
VHIS Prestige Care

Terms and Conditions

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TERMS AND CONDITIONS

Part 1 Insuring Clause and The Policy

Insuring Clause

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

Type of the Certified Plan -	Flexi Plan
Name of the Certified Plan -	VHIS Prestige Care

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

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

The Policy

The Policy Holder and the Company agree that –

1. No alteration to these Terms and Benefits shall be valid unless it is made in accordance with these Terms and Conditions.
2. All statements made by or for the Insured Person in the Application shall be treated as representations and not warranties.
3. All information provided and all statements made by or for the Insured Person as required under this Policy and the Application shall be provided to the best of his knowledge and in his utmost good faith.
4. These Terms and Benefits come into force on the Policy Effective Date as specified in the Policy Schedule on the condition that the Policy Holder has paid the first premium in full.
5. At the inception of these Terms and Benefits and at each Renewal, in the event of any inconsistency between –
 - (a) the terms and benefits of this Policy; and
 - (b) the Standard Plan Terms and Benefits of such version as may be determined by the Government and is referred to in Sections 1 (a) to (c) of Part 4,then –
 - (i) so far as the scope of Standard Plan Terms and Benefits is concerned, the terms and benefits which are more favourable to the Policy Holder or the Insured Person shall prevail to the extent of such inconsistency; and
 - (ii) so far as the scope of Standard Plan Terms and Benefits is concerned, the terms and benefits which impose additional restrictions or limitations to the Policy Holder or the Insured Person shall become ineffective.

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

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

6. At the inception of these Terms and Benefits and at each Renewal, if this Policy covers any benefits that exceed the Standard Plan Terms and Benefits and the terms and benefits applicable to such benefits differ from the terms and benefits applicable to the Standard Plan Terms and Benefits, the difference shall not amount to an inconsistency contemplated under Section 5 of this Part 1.
7. At the time these Terms and Benefits are first issued, the Company may apply Case-based Exclusion(s) due to a Pre-existing Condition or other factor that affects the insurability of the Insured Person notified to the Company in the Application.
8. The Company acknowledges that, as part of the underwriting process, it is the obligation of the Company to ask the Policy Holder and the Insured Person in the Application all requisite information for the Company to make the underwriting decision. If the Company requires the Policy Holder and/or the Insured Person to disclose any updates of or changes to such requisite information after the time of submission of Application and before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Company must make such a request prominently to the Policy Holder and the Insured Person (including without limitation in the application form), in which case the Policy Holder and/or the Insured Person shall have the obligation to inform the Company on such updates and changes. Each of the Policy Holder and the Insured Person shall have the obligation to respond to the questions, and to disclose such material facts as requested in the questions. The Company agrees that if any such questions are not included in the Application, the Company shall be deemed to have waived the disclosure obligation of the Policy Holder and the Insured Person in respect of the information that was not requested.
9. All questions and required information included in the Application must be sufficiently specific and unambiguous, and consistent with the rules and regulations of the VHIS, so as to allow the Policy Holder and the Insured Person (as the case may be) to understand the information being requested and to provide clear and unequivocal responses. In case of dispute, the burden of proving that the questions are sufficiently specific and unambiguous shall rest with the Company.
10. If the Policy Holder or the Insured Person fails to make the relevant disclosures under Section 8 or 9 of this Part 1, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right as provided in Sections 13 and 14 of Part 2.

Part 2 General Conditions

1. Interpretation

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

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

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

2. Cancellation within cooling-off period

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

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

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

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

The above cancellation right shall not apply at Renewal.

To exercise this cancellation right, the Policy Holder must –

- (c) return the original of these Terms and Benefits and the Policy Schedule; and
- (d) attach a letter, signed by the Policy Holder, requesting cancellation or in other forms acceptable by the Company.

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

3. Cancellation

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

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

4. Benefit entitlement

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

5. Assignment

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

6. Clerical error

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

7. Currency

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

8. Interest

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

9. Company's obligation

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

10. Governing law

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

11. Dispute resolution

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

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

12. Liability

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

13. Misstatement of personal information

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

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

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

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

14. Misrepresentation or fraud

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

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

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

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

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

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

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

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

15. Termination of Policy

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

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

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

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

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

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

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

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

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

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

16. Notices to Company

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

17. Notices from Company

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

- (a) if sent by post, two (2) working days after posting; or
- (b) if sent by email, on the date and time transmitted.

18. Other insurance coverage

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

19. Ownership and discharge under this Policy

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

20. Change of ownership of the Policy

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

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

- (a) the Insured Person if he has reached the Age of eighteen (18) years;
- (b) the parent or the Guardian of the Insured Person if he is a Minor; or
- (c) any person whose familial relationship with the Insured Person is accepted by the Company according to its prevailing underwriting practices which are readily accessible by the Policy Holder.

21. Death of Policy Holder

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

- (a) the Insured Person if he has reached the Age of eighteen (18) years; or
- (b) the parent or the Guardian if the Insured Person is a Minor. If the parent or the Guardian refuses the transfer, the ownership of this Policy shall be transferred to the administrator or executor of the Policy Holder's estate.

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

22. Rights of third parties

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

23. Subrogation

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

24. Suits against third parties

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

25. Waiver

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

26. Compliance with law

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

27. Personal data privacy

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

Part 3 Premium Provisions

1. Premium payable

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

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

2. Payment of premiums

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

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

3. Grace period

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

Part 4 Renewal Provisions

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

1. Renewal

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

- (a) Unless the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write these Terms and Benefits, or has ceased to maintain its registration with the Government as a VHIS provider, or the Policy Holder decides not to Renew these Terms and Benefits by giving the Company not less than thirty (30) days prior notice in writing in accordance with Section 3 of Part 2, Renewal shall be arranged automatically with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time of Renewal, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.
- (b) At the time of Renewal, if the Company shall cease or has ceased to maintain its registration with the Government as a VHIS provider while maintaining the requisite authorisation under the Insurance Ordinance to write these Terms and Benefits, Renewal shall be arranged automatically with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time when the Company ceased to maintain its registration as a VHIS provider, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.
- (c) After the Company has ceased to maintain its registration with the Government, if the Company subsequently re-registers with the Government as a VHIS provider, then at the Renewal Date coinciding with or immediately following such re-registration, these Terms and Benefits shall be Renewed with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time of the Renewal, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.

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

2. Adjustment of premium

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

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

3. Notification of Renewal

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

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

4. No re-underwriting except in limited circumstances

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

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

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

- (a) Where the Policy Holder requests the Company to re-underwrite these Terms and Benefits at the time of Renewal for reduction in Premium Loading or removal of Case-based Exclusion(s) according to the Company's underwriting practices. For the avoidance of doubt, the Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;
- (b) At any time where the Policy Holder requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits (in which cases the re-underwriting shall be limited to such upgrade or additional benefits).
 - (i) However, at any time where the Policy Holder requests to unsubscribe the additional benefits (if any) in these Terms and Benefits, or switch to another insurance plan which provides downgrade or reduction of benefits, the Company shall not have the right to re-underwrite these Terms and Benefits but shall have the discretion to accept or reject the request according to its prevailing practices in handling similar requests; and
 - (ii) The Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;
- (c) Where there is change in the Place of Residence of the Insured Person

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

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

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

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

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

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

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

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

The Company and Policy Holder acknowledge that –

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

Part 5 Claim Provisions

1. Submission of claims

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

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

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

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

2. Claimable amount estimate

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

3. Legal action

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

4. Medical examination

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

Part 6 Benefit Provisions

1. General

(a) Territorial scope of cover

Except for the psychiatric treatment as stated in Section 3(l) of this Part 6, and/or the increased international cover as stated in Supplement 4 and/or the supplementary major medical benefit as stated in Supplement 5, if applicable, all benefits described in these Terms and Benefits shall be applicable worldwide.

The geographical limitation related to the increased international cover as stated in Supplement 4 and/or the supplementary major medical benefit as stated in Supplement 5, if applicable, shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

(b) Lifetime Benefit Limit

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 Sections 3 of Part 6 and Supplement 1, Supplement 2, Supplement 3 and Supplement 6 of these Terms and Benefits, and Supplement 4 of these Terms and Benefits, if applicable, are not subject to any restriction in the choice of ward class in Hospital.

The benefits described in Supplement 5 of these Terms and Benefits, if applicable, are subject to the restriction in the choice of ward class as stated in Supplement 5 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 or outpatient kidney dialysis,

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

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

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

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

3. Benefits covered

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

(a) Room and board

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

(b) Miscellaneous charges

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

- (i) Road ambulance service to and/or from the Hospital;
- (ii) Anaesthetic and oxygen administration;
- (iii) Administration charges for blood transfusion;
- (iv) Dressing and plaster casts;
- (v) Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;
- (vi) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
- (vii) Additional surgical appliances, equipment and devices other than those inclusively paid under Section 3(h) of this Part 6, and implants, disposables and consumables used during surgical procedure;
- (viii) Medical disposables, consumables, equipment and devices;
- (ix) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Section 3(i) of this Part 6;
- (x) Intravenous (“IV”) infusions including IV fluids;
- (xi) Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
- (xii) Rental of walking aids and wheelchair for Inpatients; and
- (xiii) Physiotherapy, occupational therapy and speech therapy during Confinement.

(c) Attending doctor's visit fee

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

(d) Specialist's fee

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

(e) Intensive care

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

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

(f) **Surgeon's fee**

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

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

(g) **Anaesthetist's fee**

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

(h) **Operating theatre charges**

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

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

(i) **Prescribed Diagnostic Imaging Tests**

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

(j) **Prescribed Non-surgical Cancer Treatments**

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

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

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

This benefit shall be payable for the Eligible Expenses for –

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

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

(l) Psychiatric treatments

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

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

(m) Private nursing

This benefit shall be payable for the cost charged on full-time or part-time private nursing services (not being the general nursing services provided by the Hospital) of a legally qualified nurse, as recommended by the attending Registered Medical Practitioner during Hospital Confinement, received in a Hospital or at home following discharge from Hospital for the continued treatment of the specific medical condition for which the Insured Person was Confined, provided that such services are essential for medical as distinct from domestic reasons of the Insured Person. Cover is limited to a maximum period of one hundred and eighty (180) days per Policy Year.

(n) Outpatient kidney dialysis

This benefit shall be payable for the Eligible Expenses charged on regular haemodialysis or peritoneal dialysis as a result of chronic and irreversible kidney failure, as recommended by the attending Registered Medical Practitioner, in a setting for providing Medical Services to a Day Patient, including outpatient consultation by a Specialist in treatment planning, and monitoring of prognosis and development during the course of kidney dialysis.

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.

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.

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 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 for the operation and cancer recovery benefit (v) as stated in Supplement 6, 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 1, Supplement 2, Supplement 3, Supplement 4, Supplement 5 and Supplement 6.
"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 MSIG Insurance (Hong Kong) 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 Condition(s)"	shall mean (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.

"Deductible"	shall mean a fixed amount of Eligible Expenses that, in a Policy Year, the Policy Holder must pay before the Company shall reimburse the remaining Eligible Expenses.
"Delivery"	shall mean the delivery of these Terms and Benefits and the Policy Schedule or the cooling-off notice as stated in Section 2(a) of Part 2 to the Policy Holder, or to nominated representative of the Policy Holder, by any the following means: (a) by hand; (b) by post (including registered post); or (c) by electronic means. Regardless of the means of delivery is used, it is the responsibility of the Company, to have sufficient proof of delivery and the timing of delivery.
"Disability"	shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.
"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Disability.
"Emergency"	shall mean an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.
"Emergency Treatment"	shall mean Medical Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.
"Flexi Plan"	shall mean any individual indemnity hospital insurance plan under the VHIS framework with enhancement(s) to any or all of the protections or terms and benefits that the Standard Plan provides to the Policy Holder and the Insured Person, subject to certification by the Government. Such plan shall not contain terms and benefits which are less favourable than those in the Standard Plan, save for the exception as may be approved by the Government from time to time.
"Government"	shall mean the Hong Kong Special Administrative Region Government.
"Guardian"	in respect of a Minor shall mean the person(s) appointed as the guardian(s) under or acting by virtue of the Guardianship of Minors Ordinance (Cap 13. of the Laws of Hong Kong).
"HKD"	shall mean Hong Kong dollars.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which - (a) has facilities for diagnosis and major operations; (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Injury"	shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.

"Inpatient"	shall mean an Insured Person who is Confined.
"Insurance Authority"	shall mean the Insurance Authority of Hong Kong established pursuant to section 4AAA of the Insurance Ordinance.
"Insurance Ordinance"	shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).
"Insured Person"	shall mean any person whose risks are covered by these Terms and Benefits, and named as the "Insured Person" in the Policy Schedule.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
"Lifetime Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder cumulatively since the inception of these Terms and Benefits, irrespective whether any limits of any benefit items stated in the Benefit Schedule have been reached or whether the Annual Benefit Limit in a Policy Year has been reached.
"Medical Services"	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.
"Medically Necessary"	shall mean the need to have medical service for the purpose of investigating or treating the relevant Disability in accordance with the generally accepted standards of medical practice and such medical service must – (a) require the expertise of, or be referred by, a Registered Medical Practitioner; (b) be consistent with the diagnosis and necessary for the investigation and treatment of the Disability; (c) be rendered in accordance with standards of good and prudent medical practice, and not be rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner; (d) be rendered in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice for the medical services; and (e) be furnished at the most appropriate level which, in the prudent professional judgment of the attending Registered Medical Practitioner, can be safely and effectively provided to the Insured Person. For the purpose of these Terms and Benefits, without prejudice to the generality of the foregoing, circumstances where a Confinement is considered Medically Necessary include, but not limited to – (i) the Insured Person is having an Emergency that requires urgent treatment in Hospital; (ii) surgical procedures are performed under general anaesthesia; (iii) equipment for surgical procedure is available in Hospital and procedure cannot be done on a Day Patient basis; (iv) there is significantly severe co-morbidity of the Insured Person; (v) taking into account the individual circumstances of the Insured Person, the attending Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, the medical service should be conducted in Hospital;

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

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

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

"Minor"	shall mean a person below the Age of eighteen (18) years.
"Place(s) of Residence"	shall mean the jurisdiction(s) in which a person legally has the right of abode. A change in the Place(s) of Residence refers to the situation where a person has been granted the right of abode of additional jurisdiction(s), or has ceased to have the right of abode of existing jurisdiction(s). The above definition of "Place(s) of Residence" is used solely for the purpose of these Terms and Benefits. For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, shall not be treated as a Place of Residence.
"Policy"	shall mean this policy underwritten and issued by the Company, which is the contract between the Policy Holder(s) and the Company in respect of this Certified Plan including but not limited to these Terms and Conditions, Benefit Schedule, Application, declarations, Policy Schedule and any Supplement(s) attached to this policy, if applicable. Where this Policy contains additional terms and benefits other than those of this Certified Plan, the meaning of Policy shall also cover such additional terms and benefits.
"Policy Effective Date"	shall mean the commencement date of these Terms and Benefits which is specified as "Policy Effective Date" in the Policy Schedule.
"Policy Holder"	shall mean the person who is a legal holder of this Policy and is named as the "Policy Holder" in the Policy Schedule.
"Policy Issuance Date"	shall mean the date of first issuance of these Terms and Benefits.
"Policy Schedule"	shall mean a schedule attached to these Terms and Benefits, which sets out, among others, the Policy Effective Date, Renewal Date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, premium and other relevant details in respect of these Terms and Benefits.
"Policy Year"	shall mean the period of time these Terms and Benefits are in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Renewal Date as specified in the Policy Schedule (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year period from each Renewal Date.

"Portfolio"	shall mean all policies of the same terms and conditions and the benefit schedule as certified by the Government as a Certified Plan under VHIS.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where - (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.
"Prescribed Diagnostic Imaging Tests"	shall mean computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.
"Prescribed Non-surgical Cancer Treatments"	shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.
"Reasonable and Customary"	shall mean, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar Age, for a similar Disability, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred. In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable) - (a) treatment or service fee statistics and surveys in the insurance or medical industry; (b) internal or industry claim statistics; (c) gazette published by the Government; and/or (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.
"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"	shall mean a medical practitioner of western medicine, (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the practitioner is not duly qualified and registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith), the Company shall exercise reasonable judgment to determine whether such practitioner shall nonetheless be considered qualified and registered.

"Renewal", "Renew", "Renewed" or "Renewable"	shall mean renewal of these Terms and Benefits in accordance with their terms without any discontinuance.
"Renewal Date"	shall mean the effective date of Renewal. The first Renewal Date shall be the date as specified in the Policy Schedule (which shall not be later than the first anniversary of the Policy Effective Date) and the subsequent Renewal Date(s) shall be the anniversary(ies) of the first Renewal Date. The relevant Renewal Date shall be specified in the notification of Renewal in accordance with Section 3 of Part 4.
"Schedule of Surgical Procedures"	shall mean the list of surgical procedures attached to the Benefit Schedule which sets out the surgical category of different surgical procedures according to their relative degree of complexity, which is from time to time published and subject to regular review by the Government.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured Person and whether or not any diagnosis is confirmed.
"Standard Plan"	shall mean the insurance plan with terms and conditions and the benefit schedule equivalent to the minimum compliant product requirements of VHIS, which are from time to time published and subject to regular review by the Government.
"Standard Plan Terms and Benefits"	shall mean the terms and conditions and the benefit schedule of the Standard Plan, which are from time to time published and subject to regular review by the Government (https://www.vhis.gov.hk/doc/en/information_centre/e_standard_plan_template.pdf).
"Standard Premium"	shall mean the basic premium for the coverage under this Certified Plan, as charged by the Company to the Policy Holder on an overall Portfolio basis, which may be adjusted in accordance with the Age, gender and/or lifestyle factors of the Insured Person.
"Supplement(s)"	shall mean any document which may add, delete, amend or replace the terms and benefits of this Policy. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Policy.
"Terms and Benefits"	shall mean the Terms and Conditions together with the Benefit Schedule (including the Schedule of Surgical Procedures) and any related Supplement(s) as certified by the Government under this Certified Plan.
"Terms and Conditions"	shall mean Part 1 to Part 8 of this Certified Plan.

SUPPLEMENT 1

VHIS Prestige Care

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

Companion bed

Subject to the Terms and Conditions of this Policy, this benefit shall be payable for the cost of companion bed charged by the Hospital for one Family Member of the Insured Person if the Insured Person is Confined in a Hospital.

For the purpose of this benefit, Family Member shall mean the spouse, child, parent, grandparent and sibling of the Insured Person.

SUPPLEMENT 2

VHIS Prestige Care

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

Other Benefit - Day surgery cash allowance

Subject to the Terms and Conditions of this Policy, this day surgery cash allowance benefit shall be payable for eligible claim, for which the Company has agreed to pay benefit for Surgeon's fee, if the Insured Person has undergone any of the Day Case Procedures specified below which is performed in a medical clinic, or day case procedure centre or Hospital as a Day Patient. The benefit is not payable if the Insured Person has been admitted into a hospital as an Inpatient, regardless of the hours of stay in Hospital and in no event shall the Company pay the cash allowance benefit for more than one Day Case Procedure per day.

Day surgery cash allowance is applicable to the following Day Case Procedures, with or without other concurrent surgical procedure :

- (a) Gastroscopy
- (b) Oesophagogastrroduodenoscopy (OGD)
- (c) Sigmoidoscopy
- (d) Colonoscopy
- (e) Endoscopic retrograde cholangio-pancreatography (ERCP)
- (f) Cystoscopy
- (g) Arthroscopic examination of joint
- (h) Colposcopy
- (i) Bronchoscopy
- (j) Extracapsular / intracapsular extraction of lens (Cataract)

SUPPLEMENT 3

VHIS Prestige Care

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

Other Benefit - Second claim cash allowance benefit

Subject to the Terms and Conditions of this Policy, this benefit shall be payable if the Eligible Expenses incurred by the Insured Person during Confinement at a Hospital has first been partially or fully reimbursed by other insurance company(ies). In no event shall the Company pay this cash allowance benefit for more than one claim per Confinement.

SUPPLEMENT 4

VHIS Prestige Care

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

Increased international cover

(This benefit only applicable to Plan C)

Subject to the Terms and Conditions of this Policy, the Annual Benefit Limit will be increased automatically up to the Annual Benefit Limit of increased international cover stated on the Benefit Schedule for Emergency Treatment of the Insured Person while travelling or located outside the Place(s) of Residence (not exceeding ninety (90) days per trip).

If applicable, this cover is shown on the Benefit Schedule.

SUPPLEMENT 5

VHIS Prestige Care

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

Optional Supplementary Major Medical Benefit

(This benefit is payable if it is shown on the Policy Schedule)

This benefit shall be payable for the eligible expenses charged for Hospital Confinement and Day Case Procedure if the benefit amount payable under Sections 3(a) to (j) and/or (l) to (n) of Part 6, and Supplement 1 is exhausted.

- (a) Subject to the maximum limit per Policy Year, the amount payable under this Supplementary Major Medical Benefit shall be calculated as follows:

Amount of eligible expenses incurred and actually paid	less	Benefit payable under Sections 3(a) to (j) and (l) to (n) of Part 6, and Supplement 1	less	Excess per claim for this benefit as stated in the Benefit Schedule	times	1 - Coinsurance for this benefit as stated in the Benefit Schedule	times	Adjustment factor (if applicable)
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- (b) This benefit shall not be payable for:-
- (1) Hospital Confinement and Day Case Procedure outside Place(s) of Residence except for Emergency Treatment in respect of Accident or acute Sickness occurring during short period business or holiday travel (not exceeding ninety (90) days per trip) outside the Place(s) of Residence and which requires immediate medical attention as certified by a Registered Medical Practitioner; or
 - (2) Confinement in room class other than General Ward, Semi-private Room and Private Room of a Hospital.
- (c) If the Insured Person is Confined to a Hospital room class higher than his entitled room class as specified in the Benefit Schedule on a voluntary basis (circumstances not falling within those listed under (d) below shall be considered as voluntary), an adjustment factor shall be applied to the amount payable under this benefit as follows:

Entitled room class	Confined room class	Adjustment factor
General Ward / Semi-private Room	Private Room	50%

- (d) The above benefit adjustment does not apply in the event of involuntary room upgrade arising from :-
- (1) unavailability of accommodation at the specified entitled room class due to room shortage for Emergency Treatment;
 - (2) isolation reasons that require a specific room class; or
 - (3) other reasons not involving personal preference of the Policy Holders and/or the Insured Persons.
- (e) In the event of voluntary room upgrade, the adjustment factor shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits.
- (f) For the purpose of this benefit:-
- (1) General Ward shall mean an accommodation in a Hospital where three (3) or more patients are sharing the room.
 - (2) Semi-private Room shall mean a dual occupancy accommodation or single occupancy accommodation with shared bathroom in a Hospital.
 - (3) Private Room shall mean a standard single occupancy accommodation with private bathroom, excluding deluxe / suite / VIP room or a similarly classed room, in a Hospital.

SUPPLEMENT 6

VHIS Prestige Care

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

Operation and cancer recovery benefit

Subject to the Terms and Conditions of this Policy, this benefit shall be payable for fees charged for follow-up outpatient service within ninety (90) days after Confinement for surgery or for cancer, up to five (5) visits per Policy Year for each of the following services, subject to Coinsurance as shown on the Benefit Schedule.

(i) Psychological counselling (consultation fee only)

Psychological counselling performed by registered psychologist. Written referral from attending Registered Medical Practitioner is required.

(ii) Dietetic consultation (consultation fee only)

Dietetic consultation performed by qualified dietitian. Written referral from attending Registered Medical Practitioner is required.

(iii) Speech therapy (treatment fee only)

Speech therapy performed by qualified speech therapist. Written referral from attending Registered Medical Practitioner is required.

(iv) Occupational therapy (treatment fee only)

Occupational therapy performed by registered occupational therapist. Written referral from attending Registered Medical Practitioner is required.

(v) Chinese herbalist consultation and acupuncture (consultation and medication fee)

Chinese herbalist consultation and acupuncture performed by registered Chinese medicine practitioner.

Where Eligible Expenses under this benefit are also covered under Section 3 of Part 6, such Eligible Expenses shall be payable in the following order:

- (i) Section 3 of Part 6;
- (ii) this operation and cancer recovery benefit.

For the purpose of the operation and cancer recovery benefit, the above services should be provided by a professional who is legally authorised for rendering relevant service in Hong Kong or the relevant jurisdiction outside Hong Kong where the 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 professional 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 professional shall nonetheless be considered qualified and registered.

