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Thank you for considering Sun Flower to be one of your selected intermediaries.

We are pleased to get in touch should you have any enquiry regarding the captioned insurance.

bolttech Insurance

TheChoice Medical Insurance

Contents

1 Definitions

Accident – shall mean an unforeseen, unexpected, violent, and involuntary external event or contiguous series of events of accidental and visible nature which shall be the sole and direct cause of a bodily injury and independently of any other causes including but not limited to illness or any naturally occurring condition or degenerative process while this Policy is in force.

Acquired Immune Deficiency Syndrome or **AIDS** – shall have the meaning ascribed to such term by the World Health Organization from time to time.

Anaesthetist – shall mean an Independent Person (other than the attending Physician or Surgeon operating on the Insured), who is licensed and registered under Anesthesiology of the Specialist Register of the Medical Council of Hong Kong or equivalent to perform anesthesiology services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

Annual Deductible – shall mean the part of Eligible Expenses which shall be borne by the Policyholder or the Insured and which has to be deducted from the reimbursable sum. Where applied, the amount of deductibles payable by the Policyholder or the Insured per Policy Year is shown in the Policy Schedule.

Annual Limit – shall mean the maximum aggregate amount of benefits payable by the Company under clause 4 of this Policy and applicable supplementary benefits (if any) in any one (1) Policy Year and is shown in the Policy Schedule.

Balance of Annual Deductible – shall mean the remaining amount of Annual Deductible to be borne by the Policyholder or the Insured within the relevant Policy Year under this Policy.

Benefit Schedule – shall mean the benefit schedule attached to the Policy Schedule as amended or renewed from time to time

Chinese Medicine Practitioner – shall mean an Independent Person who is licensed and registered under the Chinese Medicine Ordinance of Hong Kong or otherwise legally authorized and having at least equivalent qualifications to perform equivalent Chinese medicine treatment in accordance with the laws of that location where the Eligible Expenses are incurred, and who is acceptable to the Company.

Chiropractor – shall mean an Independent Person who is registered with the Chiropractor Council of Hong Kong according to the Chiropractor Registration Ordinance or with the local medical authorities at the place of treatment if such treatment is received outside Hong Kong and renders chiropractic treatment to diagnose and cure the disorders of the musculoskeletal system and the effects of these disorders on the nervous system and general health.

Clinical Surgery – shall mean an Out-Patient surgical procedure, which may effectively be undertaken in the office or clinic of a Physician or in the out-patient department or emergency treatment room of a Hospital provided that the surgical procedure falls under the Clinical Surgery List.

Commencement Date – shall mean the date of premium commencing and the date used for determining the issue age of the Insured and is shown in the Policy Schedule.

Company, us or our – shall mean Bolttech Insurance (Hong Kong) Company Limited.

Confinement or Confined – shall mean admission of the Insured into a Hospital or Mental/Psychiatric Hospital as an In-Patient on written recommendation of a Physician for Medically Necessary treatment as a result of Covered Illness or Covered Injury, provided that the duration of such stay is at least six (6) consecutive hours. Throughout the period from the Insured's admission until his/her Discharge, the Insured is required to be continuously confined in the Hospital or Mental/Psychiatric Hospital without any physical absence or interruption.

Congenital Conditions – shall mean medical abnormalities existing at the time of birth, regardless of whether they are known or unknown to the Policyholder or the Insured, as well as neonatal physical abnormalities developing before the Insured attains sixteenth (16th) years of age, and shall include but are not limited to strabismus (squint), hydrocephalus, undescended testicle, Meckel's diverticulum, flat foot, heart septal defect and indirect inguinal hernias.

Covered Illness – shall mean a physical condition marked by a pathological deviation from the normal healthy state which manifests and commences more than thirty (30) days after the Policy Date of this Policy. In this Policy, an illness is regarded as having occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested which would cause an ordinary prudent person to seek diagnosis, care or treatment. In the event of any conflict or discrepancy of opinions relating to the signs or symptoms of an illness and their manifestation between a Physician and the Insured, the Company shall adopt and follow the Physician's professional opinion.

