

avoidance of doubt, if the Premium Loading is set as a percentage of the Standard Premium (i.e. rate of Premium Loading), the amount of Premium Loading payable shall be automatically adjusted according to the change in Standard Premium.

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

3. Notification of Renewal

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

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

4. No re-underwriting except in limited circumstances

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

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

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

- (a) Where the Policy Holder requests the Company to re-underwrite these Terms and Benefits at the time of Renewal for reduction in Premium Loading or removal of Case-based Exclusion(s) according to the Company's underwriting practices. For the avoidance of doubt, the Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;
- (b) At any time where the Policy Holder requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits (in which cases the re-underwriting shall be limited to such upgrade or additional benefits).

- (i) However, at any time where the Policy Holder requests to unsubscribe the additional benefits (if any) in these Terms and Benefits, or switch to another insurance plan which provides downgrade or reduction of benefits, the Company shall not have the right to re-underwrite these Terms and Benefits but shall have the discretion to accept or reject the request according to its prevailing practices in handling similar requests; and
 - (ii) The Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;
- (c) Where there is change in the Place of Residence of the Insured Person

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

- (i) The Company has taken into account the Place of Residence of the Insured Person in underwriting these Terms and Benefits before its inception;
- (ii) The Company has specifically informed the Policy Holder of the consideration at the time of submission of Application of these Terms and Benefits and that any change in the Place of Residence could lead to re-underwriting upon Renewal;
- (iii) The Company has maintained underwriting practices which show unambiguously how changes in the Place of Residence will affect the underwriting result, and the underwriting practices are readily accessible by the Policy Holder;
- (iv) The Company shall carry out the re-underwriting solely in respect of the said changes (i.e. the change in the Place of Residence of the Insured Person); and
- (v) The re-underwriting result may be more advantageous or adverse to the Policy Holder and the Insured Person.

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

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

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

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

- (ii) The Company has specifically informed the Policy Holder of the consideration at the time of submission of Application of these Terms and Benefits and that any change in the occupation could lead to re-underwriting upon Renewal;
- (iii) The Company has maintained underwriting practices which show unambiguously how changes in the occupation will affect the underwriting result, and the underwriting practices are readily accessible by the Policy Holder;
- (iv) The Company shall carry out the re-underwriting solely in respect of the said change (i.e. the change in the occupation of the Insured Person); and
- (v) The re-underwriting result may be more advantageous or adverse to the Policy Holder and the Insured Person.

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

The Company and Policy Holder acknowledge that -

- (e) if under the terms of this Part 4, the Company has the right, or is required, to re-underwrite these Terms and Benefits based on certain factors at Renewal, the Company shall, in accordance with the terms of this Part 4 and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and
- (f) as a result of re-underwriting, these Terms and Benefits may be terminated, new Premium Loading may be applied, existing Premium Loading may be adjusted upwards or downwards, new Case-based Exclusion(s) may be applied, and existing Case-based Exclusion(s) may be revised or removed.

Part 5 Claim Provisions

1. Submission of claims

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

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

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

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

2. Claimable amount estimate

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

3. Legal action

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

4. Medical examination

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

SAMPLE

Part 6 Benefit Provisions

1. General

(a) **Territorial scope of cover**

Except for the psychiatric treatment as stated in Section 3(1) of this Part 6, all benefits described in these Terms and Benefits shall be applicable worldwide.

(b) **Lifetime Benefit Limit**

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

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

All benefits described in these Terms and Benefits are not subject to any restriction in the choice of healthcare services providers, including but not limited to Registered Medical Practitioner and Hospital.

(d) **Choice of ward class**

All benefits described in Section 3 of Part 6 and Sections 1 to 6, 8 to 10 of Supplement B of these Terms and Benefits are not subject to any restriction in the choice of ward class in Hospital.

