EBeyond Medical Insurance Solution
Policy Provisions

EBeyond Medical Insurance Solution
Terms and Conditions

Contents

TERMS AND CONDITIONS

Part 1 Insuring Clause and The Policy

Insuring Clause

These Terms and Conditions together with the Benefit Schedule (hereafter "Terms and Benefits") apply to the following Plan offered by the Company –

Name of the Plan - EBeyond Medical Insurance Solution

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

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

The Policy

The Policy Owner and the Company agree that –

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

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

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

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

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

6. The Company acknowledges that, as part of the underwriting process (where applicable), it is the obligation of the Company to ask the Policy Owner and the Insured Person in the Application and reinstatement request document all requisite information for the Company to make the underwriting decision. If the Company requires the Policy Owner and/or the Insured Person to disclose any updates of or changes to such requisite information after the time of submission of Application and reinstatement request document, the Policy Owner and/or the Insured Person shall have the obligation to inform the Company on such updates and

changes. Each of the Policy Owner and the Insured Person shall have the obligation to respond to the questions, and to disclose such material facts as requested in the questions.

7. If the Policy Owner or the Insured Person fails to make the relevant disclosures under Section 6 of this Part 1, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right as provided in Sections 13 and 14 of Part 2.

Part 2 General Conditions

1. Interpretation

(a) Throughout these Terms and Benefits, where the context so requires, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.
(b) Headings are for convenience only and shall not affect the interpretation of these Terms and Benefits.
(c) A time of day is a reference to the time in Hong Kong.
(d) Unless otherwise defined, capitalised terms used in these Terms and Benefits shall have the meanings ascribed to them under Part 8.

2. Cancellation within cooling-off period

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

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

(i) these Terms and Benefits and the Policy Schedule; or
(ii) the cooling-off notice;

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

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

The above cancellation right shall not apply at Renewal.

To exercise this cancellation right, the Policy Owner must –

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

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

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

3. Cancellation

After the cooling-off period, the Policy Owner can request cancellation of these Terms and Benefits by giving thirty (30) days prior written notice to the Company, provided that there has been no benefit payment under these Terms and Benefits during the relevant Policy Year.

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

4. Benefit entitlement

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

5. Assignment

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

6. Clerical error

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

7. Currency

Any claim for Eligible Expenses made by the Insured Person in any foreign currency shall be converted to HKD at the rate certified as appropriate by the Company's bankers which shall be deemed to be final and binding.

8. Interest

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

9. Company's obligation

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

10. Governing law

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

11. Dispute resolution

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

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

12. Liability

The Company shall not accept any liability under this Policy unless the terms of this Policy relating to anything to be done or not to be done are duly observed and complied with by the Policy Owner and the Insured Person, and the information and representations made in the Application, reinstatement request document and declaration are correct.

13. Misstatement of personal information

Without prejudice to the Company's right to declare this Policy void in the case of misrepresentation on health related information or fraud as provided in Section 14 of this Part 2, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or eligibility based on the application criteria as determined by the Company from time to time, if any and if applicable) is misstated in the Application, reinstatement request document or in any subsequent information or document submitted to the Company for the purpose of the application or reinstatement request, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1), the Company may adjust the premium, for the past, current or future Policy Years, on the basis of the correct information. Where additional premium is required, no benefits shall be payable unless the additional premium has been paid. If the additional required premium is not paid within a grace period of thirty (30) days after the due date as notified by the Company to the Policy Owner, the Company shall have the right to terminate this Policy with effect from such due date, in which case Section 15 of this Part 2 shall apply. Where there has been an overpayment of premium by the Policy Owner, the Company shall refund the overpaid premium.

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

(a) the right to demand refund of the benefits previously paid; and
(b) the obligation to refund the premium received,

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

14. Misrepresentation or fraud

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

(a) any material fact relating to the health related information of the Insured Person which may impact the risk assessment by the Company is incorrectly stated in, or omitted from, the Application or reinstatement request document or any statement or declaration made for or by the Insured Person in the Application, reinstatement request document or in any subsequent information or document submitted to the Company for the purpose of the application or reinstatement request, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1). The circumstances that a fact shall be considered "material" include, but are not limited to, the situation where the disclosure of such fact as required by the Company would have affected the underwriting decision of the Company, such that the Company would have imposed Premium Loading, included Case-based Exclusion(s), or rejected the application or reinstatement request. For the avoidance of doubt, this paragraph (a) shall not apply to non-health related information of the Insured Person, which shall be governed by Section 13 of this Part 2; or
(b) any Application, reinstatement request document or claim submitted is fraudulent or where a fraudulent representation is made.

The Company shall have the duty to make all necessary inquiries on all facts which are material to the Company for underwriting purpose as provided in Section 6 of Part 1.

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

(i) the right to demand refund of the benefits previously paid; and
(ii) the obligation to refund the premium received,

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

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

(iii) the right to demand refund of the benefits previously paid; and
(iv) the right not to refund the premium received.

15. Termination of Policy

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

(a) where this Policy is terminated due to non-payment of premiums after the grace period as specified in Section 13 of this Part 2 or Section 3 of Part 3;
(b) the day immediately following the death of the Insured Person; or
(c) the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write or continue to write this Policy.

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

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

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

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

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

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

(d) the Terms and Benefits of this Plan which shall continue to be in full force and effect; and
(e) the continuity of these Terms and Benefits, and shall not adversely affect the Company's compliance with the licensing requirement in order to continue to write these Terms and Benefits.

16. Notices to Company

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

17. Notices from Company

Any notice to be given under this Policy shall be sent to the Policy Owner by electronic means or/and by post according to the latest contact information provided by the Policy Owner. Any notice so served shall be deemed to have been duly received by the Policy Owner as follows –

(a) If sent by electronic means, on the date and time transmitted; or

(b) If sent by post, two (2) working days after posting.

18. Other insurance coverage

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

Notwithstanding the above, where requested by the Company upon submission of a claim, the Policy Owner or the Insured Person must declare whether the Insured Person is covered under any group medical scheme provided by other licensed insurance companies. Claim payments shall first be made under such group medical policy of the Insured Person (if any). Any unpaid portion of the Eligible Expenses and/or expenses shall then be claimable under this Policy, subject to the Terms and Benefits of this Policy.

19. Ownership and discharge under this Policy

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

20. Policy Owner and beneficiary

The Policy Owner is the only person who can request changes to, and exercise the rights related to this Policy while this Policy is in force.

The Policy Owner is entitled to any proceeds of this Policy that do not result from the death of the Insured Person. If the Policy Owner dies, the proceeds will be paid to the appointed executors or administrators of the Policy Owner’s estate. If the Policy Owner is also the Insured Person, the proceeds will instead be paid to the beneficiary.

A beneficiary is someone the Policy Owner nominates to receive proceeds of this Policy if the Insured Person dies. The Policy Owner can nominate multiple beneficiaries as well as each beneficiary's share of any proceeds.

During the Insured Person's lifetime, the beneficiary cannot request any changes to, claim benefits from, or exercise any rights in relation to this Policy.

If no beneficiaries are nominated, or if all of the beneficiaries die before the Insured Person, the Company will pay the proceeds to the Policy Owner, or the executors or administrators of the Policy Owner's estate (if the Policy Owner dies).

If a beneficiary dies before the Insured Person, and the Policy Owner does not provide an update to the beneficiary nomination, his or her share of the Policy benefits will be redistributed to any surviving beneficiaries in proportion to their nominated share (or equally if no nomination has been made).

If both the Insured Person and a beneficiary die in the same incident and the official time of death is the same, any Policy proceeds will be paid as if the elder of the two (2) people had died first.

21. Change of Policy Owner and beneficiary

The Policy Owner may change the Policy Owner or beneficiary of this Policy while it is in force by submitting a written request to the Company. The Company will register the change in the Company's records when the Company determines that all relevant information has been received, from which time the change will be effective.

22. Rights of third parties

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

23. Subrogation

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

24. Suits against third parties

Nothing in this Policy shall oblige the Company to join, respond to or defend (or indemnify in respect of the costs for) any suit or alternative dispute resolution process for damages for any cause or reason which may be instituted by the Policy Owner or the Insured Person against any Registered Medical Practitioner, Hospital or

healthcare services provider, including but not limited to any suit or alternative dispute resolution process for negligence, malpractice or professional misconduct or any other causes in relation to or arising out of the medical investigation or treatment of the Disability of the Insured Person under the terms of this Policy.

25. Waiver

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

26. Compliance with law

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

27. Personal data privacy

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

28. Suicide

If the Insured Person commits suicide (whether sane or insane at that time) within thirteen (13) calendar months from the Policy Date, the Company's liability under this Policy will be limited to the refund of premiums paid (without interest) less any outstanding insurance levy and any benefit which has been paid under this Policy.

29. Obligation to Provide Information

The Policy Owner acknowledges that the Company and/or its affiliates are obliged to comply with legal and/or regulatory requirements in various jurisdictions as promulgated and amended from time to time, such as the United States Foreign Account Tax Compliance Act, and the automatic exchange of information regime ("AEOI") followed by the Inland Revenue Department (the "Applicable Requirements"). These obligations include providing information of clients and related parties (including personal information) to relevant local and international authorities and/or to verify the identity of the clients and related parties. In addition, the Company's obligations under the AEOI are to:

(a) identify accounts as non-excluded "financial accounts" ("NEFAs");
(b) identify the jurisdiction(s) in which NEFA-holding individuals and NEFA-holding entities reside for tax purposes;

(c) determine the status of NEFA-holding entities as "passive non-financial entities (NFEs)" and identify the jurisdiction(s) in which their controlling persons reside for tax purposes;
(d) collect information on NEFAs ("Required Information") which is required by various authorities; and
(e) furnish Required Information to the Inland Revenue Department.

The Policy Owner agrees that from time to time the Company shall have the right to request from the Policy Owner, and disclose to relevant authority(ies), various information about the Policy Owner, the Beneficiary and this Policy as required under Applicable Requirements for the following purposes:

(f) for the Company to issue this Policy to the Policy Owner;
(g) for the Company to provide benefits available to the Policy Owner and/or the beneficiary under the terms of this Policy; and/or
(h) for this Policy to remain in force in accordance with its terms.

In addition, the Policy Owner agrees to notify the Company in writing within thirty (30) days if there is any change of any of the information previously provided to the Company (whether at time of application or at any other times).

If the Policy Owner does not provide such information within a time period as reasonably requested by the Company, the Company shall be entitled to, upon prior written notice to the Policy Owner (to the extent permitted by Applicable Requirements):

(i) Report this Policy and/or information about the Policy Owner and/or the beneficiary to relevant authority(ies);
(j) Terminate this Policy and return to the Policy Owner the surrender value (if any) without interest which shall be calculated pursuant to applicable terms and conditions under this Policy net of any outstanding amounts relating to this Policy; or
(k) Take any such other action(s) as may be reasonably required including but not limited to making adjustments to the values, balances, benefits or entitlements under this Policy.

Prior to the expiry of such time period and notwithstanding any other provisions of this Policy, the Company shall have the sole discretion to suspend or defer any transaction or provision of any services to the Policy Owner under this Policy if any information reasonably requested by the Company under Applicable Requirements remains outstanding.

Part 3 Premium Provisions

1. Premium payable

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

(a) the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company; and
(b) the Premium Loading, if applicable.

2. Payment of premiums

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

Premium due dates, Policy Anniversaries and Policy Years are determined with reference to the Commencement Date as stated in the Policy Schedule. The first premium is due on the Commencement Date.

After payment of the first premium, failure to pay a premium on or before its due date shall constitute default in payment of premium.

3. Grace period

The Company shall allow a grace period of thirty (30) days after the premium due date for payment of each premium. This Policy shall continue to be in effect during the grace period but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, this Policy shall be terminated immediately on the date on which the unpaid premium is first due.

4. Reinstatement

Within one (1) year from the date of a default in payment of premium pursuant to which this Policy was terminated, this Policy may be reinstated at the Company's absolute discretion, provided that the Insured Person is still alive and insurable by the Company's underwriting rules. In order to reinstate this Policy, the Policy Owner must:

(a) apply to the Company in writing within one (1) year from the date of termination of this Policy;
(b) provide the Company with satisfactory evidence that the Insured Person still qualifies for this Policy in accordance with the Company's prevailing rules and regulations; and
(c) repay all unpaid premiums (with interest at an interest rate that the Company sets) and any outstanding insurance levy(ies).

The Company may refuse the application for reinstatement or may adjust the terms of this Policy. If the Company accepts the application for reinstatement, this Policy will recommence from a date that the Company determines. No coverage is provided under this Policy during the period starting from the date on which the Policy lapses and ending on the date of reinstatement.

5. Deduction of unpaid premium and outstanding insurance levy

If the Policy Owner pays premiums at a frequency other than annually (for example, monthly), the Company will deduct from any death benefit payment the amount of unpaid premiums and/or outstanding insurance levy(ies) (if any) for the Policy Year in which the Insured Person died, as well as any other amounts owed to the Company before paying the death benefits. Any due and unpaid premium and/or outstanding insurance levy will be deducted from any benefit otherwise payable.

6. No claims premium discount

If:

(a) this Policy has been in force for two (2) or more consecutive Policy Years; and

(b) no claims have been incurred under these Terms and Benefits during two (2) or more consecutive Policy Years immediately prior to the Policy's Renewal and no claims have been settled by the Company. For the purpose of this clause, a claim is considered as incurred on

(i) the first date of admission if the Insured Person is Confined in a Hospital, admitted to a Registered Rehabilitation Centre or a registered hospice; or

(ii) the date on which the Medical Service is performed on the Insured Person as a Day Patient;

then the Policy Owner shall be eligible for a no claims premium discount on the Renewal premium of these Terms and Benefits (including the premium of supplementary major medical benefit, if applicable) at the following rate:

No claims period immediately prior to the Policy's Renewal	**No claims premium discount (Discount rate on Renewal premium)**
Two (2) consecutive Policy Years	10%
Three (3) consecutive Policy Years	10%
Four (4) consecutive Policy Years	10%
Five (5) or more consecutive Policy Years	15%

(c) Notwithstanding the above condition (b) of this Section 6, any benefits paid under Sections 4(a)(i), 4(a)(vi), 4(b) or 4(c)(i) (excluding Chinese medicine treatments) of Part 6 of these Terms and Benefits for any designated Day Case Procedure(s) performed at any Designated Healthcare Services Providers, which are performed on the Insured Person during the no claims period, shall not affect the eligibility for no claims premium discount. This condition (c) of this Section 6 shall be subject to the terms and conditions for designated Day Case Procedures performed at a Designated Healthcare Services Provider as stated in Sections 1(c)(i) to 1(c)(iv) of Part 6 of these Terms and Benefits.

(d) Where the supplementary major medical benefit is attached after the Policy has come into force, the no claims premium discount applicable to the Renewal premium of such supplementary major medical benefit shall be calculated by reference to the date of attachment, provided that the conditions set out in Sections 6(a) and 6(b) of this Part 3 are satisfied. Such calculation shall be subject to the terms and conditions as determined by the Company at its sole discretion from time to time and the prevailing rules adopted by the Company.