Covered Injury – shall mean bodily damage to the Insured caused solely and directly by an Accident that occurs while this Policy is in force.

Cover Limit – shall mean the limit of the Company's liability for each item of benefit specified in the Benefit Schedule.

Dietitian – shall mean an Independent Person who is a registered dietitian legally authorized by the government in the geographical area of his practice to assess, diagnose, and treat nutritional problems.

Discharge – shall mean the departure of the Insured from the Hospital or Mental/Psychiatric Hospital, following finalization of all formal procedures within the Hospital or Mental/Psychiatric Hospital to end the Confinement and billing of outstanding charges for full settlement, with no room or bed retained for the Insured at the Hospital or Mental/Psychiatric Hospital.

Eligible Expenses – shall mean only those Reasonable and Customary amount incurred by the Insured for the Medically Necessary treatment or services in respect of Covered Illness or Covered Injury as provided under this Policy.

Family Member – shall mean in respect to a person, his/her spouse, children, parents, parents-in-law, brothers or sisters, grandparents, grandchildren, other relatives or legal guardian.

HIV Infection – shall mean the infection deemed to have occurred where blood or other relevant test(s) indicate, in the opinion of the Company, the presence of any Human Immunodeficiency Virus, antigens or antibodies to such virus.

Hong Kong – shall mean the Hong Kong Special Administrative Region.

Hospital – shall mean an establishment registered and licensed as a hospital under the laws of the territory in which the establishment is situated to provide medical services for sick and injured persons as paying bed patients that require medical treatment, and which:

1. has facilities for diagnosis and major surgical operations;
2. provides twenty-four (24) hours a day nursing services by qualified nurses;
3. is under the supervision of one or more Physicians in regular attendance; and
4. is not, primarily a clinic; a place for the care of alcoholics or drug addicts; a sanatorium, a nursing, rest or convalescent home; or home for the aged or a hospice; or a natural cure clinic or health resort; or the place for the treatment of mental disorders; or an establishment for similar purposes.

Independent Person – shall mean a person other than (a) the Policyholder or the Insured; (b) Family Member of the Policyholder or the Insured; (c) a business partner of the Policyholder or the Insured; (d) the employer or employee of the Policyholder or the Insured; (e) an insurance agent of the Company; or (f) an insurance representative of the Policyholder or the Insured, unless approved in advance by the Company in writing.

In-Patient – shall mean the Confinement of the Insured for Covered Illness or Covered Injury as a registered resident bed patient where the Insured uses and is charged for room and board facilities of the Hospital.

Insured – shall mean the person as shown on the Policy Schedule as the "Insured".

Insurance Period – shall mean the period of time during which this Policy is in force, which is specified as "Insurance Period" in the Policy Schedule.

Intensive Care Unit or ICU – shall mean a section within a Hospital which is designated as an intensive care unit by the Hospital with one-to-one nursing care, in which patients undergo specialized resuscitation, monitoring and treatment procedures. The unit must be staffed twenty-four (24) hours a day with highly trained nurses, technicians and doctors, and be equipped with necessary life-saving equipment and monitoring devices that allow continuous assessment of vital body functions such as heart rate, blood pressure and blood chemistry.

Lifetime Limit – shall mean the maximum aggregate amount of benefits payable under all insurance policies and supplemental benefits (if any) (including this Policy) issued by the Company covering the Insured during his/her lifetime, regardless whether the insurance policies are still in force. The amount of Lifetime Limit is specified in the Policy Schedule of this Policy.

