠償後簽訂的收據，均被視為本公司在這段住院期間最終和完全履行所有法律責任。在本保單下的賠償將於住院期終止時支付。

16. 貨幣

根據本保單，所應支付的保費及保障額均以香港貨幣支付。若受保人以任何外國貨幣提出索償，須以受保人支付費用時該外幣官方買入價折算為港幣。若無此類官方匯率，則此類索償將以本公司的往來銀行確定為適當的匯率折算為港幣。此匯率將視為最終和具約束力。

17. 利息

本保單支付的保障均不帶利息。

18. 未繳保費

倘若投保人根據本保單而獲得賠償，本公司會先扣除任何尚未繳付的保費，然後發放賠償金。

19. 保單復效

若本保單基於任何原因而終止，投保人其後須於保費到期日後 90 日內遞交要求復效的投保書予本公司接納及批准。經復效的保單只承保在復效日後因受傷導致的住院及復效日 60 日以後出現的疾病而導致的住院。

20. 錯誤與遺漏

整理記錄時的文書錯誤不應使在其他方面均有效的保障項目失效，亦不會使在其他方均應有效地終止的保障項目繼續有效。若受保人的年齡或出生日期或其他有關資料無意中報錯，以致影響賠償或保障範圍或本保單任何條款，則本公司將按真實的年齡及資料來決定是否就本保單的條款給予賠償，並決定賠償額。若本公司認為應按本保單支付賠償，則絕對有權酌情調整保費。

21. 合約(第三者權利)條例

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

22. 制裁限制及除外條款 (LMA3100)

保險人（再保險人）不得提供承保及支付任何賠款或提供任何利益給下述，依據聯合國決議有關制裁、禁令或限制之國家，或經歐盟、英國或美國所作貿易或經濟制裁、法律或規範之國家。

23. 信託或轉讓之禁制

本保單不可轉讓，同時投保人保證本保單並不隸屬於任何信託，亦不涉及任何留置權或押記。本保單將於保險期內由投保人擁有。

24. 法律及司法管轄權

本保單在所有方面均受香港法律管限，並按香港法律釋義。對於本保單有關的任何事項所產生的爭議、索償或法律訴訟，香港法院將具有唯一和獨有的司法管轄權。

25. 仲裁

所有因本保單而引起之歧見須根據仲裁條例(及不時之修訂)作出決定。若然雙方對委任一名仲裁人不能達成協議，則有關選擇需交由香港國際仲裁中心之主席作出決定，在這裏明確申明，取得仲裁裁決為任何有關本保單之訴訟權利或官司之先決條件。若然本公司對受保人就任何依本保單提出之索償表示無須負責，而該索償又未在作出拒賠日後 12 個月內轉交仲裁，則無論如何，該索償將被視作已被放棄，而此後亦不得再追討。

24 小時全球緊急支援服務熱線: (852)2861 9235

本公司與國際救援(亞洲)公司 (以下稱為"國際救援") 洽商為投保人及/或其受保家屬在本保單有效期內提供下述的 24 小時支援熱線服務。

1. <u>緊急救援服務</u>

若受保人在原居地以外地方旅行或公幹時因發生嚴重身體損傷或疾病或需要醫療、法律諮詢緊急協助，而這旅程並非

- 違反醫生的勸告；及/或
- 是為接受或尋求海外醫療或手術治療

受保人或其代表可直接通知國際救援 24 小時緊急中心，要求以下服務及保障。任何由受保人自行支付的有關費用，將不會獲發還。

(1) 電話醫療建議、評估及轉介約見
當需要醫療建議時，受保人或其代表可致電國際救援的緊急中心向中心內當值醫生索取醫療建議及評估，但該項電話對話只屬建議性質，並不能視作對受保人之診斷。若醫療上有需要，受保人可轉介至合適之醫生或專科醫生，以獲取其個人評估；而國際救援可代為預約有關醫生。但所有醫療費用及相關之費用需由受保人自行支付。