(e) For the avoidance of doubt, if a claim under these Terms and Benefits is incurred prior to the Renewal Date but is not made or settled until after the Renewal Date, and the Policy Owner has already received the no claims premium discount, the Policy Owner shall upon demand immediately repay the Company

the difference between the no claims premium discount amount already received and the eligible discount amount under these Terms and Benefits as recalculated according to conditions (a) to (d) as set out in this Section 6.

Part 4 Renewal Provisions

These Terms and Benefits shall be effective from the Policy Date in consideration of the payment of premium and is Renewable for each Policy Year in accordance with the terms of this Part 4. Renewal is guaranteed up to the Age of one hundred and one (101) years of the Insured Person.

1. Renewal

Unless the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write these Terms and Benefits, or the Policy Owner decides not to Renew these Terms and Benefits by giving the Company not less than thirty (30) days prior notice in writing in accordance with Section 3 of Part 2, Renewal shall be arranged automatically by the Company. The Company reserves the right to revise, modify or adjust the Terms and Benefits upon Renewal.

2. Adjustment of premium

Irrespective of whether the Company revises these Terms and Benefits upon Renewal, by giving a thirty (30) days prior written notice, the Company shall have the right from time to time to review and adjust the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company on an overall basis, due to factors including but not limited to Age, medical inflation, and claims experience and policy persistency in all other policies of the same kind. For the avoidance of doubt, if the Premium Loading is set as a percentage of the Standard Premium (i.e. rate of Premium Loading), the amount of Premium Loading payable shall be automatically adjusted according to the change in Standard Premium.

3. Change of Place of Residence or occupation

The Policy Owner must immediately inform the Company if the Insured Person's occupation or Place of Residence changes and the Company will re-underwrite in respect of such changes based on the Company's underwriting rules. If the Company needs to reduce or increase the premium, the Company will inform the Policy Owner the amount of new premium and the due date in writing.

The Policy Owner also acknowledges that, the Company will carry out the re-underwriting solely in respect of the said change and the re-underwriting result may be more advantageous or adverse to the Policy Owner and the Insured Person.

If the Company considers the new occupation or Place of Residence to be subject to a higher premium rate, based on the Company's underwriting rules, the Company may increase the premium and collect any premium shortfall with interest and any additional insurance levy.

If the Company considers the new occupation or Place of Residence to be subject to a lower premium rate, based on the Company's underwriting rules, the Company may decrease the premium and refund the excess premium and insurance levy without interest.

If the new occupation or Place of Residence is unable to be insured based on the Company's underwriting rules, the Company may terminate this Policy or refuse to pay any Policy benefits that become payable after the change.

4. Revision of benefits and limitations

The Company can revise, amend or modify this Policy, including the premium, by notifying the Policy Owner in writing at least thirty (30) days before the Policy Anniversary after which the revisions will take effect.

Upgrade in plan level

While this Policy is in force, the Policy Owner may request an increase in benefits by changing the plan level within the same plan option (i.e., EBridge Plans or EBoost Plans), and the revised plan level shall take effect from the Policy Anniversary following the Company's approval of the Policy Owner's request.

Such increase in benefits shall be subject to underwriting or re-underwriting (as the case may be) in accordance with the terms and conditions as determined by the Company from time to time and the prevailing operational rules as adopted by the Company at the time of request. The Company may require the Policy Owner to provide evidence of insurability which is acceptable to the Company, and any increase in benefits shall be subject to rules and policies of the Company.

In the event that underwriting or re-underwriting is required, any increase in benefits arising from a change in plan level shall be adjusted as follows after considering the latest rules and exclusions and shall take effect on the same day as the plan level upgrade:

(a) for any benefit payable under Sections 4(a) to 4(c), 4(e)(iii) to 4(e)(viii) and 4(f) (if applicable) of Part 6 of these Terms and Benefits, if the benefit is payable as a result of a Disability, the increased benefit shall only be payable where the First Symptoms appear, the condition occurs, and the diagnosis or surgery related to the relevant Disability occurs after the date of the benefit increase. If the benefit is payable as a result of an Injury, the increased benefit shall only be payable where the Accident occurs on or after the date of the benefit increase;

(b) for any benefit payable under Section 4(d)(ii) of Part 6 of these Terms and Benefits, the increased benefit shall only be payable if the date of diagnosis of Alzheimer's Disease occurs after two (2) consecutive years from the date of the benefit increase;

(c) for any benefit payable under Sections 4(e)(i) and 4(e)(ii) of Part 6 of these Terms and Benefits, the increased benefit shall only be payable if the death occurs on or after the date of the benefit increase;

(d) for any benefit payable in relation to Human Immunodeficiency Virus ("HIV") and its related Disability, where Section 3 of Part 7 of these Terms and Benefits applies, the increased benefit shall only be payable for the expenses arising from HIV and its related Disability if the manifestation of HIV and its related Disability occurs after five (5) consecutive years calculated from the date of the benefit increase.

The Company will not pay any additional benefit in respect of any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that occurs before the date of the benefit increase.

Notwithstanding the above, an upgrade in plan level may be allowed without underwriting or re-underwriting, where designated criteria are met or on any other grounds accepted by the Company at its sole discretion from time to time. The revised plan level shall take effect from the Policy Anniversary following the Company's approval of the Policy Owner's request. Any claims incurred before such Policy Anniversary shall be reimbursed in accordance with the coverage under the plan level prior to the upgrade, while any claims incurred on or after such Policy Anniversary shall be reimbursed in accordance with the revised plan level.

Attachment of supplementary major medical benefit

(Applicable to Plans 2, 3 or 4 under EBridge Plans) While this Policy is in force, the Policy Owner may request the attachment of the supplementary major medical benefit. Such attachment shall be subject to underwriting or re-underwriting (as the case may be), unless designated criteria are met or otherwise permitted by the Company at the Company's sole discretion from time to time, and shall also be subject to the terms and conditions as determined by the Company from time to time. The coverage under the supplementary major medical benefit shall take effect from the Policy Anniversary following the Company's approval of the Policy Owner's request.

Benefit layering may be applied to specified health condition(s) as a result of underwriting. For all specified health conditions that are imposed as Case-based Exclusions under the supplementary major medical benefit, no benefit shall be payable under Section 4(f) of Part 6 of these Terms and Benefits. Where the Eligible Expenses or other expenses involve both specified health conditions and non-specified health conditions and apportionment of such expenses is not available, the expenses in their entirety shall not be subject to the benefit layering specified herein.

Downgrade in plan level or cancellation of supplementary major medical benefit

While this Policy is in force, the Policy Owner may request a decrease in benefits by changing the plan level within the same plan option (i.e. EBridge Plans or EBoost Plans), or request the cancellation of the supplementary major medical benefit (if applicable). The Insured Person will not be subject to re-underwriting when the Policy Owner requests a downgrade in plan level or the cancellation of supplementary major medical benefit (if applicable), and such change shall take effect from the Policy Anniversary after the Company's approval of the Policy Owner's request. The Company will reimburse benefits based on the revised plan level from the Policy Anniversary after the Company approves Policy Owner's request.

(Applicable to EBridge Plans) Where the plan level after the downgrade is not eligible for the attachment of the supplementary major medical benefit, the supplementary major medical benefit shall be automatically terminated from the Policy Anniversary after the Company's approval of the request for a downgrade in plan level.

Part 5 Claim Provisions

1. Submission of claims

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

(a) all original receipts and/or original itemised bills together with the diagnosis, type of treatment, procedure, test or service provided shall have been submitted to the Company; and
(b) all relevant information, certificates, reports, evidence, referral letter and other data or materials as reasonably required by the Company shall have been furnished to the Company for processing of such claim.

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

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

2. Legal action

If a claim is false, fraudulent, intentionally exaggerated or if any person has used fraudulent means to attempt to claim a benefit, the Company will terminate this Policy immediately without refunding the premiums and insurance levy paid. The Company will also recover any benefit which have been paid but which should not have been paid because of this fraud.

Any legal action taken on this Policy cannot be pursued until three (3) months following the date the Company was given the submission of claims under Section 1 of this Part 5, and cannot be pursued after three (3) years following that date. If the Policy Owner does not take legal action to contest the Company’s rejection of a claim within twelve (12) calendar months of being notified of Company’s rejection, the Company will consider the claim to be abandoned and it cannot be reinstated.

3. Medical examination

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

Part 6 Benefit Provisions

1. General

(a) Territorial scope of cover

Except for (1) the psychiatric treatments as stated in Section 4(a)(ix) of this Part 6, (2) the coverage of network benefits as stated in Section 3 of this Part 6, (3) the cash benefit for Confinement in general ward in a public Hospital in Hong Kong as stated in Section 4(e)(iii) of this Part 6, (4) the cash benefit for Confinement in Intensive Care Unit in Hong Kong as stated in Section 4(e)(vii) of this Part 6 and (5) the cash benefit for room and board Confinement below entitled ward class in a private Hospital in Hong Kong as stated in Section 4(e)(viii) of this Part 6, all benefits described in these Terms and Benefits shall be applicable worldwide.

(b) Lifetime Benefit Limit

All benefits described in these Terms and Benefits are not subject to any Lifetime Benefit Limit.

(c) Choice of healthcare services providers

Except for (1) the coverage of network benefits as stated in Section 3 of this Part 6; (2) the cash benefit for designated Day Case Procedure which is performed at a Designated Healthcare Services Provider as stated in Section 4(e)(iv) of this Part 6; (3) the cash benefit for Confinement in general ward in a public Hospital in Hong Kong as stated in Section 4(e)(iii) of this Part 6; and (4) the cash benefit for room and board Confinement below entitled ward class in a private Hospital in Hong Kong as stated in Section 4(e)(viii) of this Part 6, all benefits are not subject to any restriction in the choice of healthcare services providers, including but not limited to Registered Medical Practitioner and Hospital.

(1) The coverage of network benefits as stated in Section 3 of this Part 6; and (2) the cash benefit for designated Day Case Procedure which is performed at a Designated Healthcare Services Provider as stated in Section 4(e)(iv) of this Part 6 are subject to the restrictions on the choice of healthcare services providers as set out below.

(i) Before receiving the Medical Services (including designated Day Case Procedures) or other services provided by Designated Healthcare Services Providers, the Insured Person must make a reservation for a consultation with a Registered Medical Practitioner through the service hotline and follow the procedures as specified in (1) the list of Designated Healthcare Services Providers for network benefit in Hong Kong (**"List 1"**) and (2) the list of designated Day Case Procedures and Designated Healthcare Services Providers (**"List 2"**) (collectively **"Lists"**) and present his Hong Kong Identity Card (or other valid identification documents) upon registration for identification purposes.

(ii) The Lists are published on the Company's website (www.fwd.com.hk/en/support/medical-support/). The Lists may be added, deleted, amended or replaced from time to time at the Company's sole discretion without prior notification. Any change shall be deemed as effective as of the effective date as stated in the Lists. The Policy Owner and/or Insured Person is

recommended to refer to the Company's website for the latest Lists before receiving the Medical Services (including designated Day Case Procedures) or other services.

(iii) Designated Healthcare Services Providers are not operated by the Company or the Company's agents or employees. The Company is not the agent of the Designated Healthcare Services Providers; and accepts no responsibility or liability for the quality and availability of the services and shall not be liable or responsible for any acts or omissions of a Designated Healthcare Services Provider in the provision of such services.

(iv) The Company is not responsible for maintaining any medical information of the Insured Person in relation to services provided by Designated Healthcare Services Providers. Any information disclosed to the Designated Healthcare Services Providers by the Policy Owner or Insured Person shall not constitute any actual, constructive, or deemed knowledge of the Company of the same, and shall not affect the Company's right to contest any other policy(ies) the Company issued/issues to the Insured Person, unless such information has actually been disclosed by the Policy Owner or Insured Person to the Company or the Company has actual knowledge of such information.

(3) The cash benefit for Confinement in general ward in a public Hospital in Hong Kong and (4) the cash benefit for room and board Confinement below entitled ward class in a private Hospital in Hong Kong are subject to the restrictions in the choice of healthcare services providers as stated in Sections 4(e)(iii) and 4(e)(viii) of this Part 6 respectively.

(d) Choice of ward class

The benefits described in these Terms and Benefits are subject to the restriction in the choice of ward class as stated in the Benefit Schedule (if any) and the ward class adjustment factor as set out below.

If on any day of Confinement, the Insured Person is voluntarily Confined in a ward class of Hospital accommodation higher than his/her entitled ward class as specified in the Benefit Schedule, the ward class adjustment factor set out below shall be applied to the Eligible Expenses and/or expenses which are reasonable and customary incurred on that day.

Ward class adjustment factor

Entitled ward class as specified in the Benefit Schedule	Actual ward class occupied by the Insured Person during Confinement	Ward class adjustment factor
Standard Ward Room	Standard Semi-private Room	50%
Standard Ward Room	Standard Private Room	25%
Standard Ward Room	Above Standard Private Room	12.5%
Standard Semi-private Room	Standard Private Room	50%
Standard Semi-private Room	Above Standard Private Room	25%
Standard Private Room	Above Standard Private Room	25%

The ward class adjustment factor shall not be applied under the following circumstances:

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

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

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

(e) Benefit calculation

For benefits items specified as payable on a **"per Disability"** basis in the Benefit Schedule (if applicable), the respective benefit limits shall be counted afresh in the following conditions –

(i) When Eligible Expenses and/or expenses are incurred, and/or cash benefits are paid for different Disabilities, the applicable benefit limits shall be counted anew for each Disability, except where the Insured Person is Confined or receives any Day Case Procedures involving more than one (1) Disability, then the Eligible Expenses, expenses and/or cash benefits payable for all Disabilities involved in the same Confinement or Day Case Procedure would be subject to one (1) limit under the corresponding benefit item(s); or

(ii) When Eligible Expenses and/or expenses are incurred, and/or cash benefits are paid for more than one (1) Confinement or Day Case Procedure for the same Disability (regardless of whether there are any other Disability(ies) involved in the Confinement or Day Case Procedure), provided that such Confinement or Day Case Procedure does not occur within ninety (90) consecutive days following the Last Date of the previous Confinement or Day Case Procedure in relation to the same Disability, the applicable benefit limits shall be counted anew for such Confinement or Day Case Procedure concerning the same Disability. "Last Date" of a Confinement or Day Case Procedure for the same Disability shall mean the later of (1) the discharge date of Confinement or (2) the date on which the Insured Person undergoes a Day Case Procedure.

For benefit items specified as payable on a **"per Policy Year"** basis in the Benefit Schedule (if applicable), where the Eligible Expenses and/or expenses are incurred, and/or cash benefits are paid in different Policy Years regardless of whether the Eligible Expenses, expenses and/or cash benefits relate to the same or different Disability(ies), the applicable benefit limits shall be counted anew every Policy Year.

For benefit items specified as payable on a **"per Policy"** basis in the Benefit Schedule, once the aggregate amount paid or payable under the respective benefit items reaches the maximum amount specified, the benefit will automatically terminate.