Medically Necessary – shall mean medical service, procedure or supply which are necessary and is (a) consistent with the diagnosis and customary medical treatment for the Covered Illness or Covered Injury; (b) recommended by a Physician or Surgeon for the care or treatment of the Covered Illness or Covered Injury involved and must be widely accepted professionally in Hong Kong as effective, appropriate and essential based upon recognized standards of the health care specialty involved; (c) not furnished primarily for the personal comfort or convenience of the Insured or any medical service provider; and (d) for Confinement, which the Insured's Covered Illness or Covered Injury could not safely and adequately be treated while not confined, and for Clinical Surgery which the Insured's Covered Illness or Covered Injury could not safely and adequately be treated without any surgery. Experimental, screening and preventive services or supplies shall not be considered as Medically Necessary.

Mental/Psychiatric Hospital – shall mean a licensed institution which specializes in providing mental, psychiatric or psychological treatment under the laws of the territory where the institution is situated, and which:

1. provides twenty-four (24) hours a day nursing services by qualified nurses;
2. is under the supervision of a Specialist in psychiatry in regular attendance; and
3. is not primarily a clinic; a place for the care of alcoholics or drug addicts; a sanatorium, a nursing, rest or convalescent home; or home for the aged or a hospice; or natural cure clinic or health resort; or an establishment for similar purposes.

Occupational Therapist – shall mean an Independent Person who is legally authorized by the government in the geographical area of his practice to perform occupational therapy.

Out-Patient – shall mean the Insured receives Medically Necessary western medical services and supplies in connection with treatment for Covered Illness or Covered Injury in the office or clinic of a Physician or in the out- patient department or emergency treatment room of a Hospital.

Physician or Surgeon – shall mean an Independent Person who is licensed and registered under the Medical Registration Ordinance of Hong Kong or otherwise with equivalent qualifications and legally authorized to practice western medical and surgical services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

Physiotherapist – shall mean an Independent Person who is legally authorized in the geographical area of his practice to render assessment and treatment service on physical disability by means of cryotherapy, heat therapy, electrotherapy, manual therapy, traction, exercise therapy and hydrotherapy.

Plan – shall mean the type of plan chosen by the Policyholder under this Policy. Details of the chosen Plan are specified in the Policy Schedule. The Company offers three different plans, subject to eligibility requirement:

(1) the "Standard Plan" and "Advance Plan": shall mean subject to all the terms and conditions of this Policy, the Company shall cover the Reasonable and Customary medical expenses incurred by the Insured in the following countries and territories in Asia: Bangladesh, Bhutan, Brunei, Cambodia, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Mainland China, Malaysia, Maldives, Mongolia, Nepal, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, and Vietnam.

(2) the "Prestige Plan": shall mean subject to all the terms and conditions of this Policy, the Company shall cover the Reasonable and Customary medical expenses incurred by the Insured anywhere in the world excluding the United States of America ("USA").

Plan Level – shall mean the level of plan chosen by the Policyholder under this Policy as specified in the Benefit Schedule.

Policy – shall mean the terms and conditions of TheChoice Medical Insurance mentioned herein.

Policy Anniversary – shall mean the same date each year as the Commencement Date while this Policy is in force.

Policy Date – shall mean the date when coverage under this Policy becomes effective as shown in the Policy Schedule.

Policyholder – shall mean the person designated as the "Policyholder" in the Policy Schedule.

Policy Schedule – shall mean the Health Insurance Policy Schedule issued with and attached to this Policy as amended by way of endorsement issued by the Company from time to time which contains the policy number of this Policy, details of the Insured, coverage of this Policy, and other particulars for identification purposes.

Policy Year – shall mean each twelve (12) month period from the Commencement Date.

Pre-existing Conditions – shall mean (1) any physical, medical or mental condition or (2) any illness or injury:

(a) that existed whether it was known or unknown to the Policyholder or the Insured; or
(b) that was investigated, diagnosed, or treated by a Physician; or
(c) for which Physician was consulted; or
(d) the signs or symptoms of which commenced,

before the Policy Date.