The benefits described in Section 7 of Supplement B of these Terms and Benefits, if applicable, are subject to the restriction in the choice of ward class as stated in Section 7 of Supplement B of these Terms and Benefits. Such restriction shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

2. Coverage of Confinement and non-Confinement services

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

(a) is Confined in a Hospital; or

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

The content on this page is part of the Terms and Benefits of Certified Plan (No. F00026-01-001-02).

the Company shall reimburse the Eligible Expenses which are Reasonable and Customary in accordance with benefit items under Section 3 of this Part 6 and Sections 1 to 4, 6 and 7 of the Supplement B.

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

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

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

3. Benefits covered

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

(a) **Room and board**

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

(b) **Miscellaneous charges**

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

- (i) Road ambulance service to and/or from the Hospital;
- (ii) Anaesthetic and oxygen administration;
- (iii) Administration charges for blood transfusion;
- (iv) Dressing and plaster casts;
- (v) Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;
- (vi) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;

- (vii) Additional surgical appliances, equipment and devices other than those inclusively paid under Section 3(h) of this Part 6, and implants, disposables and consumables used during surgical procedure;
- (viii) Medical disposables, consumables, equipment and devices;
- (ix) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Section 3(i) of this Part 6;
- (x) Intravenous ("IV") infusions including IV fluids;
- (xi) Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
- (xii) Rental of walking aids and wheelchair for Inpatients; and
- (xiii) Physiotherapy, occupational therapy and speech therapy during Confinement.

(c) Attending doctor's visit fee

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

(d) Specialist's fee

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

(e) Intensive care

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

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

(f) Surgeon's fee

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

This benefit shall be payable according to the relevant surgical category and the categorisation of such surgical procedure under the Schedule of Surgical Procedures as categorised and reviewed from time to time by the Government. If a surgical procedure performed is not included in the Schedule of Surgical Procedures, the Company may reasonably determine its surgical category according to the gazette published by the

Government or any other relevant publication or information including but not limited to the schedule of fees recognised by the government, relevant authorities and medical association in the locality where the surgical procedure is performed.

(g) Anaesthetist's fee

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

(h) Operating theatre charges

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

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

(i) Prescribed Diagnostic Imaging Tests

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

(j) Prescribed Non-surgical Cancer Treatments

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

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

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

This benefit shall be payable for the Eligible Expenses for -

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

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

(I) Psychiatric treatments

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

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

4. Pre-existing Condition(s)

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

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

First Policy Year	no coverage
Second Policy Year	25% reimbursement
Third Policy Year	50% reimbursement
Fourth Policy Year onwards	full coverage

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

If the Policy Holder or the Insured Person is requested but fails to disclose to the Company upon submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 8 of Part 1), that the Insured Person is suffering from a Pre-existing Condition, and such Pre-existing Condition has been treated or diagnosed or has manifested signs or symptoms of which the Policy Holder or the Insured Person is aware or should have reasonably been aware of at the time of submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 8 of Part 1), the Company has the right to declare these Terms and Benefits void, demand repayment of any benefits paid and/or refuse to provide coverage under these Terms and Benefits. In such event, the Company shall refund the premium in accordance with Section 14 of Part 2. The burden of proving the above shall rest with the Company.

5. Cost-sharing requirement

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

SAMPLE

Part 7 General Exclusions

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

1. Expenses incurred for treatments, procedures, medications, tests or services which are not Medically Necessary.
2. Expenses incurred for the whole or part of the Confinement solely for the purpose of diagnostic procedures or allied health services, including but not limited to physiotherapy, occupational therapy and speech therapy, unless such procedure or service is recommended by a Registered Medical Practitioner for Medically Necessary investigation or treatment of a Disability which cannot be effectively performed in a setting for providing Medical Services to a Day Patient.
3. Expenses arising from Human Immunodeficiency Virus (“HIV”) and its related Disability, which is contracted or occurs before the Policy Effective Date. Irrespective of whether it is known or unknown to the Policy Holder or the Insured Person at the time of submission of Application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1) such Disability shall be generally excluded from any coverage of these Terms and Benefits if it exists before the Policy Effective Date. If evidence of proof as to the time at which such Disability is first contracted or occurs is not available, manifestation of such Disability within the first five (5) years after the Policy Effective Date shall be presumed to be contracted or occur before the Policy Effective Date, while manifestation after such five (5) years shall be presumed to be contracted or occur after the Policy Effective Date.