(2) 跟進病情
當受保人身在香港以外地方接受住院治療，國際救援的醫療隊將會聯同受保人的主診醫生跟進受保人的醫療狀況。

(3) 旅遊諮詢
受保人可在旅程前或旅程期間，向國際救援諮詢以下資料或服務：
- 最新的免疫及防疫要求及需要
- 世界各地天氣
- 機場稅
- 海關條例
- 護照/簽證要求
- 領事館/大使館之地址及聯絡電話
- 貨幣兌換率
- 銀行工作日
- 當地語言及翻譯服務
- 護送小童回國
- 因醫療緣故需轉遞緊急訊息

(4) 代尋行李
如運送機構遺失或誤送受保人的行李，國際救援可代為向有關機構包括航空公司、海關及政府機關查詢代尋。若尋回行李將轉送到受保人之指定地方。

(5) 更改行程之緊急安排
若受保人遇緊急事故需更改原先行程，國際救援將會協助受保人重新安排所乘坐之飛機班次。

(6) 護照補發遞送
當受保人旅程所需之文件或個人證件(如護照、簽證等)遺失或被盜竊，國際救援將向受保人提供所需資料，以便受保人向有關當局補辦證件。

(7) 法律轉介
應受保人要求，國際救援可提供律師及律師行的地址及電話。

(8) 親友探病
若受保人在香港以外地方，因嚴重之身體受傷或染急病，國際救援將安排受保人一名親屬或其指定人士，由香港前往探望受保人。有關之費用需由受保人自行支付。

(9) 護送隨行之未成年子女返港
若投保人在香港以外地區，因嚴重之身體受傷或急病而住院或不幸去世，遺下同行而未滿十八歲受供養之子女，國際救援將安排該名子女返港，如有需要更會聘請符合資格人士，陪同投保人該名子女返港。有關之費用需由投保人自行支付。

(10) 住院按金保證
當國際救援緊急支援中心之醫生及當地主診醫生均同意受保人因意外受傷或患上急病須入住醫院時，國際救援可在受保人無法即時支付住院按金的情況下，提供達港幣 40,000 元之住院按金保證。國際救援緊急支援中心有權在替受保人支付住院按金前，索取有效之信用保證。

(11) 出院後療養住宿
若受保於出院後需即時進行療養，國際救援將會為受保人安排出院後之酒店住宿。有關之費用需由受保人自行支付。

(12) 安排緊急回港
國際救援將安排受保人乘坐固定班次之航機回港。有關之費用需由受保人自行支付。

2. 不可抗力之免責事由
國際救援將不負責因罷工、戰爭、敵國入侵、武裝衝突（不論是否正式宣戰）、內戰、內亂、叛亂、恐怖行動、政變、暴動、群眾騷擾、政治或行政干預、輻射或自然災難等的不可抗力事項或不可歸責於國際救援之事由所導致救助行動延誤、無法提供或進行而產生的任何責任。

3. 本公司及國際救援的責任
獲推介的專業人士、醫生、診所及醫院，均非本公司或國際救援的職員、代理或僱員，這些專業人士、醫生、診所及醫院乃獨立人士或機構而需對自己所作的行為負責。在推介前，國際救援將查核這些專業人士、醫生、診所及醫院是否具備資格，並確實其獲當地政府的認可。如遇這些專業人士、醫生、診所及醫院之行為不當，本公司及國際救援概不負責。

收集個人資料聲明

您提供的資料，為中銀集團保險有限公司(“本公司”)提供保險業務所需，並可能使用於下列目的:

(i) 處理及審批您的保險申請或您將來提交的保險申請；
(ii) 執行您保單的行政工作及提供與您保單相關的服務；
(iii) 分析或調查、處理及支付您保單有關的索償；
(iv) 發出繳交保費通知及向您收取保費及欠款；
(v) 任何與保險有關的產品或服務的任何更改、變更、取消或續期；
(vi) 就以上用途聯絡您；
(vii) 本公司行使任何代位權；
(viii) 其它與上述用途有直接關係的附帶用途；及
(ix) 遵循適用法律，條例及業內守則及指引。

本公司亦可因應上述用途將您的個人資料移轉予下列各方：

(a) 就上述用途，向本公司提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問(包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商)；
(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問；
(c) 追討欠款的收數公司或索償代理；
(d) 保險資料服務公司及信貸資料服務公司；
(e) 再保公司及再保經紀；
(f) 您的保險經紀（若有）；
(g) 本公司的法律及專業業務顧問；
(h) 本公司的關連公司(以《公司條例》內的定義為準)；