Registered Dentist – shall mean an Independent Person who is qualified by a degree in dentistry and licensed and registered under the Dentists Registration Ordinance of Hong Kong or otherwise with equivalent qualifications and legally authorized to provide dental services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

Registered Nurse – shall mean an Independent Person who is licensed and registered under the Nurses Registration Ordinance of Hong Kong or otherwise with equivalent qualifications and legally authorized to render nursing services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

Reasonable and Customary – shall mean the following:

(i) in relation to a fee, a charge or an expense, shall mean any fee or expense which (a) is actually charged for treatment, supplies or medical services that are Medically Necessary and in accordance with standards of good medical practice for the care of an ill or injured person under the care, supervision or order of a Physician; (b) does not exceed the usual or reasonable average level of charges for similar treatment, supplies or medical services in the location where the expense is incurred; (c) does not include charges that would not have been made if no insurance existed; and (d) does not exceed the actual fee, charge or expense incurred. The Company reserves the right to determine whether any particular charge is Reasonable and Customary with reference but not limited to, any relevant publication or information made available, such as schedule of fees, by the government, relevant authorities and recognized medical association at the location where the Eligible Expense is incurred. The Company reserves the right to adjust any and all benefits payable under this Policy which in our opinion is not Reasonable and Customary;

(ii) in relation to a Confinement shall mean the admission and length of a Confinement, and medical services and treatment received during which, are in accordance with generally accepted professional standards of medical practice, and do not exceed the usual standard for the treatment of similar illness or injury at the location where such Confinement is made.

Specialist – shall mean an Independent Person (other than the attending Physician or Surgeon operating on the Insured) who is a Physician and is registered in the Specialist Register of the Medical Council of Hong Kong or equivalent and who possesses qualifications for and experience in a medical specialty to provide western medical services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

Speech Therapist – shall means an Independent Person who is legally authorized by the government in the geographical area of his practice to perform speech therapy.

Deluxe Room - shall mean a single occupancy room of the class higher than Private Room in a Hospital.

Private Room – shall mean a standard single occupancy room with adjoining bathroom for the Insured's use during his/her Confinement, but excluding any room of upper class with its own kitchen, dining or sitting rooms in a Hospital. If the Insured is Confined in a Hospital which offers multiple classes of private rooms, the Private Room shall refer to the lowest priced private room offered by the Hospital.

Semi-Private Room – shall mean a twin or double occupancy room in a Hospital with two (2) patient beds (not including companion bed) and one (1) adjoining bathroom.

Ward – shall mean a multi-bed room in a Hospital with more than two (2) patient beds (not including companion bed).

2 General Provisions

2.1 The Contract

This Policy is issued in consideration of the application and payment of premiums as set out in the Policy Schedule. The application for this Policy, any medical evidence, written statements and declarations furnished as evidence of insurability, and the Policy documents (including but not limited to the Policy Schedule and the documents referred hereto) constitute the entire contract.

All statements made by or for the Insured and/or the Policyholder shall be considered representations and not warranties.

2.2 Alterations

No alterations in the terms and conditions and provisions of this Policy shall be valid unless it is in a written endorsement to this Policy signed by an officer so authorized by the Company. No agent or other persons shall have the authority to change or waive any provision of this Policy.

2.3 Policyholder

Only the Policyholder can exercise all rights, privileges and options provided under this Policy while the Insured is alive and this Policy is in force.

2.4 Rights of Third Parties

The Contracts (Rights of Third Parties) Ordinance (Cap 623) of the Laws of Hong Kong does not apply to this Policy, and only the Company and the Policyholder (or their authorized representatives) can enforce the terms of this Policy.

2.5 Change of Place of Residence or Occupation

If the Insured changes his/her place of residence or occupation, the Policyholder should inform the Company accordingly. The Company reserves the right to adjust the premium or the choices of Plan available to the Insured according to then applicable administrative and underwriting rules of the Company.

