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VHIS Prestige Care

Terms and Conditions

Contents

TERMS AND CONDITIONS

Part 1 Insuring Clause and The Policy

Insuring Clause

These Terms and Conditions together with the Benefit Schedule (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, hydropathy, homeotherapy and other similar treatments.

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

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

(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.

SUPPLEMENT 7

VHIS Prestige Care

Inclusion of VAT and GST as Eligible Expenses

This Supplement shall be attached to and form part of the Terms and Benefits. Unless otherwise defined, words and expressions used in the Terms and Benefits shall have the same meanings when they are used in this Supplement.

This Supplement shall take effect from 1 March 2022.

With effect from the Effective Date, the following terms and conditions shall be applied to the Terms and Benefits –

1. With respect to any Eligible Expenses incurred on or after the Effective Date, the terms and conditions in this Supplement shall be applicable, and Eligible Expenses shall include the VAT and GST (if any) charged or imposed on the expenses incurred for Medical Services rendered with respect to a Disability.

2. For the purpose of Section 13 of Part 7 of the Terms and Benefits, any VAT and GST which is refunded to the Policy Holder or Insured Person (as the case may be) shall be excluded pursuant to such Section 13, and shall not be recoverable under the Terms and Benefits.

Definition

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

SUPPLEMENT 8

VHIS Prestige Care

Inclusion of public hospitals and private hospitals in Hong Kong in the definition of Hospital

This Supplement shall be attached to and form part of the Terms and Benefits. Unless otherwise defined, words and expressions used in the Terms and Benefits shall have the same meanings when they are used in this Supplement.

This Supplement shall take effect from 1 January 2023 ("**Effective Date**").

With effect from the Effective Date, the definition of "Hospital" in Part 8 "Definition" shall include public hospitals and private hospitals in Hong Kong, as set out below:

"**Hospital** "	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which – (a) has facilities for diagnosis and major operations, or is a public hospital as defined in the Hospital Authority Ordinance (Cap. 113 of the Laws of Hong Kong) or a hospital for which a licence is issued under the Private Healthcare Facilities Ordinance (Cap. 633 of the Laws of Hong Kong); (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.

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

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
	Submandibular gland excision	Intermediate
Respiratory system	Arytenoid subluxation – laryngoscopic reduction	Minor
	Bronchoscopy +/- biopsy	Minor
	Bronchoscopy with foreign body removal	Minor
	Laryngoscopy +/- biopsy	Minor
	Laryngeal / tracheal stenosis – endolaryngeal / open operation with stenting / reconstruction	Major
	Laryngeal diversion	Intermediate
	Laryngectomy +/- radical neck resection	Complex
	Microlaryngoscopy +/- Biopsy +/- excision of nodule / polyp / Reinke's edema	Minor
	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 iridotasis	Intermediate
	Scleral fistulization +/- iridectomy	Intermediate
	Thermocauterization of sclera +/- iridectomy	Intermediate
	Diminution of ciliary body	Intermediate
	Biopsy of extraocular muscle or tendon	Minor
	Operation on one extraocular muscle	Intermediate
	Eyeball, perforating wound of, with incarceration or prolapse of uveal tissue repair	Major
	Enucleation of eye	Intermediate
	Evisceration of eyeball / ocular contents	Intermediate
	Repair of eyeball or orbit	Intermediate
	Conjunctivocystorhinostomy	Intermediate
	Conjunctivorhinostomy with insertion of tube / stent	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lacrimal sac and passage	Minor
	Excision of lacrimal gland / dacryoadenectomy	Intermediate
	Probing +/- syringing of lacrimal canaliculi / nasolacrimal duct	Minor
	Repair of canaliculus	Intermediate
	Coreoplasty	Intermediate
FEMALE GENITAL SYSTEM		
Cervix	Amputation of cervix	Intermediate
	Colposcopy +/- biopsy	Minor
	Conization of cervix	Minor
	Destruction of lesion of cervix by excision/ cryosurgery / cauterization / laser	Minor
	Endocervical curettage	Minor
	Loop electrosurgical excision procedure (LEEP)	Minor
	Marsupialization of cervical cyst	Minor
	Repair of cervix	Minor
	Repair of fistula of cervix	Intermediate
	Suture of laceration of cervix / uterus / vagina	Intermediate
Fallopian tubes and ovaries^	Dilatation / insufflation of fallopian tube	Minor
	Excision / destruction of lesion of fallopian tube, open or laparoscopic	Major
	Repair of fallopian tube	Major
	Salpingostomy / salpingotomy	Intermediate
	Total or partial salpingectomy	Intermediate
	Tuboplasty	Intermediate
	Aspiration of ovarian cyst	Minor
	Ovarian cystectomy, open or laparoscopic	Major
	Wedge resection of ovary, open or laparoscopic	Major
	Oophorectomy	Intermediate
	Oophorectomy, laparoscopic	Major
	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

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

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

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 / diskectomy	Major
	Laminectomy with diskectomy	Complex
	Posterior spinal fusion, thoracic / cervico-thoracic / thoracolumbar / T5 to L1/ atlas-axis	Major
	Posterior spinal fusion, (excluding thoracic / cervico-thoracic / thoracolumbar / T5 to L1 / atlas-axis)	Complex
	Posterior spinal fusion with instrumentation	Complex
	Spinal biopsy	Minor
	Spinal fusion +/- foraminotomy +/- laminectomy +/- diskectomy	Complex
	Spine osteotomy	Complex
	Vertebroplasty / kyphoplasty	Intermediate
Others	Excision of ganglion / bursa	Minor
	Closed/ Percutaneous needle fasciotomy for Dupuytren disease	Minor
	Radical (or total) fasciectomy for Dupuytren disease	Major
	Release of carpal / tarsal tunnel, open or endoscopic	Intermediate
	Release of peripheral nerve	Intermediate
	Transposition of ulnar nerve	Intermediate
	Sliding / reduction genioplasty	Intermediate
SKIN AND BREAST		
Skin	Curettage / cryotherapy / cauterization / laser treatment of lesion of skin	Minor
	Drainage of subungual haematoma or abscess	Minor
	Excision of lipoma	Minor
	Excision of skin for graft	Minor
	Incision and /or drainage of skin abscess	Minor
	Incision and /or removal of foreign body from skin and subcutaneous tissue	Minor
	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue	Minor
	Suture of wound on skin	Minor
	Surgical toilet and suturing	Minor
	Wedge resection of toenail	Minor
Breast	Breast tumour/ lump excision +/- biopsy	Intermediate
	Fine needle aspiration (FNA) of breast cyst	Minor
	Incisional breast biopsy	Minor
	Modified radical mastectomy	Major
	Partial or simple mastectomy	Intermediate
	Partial or radical mastectomy with axillary lymphadenectomy	Major
	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 examinationScaling, 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 Iymphoma but excludes Kaposi's Sarcoma in the presence of any Human-lmmuno 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 (60^{th}) 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.

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 msiq.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。

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。