VHIS Prestige Care (Plan A)

Benefit Schedule

Benefit items ⁽¹⁾	Benefit limit (in HKD)
I. Basic Benefit	
(a) Room and board	\$2,000 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	Full Cover
(c) Attending doctor's visit fee	\$2,000 per day Maximum 180 days per Policy Year
(d) Specialist's fee ⁽²⁾	Full Cover
(e) Intensive care	Full Cover
(f) Surgeon's fee	Per surgery, subject to surgical category for the surgery/procedure in the Schedule of Surgical Procedures - - Complex \$320,000 - Major \$160,000 - Intermediate \$80,000 - Minor \$32,000
(g) Anaesthetist's fee	35% of Surgeon's fee payable ⁽⁵⁾
(h) Operating theatre charges	35% of Surgeon's fee payable ⁽⁵⁾
(i) Prescribed Diagnostic Imaging Tests ^{(2) (3)}	\$20,000 per Policy Year Subject to 20% Coinsurance
(j) Prescribed Non-surgical Cancer Treatments ⁽⁴⁾	\$100,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care ⁽²⁾	\$800 per visit, up to \$4,000 per Policy Year - 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure - 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	\$30,000 per Policy Year
II. Enhanced Benefit	
(a) Companion bed	Full Cover
(b) Private nursing	Full Cover Maximum 180 days per Policy Year
(c) Outpatient kidney dialysis	\$100,000 per Policy Year
(d) Operation and cancer recovery benefit	Coinsurance: 20% \$600 per visit, up to 5 visits per Policy Year for each of the following services: (i) Psychological counselling (consultation fee only) (ii) Dietetic consultation (consultation fee only) (iii) Speech therapy (treatment fee only) (iv) Occupational therapy (treatment fee only) (v) Chinese herbalist consultation and acupuncture
(e) Increased international cover	Not Applicable
III. Other Benefit	
1. Day surgery cash allowance	\$1,000 per Day Case Procedure
2. Second claim cash allowance benefit	\$1,000 per claim
Other limits	
Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d)	\$500,000 per Policy Year
Lifetime Benefit Limit for all benefit items	Nil

Notes –

- (1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above, unless otherwise specified.
- (2) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.
- (3) Tests covered here only include computed tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.
- (4) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.
- (5) The percentage here applies to the Surgeon's fee actually payable or the benefit limit for the Surgeon's fee according to the surgical categorisation, whichever is the lower.

**VHIS Prestige Care (Plan A with Supplementary Major Medical Benefit)
Benefit Schedule**

Benefit items⁽¹⁾	Benefit limit (in HKD)
I. Basic Benefit	
(a) Room and board	\$2,000 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	Full Cover
(c) Attending doctor's visit fee	\$2,000 per day Maximum 180 days per Policy Year
(d) Specialist's fee ⁽²⁾	Full Cover
(e) Intensive care	Full Cover
(f) Surgeon's fee	Per surgery, subject to surgical category for the surgery/procedure in the Schedule of Surgical Procedures - - Complex \$320,000 - Major \$160,000 - Intermediate \$80,000 - Minor \$32,000
(g) Anaesthetist's fee	35% of Surgeon's fee payable ⁽⁵⁾
(h) Operating theatre charges	35% of Surgeon's fee payable ⁽⁵⁾
(i) Prescribed Diagnostic Imaging Tests ^{(2) (3)}	\$20,000 per Policy Year Subject to 20% Coinsurance
(j) Prescribed Non-surgical Cancer Treatments ⁽⁴⁾	\$100,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care ⁽²⁾	\$800 per visit, up to \$4,000 per Policy Year - 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure - 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	\$30,000 per Policy Year
II. Enhanced Benefit	
(a) Companion bed	Full Cover
(b) Private nursing	Full Cover Maximum 180 days per Policy Year
(c) Outpatient kidney dialysis	\$100,000 per Policy Year
(d) Operation and cancer recovery benefit	Coinsurance: 20% \$600 per visit, up to 5 visits per Policy Year for each of the following services: (i) Psychological counselling (consultation fee only) (ii) Dietetic consultation (consultation fee only) (iii) Speech therapy (treatment fee only) (iv) Occupational therapy (treatment fee only) (v) Chinese herbalist consultation and acupuncture.
(e) Increased international cover	Not Applicable
III. Optional Benefit	
Supplementary major medical benefit	
- Entitled room class	General Ward / Semi-private Room
- Maximum limit	\$200,000 per Policy Year
- SMM excess per claim	\$1,000
- Coinsurance	20%
IV. Other Benefit	
1. Day surgery cash allowance	\$1,000 per Day Case Procedure
2. Second claim cash allowance benefit	\$1,000 per claim
Other limits	
Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d)	\$500,000 per Policy Year
Lifetime Benefit Limit for all benefit items	Nil

Notes –

- (1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above, unless otherwise specified.
- (2) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.
- (3) Tests covered here only include computed tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.
- (4) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.
- (5) The percentage here applies to the Surgeon's fee actually payable or the benefit limit for the Surgeon's fee according to the surgical categorisation, whichever is the lower.

**VHIS Prestige Care (Plan B)
Benefit Schedule**

Benefit items⁽¹⁾	Benefit limit (in HKD)
I. Basic Benefit	
(a) Room and board	\$2,800 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	Full Cover
(c) Attending doctor's visit fee	\$2,800 per day Maximum 180 days per Policy Year
(d) Specialist's fee ⁽²⁾	Full Cover
(e) Intensive care	Full Cover
(f) Surgeon's fee	Full Cover
(g) Anaesthetist's fee	Full Cover
(h) Operating theatre charges	Full Cover
(i) Prescribed Diagnostic Imaging Tests ^{(2) (3)}	\$30,000 per Policy Year Subject to 20% Coinsurance
(j) Prescribed Non-surgical Cancer Treatments ⁽⁴⁾	\$150,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care ⁽²⁾	\$1,000 per visit, up to \$5,000 per Policy Year - 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure - 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	\$40,000 per Policy Year
II. Enhanced Benefit	
(a) Companion bed	Full Cover
(b) Private nursing	Full Cover Maximum 180 days per Policy Year
(c) Outpatient kidney dialysis	\$150,000 per Policy Year
(d) Operation and cancer recovery benefit	Coinsurance: 20% \$800 per visit, up to 5 visits per Policy Year for each of the following services: (i) Psychological counselling (consultation fee only) (ii) Dietetic consultation (consultation fee only) (iii) Speech therapy (treatment fee only) (iv) Occupational therapy (treatment fee only) (v) Chinese herbalist consultation and acupuncture
(e) Increased international cover	Not Applicable
III. Other Benefit	
1. Day surgery cash allowance	\$1,000 per Day Case Procedure
2. Second claim cash allowance benefit	\$1,000 per claim
Other limits	
Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d)	\$750,000 per Policy Year
Lifetime Benefit Limit for all benefit items	Nil

Notes –

- (1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above, unless otherwise specified.
- (2) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.
- (3) Tests covered here only include computed tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.
- (4) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.

**VHIS Prestige Care (Plan B with Supplementary Major Medical Benefit)
Benefit Schedule**

Benefit items⁽¹⁾	Benefit limit (in HKD)
I. Basic Benefit	
(a) Room and board	\$2,800 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	Full Cover
(c) Attending doctor's visit fee	\$2,800 per day Maximum 180 days per Policy Year
(d) Specialist's fee ⁽²⁾	Full Cover
(e) Intensive care	Full Cover
(f) Surgeon's fee	Full Cover
(g) Anaesthetist's fee	Full Cover
(h) Operating theatre charges	Full Cover
(i) Prescribed Diagnostic Imaging Tests ^{(2) (3)}	\$30,000 per Policy Year Subject to 20% Coinsurance
(j) Prescribed Non-surgical Cancer Treatments ⁽⁴⁾	\$150,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care ⁽²⁾	\$1,000 per visit, up to \$5,000 per Policy Year - 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure - 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	\$40,000 per Policy Year
II. Enhanced Benefit	
(a) Companion bed	Full Cover
(b) Private nursing	Full Cover Maximum 180 days per Policy Year
(c) Outpatient kidney dialysis	\$150,000 per Policy Year
(d) Operation and cancer recovery benefit	Coinsurance: 20% \$800 per visit, up to 5 visits per Policy Year for each of the following services: (i) Psychological counselling (consultation fee only) (ii) Dietetic consultation (consultation fee only) (iii) Speech therapy (treatment fee only) (iv) Occupational therapy (treatment fee only) (v) Chinese herbalist consultation and acupuncture
(e) Increased international cover	Not Applicable
III. Optional Benefit	
Supplementary major medical benefit	
- Entitled room class	General Ward / Semi-private Room
- Maximum limit	\$300,000 per Policy Year
- SMM excess per claim	\$1,000
- Coinsurance	20%
IV. Other Benefit	
1. Day surgery cash allowance	\$1,000 per Day Case Procedure
2. Second claim cash allowance benefit	\$1,000 per claim
Other limits	
Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d)	\$750,000 per Policy Year
Lifetime Benefit Limit for all benefit items	Nil

Notes –

- (1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above, unless otherwise specified.
- (2) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.
- (3) Tests covered here only include computed tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.
- (4) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.

**VHIS Prestige Care (Plan C)
Benefit Schedule**

Benefit items⁽¹⁾	Benefit limit (in HKD)
I. Basic Benefit	
(a) Room and board	\$3,900 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	Full Cover
(c) Attending doctor's visit fee	\$3,900 per day Maximum 180 days per Policy Year
(d) Specialist's fee ⁽²⁾	Full Cover
(e) Intensive care	Full Cover
(f) Surgeon's fee	Full Cover
(g) Anaesthetist's fee	Full Cover
(h) Operating theatre charges	Full Cover
(i) Prescribed Diagnostic Imaging Tests ^{(2) (3)}	\$40,000 per Policy Year Subject to 20% Coinsurance
(j) Prescribed Non-surgical Cancer Treatments ⁽⁴⁾	\$300,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care ⁽²⁾	\$1,500 per visit, up to \$7,500 per Policy Year - 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure - 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	\$50,000 per Policy Year
II. Enhanced Benefit	
(a) Companion bed	Full Cover
(b) Private nursing	Full Cover Maximum 180 days per Policy Year
(c) Outpatient kidney dialysis	\$300,000 per Policy Year
(d) Operation and cancer recovery benefit	Coinsurance: 20% \$1,000 per visit, up to 5 visits per Policy Year for each of the following services: (i) Psychological counselling (consultation fee only) (ii) Dietetic consultation (consultation fee only) (iii) Speech therapy (treatment fee only) (iv) Occupational therapy (treatment fee only) (v) Chinese herbalist consultation and acupuncture
(e) Increased international cover	Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d) will be increased to \$6,000,000 per Policy Year
III. Other Benefit	
1. Day surgery cash allowance	\$1,000 per Day Case Procedure
2. Second claim cash allowance benefit	\$1,000 per claim
Other limits	
Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d)	\$1,500,000 per Policy Year
Lifetime Benefit Limit for all benefit items	Nil

Notes –

- (1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above, unless otherwise specified.
- (2) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.
- (3) Tests covered here only include computed tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.
- (4) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.

**VHIS Prestige Care (Plan C with Supplementary Major Medical Benefit)
Benefit Schedule**

Benefit items⁽¹⁾	Benefit limit (in HKD)
I. Basic Benefit	
(a) Room and board	\$3,900 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	Full Cover
(c) Attending doctor's visit fee	\$3,900 per day Maximum 180 days per Policy Year
(d) Specialist's fee ⁽²⁾	Full Cover
(e) Intensive care	Full Cover
(f) Surgeon's fee	Full Cover
(g) Anaesthetist's fee	Full Cover
(h) Operating theatre charges	Full Cover
(i) Prescribed Diagnostic Imaging Tests ^{(2) (3)}	\$40,000 per Policy Year Subject to 20% Coinsurance
(j) Prescribed Non-surgical Cancer Treatments ⁽⁴⁾	\$300,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care ⁽²⁾	\$1,500 per visit, up to \$7,500 per Policy Year - 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure - 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	\$50,000 per Policy Year
II. Enhanced Benefit	
(a) Companion bed	Full Cover
(b) Private nursing	Full Cover Maximum 180 days per Policy Year
(c) Outpatient kidney dialysis	\$300,000 per Policy Year
(d) Operation and cancer recovery benefit	Coinsurance: 20% \$1,000 per visit, up to 5 visits per Policy Year for each of the following services: (i) Psychological counselling (consultation fee only) (ii) Dietetic consultation (consultation fee only) (iii) Speech therapy (treatment fee only) (iv) Occupational therapy (treatment fee only) (v) Chinese herbalist consultation and acupuncture
(e) Increased international cover	Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d) will be increased to \$6,000,000 per Policy Year
III. Optional Benefit	
Supplementary major medical benefit	
- Entitled room class	Private Room
- Maximum limit	\$600,000 per Policy Year
- SMM excess per claim	\$1,000
- Coinsurance	20%
IV. Other Benefit	
1. Day surgery cash allowance	\$1,000 per Day Case Procedure
2. Second claim cash allowance benefit	\$1,000 per claim
Other limits	
Annual Benefit Limit for benefit items I (a) – (l) and II (a) – (d)	\$1,500,000 per Policy Year
Lifetime Benefit Limit for all benefit items	Nil

Notes –

- (1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above, unless otherwise specified.
- (2) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.
- (3) Tests covered here only include computed tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.
- (4) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.

Schedule of Surgical Procedures

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

The content on this page is part of the Terms and Benefits of Certified Plan (No. F00023).

Procedure / Surgery		Category
	Bilateral repair of inguinal hernia, open or laparoscopic	Major
	Unilateral herniotomy / herniorrhaphy, open or laparoscopic	Intermediate
	Bilateral herniotomy / herniorrhaphy, open or laparoscopic	Major
BRAIN AND NERVOUS SYSTEM		
Brain	Brain biopsy	Major
	Burr hole(s)	Intermediate
	Craniectomy	Complex
	Cranial nerve decompression	Complex
	Irrigation of cerebroventricular shunt	Minor
	Maintenance removal of cerebroventricular shunt, including revision	Intermediate
	Creation of ventriculoperitoneal shunt or subcutaneous cerebrospinal fluid reservoir	Major
	Clipping of intracranial aneurysm	Complex
	Wrapping of intracranial aneurysm	Complex
	Excision of arteriovenous malformation, intracranial	Complex
	Excision of acoustic neuroma	Complex
	Excision of brain tumour or brain abscess	Complex
	Excision of cranial nerve tumour	Complex
	Radiofrequency thermocoagulation of trigeminal ganglion	Intermediate
	Closed trigeminal rhizotomy using radiofrequency	Major
	Decompression of trigeminal nerve root/ open trigeminal rhizotomy	Complex
	Excision of brain, including lobectomy	Complex
	Hemispherectomy	Complex
Spine	Lumbar puncture or cisternal puncture	Minor
	Decompression of spinal cord or spinal nerve root	Major
	Cervical sympathectomy	Intermediate
	Thoracoscopic or lumbar sympathectomy	Major
	Excision of intraspinal tumour, extradural or intradural	Complex
CARDIOVASCULAR SYSTEM		
Heart	Cardiac catheterization	Intermediate
	Coronary artery bypass graft (CABG)	Complex
	Cardiac transplantation	Complex
	Insertion of cardiac pacemaker	Intermediate
	Pericardiocentesis	Minor
	Pericardiotomy	Major
	Percutaneous transluminal coronary angioplasty (PTCA) and related procedures, including use of laser, stenting, motor-blade, balloon angioplasty, radiofrequency ablation technique, etc.	Major
	Pulmonary valvotomy, Balloon / Transluminal laser / Transluminal radiofrequency	Major
	Percutaneous valvuloplasty	Major
	Balloon aortic / mitral valvotomy	Major
	Closed heart valvotomy	Complex
	Open heart valvuloplasty	Complex
	Valve replacement	Complex
Vessels	Intra-abdominal venous shunt/ spleno-renal shunt / portal-caval shunt	Complex
	Resection of abdominal vessels with replacement / anastomosis	Complex
ENDOCRINE SYSTEM		
Adrenal Gland	Unilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Major
	Bilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Complex
Pineal gland	Total excision of pineal gland	Complex
Pituitary Gland	Operation of pituitary tumour	Complex
Thyroid Gland	Fine needle aspiration (FNA) of thyroid gland +/- imaging guidance	Minor
	Hemithyroidectomy / partial thyroidectomy / subtotal thyroidectomy / parathyroidectomy	Major
	Total thyroidectomy / complete parathyroidectomy / robotic-assisted total thyroidectomy	Major

Procedure / Surgery		Category
	Excision of thyroglossal cyst	Intermediate
EAR/ NOSE / THROAT / RESPIRATORY SYSTEM		
Ear	Canaloplasty for aural atresia / stenosis	Major
	Excision of preauricular cyst / sinus	Minor
	Haematoma auris, drainage / buttoning / excision	Minor
	Meatoplasty	Intermediate
	Removal of foreign body	Minor
	Excision of middle ear tumour via tympanotomy	Major
	Myringotomy +/- insertion of tube	Minor
	Myringoplasty / tympanoplasty	Major
	Ossiculoplasty	Major
	Labyrinthectomy, total / partial excision	Major
	Mastoidectomy	Major
	Operation on cochlea and / or cochlear implant	Complex
	Operation on endolymphatic sac / decompression of endolymphatic sac	Major
	Repair of round window or oval window fistula	Intermediate
	Tympanosympathectomy	Major
	Vestibular neurectomy	Intermediate
Nose, mouth and pharynx	Antral puncture and lavage	Minor
	Cauterization of nasal mucosa / control of epistaxis	Minor
	Closed reduction for fracture nasal bone	Minor
	Closure of oro-antral fistula	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lesion of nose	Minor
	Nasopharyngoscopy / rhinoscopy +/- including rhinoscopic biopsy +/- removal of foreign body	Minor
	Polypectomy of nose	Minor
	Caldwell-Luc operation / Maxillary sinusectomy with Caldwell-Luc approach	Intermediate
	Endoscopic sinus surgery on ethmoid / maxillary / frontal / sphenoid sinuses	Intermediate
	Extended endoscopic frontal sinus surgery with trans-septal frontal sinusotomy	Major
	Frontal sinusotomy or ethmoidectomy	Intermediate
	Frontal sinusectomy	Major
	Functional endoscopic sinus surgery (FESS)	Major
	Functional endoscopic sinus surgery (FESS) bilateral	Complex
	Maxillary / sphenopalatine / ethmoid artery ligation	Intermediate
	Other intranasal operation, including use of laser (excluding simple rhinoscopy, biopsy and cauterisation of vessel)	Intermediate
	Rhinoplasty	Intermediate
	Resection of nasopharyngeal tumour	Intermediate
	Sinoscopy +/- biopsy	Minor
	Septoplasty +/- submucous resection of septum	Intermediate
	Submucous resection of nasal septum	Intermediate
	Turbinectomy / submucous turbinectomy	Intermediate
	Adenoidectomy	Minor
	Tonsillectomy +/- adenoidectomy	Intermediate
	Excision of pharyngeal pouch / diverticulum	Intermediate
	Pharyngoplasty	Intermediate
	Sleep related breathing disorder – hyoid suspension, maxilla / mandible / tongue advancement, laser suspension / resection, radiofrequency ablation assisted uvulopalatopharyngoplasty, uvulopalatopharyngoplasty	Intermediate
	Marsupialization / excision of ranula	Intermediate
	Parotid gland removal, superficial	Intermediate
	Parotid gland removal / parotidectomy	Major
	Removal of submandibular salivary gland	Intermediate
	Submandibular duct relocation	Intermediate

Procedure / Surgery		Category
Respiratory system	Submandibular gland excision	Intermediate
	Arytenoid subluxation – laryngoscopic reduction	Minor
	Bronchoscopy +/- biopsy	Minor
	Bronchoscopy with foreign body removal	Minor
	Laryngoscopy +/- biopsy	Minor
	Laryngeal / tracheal stenosis – endolaryngeal / open operation with stenting / reconstruction	Major
	Laryngeal diversion	Intermediate
	Laryngectomy +/- radical neck resection	Complex
	Micro-laryngoscopy +/- Biopsy +/- excision of nodule / polyp / Reinke's edema	Minor
	Partial / total resection of laryngeal tumour	Intermediate
	Removal of vallecular cyst	Intermediate
	Repair of laryngeal fracture	Major
	Injection for vocal cord paralysis	Minor
	Tracheoesophageal puncture for voice rehabilitation	Minor
	Thyroplasty for vocal cord paralysis	Intermediate
	Vocal cord operation, including use of laser (excluding carcinoma)	Minor
	Tracheostomy, temporary / permanent / revision	Minor
	Lobectomy of lung / pneumonectomy	Complex
	Pleurectomy	Major
	Segmental resection of lung	Major
	Thoracocentesis / insertion of chest tube for pneumothorax	Minor
	Thoracoscopy +/- biopsy	Intermediate
	Thoracoplasty	Major
	Thymectomy	Major
EYE		
Eye	Excision / curettage / cryotherapy of lesion of eyelid	Minor
	Blepharorrhaphy / tarsorrhaphy	Minor
	Repair of entropion or ectropion +/- wedge resection	Minor
	Reconstruction of eyelid, partial-thickness	Intermediate
	Excision / destruction of lesion of conjunctiva	Minor
	Excision of pterygium	Minor
	Corneal grafting, severe wound repair and keratoplasty, including corneal transplant	Major
	Laser removal / destruction of corneal lesion	Intermediate
	Removal of corneal foreign body	Minor
	Repair of cornea	Intermediate
	Suture / repair of corneal laceration or wound with conjunctival flap	Intermediate
	Aspiration of lens	Intermediate
	Capsulotomy of lens, including use of laser	Intermediate
	Extracapsular / intracapsular extraction of lens	Intermediate
	Intraocular lens / explant removal	Intermediate
	Chorioretinal lesion operations	Intermediate
	Phacoemulsification and implant of intraocular lens	Intermediate
	Pneumatic retinopexy	Intermediate
	Retinal Photocoagulation	Intermediate
	Repair of retinal detachment / tear	Intermediate
	Repair of retinal tear / detachment with buckle	Major
	Scleral buckling / encircling of retinal detachment	Major
	Cyclodialysis	Intermediate
	Trabeculectomy, including use of laser	Intermediate
	Surgical treatment for glaucoma including insertion of implant	Intermediate
	Diagnostic aspiration of vitreous	Minor
	Injection of vitreous substitute	Intermediate
	Mechanical vitrectomy / removal of vitreous	Major
	Biopsy of iris	Minor

Procedure / Surgery		Category
	Excision of lesion of iris / anterior segment of eye / ciliary body	Intermediate
	Excision of prolapsed iris	Intermediate
	Iridotomy	Intermediate
	Iridectomy	Intermediate
	Iridoplasty +/- coreoplasty by laser	Intermediate
	Iridencleisis and iridotaxis	Intermediate
	Scleral fistulization +/- iridectomy	Intermediate
	Thermocauterization of sclera +/- iridectomy	Intermediate
	Diminution of ciliary body	Intermediate
	Biopsy of extraocular muscle or tendon	Minor
	Operation on one extraocular muscle	Intermediate
	Eyeball, perforating wound of, with incarceration or prolapse of uveal tissue repair	Major
	Enucleation of eye	Intermediate
	Evisceration of eyeball / ocular contents	Intermediate
	Repair of eyeball or orbit	Intermediate
	Conjunctivocystorhinostomy	Intermediate
	Conjunctivorhinostomy with insertion of tube / stent	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lacrimal sac and passage	Minor
	Excision of lacrimal gland / dacryoadenectomy	Intermediate
	Probing +/- syringing of lacrimal canaliculi / nasolacrimal duct	Minor
	Repair of canaliculus	Intermediate
	Coreoplasty	Intermediate
FEMALE GENITAL SYSTEM		
Cervix	Amputation of cervix	Intermediate
	Colposcopy +/- biopsy	Minor
	Conization of cervix	Minor
	Destruction of lesion of cervix by excision/ cryosurgery / cauterization / laser	Minor
	Endocervical curettage	Minor
	Loop electrosurgical excision procedure (LEEP)	Minor
	Marsupialization of cervical cyst	Minor
	Repair of cervix	Minor
	Repair of fistula of cervix	Intermediate
	Suture of laceration of cervix / uterus / vagina	Intermediate
Fallopian tubes and ovaries^	Dilatation / insufflation of fallopian tube	Minor
	Excision / destruction of lesion of fallopian tube, open or laparoscopic	Major
	Repair of fallopian tube	Major
	Salpingostomy / salpingotomy	Intermediate
	Total or partial salpingectomy	Intermediate
	Tuboplasty	Intermediate
	Aspiration of ovarian cyst	Minor
	Ovarian cystectomy, open or laparoscopic	Major
	Wedge resection of ovary, open or laparoscopic	Major
	Oophorectomy	Intermediate
	Oophorectomy, laparoscopic	Major
	Salpingo-oophorectomy, open or laparoscopic	Major
	Drainage of tubo-ovarian abscess, open or laparoscopic	Intermediate
	^ The category applies to both unilateral and bilateral procedures unless otherwise specified.	
Uterus	Dilatation and curettage of Uterine (D&C)	Minor
	Hysteroscopy +/- biopsy	Minor
	Hysteroscopy with excision or destruction of uterus and supporting structures	Intermediate
	Hysterotomy	Major
	Laparoscopic assisted vaginal hysterectomy (LAVH)	Major
	Vaginal hysterectomy +/- repair of cystocele and/or rectocele	Major
	Total / subtotal abdominal hysterectomy +/- bilateral salpingo- oophorectomy, open	Major