If the Policyholder fails to inform the Company about the change of occupation of the Insured and the new occupation is classified by the Company as more hazardous than that stated in the application or any endorsement attached to this Policy (whichever is later), the Company shall have the right to adjust the premium in accordance with the new occupation and collect the premium shortfall with interest.

If the Policyholder fails to inform the Company about the change of place of residence of the Insured and the new place of residence is, according to the applicable administrative and underwriting rules of the Company, subject to higher premium rate, the Company shall have the right to adjust the premium in accordance with the new place of residence and collect the premium shortfall with interest.

If the change of place of residence or occupation of the Insured is to one which is classified by the Company as not insurable pursuant to the Company's then underwriting rules, the Company shall not be liable to cover any loss or expenses incurred after the change and the Company shall have the absolute right to terminate this Policy.

2.6 Renewal

Before the end of Insurance Period, the Company will send to the Policyholder a renewal notice with the renewal terms subject to the Insured's age not exceeding 100. Upon the expiry of the Policy, this Policy may be renewed by the Policyholder for another Insurance Period at such rate or on such terms as the Company may determine depending on the benefits and the scope of coverage at the time of each renewal and the Company guarantees to offer renewal of this Policy up to the Insured reaching the age of 100 provided that the Plan is continually being offered by the Company. The Company reserves the right to revise the benefits, premiums, terms and conditions, and to make changes to this Policy upon renewal at its sole discretion.

2.7 Incorrect Disclosure or Non-Disclosure

Incorrect disclosure or non-disclosure of any material facts which, in our opinion, may affect our risk assessment, including but not limited to, age, gender and other material facts declared on the relevant application form, may render this Policy void from the Policy Date, unless the Company confirms otherwise in writing.

2.8 Freedom from Restriction

Unless otherwise specified, this Policy contains no restrictions upon the Insured in respect of travel, residence, or occupation.

2.9 Currency of Payment

All amounts payable to or by the Company shall be made in Hong Kong Dollars at the Company's sole discretion. The conversion between the currency specified in the Policy Schedule and Hong Kong Dollars shall be subject to the applicable rules and made at an exchange rate which is solely determined by the Company based on the prevailing market rate.

2.10 Interpretation

Throughout this Policy, where the context so admits, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.

Should any conflict arise in respect of the interpretation of any provisions in this Policy and any other material otherwise produced by the Company, the provisions of this Policy shall prevail.

2.11 Governing Law

This Policy shall be governed by and construed in accordance with the laws of Hong Kong.

3 Payment of Premiums

3.1 Payment of Premiums

Premiums shall be paid on a yearly basis or with such other frequency as the Company permits.

Premium due dates, Policy Anniversaries and Policy Years are determined from the Commencement Date as shown in the Policy Schedule or any endorsement attached thereto.

3.2 Grace Period

The Company shall allow a grace period of 31 days following the premium due date for payment of each premium. If any premium is still unpaid at the expiration of the grace period, this Policy shall cease to be in effect as from the due date for payment of such premium.

3.3 Deduction of Unpaid Premium

Upon the death of the Insured while this Policy is in force, in the event of the premiums being paid by installments other than yearly, the Company shall deduct from any amount payable under this Policy the amount of unpaid premiums (if any) for the whole of the then current year of insurance, together with any other indebtedness which may be owing under the Policy.

4 Benefit Provisions

While this Policy is in force, subject to other terms of this Policy and the various limitations or exclusions forming part of this Policy, all benefits under this Policy, other than the Health Screening Benefit, shall be payable, provided:

a. it is Medically Necessary for Covered Illness or Covered Injury; and

b. the fees and expenses incurred are Reasonable and Customary charges; and

c. the fees and expenses do not exceed the maximum limits set out in the Benefit Schedule or any endorsement attached thereto.

