Cigna HealthFirst Elite 360 Medical Plan

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Part I Definition

1.1 Unless otherwise stated, capitalized words or terms that appear in this Policy shall have the meaning as defined below:

"Accident" or **"Accidental"** shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured Person and caused by violent, external and visible means.

"Accidental Death Benefit" shall mean the Accidental Death Benefit payable under Clause 4.3.32 of Part IV of this Policy.

"Accommodation Room Type" shall mean the accommodation room type selected by the Policy Holder in respect of this Policy and as specified in the Policy Schedule.

"Age" shall mean the attained age of the Insured Person upon the Policy Effective Date or any Anniversary Date thereafter.

"Anniversary Date" shall mean each anniversary date of the Policy Effective Date.

"Annual Benefit Limit" shall mean the maximum aggregate sum of benefits payable by the Company to the Policy Holder under this Policy in a Policy Year. The Annual Benefit Limit is specified in the Benefit Schedule and applies irrespective of whether any benefit limits 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 (whether written or verbal) submitted to the Company in respect of this Policy, including the application form, questionnaires, evidence of insurability, any documents and information submitted and any statements and declarations made in relation to such application, including any updates of and changes to such requisite information.

"Area of Cover" shall mean one of the following selected by the Policy Holder in respect of this Policy and as specified in the Policy Schedule:
(a) Worldwide: worldwide; or
(b) Worldwide excluding the US: worldwide excluding the United States and the US Minor Outlying Islands; or
(c) Asia: Afghanistan, Australia, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, New Zealand, North Korea, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, United Arab Emirates and Vietnam only.

"Basic Policy" shall mean this Policy as may be amended by endorsement from time to time, but excluding -
(a) the Optional Insurance Benefits payable under Clauses 4.3.35, 4.3.36 and 4.3.37 of Part IV of this Policy; and
(b) any additional benefits issued under a rider which are not related to other benefits payable under Part IV of this Policy.

"Beneficiary" shall mean the person, if any, designated by the Policy Holder from time to time and subject to the approval of the Company as the recipient of Accidental Death Benefit payable under Clause 4.3.32 of Part IV of this Policy.

"Benefit Schedule" shall mean a schedule of benefits attached to this Policy which sets out, among others, the benefit items and maximum benefits covered.

"Calendar Month" shall mean the period of time between any day in a month and the day immediately preceding the same day of the next succeeding month or, if there is no corresponding day in the next succeeding month, the last day of the next succeeding month.

"Cancer" shall have the meaning ascribed to it under Part V of this Policy.

"Chinese Medicines" shall mean the Chinese medicines legally registered in the Chinese Medicines Board under Chinese Medicine Council in 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).

For the avoidance of doubt, this Policy does not cover the health supplements and all specialized Chinese herbs and/or tonic medicine such as but not limited to bird's nest, Lingzhi, ginseng, cordceps sinensis, agaricus blazei murill, deer antler etc.

"Cigna Designated Plans" shall mean the plans including "Cigna Cathay Premier Health Plan'', "Cigna HealthFirst Choice Medical Plan", "Cigna HealthFirst DiaMedic Plan", "Cigna HealthFirst Elite Medical Plan", "Cigna HealthFirst Elite 360 Medical Plan", "Cigna VHIS Series — Standard Plan", "Cigna VHIS Series — Flexi Plan (SMM)", "Cigna VHIS Series — Flexi Plan (Superior)", and any other plans that are designated and issued by the Company from time to time.

"Civil Commotion" shall mean a disturbance, commotion or disorder created by civilians usually against a governing body or the policies of that body.

"Company", **"we"**, or **"us"** shall mean Cigna Worldwide General Insurance Company Limited.

"Confinement" or **"Confined"** shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition.

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 Conditions" 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) Calendar Months of birth.

"Country of Residence" shall mean the country where the Insured Person lives or intends to live. Country of Residence is the country where the Insured Person has stayed in that country for one hundred and eighty five (185) days or more during the period of three hundred and sixty five (365) consecutive days before the Eligible Expenses Incurred Date or before the day when other payable expenses are incurred. For the avoidance of doubt, the aforementioned three hundred and sixty five (365) consecutive days are inclusive of both the day of arrival and the day of departure.

"Critical Illness" shall mean any of the critical illness(es) listed and defined under Part V of this Policy.

"Day Case Procedure" shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, day case procedure centre or Hospital with facilities for recovery as a Day Patient.

"Day Patient" shall mean an Insured Person receiving Medical Services given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.

"Designated Day Case Procedures" shall have the meaning ascribed to it as stated in the Benefit Schedule.

"**Designated Mainland China Hospital**" shall mean the mainland China Hospitals that are included in the list of Designated Mainland China Hospitals which may be updated, varied and amended from time to time at the Company's discretion, and any change shall be deemed as effective on the date of publication irrespective of whether any separate notice is given.

"Deductible" shall mean a fixed amount, as specified in the Policy Schedule, that the Policy Holder must pay in a Policy Year before the Company shall reimburse the remaining Eligible Expenses or other payable expenses.

"Disability" shall mean a Sickness, Disease or Injury, including any and all complications arising therefrom.

"Eligible Expenses" shall mean Reasonable and Customary expenses incurred for Medical Services rendered with respect to a Disability.

"Eligible Expenses Incurred Date" shall mean the date when any Medical Service is performed to the Insured Person, except when Confinement or Stay is involved, the date should be the date of admission of the Insured Person to a Hospital, a registered hospice, a registered palliative care facility or a Rehabilitation Centre (as the case may be).

"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 and the required Medical Service cannot be and are not separated by an unreasonable period of time.

"General Practitioner" shall mean a Registered Medical Practitioner who is not a Specialist.

"Grace Period" shall mean a period of thirty (30) days after any Premium Due Date excluding the Policy Effective Date.

"Health Worker in Hong Kong" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who is registered in

(a) the register of health workers as established and maintained by the Director of Social Welfare Department of Hong Kong under the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A of the Laws of Hong Kong) or
(b) the register of health workers as established and maintained by the Director of Social Welfare Department of Hong Kong under the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A of the Laws of Hong Kong).

"Heart Attack" shall have the meaning ascribed to it under Part V of this Policy.

"Hereditary Conditions" shall mean medical conditions genetically transmitted from parent to offspring.

"HIV/AIDS Treatment Waiting Period" shall mean a period of five (5) years from the latest of:
(a) the Policy Issuance Date or the Policy Effective Date (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

In respect of the increased portion of any increase in benefits under this Policy, "HIV/AIDS Treatment Waiting Period" shall mean a period of five (5) years from the latest of:
(a) the issue date or the effective date of the increase in benefits (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

"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 meets all of the following requirements:
(a) is for providing Medical Services for sick and injured persons as Inpatients;
(b) has facilities for diagnosis and major operations;
(c) provides twenty-four (24) hours nursing services by Nurses;
(d) has one (1) or more Registered Medical Practitioners; and
(e) 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, a palliative care facility, a Rehabilitation Centre, an elderly home or similar establishment.

Hospitals in the mainland China must be of Tier 3 Class A or above, or included in our list of Designated Mainland China Hospitals.

"Indebtedness" shall mean any amounts owed to us in respect of this Policy, including without limitation any outstanding Standard Premium, Premium Loading, Deductible, Shortfall, and any accrued interest as determined by us.

"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.

"Insured Person" shall mean the person, as specified in the Policy Schedule, whose risks are covered by this Policy.

"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 aggregate sum of benefits payable by the Company to the Policy Holder under this Policy over the lifetime of the Insured Person. The Lifetime Benefit Limit is specified in the Benefit Schedule and applies irrespective of whether any benefit limits 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 can be safely and effectively provided to the Insured Person.

"Nurse" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who -
(a) 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); and
(b) is legally authorised for rendering nursing treatment or service in Hong Kong or the relevant jurisdiction outside Hong Kong where the nursing treatment or service is provided to the Insured Person.

"Optional Dental Benefits" shall mean benefits payable under Clause 4.3.36 of Part IV of this Policy.

"Optional Insurance Benefits" shall mean -
(a) any additional insurance benefit other than the benefits provided under the Basic Policy, namely Optional Outpatient Benefits, Optional Dental Benefits and Optional Pharmacy Benefit; and
(b) as selected by the Policy Holder in respect of this Policy and as specified in the Policy Schedule.

"Optional Insurance Benefit Issue Date" shall mean the issue date of the Optional Insurance Benefit.

"Optional Outpatient Benefits" shall mean benefits payable under Clause 4.3.35 of Part IV of this Policy.

"Optional Pharmacy Benefit" shall mean benefits payable under Clause 4.3.37 of Part IV of this Policy.

"Optional Pharmacy Benefit Waiting Period" shall mean a period of one hundred and eighty (180) days from the latest of:
(a) the Policy Issuance Date or the Policy Effective Date (whichever is the later);
(b) the effective date of reinstatement (if the Policy has been reinstated with Optional Pharmacy Benefit); and
(c) the Optional Insurance Benefit Issue Date with respect to Optional Pharmacy Benefit (if the Optional Pharmacy Benefit is added after the Policy Issuance Date or the Policy Effective Date (whichever is the later)).

"Period of Cover" shall mean the period, as specified in the Policy Schedule, during which the Policy shall remain in force.

"Palliative Care Benefit Waiting Period" shall mean a period of two (2) years from the latest of:
(a) the Policy Issuance Date or the Policy Effective Date (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated)

In respect of the increased portion of any increase in benefits under this Policy, "Palliative Care Benefit Waiting Period " shall mean a period of two (2) year from the latest of:
(a) the issue date or the effective date of the increase in benefits (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

"Policy" shall mean the Application, the Basic Policy, the Policy Schedule, the Benefit Schedule, the Optional Insurance Benefits (if applicable), any endorsement(s) or supplement(s) attached to this policy, and any rider(s) issued to this policy.

"Policy Effective Date" shall mean the date on which the Policy becomes effective and as specified in the Policy Schedule.

"Policy Holder" or **"you"** shall mean the person, as specified in the Policy Schedule, who is a legal holder of this Policy.

"Policy Issuance Date" shall mean the date on which the Policy is issued by the Company and as specified in the Policy Schedule.

"Policy Schedule" shall mean a schedule attached to this Policy, which sets out, among others, the Policy Effective Date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, the premium and other relevant details in respect of this Policy.

"Policy Year" shall mean the period of time during which this Policy is in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Renewal Date (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year period from each Renewal Date to the day immediately preceding the next Renewal Date (both days inclusive).

"Pre-existing Conditions" shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical or mental or medical condition, physiological degradation, Hereditary Condition, or Congenital Condition, that has existed prior to the Policy Issuance Date, the Policy Effective Date, or the effective date of reinstatement (if the Policy has been reinstated), whichever is the latest.

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.

Notwithstanding the foregoing, "Pre-existing Conditions" shall not include any Disability which:
(a) has been fully disclosed in the Application; and
(b) the Company agrees not to classify as an exclusion under the Policy.

"Pregnancy Complications Waiting Period" shall mean a period of one (1) year from the latest of:
(a) the Policy Issuance Date or the Policy Effective Date (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

In respect of the increased portion of any increase in benefits under this Policy, "Pregnancy Complications Waiting Period" shall mean a period of one (1) year from the latest of:
(a) the issue date or the effective date of the increase in benefits (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

"Premium Due Date" shall mean the Policy Effective Date, the Anniversary Dates or (in case the payment frequency as specified in the Policy Schedule is not on an annual basis) such other dates which correspond to the payment frequency, when the Standard Premium and the Premium Loading (if any) is due and payable.

"Premium Loading" shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.

"Prescribed Diagnostic Imaging Tests" shall mean computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined, and PET-MRI combined.

"Prescribed Non-surgical Cancer Treatments" shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy, hormonal therapy, proton therapy, gamma knife and cyberknife.

"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. 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 Chinese Medicine Practitioner" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who –
(a) is a Chinese herbalist, a bonesetter or an acupuncturist;
(b) 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); and
(c) is legally authorised for rendering relevant traditional Chinese medicine treatment in Hong Kong or the relevant jurisdiction outside Hong Kong where the traditional Chinese medicine treatment is provided to the Insured Person.

"Registered Chiropractor" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who –
(a) is duly qualified and is registered with the Chiropractor Council of Hong Kong pursuant to the Chiropractor Registration Ordinance (Cap. 428 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company); and
(b) is legally authorised for rendering chiropractic treatment to prevent, diagnose and treat functional disorders of the human body through manipulation of the joints (particularly of the vertebral column and peripheral joints, including the pelvis) in Hong Kong or the relevant jurisdiction outside Hong Kong where the chiropractic treatment is provided to the Insured Person.

"Registered Dentist" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who -
(a) is duly qualified and is registered as a registered dentist with the Dental Council of Hong Kong pursuant to the Dentists Registration Ordinance (Cap. 156 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company); and
(b) is legally authorised for rendering dental service in Hong Kong or the relevant jurisdiction outside Hong Kong where the dental service is provided to the Insured Person.

"Registered Dietitian" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who –
(a) is duly qualified and is registered with Hong Kong Academy of Accredited Dietitians (HKAAD) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company); and
(b) is legally authorised for rendering dietitian consultation in Hong Kong or the relevant jurisdiction outside Hong Kong where the dietitian consultation is provided to the Insured Person.

"Registered Medical Practitioner", **"Surgeon"** or **"Anaesthetist"** shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who -
(a) is a medical practitioner of western medicine;
(b) 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); and
(c) is 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 Occupational Therapist" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who is -
(a) is duly qualified and is registered with the Occupational Therapists Board in Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company); and
(b) is legally licensed for rendering occupational therapy in Hong Kong or the relevant jurisdiction outside Hong Kong where the occupational therapy is provided to the Insured Person.

"Registered Physiotherapist" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who is -
(a) is duly qualified and is registered with the Physiotherapists Board in Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company); and

(b) is legally licensed for rendering assessment and treatment service on physical disabilities by mean of remedial exercises, manual therapy and mechanical, thermal or electrical therapy, in Hong Kong or the relevant jurisdiction outside Hong Kong where the physiotherapy is provided to the Insured Person.

"Registered Psychologist in Hong Kong" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who –
(a) is duly qualified and is registered with Hong Kong Psychological Society Limited, Hong Kong Association of Doctors in Clinical Psychology Limited, Hong Kong Association of Educational Psychologists (HKAEP) and/or Hong Kong Institute of Clinical Psychologists (HKICP); and
(b) is legally authorised for rendering relevant psychological consultation services in Hong Kong.

"Registered Speech Therapist" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who –
(a) Is duly qualified and is registered with Hong Kong Institute of Speech Therapist or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company); and
(b) Is legally authorised for rendering speech therapy in Hong Kong or the relevant jurisdiction outside Hong Kong where the speech therapy is provided to the Insured Person.

"Rehabilitation Centre" shall mean a registered institution (other than a Hospital) which provides physiotherapy, occupational therapy and other rehabilitative treatment for dysfunction or Disability.

"Renewal", **"Renew"**, **"Renewed"** or **"Renewable"** shall mean renewal of this Policy in accordance with Clause 2.7 of Part II of this Policy.

"Renewal Date" shall mean the effective date of Renewal of the Policy. The first Renewal Date shall be the date as specified in the renewal notice (which shall not be later than the first Anniversary Date and the subsequent Renewal Date(s) shall be the subsequent Anniversary Date(s).

"Semi-Private Room" shall mean a room categorized as a semi-private or second class room by a Hospital. If a Hospital does not have any room categorisation, a "Semi-Private Room" shall mean a single or double occupancy room, with a shared bath or shower room, in the Hospital.

"Shortfall" shall mean any expenses incurred by the Insured Person which are not covered or which exceed the benefit limits under this Policy, and which have been paid to a medical service provider by the Company on behalf of the Insured Person.

"**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.

"Specialist" shall mean a person, other than the Policy Holder, the Insured Person, or any insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing), who -
(a) is a medical practitioner of western medicine;
(b) is duly qualified and is registered in the specialist register 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); and
(c) is 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.

"Standard Premium" shall mean the premium for the coverage under the Basic Policy or any Optional Insurance Benefits (if applicable), as charged by the Company to the Policy Holder.

"Standard Private Room" shall mean a room categorised as a single, private or first class room by a Hospital. If a Hospital does not have any room categorisation, a "Standard Private Room" shall mean a single occupancy room, with a private bath or shower room, in the Hospital. For the avoidance of doubt, a "Standard Private Room" does not include any room with amenities upgraded beyond a basic single occupancy room with private bath or shower room, in a Hospital.

"Stay" or **"Stayed"** shall mean an admission of the Insured Person to a registered hospice, a registered palliative care facility or a Rehabilitation Centre that is recommended by a Registered Medical Practitioner for Medical Service as a result of a Medically Necessary condition.

"Stroke" shall have the meaning ascribed to it under Part V of this Policy.

"Terrorism" shall mean the use or threatened use of force or violence against person or property, or commission of an act dangerous to human life or property, or commission of an act that interferes with or disrupts an electronic or communication system, undertaken by any person or group, whether or not acting on behalf of or in any connection with any organization, government, power, authority or military force, when the intent is to intimidate, coerce or harm a government, the civilian population or any segment thereof, or to disrupt any segment of the economy. Terrorism shall also include any act which is verified or recognized by the relevant local government as an act of terrorism.

"Three Critical Illnesses Benefit Waiting Period" shall mean a period of ninety (90) days from the latest of:
(a) the Policy Issuance Date or the Policy Effective Date (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

In respect of the increased portion of any increase in benefits under this Policy, "Three Critical Illnesses Benefit Waiting Period " shall mean a period of ninety (90) days from the latest of:
(a) the issue date or the effective date of the increase in benefits (whichever is the later); and
(b) the effective date of reinstatement (if the Policy has been reinstated).

"The US" shall mean the United States and the US Minor Outlying Islands.

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

"War" shall mean war, whether declared or not, or any warlike activities including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

"Western Medication" shall mean the western medication legally registered with the Pharmacy and Poisons Board in Hong Kong pursuant to the Pharmacy and Poisons Ordinance (Cap. 138 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company).

1.2 Unless the context otherwise provides, singular words shall include the plural form and masculine words shall include the feminine form and vice versa. General words shall not be given a restrictive meaning by reason of the fact that they are followed by particular examples intended to be embraced by the general words.

1.3 Reference to Clauses refers to clauses of this Policy. Headings are inserted for convenience of reference only and shall not affect the interpretation of this Policy.

1.4 If any provision of this Policy shall be determined by a court of competent jurisdiction to be illegal, invalid or unenforceable, it shall not affect the legality, validity or enforceability of any other provision of this Policy.

1.5 No failure or delay in exercising any right under this Policy by the Company shall operate as a waiver of any such right by the Company.

Part II General Provisions

2.1 The Policy contract

In consideration of the payment of the Standard Premium and Premium Loading (if any), and on the basis of the Application submitted to the Company, the Company hereby agrees to issue this Policy to cover the Insured Person and provide for benefits in accordance with the terms and conditions of this Policy.

2.2 Governing law and jurisdiction

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 the Policy Holder agree to be subject to the exclusive jurisdiction of the Hong Kong courts.

2.3 Policy currency

All dollar amounts referred to in this Policy are expressed in the currency specified in the Policy Schedule.

2.4 Policy changes

2.4.1 The Company reserves the right to revise, amend or modify the terms and conditions of this Policy at any time whilst this Policy is in force, as considered necessary by the Company to comply with any applicable legislation and/or regulatory requirements effective at the Policy Effective Date or during the term of this Policy.

2.4.2 No change in the terms and conditions of this Policy shall be valid unless recorded in an endorsement to this Policy and issued by the Company.

2.5 Change of details

The Insured Person and the Policy Holder shall give immediate notice to the Company of any change in any of their personal particulars in a form prescribed by us, including but not limited to, names, occupation, resident country or territory and addresses. Such change is valid only if recorded in a written notice effecting such change last issued by the Company.

2.6 Change of Accommodation Room Type / Area of Cover / Deductible / Optional Insurance Benefits

2.6.1 Downgrade or upgrade of level of cover refers to any change in the Accommodation Room Type, Area of Cover, Deductible, and/or Optional Insurance Benefits under this Policy.

2.6.2 The Policy Holder may request to upgrade or downgrade the level of cover specified in the Policy Schedule to change the Accommodation Room Type, Area of Cover, Deductible and/or Optional Insurance Benefits under this Policy in a form prescribed by the Company.

2.6.3 Subject to the terms and conditions of this Policy and the Company's approval (if recorded in a Policy Schedule last issued by the Company), the new level of cover shall become the Accommodation Room Type, Area of Cover, Deductible and/or Optional Insurance Benefits under this Policy. The new level of cover and the corresponding premium will be effective from the Anniversary Date following the approval of such request provided that the request is received by the Company at least before thirty (30) days prior to that Anniversary Date.

2.6.4 Any upgrade of level of cover or increase in benefits resulting from a higher level of Accommodation Room Type or Area of Cover, and/or an addition of Optional Insurance Benefits, and/or a lower Deductible under Clause 2.6.3 of Part II of this Policy shall only be applicable to:
(a) Injury sustained on or after the issue date or the effective date of the upgrade (whichever is the later); or
(b) Sickness or Disease which has been diagnosed, has exhibited symptoms, has occurred, or has required medical advice and/or treatment and/or prescription of drugs, for the first time on or after the issue date or the effective date of the upgrade (whichever is the later).

2.6.5 Subject to Clause 2.6.3 of Part II of this Policy, the Policy Holder can enjoy the privilege of requesting to lower the Deductible without any medical underwriting provided that:
(a) the privilege is only applicable within thirty (30) days before the Anniversary Date on or immediately following the Insured Person's fifty-fifth (55th) or sixtieth (60th) or sixty-fifth (65th) or seventieth (70th) birthday;
(b) this privilege can only be exercised once per lifetime of the Insured Person; and
(c) this privilege cannot be exercised if three Critical Illnesses premium waiver benefit under Clause 4.3.33 (b) of Part IV of this Policy is in effect.

2.7 Renewal

2.7.1 Subject to Clause 2.16 of Part II of this Policy, the Basic Policy and the Optional Insurance Benefits (if applicable) under this Policy shall be effective for an initial period of twelve (12) Calendar Months and thereafter guaranteed to be automatically Renewable, for successive periods of twelve (12) Calendar Months each, provided that payment of the Standard Premium and Premium Loading (if any) is paid on or before each Anniversary Date and that we continue to issue new policy(ies) under the Basic Policy and the Optional Insurance Benefits (if applicable).

2.7.2 The Company reserves the right to revise the terms and conditions, the Standard Premium and/or the Benefit Schedule of this Policy upon each Renewal. If the Premium Loading is set as a percentage of the Standard Premium, the amount of Premium Loading will be adjusted automatically according to the change in the Standard Premium.

2.7.3 If the Basic Policy and/or the respective Optional Insurance Benefits of the "Cigna HealthFirst Elite 360 Medical Plan" are not Renewed by the Company, we will send a written notice to you, at least before thirty (30) days prior to the next Anniversary Date, to notify you that this Policy will not be Renewed.

2.8 Misstatement of personal information

2.8.1 Without prejudice to the Company's right to declare this Policy void as provided in Clause 2.9 of Part II of this Policy, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or smoking habit) is misstated in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information, the Company may adjust the Standard Premium and Premium Loading (if applicable), 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 thirty (30) days after the due date as notified by the Company to the Policy Holder, the Company shall have the right to terminate this Policy with effect from such due date. Where there has been an overpayment of premium by the Policy Holder, the Company shall refund the overpaid premium less any Indebtedness.

2.8.2 Where the Company, based on the correct information of the Insured Person and the Company's underwriting guidelines, considers that the application of the Insured Person should have been rejected, the Company shall have the right to declare this Policy void as from the Policy Effective Date and no cover shall be provided for the Insured Person. The Company shall, for the current and all previous Policy Years, have:

(a) the right to demand refund of the benefits previously paid;
(b) the obligation to refund the premium paid after deducting the benefits previously paid, any Indebtedness and a reasonable administration charge payable to the Company; and
(c) the obligation to refund the insurance levy paid.

2.9 Misrepresentation or fraud

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

(a) any material fact relating to the health related information of the Insured Person which may impact the risk assessment by the Company is incorrectly stated in, or omitted from, the Application or any statement or declaration made for or by the Insured Person in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information. The circumstances that a fact shall be considered "material" include, but not limited to, the situation where the disclosure of such fact as required by the Company would have affected the underwriting decision of the Company, such that the Company would have imposed Premium Loading, included exclusion(s), or rejected the application; or
(b) any Application or claim submitted is fraudulent or where a fraudulent representation is made.

In the event of (a), the Company shall, for the current and all previous Policy Years, have:
(i) the right to demand refund of the benefits previously paid;
(ii) the obligation to refund the premium paid after deducting the benefits previously paid, any Indebtedness and a reasonable administration charge payable to the Company; and
(iii) the obligation to refund the insurance levy paid.

In the event of (b), the Company shall have:
(i) the right to demand refund of the benefits previously paid; and
(ii) the right not to refund the premium and the insurance levy paid.

2.10 Subrogation

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

2.11 Notification and proof of claims

2.11.1 Notification of claim

A fully completed claim form prescribed by the Company must be given to the Company within thirty (30) days (a) after the Insured Person is discharged from a Hospital if there is Confinement or (b) after the date on which the Medical Service is performed to the Insured Person if there is no Confinement. Such form shall include information sufficient to identify the Insured Person and the nature of the claim.

2.11.2 Proof of claim

(a) Proof of claim must be given to the Company within ninety (90) days (a) after the Insured Person is discharged from a Hospital if there is Confinement, or (b) after the date on which the Medical Service is performed to the Insured Person if there is no Confinement. If proof of claim is not given within the prescribed period, it must be shown that proof of claim has been given as soon as reasonably possible; otherwise, the Company shall have the right not to pay the claim.

(b) All information and documents (including but not limited to a copy of the Insured Person’s medical records and reports, the original receipts for all expenses and the documentary proof of Age of the Insured Person) that we need to process the claim shall be submitted to the Company, at the Policy Holder’s, the Insured Person’s and/or any relevant claimant’s own expense. The Policy Holder, the Insured Person and/or any relevant claimant shall sign all authorization forms necessary to authorize the Company to obtain a full and complete medical history of the Insured Person.

(c) In the event that the Policy Holder, the Insured Person and/or any relevant claimant opts to make a claim in respect of the same expenses under an insurance policy issued by another insurer, a copy of the settlement letter and the receipt of the claim payment issued by that insurer shall also be submitted to the Company.

(d) The Company reserves the right to require that the Insured Person be examined by Registered Medical Practitioner(s) and/or Specialist(s) of our choice.

(e) It is a condition precedent to the Company’s liability to make any payment under this Policy that the Policy Holder, the Insured Person and any relevant claimant fully comply with the terms and conditions of this Policy.

2.11.3 Deduction of claim payment

The Company shall have the right to deduct any Indebtedness from any benefit payable under this Policy.

2.12 Other insurance coverage

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

2.13 Payment

2.13.1 Except for the Accidental Death Benefit payment, we shall pay any benefit payable under this Policy to the Policy Holder or if the Policy Holder is not living at the time of payment, to the Policy Holder's estate.

2.13.2 For the Accidental Death Benefit payment, we shall pay it to the Beneficiary, and if no Beneficiary is designated or the Beneficiary is not living at the time of the payment, to the Policy Holder.

2.13.3 Notwithstanding any provision in this Policy, all payments under this Policy shall be conditional upon production of valid documents verifying the identity of the Policy Holder and/or the personal representative(s) of the Policy Holder's estate and/or the Insured Person and/or the Beneficiary (as the case may be) to our satisfaction. For the purpose of Clause 2.13 of Part II of this Policy, "personal representative" shall have the meaning as defined under the Probate and Administration Ordinance (Cap.10 of the Laws of Hong Kong).

2.13.4 The payment of benefits under this Policy in the manner pursuant to Clauses 2.13.1 to 2.13.3 of Part II of this Policy shall be deemed as a full and final discharge of all liabilities of the Company under this Policy.

2.14 Interest

Unless otherwise expressly provided in this Policy, all amounts payable by the Company under this Policy shall not carry any interest.

2.15 Cooling-off period

2.15.1 The Policy Holder may during the cooling-off period exercise the right to cancel this Policy and obtain a refund of the Standard Premium and Premium Loading (if any) and insurance levy paid. In such event, this Policy shall be deemed to have been void from the Policy Effective Date and the Company shall not be liable to pay any benefit.