2. Coverage of Confinement and non-Confinement services

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

(a) is Confined in a Hospital; or

(b) undergoes any Day Case Procedure, Prescribed Diagnostic Imaging Test, Prescribed Non-surgical Cancer Treatment, Emergency outpatient accidental treatment or outpatient kidney dialysis (in a setting for providing Medical Services to a Day Patient),

the Company shall reimburse the Eligible Expenses or expenses which are reasonable and customary in accordance with benefit items under Sections 4(a) to 4(c) and 4(f) of this Part 6.

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

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

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

3. Coverage of network and non-network benefits

"Network benefits" refer to the benefits payable for Medical Services or other services performed at a Designated Healthcare Services Provider in Hong Kong and are subject to the terms and conditions as specified in Sections 1(c)(i) to 1(c)(iv) of this Part 6. Otherwise, such benefits shall be referred to as "non-network benefits".

With supplement to Section 2 of this Part 6 above, where Medical Services or other services are performed at a Designated Healthcare Services Provider in Hong Kong and the terms and conditions specified in Sections 1(c)(i) to 1(c)(iv) of this Part 6 are fulfilled,

(a) (Applicable to EBridge Plans) Eligible Expenses or expenses incurred for the benefit items under Sections 4(a), 4(b), 4(c)(i) to 4(c)(ii), 4(c)(v) to 4(c)(vii) and 4(f) of this Part 6 are payable under these Terms and Benefits as "network benefits" and are subject to the limits and Coinsurance (if applicable) specified as "network" in the Benefit Schedule.

Where Medical Services or other services are performed at a Designated Healthcare Services Provider outside Hong Kong, or at any non-Designated Healthcare Services Provider, or where any of the terms and conditions specified in Sections 1(c)(i) to 1(c)(iv) of this Part 6 are not fulfilled, Eligible Expenses or expenses incurred for the benefit items under Sections 4(a), 4(b), 4(c)(i) to 4(c)(ii), 4(c)(v) to 4(c)(vii) and 4(f) of this Part 6 shall be payable under these Terms and Benefits as "non-network benefits" and shall be subject to the limits and Coinsurance (if applicable) specified as "non-network" in the Benefit Schedule.

In any event, the aggregate amount payable for "network benefits" and "non-network benefits" for the respective benefit items as set out above, shall not exceed the limits specified as "network" in the Benefit Schedule, including but not limited to per day limit and maximum limit per Disability.

(b) (Applicable to EBoost Plans) The Eligible Expenses or expenses incurred for the applicable benefit items that are covered under the Annual Benefit Limit and subject to reimbursement percentage as stated in the Benefit Schedule are payable under these Terms and Benefits as "network benefits", and are subject to the "network" Annual Benefit Limit and reimbursed at the "network" reimbursement percentage as specified in the Benefit Schedule.

Where Medical Services or other services are performed at a Designated Healthcare Services Provider outside Hong Kong, or at any non-Designated Healthcare Services Provider, or where any of the terms and conditions specified in Sections 1(c)(i) to 1(c)(iv) of this Part 6 are not fulfilled, any Eligible Expenses or expenses incurred for the applicable benefit items shall be payable under these Terms and Benefits as "non-network benefits", and shall be subject to the "non-network" Annual Benefit Limit and reimbursed at the "non-network" reimbursement percentage as specified in the Benefit Schedule.

In any event, the aggregate amount payable for "network benefits" and "non-network benefits" for the applicable benefit items in any Policy Year shall not exceed the "network" Annual Benefit Limit as specified in the Benefit Schedule.

4. Benefits covered

(a) Hospitalisation benefits

(i) Room and board

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

(ii) Intensive care

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

For the avoidance of doubt, the Eligible Expenses so incurred and payable under this benefit shall not be payable under Section 4(a)(i) of this Part 6.

(iii) Companion bed

This benefit shall be payable for expenses charged by the Hospital in which the Insured Person is Confined for an extra companion bed for one (1) person who accompanies the Insured Person in Hospital during his/her Confinement.

(iv) Attending doctor's visit fee

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

(v) Specialist's fee

If on any day of Confinement, the Insured Person is treated by a Specialist (not being the attending Registered Medical Practitioner under Section 4(a)(iv) of this Part 6) as recommended in writing by the attending Registered Medical Practitioner, this benefit shall be payable for the Eligible Expenses charged by the Specialist for such visit or consultation.

(vi) Miscellaneous charges

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

1. Road ambulance service to and/or from the Hospital;
2. Anaesthetic and oxygen administration;
3. Administration charges for blood transfusion;
4. Dressing and plaster casts;
5. Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;
6. Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
7. Additional surgical appliances, equipment and devices other than those inclusively paid under Section 4(b)(iii) of this Part 6, and implants, disposables and consumables used during surgical procedure;
8. Medical disposables, consumables, equipment and devices;
9. Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Section 4(c)(v) of this Part 6;
10. Intravenous ("IV") infusions including IV fluids;
11. Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
12. Rental of walking aids and wheelchair for Inpatients; and
13. Physiotherapy, occupational therapy and speech therapy during Confinement.

(vii) Private nurse's fee

In addition to the general nursing services provided by the Hospital to the Insured Person during Confinement, this benefit shall be payable for the Eligible Expenses the Insured Person incurred for private nursing service provided by a Registered Nurse recommended in writing by the Insured Person's attending Registered Medical Practitioner during the Insured Person's Confinement following –

1. a surgical procedure performed on the Insured Person for which the Eligible Expenses incurred are payable under Section 4(b)(i) of this Part 6; or
2. the Insured Person's discharge from an Intensive Care Unit for which the Eligible Expenses incurred are payable under Section 4(a)(ii) of this Part 6,

subject to the limits as stated in the Benefit Schedule.

This benefit is subject to a maximum of one (1) nursing visit on each day of such eligible Confinement. In the event that more than one (1) Registered Nurse provides nursing services at the same visit, only the Eligible Expenses in respect of up to one (1) Registered Nurse with the highest fee shall be payable; or if the Insured Person has received more than one (1) nursing visit on the same day, only the one (1) nursing visit incurring the highest Eligible Expenses on that day shall be payable. For the avoidance of doubt, regardless of whether nursing service(s) is/are provided for all or part of a day on a particular day, the day on which the nursing service(s) is/are provided shall be counted as one (1) day for the purpose of

counting the maximum number of days per Disability (for EBridge Plans) or the maximum number of days per Policy Year (for EBoost Plans) allowed for this benefit as specified in the Benefit Schedule.

If (1) Eligible Expenses for private nursing services provided by a Registered Nurse, which are payable under Section 4(a)(vii) of this Part 6, and (2) expenses for inpatient care services provided by a Healthcare Assistant, which are payable under Section 4(a)(viii) of this Part 6, are incurred on the same day, only the session with the higher fee payable under these Terms and Benefits shall be reimbursed for that day. Where the private nursing fee is higher and reimbursed, the Healthcare Assistant's fees for that day shall not be covered. In such case, the Healthcare Assistant's visit on that day shall not be counted toward the maximum number of days per Disability (for EBridge Plans) or the maximum number of days per Policy Year (for EBoost Plans) for golden years Hospital companion care under Section 4(a)(viii) of this Part 6. Conversely, where the Healthcare Assistant's fee is higher and reimbursed, the private nursing fees for that day shall not be covered, and the Registered Nurse's visit providing private nursing service for that day shall not be counted toward the maximum number of days per Disability (for EBridge Plans) or the maximum number of days per Policy Year (for EBoost Plans) applicable to private nurse's fee under Section 4(a)(vii) of this Part 6.

(viii) Golden years Hospital companion care

In addition to the general nursing services provided by the Hospital to the Insured Person during Confinement, this benefit shall be payable for the expenses incurred for inpatient care services provided by a Healthcare Assistant during the Insured Person's Confinement, where such services are recommended in writing by the Insured Person's attending Registered Medical Practitioner, or where the benefit is otherwise payable as approved by the Company at its sole discretion, subject to the limits stated in the Benefit Schedule, provided that the Insured Person is aged sixty (60) or above (age next birthday) on the day the expenses are incurred during the Confinement.

This benefit shall be payable starting from the third (3rd) day of Confinement and is subject to a maximum of one (1) visit per day of such Confinement. In the event that more than one (1) Healthcare Assistant provides inpatient care services during the same visit, only the expenses in respect of up to one (1) Health Assistant with the highest fee shall be payable; or if the Insured Person receives more than one (1) visit on the same day, only the visit incurring the highest expenses on that day shall be payable. For the avoidance of doubt, regardless of whether inpatient care service(s) is/are provided for all or part of a day, the day on which such service(s) is/are provided shall be counted as one (1) day for the purpose of calculating the maximum number of days per Disability (for EBridge Plans) or the maximum number of days per Policy Year (for EBoost Plans) allowed for this benefit as specified in the Benefit Schedule.

If (1) Eligible Expenses for private nursing services provided by a Registered Nurse, which are payable under Section 4(a)(vii) of this Part 6, and (2) expenses for inpatient care services provided by a Healthcare Assistant, which are payable under Section 4(a)(viii) of this Part 6, are incurred on the same day, only the session with the higher fee payable under these Terms and Benefits shall be reimbursed for that day. Where the private nursing fee is higher and reimbursed, the Healthcare Assistant's fees for that day shall not be covered. In such case, the Healthcare Assistant's visit on that day shall not be counted toward the maximum number of days per Disability (for EBridge Plans) or the maximum number of days per Policy Year (for

EBoost Plans) for golden years Hospital companion care under Section 4(a)(viii) of this Part 6. Conversely, where the Healthcare Assistant's fee is higher and reimbursed, the private nursing fees for that day shall not be covered, and the Registered Nurse's visit providing private nursing service for that day shall not be counted toward the maximum number of days per Disability (for EBridge Plans) or the maximum number of days per Policy Year (for EBoost Plans) applicable to private nurse's fee under Section 4(a)(vii) of this Part 6.

(ix) Psychiatric treatments (Applicable to Plans 2, 3 and 4 under EBridge Plans and Plans A, B and C under EBoost Plans)

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

This benefit shall be payable in lieu of other benefit items under Sections 4(a)(i) to 4(a)(ii), 4(a)(iv) to 4(a)(vi), 4(b), 4(c)(i) (excluding Chinese medicine treatments), 4(c)(v) to 4(c)(vi) of this Part 6. For the avoidance of doubt, where a Confinement is not solely for the purpose of psychiatric treatments, this benefit shall only be payable for the Eligible Expenses charged on the Medical Services related to psychiatric treatments. Where the Eligible Expenses involve both psychiatric and non-psychiatric treatments and apportionment of the expenses is not available, the expenses in entirety shall be payable under this benefit if the Confinement is initially for the purpose of psychiatric treatments. If the Confinement initially is not for the purpose of psychiatric treatment, the expenses in entirety shall be payable under Sections 4(a)(i) to 4(a)(ii), 4(a)(iv) to 4(a)(vi), 4(b), 4(c)(i), 4(c)(v) to 4(c)(vi) of this Part 6.

(b) Surgical benefits

(i) Surgeon's fee

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

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

Applicable to EBridge Plans only

When determining the maximum Surgeon's fee payable in relation to surgical procedures performed on the Insured Person, if two (2) or more surgical procedures performed on the Insured Person arise from the same or related Disability, or from any complications thereof, the surgical procedures for such Disability shall be reimbursed in accordance with the rules specified below –

1. For the surgical procedure with the highest Surgeon's fee payable, such fee shall be payable subject to one hundred percent (100%) of the benefit limit of the relevant surgical category as specified in the Benefit Schedule;
2. For the surgical procedure with the second highest Surgeon's fee payable, such fee shall be payable subject to fifty percent (50%) of the benefit limit of the relevant surgical category as specified in the Benefit Schedule; and
3. For the surgical procedure(s) with the third highest Surgeon's fee payable and thereafter, the relevant Eligible Expenses shall be payable subject to twenty-five percent (25%) of the benefit limit(s) of the relevant surgical category(ies) as specified in the Benefit Schedule.

For the avoidance of doubt, for the same Disability, such rules shall be reset provided that the Confinement or Day Case Procedure occurs ninety (90) consecutive days after the Last Date of the previous Confinement or Day Case Procedure in relation to the same Disability. "Last Date" of a Confinement or Day Case Procedure for the same Disability shall mean the later of (1) the discharge date of the Confinement; or (2) the date on which the Insured Person undergoes the Day Case Procedure.

When determining the maximum Surgeon's fee payable in relation to surgical procedures performed on the Insured Person, where two (2) or more surgical procedures are performed on the Insured Person at the same time for different or unrelated Disabilities, such surgical procedures shall be reimbursed in accordance with the rules specified below –

1. For the surgical procedure with the highest Surgeon's fee payable, such fee shall be payable subject to one hundred percent (100%) of the benefit limit of the relevant surgical category as specified in the Benefit Schedule;
2. For the surgical procedure with the second highest Surgeon's fee payable, such fee shall be payable subject to fifty percent (50%) of the benefit limit of the relevant surgical category as specified in the Benefit Schedule; and
3. For the surgical procedure(s) with the third highest Surgeon's fee payable and thereafter, the relevant Eligible Expenses shall be payable subject to twenty-five percent (25%) of the benefit limit(s) of the relevant surgical category(ies) as specified in the Benefit Schedule.

(ii) Anaesthetist's fee

If Surgeon's fee is payable under Section 4(b)(i) of this Part 6, this benefit shall be payable for the Eligible Expenses charged by the Anaesthetist in relation to the surgical procedure.

(iii) Operating theatre charges

If Surgeon's fee is payable under Section 4(b)(i) of this Part 6, this benefit shall be payable for the Eligible Expenses charged for the use of operating theatre (including but not limited to a treatment room and a recovery room) during the surgical procedure.

For the avoidance of doubt, the Eligible Expenses for any additional surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be payable under Section 4(a)(vi) of this Part 6.

(c) Other medical benefits

(i) Pre- and post-Confinement/Day Case Procedure outpatient care (including post-Confinement/Day Case Procedure Chinese medicine treatment)

This benefit shall be payable for –

1. the Eligible Expenses for outpatient visit or Emergency consultation resulting in a Confinement or Day Case Procedure (including but not limited to consultation, western medication prescribed or diagnostic test);
2. the Eligible Expenses for follow-up outpatient visit (including but not limited to consultation, western medication prescribed, dressings, physiotherapy, occupational therapy, speech therapy or diagnostic test) to, or recommended in writing by, the attending Registered Medical Practitioner, within the period stated in the Benefit Schedule after discharge from Hospital or the date of Day Case Procedure, provided that such outpatient visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure; and
3. the expenses of the follow-up outpatient visit provided by a Chinese Medicine Practitioner, notwithstanding Section 10 of Part 7 of these Terms and Benefits, within the period stated in the Benefit Schedule after discharge from Hospital or the date of Day Case Procedure, provided that such outpatient visit is directly related to, and results from, the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

For the purpose of (1) and (2) above, Prescribed Diagnostic Imaging Tests and Prescribed Non-surgical Cancer Treatments shall be payable under Sections 4(c)(v) and 4(c)(vi) of this Part 6 respectively.