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Procedure / Surgery		Category
	or laparoscopic	
	Radical abdominal hysterectomy	Complex
	Myomectomy, open or laparoscopic	Major
	Uterine myomectomy, vaginal or hysteroscopic	Intermediate
	Laparoscopic drainage of female pelvic abscess	Intermediate
	Colposuspension	Major
	Pelvic floor repair	Major
	Pelvic exenteration	Complex
	Uterine suspension	Intermediate
Vagina	Destruction of lesion of vagina by excision / cryosurgery / cauterization / laser	Minor
	Insertion / removal of vaginal supportive pessaries	Minor
	Marsupialization of Bartholin's cyst	Minor
	Vaginal stripping of vaginal cuff	Minor
	Vaginotomy	Intermediate
	Partial vaginectomy	Intermediate
	Vaginectomy, complete	Major
	Radical vaginectomy	Complex
	Anterior colporrhaphy +/- Kelly plication	Intermediate
	Posterior colporrhaphy	Intermediate
	Obliteration of vaginal vault	Intermediate
	Sacrospinous ligament suspension or fixation of the vagina	Intermediate
	Sacral colpopexy	Intermediate
	Vaginal repair of enterocoele	Intermediate
	Closure of urethro-vaginal fistula	Intermediate
	Repair of rectovaginal fistula, vaginal approach	Intermediate
	Repair of rectovaginal fistula, abdominal approach	Major
	Culdocentesis	Minor
	Culdotomy	Minor
	Excision of transverse vaginal septum	Minor
	McCall's culdeplasty / culdoplasty	Intermediate
	Vaginal reconstruction	Major
Vulva and introitus	Destruction of lesion of vulva by excision / cryosurgery / cauterization / laser	Minor
	Wide local excision of vulva with cold knife or LEEP	Minor
	Excision of vestibular adenitis	Minor
	Excision biopsy of vulva	Minor
	Incision and drainage of vulva and perineum	Minor
	Lysis of vulvar adhesions	Minor
	Repair of fistula of vulva or perineum	Minor
	Suture of lacerations / repair of vulva and/or perineum	Minor
	Vulvectomy	Intermediate
	Radical vulvectomy	Major
HEMIC AND LYMPHATIC SYSTEM		
Lymph Nodes	Drainage of lesion / abscess of lymph node	Minor
	Biopsy / excision of superficial lymph nodes / simple excision of lymphatic structure	Minor
	Incisional biopsy of cervical lymph node / fine needle aspiration (FNA) biopsy of lymph nodes	Minor
	Excision of deep lymph node / lymphangioma / cystic hygroma	Intermediate
	Bilateral inguinal lymphadenectomy	Intermediate
	Cervical lymphadenectomy	Intermediate
	Inguinal and pelvic lymphadenectomy	Major
	Radical groin dissection	Major
	Radical pelvic lymphadenectomy	Major
	Selective / radical / functional neck dissection	Major
	Wide excision of axillary lymph node	Major
Spleen	Splenectomy, open or laparoscopic	Major

Procedure / Surgery		Category
MALE GENITAL SYSTEM		
Prostate	External drainage of prostatic abscess	Minor
	Photoselective vaporization of prostate	Major
	Plasma vaporization of prostate	Major
	Prostate biopsy	Minor
	Transurethral microwave therapy	Intermediate
	Transurethral prostatectomy or TURP	Major
	Prostatectomy, open or laparoscopic	Major
	Radical prostatectomy, open or laparoscopic	Complex
Penis	Circumcision	Minor
	Release of chordee	Major
	Repair of buried / avulsion of penis	Intermediate
Testicles^	Epididymectomy	Intermediate
	Exploration of testis	Intermediate
	Exploration for undescended testis, laparoscopic	Major
	Orchidopexy	Intermediate
	Orchidectomy or orchidopexy, laparoscopic	Major
	Reduction of torsion of testis and fixation	Intermediate
	Testicular biopsy	Minor
	High ligation of hydrocoele	Intermediate
	Tapping of hydrocele	Minor
	Excision of varicocoele and hydrocoele of spermatic cord	Intermediate
	Varicocelectomy (microsurgical)	Major
	^ The category applies to both unilateral and bilateral procedures unless otherwise specified.	
Spermatic cord	Vasectomy	Minor
MUSCULOSKELETAL SYSTEM		
Bone	Amputation of finger(s) / toe(s) of one limb	Intermediate
	Amputation of one arm / hand / leg / foot	Intermediate
	Bunionectomy	Intermediate
	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal	Major
	Excision of radial head	Intermediate
	Mandibulectomy for benign disease	Intermediate
	Patellectomy	Major
	Partial ostectomy of facial bone	Intermediate
	Sequestrectomy of facial bone	Intermediate
	Wedge osteotomy of bone of wrist / hand / leg	Major
	Wedge osteotomy of bone of upper arm / lower arm / thigh	Major
	Wedge osteotomy of scapula / clavicle / sternum	Major
Joint	Arthroscopic drainage and debridement	Intermediate
	Arthroscopic removal of loose body from joints	Intermediate
	Arthroscopic examination of joint +/- biopsy	Intermediate
	Arthroscopic assisted ligament reconstruction	Major
	Arthroscopic Bankart repair	Major
	Arthroscopic repair for superior labral tear from anterior to posterior of shoulder	Major
	Arthroscopic rotator cuff repair	Major
	Acromioplasty	Major
	Arthrodesis of shoulder	Major
	Arthrodesis of Elbow / Triple arthrodesis	Major
	Arthrodesis of knee / hip	Complex
	Arthroplasty of hand / finger / foot / Toe joint with implant	Major
	Fusion of wrist	Major
	Synovectomy of wrist	Intermediate
	Interphalangeal joint fusion of toes	Intermediate
	Interphalangeal fusion of finger	Major
	Excisional arthroplasty shoulder / hemiarthroplasty of shoulder	Major

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Procedure / Surgery		Category
	Excisional arthroplasty of hip / knee / Wrist / Elbow	Major
	Excisional arthroplasty of hip / knee with local antibiotic delivery	Complex
	Temporomandibular arthroplasty +/- autograft	Major
	Joint aspiration / injection	Minor
	Manipulation of joint under anesthesia	Minor
	Metal femoral head insertion	Major
	Anterior cruciate ligament reconstruction	Major
	Meniscectomy, open or arthroscopic	Major
	Posterior cruciate ligament reconstruction	Major
	Repair of the collateral ligaments	Major
	Repair of the cruciate ligaments	Major
	Suture of capsule or ligament of ankle and foot	Major
	Total shoulder replacement	Complex
	Total knee replacement	Complex
	Total hip replacement	Complex
	Partial hip replacement	Major
Muscle/ Tendon	Achilles tendon repair	Intermediate
	Achillotenotomy	Intermediate
	Change in muscle or tendon length (except hand) / excision of lesion of muscle	Intermediate
	Change in muscle or tendon length of hand	Major
	Excision of lesion of muscle	Intermediate
	Lengthening of tendon, including tenotomy	Intermediate
	Open biopsy of muscle	Minor
	Release of De Quervain's disease	Minor
	Release of trigger finger	Minor
	Release of tennis elbow	Minor
	Transfer / transplantation / reattachment of muscle	Major
	Tendon repair / Suture of tendon not involving hand	Intermediate
	Tendon repair / Suture of tendon of hand	Major
	Tenosynovectomy / synovectomy	Intermediate
	Transposition of tendon of wrist / hand	Major
	Secondary repair of tendon, including graft, transfer and / or prosthesis	Major
Fracture/ dislocation	Closed reduction of dislocation of temporomandibular / interphalangeal / acromioclavicular joint	Minor
	Closed reduction of dislocation of shoulder / elbow / wrist / ankle	Intermediate
	Closed reduction for Colles' fracture with percutaneous k-wire fixation	Major
	Closed reduction for fracture of arm / leg / patella / pelvis with internal fixation	Major
	Close reduction for mandibular fracture with internal fixation	Intermediate
	Closed reduction for fracture of clavicle / scapula / phalanges / patella without internal fixation	Minor
	Closed reduction for fracture of upper arm / lower arm / wrist / hand / leg / foot bone without internal fixation	Intermediate
	Closed reduction for fracture of clavicle / hand / ankle /foot with internal fixation	Intermediate
	Closed reduction for fracture of femur +/- internal fixation	Major
	Closed / open reduction of fracture of acetabulum with internal fixation	Complex
	Open reduction for mandibular fracture with internal fixation	Major
	Open reduction for clavicle / hand / foot (except carpal / talus / calcaneus) +/- internal fixation	Intermediate
	Open reduction for arm / leg / patella / scapula +/- internal fixation	Major
	Open reduction for femur / calcaneus / talus/ +/- internal fixation	Major
	Operative treatment of compound fracture with external fixator and extensive wound debridement	Intermediate
	Removal of screw, pin and plate, and other metal for old fracture except fracture femur	Minor
Spine	Artificial cervical disc replacement	Complex

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Procedure / Surgery		Category
	Anterior spinal fusion, cervical / cervicothoracic/ C4/5 and C5/6 and locking plate	Major
	Anterior spinal fusion (excluding cervical / cervicothoracic/ C4/5 and C5/6 and locking plate)	Complex
	Anterior spinal fusion with instrumentation	Complex
	Laminoplasty for cervical spine	Major
	Laminectomy / discectomy	Major
	Laminectomy with discectomy	Complex
	Posterior spinal fusion, thoracic / cervico-thoracic / thoracolumbar / T5 to L1/ atlas-axis	Major
	Posterior spinal fusion, (excluding thoracic / cervico-thoracic / thoracolumbar / T5 to L1 / atlas-axis)	Complex
	Posterior spinal fusion with instrumentation	Complex
	Spinal biopsy	Minor
	Spinal fusion +/- foraminotomy +/- laminectomy +/- discectomy	Complex
	Spine osteotomy	Complex
	Vertebroplasty / kyphoplasty	Intermediate
Others	Excision of ganglion / bursa	Minor
	Closed/ Percutaneous needle fasciotomy for Dupuytren disease	Minor
	Radical (or total) fasciectomy for Dupuytren disease	Major
	Release of carpal / tarsal tunnel, open or endoscopic	Intermediate
	Release of peripheral nerve	Intermediate
	Transposition of ulnar nerve	Intermediate
	Sliding / reduction genioplasty	Intermediate
SKIN AND BREAST		
Skin	Curettage / cryotherapy / cauterization / laser treatment of lesion of skin	Minor
	Drainage of subungual haematoma or abscess	Minor
	Excision of lipoma	Minor
	Excision of skin for graft	Minor
	Incision and /or drainage of skin abscess	Minor
	Incision and /or removal of foreign body from skin and subcutaneous tissue	Minor
	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue	Minor
	Suture of wound on skin	Minor
	Surgical toilet and suturing	Minor
	Wedge resection of toenail	Minor
Breast	Breast tumour/ lump excision +/- biopsy	Intermediate
	Fine needle aspiration (FNA) of breast cyst	Minor
	Incisional breast biopsy	Minor
	Modified radical mastectomy	Major
	Partial or simple mastectomy	Intermediate
	Partial or radical mastectomy with axillary lymphadenectomy	Major
	Total or radical mastectomy	Major
	Duct papilloma excision	Intermediate
	Gynaecomastia excision	Intermediate
URINARY SYSTEM		
Kidney	Extracorporeal shock wave lithotripsy for urinary stone (ESWL)	Intermediate
	Nephrolithotomy / pyelolithotomy	Major
	Nephroscopy	Major
	Percutaneous insertion of nephrostomy tube	Minor
	Renal biopsy	Minor
	Nephrectomy, open or laparoscopic or retroperitoneoscopic	Major
	Nephrectomy, partial/ lower pole	Complex
	Kidney transplant	Complex
Bladder, ureter and urethra	Cystoscopy +/- biopsy	Minor
	Cystoscopy with catheterization of ureter/ transurethral bladder clearance	Minor
	Cystoscopy with electro-cauterisation/ laser lithotripsy	Intermediate

Procedure / Surgery		Category
	Excision of urethra caruncle	Minor
	Insertion of urethral/ureter stent	Intermediate
	Diverticulectomy of urinary bladder, open or laparoscopic	Major
	Transurethral resection of bladder tumour	Major
	Partial cystectomy, open or laparoscopic	Major
	Radical/ total cystectomy, open or laparoscopic	Complex
	Ureterolithotomy, open or laparoscopic or retroperitoneoscopic	Major
	Closure of urethro-rectal fistula	Major
	Repair of urethral fistula	Major
	Repair of vesicovaginal fistula	Major
	Repair of vesicocolic fistula	Major
	Repair of rupture of urethra	Major
	Repair of urinary stress incontinence	Major
	Formation of ileal conduit, including ureteric implantation	Complex
	Ileal or colonic replacement of ureter	Major
	Unilateral reimplantation of ureter into bowel or bladder	Major
	Bilateral reimplantation of ureter into bowel or bladder	Major
DENTAL		
	Any kind of dental surgery due to injury caused by an Accident	Minor

VHIS Prestige Care

Additional Terms and Benefits for Optional Other Benefits

(This is NOT a part of VHIS Certified Plan)

Outpatient Services Benefit

(This benefit is payable if it is shown on the Policy Schedule)

Subject to the Terms and Conditions of the Policy, this benefit shall be payable for the following outpatient services if the Insured Person shall incur expenses for Medically Necessary treatment :

(1) General Outpatient Services

Outpatient consultation provided by a Registered Medical Practitioner.

(2) Specialist Outpatient Services

Outpatient specialist consultation provided by a Specialist as recommended in writing by a Registered Medical Practitioner.

(3) Outpatient Laboratory and Diagnostic Test Services

Outpatient laboratory and diagnostic test used to diagnose or for treatment of Disability as provided or recommended in writing by a Registered Medical Practitioner.

(4) Outpatient Prescribed Western Medication

Outpatient western medication prescribed for use by the Insured Person as provided or recommended in writing by a Registered Medical Practitioner.

(5) Acupuncture, bone-setting and Chiropractic Services

Treatment for Injury provided by a registered Chinese medicine practitioner for acupuncture or bone-setting, or by a registered chiropractor for chiropractic treatment.

Cover for Outpatient Services Benefit does not include expenses recoverable under any other benefit insured by the Policy.

Dental Benefit

(This benefit is payable if it is shown on the Policy Schedule)

Subject to the Terms and Conditions of the Policy, this benefit shall be payable for the following dental services if the Insured Person shall incur expenses for Medically Necessary treatment provided by a registered dentist :

- (1) Routine oral examination
- (2) Scaling, polishing and cleansing, up to two (2) visits per Policy Year
- (2) Filling and extraction
- (3) Intraoral X-ray
- (4) Medication for dental treatment
- (5) Drainage of dental abscesses
- (6) Pins for cusp restoration
- (7) Dentures, crowns or bridges (only if necessitated by an Accident)

No benefit shall be payable for the following services, products or conditions:

- (1) Dental appliances;
- (2) Charges for any dental procedure which are not included in the above-mentioned covered dental services;
- (3) Treatment by any person other than a registered dentist;
- (4) Charges for services and supplies that are partially or wholly cosmetic in nature; unless the services are recommended as necessary by a Registered Dentist with medical necessity.

Cover for Dental Benefit does not include expenses recoverable under any other benefit insured by the Policy.

Critical Illness Benefits and Lady Benefit

(This benefit is payable if it is shown on the Policy Schedule)

Subject to the Terms and Conditions of the Policy, and the Company receiving such proof as it may reasonably require, the Critical Illness Benefit and Lady Benefit shall be payable if:

- (1) The covered critical illness suffered by the Insured Person is diagnosed sixty (60) days after the effective date of the Policy, except when caused by an Accident, and
- (2) the Insured Person is alive more than twenty-one (21) days after the diagnosis is made.

The amount of benefit payable for Critical Illness Benefit and Lady Benefit is that specified in the Policy Schedule less any unpaid premiums for the specific whole Policy Year and benefit paid for Lady Benefit.

For Critical Illness Benefit and Lady Benefit:

- (1) Any Insured Person shall not be covered under more than one (1) policy in whole or in part providing benefit payable in respect of critical illnesses in the Company. If the Insured Person is covered in more than one such policy in the Company, the Company has the right to treat the Insured Person as being covered under the policy providing the greatest amount of benefit. If the amounts of benefits are identical, the Company shall treat the Insured Person as being covered under the policy first issued.
- (2) The Company shall pay benefit for Female Specific Cancers in Situ only once and will not pay for more than one of the Female Specific Cancers in Situ.
- (3) The Overall Maximum Limit for Critical Illness Benefit shall be reduced by the benefits paid under Lady Benefit.
- (4) The Critical Illness Benefit will cease immediately upon payment of the Overall Maximum Limit for critical illness.

Additional Exclusions for Critical Illness Benefit and Lady Benefit

The following items, conditions, activities and their consequences are excluded from the Critical Illness Benefit and Lady Benefit of the Policy and the Company shall not be liable for:

- (1) Illnesses diagnosed within sixty (60) days from the first inception date of the Policy or in respect of the upgraded part of the benefit amount, the Upgrade Date, except when caused by an Accident.

Upgrade Date means the date on which an upgrade to the benefit amount or coverage is approved by the Company by means of endorsement for the confirmation of such upgrade to Insured Person.

- (2) Unreasonable failure to seek or follow medical advice.

If the Company allege that by reason of these exclusions any claim is not covered by this Policy, then the burden of proving that the claim is covered shall be upon Policy Holder.

Additional Definition for Critical Illness Benefit and Lady Benefit

“Activities of Daily Living” shall mean:

- Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa, or to get on and off a toilet or commode.
- Continence: The ability to manage bowel and bladder functions such that an adequate level of personal hygiene can be maintained.
- Dressing: The ability to put on, take off, secure and unfasten all necessary garments and any braces, artificial limbs or other surgical appliances.
- Mobility: The ability to move indoor from one room to another on a level surface in the Insured Person's normal place of residence.
- Feeding: The ability to feed oneself once food and drink which has been prepared and made available.
- Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) such that an adequate level of personal hygiene can be maintained.

Critical Illness Benefits

(This benefit is payable if it is shown on the Policy Schedule)

If the Insured Person has, to the satisfaction of the Company's medical adviser, been diagnosed, by a Registered Medical Practitioner, or Specialist as required in some Critical Illnesses under this benefit, registered in the Insured Person's Place(s) of Residence, as suffering from one or more of the following and is alive more than twenty-one (21) days after the diagnosis is made, the Company will pay the overall maximum limit for Critical Illness Benefit.

Critical Illnesses refer to:

(1) Cancer

A malignant tumour characterised by the uncontrolled growth and spread of malignant cells, and the invasion of tissue. This includes leukaemia, Hodgkin's Disease and Lymphoma but excludes Kaposi's Sarcoma in the presence of any Human-Immuno Deficiency Virus, non-invasive cancer in situ and any skin cancer other than invasive malignant melanoma.

To support a claim, precise histological evidence of cancer must be produced.

(2) Stroke

A cerebrovascular incident resulting in permanent neurological damage. Transient ischaemic attacks are specifically excluded.

(3) Heart Attack

The death of a portion of heart muscle as a result of inadequate blood supply as evidenced by an episode of typical chest pain, new electrocardiographic changes and by an elevation of cardiac enzymes.

(4) Coronary Artery Bypass Surgery

The undergoing of open-heart surgery of the Insured Person on the advice of a Specialist for Cardiology to correct narrowing or blockage of one or more coronary arteries with bypass grafts but excluding balloon angioplasty, laser or any other procedures.

If the degree of obstruction in two or more coronary arteries is at least seventy (70)%, then treatment to two or more affected arteries by balloon angioplasty, atherectomy or laser will also constitute a claim under this benefit.

(5) Complete Liver Failure

End stage liver failure evidenced by jaundice, encephalopathy and ascites as diagnosed by a Registered Medical Practitioner holding an appointment in a major Hospital in the Insured Person's Place(s) of Residence.

(6) Kidney Failure

End stage kidney failure, presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular kidney dialysis or kidney transplant is initiated.

(7) Major Organ Transplant(s)

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

The definition includes simultaneous transplantation of more than one of the above organs. Transplantation of kidney is included provided a claim has not been admitted under kidney failure.

(8) Motor Neurone Disease

Motor Neurone Disease diagnosed, with the appropriate supporting evidence, by a Specialist for Neurology.

(9) Loss of Hearing

The total and permanent loss of hearing in both ears which must be established for a continuous period of twelve (12) months.

(10) Blindness

The total and permanent loss of sight in both eyes.

(11) Major Burns

Third degree burns covering at least twenty (20)% of the surface area of the Insured Person's body.

(12) Coma

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

(13) Parkinson's Disease

Confirmation by a Specialist for Neurology of a definite diagnosis before the Insured Person's sixtieth (60th) birthday of Idiopathic Parkinson's Disease (paralysis agitans) requiring treatment with a dopamine precursor.

All other types of Parkinsonism are specifically excluded.

(14) Multiple Sclerosis

Confirmation by a Neurologist of a definite diagnosis of Multiple Sclerosis producing at least moderate neurological abnormalities which have persisted for a continuous period of six (6) months.

(15) Paralysis/Paraplegia

Total and permanent loss of the use of two or more limbs of the Insured Person resulting from paralysis which has been present for at least twelve (12) consecutive months.

(16) Loss of Independent Existence

Loss of Independent Existence will mean a permanent inability to perform independently three (3) or more Activities of Daily Living, after attaining age sixty (60), with or without the use of mechanical equipment, special devices or other aids.

(17) HIV Resulting from Blood Transfusion

Infection with any Human Immuno-deficiency Virus (HIV) through a blood transfusion given as part of medical treatment received in the Insured Person's Place(s) of Residence, after the start of the Policy. There must be clear evidence satisfactory to the Company's medical adviser that the infection was acquired in this way and provided further that the institution which provided the transfusion admits liability and the Insured Person is not a haemophiliac.

(18) Aorta Surgery

The undergoing of open-heart surgery for a disease of or an injury to the aorta needing excision and surgical replacement of the aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

(19) Heart Valve Surgery

The undergoing of open-heart surgery to repair or replace one or more abnormal heart valves.

(20) Alzheimer's Disease

A clinically established diagnosis of Alzheimer's Disease or Pre-Senile Dementia of the Insured Person before attaining age sixty (60) resulting in a permanent inability to perform independently three (3) or more Activities of Daily Living.

Alzheimer's Disease and Pre-Senile Dementia will mean the deterioration or loss of intellectual capacity or abnormal behaviour (as evidenced by the clinical state and accepted standardised questionnaires or tests) arising from irreversible organic degenerative disorders, excluding neurosis and psychiatric illnesses, resulting in significant reduction in mental and social functioning requiring continuous supervision. The diagnosis must be made by a Specialist for Neurology and be supported by the Company's medical adviser.

(21) Loss of Speech

The total and permanent loss of the ability to speak due to physical damage to vocal cords which must be established for a continuous period of twelve (12) months.

(22) Benign Brain Tumour

A non-cancerous intracerebral tumour. Cysts, granulomas, malformations in or of the arteries or veins in the brain, haematomas and tumours of the pituitary gland or spine are specifically excluded.

(23) Terminal Illness

Advanced or rapidly progressing incurable disabling terminal illness where, in the opinion of the Company's medical adviser the life expectancy is no greater than twelve (12) months.

(24) Loss of Limbs

The total and permanent loss of use of two (2) or more limbs, subject to the severance of at least one (1) limb above the knee or elbow.

(25) Muscular Dystrophy

A hereditary muscular dystrophy confirmed by a Specialist for Neurology resulting in permanent and total disability.

(26) Encephalitis

Inflammation of the membranes of the brain or spinal cord resulting in significant permanent neurological deficit. The diagnosis must be confirmed by a Specialist for Neurology. Encephalitis in the presence of HIV infection is excluded.

(27) Accidental Head Injury Resulting in Major Head Trauma

Physical injury to the head as a result of an Accident resulting in residual brain damage. There must be permanent neurological deficit causing significant functional impairment as defined by a Specialist for Neurology.

(28) Pulmonary Hypertension

Primary Pulmonary Arterial Hypertension as established by clinical and laboratory investigations including cardiac catheterisation and as diagnosed by a Specialist for Cardiology. The following diagnostic criteria must be met:-

- (a) dyspnoea and fatigue; and
- (b) increased left atrial pressure (at least 20 units or more); and
- (c) pulmonary resistance of at least 3 units above normal; and
- (d) pulmonary artery pressure of at least 40mmHg; and
- (e) pulmonary wedge pressure of at least 6mmHg; and
- (f) right ventricular end-diastolic pressure of at least 8mmHg; and
- (g) right ventricular hypertrophy, dilation and signs of right heart failure and decompensation.

Lady Benefits

(This benefit is payable if it is shown on the Policy Schedule)

(1) Female Specific Cancers in Situ:

“Cancer in situ” means a focal malignant lesion that has not yet result in invasion or infiltration of normal tissues or spread to other parts of the body.

If the Insured Person has been diagnosed as suffering from one of the defined Female Specific Cancers in Situ, the Company will pay the Maximum Limit for Lady Benefit.