2.15.2 The cancellation right is subject to the following conditions –

(a) the request to cancel must be made by the Policy Holder in a form prescribed by the Company and received directly by the Company within the cooling-off period. The cooling-off period is the period of thirty (30) days immediately following the day of the delivery of this Policy or the cooling-off notice (whichever is the earlier), to the Policy Holder or the nominated representative of the Policy Holder. For the avoidance of doubt, the day of delivery of this Policy or the cooling-off notice is not included for the calculation of the thirty (30) day period. However, if the last day of the thirty (30) day period is not a working day, the period shall include the next working day;
(b) no refund can be made if a benefit payment has been made, is to be made or pending; and
(c) the above cancellation right shall not apply at Renewal.

2.16 Termination

2.16.1 This Policy shall terminate upon the occurrence of the earliest of the following events:

(a) the death of the Insured Person;
(b) the cancellation of this Policy by the Policy Holder pursuant to Clause 2.15 of Part II of this Policy;
(c) the cancellation of this Policy by the Policy Holder pursuant to Clause 2.16.3 of Part II of this Policy;
(d) the cancellation of this Policy by the Company pursuant to Clause 2.16.4 of Part II of this Policy;
(e) when this Policy is not Renewed pursuant to Clause 2.7 of Part II of this Policy;
(f) the lapse of this Policy pursuant to Clause 3.3.2 of Part III of this Policy; or
(g) when the Lifetime Benefit Limit is reached.

2.16.2 Termination of this Policy shall be without prejudice to any claim arising prior to such termination unless otherwise stated in this Policy. The payment to or acceptance by the Company of any Standard Premium and Premium Loading (if any) hereunder subsequent to the termination of this Policy shall not create any liability but the Company shall refund any such premium paid less any Indebtedness.

2.16.3 Cancellation by the Policy Holder

(a) The Policy Holder may cancel this Policy by giving not less than thirty (30) days' notice to us in a form prescribed by the Company.
(b) Termination of this Policy caused by such cancellation shall become effective on the date specified in such form or the date approved by us, whichever is the later.
(c) Where this Policy is terminated by such cancellation, there shall be no refund of the Standard Premium, the Premium Loading (if any) and insurance levy paid. The Company reserves the right to charge the Standard Premium and the Premium Loading (if any) calculated until the end of such Policy Year during which the termination of this Policy becomes effective.

2.16.4 Cancellation by the Company

(a) The Company shall be entitled to terminate this Policy pursuant to Clause 2.8.1 of Part II of this Policy.
(b) The Company shall be entitled to declare this Policy void as from the Policy Effective Date pursuant to Clauses 2.8.2, 2.9, 3.3.1 and/or 4.4.2 of Part II, Part III and/or Part IV of this Policy.
(c) The Company reserves the right to cancel this Policy immediately when the Shortfall is not settled within fourteen (14) days after a Shortfall advice is issued by the Company to the Policy Holder. Where the Shortfall continues not to be settled, any delay by the Company in cancelling this Policy pursuant to this provision shall not constitute a waiver of its right to cancel at a later time.

2.17 Clerical error

Clerical errors by the Company shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force, and this Policy shall be construed as if any such clerical errors have not been committed.

2.18 Limitations

No action at law shall be brought against the Company for the recovery of any claim under this Policy within the first sixty (60) days from the date on which proof of claim has been submitted to the Company in accordance with Clause 2.11.2 of Part II of this Policy or after two (2) years from the date of the Company's final decision in respect of such claim.

2.19 Policy ownership

While this Policy is in force, the Policy Holder can exercise all rights, privileges and options provided under this Policy. The Policy Holder may, during the lifetime of the Insured Person, request to change the ownership of this Policy in a form prescribed by us. Such change is valid only if recorded in a Policy Schedule effecting such change last issued by the Company.

2.20 Rights of third parties

Other than the Company and the Policy Holder, any person or entity who is not a party to this Policy (including but not limited to the Insured Person or the Beneficiary) 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.

2.21 Compliance with sanctions rules

2.21.1 It is the Company's global corporate policy to comply with the economic sanctions rules related to individuals, entities, and countries applicable to its global business operations, including but not limited to those imposed by the United Nations, the European Commission, the United States, and Canada. Therefore, the Company will not offer coverage or pay benefits to or on behalf of, any Policy Holder and/or Insured Person and/or Beneficiary and/or otherwise any relevant individual if doing so would violate these sanctions rules. In the event the Company learns that a sanctioned individual is enrolled under this Policy, or that a Policy Holder or Insured Person becomes sanctioned, the Company will take all appropriate action, which could include blocking, reporting, and terminating coverage. The Company is under no obligation to notify the Insured Person or Policy Holder or the Beneficiary or otherwise any individual who may be affected in advance of taking these actions, or to obtain licenses from any government to enable the extension of coverage in compliance with sanctions laws.

2.21.2 In addition, restrictions will apply to claims incurred in sanctioned countries where there is no relevant, approved license from the U.S. Office of Foreign Assets Control. Among the restrictions, the Company will not cover: (1) elective or pre-scheduled treatment in sanctioned countries; or (2) Insured Person or Policy Holder considered "ordinarily resident" in a sanctioned country. Insured Person or Policy Holder are considered ordinarily resident if they visit a sanctioned country for a period of longer than six (6) weeks over the course of any twelve (12) month period.

Part III Premium Provisions

3.1 Premium payable under this Policy

For the Basic Policy and the Optional Insurance Benefits (if applicable) as specified in the Policy Schedule, you are required to pay the Standard Premium and the Premium Loading (if any) regularly on the Premium Due Date.

3.2 Premium payment frequency

This Policy is an annual policy. Any Standard Premium and Premium Loading (if any) payable under this Policy shall be paid in accordance with the payment frequency as specified in the Policy Schedule. You may request to change the payment frequency in a form prescribed by the Company during the term of this Policy. Such change is valid only if recorded in a Policy Schedule effecting such change last issued by the Company.

3.3 Premium payment

3.3.1 If you fail to pay the initial premium in full for the Policy on or before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Policy shall be deemed to be void as from the Policy Effective Date for all purposes. Accordingly, we shall not be liable to pay any benefit under the Policy.

3.3.2 Except for the initial premium payment, a Grace Period after any Premium Due Date will be allowed for payment of premium or any part thereof. The coverage of this Policy will remain in force during this Grace Period, but the Company shall have the right to deduct at its discretion any due premium payment from the benefit payable under this Policy if there is any benefit payable during the Grace Period. If the Standard Premium and Premium Loading (if any) of the Basic Policy and/or the Optional Insurance Benefits (if applicable) as specified in the Policy Schedule or any part thereof remains unpaid at the end of the Grace Period, the Policy shall terminate on the Premium Due Date on which the unpaid Standard Premium and Premium Loading (if any) was first due.

3.3.3 The Company reserves the right to revise the Standard Premium of this Policy upon each Renewal at its sole discretion by taking into account such factors as the Company determines to be relevant for the purpose of revising the Standard Premium. If the Premium Loading is set as a percentage of the Standard Premium, the amount of Premium Loading will be adjusted automatically according to the change in the Standard Premium.

3.3.4 Unless otherwise expressly provided in the Policy, where this Policy is terminated, there shall be no refund of the Standard Premium, the Premium Loading (if any) and insurance levy paid.

3.4 Reinstatement

3.4.1 If the Policy lapses due to non-payment of the Standard Premium and the Premium Loading (if any) under Clause 3.3.2 of Part III of this Policy, the Policy may be reinstated within three (3) Calendar Months from the Premium Due Date on which the unpaid Standard Premium and Premium Loading (if any) was first due subject to all of the following and the approval of the Company:

(a) submission of an application for reinstatement in a form prescribed by the Company;
(b) submission of evidence of insurability of the Insured Person to the satisfaction of the Company; and
(c) receipt of the payment of all outstanding Standard Premium, Premium Loading and other Indebtedness (if any).

3.4.2 The Company will consider reinstatement by redating subject to our rules and regulations, including but not limited to the requirement that all claims for benefits under this Policy prior to the effective date of reinstatement be carried forward and included for purposes of applying the Annual Benefit Limit, the Lifetime Benefit Limit and/or any benefit limits as specified in the Benefit Schedule to the benefits payable under the reinstated Policy.

3.4.3 Subject to any provisions endorsed hereon or attached to this Policy in connection with the reinstatement, the Policy Holder shall have the same rights under this Policy as existing immediately before the date of termination of the Policy.

3.4.4 For the avoidance of doubt, the Company shall not be liable to pay any benefits for –
(a) Injury sustained on or after the date of termination of the Policy and prior to the effective date of reinstatement of the Policy; or
(b) Sickness or Disease which has been diagnosed, has exhibited symptoms, has occurred, or has required medical advice and/or treatment and/or prescription of drugs for the first time on or after the date of termination of the Policy and prior to the effective date of reinstatement of the Policy.

Part IV Benefit Provisions

4.1 Extent of benefits

4.1.1 Subject to the terms and conditions of this Policy, the benefits under the Basic Policy shall be payable by the Company according to the Accommodation Room Type, the Area of Cover, the Deductible, and any benefit limits as specified in the Benefit Schedule applicable on the Eligible Expenses Incurred Date or on the day when other payable expenses are incurred.

4.1.2 Subject to the terms and conditions of this Policy, the Optional Insurance Benefits, if specified in the Policy Schedule, shall be payable by the Company according to the Area of Cover and any benefit limits as specified in the Benefit Schedule applicable on the Eligible Expenses Incurred Date or on the day when other payable expenses are incurred.

4.1.3 For the avoidance of doubt, where the Insured Person is Confined in a Hospital, or Stays in a registered hospice, a registered palliative care facility or a Rehabilitation Centre, but the Confinement or Stay is considered not Medically Necessary, the expenses incurred as a result of such Confinement or Stay shall not be regarded as Eligible Expenses. However, the Policy Holder shall still have the right to claim for the relevant Eligible Expenses incurred for Day Case Procedure, Prescribed Diagnostic Imaging Test, Prescribed Non-surgical Cancer Treatment, outpatient kidney dialysis, Accidental Emergency outpatient treatment and Accidental Emergency dental treatment (excluding such Confinement or Stay) performed during such Confinement or Stay.

4.1.4 Territorial scope of cover

(a) Except Emergency Treatment, the benefits under the Basic Policy and the Optional Insurance Benefits (if applicable) shall be payable only if the Medical Services are provided in the Area of Cover. For Emergency Treatment, the coverage under this Policy is worldwide.

(b) If the Insured Person's Country of Residence is the US on the Eligible Expenses Incurred Date or on the day when other payable expenses are incurred, all benefits payable under this Policy shall be reduced to sixty percent (60%) of the Eligible Expenses and other payable expenses incurred in the US. Notwithstanding the foregoing, and for the avoidance of doubt, the benefit limits as specified in the Benefit Schedule and the Deductible shall remain unchanged.

4.1.5 Choice of healthcare services providers

For Medical Services rendered in Hospitals in the mainland China that is neither a Tier 3 Class A or above nor a Designated Mainland China Hospital, no benefits under this Policy shall be payable by the Company.

4.1.6 Choice of ward class

(a) If the Insured Person is Confined in Hong Kong or Macau in a room type of a level higher than the Accommodation Room Type, the Eligible Expenses payable and other payable expenses under the Basic Policy shall be subject to the adjustment factor applicable as follows:

Accommodation Room Type	Room type Confined	Adjustment factor
Semi-Private Room	Standard Private Room	50%

(b) No benefits under the Basic Policy shall be payable for Confinement in class of suite/ VIP/ deluxe room of a Hospital.

4.2 Calculation of benefits payable

Benefit payable shall be calculated in accordance with the formula as follows, provided that the amount payable for any one Policy Year does not exceed the Annual Benefit Limit:

Benefit Payable	{Amount of Eligible Expenses or other payable expenses **LESS (-)** (the Eligible Expenses or other payable expenses incurred for the same Disability reimbursed by another party or by us under another insurance plan, or the Deductible under this Policy, whichever is the highest)} **TIMES (x)** adjustment factor under Clause 4.1.4 (b) of Part IV of this Policy (if applicable) **TIMES (x)** adjustment factor under Clause 4.1.6 (a) of Part IV of this Policy (if applicable)

4.3 Benefits covered

4.3.1 **Room and board**

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

4.3.2 **Miscellaneous charges**

This benefit shall be payable for the Eligible Expenses charged for the following miscellaneous charges incurred during the Confinement of the Insured Person in the Hospital or on the day when the Insured Person undergoes any Day Case Procedure:

(a) Road ambulance service to and/or from the Hospital;
(b) Anaesthetic and oxygen administration;
(c) Administration charges for blood transfusion;
(d) Dressing and plaster casts;
(e) Medicine and drug prescribed and consumed during the Confinement or the Day Case Procedure;
(f) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
(g) Additional surgical appliances, equipment and devices other than those inclusively paid under Clause 4.3.6 of Part IV of this Policy, and implants, disposables and consumables used during surgical procedure;
(h) Medical disposables, consumables, equipment and devices;
(i) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Clause 4.3.9 of Part IV of this Policy;
(j) Intravenous ("IV") infusions including IV fluids;
(k) Laboratory examinations and reports, including the pathological examination performed for the surgical procedures during the Confinement or the Day Case Procedure;
(l) Rental of walking aids and wheelchair for Inpatients; and
(m) Physiotherapy during the Confinement.

4.3.3 **Attending doctor's visit fee**

If, during 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.

4.3.4 **Specialist's fee**

If, during Confinement, the Insured Person is treated by a Specialist (not being the attending Registered Medical Practitioner under Clause 4.3.3 of Part IV of this Policy) 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.

4.3.5 **Intensive care**

If, during 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 payable under this benefit shall not be payable under Clause 4.3.1 of Part IV of this Policy.

4.3.6 **Surgeon's fee**

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

4.3.7 **Anaesthetist's fee**

If Surgeon's fee is payable under Clause 4.3.6 of Part IV of this Policy, this benefit shall be payable for the Eligible Expenses charged by the Anaesthetist in relation to the surgical procedure.

4.3.8 **Operating theatre charges**

If Surgeon's fee is payable under Clause 4.3.6 of Part IV of this Policy, 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 Clause 4.3.2 of Part IV of this Policy.

4.3.9 **Prescribed Diagnostic Imaging Tests**

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

4.3.10 **Prescribed Non-surgical Cancer Treatments**

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

For the avoidance of doubt, the Eligible Expenses for Prescribed Diagnostic Imaging Tests shall be payable under Clause 4.3.9 of Part IV of this Policy.

4.3.11 **Psychiatric treatments**

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

This benefit shall be payable in lieu of other benefit items under Clause 4.3.1 to Clause 4.3.10 of Part IV of this Policy. 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 for the Medical Services (excluding the Confinement) performed during such Confinement and 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 treatments, the expenses in entirety shall be payable under Clause 4.3.1 to Clause 4.3.10 of Part IV of this Policy.

4.3.12 **Medical appliances**

If room and board is payable under Clause 4.3.1 of Part IV of this Policy, or if intensive care is payable under Clause 4.3.5 of Part IV of this Policy, this benefit shall be payable for the Eligible Expenses charged for the cost of the following medical appliances placed inside or on the surface of the Insured Person's body in a surgical procedure performed by a Registered Medical Practitioner during Confinement or a Day Case Procedure performed by a Registered Medical Practitioner, provided that such medical appliances must be non-transferable:

(a) Specified items
  (i) Pace maker;
  (ii) Stents for Percutaneous Transluminal Coronary Angioplasty;
  (iii) Basic/ Monofocal Intraocular lens;
  (iv) Artificial cardiac valve;
  (v) Metallic or artificial joint for joint replacement;
  (vi) Prosthetic ligaments for replacement or implantation between bones; and
  (vii) Prosthetic intervertebral disc.
(b) Other items
  Other medical appliances that are not mentioned above.

For the avoidance of doubt, the Eligible Expenses incurred for the cost of the above medical appliances placed inside or on the surface of the Insured Person's body shall only be payable under this benefit.

4.3.13 **Pre-Confinement/ Day Case Procedure outpatient care**

This benefit shall be payable for the Eligible Expenses charged for outpatient visits at a Registered Medical Practitioner's clinic and/or Emergency consultations resulting in a Confinement or a Day Case Procedure (including consultation, prescribed Western Medication or diagnostic tests) within the period stated in the Benefit Schedule immediately preceding the Confinement or the Day Case Procedure.

For the avoidance of doubt, the Eligible Expenses for Prescribed Diagnostic Imaging Tests shall be payable under Clause 4.3.9 of Part IV of this Policy.

4.3.14 **Post-Confinement/ Day Case Procedure outpatient care**

This benefit shall be payable for the Eligible Expenses charged for follow-up outpatient visits (including consultation, prescribed Western Medication or diagnostic tests) to, or recommended in writing by, the attending Registered Medical Practitioner at a clinic, within the period stated in the Benefit Schedule after discharge from Confinement or completion of Day Case Procedure, provided that such outpatient visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

For the avoidance of doubt, the Eligible Expenses for Prescribed Diagnostic Imaging Tests and Prescribed Non-surgical Cancer Treatments shall be payable under Clause 4.3.9 and Clause 4.3.10 of Part IV of this Policy respectively.

4.3.15 **Post-Confinement/ Day Case Procedure auxiliary treatment**

This benefit shall be payable for the Eligible Expenses charged for outpatient visits to a Registered Physiotherapist, Registered Psychologist in Hong Kong, Registered Occupational Therapist, Registered Speech Therapist or Registered Chiropractor, within the period stated in the Benefit Schedule after discharge from Confinement or completion of Day Case Procedure, provided that:

(a) 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;
(b) such outpatient visit is recommended in writing by the attending Registered Medical Practitioner; and
(c) if more than one (1) physiotherapy, psychologist therapy, occupational therapy, speech therapy or chiropractor consultation is incurred on the same day, only one (1) of such therapies or consultations will be payable under this benefit.

For the avoidance of doubt, the Eligible Expenses incurred for outpatient visits to a Registered Physiotherapist, Registered Psychologist in Hong Kong, Registered Occupational Therapist, Registered Speech Therapist or Registered Chiropractor shall only be payable under this benefit.

4.3.16 **Traditional Chinese medicine treatment**

This benefit shall be payable for the Eligible Expenses charged for traditional Chinese medicine treatment (including consultation and basic Chinese Medicines prescribed) provided by a Registered Chinese Medicine Practitioner:

(a) during the Insured Person's Confinement and the traditional Chinese medicine treatment is arranged by the Hospital; and
(b) within the period stated in the Benefit Schedule after discharge from Confinement or completion of Day Case Procedure as part of the Insured Person's rehabilitation treatment;

provided that such traditional Chinese medicine 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 or Day Case Procedure.

Where Eligible Expenses under this benefit are also covered under other benefits under Part IV of this Policy, such Eligible Expenses shall be payable in the following order:

(a) this benefit;
(b) three Critical Illnesses auxiliary benefit under Clause 4.3.33 (a) of Part IV of this Policy.

4.3.17 **Post-Confinement home nursing**

This benefit shall be payable for Eligible Expenses charged for home nursing services provided to the Insured Person by a Nurse or a Health Worker in Hong Kong immediately after discharge from Confinement, provided that such home nursing care is recommended in writing by the attending Registered Medical Practitioner and 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.

This benefit is restricted to home nursing services provided by a maximum of one (1) Nurse or Health Worker in Hong Kong per day during any given time slot. For the avoidance of doubt, regardless of -

(a) whether home nursing services are provided for all or part of one day on a particular day; and
(b) number of time slots on the same day,

that day shall be counted as one (1) day for the purpose of counting the maximum number of days per Policy Year allowed for this benefit as specified in the Benefit Schedule.

4.3.18 **Private Nurse's fees**

This benefit shall be payable for Eligible Expenses charged for private nursing services provided to the Insured Person by a Nurse during Confinement (in addition to the general nursing services provided by the Hospital), provided that such private nursing services are recommended in writing by the attending Registered Medical Practitioner and 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.

This benefit is restricted to private nursing services provided by a maximum of one (1) Nurse per day during any given time slot. For the avoidance of doubt, regardless of –

(a) whether private nursing services are provided for all or part of one day on a particular day; and
(b) number of time slots on the same day,

that day shall be counted as one (1) day for the purpose of counting the maximum number of days per Policy Year allowed for this benefit as specified in the Benefit Schedule.

4.3.19 **Outpatient kidney dialysis**

This benefit shall be payable for the Eligible Expenses charged for treatment of chronic and irreversible kidney failure (including peritoneal dialysis and regular hemodialysis) in a setting for providing Medical Services to a Day Patient.

4.3.20 **Companion bed**

If room and board is payable under Clause 4.3.1 of Part IV of this Policy, or if Intensive Care is payable under Clause 4.3.5 of Part IV of this Policy, this benefit shall be payable for the expenses charged by a Hospital for an extra bed for one (1) person who accompanies the Insured Person in the Hospital during his Confinement. This benefit is only payable if the Insured Person is under eighteen (18) years old on the day when such expenses are incurred.

For the avoidance of doubt, this benefit shall not cover any expenses charged on the cost of meal(s).

4.3.21 **Hospital cash for Confinement in a public ward of a government Hospital in Hong Kong**

If room and board is payable under Clause 4.3.1 of Part IV of this Policy, this benefit shall be payable for each day (i.e. each twenty-four (24) consecutive hours) of Confinement, provided that the Insured Person is Confined in a public ward of a government Hospital in Hong Kong and that the Eligible Expenses incurred during the Confinement are not higher than the public charges for eligible persons prescribed by the Hospital Authority of Hong Kong from time to time.

For the avoidance of doubt, this benefit is not subject to the Deductible.

4.3.22 **Hospital cash for Confinement in a lower room type of a private Hospital in Hong Kong**

If room and board is payable under Clause 4.3.1 of Part IV of this Policy, this benefit shall be payable for each day (i.e. each twenty-four (24) consecutive hours) of Confinement, provided that the Insured Person is Confined in a private Hospital in Hong Kong in a room type of a level lower than the Accommodation Room Type as follows:

Accommodation Room Type	Room type Confined
Semi-Private Room	ward
Standard Private Room	Semi-Private Room or ward

For the avoidance of doubt, this benefit is not subject to the Deductible.

4.3.23 **Cash benefit for Designated Day Case Procedures performed by network doctor**

If Surgeon's fee is payable under Clause 4.3.6 of Part IV of this Policy, this benefit shall be payable for each Designated Day Case Procedure performed by a Network Registered Medical Practitioner or a Network Specialist on the Insured Person in a setting for providing Medical Services to a Day Patient. If more than one (1) Designated Day Case Procedure is performed on the same day, only one (1) of such Designated Day Case Procedures will be payable under this benefit.

For the purpose of this provision, "Network Registered Medical Practitioner" or "Network Specialist" shall mean, when used to describe a Registered Medical Practitioner or a Specialist, that such Registered Medical Practitioner or Specialist is included in the list of Network Registered Medical Practitioners and Specialists, which may be updated, varied and amended from time to time at the Company's discretion, and any change shall be deemed as effective on the date of publication irrespective of whether any separate notice is given.

For the avoidance of doubt, this benefit is not subject to the Deductible.

4.3.24 **Accidental Emergency outpatient treatment**

This benefit shall be payable for the Eligible Expenses charged for Emergency Treatment of an Injury performed in the outpatient department of a Hospital within the period as stated in the Benefit Schedule.

Where Eligible Expenses under this benefit are also covered under other benefits under Part IV of this Policy, such Eligible Expenses shall be payable in the following order:

(a) pre-Confinement/ Day Case Procedure outpatient care under Clause 4.3.13 of Part IV of this Policy;
(b) this benefit.

4.3.25 **Accidental Emergency dental treatment**

This benefit shall be payable for the Eligible Expenses charged by a Registered Dentist, a Registered Medical Practitioner or a Hospital, solely for Emergency Treatment which is necessitated by an Injury to sound natural teeth (including consultation, staunch bleeding, tooth extraction, root canals and x-ray), and which is given to the Insured Person within the period as stated in the Benefit Schedule in a legally registered dental clinic or a Hospital.

This benefit shall not be payable for orthodontic treatment, the use of any precious metals, bridge, crowns, dentures and dental implants.

Where Eligible Expenses under this benefit are also covered under other benefits under Part IV of this Policy, such Eligible Expenses shall be payable in the following order:
(a) pre-Confinement/ Day Case Procedure outpatient care under Clause 4.3.13 of Part IV of this Policy;
(b) this benefit.

4.3.26 **HIV/ AIDS treatment**

This benefit shall be payable for Eligible Expenses charged for treatment of any HIV Infection related Disease including Acquired Immune Deficiency Syndrome ("AIDS"), as recommended in writing by the attending Registered Medical Practitioner, received by the Insured Person during Confinement , provided that the primary purpose of the Confinement is to receive the HIV/AIDS treatment and the signs or symptoms of such Disease first occur after the HIV/AIDS Treatment Waiting Period.

If the HIV Infection related Disease including AIDS is caused by sexual assault, medical assistance, organ transplant, blood transfusions or blood donation, or infection at birth, this benefit shall not be subject to the HIV/AIDS Treatment Waiting Period.

4.3.27 **Breast reconstructive surgery benefit**

If the Insured Person sustains a Sickness or Disease and undergoes a Medically Necessary mastectomy, this benefit shall be payable for the Eligible Expenses charged for the Surgeon's fee, Anaesthetist's fee, and operating theatre charges in relation to a breast reconstruction surgery performed on the Insured Person during Confinement or in a setting for providing Medical Services to a Day Patient as recommended in writing by the attending Registered Medical Practitioner, provided that such breast reconstructive surgery is received within twelve (12) Calendar Months from the date of the mastectomy.

4.3.28 **Pregnancy complications**

Subject to the Pregnancy Complications Waiting Period and recommendation in writing by the attending Registered Medical Practitioner, if the Insured Person is diagnosed with the covered pregnancy complications listed below, this benefit shall be payable for the Eligible Expenses charged for the benefit items under Clause 4.3.1 to Clause 4.3.9 of Part IV of this Policy on treatments of these covered pregnancy complications, which are received by the Insured Person during Confinement or in a setting of providing Medical Services to a Day Patient.

The covered pregnancy complications are limited to ectopic pregnancy, molar pregnancy, disseminated intravascular coagulopathy, pre-eclampsia, miscarriage, threatened abortion, medically prescribed induced abortion, foetal death, postpartum hemorrhage requiring hysterectomy, eclampsia, amniotic fluid embolism and pulmonary embolism of pregnancy.

4.3.29 **Organ transplantation benefit**

If the Insured person receives any transplantation of heart, kidney, liver, lung, pancreas or bone marrow from a legally certified and verified source of donation at a Hospital as recommended in writing by the attending Registered Medical Practitioner, this benefit shall be payable for
(a) the Eligible Expenses charged for the benefit items under Clause 4.3.1 to Clause 4.3.8 and Clause 4.3.20 of Part IV of this Policy; and
(b) the Eligible Expenses charged by the Surgeon and the Anaesthetist and for the use of operating theatre for the surgical procedure of removing the organ or bone marrow from the donor.

For the avoidance of doubt, this benefit shall not be payable for any costs of acquisition and transportation of organs or bone marrow.

The covered donor's medical cost under Clause 4.3.29(b) of Part IV of this Policy shall be reduced by the amount which is payable to the donor in relation to those costs under any other insurance or from any other source.

4.3.30 **Rehabilitation benefit**

If room and board is payable for Confinement under Clause 4.3.1 of Part IV of this Policy, this benefit shall be payable for the Eligible Expenses charged for, subject to recommendation in writing by the attending Registered Medical Practitioner, Stay in a Rehabilitation Centre and for rehabilitation treatment provided to the Insured Person during such Stay within the period stated in the Benefit Schedule after discharge from Confinement.

Where Eligible Expenses under this benefit are also covered under other benefits under Part IV of this Policy, such Eligible Expenses shall be payable in the following order:

(a) this benefit;
(b) post-Confinement/ Day Case Procedure auxiliary treatment under Clause 4.3.15 of Part IV of this Policy;
(c) three Critical Illnesses auxiliary benefit under Clause 4.3.33 (a) of Part IV of this Policy.

4.3.31 **Palliative care benefit**

Subject to the Palliative Care Benefit Waiting Period and provided that:

(a) the Insured Person has been diagnosed with a Terminal Disease;
(b) room and board is payable under Clause 4.3.1 of Part IV of this Policy for a Disability relating directly to such Terminal Disease;
(c) the Insured Person is admitted to a registered hospice or a registered palliative care facility; and
(d) the Stay in the registered hospice or the registered palliative care facility is recommended in writing by the attending Registered Medical Practitioner,

this benefit shall be payable for the Eligible Expenses and other expenses charged by such registered hospice or registered palliative care facility for the accommodation, care and nursing services provided by the facility to the Insured Person.