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

4. Expenses incurred for Medical Services as a result of Disability arising from or consequential upon the dependence, overdose or influence of drugs, alcohol, narcotics or similar drugs or agents, self-inflicted injuries or attempted suicide, illegal activity, or venereal and sexually transmitted disease or its sequelae (except for HIV and its related Disability, where Section 3 of this Part 7 applies).
5. Any charges in respect of services for –
 - (a) beautification or cosmetic purposes, unless necessitated by Injury caused by an Accident and the Insured Person receives the Medical Services within ninety (90) days of the Accident; or
 - (b) correcting visual acuity or refractive errors that can be corrected by fitting of spectacles or contact lens, including but not limited to eye refractive therapy, LASIK and any related tests, procedures and services.
6. Expenses incurred for prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests, screening procedures for asymptomatic conditions, screening or surveillance procedures based on the health history of the Insured Person and/or his family

The content on this page is part of the Terms and Benefits of Certified Plan (No. F00026-01-001-02).

members, Hair Mineral Analysis (HMA), immunisation or health supplements. For the avoidance of doubt, this Section 6 does not apply to –

- (a) treatments, monitoring, investigation or procedures with the purpose of avoiding complications arising from any other Medical Services provided;
 - (b) removal of pre-malignant conditions; and
 - (c) treatment for prevention of recurrence or complication of a previous Disability.
7. Expenses incurred for dental treatment and oral and maxillofacial procedures performed by a dentist except for Emergency Treatment and surgery during Confinement arising from an Accident. Follow-up dental treatment or oral surgery after discharge from Hospital shall not be covered.
 8. Expenses incurred for Medical Services and counselling services relating to maternity conditions and its complications, including but not limited to diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction or pre-mature ejaculation, regardless of cause.
 9. Expenses incurred for the purchase of durable medical equipment or appliances including but not limited to wheelchairs, beds and furniture, airway pressure machines and masks, portable oxygen and oxygen therapy devices, dialysis machines, exercise equipment, spectacles, hearing aids, special braces, walking aids, over-the-counter drugs, air purifiers or conditioners and heat appliances for home use. For the avoidance of doubt, this exclusion shall not apply to rental of medical equipment or appliances during Confinement or on the day of the Day Case Procedure.
 10. Except as otherwise provided related to post-Confinement / Day Case Procedure chiropractor / acupuncturist / physiotherapist treatment in Section 6 of Supplement B, 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, hydrotherapy, homeotherapy and other similar treatments.
 11. Expenses incurred for experimental or unproven medical technology or procedure in accordance with the common standard, or not approved by the recognised authority, in the locality where the treatment, procedure, test or service is received.
 12. Expenses incurred for Medical Services provided as a result of Congenital Condition(s) which have manifested or been diagnosed before the Insured Person attained the Age of eight (8) years.
 13. Eligible Expenses which have been reimbursed under any law, or medical program or insurance policy provided by any government, company or other third party.
 14. Expenses incurred for treatment for Disability arising from war (declared or undeclared), civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power.