Female Specific Cancers in Situ refer to:

- (a) Cancer in Situ of the Breast
- (b) Cancer in Situ of the Cervix
- (c) Cancer in Situ of the Uterus
- (d) Cancer in Situ of the Fallopian Tube
- (e) Cancer in Situ of the Vagina or Vulva
- (f) Cancer in Situ of the Ovary

For Cancer in Situ of the Cervix, a grading of less than CIN III shall not be covered.

To support a claim for “Cancer in situ”, precise microscopic evidence confirmed by fixed tissue biopsy showing positive diagnosis must be produced. Preliminary clinical diagnosis is not sufficient.

(2) Female Illnesses:

If the Insured Person has been diagnosed as suffering from one of the defined Female Illnesses, the Company will pay the Maximum Limit for Lady Benefit.

Female Illnesses refer to:

(a) Rheumatoid Arthritis

Rheumatoid Arthritis severely affecting ability to perform any two (2) of the Activities of Daily Living as certified by a Specialist for Rheumatology and Immunology.

(b) Osteoporosis Leading to Hip Fractures

Osteoporosis resulting in Hip Fractures as certified by a Specialist for Orthopaedic.

(c) Systemic Lupus Erythematosus with Lupus Nephritis

Systemic Lupus Erythematosus involving the kidneys, resulting in Lupus Nephritis as certified by a Specialist for Rheumatology and Immunology.

Benefit Schedule for Optional Other Benefits (HKD)

Optional Others Benefits	Plan A	Plan B	Plan C
Outpatient Services Benefit			
Maximum Limit – per Policy Year	N/A	N/A	\$25,000
General Practitioner (GP) – 1 visit per day			Full Cover
Specialist Practitioner (SP) – 1 visit per day			Full Cover
Max. Total No. of GP & SP Visits – per Policy Year			30
Prescribed Medication – per Policy Year			\$10,000
Diagnostic X-ray & Laboratory Tests – per Policy Year			\$10,000
Bonesetter, Acupuncturist, and Chiropractor treatment – for injury due to Accident – 1 visit per day up to 8 visits per Policy Year – per day			\$500
Dental Benefit			
Maximum Limit per Policy Year – Scaling and polishing (Maximum 2 visits per Policy Year): 500 per visit – Routine oral examination – Intraoral X-ray and medications – Fillings and extractions – Drainage of dental abscesses – Pins for cusp restoration – Dentures, crowns and bridges (Only if necessitated by an Accident)	\$2,500	\$2,500	\$2,500
Critical Illness Benefits			
Standard Coverage : covers Critical Illnesses item (1) – (12)			
Comprehensive Coverage : covers Critical Illnesses item (1) – (28)			
Overall Maximum Limit for Critical Illness Benefit	\$500,000	\$500,000	\$500,000
Maximum Limit for Lady Benefit	\$100,000	\$100,000	\$100,000
Remarks: Lady Benefit is a rider benefit of Critical Illness Benefit and cannot be insured separately. Benefit paid for Lady Benefit will reduce the Overall Maximum Limit for Critical Illness Benefit.			

Appendix : 24-hour International Assistance Services Terms and Conditions

This document does not form part of the Policy contract.

24-hour International Assistance Services are arranged through the Service Provider by MSIG Insurance (Hong Kong) Limited to assist the Member in an Emergency whilst he/she travels outside of Hong Kong.

SECTION 1 - DEFINITIONS

Assistance Event :

shall mean any event or occurrence with respect to the Member who is entitled to receive assistance pursuant to these terms and conditions, occurring within the Territorial Limits set in Section 2 Item 2.2 and subject to Exclusions listed in Section 6.

Close Relative :

shall mean the Member's spouse, parent(s), his/her child(ren), brother(s) or sister(s) excluding parent(s)-in-law, brother(s) / sister(s)-in-law.

the Company :

shall mean MSIG Insurance (Hong Kong) Limited.

Country of Residence :

shall mean Hong Kong unless otherwise specifically agreed by the Company.

Emergency :

shall mean a serious medical situation or distress which could not be reasonably prevented and for which specific external help is required.

Illness :

shall mean any unforeseen sickness, illness or disease first manifested during the period of insurance covered by the Company.

the Member :

shall mean the person duly covered by the Company.

Serious Medical Condition :

shall mean a condition which in the opinion of the Service Provider constitutes a serious medical Emergency requiring urgent remedial treatment to avoid death or serious impairment to the Member's immediate or long term health prospects. The seriousness of the medical condition will be judged within the context of the Member's geographical location, the nature of the medical Emergency and the local availability of appropriate medical care or facility.

the Service Provider :

shall mean the provider for emergency assistance services appointed by the Company.

SECTION 2 - DURATION OF COVER AND LIMITATIONS

2.1 DURATION OF COVER

The services mentioned in Section 3 are granted during the period of insurance covered by the Company.

2.2 TERRITORIAL LIMITS

Except for the services specifically mentioned under Section 3.2, the services mentioned in Section 3 apply worldwide outside the Country of Residence.

SECTION 3 - EMERGENCY ASSISTANCE SERVICES

3.1 EMERGENCY MEDICAL ADVICE AND ASSISTANCE

In overseas emergencies, the Member may telephone the 24-hour emergency assistance centre for medical advice and evaluation from the attending co-ordinator doctor in order to locate suitable medical services anywhere in the world or to provide referral to medical practitioners, specialists or hospitals for personal assessment and/or

treatment as medically appropriate, it being understood and agreed that such telephone conversations cannot establish a diagnosis and shall be considered as an advice only. The emergency assistance centre can facilitate necessary hospital admissions overseas by confirming the extent of insurance cover provided by the Company, monitoring claims procedures and issuing appropriate guarantees in accordance with the payment guarantees condition.

3.2 INTERNATIONAL TRAVEL ASSISTANCE SERVICES

When the Member is travelling or intends to travel outside the Country of Residence, the 24-hour emergency assistance centre can provide the following administrative assistance and services:

- visa, immunization and vaccination requirements, special medication and weather information services prior to departure,
- retrieval and redirection of lost luggage,
- replacement and delivery of essential lost travel documents such as passport, travel tickets and credit cards,
- emergency message transmission and interpreting service,

it being understood and agreed that any third party fees or charges reasonably and properly incurred by the Company in the delivery of these services shall be borne entirely by the Member.

SECTION 4 - GENERAL OBLIGATIONS /PROCEDURES

4.1 REQUEST FOR ASSISTANCE

In case of an Emergency, and prior to taking personal action where reasonable, the Member or his/her representative shall call the Service Provider's emergency assistance centre whose contact number is listed below:

HONG KONG : (852) 3122 6899

and should state :

- his/her name, the policy number, name of the insurance company and his/her I.D. Card or passport number, and
- the name of the place and the telephone number where the Service Provider can reach the Member or his/her representative, and
- a brief description of the accident and the nature of help required.

The cost of long distance calls shall be borne by the Member.

4.2 FAILURE TO NOTIFY THE SERVICE PROVIDER

In a life threatening situation, the Member or his/her representative should always try to arrange for emergency transfer to a hospital near the place of occurrence through the most appropriate and immediate means and then call the Service Provider's emergency assistance centre to provide the appropriate information as soon as possible.

The Service Provider's medical team or other representatives shall have free access to the Member in order to assess the Member's condition. Without reasonable justification for denial of such an access, the Member will not be eligible for further medical assistance.

SECTION 5 - OBLIGATIONS OF THE MEMBER

5.1 MITIGATION

The Member shall be obliged to use reasonable efforts to mitigate the effects of an Emergency.

5.2 COOPERATION WITH THE SERVICE PROVIDER

The Member shall cooperate with the Service Provider to enable the Service Provider to get all documents and receipts from the relevant sources and assisting the Service Provider at his/her expenses in complying with necessary formalities.

5.3 LIMITATION ON CLAIMS

Any claim with respect to an Assistance Event or the right to any legal action or claim shall be forfeited unless such claim is filed within one year of the occurrence of such event.

5.4 SUBROGATION

In the event that the Company makes any payment in connection with the provision of assistance to the Member, the Company shall be subrogated to the rights of such Member to obtain payments from:

- Any third party found legally responsible for the assistance, up to the amount of such payment made by the Company, and
- Any other insurance or assistance plan which provides compensation to the Assistance Events.

SECTION 6 - EXCLUSIONS

The provision of the services mentioned under Sections 3 is subject to the exclusions of the insurance cover provided by the Company. For details, please refer to the insurance cover itself.

SECTION 7 - JURISDICTION

The terms and conditions of 24-hour International Assistance Services are subject to the exclusive jurisdiction of the Hong Kong Special Administrative Region and are to be construed according to the laws of the Hong Kong Special Administrative Region.

DISCLAIMER :

The Service Provider and the professionals to whom the Members are referred by the Service Provider are to be responsible for their own acts as independent contractors and are not employees, agents or servants of the Company. The Company shall not be responsible for any act or failure to act on the part of the Service Provider and these professionals such as, and not limited to, physicians, hospitals and clinics.

自願醫保計劃 優健保

條款及細則

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條款及細則

第一部分 保險條文及保單

保險條文

本條款及細則，連同保障表(包括手術表)及政府認可的相關補充文件（下簡稱「條款及保障」），適用於以下由本公司按自願醫保計劃（下簡稱「自願醫保」）提供的認可產品 -

認可產品類別：靈活計劃

認可產品名稱：自願醫保計劃-優健保

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

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

保單

保單持有人與本公司均同意 -

1. 所有對本條款及保障的修訂必須按本條款及細則執行，否則該修訂不應視為有效。
2. 在投保申請文件內所有由**受保人**或為**受保人**作出的陳述均被視為申述，而非保證。
3. 在投保申請文件內及按本保單所要求，所有由**受保人**或為**受保人**作出的陳述及提供的資料，必須盡其所知所信，絕對真誠地提出。
4. 當**保單持有人**繳交全數首期保費後，本條款及保障將按保單資料頁內所列的**保單生效日**起生效。
5. 在本條款及保障生效及每次續保時，當以下兩者 -
 - (a) 本保單的條款及保障；及
 - (b) 按第四部分第 1 (a) - (c)節所述政府所訂定標準計劃條款及保障的版本，

有任何互相抵觸或不相符之處時，

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

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

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

6. 在本**條款及保障**生效或每次**續保**時，若本**保單**的保障範圍超過或有別於**標準計劃條款及保障**的保障範圍，即使涉及的條款及保障與**標準計劃條款及保障**有所不同，亦不會構成本第一部分第 5 節所述有抵觸或不相符的情況。
7. **本公司**可以在首次簽發本**條款及保障**時，對**受保人**於**投保申請文件**內知會**本公司**的**投保前已有病症**，及其他會影響其投保風險的因素，加設**個別不保項目**。
8. **本公司**確認，作為核保程序的一部分，**本公司**有責任向**保單持有人**及**受保人**在**投保申請文件**內提問所有影響核保決定的資料。若**本公司**要求**保單持有人**及/或**受保人**披露，在遞交**投保申請文件**後至**保單簽發日**或**保單生效日**（以較早日期為準）前，相關資料的更新或改動，**本公司**必須明確地向**保單持有人**及**受保人**作出該要求（包括但不限於列載於投保申請表內），在這情況下，**保單持有人**及/或**受保人**均有責任知會**本公司**相關資料的更新及改動。每位**保單持有人**及**受保人**均有責任回覆問題，並披露問題所要求的重要事實。**本公司**同意，若在**投保申請文件**內未有包括任何相關問題，將被視為**本公司**豁免**保單持有人**及**受保人**披露有關所需資料的責任。
9. **投保申請文件**中所有問題及要求的資料必須充分具體及明確，並符合**自願醫保**的規則及規例，協助**保單持有人**及**受保人**（按情況而定）理解所需披露的資料，從而提供清晰而明確的回覆。如有爭議，**本公司**必須負舉證責任，證明問題充分具體及明確。
10. 若**保單持有人**或**受保人**未有按本第一部分第 8 或 9 節披露有關資料，而相關的披露會對**本公司**的核保決定帶來實質影響時，**本公司**有權行使按第二部分第 13 及 14 節所賦予的權利。

第二部分 一般條件

1. 合約詮釋

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

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

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

2. 冷靜期內取消條款及保障的安排

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

- (a) 取消要求必須由**保單持有人**簽署，並確保**本公司**於冷靜期內直接收到該要求。冷靜期為緊接下列文件交付予**保單持有人**或**保單持有人**的指定代表之日起計的二十一(21)日的期間 –
 - (i) 本**條款及保障**和**保單資料頁**；或
 - (ii) 冷靜期通知書；以較早者為準。為免生疑問，交付本**條款及保障**和**保單資料頁**或冷靜期通知書當天並不包括在計算二十一(21)日的期間內。然而，若第二十一(21)日當天並非工作天，則冷靜期將包括隨後的工作天的一天在內；
及
- (b) 若曾獲賠償或將獲得賠償，則不獲發還保費。

上述取消的權利並不適用於**續保**。

行使此項取消的權利時，**保單持有人**必須 –

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

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

3. 取消保單

冷靜期過後，若**保單持有人**在該**保單年度**期間沒有就本**條款及保障**獲得任何賠償，**保單持有人**可以在三十(30)日前以書面方式通知**本公司**要求取消本**條款及保障**。

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

4. 保障權益

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

5. 轉讓

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

6. 文書錯誤

任何文書記錄錯誤，將不會令原應有效的保障失效，或令原應終止的保障繼續生效。

7. 付款貨幣

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

8. 利息

除非另有列明，本**條款及保障**的一切賠償及費用均不會計算利息。

9. 本公司的責任

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

10. 規管法律

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

11. 排解糾紛

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

雙方需要自行承擔另類排解糾紛程序的服務費用。

12. 責任

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

13. 錯誤申報個人資料

在不損害**本公司**按本第二部分第 14 節中的權利（即因健康資料的失實陳述或欺詐的情況宣告**保單**無效的權利）下，若在**投保申請文件**或任何其後就相關申請（若**本公司**在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動），提交予**本公司**的資料或文件中錯誤申報**受保人**的非健康相關資料（包括但不限於**年齡**、性別或吸煙習慣），從而可能影響**本公司**作出的風險評估，**本公司**可按正確資料調整過去、現在或未來**保單年度**的保費。若**保單持有人**因此需補交額外保費，**本公司**不會在補交前支付任何賠償。若**保單持有人**在**本公司**通知的保費到期日後三十(30)日的寬限期內仍未補交保費，**本公司**有權行使本第二部分第 15 節賦予的權利，自保費到期日起終止本**保單**。若有多繳保費，**本公司**則必須予以退還。

本頁內容屬於自願醫保認可產品(編號: F00023)的條款及保障。

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

- (a) 有權追討已支付的賠償；及
- (b) 有責任退還已繳交的保費，

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

14. 失實陳述或欺詐

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

- (a) 在**投保申請文件**，或在**投保申請文件**或任何其後就相關申請提交予**本公司**的資料或文件，其所作出的陳述或聲明中，就**受保人**健康狀況的重要事實作出失實聲明或遺漏資料（若**本公司**在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動）。「重要事實」包括但不限於由**本公司**要求提供、會影響**本公司**對**受保人**的核保決定的事實，若披露該事實**本公司**有可能因而徵收**附加保費**，增加**個別不保項目**或拒絕投保申請。為免存疑，本(a)段並不適用於本第二部分第 13 節關於**受保人**非健康相關資料；或
- (b) 在**投保申請文件**中或索償時，作出欺詐或有欺詐成分的申述。

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

在(a)的情況下，**本公司**將 -

- (i) 有權追討已支付的賠償；及
- (ii) 有責任退還已繳交的保費，

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

在(b)的情況下，**本公司**將 -

- (iii) 有權追討已支付的賠償；及
- (iv) 有權不退還已繳交的保費。

15. 終止保單

本**保單**將在以下情況時自動終止，以最先者為準 -

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

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

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

若**保單**是按(a)終止，終止生效日為未付保費的原到期日。

若**保單**是按(b)或(c)終止，則**本公司**必須按比例退還現**保單年度**已支付的相關保費。

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

若本**保單**是按本第 15 節(a) 或(c) 終止，而**受保人** 在**保單**終止前罹患**傷病**並因此 **住院**或接受**訂明非手術癌症治療**，則就有關**傷病**的**住院**或治療，所招致的**合資格費用**仍可獲得保障，直至 (i) **受保人**出院或完成治療或 (ii) 本**保單**終止後的第三十 (30) 日，以較先者為準，並按本**保單**終止生效日前一日適用的**條款及保障**作出賠償。本公司有權從任何保障賠償中扣除按本第二部分第 13 節所指的所有到期未付的保費。

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

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

16. 致本公司的通知

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

17. 致保單持有人的通知

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

- (a) 郵寄後兩(2) 個工作日；或
- (b) 電子郵件的發出日期及時間。

18. 其他保障

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

19. 保單擁有權及責任的履行

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

20. 更改保單擁有權

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

本公司不可否決**保單持有人**轉移保單擁有權至下列人士的申請 -

- (a) 年滿十八(18) 歲的**受保人**；

本頁內容屬於自願醫保認可產品(編號: F00023) 的條款及保障。

- (b) 受保人的家長或監護人（如受保人為未成人）；或
- (c) 按本公司當時適用的核保的慣常做法下，可接受的受保人的親屬。本公司必須備妥該等核保慣常做法以供保單持有人查閱。

21. 保單持有人身故

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

- (a) 年滿十八(18)歲的受保人；或
- (b) 受保人的家長或監護人（如受保人為未成人）。若家長或監護人拒絕接受本保單的轉移，本保單的擁有權將轉移至保單持有人的遺產管理人或執行人。

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

22. 第三者權利

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

23. 代位追討權

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

24. 對第三者的訴訟

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

25. 寬免

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

26. 遵守法律

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

27. 個人資料私隱

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

第三部分 保費條文

1. 應付保費

本條款及保障的應支付保費僅包括 –

- (a) 按本公司現行採用的標準保費表內的標準保費；及
- (b) 附加保費（如適用）。

2. 繳交保費

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

保費到期日、續保日及保單年度均參照保單資料頁及/或第四部分第 3 節所指的續保通知內指明的保單生效日釐定。第一期保費將於保單生效日到期。

3. 寬限期

本公司將給予保單持有人三十(30)日繳交保費的寬限期，由每期保費到期日起計。本保單於寬限期內仍然生效，惟在收到保費前，本公司於該期間內不會支付任何賠償，直至保費已獲繳清。若在寬限期屆滿後保單持有人仍未繳清保費，本保單即於保費到期日起當日終止。

第四部分 續保條文

本條款及保障會在繳交保費後於保單生效日起生效，並按本第四部分條款在每個保單年度續保，保證續保受保人至年齡一百（100）歲。

1. 續保

本公司將按下列(a) - (c)段續保本條款及保障 -

- (a) 除本公司不再獲《保險業條例》授權承保本條款及保障，或終止與政府註冊為自願醫保的產品提供者，或保單持有人按照第二部分第 3 節所述，於三十(30)日前以書面通知本公司決定不續保本條款及保障的情況外，將按以下安排續保：本條款及保障將按不差於續保時由政府公布最新版本的標準計劃條款及保障（當中第一部分第 7 節、第六部分第1(b)及第 5 節和政府不時批准的其他豁免事項則除外）自動續保。
- (b) 若本公司於續保時將會或已終止與政府註冊為自願醫保的產品提供者，但仍獲《保險業條例》授權承保本條款及保障，將按以下安排續保：本條款及保障將按不差於本公司終止與政府註冊為自願醫保的產品提供者時由政府公布最新版本的標準計劃條款及保障（當中第一部分第 7 節、第六部分第1(b)及第 5 節和政府不時批准的其他豁免事項則除外）自動續保。
- (c) 若本公司在終止與政府的註冊後，重新與政府註冊為自願醫保的產品提供者，於重新註冊生效當日或緊接的續保日，將按以下安排續保：本條款及保障將按不差於續保時由政府公布最新版本的標準計劃條款及保障（當中第一部分第 7 節、第六部分第 1(b)及第 5 節和政府不時批准的其他豁免事項除外）自動續保。

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

2. 調整保費

不論本公司在續保時有否修訂本條款及保障，本公司將有權按當時採用的標準保費表向所有同一類別保單調整標準保費。為免存疑，若附加保費設定為標準保費的某個百分比（即附加保費率），應付的附加保費金額將會按標準保費的變動自動調整。

在每個保單年度內及續保時，本公司不得因受保人的健康狀況變化而增加附加保費率（或在附加保費是以定額而非設定為標準保費某個百分比的情況下，增加其附加保費的定額），或增加受保人的個別不保項目。

3. 續保通知

不論本公司在續保時有否修訂本條款及保障，本公司應按本第 3 節的條款，在續保日前不少於三十(30)日向保單持有人發出書面通知。

該書面通知必須指明續保保費及續保日。若本公司在續保時，修訂了本條款及保障，本公司在發出書面通知書時，必須備妥已修訂的條款及保障，以供保單持有人參閱。經修訂的條款及保障及續保保費將由續保日起生效。

4. 除指定情況外不可重新核保

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

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

本公司僅在下列情況下有權重新核保本**條款及保障** -

- (a) **保單持有人**要求**本公司**在**續保**時，按**本公司**的核保慣常做法對本**條款及保障**進行重新核保，藉此減低**附加保費**或取消**個別不保項目**。為免存疑，即使**本公司**拒絕上述要求或**保單持有人**不接受重新核保的結果，**本公司**亦無權終止或不**續保**本**條款及保障**；
- (b) 在任何時候，當**保單持有人**要求在本**條款及保障**增加額外保障（如有），或轉換為另一份提供更佳或額外保障的保險計劃（在這種情況下，重新核保的範圍只限於涉及更佳或額外保障的部分）。
 - (i) 不論如何，在任何時候，**保單持有人**要求取消本**條款及保障**中新增的額外保障（如有），或轉換為另一份較低或較少保障的保險計劃，**本公司**無權重新核保本**條款及保障**，惟可按**本公司**現行處理類似要求的慣常做法接受或拒絕該要求；及
 - (ii) 即使**本公司**拒絕上述要求或**保單持有人**不接受重新核保的結果，**本公司**亦無權終止或不**續保**本**條款及保障**；
- (c) 當**受保人**改變**居住地**；

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

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

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

- (d) 當**受保人**改變**職業**

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

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

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

本公司及保單持有人均確認 -

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

第五部分 索償條文

1. 提交索償申請

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

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

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

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

2. 可賠償金額估算

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

3. 法律行動

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

4. 醫療檢查

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

第六部分 保障條文

1. 一般條件

(a) 保障地域範圍

除本第六部分第3(1)節的精神科治療及/或**補充文件4**的海外緊急醫療額外保障及/或**補充文件5**的自選附加額外醫療保障(如適用)外，本**條款及保障**內所有保障均全球適用。

有關**補充文件4**的海外緊急醫療額外保障及/或**補充文件5**的自選附加額外醫療保障(如適用)的地域範圍限制並不適用於在**標準計劃條款及保障**範圍內的條款及保障。為免存疑，適用的**標準計劃條款及保障**，為按第四部分第1(a)、(b)或(c)節所述的版本。

(b) 終身保障限額

本**條款及保障**內所有保障均不設**終身保障限額**。

(c) 選擇醫療服務提供者

本**條款及保障**內所有保障均不設選擇醫療服務提供者的限制，包括但不限於**註冊醫生**及**醫院**。

(d) 選擇病房級別

本**條款及保障**第六部分第3節及**補充文件1**、**補充文件2**、**補充文件3**及**補充文件6**，及本**條款及保障補充文件4**(如適用)內所有保障均不設**醫院**病房級別選擇的限制。

本**條款及保障補充文件5**(如適用)內的保障必須受本**條款及保障補充文件5**列明的病房級別選擇限制所規限。有關限制並不適用於在**標準計劃條款及保障**範圍內的條款及保障。為免存疑，適用的**標準計劃條款及保障**，為按第四部分第1(a)、(b)或(c)節所述的版本。

2. 住院及非住院保障

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

(a) **住院**；或

(b) 接受任何**日間手術**、**訂明診斷成像檢測**、**訂明非手術癌症治療**或非住院洗腎治療，

本公司將按本第六部分第3節所列明的保障項目，賠償**合理及慣常的合資格費用**。

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

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

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

3. 保障項目

本第六部分第2節所保障的**合資格費用**，必須按下列保障項目作賠償－

本頁內容屬於自願醫保認可產品(編號: F00023)的條款及保障。

(a) 病房及膳食

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

(b) 雜項開支

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

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

(c) 主診醫生巡房費

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

(d) 專科醫生費

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

(e) 深切治療

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

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

(f) 外科醫生費

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

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

(g) 麻醉科醫生費

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

(h) 手術室費

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

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

(i) 訂明診斷成像檢測

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

(j) 訂明非手術癌症治療

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

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

(k) 入院前或出院後 / 日間手術前後的門診護理

本保障將賠償以下**合資格費用** -

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

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

(l) 精神科治療

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

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

(m) 私家看護

本保障將賠償經住院主診**註冊醫生**轉介在**住院**期間或出院後家中聘請合資格註冊護士提供的全職或兼職私家看護服務（並非**醫院**提供的一般護理服務）的費用，以繼續治療當初**住院**醫治的有關傷病，惟有關服務必須