(ii) Post-Confinement home nursing

This benefit shall be payable for the Eligible Expenses the Insured Person incurred for home nursing service provided by a Registered Nurse recommended in writing by the Insured Person's attending Registered Medical Practitioner within thirty (30) days after the Insured Person's discharge from Hospital following an admission to an Intensive Care Unit or a surgical procedure performed during a Confinement for which the Eligible Expenses incurred are payable under Section 4(a)(ii) or 4(b)(i) of Part 6 of these Terms and Benefits respectively, subject to the limits as stated in the Benefit Schedule.

This benefit is subject to a maximum of one (1) nursing visit on each day. In the event that more than one (1) Registered Nurse provides nursing services at the same visit, only the Eligible Expenses in respect of up to one (1) Registered Nurse with the highest fee shall be payable; or if the Insured Person has received more than one (1) nursing visit on the same day, only the one (1) nursing visit incurring the highest Eligible Expenses on that day shall be payable. For the avoidance of doubt, regardless of whether nursing service(s) is/are provided for all or part of a day on a particular day, the day on which the nursing service(s) is/are provided shall be counted as one (1) day for the purpose of counting the maximum number of days per Disability (for EBridge Plans) or the maximum number of days per Policy Year (for EBoost Plans) allowed for this benefit as specified in the Benefit Schedule.

(iii) Emergency outpatient accidental treatment

This benefit shall be payable for the Eligible Expenses the Insured Person incurred for outpatient Emergency Treatment provided by a Registered Medical Practitioner at the outpatient or emergency department of a Hospital or in the Registered Medical Practitioner's clinic within seventy-two (72) hours of an Accident.

This benefit shall only be payable for the Eligible Expenses for outpatient visit or Emergency consultation (including but not limited to consultation, western medication prescribed or diagnostic test) not resulting in a Confinement or Day Case Procedure.

(iv) Emergency outpatient dental treatment

Notwithstanding Section 7 of Part 7 of these Terms and Benefits, this benefit shall be payable for the Reasonable and Customary charges of Emergency Treatment to the Insured Person's sound natural teeth solely as a direct result of an Injury, if such treatment is provided within three (3) months of the Accident causing such Injury by a registered dentist in a legally registered dental clinic.

The Company shall not pay any benefits for any restorative or remedial work (for the purpose other than Emergency Treatment), prostheses, the use of any precious metals or any kind of orthodontics, or other dental surgery performed in a legally registered dental clinic unless the dental surgery is medically necessary. For the purpose of this benefit, medically necessary shall mean the medical service, procedure or supply which are necessary and is (a) consistent with the diagnosis and customary dental treatment; (b) recommended by a Registered Medical Practitioner, Surgeon or registered dentist for such emergency dental treatment and must be widely accepted professionally in Hong Kong or the relevant jurisdictions outside Hong Kong where the legally authorized medical service is provided to the Insured Person, as effective, appropriate and essential based upon recognised standards of the health care specialty involved; and (c) not furnished primarily for the personal comfort or convenience of the Insured Person or any medical service provider. Experimental, screening and preventive services or supplies shall not be considered as medically necessary for the purpose of this benefit.

(v) Prescribed Diagnostic Imaging Tests

This benefit shall be payable for the Eligible Expenses charged on Prescribed Diagnostic Imaging Test performed during Confinement or in a setting for providing Medical Services to a Day Patient recommended in writing by the attending Registered Medical Practitioner for the investigation or treatment of a Disability.

(vi) Prescribed Non-surgical Cancer Treatments

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

For the avoidance of doubt, the Eligible Expenses for the Prescribed Diagnostic Imaging Tests shall be payable under Section 4(c)(v) of this Part 6.

(vii) Kidney dialysis

This benefit shall be payable for the Eligible Expenses the Insured Person incurred for haemodialysis or peritoneal dialysis performed on the Insured Person during Confinement or in a setting for providing Medical Services to a Day Patient recommended in writing by the Insured Person's attending Registered Medical Practitioner. This benefit shall also be payable for the rental cost of a kidney dialysis machine for use on the Insured Person at home as recommended in writing by the Insured Person's attending Registered Medical Practitioner.

Where Eligible Expenses under this benefit are also covered under Sections 4(a)(vi) and 4(f) (if applicable) of this Part 6, such Eligible Expenses shall be payable in the following order:

1. Section 4(a)(vi) of this Part 6 (applicable to Eligible Expenses incurred during Confinement only);
2. this kidney dialysis benefit;
3. Section 4(f) of this Part 6 (if the supplementary major medical benefit is selected and applicable to Eligible Expenses incurred during Confinement only).

(viii) Rehabilitation treatment

This benefit shall be payable for the Eligible Expenses and other expenses incurred for a Stay in a Registered Rehabilitation Centre and rehabilitation treatment provided to the Insured Person recommended in writing by the attending Registered Medical Practitioner within ninety (90) days after his/her discharge from Hospital, provided that the rehabilitation treatment is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement.

(ix) Hospice care

This benefit shall be payable for the Eligible Expenses and other expenses the Insured Person incurred for a stay in a registered hospice and for such care and nursing services provided by the registered hospice if he/she is diagnosed with a terminal illness, and in the opinion of the attending Registered Medical Practitioner that the advent of death of the Insured Person is highly likely within twelve (12) months. The Insured Person's stay in the registered hospice shall commence within ninety (90) days after his/her discharge from Hospital for a Disability relating directly to such terminal illness.

(d) Wellness and senior care benefits

(i) Wellness joy benefit

If this Policy has been in force for two (2) consecutive years (applicable to Plans 3 and 4 under EBridge Plans and Plans B and C under EBoost Plans) / five (5) consecutive years (applicable to Plans 1 and 2 under EBridge Plans and Plan A under EBoost Plan) from the Policy Date; and if

the Insured Person undertakes any of the following activities ("Wellness Activity(ies)") in the next Policy Year following such two (2)-year or five (5)-year period (as the case may be):

1. travel;
2. fitness or wellness course; or
3. health check-up,

the Company shall, upon receipt of satisfactory evidence of participation, reimburse the actual expenses incurred for such Wellness Activity(ies), up to the limit as specified in the Benefit Schedule.

This benefit shall be payable at the frequency specified in the Benefit Schedule, and any unused benefit will be forfeited and cannot be carried forward or refunded by cash.

(ii) Additional benefit for Alzheimer's Disease treatment

While this Policy is in force and has been in force for at least two (2) consecutive years from the Policy Date, in the event that the Insured Person has the first confirmed diagnosis of Alzheimer's Disease, this benefit shall be payable for any medication, non-drug therapies, or other forms of treatment recommended in writing by the attending Registered Medical Practitioner for the purpose of treating Alzheimer's Disease.

For the avoidance of doubt, any Eligible Expenses and/or expenses incurred for Confinement that are directly or indirectly related to Alzheimer's Disease shall be reimbursed under Sections 4(a) to 4(c) of this Part 6.

(iii) Alzheimer's Disease preventive care benefit

While this Policy is in force and has been in force for two (2) consecutive years from the Policy Date, this benefit shall be payable on a reimbursement basis for the Insured Person aged 51 (age next birthday) or above who undergoes early detection tests for Alzheimer's Disease in the next Policy Year following such two (2)-year period. The Company shall reimburse the actual expenses incurred for such tests, up to the benefit limit as stated in the Benefit Schedule, upon receipt of satisfactory evidence of the relevant tests taken.

For the avoidance of doubt, if the Insured Person reaches Age fifty (51) or above in the Policy Year immediately following the two (2)-year period, the benefit shall become eligible starting from that Policy Year. If the Insured Person has not yet reached Age fifty (51) after the two (2)-year period, the benefit shall become eligible starting from the Policy Year in which the Insured Person attains Age fifty (51).

This benefit shall be payable once every five (5) consecutive Policy Years, and any unused benefit will be forfeited and shall not be carried forward or refunded in cash.

(e) Life/income protection benefits

(i) Death benefit

While this Policy is in force, this benefit shall be payable to the beneficiary in the amount as specified in the Benefit Schedule upon the death of the Insured Person, provided that due proof of the death and any other documents as reasonably required by the Company (including all relevant certificates, reports, evidence and other data or materials) are provided to the Company. All such documents which can be reasonably provided by the Policy Owner shall be furnished at the expenses of the Policy Owner. The Company shall bear all expenses incurred in obtaining further certificates, information and evidence for the purposes of verification of the claim after the Policy Owner has submitted all required information.

(ii) Accidental death benefit

In addition to the death benefit payable as specified in the Benefit Schedule, if the cause of death of the Insured Person is an Accident, this benefit shall be payable in the amount as specified in the Benefit Schedule.

Exclusion on accidental death benefit:
No accidental death benefit is payable under this Policy when the death of the Insured Person is directly or indirectly caused by the willful participation of the Policy Owner, the Insured Person or the beneficiary in an illegal or unlawful act.

(iii) Cash benefit for Confinement in general ward in a public Hospital in Hong Kong (Applicable to EBridge Plans)

This benefit shall be payable for the cash benefit amount for each day of the Insured Person's Confinement, provided that:

1. the Insured Person is Confined in the general ward of a public Hospital in Hong Kong that is run, operated, controlled or subsidised by the Government or the Hospital Authority of Hong Kong;
2. the Insured Person holds a valid Hong Kong identity card issued by the Immigration Department of Hong Kong; and
3. Eligible Expenses incurred for the Insured Person's Confinement are payable under these Terms and Benefits.

This benefit is payable only if the Confinement is recommended in writing by a Registered Medical Practitioner for Medically Necessary treatment of a Disability, and is subject to the limits as specified in the Benefit Schedule.

(iv) Cash benefit for Day Case Procedure

In an event that an Insured Person undergoes a Day Case Procedure which is payable in accordance with these Terms and Benefits, this benefit shall be payable according to the following categorisation of Day Case Procedure in the amount specified in the Benefit Schedule, irrespective of the amount of Eligible Expenses reimbursed under any other benefit items of these Terms and Benefits, subject to the limits as specified in the Benefit Schedule and a maximum of one (1) Day Case Procedure per day.

1. Designated Day Case Procedure(s), as specified in List 2, which is/are performed at a Designated Healthcare Services Provider with terms and conditions as specified in Sections 1(c)(i) to 1(c)(iv) of this Part 6;
2. Designated Day Case Procedure(s) as specified in List 2, which is/are performed in mainland China; or
3. Any Day Case Procedure(s) other than designated Day Case Procedure(s) which is/are performed at a Designated Healthcare Services Provider or in mainland China; or any Day Case Procedure(s) which is/are performed at a non-Designated Healthcare Services Provider outside mainland China.

For the purpose of the cash benefit for a designated Day Case Procedure performed at a Designated Healthcare Services Provider, if a designated Day Case Procedure is performed at a Designated Healthcare Services Provider but the terms and conditions as specified in Sections 1(c)(i) to 1(c)(iv) of this Part 6 are not fulfilled, the benefit described under Section 4(e)(iv)(1) above shall not apply and this benefit shall instead be payable according to the benefit limit applicable to Section 4(e)(iv)(3) above.

For the avoidance of doubt, if the Insured Person undergoes more than one (1) Day Case Procedure on the same day, this benefit shall only be payable once per day in respect of the Day Case Procedure with the highest benefit limit as specified in the Benefit Schedule.

(v) Cash benefit for top-up subsidy (Applicable to EBridge Plans)

For the Insured Person covered by any other Hospital reimbursement plans offered by a licensed insurance company other than the Company, regardless of whether it is an individual or group policy, if the Eligible Expenses incurred for any Confinement of the Insured Person are payable under these Terms and Benefits after any reimbursement has been paid by such other licensed insurance companies, this benefit shall be payable for each day of Confined period in Hospital, subject to the limits as specified in the Benefit Schedule.

(vi) Cash benefit for major and complex surgeries (Applicable to Plans 2, 3 and 4 under EBridge Plans)

In the event that an Insured Person undergoes a surgical procedure for which the Eligible Expenses charged by the attending Surgeon incurred are payable and such surgical procedure is categorized as major or complex in accordance with Section 4(b)(i) of this Part 6, this benefit shall be payable in the amount as specified in the Benefit Schedule irrespective of the amount of Eligible Expenses reimbursed under any other benefit items of the Terms and Benefits. This benefit is subject to a maximum of one (1) major or complex surgical procedure on each day, subject to the limits as specified in the Benefit Schedule.

For the avoidance of doubt, if the Insured Person undergoes more than one (1) major or complex surgical procedure on the same day, this benefit shall only be payable once in respect of the surgical procedure with the highest surgical category.

(vii) Cash benefit for Confinement in Intensive Care Unit in Hong Kong (Applicable to Plans 2, 3 and 4 under EBridge Plans)

If the Insured Person is Confined in a Hospital in Hong Kong during which he/she is admitted to an Intensive Care Unit for at least three (3) consecutive days and the Eligible Expenses incurred during such Confinement period are payable in accordance with these Terms and Benefits, this benefit shall be payable in the amount as specified in the Benefit Schedule irrespective of the amount of Eligible Expenses reimbursed under any other benefit items of the Terms and Benefits.

For the avoidance of doubt, this benefit is payable once only during the whole Confinement period, regardless of the number of times the Insured Person is admitted to an Intensive Care Unit during such Confinement period, and is subject to once per Disability.

(viii) Cash benefit for room and board Confinement below entitled ward class in a private Hospital in Hong Kong (Applicable to Plans 3 and 4 under EBridge Plans and Plans B and C under EBoost Plans)

This benefit shall be payable in the amount as specified in the Benefit Schedule for each day when the Insured Person is Confined in a room of a private Hospital in Hong Kong where the ward class is below the entitled ward class as specified in the Benefit Schedule during the whole Confinement period, provided that:

1. such Confinement is considered Medically Necessary upon the recommendation of the Insured Person's attending Registered Medical Practitioner; and
2. the Eligible Expenses incurred for such Confinement are payable under these Terms and Benefits.

(f) Supplementary major medical benefit (Applicable to Plans 2, 3 and 4 under EBridge Plans)

This benefit is optional and applies only if it is selected and specified in the Benefit Schedule. While this supplementary major medical benefit remains in effect, this benefit shall be payable for the Excess Eligible Expenses, subject to the applicable Coinsurance, benefit limits (including the maximum benefit limit per Disability), and any other terms and conditions stated in the Benefit Schedule.

For the purpose of this benefit, "Excess Eligible Expenses" means the Eligible Expenses that exceed the respective benefit limits as specified in the Benefit Schedule of EBridge Plans – Plans 2, 3 or 4, including but not limited to the maximum number of days per Disability or the per Disability limit under the following items:

(i) Room and board;
(ii) Intensive care;
(iii) Attending doctor's visit fee;
(iv) Specialist's fee;
(v) Miscellaneous charges;
(vi) Surgeon's fee;
(vii) Anaesthetist's fee; and
(viii) Operating theatre charges.