For the purpose of this provision, "Terminal Disease" shall mean the conclusive unequivocal diagnosis of a Sickness or Disease that is expected to result in the death of the Insured Person within twelve (12) Calendar Months.

4.3.32 **Accidental Death Benefit**

This benefit shall be payable to the Beneficiary in the amount as specified in the Benefit Schedule if the Insured Person sustains Injury from an Accident and the Injury results in the Insured Person's death while the Policy is in force.

For the avoidance of doubt, this benefit is not subject to the Deductible.

4.3.33 **Three Critical Illnesses benefit**

The following benefits shall be payable for either Cancer, Stroke or Heart Attack that is first diagnosed after the Three Critical Illnesses Benefit Waiting Period.

(a) Three Critical Illnesses auxiliary benefit

This benefit shall be payable for the Eligible Expenses charged within the period stated in the Benefit Schedule for –

(i) the outpatient visits to a Registered Dietitian;
(ii) the outpatient visits to a Registered Chinese Medicine Practitioner (including consultation and basic Chinese Medicines prescribed); and
(iii) acupuncture treatment provided by a Registered Chinese Medicine Practitioner during the outpatient visits,

and provided that:

(i) such outpatient visits are directly related to and as a result of either Cancer, Stroke or Heart Attack that is first diagnosed after the Three Critical Illnesses Benefit Waiting Period;
(ii) such outpatient visits are recommended in writing by the attending Registered Medical Practitioner; and
(iii) if more than one (1) outpatient visit to a Registered Dietitian or a Registered Chinese Medicine Practitioner is incurred on the same day, only one (1) of such outpatient visits will be payable under this benefit.

When the Eligible Expenses under this benefit are also covered under other benefits under Part IV of this Policy, such Eligible Expenses shall be payable in the following order:

(i) traditional Chinese medicine treatment under Clause 4.3.16 of Part IV of this Policy;
(ii) this benefit.

(b) Three Critical Illnesses premium waiver benefit

After either Cancer, Stroke or Heart Attack is first diagnosed after the Three Critical Illnesses Benefit Waiting Period, the Standard Premium and the Premium Loading (if any) payable for both the Basic Policy and the Optional Insurance Benefits (if applicable) shall be waived starting from the same day as the Policy Effective Date in the succeeding Calendar Month following such diagnosis, for a period as stated in the Benefit Schedule, provided that this Policy is in full force and effect throughout.

In the period during which the Standard Premium and the Premium Loading (if any) payable is waived, the Policy Holder shall not make any changes to this Policy (including the Accommodation Room Type, Area of Cover, Optional Insurance Benefits, Deductible, and/or premium payment frequency), otherwise the Company shall cease such waiver of premium payable from the effective date of such changes.

For the avoidance of doubt, this benefit is not subject to the Deductible.

(c) Home facility enhancement benefit for Strokes

After Stroke is first diagnosed after the Three Critical Illnesses Benefit Waiting Period this benefit shall be payable for the expenses charged for the home facility enhancement recommended in writing by a Registered Occupational Therapist for the purpose of assisting the Insured Person in his/her daily life, provided that such home facility enhancement is completed within the period as stated in the Benefit Schedule after the diagnosis date of Stroke.

Home facility enhancement includes but is not limited to –

(i) Adapting bathroom facilities (for example, raising toilet, installing a back rest against the toilet cistern, installing a level deck shower, installing a bath with hoist and installing a hand basin at appropriate height);
(ii) Installing an indoor stair lift or elevator;
(iii) Installing grab rails for support;
(iv) Installing ramps to avoid using steps;
(v) Locating bathroom or bedroom facilities at ground-floor level;
(vi) Moving light switches, door handles, doorbells and entry phones to convenient heights;
(vii) Provision of specialized furniture, like adjustable beds or support chairs;
(viii) Setting up alert devices; and
(ix) Widening doorways and passageways.

4.3.34 **No claim premium discount**

If this Policy has been in force for two (2) or more consecutive Policy Years, and if no claim under the Basic Policy has been paid during the two (2) or more consecutive Policy Years immediately prior to the Renewal Date, provided that this Policy is in full force and effect throughout and subject to the terms and conditions of this Policy, the Policy Holder shall be eligible for a no claim premium discount on the Standard Premium of the Basic Policy at Renewal at the following rate:

No claim period immediately prior to the Renewal Date	No claim premium discount rate on the Standard Premium of the Basic Policy
Two (2) or more consecutive Policy Years	5%

If, after the Policy Holder has received the no claim premium discount, a claim under the Basic Policy incurred prior to the Renewal Date is paid after such Renewal Date, the Policy Holder shall immediately repay the amount of the no claim premium discount previously received upon the Company's demand.

For the avoidance of doubt, this benefit is not subject to the Deductible.

4.3.35 **Optional Outpatient Benefits (if applicable)**

(a) General Practitioner consultation

This benefit shall be payable for the Eligible Expenses charged for outpatient consultation with a General Practitioner and basic Western Medication prescribed by such General Practitioner, provided that:

(i) if more than one (1) General Practitioner consultation is incurred on the same day, only one (1) of such consultations will be payable under this benefit; and
(ii) if more than one (1) General Practitioner consultation payable under Clause 4.3.35 (a) of Part IV of this Policy, home consultation payable under Clause 4.3.35 (c) of Part IV of this Policy, Registered Chinese Medicine Practitioner consultation payable under Clause 4.3.35 (f) of Part IV of this Policy, Chinese bone-setting payable under Clause 4.3.35 (g) of Part IV of this Policy, or acupuncture treatment payable under Clause 4.3.35 (h) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or treatments will be payable.

(b) Specialist consultation

This benefit shall be payable for the Eligible Expenses charged for outpatient consultation with a Specialist and basic Western Medication prescribed by such Specialist, provided that:

(i) such consultation shall be recommended in writing by the attending Registered Medical Practitioner, except for paediatric, gynaecological, ophthalmological, dermatological and orthopaedic consultation;
(ii) if more than one (1) Specialist consultation is incurred on the same day, only one (1) of such consultations will be payable under this benefit; and
(iii) if more than one (1) Specialist consultation payable under Clause 4.3.35 (b) of Part IV of this Policy, physiotherapy payable under Clause 4.3.35 (d) of Part IV of this Policy, or chiropractor consultation payable under Clause 4.3.35 (e) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or therapies will be payable.

(c) Home consultation

This benefit shall be payable for the Eligible Expenses charged for home consultation with a General Practitioner and basic Western Medication prescribed by such General Practitioner at the Insured Person's home, provided that:

(i) if more than one (1) home consultation is incurred on the same day, only one (1) of such consultations will be payable under this benefit; and
(ii) if more than one (1) General Practitioner consultation payable under Clause 4.3.35 (a) of Part IV of this Policy, home consultation payable under Clause 4.3.35 (c) of Part IV of this Policy, Registered Chinese Medicine Practitioner consultation payable under Clause 4.3.35 (f) of Part IV of this Policy, Chinese bone-setting payable under Clause 4.3.35 (g) of Part IV of this Policy, or acupuncture treatment payable under Clause 4.3.35 (h) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or treatments will be payable.

(d) Physiotherapy

This benefit shall be payable for the Eligible Expenses charged for outpatient consultation with a Registered Physiotherapist, provided that:

(i) such consultation shall be recommended in writing by the attending Registered Medical Practitioner;
(ii) if more than one (1) physiotherapy is incurred on the same day, only one (1) of such physiotherapies will be payable under this benefit; and

(iii) if more than one (1) Specialist consultation payable under Clause 4.3.35 (b) of Part IV of this Policy, physiotherapy payable under Clause 4.3.35 (d) of Part IV of this Policy, or chiropractor consultation payable under Clause 4.3.35 (e) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or therapies will be payable.

(e) Chiropractor consultation

This benefit shall be payable for the Eligible Expenses charged for outpatient consultation with a Registered Chiropractor, provided that:

(i) such consultation shall be recommended in writing by the attending Registered Medical Practitioner;
(ii) if more than one (1) Registered Chiropractor consultation is incurred on the same day, only one (1) of such consultations will be payable under this benefit; and
(iii) if more than one (1) Specialist consultation payable under Clause 4.3.35 (b) of Part IV of this Policy, physiotherapy payable under Clause 4.3.35 (d) of Part IV of this Policy, or chiropractor consultation payable under Clause 4.3.35 (e) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or therapies will be payable.

(f) Registered Chinese Medicine Practitioner consultation

This benefit shall be payable for the Eligible Expenses charged for outpatient consultation with a Registered Chinese Medicine Practitioner and basic Chinese Medicines prescribed by such Registered Chinese Medicine Practitioner, provided that:

(i) if more than one (1) consultation is incurred on the same day, only one (1) of such consultations will be payable under this benefit; and
(ii) if more than one (1) General Practitioner consultation payable under Clause 4.3.35 (a) of Part IV of this Policy, home consultation payable under Clause 4.3.35 (c) of Part IV of this Policy, Registered Chinese Medicine Practitioner consultation payable under Clause 4.3.35 (f) of Part IV of this Policy, Chinese bone-setting payable under Clause 4.3.35 (g) of Part IV of this Policy, or acupuncture treatment payable under Clause 4.3.35 (h) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or treatments will be payable.

(g) Chinese bone-setting

This benefit shall be payable for the Eligible Expenses charged by a Registered Chinese Medicine Practitioner in providing outpatient Chinese bone-setting treatment to the Insured Person, provided that:

(i) if more than one (1) Chinese bone-setting treatment is incurred on the same day, only one (1) of such treatments will be entitled under this benefit; and
(ii) if more than one (1) General Practitioner consultation payable under Clause 4.3.35 (a) of Part IV of this Policy, home consultation payable under Clause 4.3.35 (c) of Part IV of this Policy, Registered Chinese Medicine Practitioner consultation payable under Clause 4.3.35 (f) of Part IV of this Policy, Chinese bone-setting payable under Clause 4.3.35 (g) of Part IV of this Policy, or acupuncture treatment payable under Clause 4.3.35 (h) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or treatments will be payable.

(h) Acupuncture

This benefit shall be payable for the Eligible Expenses charged by a Registered Chinese Medicine Practitioner in providing outpatient acupuncture treatment to the Insured Person, provided that:

(i) if more than one (1) acupuncture treatment is incurred on the same day, only one (1) of such treatments will be payable under this benefit; and
(ii) if more than one (1) General Practitioner consultation payable under Clause 4.3.35 (a) of Part IV of this Policy, home consultation payable under Clause 4.3.35 (c) of Part IV of this Policy, Registered Chinese Medicine Practitioner consultation payable under Clause 4.3.35 (f) of Part IV of this Policy, Chinese bone-setting payable under Clause 4.3.35 (g) of Part IV of this Policy, or acupuncture treatment payable under Clause 4.3.35 (h) of Part IV of this Policy is incurred on the same day, only one (1) of such consultations or treatments will be payable.

(i) Psychiatric outpatient treatment or psychological outpatient treatment

This benefit shall be payable for the Eligible Expenses charged for outpatient consultation with a Registered Psychologist in Hong Kong or with a Specialist in providing psychiatric or psychological treatment for the Insured Person, provided that:

(i) such consultation shall be recommended in writing by the attending Registered Medical Practitioner; and
(ii) if more than one (1) psychiatric or psychological consultation is incurred on the same day, only one (1) of such consultations will be payable under this benefit.

(j) Dietitian consultation, speech therapy or occupational therapy

This benefit shall be payable for the Eligible Expenses charged for outpatient consultation with a Registered Dietitian, a Registered Speech Therapist or a Registered Occupational Therapist, provided that:

(i) such consultation shall be recommended in writing by the attending Registered Medical Practitioner; and
(ii) if more than one (1) dietitian consultation, speech therapy or occupational therapy is incurred on the same day, only one (1) of such consultations or therapies will be payable under this benefit.

(k) Prescribed Western Medication

This benefit shall be payable for the Eligible Expenses charged for Western Medication prescribed to the Insured person, provided that:

(i) a written prescription from a Registered Medical Practitioner shall be presented at time of claim; and
(ii) the prescribed Western Medication must be obtained from legitimate sources, including a licensed or registered pharmacy, dispensary, clinic or Hospital under the laws of Hong Kong or other jurisdictions.

(l) Diagnostic imaging and laboratory tests

This benefit shall be payable for the Eligible Expenses charged for outpatient diagnostic imaging and laboratory tests , provided that:

(i) such diagnostic imaging or laboratory tests shall be recommended in writing by the attending Registered Medical Practitioner; and
(ii) such diagnostic imaging or laboratory tests must be consistent with the symptom(s) and diagnosis of the Insured person.

(m) Vaccination

This benefit shall be payable for the expenses charged for vaccinations received by the Insured Person.

4.3.36 **Optional Dental Benefits (if applicable)**

This benefit shall be payable for the Eligible Expenses charged by a Registered Dentist for dental treatments received by the Insured Person in a legally registered dental clinic, including –

(a) filings (including amalgam fillings, composite resin filling, ceramic filling and glass ionomer cement filling (molar and pre-molar));
(b) dentures, crowns and bridges (only if necessitated by an Accident);
(c) drainage of abscesses;
(d) Intraoral extractions;
(e) X-ray;
(f) root canal fillings;
(g) routine oral examination; and
(h) scaling and polishing (once every six (6) Calendar Months).

4.3.37 **Optional Pharmacy Benefit (if applicable)**

(a) This benefit shall be payable for Eligible Expenses charged by a licensed or registered pharmacy, dispensary, clinic or Hospital under the laws of Hong Kong or other jurisdictions, for Western Medication prescribed by a Registered Medical Practitioner to treat the Insured Person, provided that:

(i) the Insured Person suffers from any Critical Illnesses listed under Clause 5.1 of Part V of this Policy (except for Heart Attack);
(ii) the first diagnosis of such Critical Illnesses, including any occurrence, diagnosis, exhibited symptoms which may have resulted in requiring medical advice, treatment and/or prescription of drugs, occurs after the Optional Pharmacy Benefit Waiting Period; and
(iii) the Insured Person has survived for a period of at least thirty (30) days after the first diagnosis of such Critical Illnesses.

(b) If the Insured Person's Age at the Policy Effective Date is sixteen (16) or above, this benefit shall be payable for the first diagnosis of the Critical Illnesses below:

• Alzheimer's Disease/Dementia • Amyotrophic Lateral Sclerosis • Aplastic Anaemia • Bacterial Meningitis • Benign Brain Tumor • Blindness • Brain Surgery • Cancer • Carcinoma-in-situ • Cardiomyopathy • Chronic Relapsing Pancreatitis • Coma • Coronary Angioplasty • Coronary Artery Bypass Surgery • Creutzfeldt-Jakob Disease • Crohn's Disease • Ebola • Elephantiasis • Encephalitis • End Stage Lung Disease • Fulminant Viral Hepatitis • Heart Valve Replacement • HIV Infection due to Blood Transfusion • Kidney Failure • Liver Failure • Loss of Hearing • Loss of Limbs	• Loss of Speech • Major Burns • Major Organ Transplantation • Meningeal Tuberculosis • Medullary Cystic Disease • Multiple Sclerosis • Muscular Dystrophy • Myocardial Infarction • Necrotising Fasciitis/Gangrene • Occupationally acquired HIV • Parkinson's Disease • Poliomyelitis • Primary Lateral Sclerosis • Primary Pulmonary Arterial Hypertension • Progressive Bulbar Palsy • Progressive Muscular Atrophy • Progressive Supranuclear Palsy • Rheumatoid Arthritis (Adult) • Severe Brain Damage • Severe Myasthenia Gravis • Severe Ulcerative Colitis • Spinal Muscular Atrophy • Stroke • Surgery to Aorta • Terminal Illness • Total and Permanent Disability • Vegetative State

(c) If the Insured Person's Age at the Policy Effective Date is below sixteen (16), this benefit shall be payable for the first diagnosis of the Critical Illnesses below, and up to the Age limit as stated below (if any):

Critical Illnesses which are payable until the Age of sixteen (16)	Critical Illnesses which are payable with no Age limit
• Hand, Foot and Mouth Diseases with severe (life threatening) Complications • Insulin-Dependent Diabetes Mellitus • Kawasaki Disease with Heart Complications • Rheumatic Fever with Valvular Impairment • Severe Asthma • Severe Epilepsy	• Cancer • Coma • Coronary Artery Bypass Surgery • Kidney Failure • Liver Failure • Major Burns • Major Organ Transplantation • Myocardial Infarction • Poliomyelitis • Stroke

(d) For the avoidance of doubt, the Optional Pharmacy Benefit payable for Carcinoma-in-situ and Coronary Angioplasty is limited to twenty percent (20%) of the annual limit and the lifetime limit as specified under the Optional Pharmacy Benefit section in the Benefit Schedule.

(e) The covered Western Medication under this benefit must be:
(i) prescribed in writing by a Registered Medical Practitioner and dispensed within six (6) Calendar Months of being prescribed;
(ii) for the direct treatment or management of the Insured Person's Critical Illnesses; however dietary supplements, health aids or drugs for cosmetic purposes are not covered, even if prescribed by a Registered Medical Practitioner for the care and treatment of the Insured Person's Critical Illnesses;
(iii) purchased from a licensed or registered pharmacy, dispensary, clinic or Hospital under the laws of Hong Kong or other jurisdictions;
(iv) each prescription order or refill shall be limited up to a consecutive sixty (60) days of supply, unless limited by the drug manufacturer's packaging; and
(v) where a prescription provides certain number of days of supply, any refill can only be made the same number of days after the previous order or refill.

(f) This Optional Pharmacy Benefit shall automatically terminate upon the first Anniversary Date immediately after the lifetime limit as specified under the Optional Pharmacy Benefit section in the Benefit Schedule has been exhausted. The Company reserves the right to charge the Standard Premium and the Premium Loading (if any) calculated until the date of such termination of the Optional Pharmacy Benefit.

4.4 Duplicated Policy

4.4.1 Any Insured Person shall be entitled to coverage under a maximum of one (1) policy of the Cigna Designated Plans issued by the Company. If the Insured Person is insured under more than one policy of the Cigna Designated Plans due to any reason, the Insured Person shall be deemed to be covered under only the one (1) policy which:
(a) provides the highest benefit amount in respect of the basic policy; or
(b) was issued first if the benefit amount of the basic policy under each policy is the same.

4.4.2 Other than the one (1) single policy of the Cigna Designated Plans which is considered to validly cover the Insured Person under Clause 4.4.1 of Part IV of this Policy, any other policies of Cigna Designated Plans for the Insured Person issued by the Company ("Void Policies") shall be null and void from the date when the policy becomes effective.

4.4.3 You are required to immediately return to us the benefits previously paid and any Indebtedness under the Void Policies. Upon our receipt of your full refund of such payments, we will refund the premium and insurance levy paid for the Void Policies. Alternatively, we shall have the right to set off the benefits previously paid and any Indebtedness against the premium paid for the Void Policies, and we shall refund the remaining premium (if any) and the insurance levy paid for the Void Policies.

Part V Critical Illnesses Definitions

5.1 **"Alzheimer's Disease/Dementia"** Deterioration or loss of intellectual capacity, due to irreversible global failure of brain functioning, as confirmed by clinical evidence and standardized tests for Alzheimer's Disease and Dementia. The Disease must result in significant cognitive impairment and the diagnosis must be confirmed by a consultant neurologist. Dementia related to alcohol, drug abuse or AIDS is excluded.

5.2 **"Amyotrophic Lateral Sclerosis"** Unequivocal diagnosis of Amyotrophic Lateral Sclerosis by a consultant neurologist supported by definitive evidence of appropriate and relevant neurological signs.

5.3 **"Aplastic Anaemia"** Persistent bone marrow failure which results in anaemia, leukopenia and thrombocytopenia requiring treatment with at least one (1) of the following:
(a) blood product transfusion;
(b) immunosuppressive agents; or
(c) bone marrow transplantation.

5.4 **"Bacterial Meningitis"** Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit (persisting for at least six (6) consecutive Calendar Months), such diagnosis to be confirmed by a neurologist.

5.5 **"Benign Brain Tumor"** A non-cancerous tumor in the brain which either requires surgical excision or causes significant permanent and irrecoverable neurological deficit (persisting for at least six (6) consecutive Calendar Months). For the avoidance of doubt, the following shall not fall within the definition of

"Benign Brain Tumor" and are not covered:
(a) cysts, granulomas, malformations in, or of the arteries or veins of the brain; and
(b) haematomas and tumors in the pituitary gland or spine.

5.6 **"Blindness"** The total and irrecoverable loss of sight of both eyes due to traumatic Injury or Disease. The diagnosis must be clinically confirmed by an ophthalmologist. The blindness must not be able to be corrected by medical procedure.

5.7 **"Brain Surgery"** The actual undergoing of surgery to the brain under general anaesthesia during which a craniotomy is performed. Keyhole surgery is included, however Brain Surgery as a result of an Accident is excluded. The procedure must be considered necessary by a Specialist.

5.8 **"Cancer"** A malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. The cancer should be confirmed by histological evidence of malignancy on a pathology report.

This includes leukaemia, but excludes any of the following:

(a) Any lesions described as pre-malignant, non-invasive, carcinoma-in-situ, stage Ta or cervical dysplasia CIN-1, CIN-2 and CIN-3;
(b) Any non melanoma skin cancers or malignant melanoma of AJCC stage 1;
(c) Papillary thyroid cancer which are histologically described as TNM Classification T1N0M0 or are of another equivalent or lesser classification;
(d) Prostate cancers which are histologically described as TNM Classification T1a,T1b, T1c or are of another equivalent or lesser classification;
(e) Chronic Lymphocytic Leukaemia (CLL) at RAI Stage 2 or less; or
(f) All tumours in the presence of any Human Immunodeficiency Virus (HIV).

5.9 **"Carcinoma-in-situ"** Carcinoma-in-situ is defined as a focal autonomous new group of carcinomatous cells which has not yet resulted in the invasion of normal tissue. Invasion means an infiltration and/or active destruction of normal tissue beyond the basement membrane. Diagnosis of carcinoma-in-situ must be supported by a histopathological report.

For the purpose of this Policy, carcinoma-in-situ is limited only to the following eight (8) organs:
(a) Cervix Uteri (which must be at a grading of not less than CIN-3; and be positively diagnosed upon the basis of a microscopic examination of fixed tissue from a cone biopsy or colposcopy with cervical biopsy. Clinical diagnosis does not meet this standard);
(b) Uterus;
(c) Breast;
(d) Vagina;
(e) Fallopian Tube;
(f) Ovary – for carcinoma-in-situ of ovary, the tumours should be capsule intact, with no tumour on the ovarian surface, classified as T1aN0M0, T1bN0M0 (TMN classification) or FIGO 1A, FIGO 1B (The Federation Internationale de Gynecologie et d'Obstetrique);
(g) Testicles; and
(h) Early Stage Cancer of Prostate: A prostate malignant tumour histologically described as TNM classification T1a, T1b, T1c or which is of another equivalent classification. Prostatic Intra-epithelial Neoplasia (PIN) is excluded. Diagnosis must be supported by a histopathological report.

The diagnosis of carcinoma-in-situ must be supported by a positive result of a microscopic examination of fixed tissue and confirmed by a biopsy result. Clinical diagnosis does not meet this standard.

5.10 **"Cardiomyopathy"** Condition of impaired ventricular function resulting in significant physical impairment of at least Class 4 on the New York Heart Association classification of cardiac impairment.

The diagnosis must be confirmed by a consulting cardiologist. Cardiomyopathy includes dilated, hypertrophic and restrictive cardiomyopathy. Cardiomyopathy secondary to alcohol abuse is excluded.

NYHA Class 4 cardiomyopathy impairment is a form of cardiac impairment where the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination & laboratory studies.

5.11 **"Chronic Relapsing Pancreatitis"** A condition with repeated attacks of proven acute interstitial pancreatitis leading to progressive destruction of the pancreas. The diagnosis must be confirmed by a Specialist based on clinical evidence and modern imaging techniques.

5.12 **"Coma"** A state of unconsciousness for at least six (6) consecutive Calendar Months with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems for at least six (6) consecutive Calendar Months, resulting in a neurological deficit which in the opinion of the Registered Medical Practitioner(s) and/or Specialist(s) of our choice is of a permanent nature.

5.13 **"Coronary Angioplasty"** First treatment for narrowing or obstruction in one or more coronary arteries, by a balloon angioplasty, Percutaneous Transluminal Coronary Angioplasty (PTCA) or similar intra arterial catheter procedure. The angioplasty must be considered Medically Necessary by a consultant cardiologist, and there must be angiographic evidence of significant coronary artery Disease.

5.14 **"Coronary Artery Bypass Surgery"** Open heart surgery undergone to correct narrowing or blockage of two (2) or more coronary arteries by the use of saphenous vein grafts or internal mammary artery grafting. Angiographic evidence of the underlying Disease must be provided. For the avoidance of doubt, non-open heart procedures such as balloon angioplasty or laser techniques shall not fall within the definition of "Coronary Artery Bypass Surgery" and are not covered.

5.15 **"Creutzfeldt-Jakob Disease"** A neurological Disease, fatal spongioform encephalopathy accompanied by signs and symptoms of cerebellar dysfunction, severe progressive dementia, uncontrolled muscle spasm, tremor and athetosis. The diagnosis must be made by a neurologist and supported by imaging evidence.

5.16 **"Crohn's Disease"** Crohn's Disease is a chronic granulomatous inflammatory Disease of the intestine. The diagnosis must be confirmed by characteristic histopathological features.

The Disease must have resulted in at least one (1) of the following intestinal complications:
(a) fistula formulation (Excluding Fistula-in-ano);
(b) obstruction; and
(c) perforation (not caused by an intervention).

5.17 **"Ebola"** Infection with Ebola virus where the following conditions are met:
(a) presence of the Ebola virus has been confirmed by laboratory testing;
(b) there are ongoing complications of the infections persisting beyond thirty (30) days from the onset of symptoms; and
(c) the infection does not result in death.

5.18 **"Elephantiasis"** End stage Lymphatic Filariasis, characterized by significant enlargement and disfiguration of the infected body area (legs, genitals or breasts) due to blockage of the lymphatic system by filariae parasites. The diagnosis of permanent lymphatic obstruction must be confirmed by a Specialist, and supported by laboratory tests showing circulating filariae antigen or microfilariae in a blood smear (Wuchereria bancrofti or Brugia malayi). Other forms of lymphedema or acute lymphangitis are specifically excluded.

5.19 **"Encephalitis"** Diagnosis of inflammation of the brain (cerebral hemisphere, brainstem or cerebellum), usually associated with viral or bacterial infections, resulting in significant complications lasting at least six (6) weeks, which include permanent neurological deficit and confirmed by a neurologist. Permanent neurological deficit may include mental retardation, emotional lability, blindness, deafness, speech disorders, hemiplegia or paralysis. The Disease may take a primary, post-infectious or para-infectious form. In addition to any specific requirements set out in the definitions above, each of the above conditions must be diagnosed as may be appropriate by a Registered Medical Practitioner and must be supported by clinical, radiological, histological and laboratory evidence acceptable to us.

5.20 **"End Stage Lung Disease"** The final or end stage of lung Disease, causing chronic respiratory failure, as demonstrated by all of the following:
(a) FEV1 test results consistently less than 1 liter;
(b) requiring permanent supplementary oxygen therapy for hypoxemia;
(c) arterial blood gas analyses with partial oxygen pressure (pO2 of 55mmHg or less); and
(d) dyspnea at rest.

The diagnosis must be confirmed by a respiratory medical Specialist.

5.21 **"Fulminant Viral Hepatitis"** A submassive to massive necrosis of the liver caused by the hepatitis virus, leading precipitously to liver failure. All the following diagnostic criteria must be met:-
(a) a rapidly decreasing liver size;
(b) necrosis involving entire lobules, leaving only a collagen reticular framework;
(c) rapidly deteriorating liver function tests; and
(d) jaundice.

5.22 **"Heart Attack"** The death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply, where all of the following criteria are met:
(a) new characteristic ECG changes indicating acute myocardial infarction at the time of the relevant cardiac incident;
(b) either elevation of the cardiac biomarker, CK-MB above the generally accepted normal laboratory levels, or Troponin T > 0.5ng/ml or Troponin I > 0.5ng/ml; and
(c) Angina, heart attack of indeterminate age, and rise in cardiac biomarkers or Troponin T or Troponin I following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty are specifically excluded.