乃醫療上必需，而非因**受保人**的家庭狀況所需。就私家看護費用，本公司只會提供每**保單年度**最多至一百八十（180）日之保障。

(n) 非住院洗腎費用

本保障將賠償經主診**註冊醫生**建議，在為**日症病人**提供醫療服務的設備下，進行由於慢性和不可逆轉的腎衰竭需長期及定期血液透析或腹膜透析所收取的**合資格費用**，包括在接受血液透析或腹膜透析期間就進行治療計劃、監察預後及病況進展的**專科醫生**門診收費。

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

4. 投保前已有病症

所有在**投保申請文件**或任何其後就相關申請提交予**本公司**的資料或文件（若**本公司**在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動）中，向**本公司**披露的**投保前已有病症**，除非受**個別不保項目**（如有）所規限，**本公司**將按本**條款及保障**賠償該病症的**合資格費用**。**本公司**可因應在**投保申請文件**或任何其後就相關申請提交予**本公司**的資料或文件（若**本公司**在第一部分第8節提出要求，則包括相關必需資料的任何更新及改動）中披露的**投保前已有病症**或影響可保性的因素，對本**條款及保障**加設**個別不保項目**。在**保單簽發日**或**保單生效日**（以較早日期為準）後，除在第四部分第 4 節列明的情況外，**本公司**將無權再加設任何**個別不保項目**。

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

首個 保單年度	沒有保障
第二個 保單年度	按保障限額賠償百分之二十五
第三個 保單年度	按保障限額賠償百分之五十
第四個 保單年度 起	按保障限額全數賠償

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

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

5. 分擔費用規定

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

第七部分 一般不保事項

按本**條款及保障**，本公司不會賠償與下列項目相關或由其引致的費用 -

1. 任何非**醫療所需**治療、治療程序、藥物、檢測或服務的費用。
2. 若純粹為接受診斷程序或專職醫療服務（包括但不限於物理治療、職業治療及言語治療）而**住院**，該**住院**期間所招致的全部或部分費用。惟若該等程序或服務是在**註冊醫生**建議下因而進行**醫療所需**的診斷，或無法以為**日症病人**提供**醫療服務**的方式下有效地進行的**傷病**治療，則不屬此項。
3. 在**保單生效日**前，因感染或出現人體免疫力缺乏病毒（“HIV”）及其相關的**傷病**所招致的費用。不論**保單持有人**或**受保人**在遞交**投保申請文件**（若本公司在第一部分第 8 節提出要求，則包括相關必需資料的任何更新及改動）時是否知悉，若此**傷病**在**保單生效日**前已存在，本**條款及保障**則不會賠償此**傷病**。若無法證明初次感染或出現此**傷病**的時間，則此**傷病**於**保單生效日**起計五（5）年內發病，將被推定為於**保單生效日**前已感染或出現；若在這五（5）年後發病，將被推定為於**保單生效日**後感染或出現。

惟本第 3 節的不保事項並不適用於因性侵犯、醫療援助、器官移植、輸血或捐血、或出生時受 HIV 感染所引致的**傷病**，有關賠償將按本**條款及保障**內其他條款處理。
4. 因倚賴或過量服用藥物、酒精、毒品或類似物質（或受其影響）、故意自殘身體或企圖自殺、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（HIV 及其相關的**傷病**將按本第七部分第 3 節處理）的**醫療服務**費用。
5. 以下服務的收費 -
 - (a) 以美容或整容為目的的服務，惟**受保人**因**意外**而**受傷**，並於**意外**後九十（90）日內接受的必要**醫療服務**則不屬此項；或
 - (b) 矯正視力或屈光不正的服務，而該等視力問題可透過驗配眼鏡或隱形眼鏡矯正，包括但不限於眼部屈光治療、角膜激光矯視手術（LASIK），以及任何相關的檢測、治療程序及服務。
6. 預防性治療及預防性護理的費用，包括但不限於並無症狀下的一般身體檢查、定期檢測或篩查程序、或僅因**受保人**及/或其家人過往病歷而進行的篩查或監測程序、頭髮重金屬元素分析、接種疫苗或 健康補充品。為免存疑，本第 6 節並不適用於 -
 - (a) 為了避免因接受其他**醫療服務**引起的併發症而進行的治療、監測、檢查或治療程序；
 - (b) 移除癌前病變；及
 - (c) 為預防過往**傷病**復發或其併發症的治療。
7. 牙科醫生進行的牙科治療及口腔頷面手術的費用，惟**受保人**因**意外**引致在**住院**期間接受的**急症治療**及手術則不屬此項。出院後的跟進牙科治療及口腔手術則不會獲得賠償。
8. 下列**醫療服務**及輔導服務的費用 - 產科狀況及其併發症，包括但不限於懷孕、分娩、墮胎或流產的診斷檢測；節育或恢復生育；任何性別的結紮或變性；不育（包括體外受孕或任何其他人工受孕）；以及性機能失常，包括但不限於任何原因導致的陽萎、不舉或早泄。
9. 購買屬耐用品的醫療設備及儀器的費用，包括但不限於輪椅、床及家具、呼吸道壓力機及面罩、可攜式氧氣及氧氣治療儀器、血液透析機、運動設備、眼鏡、助聽器、特殊支架、輔助步行器具、非處方藥物、家居使用的空氣清新機或空調及供熱裝置。為免存疑，**住院**期間或**日間手術**當日所租用的醫療設備及儀器則不屬此項。

10. 除**補充文件 6**的手術或癌症復康保障(v)外，傳統中醫治療的費用，包括但不限於中草藥治療、跌打、針灸、穴位按摩及推拿，以及另類治療，包括但不限於催眠治療、氣功、按摩治療、香薰治療、自然療法、水療法、順勢療法及其他類似的治療。
11. 按接受治療、治療程序、檢測或服務所在地的普遍標準（或尚未經當地認可機構批准）界定為實驗性或未經證實醫療成效的醫療技術或治療程序的費用。
12. **受保人**年屆八（8）歲前發病或確診的**先天性疾病**所招致的**醫療服務**費用。
13. 已獲任何法律，或由任何政府、僱主或第三方提供的醫療或保險計劃賠償的**合資格費用**。
14. 因戰爭（不論宣戰與否）、內戰、侵略、外敵行動、敵對行動、叛亂、革命、起義、或軍事政變或奪權事故所招致的治療費用。

第八部分 釋義

本條款及保障中使用的字詞及表述必須按照以下所述解釋

- 「意外」 是指因暴力、外在及可見因素引致的突發事故，並且完全非**受保人**所能預見及控制。
- 「年齡」 是指**受保人**的實際年齡。
- 「每年保障限額」 是指**本公司**在每個**保單年度**內向**保單持有人**支付的最高賠償限額，不論任何在**保障表**中所列的保障項目是否已經達到其相關項目的賠償限額。
- 每年保障限額**在每個新**保單年度**會重新計算。
- 「投保申請文件」 是指向**本公司**就本**認可產品**遞交的投保申請，包括與該投保申請有關的投保申請表格、問卷、可保性的證明、任何已提交的文件或資料，以及已作出的陳述及聲明（若**本公司**在第一部分第8節提出要求，則包括相關必需資料的任何更新及改動）。
- 「保障表」 是指本條款及保障所附的保障表，當中必須列明所涵蓋的保障項目及最高賠償限額。
- 「個別不保項目」 是指**本公司**可按**受保人**的**投保前已有病症**或其他影響其可保性的因素，就特定的**不適或疾病**而加設的不保承項目，訂明在本條款及保障中不保障。
- 「認可產品」 是指經**政府**認可為符合**自願醫保**內相關合規要求的保險產品內所有條款及保障(包括任何**補充文件**)。本**認可產品**內容包括本條款及細則和**保障表**及以下文件-**補充文件 1**、**補充文件 2**、**補充文件 3**、**補充文件 4**、**補充文件 5**及**補充文件 6**。
- 「共同保險」 是指**保單持有人**在支付每個**保單年度**的**自付費**後(如有)，必須按比率分擔的**合資格費用**。為免存疑，**共同保險**並非指在實際費用超出本條款及保障賠償限額的情況下，**保單持有人**需支付的任何差額。
- 「本公司」 是指三井住友海上火災保險（香港）有限公司。
- 「住院」 是指**受保人**在**醫療所需**的情況下，按**註冊醫生**的建議以**住院病人**身份入住**醫院**以接受**醫療服務**。
- 住院**必須以**醫院**開出的每日病房費單據作證明，**受保人**必須在整個**住院**期間連續留院。
- 「先天性疾病」 是指（a）任何於出生時或之前已存在的醫學、生理或精神上的異常，不論於出生時有關異常是否已出現、被確診或獲知悉；或（b）任何於出生後六(6)個月內出現的新生嬰兒異常。
- 「日間手術」 是指**受保人**作為**日症病人**在具備康復設施的診所、日間手術中心或**醫院**內因檢查或治療而進行**醫療所需**的外科手術。
- 「日症病人」 是指在診所、日間手術中心或**醫院**（非**住院**性質）接受**醫療服務**或治療的**受保人**。

「自付費」	是指在本公司賠償餘下的合資格費用前，保單持有人在每個保單年度必須分擔的定額合資格費用。
「交付」	是指於第二部分第2(a)節所述以下列任何方式將本條款及保障及保單資料頁或冷靜期通知書交付予保單持有人或其指定代表： (a) 由專人交付； (b) 以郵遞方式（包括掛號郵遞方式）；或 (c) 電子方式。 不論以何種方式交付，本公司有責任就交付的行為及交付的時間備存充分的證據作證明。
「傷病」	是指不適、疾病或受傷，包括任何由此而引發的併發症。
「合資格費用」	是指就傷病接受醫療服務所需的費用。
「急症」	是指受保人需立即接受醫療服務的事件或情況，以防止受保人身故、健康遭永久損害或遭受其他嚴重健康後果。
「急症治療」	是指急症所需的醫療服務，而所需的醫療服務必須在急症事件或情況出現後的合理時間內進行。
「靈活計劃」	是指在自願醫保的框架下，為保單持有人及受保人提供較標準計劃部分或全部更佳條款及保障，並必須經由政府認可的個人償款住院保險產品。除政府可能不時批准的豁免事項外，該等產品不得包含較標準計劃差的條款及保障。
「政府」	是指「香港特別行政區政府」。
「監護人」	是指按香港法例第 13 章《未成年人監護條例》被委任為或憑藉此條例成為未成年人的監護人的人士。
「港元」	是指香港法定貨幣。
「香港」	是指「中華人民共和國香港特別行政區」。
「醫院」	是指按其所在地法律妥為成立及註冊為醫院的機構，為不適及受傷的住院病人提供醫療服務，並－ (a) 具備診斷及進行大型手術的設施； (b) 由持牌或註冊護士提供二十四（24）小時護理服務； (c) 由一(1)位或以上註冊醫生駐診；及 (d) 非主要作為診所、戒酒或戒毒中心、自然療養院、水療中心、護理或療養院、寧養或舒緩護理中心、復康中心、護老院或同類機構。
「受傷」	是指完全因意外而非涉及任何其他原因所引致的身體損害（包括有或沒有可見的傷口）。
「住院病人」	是指住院中的受保人。
「保險業監管局」	是指按《保險業條例》第 4AAA 條設立的香港保險業監管局。

「保險業條例」	是指香港法例第 41 章《保險業條例》。
「受保人」	是指本條款及保障所保障，並在保單資料頁中列為「受保人」的人士。
「深切治療部」	是指醫院內專為住院病人提供深切醫療及護理服務而設的部門。
「終身保障限額」	是指本公司由本條款及保障生效起向保單持有人累計支付的最高賠償限額，不論保障表中所列的保障項目是否已經達到其相關項目的賠償限額，或個別保單年度的賠償是否已經達到每年保障限額。
「醫療服務」	是指就診斷或治療受保人的傷病所提供的醫療所需服務，包括按情況所需的住院、治療、程序、檢測、檢查或其他相關服務。
「醫療所需」	是指按照一般公認的醫療標準，就診斷或治療相關傷病接受醫療服務的需要，而醫療服務必須符合下列條件－ (a) 需要註冊醫生的專業知識或轉介； (b) 符合該傷病的診斷及治療所需； (c) 按良好而審慎的醫學標準及主診註冊醫生審慎的專業判斷提供，而非主要為對受保人、其家庭成員、照顧人員或主診註冊醫生帶來方便或舒適而提供； (d) 在環境最適當及符合一般公認的醫療標準的設備下，提供醫療服務；及 (e) 按主診註冊醫生審慎的專業判斷，以最適當的水平向受保人安全及有效地提供。 就本條款及保障的釋義而言，在不抵觸上述一般條件下，符合醫療所需條件的住院情況包括但不限於以下例子－ (i) 受保人因急症需要在醫院接受緊急治療； (ii) 手術是在全身麻醉下進行； (iii) 醫院具備手術或治療程序所需的設備，有關手術或治療程序並不能以日症病人的方式進行； (iv) 受保人同時發生的傷病屬明顯嚴重； (v) 主診註冊醫生考慮到受保人的個人情況下，經過審慎的專業判斷及考慮受保人安全後，所需的醫療服務應在醫院內進行； (vi) 經過主診註冊醫生審慎的專業判斷，住院時間對受保人接受的醫療服務是合適的；及 / 或 (vii) 如屬註冊醫生認為需要的診斷程序或專職醫療服務，經該註冊醫生審慎的專業判斷及考慮受保人安全後，所需治療程序或服務應在醫院內進行。 在上文(v)至(vii)的情況下，主診註冊醫生行使審慎的專業判斷時，應該考慮該住院是否－ (aa) 按照當地良好及審慎的醫療標準提供該醫療服務，而非主要為受保人、其家庭成員、照顧人員或主診註冊醫生提供方便或舒適的環境；及 (bb) 在環境最適當及符合當地一般公認的醫療標準的設備下，提供該醫療服務。
「未成年人」	是指年齡未滿十八(18)歲的人士。
「居住地」	是指某人士在法律上擁有居留權的司法管轄區。居住地變更包括該人士獲得新增司法管轄區的居留權或停止擁有現有司法管轄區的居留權。上述關於居住地解釋僅適用於本條款及保障。為免存疑，某人士若對該司法管轄區只有法律上的入境許可，而非居留權（例如留學、工作或旅遊），該司法管轄區並不可被視為該人士的居住地。

「保單」	是指由 本公司 承保及簽發的本保單，並作為 保單持有人 與 本公司 之間就 本認可產品 的合約，當中包括但不限於本 條款及細則 、 保障表 、 投保申請文件 、聲明、 保單資料頁 及任何附於本保單的 補充文件 （如適用）。當本 保單 包含有本認可產品以外的條款及保障，該等條款及保障亦將被視作本 保單 的一部分。
「保單生效日」	是指本 條款及保障 的起始日，即 保單資料頁 內載明的「 保單生效日 」。
「保單持有人」	是指在法律上擁有本 保單 ，並於 保單資料頁 內列為「 保單持有人 」的人士。
「保單簽發日」	是指首次簽發本 條款及保障 的日期。
「保單資料頁」	是指本 條款及保障 的附表，當中載有 保單 細節、 保單生效日 、 續保日 、 保單持有人 及 受保人 的姓名及個人資料，以及本 條款及保障 所適用的保障、保費及其他細節。
「保單年度」	是指本 條款及保障 的生效期限。首個 保單年度 是指由 保單生效日 起一(1)年內，直至首個 續保日 前一日為止(包括首尾兩日)的期限。至於在繼後的 保單年度 ，則由每個 續保日 起計一(1)年。
「同一類別保單」	是指所有具備相同條款及細則及保障表，並在 自願醫保 下經 政府 認可為 認可產品 的 保單 。
「投保前已有病症」	是指 受保人 於 保單簽發日 或 保單生效日 (以較早日期為準)前已存在的任何 不適 、 疾病 、 受傷 、生理、心理或醫療狀況或機能退化，包括 先天性疾病 。在以下情況發生時，一般審慎人士理應已可察覺到 投保前已有病症 – (a) 病症已被確診；或 (b) 病症已出現清楚明顯的病徵或症狀；或 (c) 已尋求、獲得或接受病症的醫療建議或治療。
「附加保費」	是指 本公司 因承受 受保人 的額外風險向 保單持有人 收取 標準保費 以外的額外保費。
「訂明診斷成像檢測」	是指電腦斷層掃描(“CT”掃描)、磁力共振掃描(“MRI”掃描)、正電子放射斷層掃描(“PET”掃描)、PET – CT組合及PET – MRI組合。
「訂明非手術癌症治療」	是指治療癌症的放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。
「合理及慣常」	是指就 醫療服務 的收費而言，對情況類似的人士(例如同性別及相近 年齡)，就類似 傷病 提供類似治療、服務或物料時，不超過當地相關醫療服務供應者收取的一般收費範圍的水平。 合理及慣常 的收費水平由 本公司 合理及絕對真誠地決定，在任何情況下，此收費不得高於實際收費。

本公司必須參照以下資料(如適用)以釐定**合理及慣常**收費 –

- (a) 由保險或醫學業界進行的治療或服務費用統計及調查；
- (b) 公司內部或業界的賠償統計；
- (c) **政府**憲報；及 / 或
- (d) 提供治療、服務或物料當地的其他相關參考資料。

「註冊醫生」、 「專科醫生」、 「外科醫生」及 「麻醉科醫生」	是指符合以下資格的西醫 – (a) 具有正式資格並已按香港法例第161章《醫療註冊條例》在香港醫務委員會註冊，或在 香港境外的司法管轄區內由 本公司絕對真誠及合理地認為具有同等效力的團體註冊；及 (b) 在 香港或 香港境外的司法管轄區，經當地法例許可提供相關 醫療服務， 下列人士在任何情況下均不得包括在內 – 受保人、保單持有人、保險中介人、或 保單持有人及 / 或 受保人的僱主、僱員、直系親屬或業務夥伴（除非事先經 本公司的書面批准）。若該醫生未能按 香港法例或在 香港以外的司法管轄區具有同等效力的團體註冊（由 本公司絕對真誠及合理地決定），本公司必須作出合理的判斷，以決定該醫生是否仍被視為符合資格及已註冊。
「續保」	是指就按本 條款及保障 不曾中斷地繼續承保。
「續保日」	是指 續保 的生效日期。首個 續保日 必須訂明於 保單資料頁 上（並不可遲於 保單生效日 的首個週年日），至於繼後的 續保日 則為首個 續保日 的週年日。有關 續保日 將在第四部分第3節所述的 續保 通知中列明。
「手術表」	是指附於本 保障表 的手術列表，表內的手術或治療程序按其複雜程度分類。 政府 將定期審視其內容，並不時公布有關修訂。
「不適」或「疾病」	是指正常健康狀態因受到病理偏差而出現的生理、心理或醫療狀況，包括但不限於 受保人 有否出現病徵或症狀的情況，亦不論是否已確診。
「標準計劃」	是指條款及細則與保障表等同 自願醫保 最低產品規格要求的保險計劃。 政府 將定期審視其內容，並不時公布有關修訂。
「標準計劃條款及保障」	是指 標準計劃 的條款及細則和保障表。 政府 將定期審視其內容，並不時公布有關修訂。 (https://www.vhis.gov.hk/doc/tc/information_centre/c_standard_plan_template.pdf)
「標準保費」	是指 本公司 向 保單持有人 就本 認可產品 的保障所收取的基本保費，適用於所有 同一類別保單 。保費可按 受保人 的 年齡 、性別及 / 或生活方式等因素進行調整。
「補充文件」	是指任何對本 保單 的條款及保障作出增刪、修改或取替的文件。 補充文件 包括但不限於附加於本 保單 並一併簽發的批注、附加契約、附錄或附表。
「條款及保障」	是指經 政府 認可後，本 認可產品 的 條款及細則 ，以及 保障表 （包括 手術表 ）和相關的 補充文件 。
「條款及細則」	是指本 認可產品 的第一至第八部分。

補充文件 1

自願醫保計劃 - 優健保

(本文件旨在補充**條款及保障**第六部分的保障條文。)

加床費用

根據本**保單之條款及細則**，本保障將賠償**受保人**在**住院**時由一位**家庭成員**陪伴並由**醫院**收取之加床費用。

就本保障而言，**家庭成員**指**受保人**的配偶、子女、父母、祖父母和兄弟姐妹。

補充文件 2

自願醫保計劃 - 優健保

(本文件旨在補充**條款及保障**第六部分的保障條文。)

其他保障項目 - 日間手術現金津貼

若**受保人**於醫療診所或日間手術中心或**醫院**作為**日症病人**接受以下所列之**日間手術**，而**本公司**已同意支付**外科醫生**費保障，**本公司**將會根據本**保單**之**條款及細則**支付日間手術現金津貼保障予合資格之索償。如受保人以**住院病人**身份入住**醫院**，無論留院之時間長或短，亦不會獲現金津貼賠償。在任何情況下，**本公司**支付的現金津貼，每天不會多於一個**日間手術**。

日間手術現金津貼適用於以下所列之**日間手術**，連或不連其他同時進行的手術：

- (a) 胃內窺鏡檢查
- (b) 食道胃十二指腸內窺鏡檢查
- (c) 乙狀結腸內窺鏡檢查
- (d) 結腸鏡檢查
- (e) 逆行內窺鏡膽胰管造影術
- (f) 膀胱鏡檢查
- (g) 關節鏡檢查
- (h) 陰道鏡檢查
- (i) 支氣管鏡檢查
- (j) 囊外 / 囊內晶狀體摘除術 (白內障)

補充文件 3

自願醫保計劃 - 優健保

(本文件旨在補充**條款及保障**第六部分的保障條文。)

其他保障項目 - 第二索償現金津貼保障

若**受保人**於**醫院**的**住院**期間招致之**合資格費用**，已先被其他保險公司部分或全額賠償，**本公司**將會根據本**保單**之**條款及細則**支付此保障。在任何情況下，**本公司**支付的現金津貼保障，就每次**住院**不會多於一次賠償。

補充文件 4

自願醫保計劃 - 優健保

(本文件旨在補充**條款及保障**第六部分的保障條文。)

海外緊急醫療額外保障 (此保障只適用於計劃C)

根據本**保單之條款及細則**，如**受保人**在**居住地**以外旅遊或逗留(每次行程不得超過九十(90)日)期間需要**急症治療**，**本公司**會自動增加**每年保障限額**至**保障表**列明之海外緊急醫療額外保障**每年保障限額**。

如適用者，海外緊急醫療額外保障已列明於**保障表**。

補充文件 5

自願醫保計劃 – 優健保

(本文件旨在補充條款及保障第六部分的保障條文。)

自選附加額外醫療保障

(如保單資料頁上有顯示此項保障，有關保障賠償才適用。)

本保障賠償就本第六部分第 3(a)至(j)節及/或(1)至(n)節、及補充文件1的保障限額已耗盡後，有關住院及日間手術招致的合資格費用。

(a) 附加額外醫療保障之賠償額，根據每保單年度保障額，將按以下公式計算：

招致及實際 支付的合資 格費用金額	減	本第六部分第 3(a)至(j)及(1) 至(n)節、及補 充文件1保障之 應付賠償額	減	保障表列明之附加 額外醫療保障的每 次索償墊底費	乘	1 - 保障表列明 之附加額外醫療 保障的共同保險	乘	調整率 (如適用)
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(b) 本保障不會就以下情況作出賠償：

- (1) 於居住地以外之住院及日間手術，惟受保人短暫離開居住地出外公幹或渡假旅遊（每次行程不得超過九十(90日)）而招致意外或急性疾病，經註冊醫生建議，需要立即接受急症治療，則屬例外；或
- (2) 入住大房、半私家房及私家房以外的醫院病房級別。

(c) 如受保人自願選擇入住保障表列明之適用病房級別更高級別的病房(下述(d) 節列出的情況以外將被視為自願選擇)，本保障之賠償將會按如下的調整率作出調整：

適用病房級別	入住之病房級別	調整率
大房 / 半私家房	私家房	50%

(d) 上述調整並不適用於由以下原因引起之非自願的病房級別提升：-

- (1) 由於病房房間短缺而無法在指定之適用病房級別進行急症治療；
- (2) 需要特定病房級別的隔離原因；或
- (3) 不涉及保單持有人和/或受保人之個人偏好的其他原因。

(e) 如自願選擇更高級別的病房，有關調整率並不適用於在標準計劃條款及保障範圍內的條款及保障。

(f) 就本保障釋義： -

- (1) 大房是指病人需三(3)人或以上共用病房的醫院病房級別。
- (2) 半私家房是指雙人病房或共用衛生間的單人病房的醫院病房級別。
- (3) 私家房是指附有私人衛生間的標準單人病房，惟不包括豪華/套房/貴賓房或類似的醫院病房級別。

補充文件 6

自願醫保計劃 - 優健保

(本文件旨在補充**條款及保障**第六部分的保障條文。)

手術或癌症復康保障

根據本**保單之條款及細則**，本保障賠償包括因手術或癌症**住院**後九十 (90)天內進行下列服務的跟進門診收費，每項服務以每**保單年度**五(5)次為上限，並按照**保障表**列明的**共同保險**作出賠償。