(g) First-dollar conversion option (Applicable to EBoost Plans)

After the Policy has been in force for two (2) consecutive years from the Policy Date, the Policy Owner shall have the one-off right to convert the EBoost Plan to an EBridge Plan (Plan 1 or any other plan level covering the same or a lower ward class, to which the supplementary major medical benefit (if applicable) may also be attached) without health underwriting of the Insured Person. This conversion option shall only be exercised if all of the following conditions are satisfied:

(i) The request is made not less than thirty (30) days prior to the Policy Anniversary on or immediately following the Insured Person's birthday at Age forty-five (45), fifty (50), fifty-five (55), sixty (60) or sixty-five (65) (age next birthday);

(ii) This right may be exercised once only and, once exercised, shall be irrevocable.

The Policy Owner can choose whether to exercise such right and the Age at which to do so.

Once the option is exercised, the respective limits for benefits payable on a "per Disability" basis shall be counted anew when the coverage under the new EBridge Plan takes effect.

For the avoidance of doubt, for benefits payable on a "per Policy" basis, any benefits previously paid shall continue to be counted towards the corresponding "per Policy" limit. For benefits payable on a recurring basis, the counting of such benefits shall continue accordingly.

5. Pre-existing Condition(s)

Eligible Expenses arising from Pre-existing Condition(s) that are notified to the Company in the Application, reinstatement request document and subsequent information or document submitted to the Company for the purpose of the application or reinstatement request, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1), subject to the Case-based Exclusion(s) (if any), shall be payable in accordance with these Terms and Benefits. The Company may impose Case-based Exclusion(s) to these Terms and Benefits by reason of a Pre-existing Condition or other factor that affects the insurability of the Insured Person notified to the Company in the Application, reinstatement request document and any subsequent information or document submitted to the Company for the purpose of the application or reinstatement request, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1).

Eligible Expenses arising from Pre-existing Condition(s) that the Policy Owner and/or Insured Person was not aware and would not reasonably have been aware of at the time of submission of Application or reinstatement request document, including any updates of and changes to the required information (if so requested by the Company under Section 6 of Part 1), shall be payable in accordance with these Terms and Benefits, subject to the following waiting period and reimbursement arrangement –

On or before the 30th day from the Policy Date as shown in the Policy Schedule	no coverage
31st day from the Policy Date as shown in the Policy Schedule onwards	full coverage

If the Policy Owner or the Insured Person is requested but fails to disclose to the Company upon submission of Application or reinstatement request document, including any updates of and changes to the required information (if so requested by the Company under Section 6 of Part 1), that the Insured Person is suffering from a Pre-existing Condition, and such Pre-existing Condition has been treated or diagnosed or has manifested signs or symptoms of which the Policy Owner or the Insured Person is aware or should have

reasonably been aware of at the time of submission of Application or reinstatement request document, including any updates of and changes to the required information (if so requested by the Company under Section 6 of Part 1), the Company has the right to declare these Terms and Benefits void, demand repayment of any benefits paid and/or refuse to provide coverage under these Terms and Benefits. In such event, the Company shall refund the premium in accordance with Section 14 of Part 2.

6. Cost-sharing requirement

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

Part 7 General Exclusions

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

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

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

3. Expenses arising from Human Immunodeficiency Virus ("HIV") and its related Disability, which is contracted or occurs before the Policy Date. Irrespective of whether it is known or unknown to the Policy Owner or the Insured Person at the time of submission of Application or reinstatement request document, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1) such Disability shall be generally excluded from any coverage of these Terms and Benefits if it exists before the Policy Date. If evidence of proof as to the time at which such Disability is first contracted or occurs is not available, manifestation of such Disability within the first five (5) years after the Policy Date shall be presumed to be contracted or occur before the Policy Date, while manifestation after such five (5) years shall be presumed to be contracted or occur after the Policy Date.

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

4. Expenses incurred for Medical Services as a result of Disability arising from or consequential upon the dependence, overdose or influence of drugs, alcohol, narcotics or similar drugs or agents, self-inflicted injuries or attempted suicide, illegal activity, or venereal and sexually transmitted disease or its sequelae (except for HIV and its related Disability, where Section 3 of this Part 7 applies).

5. Any charges in respect of services for –

   (a) beautification or cosmetic purposes, unless necessitated by Injury caused by an Accident and the Insured Person receives the Medical Services within ninety (90) days of the Accident; or
   (b) correcting visual acuity or refractive errors that can be corrected by fitting of spectacles or contact lens, including but not limited to eye refractive therapy, LASIK and any related tests, procedures and services.

6. Expenses incurred for prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests, screening procedures for asymptomatic conditions, screening or surveillance procedures based on the health history of the Insured Person and/or his family members, Hair Mineral Analysis (HMA), immunisation or health supplements. For the avoidance of doubt, this Section 6 does not apply to –
   (a) treatments, monitoring, investigation or procedures with the purpose of avoiding complications arising from any other Medical Services provided;
   (b) removal of pre-malignant conditions; and

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

7. Except as otherwise provided in Section 4(c)(iv) of Part 6 of these Terms and Benefits, expenses incurred for dental treatment and oral and maxillofacial procedures performed by a dentist except for Emergency Treatment and surgery during Confinement arising from an Accident. Follow-up dental treatment or oral surgery after discharge from Hospital shall not be covered.

8. Expenses incurred for Medical Services and counselling services relating to maternity conditions and its complications, including but not limited to diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction or pre-mature ejaculation, regardless of cause.

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

10. Except as otherwise provided in Section 4(c)(i) of Part 6 of these Terms and Benefits, expenses incurred for traditional Chinese medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na, and other forms of alternative treatment including but not limited to hypnotism, qigong, massage therapy, aromatherapy, naturopathy, hydropathy, homeotherapy and other similar treatments.

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

12. Expenses incurred for Medical Services provided as a result of Congenital Condition(s) which have manifested or been diagnosed before the Insured Person attained the Age of nine (9) years.

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

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

Part 8 Definitions

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

"Accident"	shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured Person and caused by violent, external and visible means.
"Age"	shall mean the age next birthday of the Insured Person of this Policy, unless otherwise specified.
"Alzheimer's Disease"	Progressive 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 care and supervision of the Insured Person. The diagnosis must be clinically confirmed by an appropriate Specialist.
"Annual Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Owner in a Policy Year irrespective of whether any limits of any benefit items stated in the Benefit Schedule have been reached. The Annual Benefit Limit is counted afresh in a new Policy Year.
"Application"	shall mean the application submitted to the Company in respect of this Plan, including the application form, questionnaires, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such application (including the application for the supplementary major medical benefit, if applicable), including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1).
"Benefit Schedule"	shall mean a schedule of benefits attached to these Terms and Benefits which sets out, among others, the benefit items and maximum benefits covered.
"Case-based Exclusion"	shall mean the exclusion of a particular Sickness or Disease from the coverage of these Terms and Benefits that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.
"Chinese Medicine Practitioner"	shall mean any person other than the Insured Person, the Policy Owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Owner and/or Insured Person (unless approved in advance by the Company in writing) who is duly qualified and is registered with the Chinese Medicine Council of Hong Kong pursuant to the Chinese Medicine Ordinance (Cap. 549 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith) and legally authorised for rendering relevant Chinese medical service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Chinese medical service is provided to the Insured Person.
"Coinsurance"	shall mean a percentage of Eligible Expenses the Policy Owner must contribute. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policy Owner is

	required to pay if the actual expenses exceed the benefit limits under these Terms and Benefits.
"Commencement Date"	shall mean the date the first premium is due and is the date used for calculating the Insured Person's Age at the start of the Policy, as shown on the Policy Schedule.
"Company"	shall mean FWD Life Insurance Company (Bermuda) Limited, a company incorporated in Bermuda with limited liability.
"Confinement" or "Confined"	shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition. Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured Person must stay in the Hospital continuously for the entire period of Confinement.
"Congenital Condition(s)"	shall mean (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.
"Deductible"	shall mean a fixed amount of Eligible Expenses or expenses that, in a Policy Year, the Policy Owner must pay before the Company shall reimburse the remaining Eligible Expenses or remaining expenses.
"Delivery"	shall mean the delivery of these Terms and Benefits and the Policy Schedule or the cooling-off notice as stated in Section 2(a) of Part 2 to the Policy Owner, or to nominated representative of the Policy Owner, by any the following means: (a) by hand; (b) by post (including registered post); or (c) by electronic means. Regardless of the means of delivery is used, it is the responsibility of the Company, to have sufficient proof of delivery and the timing of delivery.
"Designated Healthcare Services Provider"	shall mean a healthcare services provider that has entered into valid written agreements with the Company, with a healthcare network (including but not limited to medical clinic, day case procedure centre or Hospital with a setting for providing Medical Services to a Day Patient) which provides Medical Services to the Insured Person.
"Disability"	shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.

"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Disability.
"Emergency"	shall mean an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.
"Emergency Treatment"	shall mean Medical Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.
"First Symptoms"	shall mean the first time that the Insured Person experiences a physical symptom that would cause a reasonable and prudent person to seek medical advice, diagnosis or treatment, or where a medical examination or investigation shows the likely presence of a medical condition.
"Government"	shall mean the Hong Kong Special Administrative Region Government.
"Healthcare Assistant"	shall mean any person other than the Insured Person, the Policy Owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Owner and/or the Insured Person (unless approved in advance by the Company in writing), who is duly qualified and registered as a health worker under the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A of the Laws of Hong Kong) and/or the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A of the Laws of Hong Kong), or engaged by or registered with a legally established and recognised healthcare or care service provider in Hong Kong or a body of equivalent standing in a jurisdiction outside Hong Kong (as reasonably determined by the Company in utmost good faith), and who is legally authorised to render the relevant Medical Services or services in Hong Kong or in the jurisdiction outside Hong Kong where the Medical Service or service is provided to the Insured Person.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which – (a) has facilities for diagnosis and major operations, or is a Hong Kong Public Hospital, or a hospital for which a licence is issued under the Private Healthcare Facilities Ordinance (Cap. 633 of the Laws of Hong Kong); (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Injury"	shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.

"Inpatient"	shall mean an Insured Person who is Confined.
"Insurance Authority"	shall mean the Insurance Authority of Hong Kong established pursuant to section 4AAA of the Insurance Ordinance.
"Insurance Ordinance"	shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).
"Insured Person"	shall mean any person whose risks are covered by these Terms and Benefits, and named as the "Insured Person" in the Policy Schedule.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
"Lifetime Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Owner cumulatively since the inception of these Terms and Benefits, irrespective whether any limits of any benefit items stated in the Benefit Schedule have been reached or whether the Annual Benefit Limit in a Policy Year has been reached.
"Medical Services"	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.
"Medically Necessary"	shall mean the need to have medical service for the purpose of investigating or treating the relevant Disability in accordance with the generally accepted standards of medical practice and such medical service must –

(a) require the expertise of, or be referred by, a Registered Medical Practitioner;
(b) be consistent with the diagnosis and necessary for the investigation and treatment of the Disability;
(c) be rendered in accordance with standards of good and prudent medical practice, and not be rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner;
(d) be rendered in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice for the medical services; and
(e) be furnished at the most appropriate level which, in the prudent professional judgment of the attending Registered Medical Practitioner, can be safely and effectively provided to the Insured Person.

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

(i) the Insured Person is having an Emergency that requires urgent treatment in Hospital;
(ii) surgical procedures are performed under general anaesthesia;
(iii) equipment for surgical procedure is available in Hospital and procedure cannot be done on a Day Patient basis;
(iv) there is significantly severe co-morbidity of the Insured Person;

(v) taking into account the individual circumstances of the Insured Person, the attending Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, the medical service should be conducted in Hospital;

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

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

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

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

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

"Place(s) of Residence"	shall mean the jurisdiction(s) in which a person legally has the right of abode. A change in the Place(s) of Residence refers to the situation where a person has been granted the right of abode of additional jurisdiction(s), or has ceased to have the right of abode of existing jurisdiction(s). The above definition of "Place(s) of Residence" is used solely for the purpose of these Terms and Benefits. For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, shall not be treated as a Place of Residence.
"Plan"	shall mean all the terms and benefits that form an insurance plan. This Plan comprises these Terms and Conditions and the Benefit Schedule.
"Policy"	shall mean this policy underwritten and issued by the Company, which is the contract between the Policy Owner(s) and the Company in respect of this Plan including but not limited to these Terms and Conditions, Benefit Schedule, Application, declarations, Policy Schedule and endorsement(s) attached to this policy, if applicable. Where this Policy contains additional terms and benefits other than those of this Plan, the meaning of Policy shall also cover such additional terms and benefits.
"Policy Anniversary"	shall mean the same date each year as the Commencement Date.
"Policy Date"	shall mean the commencement date of these Terms and Benefits which is specified as "Policy Date" in the Policy Schedule or the date that the Company reinstates the coverage of this Policy under Section 4 of Part 3, whichever is later.

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

"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"	shall mean a medical practitioner of western medicine, (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person, but in no circumstance shall include the following persons - the Insured Person, the Policy Owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Owner and/or the Insured Person (unless approved in advance by the Company in writing). If the practitioner is not duly qualified and registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith), the Company shall exercise reasonable judgment to determine whether such practitioner shall nonetheless be considered qualified and registered.
"Registered Nurse"	shall mean any person other than the Insured Person, the Policy Owner, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Owner and/or the Insured Person (unless approved in advance by the Company in writing) who is duly qualified and is registered with the Nursing Council of Hong Kong pursuant to the Nurses Registration Ordinance (Cap. 164 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith) and legally authorised for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person.
"Registered Rehabilitation Centre"	shall mean a registered institution (other than a Hospital) which provides physiotherapy, occupational therapy and other rehabilitative treatment for physical injury, dysfunction or disability.
"Renewal", "Renew", "Renewed" or "Renewable"	shall mean renewal of these Terms and Benefits in accordance with their terms without any discontinuance.
"Schedule of Surgical Procedures"	shall mean the list of surgical procedures in Part 9 of these Terms and Benefits which sets out the surgical category of different surgical procedures according to their relative degree of complexity, which is subject to regular review by the Company.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured Person and whether or not any diagnosis is confirmed.
"Standard Premium"	shall mean the basic premium for the coverage under this Plan, including the premium of supplementary major medical benefit (if selected), as charged by the Company to the Policy Owner on an overall basis, which may be adjusted in accordance with the Age, gender and/or lifestyle factors of the Insured Person.