5.23 **"Heart Valve Replacement"** The actual undergoing of the replacement of one (1) or more heart valves with artificial valves due to stenosis or incompetence. For the avoidance of doubt, heart valve repair and valvotomy shall not fall within the definition of "Heart Valve Replacement" and are not covered.

5.24 **"HIV Infection due to Blood Transfusion"** Infection by the Human Immunodeficiency Virus or being diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), if the infection can be proved to the satisfaction of the Company as being due to the transfusion of infected blood or blood products from a blood transfusion service that is officially registered with and recognised by the health authorities in Hong Kong, after the Policy Effective Date of this Policy. Sero-conversion to HIV infection must occur within six (6) Calendar Months after the transfusion. This cover shall cease in the event of a cure being found for AIDS.

5.25 **"Kidney Failure"** End stage renal Disease with permanent and irreversible loss of function of both kidneys as a result of which the Insured Person is required to undergo regular renal dialysis or kidney transplantation.

5.26 **"Liver Failure"** End stage liver failure which is permanent and irreversible and characterized by permanent jaundice, oesophageal varices, ascites and hepatic encephalopathy. For the avoidance of doubt, liver Disease secondary to drug or alcohol abuse shall not fall within the definition of "Liver Failure" and is not covered.

5.27 **"Loss of Hearing"** Total, bilateral and irreversible loss of hearing for all sounds as a result of acute Sickness or Accident. Medical evidence must be supplied by an Ear, Nose and Throat Specialist and must include audiometric and sound-threshold test. The loss of hearing must not be able to be corrected by medical procedure.

5.28 **"Loss of Limbs"** The irreversible severance from the body of two (2) or more limbs where severance is above the ankle or wrist.

5.29 **"Loss of Speech"** Total and irrecoverable loss of the ability to speak due to Injury or Disease of vocal cords which must be established for a period of twelve (12) consecutive Calendar Months. Medical evidence is to be supplied by an Ear, Nose and Throat Specialist and to confirm Injury or Disease to the vocal cords. For the avoidance of doubt, loss of speech directly or indirectly due to psychiatric related causes shall not fall within the definition of Loss of Speech herein and is not covered.

5.30 **"Major Burns"** Third degree burns which result in full thickness skin destruction of at least twenty percent (20%) of the total skin area.

5.31 **"Major Organ Transplantation"** The actual undergoing of a transplant of the heart, lung, liver, pancreas or bone marrow as a recipient. For the avoidance of doubt, transplantation of isolated pancreatic islets shall not fall within the definition of "Major Organ Transplantation" and is not covered.

5.32 **"Meningeal Tuberculosis"** Meningitis caused by tubercle bacilli, resulting in permanent neurological deficit. Such a diagnosis must be confirmed by a Specialist in neurology.

5.33 **"Medullary Cystic Disease"** A hereditary kidney disorder characterized by gradual and progressive loss of kidney function due to cysts in the kidney medulla. The diagnosis must be confirmed by a consultant nephrologist and supported by imaging evidence of multiple medullary cysts with cortical atrophy.

5.34 **"Multiple Sclerosis"** Multiple neurological deficit over a period of more than six (6) Calendar Months, as a result of demyelination in the brain and spinal cord. The diagnosis has to be unequivocal and made by a consultant neurologist, following more than one episode of well-defined neurological symptoms, involving any combination of deficit in the optic nerves, brain stem, spinal cord, co-ordination or sensory function.

5.35 **"Muscular Dystrophy"** The diagnosis of muscular dystrophy confirmed by a consultant neurologist, and based on a combination of all of the following:
(a) clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;
(b) characteristic electromyogram; and
(c) clinical suspicion confirmed by muscle biopsy.

5.36 **"Myocardial Infarction"** The first occurrence of myocardial infarction which means the death of a portion of the heart muscle, as a result of an acute interruption of blood supply to the myocardium. The diagnosis must be based on a history of typical chest pain, new electrocardiographic changes proving infarction, and significant elevation of cardiac enzymes. Angina is specifically excluded.

5.37 **"Necrotising Fasciitis/Gangrene**" Life threatening gangrene or life threatening necrotizing fasciitis where the necrotic process is fulminant (spreads rapidly) and need immediate major surgical intervention, debridement of necrotic tissue and treatment with antimicrobials. Definitive diagnosis of life threatening gangrene or necrotizing fasciitis must be confirmed by a Specialist. Frostbite is specifically excluded.

5.38 **"Occupationally acquired HIV"** Infection by any Human Immunodeficiency Virus (HIV) acquired as a result of an Accident while carrying out normal occupational duties. Any Accident giving rise to a potential claim must be reported to the Company within seven (7) days and must be evidenced by a negative HIV antibody test taken immediately after the Accident. Seroconversion to HIV infection must occur within six (6) Calendar Months of the Accident.

HIV infection resulting from, or transmitted by any other means, including sexual activity or recreational intravenous drug use, is specifically excluded from this benefit. This benefit shall not apply if a cure has become available prior to the Accident.

5.39 **"Parkinson's Disease"** Unequivocal diagnosis of Parkinson's Disease by a neurologist where all the following conditions of the Disease are fulfilled:-
(a) cannot be controlled with medication;
(b) idiopathic in nature (all other forms of Parkinsonism are excluded);
(c) show signs of progressive impairment; and
(d) inability of the Insured Person to perform without assistance three (3) or more of the activities of daily living:
    (i) Dressing – the ability to put on and take off clothing without assistance;
    (ii) Mobility – the ability to move from room to room without physical assistance;
    (iii) Transfer – the ability to get in and out of bed or a chair without assistance;
    (iv) Continence – the ability to control bowel and bladder function;
    (v) Feeding – the ability to get food from a plate into the mouth without assistance; and
    (vi) Bathing and showering – the ability to bathe and shower without assistance.

5.40 **"Poliomyelitis"** Unequivocal diagnosis by a neurologist of infection by the polio virus leading to paralytic Disease as evidenced by impaired motor function or respiratory weakness. Cases other than the foregoing shall not be regarded as poliomyelitis. For the avoidance of doubt, poliomyelitis not involving paralysis and other cases of paralysis shall not fall within this definition of "Poliomyelitis" and are not covered.

5.41 **"Primary Lateral Sclerosis"** A progressive degenerative disorder of the motor neurons of the cerebral cortex resulting in widespread weakness on an upper motor neuron basis. Clinically it is characterized by progressive spastic weakness of the limbs, preceded or followed by spastic dysarthria and dysphagia, indicating combined involvement of the corticospinal and corticobulbar tracts. The diagnosis must be made by a consultant neurologist and confirmed by appropriate neuromuscular testing.

5.42 **"Primary Pulmonary Arterial Hypertension"** Primary pulmonary arterial hypertension associated with right ventricular enlargement established by investigations including catheterisation resulting in significant permanent physical impairment to the degree of at least Class 3 of the New York Heart Association classification of cardiac impairment.

NYHA Class 3 cardiac impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination & laboratory studies.

5.43 **"Progressive Bulbar Palsy"** Unequivocal diagnosis of Progressive Bulbar Palsy by a consultant neurologist supported by definitive evidence of appropriate and relevant neurological signs.

5.44 **"Progressive Muscular Atrophy"** Unequivocal diagnosis of Progressive Muscular Atrophy by a consultant neurologist supported by definitive evidence of appropriate and relevant neurological signs.

5.45 **"Progressive Supranuclear Palsy"** Progressive supranuclear palsy resulting independently of all other causes and directly in the Insured Person's permanent inability to perform at least three (3) of the below activities of daily living. The diagnosis must be made by a Specialist as progressive and resulting in permanent neurological deficit. Only Insured Person's Age of above five (5) on first diagnosis is eligible to receive the Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy under this Disease.
(a) Dressing – the ability to put on and take off clothing without assistance;
(b) Mobility – the ability to move from room to room without physical assistance;
(c) Transfer – the ability to get in and out of bed or a chair without assistance;

(d) Continence – the ability to control bowel and bladder function;
(e) Feeding – the ability to get food from a plate into the mouth without assistance; and
(f) Bathing and showering – the ability to bathe and shower without assistance.

5.46 **"Rheumatoid Arthritis"** (Adult) Widespread joint destruction with major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, cervical spine, knees, ankles, metatarsophalangeal joints in the feet. The condition shall be such that it results in a permanent inability to perform independently three (3) or more of the activities of daily living:
(a) Dressing – the ability to put on and take off clothing without assistance;
(b) Mobility – the ability to move from room to room without physical assistance;
(c) Transfer – the ability to get in and out of bed or a chair without assistance;
(d) Continence – the ability to control bowel and bladder function;
(e) Feeding – the ability to get food from a plate into the mouth without assistance; and
(f) Bathing and showering – the ability to bathe and shower without assistance.

5.47 **"Severe Brain Damage"** Impairment or loss of intellectual capacity as a result of brain damage sustained in an Accident, following which permanent supervision or assistance is required to maintain existence.

5.48 **"Severe Myasthenia Gravis"** An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatiguability, where all of the following criteria are met:
(a) Presence of permanent muscle weakness categorized as Class IV or V according to the Myasthenia Gravis Foundation of America Clinical Classification below; and
(b) The Diagnosis of Myasthenia Gravis and categorization are confirmed by a neurologist.

Myasthenia Gravis Foundation of America Clinical Classification:
Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere.
Class II: Eye muscle weakness of any severity, mild weakness of other muscles.
Class III: Eye muscle weakness of any severity, moderate weakness of other muscles.
Class IV: Eye muscle weakness of any severity, severe weakness of other muscles.
Class V: Intubation needed to maintain airway.

5.49 **"Severe Ulcerative Colitis"** The actual undergoing of total proctocolectomy for ulcerative colitis, which must be diagnosed by a Specialist in the relevant field and confirmed by histological evidence.

5.50 **"Spinal Muscular Atrophy"** Degenerative Disease of the anterior horn cells in the spinal cord and motor nuclei of the brainstem, characterized by profound proximal muscular weakness and wasting, primarily in the legs, followed by distal muscle involvement. The Disease must result in a permanent bedridden situation and inability to get up without assistance, or a permanent inability to perform independently three (3) or more of the activities of daily living:
(a) Dressing – the ability to put on and take off clothing without assistance;
(b) Mobility – the ability to move from room to room without physical assistance;
(c) Transfer – the ability to get in and out of bed or a chair without assistance;
(d) Continence – the ability to control bowel and bladder function;
(e) Feeding – the ability to get food from a plate into the mouth without assistance; and
(f) Bathing and showering – the ability to bathe and shower without assistance.

These conditions must be last for not less than three (3) Calendar Months and be supported by medical documentation. The diagnosis must be made by a consultant neurologist and confirmed by appropriate neuromuscular testing.

5.51 **"Stroke"** Any cerebrovascular accident or incident causing a Permanent Neurological Deficit, lasting at least four (4) weeks. Infarction of brain tissue, haemorrhage and embolism from an extracranial source are included. The diagnosis of Stroke must be confirmed by a neurologist, based on new radiological changes as seen in a Computed Tomography (CT) Scan or Magnetic Resonance Imaging (MRI) which correlate to the functional impairments observed.

The following are excluded:
(a) Cerebral symptoms due to transient ischaemic attacks;
(b) Cerebral symptoms due to migraine; and
(c) Vascular Disease affecting the eye or optic nerve or vestibular functions.

5.52 **"Surgery to Aorta"** The actual undergoing of a surgery for Disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta, but not its branches. Surgery performed to cure traumatic Injury to the aorta shall not be regarded as "Surgery to Aorta".

5.53 **"Terminal Illness"** The Insured Person must be suffering from a Disease which in the opinion of an appropriate consultant and supported by Registered Medical Practitioner(s) and/or Specialist(s) of our choice, is likely to lead to death within six (6) Calendar Months from the date of notification of a claim under Clause 2.11.1 of Part II of this Policy.

5.54 **"Total and Permanent Disability"** The inability of the Insured Person to engage in any occupation or employment for remuneration or profit as a result of Injury or Sickness and the inability of the Insured Person to perform without assistance three (3) or more of the Activities of Daily Living, and the inabilities described above must have continued without interruption for at least six (6) consecutive Calendar Months, or for such longer period as the Company may reasonably require and it is certified by a Registered Medical Practitioner that such inabilities are and shall be total, continuous and permanent for the remainder of the Insured Person's life.

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

5.56 **"Hand, Foot and Mouth Diseases with Severe (life threatening) Complications"** A viral syndrome associated with exanthem-enanthem caused by Coxsackie A17 and Entenovirus 71. For the purpose of this provision, only severe hand, foot and mouth Disease associated with either encephalitis and/or myocarditis will be covered. Positive isolation of the causative virus to support the diagnosis has to be provided together with documented evidence of the presence of encephalitis and/or myocarditis. A claim for this benefit will only be made with evidence of neurological deficit at least thirty (30) days after the event.

5.57 **"Insulin-Dependent Diabetes Mellitus"** The occurrence of Insulin Dependent Diabetes Mellitus where the following conditions are met:
(a) There is an ongoing absence of insulin production by the pancreas due to auto-immune Disease;
(b) Exogenous insulin administration is Medically Necessary to maintain normal glucose metabolism; and
(c) The condition has been present for at least six (6) Calendar Months.

5.58 **"Kawasaki Disease with Heart Complications"** The occurrence of Kawasaki's Disease where there is evidence of dilation or aneurysm formation in the coronary arteries present for at least six (6) Calendar Months after the diagnosis of the illness.

5.59 **"Rheumatic Fever with Valvular Impairment"** Acute Rheumatic Fever where the following conditions are met:
(a) The diagnosis is according to diagnostic criteria specified by the American Heart Association; and
(b) Moderate incompetence of at least one heart valve has developed as a sole consequence of Rheumatic Fever.

5.60 **"Severe Asthma"** Frequent shortness of breath (one attack or more per Calendar Month) or chronic shortness of breath caused by an obstruction (occlusion) in the respiratory tract as in the case of severe bronchial asthma. Between attacks, an examination of the functioning of the lungs must show evidence of a significant obstructive limitation. The Disease must be diagnosed as severe bronchial asthma by a pediatrician and must have persisted for at least six (6) Calendar Months in its severe form despite adequate treatment. Status asthmaticus is also indicative of a severe course of the Disease.

5.61 **"Severe Epilepsy"** Unequivocal diagnosis of severe epilepsy confirmed by a consultant neurologist or pediatrician and evidenced by typical clinical symptoms as well as characteristic findings in electroencephalography (EEG) and/or other brain imaging techniques (e.g. magnetic resonance imaging (MRI), positron emission tomography (PET), computerized tomography CT). The Insured Person must either exhibit recurrent unprovoked tonic-clonic or grand mal seizures which cannot be controlled by antiepileptic therapy for a period of at least six (6) Calendar Months or he/she must already have undergone neurosurgery for the treatment of the recurrent epileptic seizures.

Excluded are:
(a) Febrile seizures alone; and
(b) Absences (Petit Mal) alone without generalization.

Part VI Exclusion Provisions

6.1 Exclusions

6.1.1 Under this Policy, the Company shall not pay any benefits in relation to or arising from the following expenses:

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

(b) 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.

(c) Expenses incurred for treatment for Human Immunodeficiency Virus ("HIV") and its related Disability, except such occurrences are covered under HIV/ AIDS treatment under Clause 4.3.26 of Part IV of this Policy, "HIV Infection due to Blood Transfusion" under Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy, or "Occupationally acquired HIV" under Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy.

(d) 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 Clause 6.1.1 (c) of Part VI of this Policy applies).

(e) Expenses incurred for – services for

(i) beautification or cosmetic purposes, except for breast reconstruction surgery covered by breast reconstructive surgery benefit under Clause 4.3.27 of Part IV of this Policy; or
(ii) correcting visual acuity or refractive errors that can be corrected by fitting of spectacles or contact lenses, including but not limited to eye refractive therapy, LASIK and any related tests, procedures and services.

(f) Expenses incurred for prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests or 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.

(g) Expenses incurred for dental treatment and oral and maxillofacial procedures performed by a Registered Dentist except for Emergency Treatment and surgery during Confinement arising from an Accident or to the extent covered by the Accidental Emergency dental treatment under Clause 4.3.25 of Part IV of this Policy. Follow-up dental treatment or oral surgery after discharge from Confinement shall not be covered. For the avoidance of doubt, this exclusion shall not apply to Optional Dental Benefits (if applicable) under Clause 4.3.36 of Part IV of this Policy.

(h) Expenses incurred for Medical Services and counselling services relating to maternity conditions and its complications, including but not limited to diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction or pre-mature ejaculation, regardless of cause, except such occurrences of maternity conditions and its complications are covered under pregnancy complications under Clause 4.3.28 of Part IV of this Policy.

(i) 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, except such expenses are covered by home facility enhancement benefit for Stroke under Clause 4.3.33 (c) of Part IV of this Policy. 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.

(j) Expenses incurred for traditional Chinese medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na, and other forms of alternative treatment including but not limited to hypnotism, qigong, massage therapy, aromatherapy, naturopathy, hydropathy, homeotherapy and other similar treatments, except to the extent covered by the traditional Chinese medicine treatment under Clause 4.3.16 of Part IV of this Policy and three Critical Illnesses auxiliary benefit under Clause 4.3.33 (a) of Part IV of this Policy. For the avoidance of doubt, this exclusion shall not apply to Optional Outpatient Benefits (if applicable) under Clause 4.3.35 of Part IV of this Policy.

(k) 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.

(l) Expenses incurred for Medical Services provided as a result of birth defect(s), Congenital Condition(s), Hereditary Condition(s), or any related Disability, except such occurrences of birth defect(s), Congenital Condition(s), Hereditary Condition(s), or any related Disability are covered under "Medullary Cystic Disease" under Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy.

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

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

(o) Expenses incurred for Medical Services provided as a result of Pre-existing Conditions and any special exclusion(s) set out under this Policy, except for Disability which has been fully disclosed in the Application and the Company agrees not to classify as an exclusion under this Policy.

(p) Expenses incurred for treatment for developmental conditions including but not limited to learning difficulties such as dyslexia, behavioral problems such as autism or attention deficit disorder (ADHD); or physical development problems such as short height.

(q) Expenses incurred for treatment for obesity, or which is necessary because of obesity, which includes but not limited to slimming class, aids and drugs. The Company shall only pay for gastric banding or gastric bypass surgery if the Insured Person has a body mass index (BMI) of fourty (40) or over and had been diagnosed as being morbidly obese; and can provide documented evidence of other methods of weight loss which have been tried over the past twenty-four (24) Calendar Months.

(r) Expenses incurred for artificial life maintenance including mechanical ventilation where such treatment will not or is not expected to result in the Insured Person's recovery, or restore the Insured Person to his/her previous state of health, except such expenses are covered under "Vegetative State" under Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy.

(s) Expenses incurred for fetal surgery or treatment.

(t) Expenses incurred for treatment for a related condition resulting from addictive conditions and disorders, including but not limited to smoking cessation.

(u) Expenses arising from sleeping disorders except for –

(i) sleep test (subject to a limit of one (1) sleep test per Policy Year) if there is a diagnosis of sleep apnea of the Insured Person; and
(ii) treatment in relation to sleep apnea and as recommended in writing by a Specialist.

(v) Expenses incurred for or in connection with speech therapy that is not restorative in nature; or if such therapy is used to improve speech skills that have not fully developed, can be considered custodial or educational or intended to maintain speech communication.

(w) Expenses incurred for sex change operations or any treatment needed to prepare for or recover from these operations including complication arising out of such treatment.

(x) Expenses incurred for gene therapy and cell therapy.

(y) Expenses incurred for non-medical services, including but not limited to guest meals, radio, telephone, photocopy, taxes (apart from VAT and GST charged on Eligible Expenses), medical report charges, fax and the like.

(z) Expenses incurred for mental, psychiatric or nervous illness, personality disorder and character disorders, except such occurrences are covered under psychiatric treatments under Clause 4.3.11 of Part IV of this Policy, post-Confinement/ Day Case Procedure auxiliary treatment under Clause 4.3.15 of Part IV of this Policy, psychiatric outpatient treatment or psychological outpatient treatment under Clause 4.3.35 (i) of Part IV of this Policy , or "Alzheimer's Disease/Dementia" under Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy.

(aa) Expenses incurred for organ transplantation, except such occurrences are covered under organ transplantation benefit under Clause 4.3.29 of Part IV of this Policy or "Major Organ Transplantation" under Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy .

(bb) Expenses arising from the Insured Person's engagement and participation in:

(i) naval, military or air force service or operations, armed force or service with the police of any nation;
(ii) professional sports or hazardous activities such as but not limited to rock climbing or mountaineering, parachuting, hang-gliding (whether powered or not), para-gliding, bungee-jumping or any kind of race other than by foot;
(iii) cave, wreck or free diving, professional diving, diving without holding the correct diving certification such as a Professional Association of Diving Instructors (PADI) and diving at depths more than forty (40) meters;
(iv) professional, semiprofessional or competitive winter sports, cross country skiing or snowboarding, ski or snowboard jumping, heli-skiing, off-piste skiing or snowboarding, speed skiing;
(v) working at height (over twenty (20) feet);
(vi) operating heavy machinery;
(vii) aviation or aerial activities, except air travel as a fare-paying passenger in or as a member of the aircrew of a properly licensed, fixed-wing multi-engined aircraft constructed to carry passengers and operated by a licensed commercial air carrier, or in a helicopter owned and operated by a commercial concern which is licensed for the regular transportation of fare-paying passengers provided such helicopter is operating only between commercial airports and/or licensed commercial heliports, and provided further that in either event such travel is not for the purpose of any trade or technical operation in or on the aircraft; or
(viii) manufacture, storage, filling, breakdown, handling and transport of any explosive (including but not limited to firework or firecracker) or chemical material.

(cc) In respect of any Optional Dental Benefits (if applicable) under Clause 4.3.36 of Part IV of this Policy, in addition to Clause 6.1.1 (a) to Clause 6.1.1 (bb) of Part VI of this Policy, the Company shall not pay expenses incurred for the following:

(i) Appliances or restoration necessary to increase vertical dimension or restore an occlusion;
(ii) Dental implants or transplants;
(iii) Cosmetic dentistry procedures such as bleaching and veneers;
(iv) Orthodontic services;
(v) Repair or replacement of orthodontic appliances;
(vi) Placement of bone grafts or extra-oral substances in the treatment of periodontal disorders;
(vii) Procedures or appliances to correct congenital malformations;
(viii) Treatment of malignancies, cysts, or neoplasms;
(ix) Replacement of lost or stolen dentures;
(x) Services or treatment for, or associated with, temporomandibular joint (TMJ) dysfunction or disorder, or for orthognathic surgery;
(xi) Services or supplies intended to diagnose or treat any condition that is occupational Injury or Disease; or
(xii) Replacement or additions to existing dentures or bridgework.

(dd) In respect of the Optional Pharmacy Benefit (if applicable) under Clause 4.3.37 of Part IV of this Policy, in addition to Clause 6.1.1 (a) to Clause 6.1.1 (bb) of Part VI of this Policy, the Company shall not pay expenses incurred for the following:

(i) Any drugs that are experimental or investigational; or
(ii) Replacement of claimed Western Medications due to loss, theft, damaged, spoiled or expired.

6.1.2 Under this Policy, in addition to Clause 6.1.1 of Part VI of this Policy, the Company shall not pay any Accidental Death Benefit under Clause 4.3.32 of Part IV of this Policy in relation to or arising from the following:

(a) Illness, Disease, bacterial or viral infection, even if contracted by an Accident. This does not exclude bacterial infection that is the direct result of an Accidental cut or wound or Accidental food poisoning.

(b) Medical or surgical treatment, except where such treatment is rendered necessary by Injury within the scope of the Accidental Death Benefit.

(c) Pregnancy, childbirth, miscarriage, abortion or complications arising from any of them even though such loss may have been accelerated or induced by Injury.

(d) Any illegal act of the Insured Person in the country or territory where Injury occurs.

(e) Being in a state of insanity or psychiatric or psychological disturbance.

(f) Being under the influence of alcohol or drugs unless the drugs are properly prescribed by a Registered Medical Practitioner and were not taken for the treatment of drug addiction.

(g) Driving any kind of vehicle while the alcohol level in the Insured Person's breath, blood or urine is higher than the legal limit in the country or territory where Injury occurs.

(h) Service in any armed force while: i) in the time of War; ii) under orders for warlike operations; or iii) restoration of public order. For the avoidance of doubt, armed force shall include any police force of a country or territory.

(i) War or any act of War, invasion, act of foreign enemy, hostilities (whether War be declared or not), strike, riot and/or Civil Commotion, civil war, rebellion, revolution, insurrection, military or usurped power, or Terrorism.

(j) Taking part in any air sport, air travel or any other kind of aviation activities, other than travelling as a fare-paying passenger on regular scheduled commercial aircraft which is provided and operated by an airline or air charter company which is properly licensed to do so.

(k) Suicide, attempted suicide, suicide pact or deliberate self-inflicted Injury, while sane or insane.

(l) Workers involved in the manufacture, storage, filling, breakdown, handling and transport of any explosive (including but not limited to firework or firecracker).

(m) The Insured Person participating in or conducting training for any of the following activities:
- (i) underwater swimming or diving and use any type of equipment to aid breathing;
- (ii) any kind of climbing, or mountaineering using rope or guides;
- (iii) pot-holing;
- (iv) parachuting, any kind of gliding, ballooning, bungee-jumping or micro-lighting;
- (v) cave, wreck or free diving, professional diving, diving without holding the correct diving certification such as a Professional Association of Diving Instructors (PADI) and diving at depths more than forty (40) meters;
- (vi) professional, semiprofessional or competitive winter sports, cross country skiing or snowboarding, ski or snowboard jumping, heli-skiing, off-piste skiing or snowboarding, speed skiing;
- (vii) hunting;
- (viii) driving or riding in any kind of race; or
- (ix) professional sports.