- (i) **心理輔導** (只限診症費)
由註冊心理學家進行及獲主診**註冊醫生**書面轉介的心理輔導。
- (ii) **營養諮詢** (只限診症費)
由合資格之營養師進行及獲主診**註冊醫生**書面轉介的營養諮詢。
- (iii) **言語治療** (只限診療費)
由合資格之言語治療師進行及獲主診**註冊醫生**書面轉介的言語治療。
- (iv) **職業治療** (只限診療費)
由註冊職業治療師進行及獲主診**註冊醫生**書面轉介的職業治療。
- (v) **中醫及針灸治療** (診症費及藥費)
由註冊中醫進行的中醫及針灸治療。

若本項保障下的**合資格費用**亦包含在第六部份第3節的保障範圍內，則應按下列順序支付有關**合資格費用**：

- (i) 第六部份第3節；
- (ii) 本手術或癌症復康保障。

就手術或癌症復康保障而言，上述服務必須由在**香港**或**香港**境外的司法管轄區經當地法例許可提供相關服務的專業人士提供。下列人士在任何情況下均不得包括在內 - **受保人**、**保單持有人**、保險中介人、或**保單持有人**及/或**受保人**的僱主、僱員、直系親屬或業務夥伴(除非事先經**本公司**的書面批准)。若該專業人士未能按**香港**法例或在**香港**以外的司法管轄區具有同等效力的團體註冊(由**本公司**絕對真誠及合理地決定)，**本公司**必須作出合理的判斷，以決定該專業人士是否仍被視為符合資格及已註冊。

**自願醫保計劃 – 優健保（計劃 A）
保障表**

保障項目 ⁽¹⁾	賠償限額（港元）
I. 基本保障	
(a) 病房及膳食	每日\$2,000 每保單年度最多 180 日
(b) 雜項開支	全額賠償
(c) 主診醫生巡房費	每日\$2,000 每保單年度最多 180 日
(d) 專科醫生費 ⁽²⁾	全額賠償
(e) 深切治療	全額賠償
(f) 外科醫生費	每項手術，按 手術表 劃分的手術分類 – - 複雜 \$320,000 - 大型 \$160,000 - 中型 \$80,000 - 小型 \$32,000
(g) 麻醉科醫生費	外科醫生費 的35% ⁽⁵⁾
(h) 手術室費	外科醫生費 的35% ⁽⁵⁾
(i) 訂明診斷成像檢測 ⁽²⁾⁽³⁾	每保單年度 \$20,000 設20% 共同保險
(j) 訂明非手術癌症治療 ⁽⁴⁾	每保單年度 \$100,000
(k) 入院前或出院後 / 日間手術 前後的門診護理 ⁽²⁾	每次\$800，每保單年度 \$4,000 - 住院 / 日間手術前最多1次門診或急症診症 - 出院 / 日間手術後90日內最多3次跟進門診
(l) 精神科治療	每保單年度 \$30,000
II. 升級保障	
(a) 加床費用	全額賠償
(b) 私家看護	全額賠償 每保單年度最多 180 日
(c) 非住院洗腎費用	每保單年度 \$100,000
(d) 手術及癌症復康保障	共同保險 : 20% 每次\$600，下列每項服務每保單年度最多5次: (i) 心理輔導（只限診症費） (ii) 營養諮詢（只限診症費） (iii) 言語治療（只限診療費） (iv) 職業治療（只限診療費） (v) 中醫及針灸治療
(e) 海外緊急醫療額外保障	不適用
III. 其他保障項目	
1. 日間手術現金津貼	每宗 日間手術 \$1,000
2. 第二索償現金津貼保障	每宗索償\$1,000
其他限額	
保障項目I(a) – (l)及II(a) – (d) 的 每年保障限額	每保單年度 \$500,000
所有保障項目的 終身保障限額	無

註解

- (1) 同一項目的**合資格費用**不可獲上述表中多於一個保障項目的賠償(另有說明除外)。
- (2) **本公司**有權要求有關書面建議的證明，例如轉介信或由主診醫生或**註冊醫生**在索償申請表內提供的陳述。
- (3) 檢測只包括電腦斷層掃描（“CT”掃描）、磁力共振掃描（“MRI”掃描）、正電子放射斷層掃描（“PET”掃描）、PET-CT 組合及 PET-MRI 組合。
- (4) 治療只包括放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。
- (5) 此百分比適用於**外科醫生費**實際賠償的金額或根據手術分類下**外科醫生費**的保障限額，以較低者為準。

自願醫保計劃 - 優健保（計劃 A，包括附加額外醫療保障）
保障表

保障項目 ⁽¹⁾	賠償限額（港元）
I. 基本保障	
(a) 病房及膳食	每日\$2,000 每保單年度最多 180 日
(b) 雜項開支	全額賠償
(c) 主診醫生巡房費	每日\$2,000 每保單年度最多 180 日
(d) 專科醫生費 ⁽²⁾	全額賠償
(e) 深切治療	全額賠償
(f) 外科醫生費	每項手術，按 手術表 劃分的手術分類 - - 複雜 \$320,000 - 大型 \$160,000 - 中型 \$80,000 - 小型 \$32,000
(g) 麻醉科醫生費	外科醫生費 的35% ⁽⁵⁾
(h) 手術室費	外科醫生費 的35% ⁽⁵⁾
(i) 訂明診斷成像檢測 ^{(2) (3)}	每保單年度\$20,000 設20% 共同保險
(j) 訂明非手術癌症治療 ⁽⁴⁾	每保單年度\$100,000
(k) 入院前或出院後 / 日間手術 前後的門診護理 ⁽²⁾	每次\$800，每保單年度 \$4,000 - 住院 / 日間手術 前最多1次門診或 急症 診症 - 出院/ 日間手術 後90日內最多3次跟進門診
(l) 精神科治療	每保單年度 \$30,000
II. 升級保障	
(a) 加床費用	全額賠償
(b) 私家看護	全額賠償 每保單年度最多180日
(c) 非住院洗腎費用	每保單年度 \$100,000
(d) 手術及癌症復康保障	共同保險 : 20% 每次\$600，下列每項服務每保單年度最多5次: (i) 心理輔導（只限診症費） (ii) 營養諮詢（只限診症費） (iii) 言語治療（只限診療費） (iv) 職業治療（只限診療費） (v) 中醫及針灸治療
(e) 海外緊急醫療額外保障	不適用
III. 自選保障	
附加額外醫療保障	
- 適用病房級別	大房 / 半私家房
- 最高保障額	每保單年度 \$200,000
- 每次索償墊底費	\$1,000
- 共同保險	20%
IV. 其他保障項目	
1. 日間手術現金津貼	每宗 日間手術 \$1,000
2. 第二索償現金津貼保障	每宗索償\$1,000
其他限額	
保障項目 I(a) - (l) 及 II(a) - (d) 的 每年保障限額	每保單年度 \$500,000
所有保障項目的 終身保障限額	無

註解

- (1) 同一項目的**合資格費用**不可獲上述表中多於一個保障項目的賠償(另有說明除外)。
- (2) **本公司**有權要求有關書面建議的證明，例如轉介信或由主診醫生或**註冊醫生**在索償申請表內提供的陳述。
- (3) 檢測只包括電腦斷層掃描(“CT”掃描)、磁力共振掃描(“MRI”掃描)、正電子放射斷層掃描(“PET”掃描)、PET-CT 組合及 PET-MRI 組合。
- (4) 治療只包括放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。
- (5) 此百分比適用於**外科醫生費**實際賠償的金額或根據手術分類下**外科醫生費**的保障限額，以較低者為準。

自願醫保計劃 – 優健保（計劃 B）
保障表

保障項目 ⁽¹⁾	賠償限額（港元）
I. 基本保障	
(a) 病房及膳食	每日\$2,800 每保單年度最多 180 日
(b) 雜項開支	全額賠償
(c) 主診醫生巡房費	每日\$2,800 每保單年度最多 180 日
(d) 專科醫生費 ⁽²⁾	全額賠償
(e) 深切治療	全額賠償
(f) 外科醫生費	全額賠償
(g) 麻醉科醫生費	全額賠償
(h) 手術室費	全額賠償
(i) 訂明診斷成像檢測 ⁽²⁾⁽³⁾	每保單年度\$30,000 設20%共同保險
(j) 訂明非手術癌症治療 ⁽⁴⁾	每保單年度\$150,000
(k) 入院前或出院後 / 日間手術前後的門診護理 ⁽²⁾	每次\$1,000，每保單年度 \$5,000 - 住院 / 日間手術前最多1次門診或急症診症 - 出院/日間手術後90日內最多3次跟進門診
(l) 精神科治療	每保單年度 \$40,000
II. 升級保障	
(a) 加床費用	全額賠償
(b) 私家看護	全額賠償 每保單年度最多180 日
(c) 非住院洗腎費用	每保單年度 \$150,000
(d) 手術及癌症復康保障	共同保險: 20% 每次\$800，下列每項服務每保單年度最多5次: (i) 心理輔導（只限診症費） (ii) 營養諮詢（只限診症費） (iii) 言語治療（只限診療費） (iv) 職業治療（只限診療費） (v) 中醫及針灸治療
(e) 海外緊急醫療額外保障	不適用
III. 其他保障項目	
1. 日間手術現金津貼	每宗日間手術 \$1,000
2. 第二索償現金津貼保障	每宗索償\$1,000
其他限額	
保障項目I(a) – (l)及II(a) – (d)的每年保障限額	每保單年度 \$750,000
所有保障項目的終身保障限額	無

註解

- (1) 同一項目的**合資格費用**不可獲上述表中多於一個保障項目的賠償(另有說明除外)。
- (2) **本公司**有權要求有關書面建議的證明，例如轉介信或由主診醫生或**註冊醫生**在索償申請表內提供的陳述。
- (3) 檢測只包括電腦斷層掃描（“CT”掃描）、磁力共振掃描（“MRI”掃描）、正電子放射斷層掃描（“PET”掃描）、PET-CT 組合及 PET-MRI 組合。
- (4) 治療只包括放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。

**自願醫保計劃 – 優健保（計劃 B，包括附加額外醫療保障）
保障表**

保障項目 ⁽¹⁾	賠償限額（港元）
I. 基本保障	
(a) 病房及膳食	每日\$2,800 每保單年度最多 180 日
(b) 雜項開支	全額賠償
(c) 主診醫生巡房費	每日\$2,800 每保單年度最多 180 日
(d) 專科醫生費 ⁽²⁾	全額賠償
(e) 深切治療	全額賠償
(f) 外科醫生費	全額賠償
(g) 麻醉科醫生費	全額賠償
(h) 手術室費	全額賠償
(i) 訂明診斷成像檢測 ⁽²⁾⁽³⁾	每保單年度\$30,000 設20%共同保險
(j) 訂明非手術癌症治療 ⁽⁴⁾	每保單年度\$150,000
(k) 入院前或出院後 / 日間手術前後的門診護理 ⁽²⁾	每次\$1,000，每保單年度 \$5,000 - 住院 / 日間手術前最多1次門診或急症診症 - 出院 / 日間手術後90日內最多3次跟進門診
(l) 精神科治療	每保單年度 \$40,000
II. 升級保障	
(a) 加床費用	全額賠償
(b) 私家看護	全額賠償 每保單年度最多180日
(c) 非住院洗腎費用	每保單年度 \$150,000
(d) 手術及癌症復康保障	共同保險: 20% 每次\$800，下列每項服務每保單年度最多5次： (i) 心理輔導（只限診症費） (ii) 營養諮詢（只限診症費） (iii) 言語治療（只限診療費） (iv) 職業治療（只限診療費） (v) 中醫及針灸治療
(e) 海外緊急醫療額外保障	不適用
III. 自選保障	
附加額外醫療保障	
- 適用病房級別	大房 / 半私家房
- 最高保障額	每保單年度 \$300,000
- 每次索償墊底費	\$1,000
- 共同保險	20%
IV. 其他保障項目	
1. 日間手術現金津貼	每宗日間手術 \$1,000
2. 第二索償現金津貼保障	每宗索償\$1,000
其他限額	
保障項目 I(a) - (l) 及 II(a) - (d) 的每年保障限額	每保單年度 \$750,000
所有保障項目的終身保障限額	無

註解

- (1) 同一項目的**合資格費用**不可獲上述表中多於一個保障項目的賠償(另有說明除外)。
- (2) **本公司**有權要求有關書面建議的證明，例如轉介信或由主診醫生或**註冊醫生**在索償申請表內提供的陳述。
- (3) 檢測只包括電腦斷層掃描（“CT”掃描）、磁力共振掃描（“MRI”掃描）、正電子放射斷層掃描（“PET”掃描）、PET-CT 組合及 PET-MRI 組合。
- (4) 治療只包括放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。

自願醫保計劃 – 優健保（計劃 C）
保障表

保障項目 ⁽¹⁾	賠償限額（港元）
I. 基本保障	
(a) 病房及膳食	每日\$3,900 每保單年度最多 180 日
(b) 雜項開支	全額賠償
(c) 主診醫生巡房費	每日\$3,900 每保單年度最多 180 日
(d) 專科醫生費 ⁽²⁾	全額賠償
(e) 深切治療	全額賠償
(f) 外科醫生費	全額賠償
(g) 麻醉科醫生費	全額賠償
(h) 手術室費	全額賠償
(i) 訂明診斷成像檢測 ⁽²⁾⁽³⁾	每保單年度\$40,000 設20%共同保險
(j) 訂明非手術癌症治療 ⁽⁴⁾	每保單年度\$300,000
(k) 入院前或出院後 / 日間手術 前後的門診護理 ⁽²⁾	每次\$1,500，每保單年度 \$7,500 - 住院 / 日間手術 前最多1次門診或 急症 診症 - 出院 / 日間手術 後90日內最多3次跟進門診
(l) 精神科治療	每保單年度 \$50,000
II. 升級保障	
(a) 加床費用	全額賠償
(b) 私家看護	全額賠償 每保單年度最多180日
(c) 非住院洗腎費用	每保單年度 \$300,000
(d) 手術及癌症復康保障	共同保險 : 20% 每次\$1,000，下列每項服務每保單年度最多5次： (i) 心理輔導（只限診症費） (ii) 營養諮詢（只限診症費） (iii) 言語治療（只限診療費） (iv) 職業治療（只限診療費） (v) 中醫及針灸治療
(e) 海外緊急醫療額外保障	保障項目I(a) – (l)及II(a) – (d) 的 每年保障限額 將增加至每保單年度 \$6,000,000
III. 其他保障項目	
1. 日間手術現金津貼	每宗 日間手術 \$1,000
2. 第二索償現金津貼保障	每宗索償\$1,000
其他限額	
保障項目I(a) – (l)及II(a) – (d) 的 每年保障限額	每保單年度 \$1,500,000
所有保障項目的 終身保障限額	無

註解

- (1) 同一項目的**合資格費用**不可獲上述表中多於一個保障項目的賠償(另有說明除外)。
- (2) **本公司**有權要求有關書面建議的證明，例如轉介信或由主診醫生或**註冊醫生**在索償申請表內提供的陳述。
- (3) 檢測只包括電腦斷層掃描（“CT”掃描）、磁力共振掃描（“MRI”掃描）、正電子放射斷層掃描（“PET”掃描）、PET-CT 組合及 PET-MRI 組合。
- (4) 治療只包括放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。

**自願醫保計劃 – 優健保（計劃 C，包括附加額外醫療保障）
保障表**

保障項目 ⁽¹⁾	賠償限額（港元）
I. 基本保障	
(a) 病房及膳食	每日\$3,900 每保單年度最多 180 日
(b) 雜項開支	全額賠償
(c) 主診醫生巡房費	每日\$3,900 每保單年度最多 180 日
(d) 專科醫生費 ⁽²⁾	全額賠償
(e) 深切治療	全額賠償
(f) 外科醫生費	全額賠償
(g) 麻醉科醫生費	全額賠償
(h) 手術室費	全額賠償
(i) 訂明診斷成像檢測 ⁽²⁾⁽³⁾	每保單年度\$40,000 設20%共同保險
(j) 訂明非手術癌症治療 ⁽⁴⁾	每保單年度\$300,000
(k) 入院前或出院後 / 日間手術前後的門診護理 ⁽²⁾	每次\$1,500，每保單年度 \$7,500 - 住院 / 日間手術前最多1次門診或急症診症 - 出院 / 日間手術後90日內最多3次跟進門診
(l) 精神科治療	每保單年度 \$50,000
II. 升級保障	
(a) 加床費用	全額賠償
(b) 私家看護	全額賠償 每保單年度最多180日
(c) 非住院洗腎費用	每保單年度 \$300,000
(d) 手術及癌症復康保障	共同保險: 20% 每次\$1,000，下列每項服務每保單年度最多5次： (i) 心理輔導（只限診症費） (ii) 營養諮詢（只限診症費） (iii) 言語治療（只限診療費） (iv) 職業治療（只限診療費） (v) 中醫及針灸治療
(e) 海外緊急醫療額外保障	保障項目I(a) - (l)及II(a) - (d) 的每年保障限額 將增加至每保單年度 \$6,000,000
III. 自選保障	
附加額外醫療保障	
- 適用病房級別	私家房
- 最高保障額	每保單年度 \$600,000
- 每次索償墊底費	\$1,000
- 共同保險	20%
IV. 其他保障項目	
1. 日間手術現金津貼	每宗日間手術\$1,000
2. 第二索償現金津貼保障	每宗索償\$1,000
其他限額	
保障項目I(a) - (l)及II(a) - (d)的每年保障限額	每保單年度 \$1,500,000
所有保障項目的終身保障限額	無

註解

- (1) 同一項目的**合資格費用**不可獲上述表中多於一個保障項目的賠償(另有說明除外)。
- (2) **本公司**有權要求有關書面建議的證明，例如轉介信或由主診醫生或**註冊醫生**在索償申請表內提供的陳述。
- (3) 檢測只包括電腦斷層掃描(“CT”掃描)、磁力共振掃描(“MRI”掃描)、正電子放射斷層掃描(“PET”掃描)、PET-CT 組合及 PET-MRI 組合。
- (4) 治療只包括放射性治療、化療、標靶治療、免疫治療及荷爾蒙治療。

手術表

程序 / 手術		分類
腹部及消化系統		
食道、胃及十二指腸	食道病變組織切除術/ 經頸進行食道病變組織或組織破壞術	大型
	高選擇性胃迷走神經切斷術	大型
	腹腔鏡胃底摺疊術	大型
	腹腔鏡式食道裂孔疝氣修補術	大型
	食道胃十二指腸內窺鏡檢查，連或不連活體組織檢查及 / 或息肉切除術	小型
	食道胃十二指腸內窺鏡檢查連異物清除	小型
	食道胃十二指腸內窺鏡連食道 / 胃靜脈曲張結紮 / 綁紮術	中型
	食道切除術	複雜
	食道全切除術及腸插入手術	複雜
	經皮膚進行胃造口術	小型
	永久胃切開術/ 胃腸造口術	大型
	部分胃切除術連或不連空腸移位術	大型
	部分胃切除術連十二指腸/ 空腸接合術	大型
	部分胃切除術連接合食道術	複雜
	近端胃切除術/ 根治性胃切除術/ 全部胃切除術連或不連腸插入術	複雜
	十二指腸撕裂縫合術/ 十二指腸潰瘍修補術	大型
	胃迷走神經切斷術及/ 或幽門成形術	大型
空腸、迴腸及大腸	開放式或腹腔鏡式闌尾炎切除術	中型
	肛裂切除術	小型
	肛瘻管切開術或切除術	中型
	肛周膿腫的切除術及引流術	小型
	修補直腸脫垂的德洛姆手術	大型
	結腸鏡檢查連或不連活體組織檢查	小型
	結腸鏡檢查，連息肉切除術	小型
	乙狀結腸內窺鏡檢查	小型
	外痔或內痔切除術	中型
	痔瘡的注射療法或綁紮術	小型
	迴腸造口術或結腸造口術	大型
	開放式或腹腔鏡式直腸前位切除術	複雜
	開放式或腹腔鏡式經腹部會陰切除術	複雜
	開放式或腹腔鏡式結腸切除術	複雜
	開放式或腹腔鏡式直腸低前位切除術	複雜
	腸扭結或腸套疊復位術	中型
	小腸切除術及接合術	大型
膽管	開放式或腹腔鏡式膽囊切除術	大型
	逆行內窺鏡膽胰管造影術	中型
	逆行內窺鏡膽胰管造影術連乳突物手術、膽結石摘取或其他相關手術	中型
肝臟	幼針抽吸肝活體組織檢查	小型
	肝移植手術	複雜
	開放式肝病變組織 / 肝囊腫或肝膿腫袋形縫合術	大型
	開放式或腹腔鏡式移除肝病變組織	大型
	開放式或腹腔鏡式肝次葉切除術	大型
	開放式或腹腔鏡式肝葉切除術	複雜
	開放式或腹腔鏡式肝楔形切除術	大型

程序 / 手術		分類
胰臟	閉合式胰管活體組織檢查	中型
	胰臟 / 胰管病變組織或組織的切除術或破壞術	大型
	胰臟十二指腸切除術（惠普爾手術）	複雜
腹部	剖腹探查	大型
	腹腔鏡檢查 / 腹膜內窺鏡檢查	中型
	開放式或腹腔鏡式的單側疝切開 / 縫合術	中型
	開放式或腹腔鏡式的兩側疝切開 / 縫合術	大型
	開放式或腹腔鏡式的單側腹腔溝疝修補術	中型
	開放式或腹腔鏡式的兩側腹腔溝疝修補術	大型
腦部及中樞神經系統		
神經外科手術	腦部活體組織檢查	大型
	顱骨鑽孔術	中型
	顱骨切除術	複雜
	顱神經減壓術	複雜
	腦室引流沖洗術	小型
	腦室引流的維修清除術，包括修正術	中型
	建立腦室腹腔引流或皮下腦脊液儲存器	大型
	顱內動脈瘤鉗夾術	複雜
	顱內動脈瘤包裹術	複雜
	顱內動靜脈血管畸型切除手術	複雜
	聽覺神經瘤切除術	複雜
	腦腫瘤或腦膿腫切除術	複雜
	顱神經腫瘤切除手術	複雜
	治療三叉神經節氣囊的射頻溫熱凝固術	中型
	使用射頻進行閉合式三叉神經根切斷術	大型
	三叉神經根減壓術 / 開放式三叉神經根切斷術	複雜
	大腦包括腦葉切除手術	複雜
	大腦半球切除術	複雜
脊椎手術	腰椎穿刺或小腦延髓池穿刺手術	小型
	脊髓或脊神經根減壓術	大型
	頸交感神經切除術	中型
	胸腔鏡或腰交感神經切除術	大型
	脊髓管內硬膜內或硬膜外的腫瘤切除術	複雜
心血管系統		
心臟	心臟導管插入	中型
	冠狀動脈分流手術	複雜
	心臟移植	複雜
	心臟起搏器置入	中型
	心包穿刺術	小型
	心包切開術	大型
	經皮刺穿冠狀動脈腔內成形術及有關程序，包括：激光、支架置入、馬達扇頁切割、氣囊擴張或射頻切割技術	大型
	肺動脈瓣切開術、氣囊 / 腔內激光 / 腔內射頻術	大型
	經皮心瓣成形術	大型
	主動脈瓣擴張術 / 二尖瓣切開術	大型
	閉合式心瓣切開術	複雜
	心臟直視心瓣成形術	複雜

程序 / 手術		分類
血管	心瓣置換	複雜
	腹內動脈/ 脾靜脈腎靜脈/ 門靜脈腔靜脈分流術	複雜
	腹腔血管切除術連置換/ 接合術	複雜
內分泌系統		
腎上腺	腹腔鏡式或腹膜後腔鏡式單側腎上腺切除術	大型
	腹腔鏡式或腹膜後腔鏡式兩側腎上腺切除術	複雜
松果腺	松果腺全切除術	複雜
腦下垂體	腦下垂體腫瘤切除術	複雜
甲狀腺	幼針抽吸甲狀腺活組織檢查連或不連影像導引	小型
	半甲狀腺切除術/ 部分甲狀腺切除術 / 大部分甲狀腺切除術/ 副甲狀腺切除術	大型
	甲狀腺全切除術/ 副甲狀旁腺全切除術 / 機械人輔助式甲狀腺全切除術	大型
	甲狀舌管囊腫切除術	中型
耳鼻喉 / 呼吸系統		
耳	耳道閉鎖/ 耳道狹窄的耳道成形術	大型
	耳前囊腫/ 耳前竇切除術	小型
	耳廓血腫引流/ 裝鈕/ 切除術	小型
	耳道成形術	中型
	(耳科) 異物清除術	小型
	切開鼓室進行中耳腫瘤切除術	大型
	鼓膜切開術連或不連導管插入	小型
	鼓膜成形術 / 鼓室成形術	大型
	聽小骨成形術	大型
	全部 / 部分迷路切除術	大型
	乳突切除術	大型
	耳蝸手術及 / 或人工耳蝸植入	複雜
	內淋巴囊手術/ 內淋巴囊減壓術	大型
	圓窗或卵圓窗瘻管修補術	中型
	鼓室交感神經切除術	大型
	前庭神經切除術	中型
鼻、口及咽喉	上頷竇穿刺及沖洗術	小型
	鼻粘膜燒灼術/ 鼻衄控制	小型
	鼻骨折閉合復位術	小型
	口竇瘻管閉合術	中型
	淚囊鼻腔造口術	中型
	鼻病變組織切除術	小型
	鼻咽鏡檢查或鼻鏡檢查連或不連鼻腔活體組織檢查連或不連清除異物	小型
	鼻瘻肉切除術	小型
	考一路二氏手術/ 以考一路二氏式進行/ 上頷竇切除術	中型
	篩竇 / 上頷竇/ 額竇 / 蝶竇內窺鏡手術	中型
	延伸性額竇內窺鏡手術連經中隔的額竇切開術	大型
	額竇切開術或篩竇切除術	中型
	額竇切除術	大型
	功能性鼻竇內窺鏡手術	大型
	兩側功能性鼻竇內窺鏡手術	複雜
	上頷竇/ 蝶竇/ 篩竇動脈結紮術	中型
	其他鼻內手術，包括激光手術（除了簡易的鼻鏡檢查、活體組織檢查及血管燒灼術）	中型