Part 8 Definitions

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

"Accident"	shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured Person and caused by violent, external and visible means.
"Age"	shall mean the attained age of the Insured Person.
"Annual Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder in a Policy Year irrespective of whether any limits of any benefit items stated in the Benefit Schedule have been reached. The Annual Benefit Limit is counted afresh in a new Policy Year.
"Application"	shall mean the application submitted to the Company in respect of this Certified Plan, including the application form, questionnaires, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1).
"Benefit Schedule"	shall mean a schedule of benefits attached to these Terms and Benefits which sets out, among others, the benefit items and maximum benefits covered.
"Case-based Exclusion"	shall mean the exclusion of a particular Sickness or Disease from the coverage of these Terms and Benefits that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.
"Certified Plan"	shall mean all the terms and benefits (including any Supplement(s)) that form an insurance plan certified by the Government to be compliant with the requirements of the VHIS. This Certified Plan comprises these Terms and Conditions and the Benefit Schedule, and the followings – Supplement A and Supplement B.
"Coinsurance"	shall mean a percentage of Eligible Expenses the Policy Holder must contribute after paying the Deductible (if any) in a Policy Year. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits under these Terms and Benefits.
"Company"	shall mean Sun Life Hong Kong Limited.

"Confinement" or "Confined"	<p>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.</p> <p>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.</p>
"Congenital Condition(s)"	<p>shall mean (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.</p>
"Day Case Procedure"	<p>shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.</p>
"Day Patient"	<p>shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.</p>
"Deductible"	<p>shall mean a fixed amount of Eligible Expenses that, in a Policy Year, the Policy Holder must pay before the Company shall reimburse the remaining Eligible Expenses.</p>
"Delivery"	<p>shall mean the delivery of these Terms and Benefits and the Policy Schedule or the cooling-off notice as stated in Section 2(a) of Part 2 to the Policy Holder, or to nominated representative of the Policy Holder, by any the following means:</p> <ul style="list-style-type: none"> (a) by hand; (b) by post (including registered post); or (c) by electronic means. <p>Regardless of the means of delivery is used, it is the responsibility of the Company, to have sufficient proof of delivery and the timing of delivery.</p>
"Disability"	<p>shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.</p>
"Eligible Expenses"	<p>shall mean expenses incurred for Medical Services rendered with respect to a Disability.</p>
"Emergency"	<p>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.</p>
"Emergency Treatment"	<p>shall mean Medical Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.</p>

"Flexi Plan"	shall mean any individual indemnity hospital insurance plan under the VHIS framework with enhancement(s) to any or all of the protections or terms and benefits that the Standard Plan provides to the Policy Holder and the Insured Person, subject to certification by the Government. Such plan shall not contain terms and benefits which are less favourable than those in the Standard Plan, save for the exception as may be approved by the Government from time to time.
"Government"	shall mean the Hong Kong Special Administrative Region Government.
"Guardian"	in respect of a Minor shall mean the person(s) appointed as the guardian(s) under or acting by virtue of the Guardianship of Minors Ordinance (Cap 13. of the Laws of Hong Kong).
"HKD"	shall mean Hong Kong dollars.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which - <ul style="list-style-type: none"> (a) has facilities for diagnosis and major operations; (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Injury"	shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.
"Inpatient"	shall mean an Insured Person who is Confined.
"Insurance Authority"	shall mean the Insurance Authority of Hong Kong established pursuant to section 4AAA of the Insurance Ordinance.
"Insurance Ordinance"	shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).
"Insured Person"	shall mean any person whose risks are covered by these Terms and Benefits, and named as the "Insured Person" in the Policy Schedule.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.

"Lifetime Benefit Limit" shall mean the maximum amount of benefits paid by the Company to the Policy Holder cumulatively since the inception of these Terms and Benefits, irrespective whether any limits of any benefit items stated in the Benefit Schedule have been reached or whether the Annual Benefit Limit in a Policy Year has been reached.

"Medical Services" shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.

"Medically Necessary" shall mean the need to have medical service for the purpose of investigating or treating the relevant Disability in accordance with the generally accepted standards of medical practice and such medical service must –

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

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

- (i) the Insured Person is having an Emergency that requires urgent treatment in Hospital;
- (ii) surgical procedures are performed under general anaesthesia;
- (iii) equipment for surgical procedure is available in Hospital and procedure cannot be done on a Day Patient basis;
- (iv) there is significantly severe co-morbidity of the Insured Person;
- (v) taking into account the individual circumstances of the Insured Person, the attending Registered Medical Practitioner has exercised his prudent professional judgment and is of the view

that for the safety of the Insured Person, the medical service should be conducted in Hospital;

- (vi) in the prudent professional judgment of the attending Registered Medical Practitioner, the length of Confinement of the Insured Person is appropriate for the medical service concerned; and/or
- (vii) in the case of diagnostic procedures or allied health services prescribed by a Registered Medical Practitioner, such Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, such procedures or services should be conducted in Hospital.