"Standard Private Room"	shall mean a room categorised as a private room by a Hospital in Hong Kong. For Hospitals without the corresponding ward class categorisation or any Hospitals outside Hong Kong, a Standard Private Room shall mean a room for Insured Person's private use during the Confinement with its own private facilities including a bedroom and bath/shower room(s) only. In any case mentioned above, a Standard Private Room shall exclude any room of upper class with its own kitchen, dining or sitting room(s).
"Standard Semi-private Room"	shall mean a room categorised as a semi-private room by a Hospital in Hong Kong. For Hospitals without the corresponding ward class categorisation or any Hospitals outside Hong Kong, a Standard Semi-private Room shall mean (i) a single or two-bedded room; or (ii) a room with maximum double occupancy, and with a shared bath / shower room in a Hospital. In any case mentioned above, a Standard Semi-private Room shall exclude any room of upper class with its own kitchen, dining or sitting room(s).
"Standard Ward Room"	shall mean a room categorised as a ward class lower than a Standard Semi-private Room including the room categorised as a general ward or standard room by a Hospital in Hong Kong. For Hospitals without the corresponding ward class categorisation or any Hospitals outside Hong Kong, a Standard Ward Room shall mean a room in a Hospital with more than two (2) patient beds (not including companion bed).
"Stay"	shall mean an admission of the Insured Person to a Registered Rehabilitation Centre that is recommended by a Registered Medical Practitioner for Medical Service as a result of a Medically Necessary condition for a period of no less than six (6) consecutive hours.
"Terms and Benefits"	shall mean the Terms and Conditions together with the Benefit Schedule under this Plan.
"Terms and Conditions"	shall mean Part 1 to Part 9 of this Plan.

Part 9 Schedule of Surgical Procedures

Procedure / Surgery		Category
ABDOMINAL AND DIGESTIVE SYSTEM		
Oesophageal / stomach / duodenum	Excision of oesophageal lesion / destruction of lesion or tissue of oesophagus, cervical approach	Major
	Highly selective vagotomy	Major
	Laparoscopic fundoplication	Major
	Laparoscopic repair of hiatal hernia	Major
	Oesophagogastroduodenoscopy (OGD) +/- biopsy and/or polypectomy	Minor
	OGD with removal of foreign body	Minor
	OGD with ligation / banding of oesophageal/ gastric varices	Intermediate
	Oesophagectomy	Complex
	Total oesophagectomy and interposition of intestine	Complex
	Percutaneous gastrostomy	Minor
	Permanent gastrostomy / gastroenterostomy	Major
	Partial gastrectomy +/- jejunal transposition	Major
	Partial gastrectomy with anastomosis to duodenum / jejunum	Major
	Partial gastrectomy with anastomosis to oesophagus	Complex
	Proximal gastrectomy / radical gastrectomy / total gastrectomy +/- intestinal interposition	Complex
	Suture of laceration of duodenum / patch repair, duodenal ulcer	Major
	Vagotomy and / or pyloroplasty	Major
Jejunum, ileum and large intestine	Appendicectomy, open or laparoscopic	Intermediate
	Anal fissurectomy	Minor
	Anal fistulotomy / fistulectomy	Intermediate
	Incision & drainage of perianal abscess	Minor
	Delorme operation for repair of prolapsed rectum	Major
	Colonoscopy +/- biopsy	Minor
	Colonoscopy with polypectomy	Minor
	Sigmoidoscopy	Minor
	Haemorrhoidectomy, internal or external	Intermediate
	Injection / banding of haemorrhoid	Minor
	Ileostomy or colostomy	Major
	Anterior resection of rectum, open or laparoscopic	Complex
	Abdominoperineal resection, open or laparoscopic	Complex
	Colectomy, open or laparoscopic	Complex
	Low anterior resection of rectum, open or laparoscopic	Complex
	Reduction of volvulus or intussusception	Intermediate
	Resection of small intestine and anastomosis	Major
Biliary tract	Cholecystectomy, open or laparoscopic	Major
	Endoscopic retrograde cholangio-pancreatography (ERCP)	Intermediate
	ERCP with papilla operation, stone extraction or other associated operation	Intermediate
Liver	Fine needle aspiration (FNA) biopsy of liver	Minor
	Liver transplantation	Complex

Procedure / Surgery		Category
	Marsupialization of lesion / cyst of liver or drainage of liver abscess, open approach	Major
	Removal of liver lesion, open or laparoscopic	Major
	Sub-segmentectomy of liver, open or laparoscopic	Major
	Segmentectomy of liver, open or laparoscopic	Complex
	Wedge resection of liver, open or laparoscopic	Major
Pancreas	Closed biopsy of pancreatic duct	Intermediate
	Excision / destruction of lesion of pancreas or pancreatic duct	Major
	Pancreaticoduodenectomy (Whipple's Operation)	Complex
Abdominal wall	Exploratory laparotomy	Major
	Laparoscopy / peritoneoscopy	Intermediate
	Unilateral repair of inguinal hernia, open or laparoscopic	Intermediate
	Bilateral repair of inguinal hernia, open or laparoscopic	Major
	Unilateral herniotomy / herniorrhaphy, open or laparoscopic	Intermediate
	Bilateral herniotomy / herniorrhaphy, open or laparoscopic	Major
BRAIN AND NERVOUS SYSTEM		
Brain	Brain biopsy	Major
	Burr hole(s)	Intermediate
	Craniectomy	Complex
	Cranial nerve decompression	Complex
	Irrigation of cerebroventricular shunt	Minor
	Maintenance removal of cerebroventricular shunt, including revision	Intermediate
	Creation of ventriculoperitoneal shunt or subcutaneous cerebrospinal fluid reservoir	Major
	Clipping of intracranial aneurysm	Complex
	Wrapping of intracranial aneurysm	Complex
	Excision of arteriovenous malformation, intracranial	Complex
	Excision of acoustic neuroma	Complex
	Excision of brain tumour or brain abscess	Complex
	Excision of cranial nerve tumour	Complex
	Radiofrequency thermocoagulation of trigeminal ganglion	Intermediate
	Closed trigeminal rhizotomy using radiofrequency	Major
	Decompression of trigeminal nerve root/ open trigeminal rhizotomy	Complex
	Excision of brain, including lobectomy	Complex
	Hemispherectomy	Complex
Spine	Lumbar puncture or cisternal puncture	Minor
	Decompression of spinal cord or spinal nerve root	Major
	Cervical sympathectomy	Intermediate
	Thoracoscopic or lumbar sympathectomy	Major
	Excision of intraspinal tumour, extradural or intradural	Complex
CARDIOVASCULAR SYSTEM		
Heart	Cardiac catheterization	Intermediate
	Coronary artery bypass graft (CABG)	Complex
	Cardiac transplantation	Complex
	Insertion of cardiac pacemaker	Intermediate
	Pericardiocentesis	Minor
	Pericardiotomy	Major

Procedure / Surgery		Category
	Percutaneous transluminal coronary angioplasty (PTCA) and related procedures, including use of laser, stenting, motor-blade, balloon angioplasty, radiofrequency ablation technique, etc.	Major
	Pulmonary valvotomy, Balloon / Transluminal laser / Transluminal radiofrequency	Major
	Percutaneous valvuloplasty	Major
	Balloon aortic / mitral valvotomy	Major
	Closed heart valvotomy	Complex
	Open heart valvuloplasty	Complex
	Valve replacement	Complex
Vessels	Intra-abdominal venous shunt/ spleno-renal shunt / portal-caval shunt	Complex
	Resection of abdominal vessels with replacement / anastomosis	Complex
ENDOCRINE SYSTEM		
Adrenal Gland	Unilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Major
	Bilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Complex
Pineal gland	Total excision of pineal gland	Complex
Pituitary Gland	Operation of pituitary tumour	Complex
Thyroid Gland	Fine needle aspiration (FNA) of thyroid gland +/- imaging guidance	Minor
	Hemithyroidectomy / partial thyroidectomy / subtotal thyroidectomy / parathyroidectomy	Major
	Total thyroidectomy / complete parathyroidectomy / robotic-assisted total thyroidectomy	Major
	Excision of thyroglossal cyst	Intermediate
EAR/ NOSE / THROAT / RESPIRATORY SYSTEM		
Ear	Canaloplasty for aural atresia / stenosis	Major
	Excision of preauricular cyst / sinus	Minor
	Haematoma auris, drainage / buttoning / excision	Minor
	Meatoplasty	Intermediate
	Removal of foreign body	Minor
	Excision of middle ear tumour via tympanotomy	Major
	Myringotomy +/- insertion of tube	Minor
	Myringoplasty / tympanoplasty	Major
	Ossiculoplasty	Major
	Labyrinthectomy, total / partial excision	Major
	Mastoidectomy	Major
	Operation on cochlea and / or cochlear implant	Complex
	Operation on endolymphatic sac / decompression of endolymphatic sac	Major
	Repair of round window or oval window fistula	Intermediate
	Tympanosympathectomy	Major
	Vestibular neurectomy	Intermediate
Nose, mouth and pharynx	Antral puncture and lavage	Minor
	Cauterization of nasal mucosa / control of epistaxis	Minor
	Closed reduction for fracture nasal bone	Minor
	Closure of oro-antral fistula	Intermediate
	Dacryocystorhinostomy	Intermediate

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

Procedure / Surgery		Category
	Partial / total resection of laryngeal tumour	Intermediate
	Removal of vallecular cyst	Intermediate
	Repair of laryngeal fracture	Major
	Injection for vocal cord paralysis	Minor
	Tracheoesophageal puncture for voice rehabilitation	Minor
	Thyroplasty for vocal cord paralysis	Intermediate
	Vocal cord operation, including use of laser (excluding carcinoma)	Minor
	Tracheostomy, temporary / permanent / revision	Minor
	Lobectomy of lung / pneumonectomy	Complex
	Pleurectomy	Major
	Segmental resection of lung	Major
	Thoracocentesis / insertion of chest tube for pneumothorax	Minor
	Thoracoscopy +/- biopsy	Intermediate
	Thoracoplasty	Major
	Thymectomy	Major
EYE		
Eye	Excision / curettage / cryotherapy of lesion of eyelid	Minor
	Blepharorrhaphy / tarsorrhaphy	Minor
	Repair of entropion or ectropion +/- wedge resection	Minor
	Reconstruction of eyelid, partial-thickness	Intermediate
	Excision / destruction of lesion of conjunctiva	Minor
	Excision of pterygium	Minor
	Corneal grafting, severe wound repair and keratoplasty, including corneal transplant	Major
	Laser removal / destruction of corneal lesion	Intermediate
	Removal of corneal foreign body	Minor
	Repair of cornea	Intermediate
	Suture / repair of corneal laceration or wound with conjunctival flap	Intermediate
	Aspiration of lens	Intermediate
	Capsulotomy of lens, including use of laser	Intermediate
	Extracapsular / intracapsular extraction of lens	Intermediate
	Intraocular lens / explant removal	Intermediate
	Chorioretinal lesion operations	Intermediate
	Phacoemulsification and implant of intraocular lens	Intermediate
	Pneumatic retinopexy	Intermediate
	Retinal Photocoagulation	Intermediate
	Repair of retinal detachment / tear	Intermediate
	Repair of retinal tear / detachment with buckle	Major
	Scleral buckling / encircling of retinal detachment	Major
	Cyclodialysis	Intermediate
	Trabeculectomy, including use of laser	Intermediate
	Surgical treatment for glaucoma including insertion of implant	Intermediate
	Diagnostic aspiration of vitreous	Minor
	Injection of vitreous substitute	Intermediate
	Mechanical vitrectomy / removal of vitreous	Major
	Biopsy of iris	Minor
	Excision of lesion of iris / anterior segment of eye / ciliary body	Intermediate

Procedure / Surgery		Category
	Excision of prolapsed iris	Intermediate
	Iridotomy	Intermediate
	Iridectomy	Intermediate
	Iridoplasty +/- coreoplasty by laser	Intermediate
	Iridencleisis and iridotasis	Intermediate
	Scleral fistulization +/- iridectomy	Intermediate
	Thermocauterization of sclera +/- iridectomy	Intermediate
	Diminution of ciliary body	Intermediate
	Biopsy of extraocular muscle or tendon	Minor
	Operation on one extraocular muscle	Intermediate
	Eyeball, perforating wound of, with incarceration or prolapse of uveal tissue repair	Major
	Enucleation of eye	Intermediate
	Evisceration of eyeball / ocular contents	Intermediate
	Repair of eyeball or orbit	Intermediate
	Conjunctivocystorhinostomy	Intermediate
	Conjunctivorhinostomy with insertion of tube / stent	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lacrimal sac and passage	Minor
	Excision of lacrimal gland / dacryoadenectomy	Intermediate
	Probing +/- syringing of lacrimal canaliculi / nasolacrimal duct	Minor
	Repair of canaliculus	Intermediate
	Coreoplasty	Intermediate
FEMALE GENITAL SYSTEM		
Cervix	Amputation of cervix	Intermediate
	Colposcopy +/- biopsy	Minor
	Conization of cervix	Minor
	Destruction of lesion of cervix by excision/ cryosurgery / cauterization / laser	Minor
	Endocervical curettage	Minor
	Loop electrosurgical excision procedure (LEEP)	Minor
	Marsupialization of cervical cyst	Minor
	Repair of cervix	Minor
	Repair of fistula of cervix	Intermediate
	Suture of laceration of cervix / uterus / vagina	Intermediate
Fallopian tubes and ovaries^	Dilatation / insufflation of fallopian tube	Minor
	Excision / destruction of lesion of fallopian tube, open or laparoscopic	Major
	Repair of fallopian tube	Major
	Salpingostomy / salpingotomy	Intermediate
	Total or partial salpingectomy	Intermediate
	Tuboplasty	Intermediate
	Aspiration of ovarian cyst	Minor
	Ovarian cystectomy, open or laparoscopic	Major
	Wedge resection of ovary, open or laparoscopic	Major
	Oophorectomy	Intermediate
	Oophorectomy, laparoscopic	Major

Procedure / Surgery		Category
	Salpingo-oophorectomy, open or laparoscopic	Major
	Drainage of tubo-ovarian abscess, open or laparoscopic	Intermediate
	^ The category applies to both unilateral and bilateral procedures unless otherwise specified.	
Uterus	Dilatation and curettage of Uterine (D&C)	Minor
	Hysteroscopy +/- biopsy	Minor
	Hysteroscopy with excision or destruction of uterus and supporting structures	Intermediate
	Hysterotomy	Major
	Laparoscopic assisted vaginal hysterectomy (LAVH)	Major
	Vaginal hysterectomy +/- repair of cystocele and/or rectocele	Major
	Total / subtotal abdominal hysterectomy +/- bilateral salpingo-oophorectomy, open or laparoscopic	Major
	Radical abdominal hysterectomy	Complex
	Myomectomy, open or laparoscopic	Major
	Uterine myomectomy, vaginal or hysteroscopic	Intermediate
	Laparoscopic drainage of female pelvic abscess	Intermediate
	Colposuspension	Major
	Pelvic floor repair	Major
	Pelvic exenteration	Complex
	Uterine suspension	Intermediate
Vagina	Destruction of lesion of vagina by excision / cryosurgery / cauterization / laser	Minor
	Insertion / removal of vaginal supportive pessaries	Minor
	Marsupialization of Bartholin's cyst	Minor
	Vaginal stripping of vaginal cuff	Minor
	Vaginotomy	Intermediate
	Partial vaginectomy	Intermediate
	Vaginectomy, complete	Major
	Radical vaginectomy	Complex
	Anterior colporrhaphy +/- Kelly plication	Intermediate
	Posterior colporrhaphy	Intermediate
	Obliteration of vaginal vault	Intermediate
	Sacrospinous ligament suspension or fixation of the vagina	Intermediate
	Sacral colpopexy	Intermediate
	Vaginal repair of enterocoele	Intermediate
	Closure of urethro-vaginal fistula	Intermediate
	Repair of rectovaginal fistula, vaginal approach	Intermediate
	Repair of rectovaginal fistula, abdominal approach	Major
	Culdocentesis	Minor
	Culdotomy	Minor
	Excision of transverse vaginal septum	Minor
	McCall's culdeplasty / culdoplasty	Intermediate
	Vaginal reconstruction	Major
Vulva and introitus	Destruction of lesion of vulva by excision / cryosurgery / cauterization / laser	Minor
	Wide local excision of vulva with cold knife or LEEP	Minor