程序 / 手術		分類
	鼻成形術	中型
	鼻咽腫瘤切除術	中型
	竇腔鏡連或不連活體組織檢查	小型
	鼻中隔成形術連或不連黏膜下層切除術	中型
	鼻中隔黏膜下層切除術	中型
	鼻甲切除術 / 黏膜下鼻甲切除術	中型
	腺樣體切除術	小型
	扁桃體切除術連或不連腺樣體切除術	中型
	咽囊 / 咽憩室切除術	中型
	咽成形術	中型
	治療睡眠相關呼吸疾病的舌骨懸吊術、上顎 / 下顎 / 舌頭前移術、激光懸吊術 / 切除術、射頻切割輔助垂腭咽成形術、垂腭咽成形術	中型
	治療舌下囊腫的袋形縫合術 / 切除術	中型
	表層腮腺清除術	中型
	腮腺清除術 / 腮腺切除術	大型
	下頷唾腺液清除術	中型
	下頷腺導管移位術	中型
	下頷腺切除術	中型
呼吸系統	杓狀軟骨半脫位 - 喉鏡復位術	小型
	支氣管鏡檢查連或不連活體組織檢查	小型
	支氣管鏡連清除異物	小型
	喉鏡檢查連或不連活體組織檢查	小型
	喉頭 / 氣管狹窄 - 喉內 / 開放式支架置入術 / 重建術	大型
	喉頭分流術	中型
	喉切除術連或不連根治性頸淋巴組織切除術	複雜
	喉顯微鏡檢查連或不連活體組織檢查，連或不連小結 / 息肉 / 聲帶水腫切除術	小型
	喉腫瘤切除術	中型
	會厭窩囊腫清除術	中型
	喉骨折修補術	大型
	治療聲帶麻痺注射法	小型
	氣管食道穿刺術進行語音復建	小型
	治療聲帶麻痺的甲狀軟骨成形術	中型
	聲帶手術包括使用激光技術（惡性腫瘤除外）	小型
	氣管造口術 - 臨時性 / 永久性 / 修正術	小型
	肺葉切除術 / 肺切除術	複雜
	胸膜切除術	大型
	肺節段切除術	大型
	治療氣胸的胸腔穿刺術 / 胸管插入術	小型
	胸腔鏡連或不連活體組織檢查	中型
	胸廓成形術	大型
	胸腺切除術	大型
眼部		
眼	眼瞼損傷組織切除術 / 刮除術 / 冷凍治療	小型
	眼瞼縫合術 / 眼緣縫合術	小型
	瞼內翻或瞼外翻修補術連或不連楔型切除術	小型
	部分皮層眼瞼重建術	中型
	結膜損傷組織切除術 / 破壞術	小型

程序 / 手術	分類
贅肉切除術	小型
角膜移植術、嚴重傷口修復及角膜成形術，包括角膜移植	大型
激光清除術或角膜損傷組織破壞術	中型
角膜異物清除術	小型
角膜修復手術	中型
角膜撕裂或受傷的縫補術 / 修補術連結膜移位	中型
晶狀體囊抽吸術	中型
晶狀體囊切開術，包括使用激光	中型
囊外 / 囊內晶狀體摘除術	中型
去除眼內晶狀體/ 植入物	中型
為脈絡膜視網膜損傷組織進行的手術	中型
白內障超聲乳化手術連人工晶體植入	中型
氣體視網膜粘結術	中型
視網膜光凝固療法	中型
視網膜脫落 / 撕裂的修補手術	中型
視網膜撕裂 / 脫落的修補術連扣帶術	大型
視網膜脫落扣帶術 / 環紮術	大型
睫狀體分離術	中型
小梁切除術，包括使用激光	中型
青光眼手術治療包括置入植入物	中型
玻璃體診斷性抽吸術	小型
注入玻璃體替代物	中型
玻璃體切除術 / 移除術	大型
虹膜活體組織檢查	小型
虹膜 / 眼前半段 / 睫狀體損傷組織切除術	中型
脫垂虹膜切除術	中型
虹膜切開術	中型
虹膜切除術	中型
激光虹膜成形連或不連瞳孔成形術	中型
虹膜炭頓術及虹膜牽張術	中型
鞏膜造瘻術連或不連虹膜切除術	中型
鞏膜熱灼術連或不連虹膜切除術	中型
睫狀體縮減術	中型
眼外肌或肌腱活體組織檢查	小型
單一條眼外肌手術	中型
眼球穿孔傷口連籍閉或眼色素膜脫落修補術	大型
眼球摘除術	中型
眼球 / 眼內物摘除術	中型
眼球或眼眶修補術	中型
結膜淚囊鼻腔造口術	中型
結膜淚囊鼻腔造口術連導管或支架插入	中型
淚囊鼻腔造口術	中型
淚囊及淚道切除術	小型
淚腺切除術	中型
淚小管/ 鼻淚管探查連或不連沖洗	小型
淚小管修補術	中型
瞳孔成形術	中型

程序 / 手術		分類
女性生殖系統		
子宮頸	子宮頸截除術	中型
	陰道鏡檢查連或不連活體組織檢查	小型
	子宮頸錐形切除術	小型
	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞子宮頸病變組織	小型
	子宮頸內膜刮除術	小型
	子宮頸電環切除術	小型
	子宮頸囊腫袋形縫合術	小型
	子宮頸修補術	小型
	子宮頸瘻管修補術	中型
	子宮頸 / 子宮 / 陰道撕裂縫合術	中型
輸卵管及卵巢 [^]	輸卵管擴張術 / 吹氣術	小型
	開放式或腹腔鏡式切除 / 破壞輸卵管病變組織	大型
	輸卵管修補術	大型
	輸卵管造口術 / 輸卵管切開術	中型
	全部或部分輸卵管切除術	中型
	輸卵管成形術	中型
	卵巢囊腫抽吸術	小型
	開放式或腹腔鏡式卵巢囊腫切除術	大型
	開放式或腹腔鏡式卵巢楔形切除術	大型
	卵巢切除術	中型
	腹腔鏡式卵巢切除術	大型
	開放式或腹腔鏡式輸卵管卵巢切除術	大型
	開放式或腹腔鏡式輸卵管卵巢膿瘍引流術	中型
	[^] 除非另有說明，此類別應用於單側或兩側（輸卵管及卵巢）	
子宮	子宮頸擴張及刮宮術	小型
	宮腔鏡檢查連或不連活體組織檢查	小型
	宮腔鏡檢查連切除或破壞子宮及承重結構	中型
	子宮切開術	大型
	腹腔鏡輔助的陰道子宮切除術	大型
	經陰道切除子宮連或不連膀胱突出症及 / 或直腸突出症的修補術	大型
	開放式或腹腔鏡式經腹部切除全部 / 大部分子宮連或不連兩側輸卵管卵巢切除術	大型
	經腹部進行根治性子宮切除術	複雜
	開放式或腹腔鏡式子宮肌瘤切除術	大型
	經陰道或宮腔鏡切除子宮肌瘤	中型
	腹腔鏡式盆腔膿腫引流術	中型
	陰道懸吊術	大型
	盆腔底修補術	大型
	盆腔臟器切除術	複雜
	子宮懸吊術	中型
陰道	使用切除術 / 冷凍手術 / 燒灼術 / 激光破壞陰道病變組織	小型
	陰道承托環的嵌入或移除	小型
	巴多林氏腺囊腫袋形縫合術	小型
	陰道剝脫術或陰道斷端術	小型
	陰道切開術	中型
	陰道部分切除術	中型

程序 / 手術		分類
	陰道全切除術	大型
	根治性陰道切除術	複雜
	陰道前壁修補術使用或不使用基利氏聯針法	中型
	陰道後壁修補術	中型
	陰道穹窿閉塞術	中型
	骶棘韌帶懸吊或陰道固定術	中型
	骶骨陰道固定術	中型
	經陰道進行腸疝修補術	中型
	尿道陰道瘻管閉合術	中型
	經陰道進行直腸陰道瘻管修補術	中型
	經腹部進行直腸陰道瘻管修補術	大型
	後穹窿穿刺術	小型
	子宮直腸凹切開術	小型
	陰道橫隔切除術	小型
	麥哥氏後穹窿整型術	中型
	陰道重建術	大型
外陰及入口	使用切除術 / 冷凍手術 / 燒灼術/ 激光破壞外陰病變組織	小型
	闊邊局部外陰冷刀切除術或子宮頸電環切除術	小型
	前庭腺炎切除術	小型
	切除外陰活體組織檢查	小型
	外陰及會陰切開術及引流術	小型
	外陰粘連鬆解術	小型
	外陰或會陰瘻管修補術	小型
	外陰及/ 或會陰撕裂縫合術 / 修補術	小型
	外陰切除術	中型
	根治性外陰切除術	大型
血液淋巴系統		
淋巴結	淋巴結病變組織/ 膿腫引流術	小型
	表面淋巴結活體組織檢查/ 切除/ 淋巴結構的單純切除術	小型
	頸淋巴結切開活組織檢查/ 幼針抽吸淋巴結活組織檢查	小型
	深淋巴結/ 淋巴管瘤/ 囊狀水瘤切除術	中型
	兩側腹股溝淋巴結切除術	中型
	頸淋巴結切除術	中型
	腹股溝及盤骨淋巴結切除術	大型
	根治性腹股溝清掃術	大型
	根治性盤腔淋巴結切除術	大型
	選擇性/ 根治性 / 功能性頸淋巴切除術	大型
	腋淋巴結廣泛性切除術	大型
脾臟	開放式或腹腔鏡式脾切除術	大型
男性生殖系統		
前列腺	前列腺膿腫外部引流術	小型
	激光前列腺氣化術	大型
	等離子激光前列腺氣化術	大型
	前列腺活體組織檢查	小型
	經尿道微波電療法	中型
	經尿道前列腺切除術	大型
	開放式或腹腔鏡式前列腺切除術	大型

程序 / 手術		分類
	開放式或腹腔鏡式根治性前列腺切除術	複雜
陰莖	包皮環切術	小型
	痛性陰莖勃起鬆解術	大型
	隱藏陰莖修補術/ 陰莖抽出術	中型
睪丸 [^]	附睪切除術	中型
	睪丸探查	中型
	腹腔鏡探查未降睪丸	大型
	睪丸固定術	中型
	腹腔鏡式睪丸切除術或睪丸固定術	大型
	睪丸扭轉復位及固定術	中型
	睪丸活體組織檢查	小型
	睪丸鞘膜積水高位結紮術	中型
	睪丸鞘膜積水抽液手術	小型
	精索靜脈曲張及睪丸鞘膜積液切除術	中型
	精索靜脈曲張切除術（顯微外科）	大型
	[^] 如非特別說明，此類別應用於單側或兩側（睪丸）	
輸精管	輸精管結紮手術	小型
肌肉骨骼系統		
骨	單肢的手指 / 腳趾截肢術	中型
	單臂 / 單手/ 單腿/ 單腳截肢術	中型
	拇趾囊腫切除術	中型
	拇趾囊腫切除術並進行軟組織矯正及第一跖骨切除術	大型
	橈骨頭切除術	中型
	因良性疾病切除下頷骨	中型
	膝蓋骨切除術	大型
	部分面骨骨切除術	中型
	面部死骨切除術	中型
	腕 / 手/ 腿骨的楔形截骨術	大型
	上臂 / 下臂/ 大腿的楔形截骨術	大型
	肩胛骨/ 鎖骨/ 胸骨的楔形截骨術	大型
關節	關節鏡引流及清創手術	中型
	關節鏡移除關節內游離體	中型
	關節鏡檢查連或不連活體組織檢查	中型
	關節鏡輔助進行韌帶重建術	大型
	關節鏡班卡特修補術	大型
	經關節鏡肩關節上盂唇由前往後撕裂的修補術	大型
	關節鏡旋轉套修復術	大型
	肩峰切除術	大型
	肩關節融合術	大型
	肘關節融合術/ 三關節融合術	大型
	膝關節/ 髖關節融合術	複雜
	手 / 手指 / 足 / 足趾的關節置換連植入術	大型
	腕融合術	大型
	腕滑膜切除術	中型
	腳趾指骨間關節融合術	中型
	手指指骨間關節融合術	大型
	肩關節切除術 / 半肩關節置換術	大型

程序 / 手術		分類
	髖關節 / 膝關節 / 手腕關節 / 肘關節切除術	大型
	髖關節 / 膝關節切除術連局部釋放抗生素	複雜
	顳顎關節成形術連或不連自體移植	大型
	關節抽吸術 / 注射	小型
	麻醉下進行關節鬆弛治療	小型
	金屬股骨頭置入術	大型
	前十字韌帶重建術	大型
	開放式或關節鏡式鏡半月板切除術	大型
	後十字韌帶重建術	大型
	副韌帶修復術	大型
	十字韌帶修補術	大型
	踝及足關節囊或韌帶的縫合術	大型
	全肩置換術	複雜
	全膝置換術	複雜
	全髖置換術	複雜
	部分髖關節置換術	大型
肌肉及肌腱	跟腱修補術	中型
	跟腱切斷術	中型
	肌肉或肌腱放鬆或收緊手術（除手部以外） / 肌肉損傷組織切除術	中型
	手部肌肉或肌腱放鬆或收緊手術	大型
	肌肉損傷組織切除術	中型
	肌腱延長，包括腱切斷術	中型
	開放式肌肉活體組織檢查	小型
	橈骨莖突狹窄性腱鞘炎	小型
	板機指鬆解術	小型
	網球肘（肱骨外上髁炎）鬆解術	小型
	肌肉轉移 / 移植 / 再接合術	大型
	不涉及手部的肌腱修復術 / 縫合術	中型
	手肌腱修復術 / 縫合術	大型
	腱鞘滑膜切除術 / 滑膜切除術	中型
	手腕 / 手肌腱移位術	大型
	二期肌腱修補術，包括移植、轉移及 / 或假體置入	大型
骨折及脫位	顳顎 / 指間骨 / 肩峰關節脫位閉合復位術	小型
	肩膀 / 肘 / 腕 / 踝骨脫位閉合復位術	中型
	科雷氏骨折閉合復位術連經皮膚克氏線固定治療	大型
	手臂 / 腿骨 / 髕骨 / 盤骨骨折閉合復位術連內固定術	大型
	顎骨骨折閉合復位術連內固定術	中型
	肩胛骨 / 鎖骨 / 指骨 / 髕骨骨折閉合復位術不連內固定術	小型
	上臂 / 前臂 / 手腕 / 手 / 腿 / 足骨骨折閉合復位術不連內固定術	中型
	鎖骨 / 手骨 / 踝骨 / 足骨骨折閉合復位術連內固定術	中型
	股骨骨折閉合復位術連或不連內固定術	大型
	關節窩骨折閉合 / 開放復位術連內固定術	複雜
	顎骨骨折開放復位術連內固定術	大型
	鎖骨 / 手 / 足骨骨折開放復位術（除腕骨 / 踝骨 / 跟骨外）連或不連內固定術	中型
	手臂 / 腿骨 / 髕骨 / 肩胛骨骨折開放復位術連或不連內固定術	大型
	股骨 / 跟骨 / 踝骨骨折開放復位術連或不連內固定術	大型
	使用外固定支架及徹底傷口清創術的複合性骨折手術治療	中型

程序 / 手術		分類
	拆除因舊骨折而裝上的螺絲、釘、金屬板及其他金屬（股骨除外）	小型
脊椎	人造頸椎間盤置換術	複雜
	頸 / 頸胸 / C4/5 及 C5/6 前脊柱融合術連鎖定骨板	大型
	除頸 / 頸胸/ C4/5 及 C5/6 以外的前脊柱融合術連鎖定骨板	複雜
	前脊椎融合術連儀器設置	複雜
	頸椎板成形術	大型
	椎板切除術或椎間盤切除術	大型
	椎板切除術連椎間盤切除術	複雜
	胸 / 頸胸 / 胸腰/ T5 至 L1 / 環 - 樞椎 後脊椎融合術	大型
	（除胸/ 頸胸/ 胸腰 / T5 至 L1 / 環 - 樞椎以外的）後脊椎融合術	複雜
	後脊椎融合術連儀器設置	複雜
	脊椎活體組織檢查	小型
	脊椎融合術，連或不連椎間孔切開術，連或不連椎板切除術，連或不連椎間盤切除術	複雜
	脊椎截骨術	複雜
	椎體成形術 / 椎體矯正術	中型
其他	神經節 / 滑囊切除術	小型
	掌腱膜攣縮的閉合式 / 經皮膚刺針筋膜切開術	小型
	掌腱膜攣縮的根治性或全部筋膜切開術	大型
	開放式或內窺鏡式腕道或踝管鬆解術	中型
	周圍神經鬆解術	中型
	尺神經移位術	中型
	滑動式 / 復位式下巴整形術	中型
皮膚及乳房		
皮膚	皮膚或皮下病變組織切除術 / 冷凍術 / 電灼術 / 激光治療	小型
	指甲下血腫或膿腫引流術	小型
	脂肪瘤切除術	小型
	用於移植的切皮手術	小型
	皮膚膿腫切開術及 / 或引流術	小型
	皮膚及 / 或皮下組織切開術及 / 或異物清除	小型
	皮膚及皮下病變組織的局部切除術或破壞術	小型
	皮膚傷口縫合術	小型
	外科洗滌及縫合術	小型
	趾甲楔形切除術	小型
乳房	乳房腫瘤 / 腫塊切除術連或不連活體組織檢查	中型
	幼針抽吸乳房囊腫檢查	小型
	乳房活體組織檢查	小型
	改良式根治性乳房切除術	大型
	部分或簡易乳房切除術	中型
	部分或根治性乳房切除連腋窩淋巴切除術	大型
	全部或根治性乳房切除術	大型
	乳管內乳頭狀瘤切除術	中型
	男性乳腺增生切除術	中型
泌尿系統		
腎臟	因泌尿系統結石進行的體外衝擊波碎石術	中型
	腎石切除術 / 腎盂切開術	大型
	腎內窺鏡	大型

本頁內容屬於自願醫保認可產品(編號: F00023) 的條款及保障。

程序 / 手術		分類
	經皮膚插入腎造口管手術	小型
	腎活體組織檢查	小型
	開放式或使用腹腔鏡或後腹腔鏡的腎切除術	大型
	部分 / 下端腎切除術	複雜
	腎移植手術	複雜
膀胱、輸尿管及尿道	膀胱鏡檢查連或不連活體組織檢查	小型
	膀胱鏡連輸尿管導管插入/ 經尿道膀胱清除術	小型
	膀胱鏡連電灼術/ 激光碎石術	中型
	尿道肉阜切除術	小型
	尿道或尿管支架植入	中型
	開放式或腹腔鏡式膀胱憩室切除術	大型
	經尿道切除膀胱腫瘤	大型
	開放式或腹腔鏡式部分膀胱切除術	大型
	開放式或腹腔鏡式根治性/ 全部膀胱切除術	複雜
	開放式或使用腹腔鏡或後腹腔鏡的尿管切石術	大型
	尿道直腸瘻管閉合術	大型
	尿道瘻管修補術	大型
	膀胱陰道瘻管修補術	大型
	結腸膀胱瘻管修補術	大型
	尿道破裂修補術	大型
	應力性尿失禁修補術	大型
	迴腸導管建造，包括輸尿管植入	複雜
	迴腸或結腸代替輸尿管手術	大型
	單邊輸尿管再植入腸或膀胱	大型
	雙邊輸尿管再植入腸或膀胱	大型
牙科		
	任何因意外受傷而進行的牙科手術	小型

自願醫保計劃 – 優健保

其他自選保障之額外條款及保障

(此部份並不屬於自願醫保計劃內之認可產品)

門診保障

(保障必須於保單資料頁列明方為有效)

按本保單的條款及細則，本保障將賠償受保人因醫療所需的治療在以下門診服務所收取的費用：

(1) 普通科門診服務

由註冊醫生提供之門診診症。

(2) 專科門診服務

在註冊醫生書面建議下，由專科醫生提供之專科門診診症。

(3) 門診化驗檢測服務

由註冊醫生提供或書面建議下進行，用作診斷或治理傷病之化驗檢測。

(4) 門診處方西藥

由註冊醫生提供或書面建議予受保人使用之門診處方西藥。

(5) 針灸、跌打及脊醫服務

就意外受傷由註冊中醫進行的針灸及跌打治療，或由註冊脊醫進行的整脊治療。

門診服務保障並不包括可在本保單承保之任何其他保障類別獲得賠償的開支。

牙科保障

(保障必須於保單資料頁列明方為有效)

按本保單的條款及細則，本保障將賠償受保人因醫療所需由註冊牙醫提供的治療在以下牙科服務所收取的費用：

(1) 定期口腔檢查

(2) 洗牙，每保單年度最多兩(2)次

(3) 補牙及脫牙

(4) 口腔X光

(5) 牙科治療藥物

(6) 牙科膿瘡排放

(7) 齒尖或齒邊修復

(8) 假牙、牙冠及牙橋(只適用於因意外而導致)

本保障不會就以下服務、製品或情況作出賠償：

(1) 牙科器具

(2) 不包括在上述牙科服務中的任何牙科程序的費用

(3) 由註冊牙醫以外的任何人進行的治療

(4) 部分或完全為美容性質的服務和用品的費用，除非該服務乃經由註冊牙醫按照醫療需要建議進行

牙科保障並不包括可在本保單承保之任何其他保障類別獲得賠償的開支。

危疾保障及女性保障

(保障必須於保單資料頁列明方為有效)

按本保單的條款及細則，及在已取得合理要求之證明並且符合下述條件的情況下，本公司將支付危疾保障及女性保障：

- (1) 受保人患上之承保疾病必須在本保單生效六十(60)天後才被診斷確認患上，惟因意外導致，則屬例外；及
- (2) 受保人經診斷確認罹患承保疾病後之二十一(21)天期限內，必須仍然在世。

本公司應付之危疾保障及女性保障保障額，乃根據保單資料頁列明之保障額，扣除有關保單年度未繳之整年保費及已支付之女性保障賠償而計算。

按危疾保障及女性保障：

- (1) 任何受保人均不得投保多於一(1)份由本公司承保之危疾保障計劃，包括整份保單或保單部份範圍就危疾提供保障。如受保人於本公司投保多份危疾保障計劃，本公司有權視受保人為受最高保障額的該份保單保障。如各份保單的保險額相同，本公司將視受保人為受首份簽發的保單保障。
- (2) 本公司就女性原位癌症保障只會賠償一次，而不會就多於一種女性原位癌症作出賠償。
- (3) 女性保障一經賠償，危疾保障最高總保障額將相應遞減。
- (4) 本公司一旦支付危疾保障最高總保障額，本保單之危疾保障即告終止。

危疾保障及女性保障之附加不承保事項

本保單之危疾保障及女性保障不承保以下事項、狀況、活動及其後果，本公司亦不會承擔繳付賠償之責任：

- (1) 受保人於保單生效日或保障金額提升日起六十(60)天內被診斷確認患上之病症，惟意外事件引致的病症除外。

提升日指由本公司以背書形式核准受保人確認提升保障金額或範圍之生效日期。

- (2) 在不合理情況下，沒有尋求或遵守醫療意見或指示。

倘本公司聲稱基於此等不承保條款，本保單並不承保任何賠償，則投保人有責任自行承擔作出反證的責任。

危疾保障及女性保障之附加釋義

「日常活動」指：

- 移動：由一張床移往一張豎立椅子或輪椅的能力，相反亦然，又或坐上或離開便桶或盥洗架的能力。
- 節禁力：節禁大便及小便的能力，以保持足夠程度的個人衛生。
- 穿戴：穿上、除下、縛牢及鬆開所有必要的衣服及任何器具、人造肢體或其他外科物品的能力。
- 活動：受保人在常住樓宇內，從一間房間移動至同一層的另一房間的室內活動能力。
- 進食：當食物及飲料預備妥當時，憑個人力量進食的能力。
- 洗澡：在浴盆或淋浴間洗澡的能力（包括進出浴盆或淋浴間），以達致保持足夠個人衛生的程度。