(i) 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)及其會員，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能；
(j) 透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的；
(k) 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
(l) 保險索償投訴局及同類的保險業機構；及
(m) 法例要求或許可的政府機關。

您在此授權本公司可向「聯會」從保險業內收集的資料中查閱及/或核對您任何資料。

此外，經您同意，本公司可能會以其它方式使用及披露您的個人資料。

您有權查閱及要求更正由本公司持有有關您的個人資料。如有需要，可向本公司法律與合規部提出 (電話：2867 0888，傳真：3906 9939)。

使用資料作直接促銷

在取得您的有關書面同意下(包括您不反對之表示)，本公司擬使用您的資料作直接促銷。本公司會遵從條例內有關直接促銷的規定。請注意以下：

(1) 本公司持有您的姓名、聯絡詳情、產品及服務組合信息及統計資料可不時被本公司用於直接促銷；
(2) 以下服務類別可作推廣：
  (i) 財務、保險及相關服務和產品；
  (ii) 獎賞、年資獎勵或優惠計劃及相關服務和產品；
  (iii) 本公司的聯名合作夥伴提供之服務和產品（有關服務和產品的申請表上會提供聯名合作夥伴的名稱(視屬何情況而定)）；及
  (iv) 為慈善及或非牟利的目的之捐款及資助；
(3) 上述服務、產品及標的可由本公司及/或下述人士提供或(如涉及捐款及資助)募捐：
  (i) 本公司或中銀香港(控股)有限公司或其附屬公司之任何成員；
  (ii) 第三方獎賞、年資獎勵、聯名合作及優惠計劃供應商；
  (iii) 本公司及本集團之聯名合作夥伴(有關服務和產品的申請表上會提供聯名合作夥伴的名稱(視屬何情況而定))；及
  (iv) 慈善或非牟利組織；
(4) 除本公司推廣上述服務、產品及標的外，本公司同時擬提供列明於上述第(1)段之資料至上述第(3)段的所有或其中任何人士，該等人士藉以用於推廣上述服務、產品及標的，並本公司須為此目的取得您的同意(其中包您不反對之表示)；

若您不同意本公司使用或提供其資料予其他人士，藉以用於以上所述之直接促銷，您應通知本公司法律與合規部 (電話：2867 0888, 傳真：3906 9939) 以行使其不同意此安排的權利。