信諾尊尚 360 醫療保

目錄

信諾尊尚 360 醫療保

第一部分 釋義

1.1 除非另有述明，否則在本***保單***出現的定義詞語，將具有以下的釋義：

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

「***意外身故保障***」指本***保單***第四部分第 4.3.32 節下可獲賠償的***意外身故保障***。

「***病房類別***」指由***保單持有人***就本***保單***所選擇的並列明於***保單資料頁***內的一個病房類別。

「***年齡***」指於***保單生效日***或其後的任何***周年日***時***受保人***的實際年齡。

「***周年日***」指***保單生效日***的每個周年日。

「***每年保障限額***」指***本公司***在本***保單***下於每個***保單年度***內向***保單持有***人支付的最高賠償限額。***每年保障限額***列明於***保障表***內，而不論***保障表***內列明的任何保障項目是否已經達到其相關的賠償限額，***每年保障限額***仍然適用。***每年保障限額***在每個新***保單年度***會重新計算。

「***投保申請文件***」指向***本公司***就本***保單***遞交的投保申請（不論是書面的或口頭的），包括與該投保申請有關的投保申請表格、問卷、可保性的證明、任何已提交的文件及資料，以及已作出的陳述及聲明，包括相關必需資料的任何更新及改動。

「***受保地區***」指由***保單持有人***就本***保單***所選擇並列明於***保單資料頁***內的以下其中之一：

(a) 環球：環球；或
(b) 環球不包括***美國***：環球但不包括美國和美國本土外小島嶼；或
(c) 亞洲：只限於阿富汗、澳洲、孟加拉、不丹、汶萊、柬埔寨、中國、***香港***、印度、印尼、日本、哈薩克、吉爾吉斯、老撾、澳門、馬來西亞、馬爾代夫、蒙古、緬甸、尼泊爾、紐西蘭、北韓、巴基斯坦、菲律賓、新加坡、南韓、斯里蘭卡、台灣、塔吉克、泰國、東帝汶、土庫曼、烏茲別克、阿拉伯聯合酋長國及越南。

「***基本保單***」指可能不時以批注修改之本***保單***，但不包括
(a) 本***保單***第四部分第4.3.35節、第4.3.36節及第4.3.37節的***自選保險保障***；及
(b) 任何以附加保障簽發但與本***保單***第四部分的可獲賠償的保障無關的附加保障。

「***受益人***」指***保單持有人***不時指定的並經***本公司***批准的收取按本***保單***第四部分第4.3.32節可獲賠償的***意外身故保障***之人士（如有）。

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

「***日曆月***」指由某一月份內某一日子至下一個緊接著的月份內相同的日子之前一日（或如下一個緊接著的月份內沒有對應的相同日子，至下一個緊接著的月份內最後一日）為止的期間。

「***癌症***」指在本***保單***第五部分所指的***癌症***。

「***中藥***」指按照《中醫藥條例》（***香港***法例第549章）於***香港***中醫藥管理委員會中藥組，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體，合法註冊之中藥材。

為免存疑，本***保單***並不保障保健品及所有特別中草藥及／或補藥，包括但不限於燕窩、靈芝、人參、冬蟲夏草、姬松茸、鹿茸等。

「***信諾指定計劃***」指以下保險計劃，包括「信諾國泰優越醫療保」、「信諾自選醫療保」、「信諾糖路同行醫療保」、「信諾尊尚醫療保」、「信諾尊尚360醫療保」、「信諾自願醫保系列 - 標準計劃」、「信諾自願醫保系列 - 靈活計劃（附加保障）」、「信諾自願醫保系列 - 靈活計劃（優越）」，及任何其他由***本公司***不時指定及簽發的保險計劃。

「***內亂***」指國民反對管治組織或其政策時產生的騷亂、動亂或混亂。

「***本公司***」、「***我們***」或「***我們的***」指信諾環球保險有限公司。

「***住院***」 指***受保人***在***醫療所需***的情況下，按***註冊醫生***的建議以***住院病人***身份入住***醫院***以接受***醫療服務***。***住院***必須以***醫院***開出的每日病房費單據作證明，***受保人***必須在整個***住院***期間連續留院。

「***先天性疾病***」指

(a) 任何於出生時或之前已存在的醫學、生理或精神上的異常，不論於出生時有關異常是否已出現、被確診或獲知悉；或

(b) 任何於出生後六(6)個***日曆月***內出現的新生嬰兒異常。

「***居住國家***」指***受保人***居住或打算居住的國家。若***受保人***在***合資格費用招致日***或其他應付費用招致之前連續三百六十五(365)日內在該國家逗留一百八十五(185)日或以上，則該國家被視為***受保人***之***居住國家***。為免存疑，上述的連續三百六十五(365)日包括抵達該國家及離開該國家的日子。

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

「***日症病人***」指在診所、日間手術中心或***醫院***（非住院性質）接受***醫療服務***的***受保人***。

「***指定日間手術***」指***保障表***內所指的***指定日間手術***。

「***指定中國內地醫院***」指在***指定中國內地醫院***名單上的中國內地***醫院***，而***本公司***有酌情權對此名單不時作出更新、變更新及修改，不論有否另外發出通知，有關更改將由發佈日起生效。

「***自付費***」指列明於***保單資料頁***內，在***本公司***賠償餘下的***合資格費用***或其他應付費用前，***保單持有人***在每個***保單年度***必須分擔的定額金額。

「***傷病***」指***不適***、***疾病***或***受傷***，包括任何及所有由此而引發的併發症。

「***合資格費用***」指就***傷病***接受***醫療服務***所招致的***合理及慣常***費用。

「***合資格費用招致日***」指***受保人***接受***醫療服務***的日子。惟若涉及***住院***或***入住***的保障，***合資格費用招致日***則為***受保人***入住***醫院***、註冊緩和治療中心、註冊善終服務中心或***康復中心***(按情況而定)的日子。

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

「***急症治療***」指***急症***所需的***醫療服務***，而所需的***醫療服務***必須在***急症***出現後的合理時間內進行。

「***普通科醫生***」指並非***專科醫生***的***註冊醫生***。

「***寬限期***」指***保單生效日***除外之任何***保費到期日***後三十（30）日的期間。

「***香港保健員***」指除了***保單持有人***、***受保人***，或***保單持有人***及/或***受保人***的任何保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 按照《安老院規例》（***香港***法例第459A章），名列於***香港***社會福利署署長備存的《保健員註冊紀錄冊》；或

(b) 按照《殘疾人士院舍規例》（***香港***法例第613A章），名列於***香港***社會福利署署長備存的《保健員註冊紀錄冊》。

「***心臟病***」 指在本***保單***第五部分所指的心臟病。

「***遺傳性疾病***」指通過基因由父母遺傳給子女的疾病。

「***人體免疫力缺乏病毒／愛滋病治療等候期***」指由下列最遲的日子起計五(5)年的期間：
(a) ***保單簽發日***或***保單生效日***（以較遲者為準）；及
(b) 復效的生效日（如本***保單***已復效）。

如本***保單***有任何保障增加，就有關保障增加的部分，***人體免疫力缺乏病毒／愛滋病治療等候期***指由下列最遲的日子起計五(5)年的期間：
(a) 保障增加的簽發日或生效日（以較遲者為準）；及
(b) 復效的生效日（如本***保單***已復效）。

「***香港***」指中華人民共和國香港特別行政區。

「***醫院***」指按其所在地法律妥為成立及註冊為醫院的機構，並
(a) 為不適及受傷的***住院病人***提供***醫療服務***；
(b) 具備診斷及進行大型手術的設施；
(c) 由***護士***提供二十四（24）小時護理服務；
(d) 由一（1）位或以上***註冊醫生***駐診；及
(e) 非主要作為診所、戒酒或戒毒中心、自然療養院、水療中心、護理或療養院、寧養或紓緩護理中心、緩和治療中心、善終服務中心、***復康中心***、護老院或同類機構。

中國內地***醫院***必須為***三甲等級***或以上，或在***指定中國內地醫院***名單上。

「***欠款***」指就本***保單***而拖欠***本公司***的任何款項，包括但不限於任何未繳付的***標準保費***、***附加保費***、***自付費***、***差額***，以及任何由***本公司***決定累計的利息。

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

「***住院病人***」指***住院***的***受保人***。

「***受保人***」指本***保單***所保障，並在***保單資料頁***內列為***受保人***的人士。

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

「***終身保障限額***」指***本公司***在本***保單***下於***受保人***一生中向***保單持有人***支付的最高賠償限額。***終身保障限額***列明於***保障表***內，而不論***保障表***內列明的任何保障項目是否已經達到其相關的賠償限額，或個別***保單年度***的賠償是否已經達到***每年保障限額***，***終身保障限額***仍然適用。

「***危疾***」指本***保單***第五部分所列出及界定的任何危疾。

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

「***醫療所需***」指按照一般公認的醫療標準，就診斷或治療相關***傷病***接受醫療服務的需要，而醫療服務必須符合下列條件：
(a) 需要***註冊醫生***的專業知識或轉介；
(b) 符合該***傷病***的診斷及治療所需；
(c) 按良好而審慎的醫學標準提供，而非主要為對***受保人***、其家庭成員、照顧人員或主診***註冊醫生***帶來方便或舒適而提供；
(d) 在環境最適當及符合一般公認的醫療標準的設備下，提供***醫療服務***；及
(e) 以最適當的水平向***受保人***安全及有效地提供。

「***護士***」指除了***保單持有人***、***受保人***，或***保單持有人***及／或***受保人***的任何保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：
(a) 具有正式資格並已按照《護士註冊條例》(***香港***法例第164章)在***香港***護士管理局註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及
(b) 在***香港***或向***受保人***提供護理治療或服務的***香港***境外司法管轄區，經當地法例許可提供相關護理治療或服務。

「***自選牙科保障***」指本***保單***第四部分第4.4.36節下可獲賠償的保障。

「***自選保險保障***」指

(a) 本***基本保單***提供的保障以外的附加保險保障，即***自選門診保障***、***自選牙科保障***或***自選藥物保障***；及

(b) 由***保單持有人***就本***保單***所選擇的並列明於***保單資料頁***。

「***自選保險保障簽發日***」指***自選保險保障***的簽發日。

「***自選門診保障***」指本***保單***第四部分第4.3.35節下可獲賠償的保障。

「***自選藥物保障***」指本***保單***第四部分第4.3.37節下可獲賠償的保障。

「***自選藥物保障等候期***」指下列由最遲的日子起計一百八十 (180)日的期間：

(a) ***保單簽發日***或***保單生效日***（以較遲者為準）；

(b) 復效的生效日（如本***保單***連同***自選藥物保障***已復效）；及

(c) ***自選藥物保障***的***自選保險保障簽發日***（如在***保單簽發日***或***保單生效日***（以較遲者為準）後增加***自選藥物保障***）。

「***保障期***」指在該期間內本***保單***維持有效，並列明於***保單資料頁***內。

「***善終服務保障等候期***」指由下列最遲的日子起計兩(2)年的期間：

(a) ***保單簽發日***或***保單生效日***（以較遲者為準）；及

(b) 復效的生效日（如本***保單***已復效）。

如本***保單***有任何保障增加，就有關保障增加的部分，***善終服務保障等候期***指由下列最遲的日子起計兩(2)年的期間：

(a) 保障增加的簽發日或生效日（以較遲者為準）；及

(b) 復效的生效日（如本***保單***已復效）。

「***保單***」指***投保申請文件***，***基本保單***，***保單資料頁***，***保障表***，***自選保險保障***（如適用），任何附於本保單的批注，及任何就本***保單***簽發的附加保障。

「***保單生效日***」指本***保單***開始生效的日期，並列明於***保單資料頁***內。

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

「***保單簽發日***」指***本公司***簽發本***保單***的日期，並列明於***保單資料頁***內。

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

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

「***投保前已有病症***」指***受保人***於***保單簽發日***、***保單生效日***或復效的生效日（如本***保單***已復效）(以最後日期為準)前已存在的任何***不適***、***疾病***、***受傷***、生理或心理或醫療狀況、機能退化、***遺傳性疾病***，或***先天性疾病***。

在以下情況發生時，一般審慎人士理應已可察覺到***投保前已有病症***：

(a) 病症已被確診；

(b) 病症已出現清楚明顯的病徵或症狀；或

(c) 已尋求、獲得或接受病症的醫療建議或治療。

儘管有上述規定，***投保前已有病症***不包括下列***傷病***：
(a) 已在***投保申請文件***全面披露；及
(b) ***本公司***同意不列為本***保單***的不保事項。

「***妊娠併發症等候期***」指由下列最遲的日子起計一(1)年的期間：
(a) ***保單簽發日***或***保單生效日***（以較遲者為準）；及
(b) 復效的生效日（如本***保單***已復效）。

如本***保單***有任何保障增加，就有關保障增加的部分，***妊娠併發症等候期***指由下列最遲的日子起計一(1)年的期間：
(a) 保障增加的簽發日或生效日（以較遲者為準）；及
(b) 復效的生效日（如本***保單***已復效）。

「***保費到期日***」指***保單生效日***、***周年日***或（倘***保單資料頁***列明的保費繳款形式並非按年繳付）相對於***標準保費***及***附加保費***（如有）結算的繳款形式的該等其他相應付款日。

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

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

「***訂明非手術癌症治療***」指治療癌症的化療、放射性治療、標靶治療、免疫治療、荷爾蒙治療、質子治療、使用伽碼刀及數碼導航刀。

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

本公司將須參照以下資料（如適用）以釐定***合理及慣常***收費：
(a) 由保險或醫學業界進行的治療或服務費用統計及調查；
(b) 公司內部或業界的賠償統計；
(c) 政府憲報；及 / 或
(d) 提供治療、服務或物料當地的其他相關參考資料。

「***註冊中醫師***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的任何保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：
(a) 以中醫師、跌打醫師或針灸師身份行醫的人士；
(b) 具有正式資格並已按照《中醫藥條例》(***香港***法例第549章)在***香港***中醫藥管理委員會註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及
(c) 在***香港***或向***受保人***提供傳統中醫治療的***香港***境外司法管轄區，經當地法例許可提供相關傳統中醫治療。

「***註冊脊醫***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：
(a) 具有正式資格並已按照《脊醫註冊條例》(***香港***法例第428章)在***香港***脊醫管理局註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及
(b) 在***香港***或向***受保人***提供脊骨療法的***香港***境外司法管轄區，經當地法例許可提供相關脊骨療法，包括藉矯正關節（尤指脊椎及周圍關節，亦包括骨盆）以預防、診斷及治療人體機能失調的病症。

「***註冊牙醫***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 具有正式資格並已按照《牙醫註冊條例》(***香港***法例第156章)在***香港***牙醫管理委員會註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及

(b) 在***香港***或向***受保人***提供牙科服務的***香港***境外司法管轄區，經當地法例許可提供相關牙科服務。

「***註冊營養師***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 具有正式資格並已在***香港***認可營養師學院註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及

(b) 在***香港***或向***受保人***提供營養師診症的***香港***境外司法管轄區，經當地法例許可提供相關營養師診症。

「***註冊醫生***」、「***外科醫生***」及「***麻醉科醫生***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 為西醫；

(b) 具有正式資格並已按照《醫療註冊條例》(***香港***法例第161章)在***香港***醫務委員會註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及

(c) 在***香港***或向***受保人***提供***醫療服務***的***香港***境外司法管轄區，經當地法例許可提供相關***醫療服務***。

「***註冊職業治療師***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 具有正式資格並已在***香港***職業治療師管理委員會註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及

(b) 在***香港***或向***受保人***提供職業治療的***香港***境外司法管轄區，經當地法例許可提供相關職業治療。

「***註冊物理治療師***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 具有正式資格並已在***香港***物理治療師管理委員會註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及

(b) 在***香港***或向***受保人***提供物理治療的***香港***境外司法管轄區，經當地法例許可提供以運動、人手治療及以機械能、熱能或電能治療就身體殘疾予以評估及醫治的相關物理治療。

「***香港註冊心理學家***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 具有正式資格並已在***香港***心理學會、***香港***臨床心理學博士協會、***香港***教育心理學家公會及 / 或***香港***臨床心理學家公會註冊；及

(b) 在***香港***經法例許可提供有關心理診症服務。

「***註冊言語治療師***」指除了***受保人***、***保單持有人***，或***保單持有人***及 / 或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 具有正式資格並已在***香港***言語治療師公會註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及

(b) 在***香港***或向***受保人***提供言語治療的***香港***境外司法管轄區，經當地法例許可提供相關言語治療。

「***康復中心***」指***醫院***以外的註冊機構，並就功能障礙或***傷病***而提供物理治療，職業治療及其他康復治療服務。

「***續保***」指就按本***保單***第二部分第2.7節之本***保單***續保。

「***續保日***」指本***保單續保***的生效日期。首個***續保日***列明於***續保***通知書內並不可遲於首個***周年日***，至於繼後的***續保日***則為繼後的***周年日***。

「***半私家房***」指***醫院***列為半私家房或二等房的病房。如***醫院***沒有列明病房分類，***半私家房***指***醫院***內設有共用浴室的單人或雙人病房。

「***差額***」指由***受保人***招致的費用而又不在本***保單***保障範圍內或已超出本***保單***的保障限額，並由***本公司***代***受保人***向醫療服務提供者墊支。

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

「***專科醫生***」指除了***受保人***、***保單持有人***，或***保單持有人***及／或***受保人***的保險中介人、僱主、僱員、直系親屬或業務夥伴以外（除非事先經***本公司***的書面批准），符合以下資格的人士：

(a) 為西醫；

(b) 具有正式資格並已按照《醫療註冊條例》(***香港***法例第161章)在***香港***醫務委員會的專科醫生名單註冊，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體註冊；及

(c) 在***香港***或向***受保人***提供***醫療服務***的***香港***境外司法管轄區，經當地法例許可提供相關***醫療服務***。

「***標準保費***」指***本公司***就***基本保單***或***自選保險保障***（如適用）向***保單持有人***所收取的保費。

「***標準私家房***」指***醫院***列為單人、私人或頭等房的病房。如***醫院***沒有列明病房分類，***標準私家房***指***醫院***內設有私人浴室的單人病房。為免存疑，***標準私家房***並不包括***醫院***內附有升級設施之設有私人浴室的基本單人病房。

「***入住***」指***受保人***在***醫療所需***的情況下並按***註冊醫生***建議，入住註冊緩和治療中心、註冊善終服務中心或***康復中心***。

「***中風***」指在本***保單***第五部分所指的***中風***。

「***恐怖主義***」指任何人士或團體，不論其是否代表或與任何組織、政府、力量、權力或軍事力量有所關連，使用或威脅使用武力或暴力對付任何人或物，或進行對人命或財產構成危險的活動，或從事干擾或破壞電子或通訊系統之行為，其目的為恐嚇、強迫或傷害政府、平民社會或其任何部分，或破壞任何經濟部分。恐怖主義亦包括任何有關地方政府證實或確認之恐怖主義行為。

「***三大危疾保障等候期***」指由下列最遲的日子起計九十 (90)日的期間：

(a) ***保單簽發日***或***保單生效日***（以較遲者為準）；及

(b) 復效的生效日（如本***保單***已復效）。

如本***保單***有任何保障增加，就有關保障增加的部分，***三大危疾保障等候期***指由下列最遲的日子起計九十(90)日的期間：

(a) 保障增加的簽發日或生效日（以較遲者為準）；及

(b) 復效的生效日（如本***保單***已復效）。

「***美國***」指美國和美國本土外小島嶼。

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

「***戰爭***」指戰爭（正式宣戰與否亦然）或任何戰爭活動包括任何主權國家使用軍事力量以達致經濟、地緣、民族、政治、種族、宗教或其他目的。

「***西藥***」指按照《藥劑業及毒藥條例》(***香港***法例第138章）於***香港***藥劑業及毒藥管理局，或在***香港***境外的司法管轄區內由***本公司***合理地認為具有同等效力的團體，合法註冊之西藥。

1.2 除文意另有所指外，意含單數之詞語將包括複數，而所有陽性詞語亦包括陰性含意，反之亦然。一般詞彙不應因隨後列舉的例子如包含特定意義，而令該一般詞彙在涵義上受到限制。

1.3 凡提及條款，指本***保單***的條款。僅就方便參考起見，本***保單***加入標題。有關標題應不影響本***保單***的詮釋。

1.4 如本***保單***的任何條文經具有司法管轄權的法院裁定為不合法、無效或不可強制執行，本***保單***的任何其他條文的合法性、有效性或可強制執行性將不會因此而受到影響。

1.5 ***本公司***並未行使或遲延行使本***保單***的任何權利，均不應視為***本公司***放棄行使任何此權利。

第二部分 一般條文

2.1 *保單*合約

根據已支付的***標準保費***、***附加保費***(如有)及提交予***本公司***的***投保申請文件***，***本公司***同意簽發本***保單***以承保***受保人***，並按本***保單***的條款及細則提供有關保障。

2.2 規管法律及司法管轄權

本***保單***在***香港***簽發並須受***香港***法律管轄及闡釋。***本公司***及***保單持有人***均同意遵從***香港***法院的專有司法管轄權。

2.3 *保單*貨幣

本***保單***提及的所有款項均以***保單資料頁***所列的貨幣為單位。

2.4 保單條款更改

2.4.1 在本***保單***有效期間，如***本公司***認為必須遵守於***保單生效日***或本***保單***有效期間適用的法律及/或監管規定，***本公司***有權隨時修訂、修改或變更本***保單***的條款及細則。

2.4.2 除非***本公司***就本***保單***簽發批注以作出更改，否則任何對本***保單***的條款及細則的更改均屬無效。

2.5 資料更改

受保人及***保單持有人***必須就其個人資料的任何更改(包括但不限於名稱、職業、居住國家或地區及地址)提交***本公司***指定的表格，以立即通知***本公司***。該更改須經***本公司***最新簽發的書面通知確認才有效。

2.6 *病房類別 / 受保地區 / 自付費 / 自選保險保障*更改

2.6.1 保障級別升級或降級指對本***保單***的***病房類別***、***受保地區***、***自付費***及 / 或***自選保險保障***的任何更改。

2.6.2 ***保單持有人***可提交***本公司***指定的表格，要求升級或降級***保單資料頁***所列的保障級別，以更改本***保單***的***病房類別***、***受保地區***、***自付費***及 / 或***自選保險保障***。

2.6.3 在符合本***保單***的條款及細則的規定下及經***本公司***批准後(須經***本公司***最後簽發的***保單資料頁***確認)，新的保障級別將成為本***保單***的***病房類別***、***受保地區***、***自付費***及 / 或***自選保險保障***。新的保障級別及相關保費將於緊接著批准該申請後的***周年日***生效；惟***本公司***須於該***周年日***前最少三十(30)日之前收到該申請。

2.6.4 因根據本***保單***第二部分第2.6.3節升級***病房類別***或***受保地區***，及 / 或新增***自選保險保障***，及 / 或減低***自付費***，而引致的任何保障級別升級或保障增加僅適用於：

(a) 在升級的簽發日或生效日（以較遲者為準）當日或之後遭遇的***受傷***；或
(b) 在升級的簽發日或生效日（以較遲者為準）當日或之後首次已被確診、已出現症狀、已出現、或已需要醫療建議及 / 或治療及 / 或處方藥物的***不適***或***疾病***。

2.6.5 在符合本***保單***第二部分第2.6.3節的規定下，***保單持有人***可享申請減低***自付費***之權利而不需進行任何醫療核保；惟須受以下條款所限：

(a) 此權利只可在***受保人***五十五（55）或六十（60）或六十五（65）或七十（70）歲生辰當日的***周年日***或緊隨其後的***周年日***，之前的三十（30）日內提出；
(b) ***受保人***一生只能行使此權利一次；及
(c) 當根據本***保單***第四部分第4.3.33(b) 節的三大***危疾***保費豁免保障生效時，不能行使此權利。

2.7 續保

2.7.1 在符合本***保單***第二部分第2.16節的規定下，本***保單***的***基本保單***及***自選保險保障***(如適用)將於首十二(12)個***日曆月***有效。其後必須在每個***周年日***當日或之前繳付***標準保費***及***附加保費***(如有)，並且***本公司***必須仍就***基本保單***及***自選保險保障***(如適用)繼續簽發新保單，本***保單***的***基本保單***及***自選保險保障***(如適用)將保證自動***續保***，每次***續保***期為十二(12)個***日曆月***。

2.7.2 ***本公司***保留在每次***續保***時修訂本***保單***的條款及細則、***標準保費***及／或***保障表***之權利。若***附加保費***設定為***標準保費***的某個百分比，***附加保費***的金額將會根據***標準保費***的更改而自動調整。

2.7.3 若信諾尊尚360醫療保的***基本保單***及／或個別***自選保險保障***不獲***本公司續保***，我們將在下一個***周年日***前最少三十(30)日之前以書面通知***你本保單***將不獲***續保***。

2.8 錯誤申報個人資料

2.8.1 在不損害***本公司***按本***保單***第二部分第2.9節宣告本***保單***無效的權利下，若在***投保申請文件***或任何其後就相關申請提交予***本公司***的資料或文件（包括相關必需資料的任何更新及改動）中錯誤申報***受保人***的非健康相關資料（包括但不限於***年齡***、性別或吸煙習慣），從而可能影響***本公司***作出的風險評估，***本公司***可按正確資料調整過去、現在或未來***保單年度***的***標準保費***及***附加保費***（如有）。若***保單持有人***因此需補交額外保費，***本公司***不會在補交前支付任何賠償。若***保單持有人***在***本公司***通知的補交保費的到期日後三十（30）日內仍未補交保費，***本公司***有權行使權利，由該補交保費的到期日起終止本***保單***。若有多繳保費，***本公司***將在扣除任何***欠款***後予以退還。

2.8.2 若按***受保人***的正確資料及***本公司***的核保指引，***本公司***認為***受保人***的投保申請應當被拒絕時，***本公司***有權宣告本***保單***由***保單生效日***起無效，及本***保單***不會為***受保人***提供保障。***本公司***就現在及過往所有***保單年度***將***:***

(a) 有權追討已支付的賠償；
(b) 有責任在扣除已支付的賠償、任何***欠款***及***本公司***所收取的合理行政費用後，退還已繳交的保費；及
(c) 有責任退還已繳交的保險徵費。

2.9 失實陳述或欺詐

本公司有權在下列情況下，宣告本***保單***由***保單生效日***起無效及不會為***受保人***提供保障 –

(a) 在***投保申請文件***，或在***投保申請文件***或任何其後就相關申請提交予***本公司***的資料或文件（包括相關必需資料的任何更新及改動），其所作出的陳述或聲明中，就***受保人***健康狀況的重要事實作出失實聲明或遺漏資料。「重要事實」包括但不限於由***本公司***要求提供、會影響***本公司***對***受保人***的核保決定的事實，若披露該事實***本公司***有可能因而徵收***附加保費***、增加不保項目或拒絕投保申請；或
(b) 在***投保申請文件***中或索償時，作出欺詐或有欺詐成分的申述。

在(a)的情況下，***本公司***就現在及過往所有***保單年度***將***:***

(i) 有權追討已支付的賠償；
(ii) 有責任在扣除已支付的賠償、任何***欠款***及***本公司***所收取的合理行政費用後，退還已繳交的保費；及
(iii) 有責任退還已繳交的保險徵費。

在(b)的情況下，***本公司***將:

(i) 有權追討已支付的賠償；及
(ii) 有權不退還已繳交的保費及保險徵費。

2.10 代位追討權

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

2.11 索償通知及證明

2.11.1 索償通知

已填妥的***本公司***指定的表格必須在(a)（若曾***住院***）***受保人***出院後或 (b)（若沒有***住院***）為***受保人***進行***醫療服務***當日後的三十(30)日內向***本公司***提交。該表格須包括足以證明***受保人***的身份及索償性質的資料。

2.11.2 索償證明

(a) 索償證明必須在(a)（若曾***住院***）***受保人***出院後或(b)（若沒有***住院***）為***受保人***進行***醫療服務***當日後的九十(90)日內向***本公司***提交。如索償證明沒有在規定的限期內提交，則必須證明已盡早在合理的時間內提交，否則***本公司***有權不支付有關索償。

(b) 我們處理索償所需的所有資料及文件（包括但不限於***受保人***的醫療紀錄及報告複本、所有費用的收據正本及***受保人年齡***的證明文件）必須向***本公司***提交，而***保單持有人***、***受保人***及 / 或任何有關索償人須承擔有關費用。***保單持有人***、***受保人***及 / 或任何有關索償人必須簽署所有授權表格，以授權***本公司***取得***受保人***的全部及完整醫療記錄。

(c) 若***保單持有人***、***受保人***及 / 或任何有關索償人選擇就同一費用就另一家保險公司簽發的保單提出索償，必須將該保險公司簽發的賠償通知書及索償付款收據的複本向***本公司***提交。

(d) ***本公司***保留要求由***本公司***選擇的***註冊醫生***及 / 或***專科醫生***對***受保人***進行檢查之權利。

(e) ***本公司***履行本***保單***的任何付款責任的先決條件為***保單持有人***、***受保人***及任何有關索償人全面遵守本保單的條款及細則。

2.11.3 索償付款扣除

本公司有權從本***保單***的任何應付保障中扣除任何***欠款***(。

2.12 其他保障

若***保單持有人***擁有本***保單***以外的其他保障，***保單持有人***將有權向任何該等保障或本***保單***進行索償。不論如何，若***保單持有人***或***受保人***已從任何該等保障索償全部或部分費用，則***本公司***只會對未被任何該等保障賠償的***合資格費用***及其他應付費用作出賠償。

2.13 索償支付

2.13.1 除了***意外身故保障***賠償外，***我們***將把本***保單***的應付賠償支付予***保單持有人***，或如在款項支付之時***保單持有人***已不在世，則支付予***保單持有人***的遺產。

2.13.2 就***意外身故保障***賠償而言，***我們***將支付予***受益人***；及如沒有指定***受益人***或在款項支付之時***受益人***已不在世，則支付予***保單持有人***。

2.13.3 不論本***保單***有任何其他條文，本***保單***的所有索償付款的先決條件為必須向***本公司***提交並令***我們***信納的有效文件以證明***保單持有人***及 / 或***保單持有人***的***遺產代理人***及 / 或***受保人***及 / 或***受益人***（視情況而定）的身份。就本***保單***第二部分第2.13節而言，***遺產代理人***需以《遺囑認證及遺產管理條例》(***香港***法例第10章)所載涵意詮釋。

2.13.4 根據本***保單***第二部分第2.13.1至2.13.3節支付本***保單***的賠償後，***本公司***於本***保單***的所有責任將被視為已完全解除。

2.14 利息

除非***本保單***另有明文規定，否則***本公司***在本***保單***的所有應付款項均不附帶任何利息。

2.15 冷靜期

2.15.1 ***保單持有人***可以在冷靜期內行使權利取消本***保單***及獲發還已繳交的***標準保費***，***附加保費***(如有)及保險徵費。在此情況下，本***保單***將被視為由保單生效日起無效，本公司亦無須承擔任何賠償責任。