危疾保障

(保障必須於保單資料頁列明方為有效)

如**受保人**經**本公司**醫生同意並經**居住地的註冊醫生**或於某些承保**危疾**要求的**專科醫生**診斷證實罹患下列任何一種或多種**危疾**，並於診斷後生存超過二十一(21)天，**本公司**將支付危疾最高總保障額之現金賠償。

「**危疾**」指：

(1) 癌症

出現惡性細胞生長不受控制及擴散，並侵入鄰位組織的惡性腫瘤，包括白血病、淋巴肉芽腫病、淋巴瘤，但不包括因人體免疫力缺乏病毒引發之皮膚多發性出血性肉瘤、非侵入性原位癌及除侵入性惡性黑素瘤以外之任何皮膚癌。

索償時必須具列精確的癌病組織證明以作支持文件。

(2) 中風

腦血管意外導致永久性神經損傷，本項保障並不包括暫時性局部缺血中風。

(3) 心臟病突發

由於血液供應不足以致心臟部分肌肉壞死，導致出現典型胸口翳痛、新的心電圖轉變及心臟酵素量增加。

(4) 冠狀動脈手術

受保人遵照心臟科**專科醫生**的建議，進行直視心臟手術，利用旁道管移植手術矯正一條或多條冠狀動脈的收窄或堵塞情況。本項保障不包括氣球血管整形術、激光或其他手術。

如兩條或以上的冠狀動脈已有最少七十(70)%部份堵塞，則本項保障將包括採用氣球血管整形術、動脈硬化清除術或激光手術治療受影響之動脈。

(5) 肝臟完全衰竭

已出現黃疸、腦功能病變及腹水的末期肝衰竭，並獲得**受保人**的**居住地**之主要**醫院**聘任的**註冊醫生**診斷確定。

(6) 腎衰竭

末期腎臟衰竭，兩個腎臟均出現無法復原的慢性衰竭，需要進行定期的洗腎治療或腎臟移植手術。

(7) 主要器官移植手術

身為接受移植者，實際進行心臟、肝臟、肺、胰臟或骨髓移植的手術。

釋義包括同時移植超過一個上述的器官。如未有就腎衰竭提出索償申請，則本項將包括移植腎臟。

(8) 運動神經細胞疾病

經神經病科**專科醫生**診斷為運動神經細胞疾病，並持有合適的支持證明。

(9) 失聰

連續十二(12)個月雙耳完全及永久喪失聽覺。

(10) 失明

雙眼完全及永久喪失視力。

(11) 嚴重燒傷

受保人身體表面最少二十(20)%遭受第三級燒傷。

(12) 昏迷

陷入失去知覺的狀態，對外界刺激或體內需要持續失去反應，採用生命維持系統最少九十六(96)小時，並出現永久性神經缺陷。

(13) 帕金森病

在受保人六十(60)歲生日前，經神經病科**專科醫生**明確診斷之自發性帕金森病（震顫性麻痺），並需接受原多巴胺治療。

本項保障不包括其他帕金森神經機能障礙。

(14) 多發性硬化

經神經病科**專科醫生**明確診斷之多發性硬化，以致最少持續六(6)個月出現中度神經功能異常的狀態。

(15) 癱瘓症／截癱

受保人持續最少十二(12)個月因癱瘓症而導致兩條或以上肢體完全及永久喪失功能。

(16) 喪失獨立能力

喪失獨立能力即踏入六十(60)歲後，永久地喪失獨立進行三(3)項或以上的**日常活動**的能力，不論是否使用機械裝置、特別工具或其他輔助工具亦然。

(17) 因輸血感染愛滋病病毒

保單開始生效後，在受保人的**居住地**接受治療時，透過輸血感染任何人體免疫力缺乏病毒。受保人必須向**本公司**之醫學顧問提交令其滿意的清晰證明，以證實愛滋病乃由上述途徑感染，並獲得提供輸血服務的有關機構承擔責任，同時證明受保人並非血友病患者。

(18) 主動脈手術

因主動脈病患或受傷，需要接受主動脈切除及移植而進行直視心臟手術。根據本項釋義，主動脈即胸部及腹部的主動脈，而非主動脈的支脈。

(19) 心瓣膜手術

進行直視心臟手術以修補或更換一片或以上的異常心臟瓣膜。

(20) 阿耳滋海默氏症

受保人踏入六十(60)歲前，獲臨床診斷為阿耳滋海默氏症或早老性痴呆，以致永久喪失獨立進行三(3)項或以上**日常活動**的能力。

阿耳滋海默氏症或早老性痴呆，乃指無法恢復的器官衰退失調（神經機能病及精神病除外）引致智力退化、喪失智力或行為失常（獲臨床狀況及認可標準問卷或測試證明），以致智力或社交功能顯著減弱，而需持續接受監督指導。診斷必須由神經病科**專科醫生**進行，並獲得**本公司**之醫學顧問同意。

(21) 喪失語言能力

因聲帶損傷，以致連續十二(12)個月完全及永久喪失說話能力。

(22) 良性腦腫瘤

一種非癌性的大腦內腫瘤。本項釋義並不包括腦部動脈或靜脈出現囊腫、肉芽瘤及畸形，以及腦下垂體或脊椎出現血腫及腫瘤。

(23) 末期病症

晚期或進展迅速的不治之症，而根據**本公司**之醫學顧問判斷壽命不會超過十二(12)個月。

(24) 喪失肢體

完全及永久喪失兩(2)條或以上肢體的用途，並最少其中一(1)條肢體在膝蓋或肘部以上遭受嚴重性創傷。

(25) 肌失養症

經神經科**專科醫生**確定為遺傳性肌失養症，以致永久及完全喪失能力。

(26) 腦炎

腦部或脊髓膜發炎，以致出現嚴重的永久神經缺陷。是項診斷必須經由神經科**專科醫生**證實。本項保障並不包括因愛滋病毒感染之腦炎。

(27) 頭部意外受傷引致嚴重腦創傷

頭部**意外**受傷導致腦損傷的後遺症。經神經科**專科醫生**的證實，由於永久性神經缺陷導致嚴重的功能受損。

(28) 肺動脈高壓

經心臟科**專科醫生**診斷，並獲臨床及實驗研究（包括心導管檢查）證實之原發性肺動脈高壓，同時亦須符合以下的診斷準則：

- (a) 呼吸困難及疲勞；及
- (b) 左心房壓力上升（最少20個單位或以上）；及
- (c) 最少3個單位出現不正常的肺動脈阻力；及
- (d) 肺動脈壓力最少40毫米汞柱；及
- (e) 肺動脈楔壓最少6毫米汞柱；及
- (f) 右心室端舒張壓力最少8毫米汞柱；及
- (g) 右心室肥大，擴張及左心臟出現衰竭及代償失調的徵狀。

女性保障

(保障必須於保單資料頁列明方為有效)

(1) 女性原位癌：

「原位癌」是指癌細胞焦點式的惡性病變，但還沒有侵入到鄰位正常的組織細胞或擴散至身體其他部份。如**受保人**經診斷證實罹患下列任何一種女性原位癌，本公司將支付女性保障最高保障額之現金賠償。

女性原位癌指：

- (a) 乳房原位癌
- (b) 子宮頸原位癌
- (c) 子宮原位癌
- (d) 輸卵管原位癌
- (e) 陰道／外陰原位癌
- (f) 卵巢原位癌

子宮頸原位癌的等級小於第三級(CIN III)不在保障範圍之內。

原位癌陽性的診斷結果一定要由選定的活體組織經顯微鏡檢查而證實，初步的臨床診斷並不足夠。

(2) 女性疾病

如**受保人**經診斷證實罹患下列任何一種女性疾病，**本公司**將支付女性保障最高保障額之現金賠償。

女性疾病指：

(a) 類風濕性關節炎

經風濕及免疫科**專科醫生**診斷證實患上類風濕性關節炎，並導致嚴重影響進行任何兩(2)項**日常活動**的能力。

(b) 骨質疏鬆導致髌骨骨折

經骨科**專科醫生**診斷證實患上骨質疏鬆，並導致髌骨骨折。

(c) 系統性紅斑狼瘡導致狼瘡性腎炎

經風濕及免疫科**專科醫生**診斷證實患上涉及腎臟的系統性紅斑狼瘡，並導致狼瘡性腎炎。

其他自選保障之保障表（港元）

其他自選保障	計劃 A	計劃 B	計劃 C
門診保障			
最高保障額	不適用	不適用	\$25, 000
－ 每保單年度			
普通科門診服務			全額賠償
－ 每日一次			
專科門診服務			全額賠償
－ 每日一次			
普通科及專科門診服務最高總次數			30
－ 每保單年度			
門診處方西藥			\$9, 500
－ 每保單年度			
門診化驗檢測服務			\$9, 500
－ 每保單年度			
針灸、跌打及脊醫服務			\$450
－ 因意外受傷而引致			
－ 每日一次，每保單年度最多 8 次			
－ 每日			
牙科保障			
每保單年度最高保障額	\$2, 500	\$2, 500	\$2, 500
－ 洗牙（每保單年度最多 2 次）：每次 500			
－ 定期口腔檢查			
－ 口腔 X 光及藥物			
－ 補牙及脫牙			
－ 膿瘡排放			
－ 齒尖或齒邊修復			
－ 假牙、牙冠及牙橋 （只適用於因意外而導致）			
危疾保障			
基本保障 1 - 12 種危疾			
全面保障 1 - 28 種危疾			
危疾保障最高總保障額	\$500, 000	\$500, 000	\$500, 000
女性保障最高保障額	\$100, 000	\$100, 000	\$100, 000
注意：			
女性保障乃危疾保障之附加保障，不可獨立投保。女性保障一經索償，危疾保障之最高總保障額將相應遞減。			

附錄：24小時國際支援服務條款與規章

本節並非保單合約的一部份。

本中文譯本是旨在協助您閱讀此條款與規章之內容，並不應被視為在闡釋任何條文時有任何影響力。

24小時國際支援服務乃三井住友海上火災保險（香港）有限公司透過「服務供應商」的救援中心提供的服務，以援助海外旅途中遭遇「緊急事故」的「會員」。

第1節 - 詞彙解釋

「支援事件」

指有權根據此條款與規章使用支援服務的「會員」在第2節第2.2條訂明的「境內地區」遭遇的事件或事況，惟需遵從第6節所載的「不承保事項」。

「近親」

指「會員」的配偶、父母、其子女、兄弟或姊妹，但並不包括岳丈岳母、家翁家姑、叔伯或姑嫂。

「本公司」

指三井住友海上火災保險（香港）有限公司。

「原居國家」

指香港，除非「本公司」另有特別同意。

「緊急事故」

指不可合理預防而需要特別協助的嚴重傷病事故或危機。

「疾病」

指任何於「本公司」保障的保險期內首次發病的不可預見疾病、病症或病患。

「會員」

指「本公司」所保障的任何人士。

「嚴重傷病狀況」

指「服務供應商」認為足以構成嚴重傷病「緊急事故」的狀況而必須立刻拯救或治療，否則會導致「會員」死亡或其即時或長遠健康狀況嚴重受損。傷病狀況的嚴重程度將根據「會員」所在的地理位置、傷病「緊急事故」的性質及當地之適當醫護服務或設施的供應情況而釐定。

「服務供應商」

指「本公司」委任的緊急支援服務供應商。

第2節 - 保障期限及限制

2.1 保障期限

按「本公司」保障的保險期內提供第3節訂明的服務。

2.2 地區

除第3.2條特別訂明的服務外，第3節所述的各項服務均在「會員」「原居國家」以外的全球地區生效。

第3節 - 緊急支援服務

3.1 緊急醫療諮詢及支援

在海外緊急情況下，「會員」可致電24小時緊急支援中心，要求當值的醫生提供醫療諮詢及評估服務，以便在世界各地找到適當的醫療服務，或按醫療上的適當情況轉介「會員」至當地或其他醫生、專科醫生或醫院作個人傷病情況評估及/或治療。惟立約雙方明白及同意有關之電話交談只屬指導，而並非正式診治。緊急支援中心可透過確定由「本公司」提供之保險保障範圍協助有需要的海外入院安排、監察索償程序及根據付款保證條款發出適當之保證。

3.2 國際旅遊支援服務

「會員」在「原居國家」以外地方旅遊途中或啟程前，24小時緊急支援中心可提供下列的行政支援及服務：

- 啟程前的簽證、防疫及免疫注射規定、特別藥物及當地天氣資訊服務；
- 尋回及運送遺失行李；
- 補領及運送遺失的重要旅遊證件(如護照、機票及信用卡)；
- 傳送緊急訊息及安排傳譯服務。

立約雙方明白及同意「會員」須支付「本公司」為提供上述服務合理及正當地招致之所有第三方費用或收費。

第4節 - 一般責任/程序

4.1 要求支援

「會員」如遇「緊急事故」，以及在親自採取合理行動之前，「會員」或其代表均可撥長途電話至「服務供應商」的緊急支援中心。聯絡電話號碼如下：

香港：(852) 3122 6899

「會員」致電時應說明：

- 姓名、保單號碼、保險公司名稱及身份證號碼或護照號碼；及
- 「服務供應商」可聯絡「會員」或其代表的地點及電話號碼；及
- 簡述意外及所需支援的性質。

有關長途電話費用均由「會員」支付。

4.2 未能通知「服務供應商」

如有性命危險，「會員」或其代表應試圖透過最適當及快速的途徑安排「會員」前往就近的醫院。然後盡快致電「服務供應商」的緊急支援中心，提供適當資料。

「服務供應商」的醫療人員或其他代表應可自由接觸「會員」，以便評估「會員」的狀況。假如「會員」無理拒絕「服務供應商」的醫療人員或其他代表的接觸，「本公司」將不會提供其他醫療支援服務。

第5節 - 會員的責任

5.1 紓減「緊急事故」的影響

「會員」有責任合理地盡力紓減「緊急事故」的影響。

5.2 與「服務供應商」合作

「會員」應與「服務供應商」合作，以便「服務供應商」向有關方面取得所有文件及收據，此外並需協助「服務供應商」遵從及辦理所有必要手續，有關費用需由「會員」支付。

5.3 索償限制

任何索償如關乎「支援事件」或採取法律行動的權利，必須於事件發生後一(1)年內提出，否則一律無效。

5.4 代位權

如「本公司」就提供支援服務予「會員」及支付任何款項，則「本公司」將取代「會員」，以行使權利向下列人士索償：

- 任何應就支援服務承擔法律責任的第三者，最高索償金額為「本公司」已付的款項；及
- 任何就「支援事件」提供保障的其他保險或支援服務計劃。

第6節 - 不保障事項

第3節訂明的各項服務，一律需遵從「本公司」提供之保險保障範圍規定之不保障事項，詳情請參閱相關保險本身。

第7節 - 司法裁判權

24小時國際支援服務的條款與規章遵從香港特別行政區的專有司法管轄權，並按香港特別行政區法律詮釋。

免責條款

「服務供應商」及經該公司轉介為「會員」服務的專業人士乃獨立承辦商，並非「本公司」之職員、代理人或僱員。「本公司」不會就「服務供應商」及經該公司轉介的專業人士(例如但並非局限於醫生、醫院及診所)所提供的服務或因其未能履行有關服務事宜作出任何承擔。



Appendix: Notice to customers relating to the Personal Data (Privacy) Ordinance ("the Ordinance")

MSIG Insurance (Hong Kong) Limited ("MSIG", "we" or "us") would ask that you take the time to read this privacy policy carefully. In case of discrepancies between the English and Chinese versions of this statement, the English version shall prevail.

PRIVACY POLICY

MSIG takes your privacy very seriously. To ensure your personal information is secure, we communicate and enforce our privacy and security guidelines according to the relevant laws and regulations. MSIG takes precautions to safeguard your personal information against loss, theft, and misuse, as well as against unauthorised access, disclosure, alteration, and destruction. Furthermore, we will not sell your personal information to anyone for any purposes. MSIG imposes very strict sanction control and only authorised staff on a need-to-know basis are given access to or will handle your personal data, and we provide regular training to our staff to keep them abreast of any new developments in privacy laws and regulations.

We will only retain your personal data in our business records for as long as it is necessary for business and tax purposes as permitted by the laws. We will require our agent, contractor or third party who provides administrative or other services on our behalf to protect personal data they may receive in a manner consistent with this policy. We do not allow them to use such information for any other purposes. If you have any questions or inquiries regarding our privacy policy, please feel free to contact us.

We may amend this Privacy Policy at any time and for any reason. The updated version will be available by following the 'Privacy Policy' link on our website homepage at msig.com.hk. You should check the Privacy Policy regularly for changes.

Personal Information Collection Statement

Personal information is data that can be used to uniquely identify or contact a single person. As our customers, it is necessary from time to time for you to supply us with your personal data in relation to the general insurance services and products ("the Product") that we provide to you and in order for us to deliver and improve the customer service. This includes but not limited to the personal data contained in the proposal form or in any documents in relation to the Product or any claim made under the Product.

Your personal data may be used for **obligatory purpose** or **voluntary purpose**. If personal data are to be used for an obligatory purpose, you **MUST** provide your personal data to MSIG if you want MSIG to provide the Product. Failure to supply such data for obligatory purpose may result in MSIG being unable to provide the Product.

The **obligatory purposes** for which your personal data may be used are as follows:-

- processing and evaluating your insurance application and any future insurance application you may make;
- our daily operation and administration of the services and facilities in relation to the Product provided to you;
- variation, cancellation or renewal of the Product;
- invoicing and collecting premiums and outstanding amounts from you;
- assessing and processing claims in relation to the Product and any subsequent legal proceedings;
- exercising any right of subrogation by us;
- contacting you for any of the above purposes;
- other ancillary purposes which are directly related to the above purposes;
- complying with applicable laws, regulations or any industry codes or guidelines; and
- detecting and preventing fraud (whether or not relating to the policy issued in respect of this application).

The **voluntary purposes** for which your personal data may be used are any sales, marketing, promotion of other general insurance services and products provided by MSIG. The personal data we intend to use for voluntary purposes are your name, your address, your phone number and email address



If you do not wish MSIG to use your personal data for the voluntary purposes listed above, you should tick the box on the right and send us a copy of this Notice at the address listed below together with the required information which are necessary for us to process your opt-out request. You may also notify us by filling in the General enquiry form - Opt-out from direct marketing activities on our website at msig.com.hk. In your notification, you must supply the same required information as listed below.

☐

To enable us to process your opt-out request, please provide us below information and send to: The Data Protection Officer at 9/F, 1111 King's Road, Taikoo Shing, Hong Kong.	
Full Name:	
Contact Number:	
HKID Number:	(for identification purpose)
Policy / Certificate / Acknowledgement Number (if you have one):	
NOTE: This instruction will override all previous instructions relating to direct marketing that have been given to MSIG.	

In connection with any of the above purposes, the personal data that we have collected might be transferred to:

- third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist us to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
- in the event of a claim, loss adjudicators, claims investigators and medical advisors;
- reinsurers and reinsurance brokers;
- your insurance broker;
- our legal and professional advisors;
- our related companies as defined in the Companies Ordinance;
- the Hong Kong Federation of Insurers (or any similar association of insurance companies) and its members;
- the Insurance Complaints Bureau and similar industry bodies; and
- government agencies and authorities as required or permitted by law;
- fraud prevention organizations;
- other insurance companies (whether directly or through fraud prevention organization or other persons named in this paragraph);
- the police; and
- databases or registers (and their operators) used by the insurance industry to analyse and check information provided against existing information.

In order to confirm the accuracy of your personal data, you agree to provide us with authorisation to access to and to verify any of your personal data with the information collected by any federation of insurance companies from the insurance industry.

Under the relevant laws and regulations, you have the right to request access to and to request correction of your personal data held by us. If you wish to exercise these rights, please write to our Data Protection Officer at 9/F, 1111 King's Road, Taikoo Shing, Hong Kong.

If you have any enquiries or require assistance with this Personal Information Collection Statement, please call us at (852) 3122 6922.

附錄：致各客戶有關個人資料（私隱）條例（“條例”）通知書

三井住友海上火災保險（香港）有限公司（下稱「三井住友保險」、「我們」或「本公司」）請您仔細閱讀下列條款與條件。如此聲明的英文版本與中文版本內容有歧異，將以英文版本為準。

私隱政策

三井住友保險極為重視您的私隱。為了保障您的個人資料，我們以有關法例及規例為準則，向公司內部傳達並執行我們定立之私隱及保障指引。三井住友保險採取預防措施以保障您的個人資料免遭受遺失、盜竊、誤用，以及在未經許可之情況下被取用、洩露、更改及破壞。此外，我們均不會出售您的個人資料給任何人。三井住友保險嚴格執行認可管制，只容許獲授權之職員在必需要的情況下，取用或處理您的個人資料。我們會向職員定期提供培訓，確保他們知悉任何有關私隱法律及規例的新發展。

我們只會在法律容許並必需用於業務及稅務用途之情況下，保留您的個人資料作為我們的業務記錄。我們會向以本公司之名義提供行政或其他服務之代理、承辦商或第三者，要求他們遵循本政策保護有可能收到的個人資料。本公司不會容許他們使用有關資料於任何其他目的。如您對我們的私隱政策有任何疑問，歡迎聯絡我們查詢。

我們可能不時修改此範本。修改後的範本可於本公司網頁 msig.com.hk 下載。您應定期查閱此範本所修改的內容。

個人資料收集聲明

個人資料是可以用作獨立識別或聯絡個別人士之數據。貴為我們的客戶，您須向我們不時供給與我們提供之一般保險服務及保單產品（下稱「保單」）相關的個人資料，讓我們可向您提供客戶服務及改善服務質素。當中包括但不限於您在申請表填寫或任何與保單有關之文件上或任何透過保單索償上所載之個人資料。

您的個人資料可被用於**強制性**或**自願性**用途。如個人資料是用於強制性用途，而您希望三井住友保險提供有關保單，則您必須向三井住友保險提供有關個人資料，否則三井住友保險將不能向您提供有關保單。

您的個人資料可被用於以下**強制性**之用途：

- 處理及審批您的保險申請或您將來提交的保險申請；
- 向您提供與保單及核保相關之日常運作及行政用途；
- 保單之更改、取消或續保用途；
- 發出繳交保費通知及向您收取保費及欠款；
- 評估及處理透過保單索償及任何繼後法律訴訟之用途；
- 由本公司行使代位權利之用途；
- 就以上用途聯絡您；
- 其他與上述用途有直接關係的附帶用途；
- 遵循適用法律、條例及業內守則及指引；及
- 偵測和防止欺詐行為（無論是否與就此申請而發出的保單有關）所需的目的是。

而**自願性用途**則指任何三井住友保險提供的其他一般保險服務及保單產品之銷售、市場營銷及推廣。用作自願性用途之個人資料則為您的姓名、地址、電話號碼及電郵地址。

如您不欲 三井住友保險將您的個人資料用作上述自願性用途，您應於右列方格加上剔號並將此通告之副本連同您要求拒絕服務所必須提供的資料（詳情如下）郵寄至下列地址。您亦可填妥本公司網頁 msig.com.hk 的一般查詢表格－拒絕直銷活動。



為讓我們能夠處理您以上提出的拒絕服務之請求，請提供以下資料並寄至三井住友海上火災保險（香港）有限公司的資料保護主任：香港太古城英皇道 1111 號 9 樓。	
姓名：	
聯絡電話：	
香港身份證號碼：	(作識別之用)
保單號碼 / 證書編號 / 確認編號 (如適用)：	
附註:此拒絕服務要求將會取代您先前給予三井住友保險一切關於直接促銷的指示。	

就任何上述的用途，我們所收集的個人資料可能會被轉移至：

- 向我們提供行政、通訊、電腦、付款、保安及其他服務的第三方代理、承包商及顧問（包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商）；
- 處理索賠個案的理賠師、理賠調查員及醫療顧問；
- 再保公司及再保經紀；
- 您的保險經紀；
- 我們的法律及專業業務顧問；
- 我們的關連公司（以《公司條例》內的定義為準）；
- 香港保險業聯會（或同類的保險公司聯會）及其會員；
- 保險投訴局及同類的保險業機構；
- 法例要求或許可的政府機關；
- 防欺詐組織；
- 其他保險公司（無論是直接地，或是通過防欺詐組織或本段中指名的其他人士）；
- 警察；及
- 保險業就現有資料而對所提供的資料作出分析和檢查的數據庫或登記冊（及其運營者）。

為了確保您的個人資料之準確性，您同意授權本公司查閱並核實任何由保險業界內保險公司聯會所收集有關您的個人資料。

根據有關法例及規例，您有權查閱及更正本公司所持的任何載有您的個人資料之記錄。如您欲行使以上權利，可以書面形式投寄至香港太古城英皇道 1111 號 9 樓三井住友海上火災保險（香港）有限公司，通知本公司的資料保護主任。

如您對此個人資料收集聲明有任何疑問或須協助，請致電(852) 3122 6922 與我們聯絡。