註：本保單中文譯本只供參考之用，如與英文原文有歧異，概以英文本為準。

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賠償限額表

I. 基本保障 (項目 B 及/或 C 如載於承保表方可生效)

保障項目及承保範圍		最高賠償額(HK$)（以每名受保人計算）			
		計劃 1	**計劃 2**	**計劃 3**	**計劃 4 (醫療增值計劃)**
A	**住院及手術保障（以每保單年度每一傷病計算）- 必選項目**				
	1. 住院膳宿費 (以 100 日為限)，每日最高限額	$800	$1,550	$3,000	每保單年度最高賠償總額為$250,000，每宗索償的上限為索償額的 55%及不設每項限額。 **注意：** 索償時，受保人須持有一份有效的住院及手術醫療保險，否則此項保障將失效。
	2. 醫生巡房費 (以 100 日為限)，每日最高限額	$800	$1,550	$3,000	
	3. 醫院服務費	$12,000	$18,000	$25,000	
	4. 外科手術費 (按手術分類表賠付，包括手術前兩次的診斷費及手術後的覆診費)				
	- 複雜手術	$38,000	$50,000	$70,000	
	- 大手術	$20,000	$30,000	$47,000	
	- 中手術	$9,000	$15,000	$19,000	
	- 小手術	$5,000	$6,500	$8,000	
	(手術後接受合資格中醫治療的覆診費用，每日限 1 次，每一傷病最多 5 次)，每日最高限額	$120	$150	$180	
	5. 手術室費	按 A4 項外科手術費賠償額的 30%賠付			
	6. 麻醉師費	按 A4 項外科手術費賠償額的 30%賠付			
	7. 專科醫生費 [1]	$4,000	$6,000	$9,000	
	8. 深切治療費 (因感染傳染病而遭政府機關強制性隔離及入院接受深切治療，深切治療的最高賠償額將自動提升一倍)	$15,000	$20,000	$25,000	
	9. 出院後覆診費 (出院/門診手術後起計的 6 個星期內)	$1,200	$2,500	$4,500	
	10. 住院加床費 (陪伴受保人住院；以 100 日為限)，每日最高限額	$800	$1,000	$1,200	
	11. 意外緊急門診費	$1,500	$2,000	$2,500	
	12. 家居看護費 (以 100 日為限)，每日最高限額	$530	$850	$1,150	
	13. 醫療裝置 (指定項目) (包括起搏器、經皮冠狀動脈腔內成形術的支架、眼內人造晶體、人工心瓣、關節置換術的金屬或人工關節、置換或植入於關節的人工韌帶及人工椎間盤)	$10,000	$20,000	$30,000	
	14. 化療/電療/標靶治療/質子治療/免疫治療/荷爾蒙治療/伽馬刀/數碼導航刀/腎透析治療費	$30,000	$50,000	$70,000	
	15. 進補現金津貼 (由接受手術及住院的第 8 日起計，每一傷病最多賠償 5 日)，每日最高賠償額	$200	$300	$500	
	16. 香港公立醫院特別現金津貼 (只適用於普通病房，以 50 日為限。當項目 A「住院及手術保障」不會作出賠償時適用，但項目 A15「進補現金津貼」除外)，每日最高限額	$500	$750	$1,000	
	17. 身故恩恤金 因意外導致住院並身故	$8,000	$10,000	$12,000	
每保單年度每名 76 歲或以上的受保人於項目 A 的每年賠償總限額		**$200,000**	**$400,000**	**$600,000**	
B	**附加重症住院保障 [2]（以每保單年度每一傷病計算）**				
只適用於基本保障「住院及手術保障」的第 A3 至 A8 項金額耗盡後(賠償額以百分比計算)		$150,000	$300,000	$500,000	不適用
賠償率		80%	80%	a. 80%或 b. 100%	

保障項目及承保範圍		最高賠償額(HK$)（以每名受保人計算）			
		計劃 1	計劃 2	計劃 3	計劃 4 (醫療增值計劃)
C	**住院現金保障**				
● 無論選擇任何一項基本保障及計劃，若受保子女年齡為 18 歲或以下，本保額將只按「計劃 1」受保 ● 於中國內地住院，此保障最高賠償額將減半。於中國香港以外住院，每名受保人於每保單年度的最高賠償日數為 90 日					
	1. 每日住院現金 (每一事故的最高賠償日數為 365 日)	$300	$500	$1,000	$300
	2. 因下列任何一種情況可獲雙倍每日住院現金保障(每一事故的最高賠償日數為 365 日)	$600	$1,000	$2,000	$600
	i. 入住深切治療病房 (每一事故的最高賠償日數為 90 日)				
	ii. 接受主要器官移植或首次證實患上癌症				
	iii. 感染指定傳染病 (每種傳染病最高賠償日數為 30 日)				
	iv. 短暫離開中國香港不超過 60 日的期間住院 (不包括中國內地及中國澳門)，每一事故的最高賠償日數為 30 日				
	v. 受保人及其受保合法配偶因同一次意外同時住院				
免費服務					
24 小時全球緊急支援服務 (如身處中國香港以外並須緊急入院，可獲享高達 HK$40,000 的住院代墊保證金)		詳情請參閱本保單			