2.15.2 行使此項取消權利時，必須符合以下條件 –

(a) 取消要求必須由***保單持有人***以***本公司***指定的表格作出，並確保***本公司***於冷靜期內直接收到該表格。冷靜期為由緊接本***保單***或冷靜期通知書交付予***保單持有人***或***保單持有人***的指定代表之日（以較早者為準）起計的三十（30）日的期間。為免生疑問，交付本***保單***或冷靜期通知書當天並不包括在計算三十（30）日的期間內。然而，若第三十（30）日當天並非工 作天，則冷靜期將包括隨後的工作天的一天在內；

(b) 若曾獲賠償或將獲得賠償，則不獲發還保費；及

(c) 上述取消的權利並不適用於續保。

2.16 *保單*終止

2.16.1 本***保單***將於下列情況發生時（以最早發生者為準）即時終止：

(a) ***受保人***身故;

(b) ***保單持有人***根據本***保單***第二部分第2.15節取消本保單；

(c) ***保單持有人***根據本***保單***第二部分第2.16.3節取消本***保單***；

(d) ***本公司***根據本***保單***第二部分第2.16.4節取消本***保單***；

(e) 本***保單***根據本***保單***第二部分第2.7節不獲***續保***；

(f) 本***保單***根據本***保單***第三部分第3.3.2節失效；或

(g) 賠償達***終身保障限額***。

2.16.2 除非本***保單***另有述明，本***保單***終止不會影響在終止前已產生的任何索償。在本***保單***終止後，任何支付予***本公司***或由***本公司***接收的***標準保費***及***附加保費***（如有）將不會令***本公司***為此招致任何責任，而***本公***司將會退還已扣減***欠款***的該等保費。

2.16.3 ***保單持有人***取消***保單***

(a) ***保單持有人***可提交***本公司***指定的表格向***我們***給予不少於三十(30)日的通知以取消本***保單***。

(b) 因上述取消而導致的本***保單***終止將於該表格列明的日期或***本公司***批准的日期（以較後的日期為準）生效。

(c) 若因上述取消而導致本***保單***終止，已繳交的***標準保費***、***附加保費***（如有）及保險徵費將不獲退還。***本公司***保留權利收取本***保單***終止生效後計算至該***保單年度***完結時的***標準保費***及***附加保費***(如有)。

2.16.4 ***本公司***取消***保單***

(a) ***本公司***有權根據本***保單***第二部分第2.8.1節終止本***保單***。

(b) ***本公司***有權根據本***保單***第二部分，第三部分及 / 或第四部分的第2.8.2、2.9、3.3.1 及 / 或4.4.2節宣告本***保單***由***保單生效日***起無效。

(c) 若***差額***未能於***本公司***向***保單持有人***發出***差額***通知書後的十四(14)日內償還，***本公司***保留即時取消本***保單***之權利。若該***差額***於上述期限後尚未償還，即使***本公司***遲延根據本條文取消本***保單***，不應視為***本公司***放棄往後行使取消本***保單***之權利。

2.17 筆誤

本公司造成的任何筆誤，將不會令原已生效的***保單***失效，或令原已失效的***保單***繼續生效，而在闡釋本***保單***時，應視該等筆誤沒有發生。

2.18 限制

在根據本***保單***第二部分第2.11.2節向***本公司***提交索償證明之日後起計首六十(60)日內，或在***本公司***就有關索償作出最終決定之日起計兩(2)年後，不可向***本公司***採取任何法律行動以追討本***保單***的任何索償。

2.19 保單擁有權

在本***保單***有效期間，***保單持有人***可行使本***保單***的所有權利、特權及選項。在***受保人***在世期間，***保單持有人***可提交***本公司***指定的表格以要求更改本保單的擁有權。該更改須經***本公司***最新簽發的***保單資料頁***確認才有效。

2.20 第三者權利

除***本公司***及***保單持有人***外，任何非本***保單***合約一方的人士或法人（包括但不限於***受保人***或***受益人***）無權按《合約（第三者權利）條例》(***香港***法例第623章)強制執行本***保單***的任何條款。

2.21 遵守經濟制裁規定

2.21.1 信諾環球有責任遵守對其環球業務有關的個人、團體及國家的經濟制裁規定，包括但不限於由聯合國、歐盟委員會、美國及加拿大所實行的規定。***本公司***將不會在違反該等經濟制裁規定下向任何***保單持有人***及／或***受保人***及／或***受益人***及／或任何相關人士提供保障或支付任何賠償。若信諾環球發現受制裁的個人已在本***保單***下受保，或***保單持有人***／***受保人***被制裁，***本公司***將採取一切適當行動，包括封鎖、匯報及終止保障。在遵守經濟制裁法例下，***本公司***沒有義務在採取行動前通知***保單持有人***或***受保人***或***受益人***或任何受影響人士，或從任何政府獲取牌照以延長保障。

2.21.2 此外，在沒有得到美國財政部海外資產控制辦公室的有關批准許可而在受制裁國家的索償申請將受到限制，在此等限制中，信諾環球不會在以下情況提供保障：（1）在受制裁國家自選或預先計劃的治療；或（2）***保單持有人***或***受保人***在受制裁國家被認為是居民。若***保單持有人***或***受保人***在受制裁國家任何十二（12）個月的期間逗留超過六（6）星期，則被視為居民。

第三部分 保費條文

3.1 本*保單*應付保費

就***保單資料頁***所列的***基本保單***及***自選保險保障***(如適用)，***你***須定期按***保費到期日***繳交***標準保費***及***附加保費***(如有)。

3.2 保費繳款形式

本***保單***是一份一年的保單。本***保單***的應繳交的任何***標準保費***及***附加保費***(如有)須按***保單資料頁***所列的繳款形式繳交。在本***保單***有效期間，***你***可提交***本公司***指定的表格以要求更改繳款形式。該更改須經***本公司***最新簽發的***保單資料頁***確認才有效。

3.3 繳交保費

3.3.1 如***你***未能在***保單簽發日***或***保單生效日***(以較早者為準)當日或之前全數繳交本***保單***的首期保費，則就各方面而言，本***保單***應被視為由***保單生效日***起無效。因此，***本公司***毋須支付本***保單***的任何保障賠償。

3.3.2 除首期保費付款外，可於任何***保費到期日***後的***寬限期***內繳交保費或其任何部分。在***寬限期***內本***保單***之保障仍然生效，但若***寬限期***內有任何應獲支付的保障，***本公司***有權決定從應獲支付的保障先扣減欠繳保費。如***基本保單***及/或***自選保險保障(如適用)***的***標準保費***及***附加保費***(如有)或其任何部分在***寬限期***結束時仍未支付，則本***保單***應在首次欠繳***標準保費***及***附加保費***(如有)的***保費到期日***終止。

3.3.3 ***本公司***保留在每次***續保***時修訂本***保單***的***標準保費***之權利，並擁有全權酌情決定權只考慮***本公司***認為相關的因素以修訂***標準保費***。若***附加保費***設定為***標準保費***的某個百分比，***附加保費***的金額將會根據***標準保費***的更改而自動調整。

3.3.4 除非***本保單***另有明文規定，若本***保單***終止，已繳交的***標準保費***、***附加保費***(如有)及保險徵費將不獲退還。

3.4 復效

3.4.1 若根據本***保單***第三部分第3.3.2節本***保單***因欠繳***標準保費***及***附加保費***(如有)而失效，本***保單***可由***標準保費***及***附加保費***(如有)首次欠繳的***保費到期日***起計三(3)個***日曆月***內被復效；惟須符合下列各項並經***本公司***批准：

(a) 提交***本公司***指定的表格以申請復效；
(b) 提供令***本公司***信納的***受保人***的可保性的證明；及
(c) 收訖所有欠繳的***標準保費***、***附加保費***(如有)及其他***欠繳***(如有)。.

3.4.2 ***本公司***將考慮按***本公司***的慣例及規定重訂***保單***日期以復效本***保單***，包括但不限於，就已複效本***保單***的可獲賠償的保障，把復效的生效日之前所有本***保單***的保障索償結轉入並被應用於***每年保障限額***、***終身保障限額***及/或***保障表***所列的任何賠償限額。

3.4.3 在符合有關復效而附加或隨附於本***保單***的任何條文的規定下，***保單持有人***擁有於本***保單***終止日期之前在本***保單***下既有的相同權利。

3.4.4 為免存疑，***本公司***毋須就以下情況支付任何保障 –
(a) 在本***保單***終止日期當日或之後至本***保單***復效的生效日之前遭遇的***受傷***；或
(b) 在本***保單***終止日期當日或之後至本***保單***復效的生效日之前首次已被確診、已出現症狀、已出現、或已需要醫療建議及/或治療及/或處方藥物的***不適***或***疾病***。

第四部分 保障條文

4.1 保障範圍

4.1.1 在符合本***保單***的條款及細則的規定下，***基本保單***的保障將按***合資格費用招致日***當日或其他應付費用招致當日適用的***病房類別***、***受保地區***、***自付費***及***保障表***所列明的任何賠償限額作出賠償。

4.1.2 在符合本***保單***的條款及細則的規定下，***自選保險保障***（如列明於***保單資料頁***）將按***合資格費用招致日***當日或其他應付費用招致當日適用的***受保地區***及***保障表***所列的任何賠償限額作出賠償。

4.1.3 為免存疑，當***受保人住院***，或***入住***註冊緩和治療中心、註冊善終服務中心或***康復中心***，但該次***住院***或***入住***被視為非***醫療所需***，則因該次***住院***或***入住***所招致的費用不會被視為***合資格費用***。不過，***保單持有人***仍有權就在該次***住院***或***入住***期間所接受的***日間手術***、***訂明診斷成像檢測***、***訂明非手術癌症治療***、門診腎透析、***意外急症***門診護理及***意外急症***牙齒治療招致的相關***合資格費用(***不包括該次***住院***或***入住)***提出索償。

4.1.4 保障地域範圍

(a) 除了***緊急治療***外，***基本保單***及***自選保險保障***（如適用）的保障只賠償***受保地區***內提供的***醫療服務***。***緊急治療***在本***保單***下則可在環球獲得保障。

(b) 在***合資格費用招致日***當日或其他應付費用招致當日，若***受保人***的***居住國家***為***美國***，就本***保單***的可獲賠償的保障，所有在***美國***招致的***合資格費用***及其他應付費用將降低至百分之六十（60%）。儘管有上述規定及為免存疑，***賠償表***所列的賠償限額及***自付費***將維持不變。

4.1.5 選擇醫療服務提供者

就非中國內地***醫院***所提供的***醫療服務***，**若**該***醫院***並**非三甲等級或以上或**並**非*指定中國內地醫院***，***本公司***不會賠償本***保單***的任何保障。

4.1.6 選擇病房級別

(a) 若***受保人***在***香港***或澳門***住院***，而***住院***的病房級別高於***病房類別***，***基本保單***的***合資格費用***及其他應付費用將受限於以下調整因子：

病房類別	***住院***病房級別	調整因子
半私家房	***標準私家房***	50%

(b) ***基本保單***不會就入住***醫院***的總統套房 / 貴賓房 / 豪華房的***住院***作出任何賠償。

4.2 計算應付保障金額

應付保障金額將按下列算式釐定，惟每個***保單年度***的賠償金額不可超出於***每年保障限額***：

應付保障金額	{***合資格費用***及其他應付費用 **減 (-)** (已根據另一保險計劃，獲其他人士或***我們***就同一***傷病***所招致的***合資格費用***及其他應付費用作出賠償；或本***保單***的***自付費***，以最高者為準)} **乘以 (x)** 按本***保單***第四部分第 4.1.4(b)節的調整因子（如適用） **乘以 (x)** 按本***保單***第四部分第4.1.6(a)節的調整因子（如適用）

4.3 保障項目

4.3.1 病房及膳食

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

4.3.2 雜項開支

本保障將賠償***受保人***在***醫院住院***期間，或***受保人***在接受任何***日間手術***當日，就以下雜項開支所收取的***合資格費用***–

(a) 往返***醫院***的救護車服務；
(b) 施行麻醉及提供氧氣；
(c) 輸血行政費；
(d) 敷料及石膏模；
(e) 在***住院***或***日間手術***期間服用的處方藥物；
(f) 在出院時或完成***日間手術***後處方，以供其後四（4）星期內使用的藥物；
(g) 除了本***保單***第四部分第4.3.6節所保障以外的額外手術用具、儀器及裝置，以及手術中使用的植入儀器或裝置、即棄用品及消耗品；
(h) 醫療用即棄用品、消耗品、儀器及裝置；
(i) 診斷成像服務，包括超聲波及X光，以及其分析，但不包括本***保單***第四部分第4.3.9節所列的***訂明診斷成像檢測***；
(j) 靜脈注射，包括注射液；
(k) 化驗及其報告，包括為***住院***期間的手術或***日間手術***所進行的病理學檢驗；
(l) ***住院病人***租用輔助步行器具及輪椅的費用；及
(m) ***住院***期間的物理治療。

4.3.3 主診醫生巡房費

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

4.3.4 專科醫生費

若***受保人***在***住院***期間，在主診***註冊醫生***的書面建議下接受***專科醫生***（並非本***保單***第四部分第4.3.3節所指的主診***註冊醫生***）的診治，本保障將賠償由該***專科醫生***就巡房或診症收取的***合資格費用***。

4.3.5 深切治療

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

為免存疑，可獲本保障賠償的***合資格費用***，不會再獲本***保單***第四部分第4.3.1節的賠償。

4.3.6 *外科醫生*費

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

4.3.7 *麻醉科醫生*費

在按本***保單***第四部分第4.4.6節***外科醫生***費可獲賠償的情況下，本保障將賠償***麻醉科醫生***就相關手術所收取的***合資格費用***。

4.3.8 手術室費

在按本***保單***第四部分第4.3.6節***外科醫生***費可獲賠償的情況下，本保障將賠償在手術期間就使用手術室（包括但不限於治療室及康復室）所收取的***合資格費用***。

為免存疑，就在手術室內使用及需個別收費的額外手術用具、儀器及裝置的***合資格費用***，則將按本***保單***第四部分第4.3.2節賠償。

4.3.9 訂明診斷成像檢測

本保障將賠償***受保人***在***住院***期間，或在為***日症病人***提供***醫療服務***的設備下，因檢查或治療***傷病***進行***訂明診斷成像檢測***所收取的***合資格費用***，有關檢測必須在主診***註冊醫生***的書面建議下進行。

4.3.10 訂明非手術癌症治療

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

為免存疑，有關***訂明診斷成像檢測***的***合資格費用***將按本***保單***第四部分第4.3.9節賠償。

4.3.11 精神科治療

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

本保障將取代本***保單***第四部分第4.3.1至4.3.10節的保障項目賠償。為免存疑，若***受保人***並非純粹為接受精神科治療***住院***，則本保障只會賠償就***住院***期間提供及與精神科治療相關的***醫療服務(***不包括該次***住院)***的***合資格費用***。在***合資格費用***同時涉及精神科治療與非精神科治療但未能明確分攤費用的情況下，如精神科治療為最初導致***住院***的原因，有關***合資格費用***會全數由本保障賠償；如精神科治療並非最初導致***住院***的原因，則有關***合資格費用***會全數由本***保單***第四部分第4.3.1至4.3.10節的保障項目賠償。

4.3.12 醫療裝置

若按本***保單***第四部分第4.3.1節病房及膳食可獲賠償的情況下，或按本***保單***第四部分第4.3.5節深切治療可獲賠償的情況下，本保障將賠償就於***住院***期間由***註冊醫生***進行的手術中或由***註冊醫生***進行的***日間手術***中，在***受保人***體內或表面放置以下醫療裝置所收取的***合資格費用***，惟該醫療裝置須為不可轉讓：

(a) 指定項目
   (i) 起搏器；
   (ii) 經皮冠狀動脈腔內成形術的支架；
   (iii) 基本或單焦距眼內人工晶體；
   (iv) 人工心瓣；
   (v) 金屬或人工關節置換；
   (vi) 人工韌帶置換或植入；及
   (vii) 人工椎間盤。

(b) 其他項目
   上述指定項目以外的醫療裝置。

為免存疑，就在***受保人***體內或表面放置上述醫療裝置所收取的***合資格費用***只可獲本保障賠償。

4.3.13 入院前或*日間手術*前的門診護理

本保障將賠償就***受保人***在***住院***前或***日間手術***前所需的在***註冊醫生***診所接受的門診及 / 或***急症***診症（包括診症、處方***西藥***或診斷檢測）所收取的***合資格費用***。有關門診及 / 或***急症***診症必須在***保障表***列明的***住院***前或***日間手術***前的訂明期間內進行。

為免存疑，有關***訂明診斷成像檢測***的***合資格費用***將按本***保單***第四部分第 4.3.9 節賠償。

4.3.14 出院後或*日間手術*後的門診護理

本保障將賠償就***受保人***在出院後或完成***日間手術***後在診所接受由主診***註冊醫生***提供或書面建議的跟進門診（包括診症、處方***西藥***或診斷檢測）所收取的***合資格費用***。有關跟進門診必須在***保障表***列明的出院後或完成***日間手術***後的訂明期間內進行，並與需要***住院***或進行***日間手術***的病況（包括其任何及所有併發症）直接有關。

為免存疑，有關***訂明診斷成像檢測***及***訂明非手術癌症治療***將分別按本***保單***第四部分第 4.3.9 及 4.3.10 節賠償。

4.3.15 出院後或*日間手術*後的輔助治療

本保障將賠償就***受保人***在出院後或完成***日間手術***後由***註冊物理治療師***、***香港註冊心理學家***、***註冊職業治療師***、***註冊言語治療師***或***註冊脊醫***提供門診所收取的***合資格費用***。有關門診必須在***保障表***列明的出院後或完成***日間手術***後的訂明期間內進行，並且 –

(a) 與需要***住院***或進行***日間手術***的病況（包括其任何及所有併發症）直接有關；
(b) 由主診***註冊醫生***書面建議；及
(c) 若於同一日進行多於一(1)次的物理治療、心理學家治療、職業治療、言語治療或脊醫診症，此保障將只賠償一(1)次治療或診症；

為免存疑，由***註冊物理治療師***、***香港註冊心理學家***、***註冊職業治療師***、***註冊言語治療師***或***註冊脊醫***提供門診所收取的合資格費用只會在本保障下獲得賠償。

4.3.16 傳統中醫藥物治療

本保障將賠償在下列情況下***註冊中醫師***提供傳統中醫藥物治療(包括診症及處方基本***中藥***)所收取的***合資格費用***-
(a) ***受保人***在***住院***期間由***醫院***提供傳統中醫藥物治療；*及*
(b) ***受保人***在***保障表***列明的出院後或完成***日間手術***後的訂明期間內進行傳統中醫藥物治療，作為***受保人***的復康治療的一部分，
惟有關傳統中醫藥物治療與需要***住院***或進行***日間手術***的病況（包括其任何及所有併發症）直接有關。

當本保障的***合資格費用***同時可於本***保單***第四部分的其他保障下獲得賠償，有關***合資格費用***將按下列順序獲得賠償：
(a) 本保障；
(b) 本***保單***第四部分第4.3.33 (a)節的三大***危疾***輔助治療保障。

4.3.17 出院後家中看護

本保障將賠償***受保人***緊接出院後接受由***護士***或***香港保健員***提供的家中看護服務所收取的***合資格費用***；惟有關家中看護服務必須由主診***註冊醫生***書面建議，並且必須與需要***住院***的病況（包括其任何及所有併發症）直接相關。

本保障只限每日，不論任何時段，最多一（1）位***護士***或***香港保健員***提供家中看護服務。為免存疑，不論
(a) 該日之家中看護服務是全日或部分時間提供；及
(b) 同日有多少個時段，

該日會被算作一(1)日，以計算***保障表***列明的每個***保單年度***中本保障的最高可賠償日數。

4.3.18 私家看護費

本保障將賠償***受保人***在***住院***期間接受由***護士***提供的私家看護服務(除了***醫院***提供的一般護理服務以外)所收取的***合資格費用***；惟有關護理服務必須由主診***註冊醫生***書面建議，並且必須與需要***住院***的病況（包括其任何及所有併發症）直接相關。

本保障只限每日，不論任何時段，最多一（1）位***護士***提供私家看護服務。為免存疑，不論

(a) 該日之私家看護服務是全日或部分時間提供；及

(b) 同日有多少個時段，

該日會被算作一(1)日，以計算***保障表***列明的每個***保單年度***中本保障的最高可賠償日數。

4.3.19 門診腎透析

本保障將賠償***受保人***在為***日症病人***提供***醫療服務***的設備下，接受慢性和不可復原之腎功能衰竭治療(包括腹膜透析及血液透析)所收取的***合資格費用***。

4.3.20 陪伴床位費

若本***保單***第四部分第 4.3.1 節病房及膳食可獲賠償的情況下，或按本***保單***第四部分第 4.3.5 節深切治療可獲賠償的情況下，本保障將賠償就***受保人***在***住院***期間，在***醫院***陪伴***受保人***的一（1）位人士的一（1）個額外床位，由***醫院***所收取的費用。惟***受保人***在有關費用招致當日必須為 18 歲以下，本保障方可獲得賠償。

為免存疑，本保障不賠償就膳食收取的任何費用。

4.3.21 入住***香港***政府***醫院***公眾病房之***住院***現金

若按本***保單***第四部分第4.3.1節病房及膳食可獲賠償的情況下，本保障將就***受保人***入住***香港***政府***醫院***公眾病房期間的每日***住院***（每連續二十四（24）小時的***住院***）支付賠償。惟***住院***期間所招致的***合資格費用***不可高於***香港***醫院管理局不時訂明的符合資格人士公眾收費。

為免存疑，本保障的賠償不受***自付費***所規限。

4.3.22 入住*香港*私家*醫院*較低級別病房之*住院*現金

若按本***保單***第四部分第4.3.1節病房及膳食可獲賠償的情況下，本保障將就***受保人***入住***香港***私家***醫院***級別低於***病房類別***的病房（如下所述）期間的每日***住院***（每連續二十四（24）小時的***住院***）支付賠償。

病房類別	住院病房級別
半私家房	普通病房
標準私家房	***半私家房***或普通病房

為免存疑，本保障的賠償不受***自付費***所規限。

4.3.23 網絡醫生進行的*指定日間手術*之現金保障

若按本***保單***第四部分第4.3.6節***外科醫生***費可獲賠償的情況下，就由***網絡註冊醫生***或***網絡專科醫生***在為***日症病人***提供***醫療服務***的設備下為***受保人***進行的每個***指定日間手術***，本保障將支付賠償。若於同一(1)日進行多於一次的***指定日間手術***，此保障將只賠償一(1)次***指定日間手術***。

就本條款而言，「***網絡註冊醫生***」或「***網絡專科醫生***」指在***網絡註冊醫生***及***網絡專科醫生***名單上的***註冊醫生***或***專科醫生***，而***本公司***有酌情權對此名單不時作出更新、變更及修改，不論有否另外發出通知，有關更改將由發佈日起生效。

為免存疑，本保障的賠償不受***自付費***所規限。

4.3.24 *意外急症*門診護理

本保障將賠償***受保人***因***受傷***，在***保障表***所列明的期間內於***醫院***門診部就該***受傷***接受***急症治療***所收取的***合資格費用***。

當本保障的***合資格費用***同時可於本***保單***第四部分的**其他保障**下獲得賠償，有關***合資格費用***將按下列順序獲得賠償：

(a) 本***保單***第四部分第4.3.13節**的入院前或*日間手術*前的門診護理**；

(b) 本保障。

4.3.25 *意外急症*牙齒治療

本保障將賠償***受保人***在***保障表***所列明的期間內，因其健康天生牙齒***受傷***，在合法註冊牙科診所或***醫院***接受必須的***急症治療***（包括診症、止血、脫牙、齒根管治療及 X 光），由***註冊牙醫***、***註冊醫生***或***醫院***為此所收取的***合資格費用***。

本保障不會賠償牙齒矯正治療，以及任何貴金屬、牙橋、牙冠、假牙及植牙的使用。

當本保障的***合資格費用***同時可於本***保單***第四部分的其他保障下獲得賠償，有關***合資格費用***將按下列順序獲得賠償：

(a) 本***保單***第四部分第4.3.13節的入院前或***日間手術***前的門診護理；

(b) 本保障。

4.3.26 人體免疫力缺乏病毒 / 愛滋病治療

本保障將賠償***受保人***在***住院***期間接受由主診***註冊醫生***書面建議的人體免疫力缺乏病毒感染相關之***疾病***（包括愛滋病）之治療的***合資格費用***，惟該***住院***的主要目的必須為接受人體免疫力缺乏病毒 / 愛滋病治療，並且該***疾病***的徵狀或病徵在***人體免疫力缺乏病毒／愛滋病治療等候期***完結後首次出現。

若該人體免疫力缺乏病毒感染相關之***疾病***（包括愛滋病）是因性侵犯、醫療援助、器官移植、輸血或捐血、或出生時受 感染所引致，本保障則不受***人體免疫力缺乏病毒／愛滋病治療等候期***所規限。

4.3.27 乳房重建手術保障

若***受保人***患上***不適***或***疾病***並進行***醫療所需***乳房切除術，本保障將賠償***受保人***在***住院***期間或在為***日症病人***提供***醫療服務***的設備下進行，由主診***註冊醫生***書面建議的乳房重建手術所收取的***合資格費用***，包括與乳房重建手術有關的***外科醫生***費，***麻醉科醫生***費及手術室費；惟有關乳房重建手術必須在乳房切除術進行日後的十二（12）個***日曆月***內進行。

4.3.28 妊娠併發症

若***受保人***確診以下列明的受保妊娠併發症，在符合***妊娠併發症等候期***的規定下並在主診***註冊醫生***的書面建議下，本保障將按本***保單***第四部分第4.3.1至4.3.10節的保障項目賠償***受保人***在***住院***期間或在為***日症病人***提供***醫療服務***的設備下接受有關受保妊娠併發症之治療所收取的***合資格費用***。

受保妊娠併發症僅限於異位妊娠、葡萄胎妊娠、播散性血管內之凝血機制障礙、先兆子癇、流產、先兆流產、醫學需要之人工流產、胎兒夭折、因產後出血切除子宮、子癇、羊水栓塞及妊娠肺栓塞。

4.3.29 器官移植保障

若***受保人***在主診***註冊醫生***的書面建議下，於***醫院***接受經過法律認可和驗證的器官捐贈來源的心臟、腎臟、肝臟、肺、胰臟或骨髓移植，本保障將賠償：

(a) 就本***保單***第四部分第4.3.1至4.3.8節及第4.3.20節的保障項目所收取的***合資格費用***；及

(b) 就捐贈者進行切除器官或抽取骨髓的手術，由***外科醫生***及***麻醉科醫生***收取的及使用手術室的***合資格費用***。

為免存疑，本保障並不賠償任何取得及運送器官或骨髓之費用。

本***保單***第四部分第 4.3.29 (b)節的受保捐贈者醫療費用，將會根據任何其他保險或從任何其他來源支付給捐贈者的費用而減少。

4.3.30 康復治療保障

若按本***保單***第四部分第4.3.1節病房及膳食因***住院***可獲賠償的情況下，本保障將賠償***受保人***在主診***註冊醫生***的書面建議下，在***保障表***列明的出院後的訂明期間內***入住康復中心***並在***入住***期間進行康復治療所收取的***合資格費用***。

當本保障的***合資格費用***同時可於本***保單***第四部分的其他保障下獲得賠償，有關***合資格費用***將按下列順序獲得賠償：

(a) 本保障；
(b) 本***保單***第四部分第4.3.15節的出院後或***日間手術***後的輔助治療；
(c) 本***保單***第四部分第4.3.33 (a)節的三大***危疾***輔助治療保障。

4.3.31 善終服務保障

在符合***善終服務保障等候期***的規定下，並須受以下條款所限：

(a) ***受保人***確診***末期疾病***；
(b) 因與該***末期疾病***直接有關的***傷病***，按本***保單***第四部分第4.4.1節病房及膳食可獲賠償；
(c) ***受保人入住***註冊緩和治療中心或註冊善終服務中心；及
(d) 該註冊緩和治療中心或註冊善終服務中心的***入住***由主診***註冊醫生***書面建議。