Procedure / Surgery		Category
	Excision of vestibular adenitis	Minor
	Excision biopsy of vulva	Minor
	Incision and drainage of vulva and perineum	Minor
	Lysis of vulvar adhesions	Minor
	Repair of fistula of vulva or perineum	Minor
	Suture of lacerations / repair of vulva and/or perineum	Minor
	Vulvectomy	Intermediate
	Radical vulvectomy	Major
HEMIC AND LYMPHATIC SYSTEM		
Lymph Nodes	Drainage of lesion / abscess of lymph node	Minor
	Biopsy / excision of superficial lymph nodes / simple excision of lymphatic structure	Minor
	Incisional biopsy of cervical lymph node / fine needle aspiration (FNA) biopsy of lymph nodes	Minor
	Excision of deep lymph node / lymphangioma / cystic hygroma	Intermediate
	Bilateral inguinal lymphadenectomy	Intermediate
	Cervical lymphadenectomy	Intermediate
	Inguinal and pelvic lymphadenectomy	Major
	Radical groin dissection	Major
	Radical pelvic lymphadenectomy	Major
	Selective / radical / functional neck dissection	Major
	Wide excision of axillary lymph node	Major
Spleen	Splenectomy, open or laparoscopic	Major
MALE GENITAL SYSTEM		
Prostate	External drainage of prostatic abscess	Minor
	Photoselective vaporization of prostate	Major
	Plasma vaporization of prostate	Major
	Prostate biopsy	Minor
	Transurethral microwave therapy	Intermediate
	Transurethral prostatectomy or TURP	Major
	Prostatectomy, open or laparoscopic	Major
	Radical prostatectomy, open or laparoscopic	Complex
Penis	Circumcision	Minor
	Release of chordee	Major
	Repair of buried / avulsion of penis	Intermediate
Testicles^	Epididymectomy	Intermediate
	Exploration of testis	Intermediate
	Exploration for undescended testis, laparoscopic	Major
	Orchidopexy	Intermediate
	Orchidectomy or orchidopexy, laparoscopic	Major
	Reduction of torsion of testis and fixation	Intermediate
	Testicular biopsy	Minor
	High ligation of hydrocoele	Intermediate
	Tapping of hydrocele	Minor
	Excision of varicocoele and hydrocoele of spermatic cord	Intermediate
	Varicocelectomy (microsurgical)	Major

Procedure / Surgery		Category
	^ The category applies to both unilateral and bilateral procedures unless otherwise specified.	
Spermatic cord	Vasectomy	Minor
MUSCULOSKELETAL SYSTEM		
Bone	Amputation of finger(s) / toe(s) of one limb	Intermediate
	Amputation of one arm / hand / leg / foot	Intermediate
	Bunionectomy	Intermediate
	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal	Major
	Excision of radial head	Intermediate
	Mandibulectomy for benign disease	Intermediate
	Patellectomy	Major
	Partial ostectomy of facial bone	Intermediate
	Sequestrectomy of facial bone	Intermediate
	Wedge osteotomy of bone of wrist / hand / leg	Major
	Wedge osteotomy of bone of upper arm / lower arm / thigh	Major
	Wedge osteotomy of scapula / clavicle / sternum	Major
Joint	Arthroscopic drainage and debridement	Intermediate
	Arthroscopic removal of loose body from joints	Intermediate
	Arthroscopic examination of joint +/- biopsy	Intermediate
	Arthroscopic assisted ligament reconstruction	Major
	Arthroscopic Bankart repair	Major
	Arthroscopic repair for superior labral tear from anterior to posterior of shoulder	Major
	Arthroscopic rotator cuff repair	Major
	Acromioplasty	Major
	Arthrodesis of shoulder	Major
	Arthrodesis of Elbow / Triple arthrodesis	Major
	Arthrodesis of knee / hip	Complex
	Arthroplasty of hand / finger / foot / Toe joint with implant	Major
	Fusion of wrist	Major
	Synovectomy of wrist	Intermediate
	Interphalangeal joint fusion of toes	Intermediate
	Interphalangeal fusion of finger	Major
	Excisional arthroplasty shoulder / hemiarthroplasty of shoulder	Major
	Excisional arthroplasty of hip / knee / Wrist / Elbow	Major
	Excisional arthroplasty of hip / knee with local antibiotic delivery	Complex
	Temporomandibular arthroplasty +/- autograft	Major
	Joint aspiration / injection	Minor
	Manipulation of joint under anesthesia	Minor
	Metal femoral head insertion	Major
	Anterior cruciate ligament reconstruction	Major
	Meniscectomy, open or arthroscopic	Major
	Posterior cruciate ligament reconstruction	Major
	Repair of the collateral ligaments	Major
	Repair of the cruciate ligaments	Major
	Suture of capsule or ligament of ankle and foot	Major

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

Procedure / Surgery		Category
	Removal of screw, pin and plate, and other metal for old fracture except fracture femur	Minor
Spine	Artificial cervical disc replacement	Complex
	Anterior spinal fusion, cervical / cervicothoracic/ C4/5 and C5/6 and locking plate	Major
	Anterior spinal fusion (excluding cervical / cervicothoracic/ C4/5 and C5/6 and locking plate)	Complex
	Anterior spinal fusion with instrumentation	Complex
	Laminoplasty for cervical spine	Major
	Laminectomy / diskectomy	Major
	Laminectomy with diskectomy	Complex
	Posterior spinal fusion, thoracic / cervico-thoracic / thoracolumbar / T5 to L1/ atlas-axis	Major
	Posterior spinal fusion, (excluding thoracic / cervico-thoracic / thoracolumbar / T5 to L1 / atlas-axis)	Complex
	Posterior spinal fusion with instrumentation	Complex
	Spinal biopsy	Minor
	Spinal fusion +/- foraminotomy +/- laminectomy +/- diskectomy	Complex
	Spine osteotomy	Complex
	Vertebroplasty / kyphoplasty	Intermediate
Others	Excision of ganglion / bursa	Minor
	Closed/ Percutaneous needle fasciotomy for Dupuytren disease	Minor
	Radical (or total) fasciectomy for Dupuytren disease	Major
	Release of carpal / tarsal tunnel, open or endoscopic	Intermediate
	Release of peripheral nerve	Intermediate
	Transposition of ulnar nerve	Intermediate
	Sliding / reduction genioplasty	Intermediate
SKIN AND BREAST		
Skin	Curettage / cryotherapy / cauterization / laser treatment of lesion of skin	Minor
	Drainage of subungual haematoma or abscess	Minor
	Excision of lipoma	Minor
	Excision of skin for graft	Minor
	Incision and /or drainage of skin abscess	Minor
	Incision and /or removal of foreign body from skin and subcutaneous tissue	Minor
	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue	Minor
	Suture of wound on skin	Minor
	Surgical toilet and suturing	Minor
	Wedge resection of toenail	Minor
Breast	Breast tumour/ lump excision +/- biopsy	Intermediate
	Fine needle aspiration (FNA) of breast cyst	Minor
	Incisional breast biopsy	Minor
	Modified radical mastectomy	Major
	Partial or simple mastectomy	Intermediate
	Partial or radical mastectomy with axillary lymphadenectomy	Major

Procedure / Surgery		Category
	Total or radical mastectomy	Major
	Duct papilloma excision	Intermediate
	Gynaecomastia excision	Intermediate
URINARY SYSTEM		
Kidney	Extracorporeal shock wave lithotripsy for urinary stone (ESWL)	Intermediate
	Nephrolithotomy / pyelolithotomy	Major
	Nephroscopy	Major
	Percutaneous insertion of nephrostomy tube	Minor
	Renal biopsy	Minor
	Nephrectomy, open or laparoscopic or retroperitoneoscopic	Major
	Nephrectomy, partial/ lower pole	Complex
	Kidney transplant	Complex
Bladder, ureter and urethra	Cystoscopy +/- biopsy	Minor
	Cystoscopy with catheterization of ureter/ transurethral bladder clearance	Minor
	Cystoscopy with electro-cauterisation/ laser lithotripsy	Intermediate
	Excision of urethra caruncle	Minor
	Insertion of urethral/ureter stent	Intermediate
	Diverticulectomy of urinary bladder, open or laparoscopic	Major
	Transurethral resection of bladder tumour	Major
	Partial cystectomy, open or laparoscopic	Major
	Radical/ total cystectomy, open or laparoscopic	Complex
	Ureterolithotomy, open or laparoscopic or retroperitoneoscopic	Major
	Closure of urethro-rectal fistula	Major
	Repair of urethral fistula	Major
	Repair of vesicovaginal fistula	Major
	Repair of vesicocolic fistula	Major
	Repair of rupture of urethra	Major
	Repair of urinary stress incontinence	Major
	Formation of ileal conduit, including ureteric implantation	Complex
	Ileal or colonic replacement of ureter	Major
	Unilateral reimplantation of ureter into bowel or bladder	Major
	Bilateral reimplantation of ureter into bowel or bladder	Major
DENTAL		
	Any kind of dental surgery due to injury caused by an Accident	Minor

Health Assistance Services

1. CANcierge

One Plan One Team One Stop Solution

Everyone would like to be along with a reliable partner, so as to focus on their recovery and enjoy life even when facing any health problems. CANcierge[1] gives the Insured Person priority treatment from a professional health management team with a one stop approach, helping the Insured Person when the Insured Person needed help most.

Professional & Experienced Medical Team as the Insured Person's Partner

A professional medical service provider is undoubtedly the Insured Person's best option to provide prompt and suitable medical advice and treatment. That's why CANcierge[1] provides the Insured Person with a dedicated network of specialists so that the Insured Person could receive suitable treatment from the best-suited doctor.

Tailor-made Support and Hospitalisation Arrangement

CANcierge[1] always puts the Insured Person's interest first. Should the Insured Person require hospitalisation and/or treatment due to a cancer as diagnosed by CANcierge's doctor[2], the team of specialists will arrange for the Insured Person to be admitted to hospital and receive tailor-made treatment, as well as provide follow-up consultation and supportive therapies.

Efficient and Seamless Claims Resolution and Cashless Facility[3]

The team of specialists will assist the Insured Person to apply for efficient and seamless claims resolution arrangement to the Company and so the Insured Person can leave the formalities of claims submission to the team.

CANcierge Hotline[4]:
Hong Kong: (852) 8120 9066
Toll-free number for Mainland: 400 9303078
24-hour full support

Note:

- The claimable amount of medical expenditure is subject to the Terms and Benefits of EBeyond Medical Insurance Solution (the "Plan"), including but not limited to limits of individual benefit items, maximum benefit limit per Disability, Coinsurance or reimbursement percentage, Deductible, Annual Benefit Limit, etc. (where applicable).
- Any medical advice, opinion or services are provided by doctors[2] of CANcierge[1] and/or its healthcare team who are all external third-party service providers. They are independent contractors and are not agents of the Company. For any specific questions on medical matters or situations, the Insured Person is advised to consult his/her doctor or other healthcare professionals. The Company shall not be responsible for any act, negligence or omission of medical advice, opinion, service or treatment on the part of them.
- The Insured Person is required to consent to the Company, HealthMutual Group Limited and its healthcare network team, recording, sharing, using and archiving the Insured Person's personal data in pursuance of CANcierge[1] being offered to the Insured Person as well as for their training and quality assurance purposes. Failure to provide the relevant personal data may result in the said service providers being unable to provide the relevant services to the Insured Person.

Remarks:

1. CANcierge, provided by HealthMutual Group Limited ("HMG") and its healthcare network team, is provided by external third party and does not form part of the Policy or benefit item under the Policy provisions. It is only applicable to this Plan. The Company reserves the right to suspend, terminate or vary CANcierge in its sole discretion without further notice. The Company is not the supplier of the service and shall have no obligation or responsibility for any act, negligence or failure to act on the part of HMG and its healthcare network team. CANcierge is only available in Hong Kong region.
2. The list of doctors of the Service may be revised from time to time without prior notice.
3. Cashless Facility is an administrative arrangement to pay the covered expenditures when the Insured Person is hospitalised, but not a benefit item under Policy provisions or guaranteed successful arrangement. Cashless Facility is only applicable to EBoost Plans under the Plan and only if the Insured Person requires hospitalisation, treatment and supportive therapies at the designated hospital due to a covered cancer. The Company reserves the right to suspend, terminate or amend relevant terms and conditions for Cashless Facility in its sole discretion without further notice. The Company would pay the medical cost to the relevant Hospital on behalf of the Insured Person after successful arrangement of Cashless Facility. If there is Deductible balance or Coinsurance (if applicable) under the Policy, Policy Owners are required to pay such amount when the Insured Person is admitted to the Hospital. If the medical cost paid by the Company is higher than the maximum claimable amount, the Company will seek reimbursement from the Policy Owner for such amount.
4. This hotline is operated and maintained by HMG. Please note that this hotline is for non-emergency reservation of doctor consultation instead of for emergencies.

The information above is for reference only and none of the above is binding upon the Company or HMG.

The service is provided by HMG and it is not guaranteed renewable. The Company shall not be responsible for any act or failure to act on the part of HMG and the professionals. The Company reserves the right to amend, suspend or terminate CANcierge and to amend the relevant terms and conditions at any time without prior notice.

2. Second Medical Opinion Service

As part of the Company's promise of care, you are given the access to some of the highest ranked medical institutions in the US through International SOS once your claim is approved and such claim is relevant to designated diseases. For the list of designated diseases, please call the International SOS at (852) 3122 2900 for details.

What is Second Medical Opinion Service?
The objective of the Second Medical Opinion Service is to meet the public's increasing demands for the best possible medical treatment bearing in mind the continual development of leading edge treatments for diseases. This is why we offer the Second Medical Opinion Service to our valuable Insured Person via International SOS.

Understand this distinguished service, the Insured Person has access to a panel of specialists at leading medical institutions in the US to obtain alternative advice on the Insured Person's medical condition and confirmation of the diagnosis in the event that the Insured Person has been diagnosed as suffering from designated disease made by the Insured Person's attending physician, plus any other relevant medical advice.