II. 自選保障 (每一承保項目如載於承保表內方可生效)

保障項目及承保範圍		最高賠償額 (HK$)（以每名受保人計算）		
		計劃 1	計劃 2	計劃 3
D	**門診保障**			
網絡及非網絡服務 (非網絡服務為 80%的賠償額)		網絡服務	網絡服務	網絡及非網絡服務
	1. 普通科 (西藥日數：3 日，每日診症次數為 1 次)			
	每次診症最高賠償額	-	-	非網絡服務$350
	每保單年度最高診症次數	不限次數	不限次數	不限次數
	自付費 – 網絡服務	$30	$10	$0
	自付費 – 非網絡服務	不適用	不適用	20%
	2. 專科 [1] (須有醫生轉介信，西藥日數：5 日，每日診症次數為 1 次)			
	每次診症最高賠償額	-	-	非網絡服務$700
	每保單年度最高診症次數	不限次數	不限次數	不限次數
	自付費 – 網絡服務	$50	$30	$20
	自付費 – 非網絡服務	不適用	不適用	20%
	3. 中醫 (包跌打及針灸，每日診症次數為 1 次)			
	每次診症最高賠償額		-	$180
	每保單年度最高診症次數	不適用	12	12
	自付費 – 網絡服務		$0	$0
	自付費 – 非網絡服務		不適用	20%
	4. 物理及脊醫治療 [1] (須有醫生轉介信，每日診症次數為 1 次)			
	每次診症最高賠償額	-	-	$340
	每保單年度最高診症次數	10	10	10
	自付費 – 網絡服務	$0	$0	$0
	自付費 – 非網絡服務	不適用	不適用	20%
	5. X 光診斷及化驗 [1] (須有醫生轉介信)			
	每保單年度診症最高賠償額	$2,500	$3,000	$4,000
	自付費 – 網絡服務	$0	$0	$0
	自付費 – 非網絡服務	不適用	不適用	20%

保障項目及承保範圍		最高賠償額 (HK$)（以每名受保人計算）		
		計劃 1	計劃 2	計劃 3
E	**牙科保障**			
賠償額以百份比計算		80%	100%	不適用
	1. 口腔 X-光檢查 (每片最高賠償額)	$60	$70	
	2. 洗牙及預防治療 (每次診症最高賠償額、每保單年度最高診症次數)	$300 (1 次)	$400 (2 次)	
	3. 補牙、脫牙 (每隻牙齒最高賠償額)	$300	$400	
	4. 膿瘡排放 (每隻牙齒最高賠償額)	$200	$300	
	5. 齒根管填補 (每隻牙根最高賠償額)	$600	$1,200	
	「牙科保障」每保單年度最高總賠償額	$2,000	$3,800	
F	**產科保障** (每次懷孕包括產前及產後門診費；不適用於本保障生效或覆效後首 9 個月內懷孕或分娩，以較後者為準)			
	1. 手術分娩	$12,000	$15,000	$22,500
	2. 自然分娩	$8,000	$10,000	$15,000
	3. 流產	$6,000	$8,000	$12,000
G	**危疾保障**			
	1. 倘不幸首次被診斷及証實患上受保危疾，可獲一筆過現金賠償，但受保人首次被診斷及証實後必須仍能最少生存 30 日，方可獲得賠償	$100,000	$200,000	$300,000
	2. 當作出一項危疾賠償後，該獲索賠受保人於此項目"G"的保障將立即被終止			
	3. 90 日等候期：由保單正式生效或復效日起計算 90 日內期間的所有索償以較後者為準，包括所有患上之疾病、病徵已出現之疾病或已被診斷患上的一種受保疾病都不會獲得賠償			
	伸延保障			
	1. 危疾醫療費用 (被診斷證實首次患上癌症、中風或心肌疾病)	$30,000	$45,000	$60,000
	2. 患上 5 種婦女危疾或嚴重疾病額外保障 (若女性受保人首次被診斷患上乳癌、子宮頸癌、卵巢癌、子宮體癌或紅斑狼瘡症 [3]，可獲一筆過現金賠償)	$50,000	$80,000	$100,000
	3. 患上 5 種男性危疾額外保障 (若男性受保人首次被診斷患上肺癌、肝癌、結腸癌、前列腺癌或心肌疾病，可獲一筆過現金賠償)	$50,000	$80,000	$100,000

所有費用必須在正常及慣常的情況內。

註:
1. 須有合資格主診醫生發出的轉介信。轉介信的發出日期與有關病症的診治日期相隔不得超過 6 個月。
2. 如受保人的住院膳宿費每日最高賠償額少於該次住院醫院實際收取的住院膳宿費，本公司保留調整附加重症住院保障的賠償金額的權利。
3. 紅斑狼瘡症：設 90 日等候期，當作出此項賠償後，該獲索賠受保人於項目"G"的保障便立即終止。