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

- (aa) is in accordance with standards of good and prudent medical practice in the locality for the medical service rendered, and, in the prudent professional judgment of the attending Registered Medical Practitioner, not rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner; and
- (bb) is in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice in the locality for the medical service rendered.

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

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

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

"Policy Effective Date"	shall mean the commencement date of these Terms and Benefits which is specified as "Policy Effective Date" in the Policy Schedule.
"Policy Holder"	shall mean the person who is a legal holder of this Policy and is named as the "Policy Holder" in the Policy Schedule.
"Policy Issuance Date"	shall mean the date of first issuance of these Terms and Benefits.
"Policy Schedule"	shall mean a schedule attached to these Terms and Benefits, which sets out, among others, the Policy Effective Date, Renewal Date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, premium and other relevant details in respect of these Terms and Benefits.
"Policy Year"	shall mean the period of time these Terms and Benefits are in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Renewal Date as specified in the Policy Schedule (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year period from each Renewal Date.
"Portfolio"	shall mean all policies of the same terms and conditions and the benefit schedule as certified by the Government as a Certified Plan under VHIS.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where - <ul style="list-style-type: none"> (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.
"Prescribed Diagnostic Imaging Tests"	shall mean computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.
"Prescribed Non-surgical Cancer Treatments"	shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.
"Reasonable and Customary"	shall mean, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant

service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar Age, for a similar Disability, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred.

In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable) -

- (a) treatment or service fee statistics and surveys in the insurance or medical industry;
- (b) internal or industry claim statistics;
- (c) gazette published by the Government; and/or
- (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.

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

shall mean a medical practitioner of western medicine,

- (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and
- (b) legally authorised for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person,

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

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

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

"Renewal Date"

shall mean the effective date of Renewal. The first Renewal Date shall be the date as specified in the Policy Schedule (which shall not be later than the first anniversary of the Policy Effective Date) and the subsequent Renewal Date(s) shall be the anniversary(ies) of the first Renewal Date.

The relevant Renewal Date shall be specified in the notification of Renewal in accordance with Section 3 of Part 4.

"Schedule of Surgical Procedures"	shall mean the list of surgical procedures attached to the Benefit Schedule which sets out the surgical category of different surgical procedures according to their relative degree of complexity, which is from time to time published and subject to regular review by the Government.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured Person and whether or not any diagnosis is confirmed.
"Standard Plan"	shall mean the insurance plan with terms and conditions and the benefit schedule equivalent to the minimum compliant product requirements of VHIS, which are from time to time published and subject to regular review by the Government.
"Standard Plan Terms and Benefits"	shall mean the terms and conditions and the benefit schedule of the Standard Plan, which are from time to time published and subject to regular review by the Government (https://www.vhis.gov.hk/doc/en/information_centre/e_standard_plan_template.pdf).
"Standard Premium"	shall mean the basic premium for the coverage under this Certified Plan, as charged by the Company to the Policy Holder on an overall Portfolio basis, which may be adjusted in accordance with the Age, gender and/or lifestyle factors of the Insured Person.
"Supplement(s) "	shall mean any document which may add, delete, amend or replace the terms and benefits of this Policy. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Policy.
"Terms and Benefits"	shall mean the Terms and Conditions together with the Benefit Schedule (including the Schedule of Surgical Procedures) and any related Supplement(s) as certified by the Government under this Certified Plan.
"Terms and Conditions"	shall mean Part 1 to Part 8 of this Certified Plan.