本保障將賠償由該註冊緩和治療中心或註冊善終服務中心為***受保人***提供的住宿、照顧及護理服務所收取的***合資格費用***及其他費用。

就本條款而言，「***末期疾病***」指***受保人***無可置疑地確診為極可能在十二（12）個***日曆月***內身故的***不適***或***疾病***。

4.3.32 意外身故保障

在***保單***生效期間，若***受保人***因***意外受傷***而該***受傷***導致***受保人***身亡，本保障將按***保障表***列明的金額向***受益人***作出賠償。

為免存疑，本保障的賠償不受***自付費***所規限。

4.3.33 三大*危疾*保障

以下保障將就在***三大危疾保障等候期***完結後首次確診的***癌症***、***中風***或***心臟病***的其中之一作出賠償。

(a) 三大***危疾***輔助治療保障

本保障將賠償在***保障表***列明的期間內就以下項目所收取的***合資格費用***：

(i) 由***註冊營養師***提供門診；
(ii) 由***註冊中醫師***提供門診(包括診症及處方基本***中藥***)；及
(iii) 由***註冊中醫師***提供門診針灸治療，

惟 -

(i) 有關門診須與在***三大危疾保障等候期***完結後首次確診的***癌症***、***中風***或***心臟病***的其中之一直接有關；
(ii) 有關門診由主診***註冊醫生***書面建議；及
(iii) 若於同一日進行多於一(1)次的***註冊營養師***門診或***註冊中醫師***門診，此保障將只賠償一(1)次門診。

當本保障的***合資格費用***同時可於本***保單***第四部分的其他保障下獲得賠償，有關***合資格費用***將按下列順序獲得賠償：

(i) 本***保單***第四部分第4.3.16節的傳統中醫藥物治療；

(ii) 本保障。

(b) 三大***危疾***保費豁免保障

在***三大危疾保障等候期***完結後首次確診***癌症***、***中風***或***心臟病***的其中之一，在確診後緊接的***日曆月***中與***保單生效日***相同的那一日起計，在按***保障表***列明的期間內，***基本保單***及***自選保險保障***（如適用）的應繳付***標準保費***及***附加保費***（如有）將獲豁免；惟本***保單***必須在有關期間維持有效。

在豁免繳付***標準保費***及***附加保費***（如有）的期間，***保單持有人***不能對本***保單***作出任何更改（包括***病房類別***、***受保地區***、***自選保險保障***、***自付費***及／或保費繳款形式），否則***本公司***將在有關更改的生效日起計停止豁免保費。

為免存疑，本保障的賠償不受***自付費***所規限。

(c) ***中風***後提升家居設備保障

在***三大危疾保障等候期***完結後首次確診***中風***後，本保障將賠償由***註冊職業治療師***書面建議為協助***受保人***的日常生活而提升家居設備所需要的費用；惟有關家居設備提升須在***保障表***列明的***中風***確診日期後的訂明期間內完成。

家居設備提升包括但不限於以下項目–

(i) 調整浴室設施(例如加高座廁、於廁所水箱安裝靠背、安裝水平淋浴、安裝浴缸坐板及於適當高度安裝洗手盆);

(ii) 安裝室內樓梯升降機或升降機;

(iii) 安裝扶手欄杆作支撐;

(iv) 安裝斜台以避免使用梯級;

(v) 於地面樓層設置浴室或睡房設施;

(vi) 移動電燈開關、門把手、門鐘及應門對講機至可觸及的高度;

(vii) 添置專用的傢俱，例如可調床或支撐椅;

(viii) 安裝警報設備; 及

(ix) 加寬門口和走廊。

4.3.34 無索償保費折扣

在本***保單***在有關期間維持有效並在符合本***保單***的條款及細則的規定下，若***本保單***已連續生效兩(2)個或以上***保單年度***，而在緊接***續保日***前連續兩(2)個或以上***保單年度***內***基本保單***下並沒有任何已支付索償，***保單持有人***在***續保***時可享無索償保費折扣，該無索償保費折扣將按以下折扣率應用於***基本保單***的***標準保費***：

緊接***續保日***前的無索償時期	應用於***基本保單***的***標準保費***的無索償保費折扣率
連續2個***保單年度***或以上	5%

在***保單持有人***已接受無索償保費折扣後，若***本公司***就***續保日***前引致的***基本保單***下的索償在該***續保日***後支付索償，***保單持有人***須按***本公司***要求立即退還已接受的無索償保費折扣金額。

為免存疑，本保障的賠償不受***自付費***所規限。

4.3.35 *自選門診保障*(如適用)

(a) ***普通科醫生***診症

本保障將賠償由***普通科醫生***就門診診症及處方基本***西藥***所收取的***合資格費用***，惟：

(i) 若於同一日進行多於一(1)次的***普通科醫生***診症，此保障將只賠償一(1)次診症；及
(ii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (a)節可獲賠償的***普通科醫生***診症、按本***保單***第四部分第4.3.35 (c)節可獲賠償的在家診症、按本***保單***第四部分第4.3.35 (f)節可獲賠償的***註冊中醫師***診症、按本***保單***第四部分第4.3.35 (g)節可獲賠償的跌打，或按本***保單***第四部分第4.3.35 (h)節可獲賠償的針灸，此保障將只賠償一(1)次診症或治療。

(b) ***專科醫生***診症

本保障將賠償由***專科醫生***就門診診症及處方基本***西藥***所收取的***合資格費用***，惟：

(i) 有關診症須由主診***註冊醫生***書面建議(兒科、婦科、眼科、皮膚科及骨科醫生診症除外)；
(ii) 若於同一日進行多於一(1)次的***專科醫生***診症，此保障將只賠償一(1)次診症；及
(iii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (b)節可獲賠償的***專科醫生***診症、按本***保單***第四部分第4.3.35 (d)節可獲賠償的物理治療，或按本***保單***第四部分第4.3.35 (e)節可獲賠償的脊醫診症，此保障將只賠償一(1)次診症或治療。

(c) 在家診症

本保障將賠償由***普通科醫生***在***受保人***家中提供在家診症及處方基本***西藥***所收取的***合資格費用***，惟：

(i) 若於同一日進行多於一(1)次的在家診症，此保障將只賠償一(1)次診症；及
(ii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (a)節可獲賠償的***普通科醫生***診症、按本***保單***第四部分第4.3.35 (c)節可獲賠償的在家診症、按本***保單***第四部分第4.3.35 (f)節可獲賠償的***註冊中醫師***診症、按本***保單***第四部分第4.3.35 (g)節可獲賠償的跌打治療，或按本***保單***第四部分第4.3.35 (h)節可獲賠償的針灸治療，此保障將只賠償一(1)次診症或治療。

(d) 物理治療

本保障將賠償由***註冊物理治療師***就門診診症所收取的***合資格費用***，惟：

(i) 有關診症須由主診***註冊醫生***書面建議；
(ii) 若於同一日進行多於一(1)次的物理治療，此保障將只賠償一(1)次治療；及
(iii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (b)節可獲賠償的***專科醫生***診症、按本***保單***第四部分第4.3.35 (d)節可獲賠償的物理治療，或按本***保單***第四部分第4.3.35 (e)節可獲賠償的脊醫診症，此保障將只賠償一(1)次診症或治療。

(e) 脊醫診症

本保障將賠償由***註冊脊醫***就門診診症所收取的***合資格費用***，惟：

(i) 有關診症須由主診***註冊醫生***書面建議；
(ii) 若於同一日進行多於一(1)次的脊醫診症，此保障將只賠償一(1)次診症；及
(iii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (b)節可獲賠償的***專科醫生***診症、按本***保單***第四部分第4.3.35 (d)節可獲賠償的物理治療，或按本***保單***第四部分第4.3.35 (e)節可獲賠償的脊醫診症，此保障將只賠償一(1)次診症或治療。

(f) ***註冊中醫師***診症

本保障將賠償由***註冊中醫師***就門診診症及處方基本***中藥***所收取的***合資格費用***，惟：

(i) 若於同一日進行多於一(1)次的診症，此保障將只賠償一(1)次診症；及

(ii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (a)節可獲賠償的***普通科醫生***診症、按本***保單***第四部分第4.3.35 (c)節可獲賠償的在家診症、按本***保單***第四部分第4.3.35 (f)節可獲賠償的***註冊中醫師***診症、按本***保單***第四部分第4.3.35 (g)節可獲賠償的跌打治療，或按本***保單***第四部分第4.3.35 (h)節可獲賠償的針灸治療，此保障將只賠償一(1)次診症或治療。

(g) 跌打

本保障將賠償由***註冊中醫師***為***受保人***提供門診跌打治療所收取的***合資格費用***，惟：

(i) 若於同一日進行多於一(1)次的跌打治療，此保障將只賠償一(1)次治療；及
(ii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (a)節可獲賠償的***普通科醫生***診症、按本***保單***第四部分第4.3.35 (c)節可獲賠償的在家診症、按本***保單***第四部分第4.3.35 (f)節可獲賠償的***註冊中醫師***診症、按本***保單***第四部分第4.3.35 (g)節可獲賠償的跌打治療，或按本***保單***第四部分第4.3.35 (h)節可獲賠償的針灸治療，此保障將只賠償一(1)次診症或治療。

(h) 針灸

本保障將賠償由***註冊中醫師***為***受保人***提供門診針灸治療所收取的***合資格費用***，惟：

(i) 若於同一日進行多於一(1)次的針灸治療，此保障將只賠償一(1)次治療；及
(ii) 若於同一日進行多於一(1)次按本***保單***第四部分第4.3.35 (a)節可獲賠償的***普通科醫生***診症、按本***保單***第四部分第4.3.35 (c)節可獲賠償的在家診症、按本***保單***第四部分第4.3.35 (f)節可獲賠償的***註冊中醫師***診症、按本***保單***第四部分第4.3.35 (g)節可獲賠償的跌打治療，或按本***保單***第四部分第4.3.35 (h)節可獲賠償的針灸治療，此保障將只賠償一(1)次診症或治療。

(i) 精神病門診診症或心理異常門診診症

本保障將賠償由***香港註冊心理學家***或由提供精神病或心理異常的治療的***專科醫生***為***受保人***提供門診診症所收取的***合資格費用***，惟：

(i) 有關診症須由主診***註冊醫生***書面建議；及
(ii) 若於同一日進行多於一(1)次的精神病診症或心理異常診症，此保障將只賠償一(1)次診症。

(j) 營養輔導 、 言語治療 或 職業治療

本保障將賠償由***註冊營養師***，***註冊言語治療師***或***註冊職業治療師***就門診診症所收取的***合資格費用***，惟：

(i) 有關診症須由主診***註冊醫生***書面建議；及
(ii) 若於同一日進行多於一(1)次的營養輔導 、言語治療或職業治療，此保障將只賠償一(1)次診症或治療。

(k) 醫生處方***西藥***

本保障將賠償為***受保人***處方的***西藥***所收取的***合資格費用***，惟：

(i) 索償時必須提交***註冊醫生***的書面處方，及
(ii) 處方***西藥***必須從合法來源取得，包括在***香港***或其他司法管轄區法律下的持牌或註冊的藥房、藥店、診所或***醫院***。

(l) 診斷影像及化驗

本保障將賠償就門診診斷影像及化驗所收取的***合資格費用***，惟：

(i) 該診斷影像及化驗須由主診***註冊醫生***書面建議；及
(ii) 該診斷影像及化驗須符合***受保人***的徵狀及診斷。

(m) 防疫注射

本保障將賠償***受保人***接受防疫注射的費用。

4.3.36 ***自選牙科保障*** **(如適用)**

本保障將賠償***受保人***在合法註冊牙科診所接受牙科治療由***註冊牙醫***收取的***合資格費用***，包括 -

(a) 補牙，包括齒科汞合金補牙、複合樹脂補牙、陶瓷補牙及玻璃離子體補牙（臼齒與臼齒前的牙）；
(b) 活動假牙、牙冠及牙橋（只適用於因***意外***而導致必需）;
(c) 膿瘡排放;
(d) 脫牙;
(e) X光;
(f) 齒根管的填補；
(g) 例行口腔檢查；及
(h) 洗牙（每六（6）個***日曆月***一次）。

4.3.37 ***自選藥物保障*** **(如適用)**

(a) 本保障將賠償就用於治療受保人並由***註冊醫生***處方的***西藥***，由在***香港***或其他司法管轄區法律下的持牌或註冊的藥房、藥店、診所或***醫院***所收取的***合資格費用***，惟 -

(i) ***受保人***患上本***保單***第五部分第5.1節下的任何危疾（***心臟病***除外）；
(ii) 該***危疾***的首次確診，包括任何發生、已被確診、或已出現症狀而導致需要醫療建議、治療及 / 或處方藥物，須在***自選藥物保障等候期***完結後發生；
(iii) ***受保人***在該***危疾***的首次確診後存活只少三十（30）日。

(b) 若***受保人***在***保單生效日***當日的***年齡***為十六（16）歲或以上，本保障將就以下***危疾***的首次確診作出賠償：

• ***亞爾茲默氏病 / 痴呆***	• ***喪失語言能力***
• ***肌萎縮性脊髓側索硬化***	• ***嚴重燒傷***
• ***再生障礙性貧血***	• ***主要器官移植***
• ***細菌性腦膜炎***	• ***結核性腦膜炎***
• ***良性腦腫瘤***	• ***腎髓質囊腫病***
• ***失明***	• ***多發性硬化症***
• ***腦部外科手術***	• ***肌營養不良症***
• ***癌症***	• ***心肌梗塞***
• ***原位癌***	• ***壞死性筋膜炎***
• ***心肌病***	• ***因職業感染人體免疫力缺乏病毒(HIV)***
• ***復發性慢性胰臟炎***	• ***柏金遜症***
• ***昏迷***	• ***脊髓灰質炎***
• ***冠狀動脈成形手術***	• ***原發性側索硬化症***
• ***冠狀動脈搭橋手術***	• ***原發性肺動脈高血壓***
• ***克雅氏症***	• ***惡化性延髓性麻痺***
• ***克隆氏症***	• ***進行性肌肉萎縮症***
• ***伊波拉***	• ***進行性核上神經麻痺症***
• ***象皮病***	• ***類風濕性關節炎（成人）***
• ***腦炎***	• ***嚴重腦部創傷***

• *末期肺病* • *暴發性肝炎* • *心瓣膜手術* • *因輸血而感染愛滋病* • *腎功能衰竭* • *肝功能衰竭* • *失聰* • *斷肢*	• *嚴重重症肌無力* • *嚴重潰瘍性結腸炎* • *脊髓肌肉萎縮症* • *中風* • *主動脈手術* • *末期疾病* • *完全及永久傷殘* • *植物人狀態*

(c) 若***受保人***在***保單生效日***當日的***年齡***為十六（16）歲以下，本保障將就以下危疾的首次確診作出賠償，直至以下所列明的***年齡***上限（如有）：

直至***年齡***為十六（16）歲可獲賠償的***危疾***	不設***年齡***上限的可獲賠償的***危疾***
• *手足口病伴有嚴重（威脅生命的）併發症* • *胰島素依賴型糖尿病* • *川崎綜合症並有心臟併發症* • *風濕性心瓣疾病* • *嚴重哮喘* • *嚴重腦癇*	• *癌症* • *昏迷* • *冠狀動脈搭橋手術* • *腎功能衰竭* • *肝功能衰竭* • *嚴重燒傷* • *主要器官移植* • *心肌梗塞* • *脊髓灰質炎* • *中風*

(d) 為免存疑，就原位癌及冠狀動脈成形手術應付的***自選藥物保障***，應限制為***保障表***內的自選藥物保障所適用之每年賠償限額及終生賠償限額的百分之二十(20%)為限。

(e) 本保障所保障的***西藥***必須是：
  (i) 由***註冊醫生***以書面形式處方及於六(6)個***日曆月***內所配的藥物；
  (ii) 為了直接治療或管理***受保人***的***危疾***，但不包括即使有***註冊醫生***處方以作護理及治療***受保人***的***危疾***之用的膳食補充劑、為美容目的的醫療用品或藥物；
  (iii) 從在***香港***或其他司法管轄區法律下的持牌或註冊的藥房、藥店、診所或***醫院***購買；
  (iv) 除非受藥品生產包裝所限，否則每張處方單或補充應限制為最多連續六十(60)日份量的藥物；及
  (v) 若處方提供一定日子份量的藥物，其後的補充只能跟隨之前的處方購買相同日數的藥物。

(f) 當***保障表***內的***自選藥物保障***所適用之終生賠償限額耗盡後，本***自選藥物保障***將在緊接其後的首個***周年日***自動終止。***本公司***保留權利收取計算至本***自選藥物保障單***終止日的***標準保費***及***附加保費***(如有)。

4.4 重複保單

4.4.1 任何***受保人***最多只可享有一（1）份由***本公司***簽發的***信諾指定計劃***保單的保障。如***受保人***因任何原因受保於多於一份***信諾指定計劃***保單，該***受保人***將會被視為受保於下列其中一份保單：

(a) 提供最高的保障金額的基本保單；或
(b) 若各保單的基本保單下的保障金額相同，則首先簽發的保單。

4.4.2 除了按本***保單***第四部分第4.4.1節被視為有效承保***受保人***的該一（1）份***信諾指定計劃***保單以外，該***受保人***的任何其他由***本公司***簽發的***信諾指定計劃***保單均被視為由有關保單的生效日起無效(「廢除保單」)。

4.4.3 ***你***須立即將就***廢除保單***將已支付的賠償及任何***欠款***退還予***我們***。當***我們***收回所有該等退還款項後，***我們***會退回就***廢除保單***已繳交的保費及保險徵費。或***我們***有權從就***廢除保單***已繳交的保費中扣除***我們***已支付的賠償及任何***欠款***以抵銷***我們***應退回的款項，並退回就***廢除保單***已繳交的餘下保費（如有）及保險徵費。

第五部分 危疾定義

5.1 「***亞爾茲默氏病 / 痴呆***」由於大腦功能有無法治愈的總衰竭而出現智力衰退或喪失，並根據臨床證據及按亞爾茲默氏病及痴呆之標準檢驗確診。此症必須顯示有明顯的認知障礙及由神經科顧問醫生確診。所有由於酗酒，藥物濫用或感染愛滋病而導致的痴呆不在此保障範圍內。

5.2 「***肌萎縮性脊髓側索硬化***」經神經科顧問醫生根據適當和相關的神經科症狀的明確證據，而作出無可置疑之診斷為肌萎縮性脊髓側索硬化。

5.3 「***再生障礙性貧血***」骨髓功能持續性衰竭而導致貧血、嗜中性白血球減少及血小板減少之出現，須接受下列最少一(1)項的治療：

(a) 輸血；
(b) 免疫系統抑性藥物；或
(c) 骨髓移植。

5.4 「***細菌性腦膜炎***」因細菌性腦膜炎引致腦膜或脊髓膜發炎而出現永久性神經系統缺陷連續長達六(6)個***日曆月***或以上。此神經系統的缺陷須經神經科專科醫生確認。

5.5 「***良性腦腫瘤***」指非惡性腦腫瘤，且必須接受手術切除或已造成嚴重及永久性的神經缺陷連續超過六(6)個***日曆月***以上。為免存疑，以下之腫瘤並不符合良性腦腫瘤的定義，不在本保障範圍之內：

(a) 腦動脈或靜脈的囊腫、肉芽腫、畸形；及
(b) 腦垂體或脊髓的血腫及腫瘤。

5.6 「***失明***」因創傷性***受傷***或***疾病***所致雙眼視力不可恢復的完全喪失。需經眼科***專科醫生***臨床確診。倘已有任何療法恢復視力，則是項保險並不適用。

5.7 「***腦部外科手術***」在全身麻醉下確實進行腦部顱骨切開手術，包括鎖孔外科手術，但因***意外***而需要進行的腦部外科手術除外。有關手術必須獲***專科醫生***認為是必要的。

5.8 「***癌症***」惡性腫瘤，並須有惡性細胞不受控制地生長和擴散以及侵略其他正常細胞組織的特徵。***癌症***應在病理報告中經組織學確診。

癌症包括白血病，並不包括下列任何一項：

(a) 任何界定為癌前病變，非侵入性病變，原位癌，Ta 期腫瘤或子宮頸上皮內贅瘤（CIN-1、CIN-2 和 CIN-3）；
(b) AJCC 1 期的任何非黑色素瘤皮膚癌或惡性黑色素瘤；
(c) TNM 組織學分級在 T1N0M0（或其他分級方法中同等或更低分級）的甲狀腺乳頭狀癌；
(d) TNM 組織學分級在 T1a、T1b 和 T1c（或其他分級方法中同等或更低分級）的前列腺癌；
(e) RAI 級別 II 或以下的慢性淋巴性白血病；或
(f) 任何存在人體免疫力缺乏病毒（HIV）的腫瘤。

5.9 「***原位癌***」原位癌是一組局部自行生長的惡性細胞群，而該細胞群並未侵襲正常組織。侵襲是指透過細胞基底膜對正常組織進行滲透及 / 或活性的破壞。原位癌診斷必須以組織病理學報告來支持。

就本***保單***而言，原位癌僅限於下列八(8)種器官：

(a) 子宮頸(必須是不低於CIN-3的級別，及以陰道鏡下活檢和宮頸椎切術後活組織病理檢查確診。單憑臨床診斷將不符合本準則。)；
(b) 子宮；
(c) 乳房；
(d) 陰道；
(e) 輸卵管；
(f) 卵巢 (在卵巢原位癌中，腫瘤的細胞囊完好，在卵巢表面沒有腫瘤，級別為T1aN0M0、T1bN0M0(TNM分級標準)或FIGO1A、FIGO1B(國際婦產科聯合會標準))；
(g) 睪丸；及

(h) 前列腺之初期癌症 列腺前列腺癌，TNM分級標準級別為T1a、T1b、T1c或其他分級標準相當的級別。前列腺上皮內瘤形成(PIN)並不在保障範圍之內。診斷必須以組織病理學報告證實。

原位癌診斷必須以陽性顯微鏡組織檢查結果證實和以活組織結果作確診。單憑臨床診斷將不符合本準則。

5.10 「***心肌病***」因各種病因而出現的心室功能障礙而使其出現嚴重的身體損害（紐約心臟病協會分類標準心臟損害最少達第四級）。

此症必須由心臟***專科醫生***確診。本保障範圍內的心肌病包括擴張型心肌病、肥大型心肌病及限制型心肌病。繼發於酒精濫用性的心肌病不在此保障範圍之內。

紐約心臟病協會分類標準心臟損害第四級是一種心臟衰竭的級別，意指儘管病人已進行了藥物治療及飲食調節，但其在日常活動中仍出現症狀，並且體檢及實驗檢查顯示有心室功能異常的證明。

5.11 「***復發性慢性胰臟炎***」重複的急性間質性胰臟炎而引致進行性的胰臟損壞。此症必須由***專科醫生***確診，並附有臨牀證據及現代顯像科技證明。

5.12 「***昏迷***」是指一種失去知覺的狀態，對外來刺激或內部組織的需求皆無反應達最少連續六(6)個***日曆月***以上，並須持續利用生命維持系統最少連續六(6)個***日曆月***以上，並必須有永久性的神經機能缺損；而此缺損必須經***註冊醫生***及／或***專科醫生***確認為永久性的。

5.13 「***冠狀動脈成形手術***」因一(1)條或以上的冠狀動脈狹窄或阻塞而接受心導管球囊擴張術，經皮腔冠狀動脈成形術或類似的動脈內導管手術的首次療程。此血管成形術必須為心臟科顧問醫生確認為***醫療所需***的，及須提供冠狀動脈造影證明，證明有嚴重的冠狀動脈*疾病*。

5.14 「***冠狀動脈搭橋手術***」為糾正狹窄或阻塞的兩(2)條或以上冠狀動脈，用隱靜脈或內乳動脈嫁接，從而進行的開胸手術。必須提供冠狀動脈造影報告顯示冠狀動脈病。為免存疑，心導管球囊擴張術及鐳射技術等非開胸手術不符合冠狀動脈搭橋手」的定義，不在本保障範圍之內。

5.15 「***克雅氏症***」此症為一種神經病及通常可以致命的海綿狀腦病，須有小腦功能障礙，嚴重進行性痴呆，肌肉不自主痙攣，顫抖及手足徐動等病徵及症狀。有關診斷必須由神經科***專科醫生***確診並附有影像證明。

5.16 「***克隆氏病***」克隆氏病是一種慢性肉芽腫炎症性腸道***疾病***。***疾病***診斷必須有典型組織病理學證據確認。
疾病必須已經造成至少一(1)項以下腸道併發症。
(a) 瘻管形成(不包括肛瘻)；
(b) 腸梗阻；及
(c) 腸穿孔(並非由治療引致)。

5.17 「***伊波拉***」符合下列條件之伊波拉病毒感染：
(a) 經實驗室化驗證明伊波拉病毒之存在；
(b) 由出現症狀起超過三十(30)日持續出現感染的併發症；及
(c) 感染並不導致死亡。

5.18 「***象皮病***」末期絲蟲病,其特徵為身體受感染部位(腿部、生殖器官或乳房)因淋巴管受絲蟲堵塞而嚴重發大或損毀。永久性淋巴堵塞必須由***專科醫生***診斷,以及循環性絲蟲病原或微絲蚴血液塗片確認(班氏吳策絲蟲或馬來絲蟲)。其他淋巴水腫或急性淋巴管炎並不在此保障範圍內。

5.19 「***腦炎***」由神經科***專科醫生***診斷為腦炎（大腦半球、腦幹或小腦），通常由病毒或細菌感染並導致嚴重併發症（包括永久性神經虧損）為期至少六(6)星期。永久性神經虧損包括智力障礙、不穩定情緒、失明、失聰、語言障礙、偏癱瘓或癱瘓。該***疾病***可以是原發性、受感染後的或傍感染的形式的。除以上定義所列的任何具體的要求外，以上每一情況還應按適當情形必須為***註冊醫生***所確定並向***本公司***提供有關之臨床、放射學、組織學和化驗證明。

5.20 「***末期肺病***」終末期肺病，導致慢性呼吸衰竭，並由下列各項顯示：
(a) 功能測試中其FEV 1持續低於一公升；
(b) 因缺氧而須持續地進行輸氧治療；
(c) 動脈血液氣體分析局部氧壓（pO2少於55mmHg）；及

(d) 靜止時感到呼吸困難。

有關診斷必須由胸肺科***專科醫生***確認。

5.21 「***暴發性肝炎***」由肝炎病毒而引起的肝臟次廣泛至廣泛性壞死並導致肝功能急速衰竭。其診斷標準必須包括以下各項：

(a) 肝臟急速萎縮；
(b) 壞死區域涵蓋整個肝葉，只存留膠原網狀結構；
(c) 肝功能檢驗急速退化；及
(d) 黃疸迅速加深。

5.22 「***心臟病***」因心臟血液供應不足，引致部分心臟肌肉（心肌）壞死，並須符合下列所有準則：

(a) 在相關心臟事故期間心電圖（ECG）顯示新近具急性心肌梗塞特徵的變化；
(b) 心肌酵素（CK-MB）提高至一般公認的實驗室水平的正常水平以上或心肌旋轉蛋白 T（Troponin T）> 0.5 ng/ml 或心肌旋轉蛋白 I（Troponin I）> 0.5ng/ml；及
(c) 心絞痛，未知年歲出現的心臟病，及因進行心臟動脈程序（包括但不限於心臟冠狀動脈電腦斷層檢查及冠狀動脈血管成形術）導致的心肌酵素、心肌旋轉蛋白 T（Troponin T）或心肌旋轉蛋白 I（Troponin I）提升並不包括在內。

5.23 「***心瓣膜手術***」因瓣膜狹窄或關閉不全並確已實施了一(1)片或以上人工心瓣膜的置換手術。為免存疑，瓣膜修復或切開術均不符合***心瓣膜手術***的定義，不在保障範圍之內。

5.24 「***因輸血而感染愛滋病***」可以證明以使***本公司***信納，在本***保單***的***保單生效日***後因輸血而導致感染人體免疫力缺乏病毒（HIV）或證實感染愛滋病。負責輸血之機構必須是正式註冊及為***香港***醫管局所認可。人體免疫力缺乏病毒（HIV）之抗體呈陰性反應須於輸血***意外***發生後六(6)個***日曆月***內轉變為陽性反應。倘已有任何療法可供醫治愛滋病，則是項保險並不適用。

5.25 「***腎功能衰竭***」雙腎功能慢性且不可恢復的衰竭所導致的終末期腎功能衰竭，使***受保人***必須定期洗腎或接受腎移植。

5.26 「***肝功能衰竭***」指永久和不可恢復的終末期肝功能衰竭；特點為持續性黃疸、食道靜脈曲張、腹水及肝性腦病。為免存疑，由於濫用藥物或酗酒所致的肝病不符合***肝功能衰竭***的定義，不在本保障範圍之內。