Panel of Second Medical Opinion Specialists
The panel provides the Insured Person access to some of the highest ranked medical institutions in the US, together with more than 15,000 specialists who practice there, including:

- Harvard Medical School
- Johns Hopkins Hospital, Baltimore
- Massachusetts General Hospital
- Brigham and Women's Hospital, Boston
- Dana-Faber Cancer Institute
- Cedars-Sinai Medical Center, Los Angeles

The list of medical institutions may be revised from time to time without prior notice.

How to seek Second Medical Opinion Service?
When the Insured Person has been diagnosed with a designated disease, he/she is required to follow the instruction below to obtain the Second Medical Opinion Service. Call International SOS at (852) 3122 2900 and request for the Second Medical Opinion Service. Within 24 hours International SOS will confirm membership and whether medical condition is eligible for the service. If the Insured Person's medical condition is eligible for the service, the Second Medical Opinion will be provided to the Insured Person by phone.
How to seek for an additional Second Medical Opinion Report
1. Receive "Information Request Form" from International SOS via fax or email. International SOS will notify the Insured Person to submit medical documents. 2. International SOS will assess the case and reply to the Insured Person if his/her case is eligible for the report. The Insured Person needs to complete the **Information Request Form** and send to International SOS together with the relevant medical documents for the Second Medical Opinion Report*. (via courier or registered mail at the Insured Person's own cost) 3. The panel of Second Medical Opinion will send acknowledgement to International SOS after receipt. If additional medical information is required, the panel of Second Medical Opinion will inform International SOS who in turn contact the Insured Person. 4. After evaluation, written Second Medical Opinion report and advice will be faxed/emailed to International SOS within 3-5 US working days depending on complexity of the report.

5. Upon receipt of the Second Medical Opinion report, International SOS will send it to the Insured Person and his/her treating physicians, as required.

If requested, International SOS will arrange transportation, accommodation and admission to the identified treating facility and with a medical escort, if medically necessary.

ALL RELATED COSTS to International SOS WILL BE BORNE BY THE INSURED PERSON.
*** Second Medical Opinion Report is US$850.** *(The cost may be reviewed from time to time.)*

The information above is for reference only and none of the above is binding upon the Company or International SOS.

The service is currently provided by International SOS and it is not guaranteed renewable. The Company shall not be responsible for any act of failure to act on the part of International SOS and the professionals. The Company reserves the right to amend, suspend or terminate the Second Medical Opinion Service and to amend the relevant terms and conditions at any time without prior notice.

Notes:

1. The Company, the medical panel, International SOS and/or any of its affiliates, record, share, use and archive the Insured Person's personal data in pursuance of the services being offered to the Insured Person as well as for their training and quality assurance purposes. The failure to provide the relevant personal data may result in the said service providers being unable to provide the relevant services to the Insured Person.
2. The Second Medical Opinion Service and report (if applicable) are provided by panel of second medical opinion specialists of International SOS who are not employees and/or agents of the Company. The opinion and report (if applicable) are general in nature to meet the Insured Person's healthcare needs and should not be used as a substitute for medical services. It is for the Insured Person and the Insured Person's physician or consulting hospital to decide the appropriate medical course of action to be pursued. The Company shall not be responsible or liable to the Policy Owner or the Insured Person for anything in relation to such opinion and report (if applicable) given by panel of second medical opinion specialists of International SOS.
3. International SOS, and/or its affiliates and the panel providing the Second Medical Opinion and report (if applicable) do not have any authority or responsibility to determine the benefits/amounts payable, its eligibility, claim procedures, etc.

3. International SOS 24-hour Worldwide Assistance Services

General Benefits and Terms

The following SOS benefits are available to the Company's Insured Persons when travelling outside the home country or usual country of residence for periods not exceeding 90 consecutive days per trip.

The International SOS 24-hour Worldwide Assistance Services is provided as a benefit by International SOS ("Intl.SOS"). Intl.SOS is not an agent of the Company and the Company shall not accept any liability for the services provided by Intl.SOS, or their availability. The contract between Intl.SOS and the Insured Persons is separate and independent to the Policy.

Medical Assistance:

1. Telephone Medical Advice
Intl.SOS will arrange for the provision of medical advice to the Insured Person over the telephone.

2. Arrangement and Payment of Emergency Medical Evacuation
Intl.SOS will arrange and pay for the air and/or surface transportation and communication for moving the Insured Person to the nearest hospital where appropriate medical care is available.

3. Arrangement and Payment of Emergency Medical Repatriation
Intl.SOS will arrange and pay for the return of the Insured Person to the home country or usual country of residence following an emergency medical evacuation for subsequent in-hospital treatment in a place outside the home country or usual country of residence.

4. Arrangement and Payment of Repatriation of Mortal Remains
Intl.SOS will arrange for transporting the Insured Person's mortal remains from the place of death to the home country or usual country of residence and pay for all expenses reasonably and unavoidably incurred in such transportation so arranged by Intl.SOS or alternatively pay the cost of burial at the place of death as approved by Intl.SOS.

5. Arrangement of Hospital Admission and Guarantee of Hospital Admission Deposit
If the medical condition of the Insured Person is of such gravity as to require hospitalisation, Intl.SOS will assist such Insured Person in the hospital admission. In case of hospital admission duly approved by Intl. SOS and the Insured Person is without means of payment of the required hospital admission deposit, Intl.SOS will on behalf of the Insured Person guarantee or provide such payment up to US$5,000. The provision of such guarantee by Intl.SOS is subject to Intl.SOS first securing payment from the Insured Person through the Insured Person's credit card or from the funds from the Insured Person's family. Intl.SOS shall not be responsible for any third party expenses which shall be solely the Insured Person's responsibility.

6. Delivery of Essential Medicine
Intl.SOS will arrange to deliver to the Insured Person essential medicine, drugs and medical supplies that are necessary for the Insured Person's care and/or treatment but which are not available at the Insured Person's location. The delivery of such medicine, drugs and medical supplies will be subject to the laws and regulations applicable locally. Intl.SOS will not pay for the costs of such medicine, drugs or medical supplies and any delivery costs thereof.

7. **Arrangement and Payment of Compassionate Visit and Hotel Accommodation (US$1,000 subject to a sub-limit US$250 per day)**
Intl.SOS will arrange and pay for one economy class return airfare and hotel accommodations for a relative or a friend of the Insured Person to join the Insured Person who, when travelling alone, is hospitalised outside the home country or usual country of residence for a period in excess of seven (7) consecutive days, subject to Intl.SOS' prior approval and only when judged necessary by Intl.SOS on medical and compassionate grounds.

8. **Arrangement and Payment of Return of Minor Children**
Intl.SOS will arrange and pay for the economy class one-way airfare for the return of minor children [aged 18 years old and below, unmarried] to the home country or usual country of residence if they are left unattended as a result of the accompanying Insured Person's illness, accident or emergency medical evacuation. Escort will be provided, when necessary, at no charge.

9. **Arrangement and Payment of Convalescence Expenses (US$1,000 subject to a sub-limit US$250 per day)**
Intl.SOS will arrange and pay for the additional hotel accommodation expenses necessarily and unavoidably incurred by the Insured Person related to an incident requiring emergency medical evacuation, emergency medical repatriation or hospitalisation. Intl.SOS' prior approval, subject to its determination on medical grounds, is required in respect of such payment.

10. **Arrangement and Payment of Unexpected Return to the Home Country or Usual Country of Residence**
In the event of the death of the Insured Person's close relative in his/her home country or usual country of residence while the Insured Person is travelling overseas (save for in the case of migration) and necessitating an unexpected return to his home country or usual country of residence, Intl.SOS will arrange and pay for one economy class return airfare for the return of the Insured Person to his/her home country or usual country of residence.

11. **Arrangement and Payment of Return of Insured Person to Original Work Site**
Following the Insured Person's emergency medical evacuation or emergency medical repatriation and within one (1) month period, Intl.SOS will, upon the Insured Person's request, arrange and pay for a one-way economy class airfare to return the Insured Person to the original work location.

Travel Assistance:

1. **Inoculation and Visa Requirement Information**
Intl.SOS shall provide information concerning visa and inoculation requirements for foreign countries, as those requirements are specified from time to time in the most current edition of World Health Organization Publication "Vaccination Certificates Requirements and Health Advice for International Travel" (for inoculations) and the "ABC Guide to International Travel Information" (for visas). This information will be provided to the Insured Person at any time, whether or not the Insured Person is travelling or an emergency has occurred.

2. **Lost Luggage Assistance**
Intl.SOS will assist the Insured Person who has lost his/her luggage while travelling outside the home country or usual country of residence by referring the Insured Person to the appropriate authorities involved.

3. Lost Passport Assistance

Intl.SOS will assist the Insured Person who has lost his/her passport while travelling outside the home country or usual country of residence by referring the Insured Person to the appropriate authorities involved.

4. Legal Referral

Intl.SOS will provide the Insured Person with the name, address, telephone numbers, if requested by the Insured Person and if available, office hours for referred lawyers and legal practitioners. Intl.SOS will not give any legal advice to the Insured Person.

5. Emergency Travel Service Assistance

Intl.SOS shall assist the Insured Person in making reservations for air ticket or hotel accommodation on an emergency basis when travelling overseas.

Definitions (applicable to the International SOS 24-hour Worldwide Assistance Services only):

1. Serious Medical Condition

means a condition which in the opinion of Intl.SOS constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the Insured Person's immediate or long-term health prospects. The seriousness of the medical condition will be judged within the context of the Insured Person's geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facilities.

2. Pre-Existing Condition

means any medical condition in respect of which the Insured Person has been hospitalised during the 12-month period immediately prior to the 1st day the Insured Person is included in Intl.SOS program or any medical condition that has been diagnosed or treated by a medical practitioner including prescribed drugs within the 6-month period prior to the 1st day the Insured Person is included in Intl.SOS program.

Exclusions (applicable to the International SOS 24-hour Worldwide Assistance Services only):

The following treatment, items, conditions, activities and their related or consequential expenses are excluded:

1. Any expense incurred as a result of a Pre-existing Condition.

2. More than one emergency evacuation and/or repatriation for any single medical condition of the Insured Person during the term of the insurance policy, subject to a maximum of one year.

3. Any cost or expense not expressly covered by the program and not approved in advance and in writing by Intl.SOS and/or not arranged by Intl.SOS. This exception shall not apply to emergency medical evacuation from remote or primitive areas when Intl.SOS cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the Insured Person.

4. Any event occurring when the Insured Person is within the territory of his/her home country or usual country of residence.

5. Any expense for Insured Persons who are travelling outside the home country or usual country of residence contrary to the advice of a medical practitioner, or for the purpose of obtaining medical treatment or for rest and recuperation following any prior accident, illness or Pre-existing Condition.

6. Any expense for medical evacuation or repatriation if the Insured Person is not suffering from a Serious Medical Condition, and/or in the opinion of the Intl.SOS physician, the Insured Person can be adequately treated locally, or treatment can be reasonably delayed until the Insured Person returns to his/her home country or usual country of residence.

7. Any expense for medical evacuation or repatriation where the Insured Person, in the opinion of the Intl.SOS physician, can travel as an ordinary passenger without a medical escort.

8. Any treatment or expense related to childbirth, miscarriage or pregnancy. This exception shall not apply to any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first twenty-four (24) weeks of pregnancy.

9. Any expense related to accident or injury occurring while the Insured Person is engaged in caving, mountaineering or rock climbing necessitating the use of guides or ropes, potholing, skydiving, parachuting, bungee-jumping, ballooning, hang gliding, deep sea diving utilizing hard helmet with air hose attachments, martial arts, rallying, racing of any kind other than on foot, and any organized sports undertaken on a professional or sponsored basis.

10. Any expense incurred for emotional, mental or psychiatric illness.

11. Any expense incurred as a result of a self-inflicted injury, suicide, drug addiction or abuse, alcohol abuse, sexually transmitted diseases.

12. Any expense incurred as a result of Acquired Immune Deficiency Syndrome (AIDS) or any AIDS related condition or disease.

13. Any expense related to the Insured Person engaging in any form of aerial flight except as a passenger on a scheduled airline flight or licensed charter aircraft over an established route.

14. Any expense related to the Insured Person engaging in the commission of, or the attempt to commit, an unlawful act.

15. Any expense related to treatment performed or ordered by a non-registered practitioner not in accordance with the standard medical practice as defined in the country of treatment.

16. Any expense incurred as a result of the Insured Person engaging in active service in the armed forces or police of any nation; active participation in war (whether declared or not), invasion, act of foreign enemy, hostilities, civil war, rebellion, riot, revolution or insurrection.

17. Any expense, regardless of any contributory cause(s), involving the use of or release or the threat thereof of any nuclear weapon or device or chemical or biological agent, including but not limited to expenses in any way caused or contributed to an Act of Terrorism or war.

18. Any expense incurred for or as a result of any activity required from or on a ship or oil-rig platform, or at a similar off-shore location.

19. Any expense in respect of the Insured Person under Group 1 (group insurance) more than 75 years old and Insured Person under Group 2 (individual insurance) more than 70 years old at the date of intervention.

20. Any expense which is a direct result of nuclear reaction or radiation.

Intl.SOS, at its sole discretion, may provide medical assistance as described above to Insured Persons on a fee-for-service basis for those cases which do not fall within the service scope, subject to Intl.SOS receiving additional financial guarantees or indemnification from the Company and/or its Insured Person(s) prior to rendering such services on a fee-for-service basis.

The information above is for reference only and none of the above is binding upon the Company or International SOS.

The service is currently provided by International SOS and the medical advice is provided by medical service providers which are not employee and/or agent of the Company. The service is not guaranteed renewable. The Company shall not be responsible or liable to the Policy Owner or the Insured Person for anything in relation to such service given by International SOS and the medical service providers. The Company reserves the right to amend, suspend or terminate the International SOS 24-hour Worldwide Assistance Services and to amend the relevant terms and conditions at any time without prior notice.

4. Dementia support program

While this Policy is in force and:

(a) When the Insured Person has the first confirmed diagnosis of Alzheimer's Disease as defined under Part 8 of the Terms and Benefits of the Plan, the Company will provide a designated support program to the Insured Person and the fee will be waived once under all policies issued by the Company during the lifetime of the Insured Person.

(b) When a parent of the Insured Person has the first confirmed diagnosis of Alzheimer's Disease as defined under Part 8 of the Terms and Benefits of the Plan, the Company will provide a referral service of designated support program once to each of the parents of the Insured Person and the fee will not be waived in any event. All relevant fees and charges will be borne by the Insured Person or users of the service including the Insured Person's parents.

The dementia support program will start within six (6) months from the date of first confirmed diagnosis of Alzheimer's Disease. This program is only available in Hong Kong.

Details of the dementia support program will be determined at the Company's sole discretion at the time the service is provided, and the service may be provided by third party service providers designated by the Company. The Company will not be responsible for any act, negligence or failure to act on the part of the service providers and their healthcare network teams (if any). The Company reserves the right to amend, suspend or terminate the dementia support program and to amend the relevant terms and conditions at any time without prior notice.