5.27 「***失聰***」因急性***疾病***或***意外***導致雙耳的永久性完全失去聽覺。醫學證明須由耳、鼻、喉科***專科醫生***提供並包括聽力測驗和聲域測驗。失聰必須是沒有任何療法可恢復的。

5.28 「***斷肢***」任何兩(2)肢或以上在腕骨或踝骨以上不可復原地被切斷。

5.29 「***喪失語言能力***」因聲帶***疾病***或***受傷***而導致不可復原之永久喪失說話能力持續十二(12)個***日曆月***。經合適的耳、鼻、喉科***專科醫生***提供醫學證據及確定聲帶***疾病***或***受傷***。為免存疑，所有因精神問題直接或間接引致喪失語言能力並不符合喪失語言能力的定義，不在受保之列。

5.30 「***嚴重燒傷***」身體表面最少有百分之二十(20%)的皮膚受到三級燒傷（皮膚全層燒傷）。

5.31 「***主要器官移植***」確實已接受器官移植手術者，包括心臟、肺、肝、胰臟或骨髓等。為免存疑，移植單獨的胰臟小島並不符合主要器官移植的定義，不在本保障範圍之內。

5.32 「***結核性腦膜炎***」結核桿菌引起的腦膜炎，導致永久性神經損害。有關診斷必須由神經***專科醫生***確診。

5.33 「***腎髓質囊腫病***」遺傳性腎科***疾病***，其特徵為因腎髓質有囊腫而引致逐漸及進行性喪失腎功能。此症必須由腎科***專科醫生***確診並附有多個腎髓質囊腫及腎皮質萎縮之影像證明。

5.34 「***多發性硬化症***」因腦部或脊髓的髓鞘脫失而導致有超過六(6)個***日曆月***的多部位神經缺損。必須由神經科顧問醫生作出無可置疑的確診，及出現超過一(1)次神經系統症狀的發作，涉及視神經、腦幹、脊髓、協調或感覺功能障礙的任何組合。

5.35 「***肌營養不良症***」經神經科顧問醫生確診為肌營養不良症，並須包括下列所有情況：

(a) 臨床檢驗包括無官感神經紊亂，正常腦脊液及輕微腱反射的減退；

(b) 特殊的肌電圖；及

(c) 臨床推測必須有肌肉活組織檢查加以證實。

5.36 「***心肌梗塞***」首次心肌梗塞是指因供應心肌的血流被突然中斷而出現急性心肌壞死的現象。其診斷標準必須包括典型的胸痛史、心電圖有新近梗塞的改變及心肌酵素明顯提高的情況。心絞痛並不在本保障範圍內。

5.37 「***壞死性筋膜炎***」致命的壞疽或致命的壞死性筋膜炎,其壞死的過程是暴發性的(迅速傳播)以及需進行緊急主要手術,清創壞死的組織以及抗菌劑治療。有關診斷必須由***專科醫生***確診。凍瘡並不在此保障範圍內。

5.38 「***因職業感染人體免疫力缺乏病毒 (HIV)***」是按其職業進行正常職務時發生***意外***，因而導致感染人體免疫力缺乏病毒(HIV)。所有因***意外***導致潛在的索償必須在***意外***後七(7)日內向***本公司***呈報，並附有事發後立刻進行人體免疫力缺乏病毒抗體測試呈陰性的報告作佐證。人體免疫力缺乏病毒感染的血清轉換必須在***意外***後六(6)個***日曆月***內出現。

任何由其他途徑包括性行為或濫用靜脈注射藥物而感染人體免疫力缺乏病毒並不在此保障範圍內。如***意外***發生前已經存在治療方法，此保障便不適用。

5.39 「***柏金遜症***」經神經科***專科醫生***作出無可置疑之診斷為柏金遜症，並符合該***疾病***的以下條件：

(a) 無法以醫藥療法控制

(b) 原發性起因（其他起因的柏金遜症並不在本保障範圍內）；

(c) 有逐步受損的症狀；及

(d) ***受保人***缺乏獨立處理以下三(3)種或以上活動的能力：

(i) 更衣：在無需其他人士幫助的情況下，可自行穿上及除掉衣物；

(ii) 活動能力：在無需他人幫助的情況下，可自行由某一房間移動至另一間相連的房間；

(iii) 移動能力：在無需他人幫助的情況下，可自行上、下床或坐上椅子或從椅子起立；

(iv) 節禁：可控制大小二便；

(v) 進食：在無需他人協助的情況下，可自行進食碟上之食物；及

(vi) 沐浴：在無需他人協助的情況下，可自行洗澡及淋浴。

5.40 「***脊髓灰質炎***」經神經科***專科醫生***確診為因脊髓灰質炎病毒感染而導致癱瘓性***疾病***，其症狀必須包括運動功能損害或呼吸功能損害。除以上情況以外的***疾病***不被視為脊髓灰質炎。為免存疑，未導致癱瘓者及其他原因所導致的癱瘓不符合***脊髓灰質炎***的定義，不在本保障範圍之內。

5.41 「***原發性側索硬化症***」廣泛性上運動神經元衰弱而引致進行性大腦皮質運動神經元之退化病。其特徵為進行性的四肢痙攣衰弱，說話及吞嚥困難，顯示皮質脊髓束和皮質延髓束皆受影響。此症必須由神經科***專科醫生***確診並附有適當的神經肌肉檢驗證明。

5.42 「***原發性肺動脈高血壓***」經各種檢查包括導管插入術而診斷為原發性肺動脈高血壓及右心室肥大並導致嚴重及永久性的身體缺損（至少達致紐約心臟協會3級心臟缺損）。

紐約心臟協會的3級缺損是指於日常活動中，即使已接受藥物治療和飲食調節，病徵依然存在，及於驗身或化驗時發現不正常的心室功能。

5.43 「***惡化性延髓性麻痺***」經神經科顧問醫生根據適當及相關的神經科症狀的明確證據，而作出無可置疑之診斷為惡化性延髓性麻痺。

5.44 「***進行性肌肉萎縮症***」經神經科顧問醫生根據適當及相關的神經科症狀的明確證據，而作出無可置疑之診斷為惡化性肌肉萎縮症。

5.45 「***進行性核上神經麻痺症***」進行性核上神經麻痺症在不涉及任何其他因素下直接導致***受保人***永久不能完成以下日常起居活動的其中最少三(3)項，及必須由***專科醫生***診斷為進行性病變並導致永久性神經損害。只有在確診時***年齡***五(5)歲或以上的***受保人***才可就此***疾病***獲得本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用）。

(a) 更衣：在無需其他人士幫助的情況下，可自行穿上及除掉衣物；

(b) 活動能力：在無需他人幫助的情況下，可自行由某一房間移動至另一間相連的房間；
(c) 移動能力：在無需他人幫助的情況下，可自行上、下床或坐上椅子或從椅子起立；
(d) 節禁：可控制大小二便；
(e) 進食：在無需他人協助的情況下，可自行進食碟上之食物；及
(f) 沐浴：在無需他人協助的情況下，可自行洗澡及淋浴。

5.46 「***類風濕性關節炎***」（成人）廣泛性關節損壞及下列之關節部位有三(3)個或以上出現臨床變形：手、手腕、手肘、頸椎、膝、足踝和足部蹠趾骨。此情況須導致永久缺乏進行以下任何三(3)種日常起居活動的能力：
(a) 更衣：在無需其他人士幫助的情況下，可自行穿上及除掉衣物；
(b) 活動能力：在無需他人幫助的情況下，可自行由某一房間移動至另一間相連的房間；
(c) 移動能力：在無需他人幫助的情況下，可自行上、下床或坐上椅子或從椅子起立；
(d) 節禁：可控制大小二便；
(e) 進食：在無需他人協助的情況下，可自行進食碟上之食物；及
(f) 沐浴：在無需他人協助的情況下，可自行洗澡及淋浴。

5.47 「嚴重腦部創傷」腦功能因腦部意外創傷喪失或受損，而需永久接受他人的照料和協助以維持生命。

5.48 「嚴重重症肌無力」是指一種引致神經肌肉傳遞障礙之自體免疫性***疾病***，而導致波動性之肌肉無力及容易疲勞，必須符合下列所有準則：
(a) 永久出現肌肉無力，並根據下列按美國重症肌無力基金會的臨床分類(Myasthenia Gravis Foundation of America Clinical Classification)定為第IV或第V級；及
(b) 症肌無力的診斷必須由神經科***專科醫生***確診。

美國重症肌無力基金會的臨床分類(Myasthenia Gravis Foundation of America Clinical Classification):
第I級: 任何眼部肌肉無力，可能性之上瞼下垂，及並無其他部位出現肌無力的證據。
第II級: 任何程度之眼部肌肉無力，及其他部位之輕度肌肉無力。
第III級: 任何程度之眼部肌肉無力，及其他部位之中度肌肉無力。
第IV級: 任何程度之眼部肌肉無力，及其他部位之嚴重肌肉無力。
第V級: 需要插管以維持氣管暢通。

5.49 「嚴重潰瘍性結腸炎」經相關***專科醫生***診斷及組織檢查證實罹患潰瘍性結腸炎，並已接受直腸結腸完全切除手術治療。

5.50 「脊髓肌肉萎縮症」脊髓前角細胞及腦幹運動細胞核的退化病並擴展至近側的肌肉無力和癱弱，以腿部及遠側的肌肉為主。此病的損害必須導致永久卧床和不能在不須協助的情況下起床；或永久不能獨立地進行其中最少三(3)項日常起居活動：
(a) 更衣：在無需其他人士幫助的情況下，可自行穿上及除掉衣物；
(b) 活動能力：在無需他人幫助的情況下，可自行由某一房間移動至另一間相連的房間；
(c) 移動能力：在無需他人幫助的情況下，可自行上、下床或坐上椅子或從椅子起立；
(d) 節禁：可控制大小二便；
(e) 進食：在無需他人協助的情況下，可自行進食碟上之食物；及
(f) 沐浴：在無需他人協助的情況下，可自行洗澡及淋浴。

此症必須有醫學證明其病徵最少達三(3)個日曆月。此症必須由神經科顧問醫生確診並附有適當的神經肌肉檢驗證明。

5.51 「***中風***」由於任何腦血管意外或事故導致永久性神經機能缺損，並必須持續最少四（4）個星期。中風包括腦組織梗塞、腦出血及由顱以外原因引致血栓梗塞。中風的診斷必須由神經科***專科醫生***根據電腦斷層掃描（CT）檢查或磁力共振（MRI）檢查中發現與所觀察到的功能障礙有關的放射學變化來確認。

並不包括下列任何一項：
(a) 因短暫性腦缺血引致的腦部症狀；
(b) 因偏頭痛引致的腦部症狀；及
(c) 對眼或視覺神經或前庭系統功能造成影響的血管***疾病***。

5.52 「***主動脈手術***」因主動脈***疾病***而確曾實施開胸手術予以切除並進行了血管移植。就本定義而言，主動脈指胸、腹主動脈，不包括其任何分支。治療主動脈受創傷之手術不被視為***主動脈手術***。

5.53 「***末期疾病***」指經適當的顧問醫生診斷，且獲由***本公司***選擇的***註冊醫生***及／或***專科醫生***所認同，***受保人***所患***疾病***可能導致該***受保人***自根據本***保單***第二部分第2.11.1節提交索償通知之日起計六(6)個***日曆月***內死亡。

5.54 「***完全及永久傷殘***」***受保人***因***受傷***或***不適***而不能從事任何職業或獲聘用以賺取薪酬及利潤，且***受保人***在無人協助的情況下無法作出三(3)項或以上的以下日常起居活動。上述傷殘之情況必須不間斷地連續至少六(6)個***日曆月***，或***本公司***在合理要求下的較長期間，而且經由***註冊醫生***證實該傷殘情況於***受保人***餘生為及將為完全、連續及永久的。

(a) 更衣：在無需其他人士幫助的情況下，可自行穿上及除掉衣物；
(b) 活動能力：在無需他人幫助的情況下，可自行由某一房間移動至另一間相連的房間；
(c) 移動能力：在無需他人幫助的情況下，可自行上、下床或坐上椅子或從椅子起立；
(d) 節禁：可控制大小二便；
(e) 進食：在無需他人協助的情況下，可自行進食碟上之食物；及
(f) 沐浴：在無需他人協助的情況下，可自行洗澡及淋浴。

5.55 「***植物人狀態***」一種臨床失去知覺的狀態及已喪失大腦皮層功能，對外來刺激或內部組織的需要皆無反應，但腦幹仍保持有功能。須持續利用生命維持系統最少達三十(30)日。必須獲神經科顧問醫生證明有永久性的神經缺損。

5.56 「***手足口病伴有嚴重（威脅生命的）併發症***」一種由柯薩奇病毒和腸病毒71型引起之病毒性綜合症，並伴有皮膚疹及黏膜疹。本規定之保障僅對於嚴重手足口病並伴有腦炎及或心肌炎之情況予以賠償，須提供證明確認致病病毒呈陽性反應及證據顯示腦炎及或心肌炎之存在。同時亦要提供證明顯示確診至少三十(30)日後存在神經功能缺損。

5.57 「***胰島素依賴型糖尿病***」胰島素依賴型糖尿病之診斷必須符合以下所有條件：

(a) 由自體免疫性***疾病***引致持續性胰島素分泌不足；
(b) ***醫療所需***依賴外源性胰島素以維持正常之血糖水平；及
(c) 此情況必須已經持續最少六(6)個***日曆月***。

5.58 「***川崎綜合症並有心臟併發症***」川崎綜合症並有證明顯示狀動脈擴張或冠狀動脈瘤之形成，此情況須於最初診斷後持續出現最少六(6)個日曆月。

5.59 「***風濕性心瓣疾病***」急性風濕熱，而診斷必須符合以下所有準則：

(a) 診斷必須符合美國心臟協會設定之準則；及
(b) 純粹因風濕熱所導致之最少一個心瓣中度關閉不全。

5.60 「***嚴重哮喘***」頻繁氣促（每月發病一(1)次或多於一(1)次）或就嚴重支氣管哮喘之情況而言由呼吸道阻塞（閉塞）而導致的慢性氣促。在哮喘發病之間，肺功能測試必須顯示顯著的阻塞局限。此***疾病***必須經由兒科***專科醫生***確診以及在給予適當治療情況之下仍持續達六(6)個***日曆月***。哮喘持續狀態亦被視為嚴重哮喘。

5.61 「***嚴重腦癇***」由神經科顧問醫生或兒科醫生確診，並有證據顯示其典型臨床症狀及有腦電圖（EEG）及或其它腦部影像素描技術（例如磁力共振掃描（MRI）之嚴重腦癇、正電子釋放斷層掃描（PET）、電腦斷層掃描（CT））的特徵性發現之嚴重腦癇。該***受保人***必須反覆出現自發性的強直陣攣性抽搐或大發作，***受保人***必須已經接受抗癲癇藥物治療至少六(6)個***日曆月***或已經進行神經外科手術以治療反覆性癲癇發作。

以下情況不屬於保障範圍內：

(a) 發熱性抽搐；及
(b) 失神性及非全腦性發作（小發作）。

第六部分 不保事項條文

6.1 不保事項

6.1.1 就本***保單***而言，***本公司***不會賠償與下列項目相關或由其引致的費用：

(a) 任何非***醫療所需***的治療、治療程序、藥物、檢測或服務所招致的費用。

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

(c) 治療人體免疫力缺乏病毒（“HIV”）及其相關的***傷病***所招致的費用。惟若該人體免疫力缺乏病毒（“HIV”）及其相關的***傷病***的出現是受保於本***保單***第四部分第4.3.26節的人體免疫力缺乏病毒 / 愛滋病治療、本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用）下的***因輸血而感染愛滋病***，或本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用）下的***因職業感染人體免疫力缺乏病毒(HIV)***，則不屬此項；

(d) 因倚賴或過量服用藥物、酒精、毒品或類似物質（或受其影響）、故意自殘身體或企圖自殺、參與非法活動，或性病及經由性接觸傳染的***疾病***或其後遺症(惟HIV 及其相關的***傷病***除外，將按本***保單***第六部分第 6.1.1 (c) 節處理）接受***醫療服務***所招致的費用。

(e) 接受以下服務的所招致的費用 -

(i) 以美容或整容為目的的服務，惟本***保單***第四部分第4.3.27節的乳房重建手術保障所保障的乳房重建手術則不屬此項；或
(ii) 矯正視力或屈光不正的服務，而該等視力問題可透過驗配眼鏡或隱形眼鏡矯正，包括但不限於眼部屈光治療、角膜激光矯視手術 (LASIK) ，以及任何相關的檢測、治療程序及服務。

(f) 預防性治療或預防性護理所招致的費用，包括但不限於並無症狀下的一般身體檢查、定期檢測或篩查程序、或因***受保人***及/或其家人過往病歷而進行的篩查或監測程序、頭髮重金屬元素分析、接種疫苗或健康補充品。

(g) 由***註冊牙醫***進行的牙科治療及口腔頜面手術所招致的費用。惟***受保人***因***意外***引致在***住院***期間接受的***急症治療***及手術，或受保於本***保單***第四部分第4.3.25節的***意外急症***牙齒治療，則不屬此項。出院後的跟進牙科治療及口腔手術則不會獲得賠償。為免存疑，此不保事項並不適用於本***保單***第四部分第4.3.36節的***自選牙科保障***（如適用）。

(h) 有關產科狀況及其併發症的***醫療服務***及輔導服務所招致的費用，產科狀況及其併發症包括但不限於懷孕、分娩、墮胎或流產的診斷檢測；節育或恢復生育；任何性別的結紮或變性；不育（包括體外受孕或任何其他人工受孕）；以及性機能失常，（包括但不限於任何原因導致的陽萎、不舉或早泄）。惟若該產科狀況及其併發症的出現是受保於本***保單***第四部分第4.3.28節的妊娠併發症，則不屬此項。

(i) 購買屬耐用品的醫療設備及儀器所招致的費用，包括但不限於輪椅、床及家具、呼吸道壓力機及面罩、可攜式氧氣及氧氣治療儀器、血液透析機、運動設備、眼鏡、助聽器、特殊支架、輔助步行器具、非處方藥物、家居使用的空氣清新機或空調及供熱裝置。惟若該等費用是受保於本***保單***第四部分第4.3.33 (c)節的中風後提升家居設備保障，則不屬此項。為免存疑，此不保事項並不適用於***住院***期間或***日間手術***當日所租用的醫療設備或儀器。

(j) 傳統中醫治療所招致的費用，包括但不限於中草藥治療、跌打、針灸、穴位按摩及推拿，以及另類治療，包括但不限於催眠治療、氣功、按摩治療、香薰治療、自然療法、水療法、順勢療法及其他類似的治療。惟若該等費用是受保於本***保單***第四部分第4.3.16節的傳統中醫藥物治療或本***保單***第四部分第4.3.33 (a)節的三大***危疾***輔助治療保障，則不屬此項。為免存疑，此不保事項並不適用於本***保單***第四部分第4.3.35節的***自選門診保障***（如適用）。

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

(l) 因先天缺陷、***先天性疾病***、***遺傳性疾病***，或任何由相關的***傷病***接受***醫療服務***所招致的費用，惟若該先天缺陷、***先天性疾病***、***遺傳性疾病***，或任何由相關的***傷病***的出現是受保於本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用）所保障下的***腎髓質囊腫病***，則不屬此項。

(m) 已獲任何法律，或由任何政府、僱主或其他第三方提供的醫療或保險計劃賠償的費用。

(n) 治療因***戰爭***、內戰、侵略、外敵行動、敵對行動、叛亂、革命、起義、軍事政變或奪權事故，或***恐怖主義***導致的***傷病***所招致的費用。

(o) 因***投保前已有病症***及本***保單***列明的特別不保事項接受***醫療服務***所招致的費用。惟已在***投保申請文件***全面披露的及***本公司***同意不列為本***保單***的不保事項的***傷病***，則不屬此項。

(p) 治療發育異常，包括但不限於學習困難（例如讀寫障礙）、行為問題（例如自閉症或注意力缺陷障礙）；或身體發育問題（例如身材矮小）所招致的費用。

(q) 治療肥胖或因肥胖而需要治療所招致的費用，包括但不限於減肥班、減肥輔助劑及藥物。***本公司***只會支付捆紮帶胃或胃繞道手術的費用，惟***受保人***的身體質量指數(BMI) 須為四十(40)或以上，並已被診斷為病態肥胖；以及在過去的二十四(24)個***日歷月***內已嘗試了其他的減肥方法，並提供書面證據。

(r) 人工生命維持包括機械通氣所招致的費用，倘此種治療不會或預計不會導致***受保人***康復或恢復***受保人***以前的健康狀況。惟若該等費用是受保於本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用）下的***植物人狀態***，則不屬此項。

(s) 胎兒手術或治療所招致的費用。

(t) 治療由成癮情況及障礙促成的相關情況所招致的費用，包括但不限於戒煙。

(u) 因睡眠障礙所招致的費用，惟以下項目除外 -

(i) 若***受保人***確診睡眠窒息症，每***保單年度***最多一(1)次睡眠測試；及
(ii) 由***專科醫生***書面建議的有關睡眠窒息症的治療。

(v) 言語治療或與之相關所招致的費用，而該治療本質上難以恢復；或該治療用於提高仍未完全發育的說話技巧、被視為管教或教育性質或是為了保持言語溝通的治療。

(w) 因變性手術、或該手術前預備或該手術後恢復所需要的治療（包括由該治療引起的併發症）所招致的費用。

(x) 基因治療及細胞療法所招致的費用。

(y) 非醫療性服務所招致的費用，包括但不限於客人膳食、收音機、電話、影印、稅項（除了就***合資格費用***所收取的***增值稅和商品及服務稅***）、醫療報告費用、傳真及類似費用。

(z) 因心理、精神或神經疾病、人格障礙及性格障礙所招致的費用，惟若該心理、精神或神經疾病、人格障礙及性格障礙的出現是受保於本***保單***第四部分第4.3.11節的精神科治療，本***保單***第四部分第4.3.15節的出院後或***日間手術***後的輔助治療，本***保單***第四部分第4.3.35 (i) 節的精神病門診診症或心理異常門診診症，或本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用）下的***亞爾茲默氏病／痴呆***，則不屬此項。

(aa) 器官移植所招致的費用，惟若該器官移植的出現是受保於本***保單***第四部分第4.3.29節的器官移植保障，或本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用）下的***主要器官移植***，則不屬此項。

(bb) 因***受保人***從事或參與以下項目所招致的費用：

(i) 海軍、陸軍或空軍服役或執勤，武裝部隊或任何國家的警隊服務；
(ii) 職業體育運動或危險活動，例如但不限於攀石、攀山、跳傘、懸吊滑翔（不論使用電源與否）、滑翔飛行、笨豬跳，或任何非使用雙足的速度競賽；
(iii) 洞穴潛水、打撈潛水或自由潛水、專業潛水、並沒有持有正確的潛水認證（例如潛水教練專業協會）的潛水，及下潛深度超過四十(40)米的潛水；

(iv) 專業、半專業或有競賽成分的冬季運動、越野滑雪或單板滑雪、滑雪橇或單板跳台滑雪、乘直升機到高山滑雪、在滑雪道外滑雪或單板滑雪、競速滑雪；

(v) 高空工作（二十(20)呎以上）；

(vi) 操作重型機器；

(vii) 航空或空中活動。惟身為購票乘客或空中工作人員，乘搭一架有適當牌照、固定機翼及多引擎、用以接載旅客並由有執照的商業航空公司營運的飛機，或乘搭一架由商業公司擁有及營運、領有牌照以定期接載購票乘客的直升機，惟該直升機必須僅在商業航機場及 / 或有牌照商業直升機場之間航行，並在上述兩個情況下，該旅程的目的概與飛機內或飛機上進行的交易或技術運作無關，則不屬此項；或

(viii) 製造、儲存、注滿、細分、處理及運送任何爆炸品(包括但不限於煙花或爆竹)或化學物品；

(cc) 有關本***保單***第四部分第4.3.36節的***自選牙科保障***（如適用），除了本***保單***第六部分第6.1.1(a)至6.1.1(bb)節以外，***本公司***亦不會賠償以下列項目所招致的費用：

(i) 為增加垂直咬合高度或填補上下齒咬合而需佩帶的矯正器或需進行的修補；

(ii) 植牙或牙齒移植；

(iii) 美容性牙齒整修，例如牙齒漂白及鑲瓷面；

(iv) 牙齒矯正；

(v) 修理或更換牙齒矯正器；

(vi) 治療牙周病的牙槽骨移植或置放口腔外物質；

(vii) 改正牙齒先天性畸形而進行的治療或需佩帶的矯正器；

(viii) 惡性腫瘤、牙齦囊腫或口腔腫瘤的治療；

(ix) 重造丟失或被人盜取的假牙；

(x) 與顳下頜關節機能不良或不適有關的服務或治療，或與顎面整形手術有關的服務或治療；

(xi) 為診斷或治療任何因職業性***受傷***或職業性***疾病***而作出的服務或醫藥用品；或

(xii) 更換或加添現有假牙或牙橋。

(dd) 有關本***保單***第四部分第4.3.37節的***自選藥物保障***（如適用），除了***本保單***第六部分第6.1.1(a)至6.1.1(bb)節以外，***本公司***亦不會賠償以下列項目所招致的費用：

(i) 任何用作實驗或研究的藥物；或

(ii) 因丟失、被盜、損壞、變質或過期更換已獲賠償的***西藥***。

6.1.2 就本***保單***而言，***本公司***不會賠償與下列項目相關或由其引致的本***保單***第四部分第4.3.32節的***意外身故保障***：

(a) 任何病症、***疾病***、細菌或真菌感染（即使因***意外***而感染）。惟直接因***意外***的損傷或***意外***食物中毒引起的細菌感染，則不屬此項。

(b) 接受醫療或手術診治，惟由***意外身故保障***範圍內所指的***受傷***而引致必須的診治除外。

(c) 懷孕、分娩、流產、墮胎或由任何一項引起之併發症，雖然該損失可能由***受傷***加速或誘發。

(d) ***受保人受傷***時在所處國家或地區內從事的不合法行為。

(e) 處於精神錯亂或患有精神病或心理失調的狀況。

(f) 受酒精或藥物影響，惟有關藥物由***註冊醫生***適當地處方及並非因醫治沉溺藥物而服食除外。

(g) ***受保人***在駕駛任何車輛時，其呼出空氣、血液或尿液的酒精含量超出在***受保人受傷***時所處國家或地區的法定標準。

(h) 服務於任何武裝部隊而執勤於 i）***戰爭***期間；ii）武裝行動；或 iii）恢復社會秩序。為免存疑，武裝部隊包括任何國家或地區之任何警隊。

(i) ***戰爭***或任何***戰爭***行動、侵略、外敵行為、敵意行動（不論有否宣戰）、罷工、暴動及／或***內亂***、內戰、叛亂、革命、起義、軍事政變或奪權事故，或***恐怖主義***。

(j) 參與任何航空運動、飛行或任何其他類型的空中活動，惟以繳費乘客身份乘坐已註冊的航空公司所提供及操控，並定期航行的商務客機的人士除外。

(k) 作出自殺、企圖自殺、執行自殺協議或協定、或蓄意自殘身體的行為，不論神志是否清醒亦然。

(l) 製造、儲存、注滿、細分、處理及運送任何爆炸品（包括但不限於煙花或爆竹）的工人。

(m) ***受保人***參與以下任何一種活動或接受有關訓練：

(i) 以呼吸設備協助的海底游泳或潛泳；

(ii) 任何類型的爬山、或使用繩索或嚮導的攀山；

(iii) 探洞；

(iv) 跳傘、任何種類的滑翔運動、氣球飛行、徒手跳躍（笨豬跳）或飄翔運動；

(v) 洞穴潛水、打撈潛水或自由潛水、專業潛水、並沒有持有正確的潛水認證（例如潛水教練專業協會）及下潛深度超過四十(40)米的潛水；

(vi) 專業、半專業或有競賽成分的冬季運動、越野滑雪或單板滑雪、滑雪橇或單板跳台滑雪、乘直升機到高山滑雪、在滑雪道外滑雪或單板滑雪、競速滑雪；

(vii) 打獵；

(viii) 任何類型駕駛或策騎之競賽；或

(ix) 專業運動。