4.1 Hospitalization Benefits

If the Insured is Confined in a Hospital for a Covered Illness or Covered Injury:

4.1.1 Room and Board Benefit

The Company shall reimburse the Reasonable and Customary charges for room and board as levied by the Hospital in line with those charged for a room as specified in the Benefit Schedule during the Insured's Confinement.

4.1.2 Companion Bed Benefit

The Company shall reimburse the Reasonable and Customary charges made by the Hospital for one (1) companion bed for one (1) of the Insured's Family Members during the Insured's Confinement.

4.1.3 Private Nursing Benefit

The Company shall reimburse the Reasonable and Customary charges for Medically Necessary nursing services provided to the Insured by a Registered Nurse following surgery or the Insured's Discharge from ICU and while the Insured is still Confined in Hospital.

This benefit is restricted to nursing services recommended by the Insured's attending Physician in writing for the Covered Illness or Covered Injury for which the Insured is Confined in the Hospital. This benefit is restricted to nursing services provided by a maximum of one (1) Registered Nurse during any given time slot, during which nursing services are provided for all or part of the day, subject to the maximum number of days per Policy Year and per lifetime of the Insured as specified in the Benefit Schedule regardless of the number of eligible Confinements.

4.1.4 Specialist's Fee Benefit

The Company shall reimburse the Reasonable and Customary fees charged by a Specialist while the Insured is under Confinement provided that such Specialist care and treatment is recommended in writing by the Insured's attending Physician.

4.1.5 Physician's Visit Benefit

The Company shall reimburse the Reasonable and Customary fees charged by the attending Physician for visiting the Insured at his/her Hospital bed during his/her Confinement.

4.1.6 Intensive Care Benefit

The Company shall reimburse the Reasonable and Customary charges made by the Hospital for the Insured's Confinement as a registered bed-paying patient in the ICU of the Hospital which is recommended by the Insured's attending Physician in writing.

Payment under this benefit shall be in lieu of any Room and Board Benefit payable under clause 4.1.1 for such Confinement.

4.1.7 Miscellaneous Hospital Services Benefit

The Company shall reimburse the Reasonable and Customary charges made by the Hospital for any of the following services which is Medically Necessary and recommended in writing by the Insured's attending Physician and is customarily supplied by the Hospital when the Insured is under Confinement:

(1) Drugs and medicines consumed by the Insured in the Hospital during his/her Confinement;

(2) Dressing, ordinary splints and plaster casts but excluding special braces, artificial limbs, appliances and equipment;

(3) Laboratory examinations;

(4) Electrocardiograms;

(5) Physiotherapy;

(6) X-Ray examinations;

(7) Intravenous injections and solutions;

(8) Administration of blood and blood plasma but excluding costs of blood or blood plasma;

(9) Local ambulance service to or from the Hospital of Confinement.

The Company shall have the sole discretion to determine what services or charges would qualify for payment under this Miscellaneous Hospital Services Benefit.

4.1.8 Daily Hospital Cash Benefit

The Company shall pay this benefit according to the amount shown on the Benefit Schedule for each day the Insured is Confined in the general ward of a Hospital Authority's Hospital in Hong Kong for Medically Necessary treatment of Covered Illness or Covered Injury. This benefit is restricted to one (1) payment per day and up to the maximum number of days per Policy Year as specified in the Benefit Schedule regardless of the number of eligible Confinements.

This benefit shall not be paid in conjunction with the Daily Hospital Cash for Voluntary Room and Board Stay Below Private Room Benefit under this Policy.

4.1.9 Daily Hospital Cash for Voluntary Room and Board Stay Below Private Room Benefit (Applicable to "Prestige Plan" only)

The Company shall pay this benefit according to the amount shown in the Benefit Schedule for each day when the Insured is Confined in a room of a private Hospital in Hong Kong where the room and board charges are below that of a Private Room in the same Hospital only for Medically Necessary treatment of Covered Illness or Covered Injury upon written recommendation by the Insured's attending Physician. This benefit is restricted to one (1) payment per day and up to the maximum number of days per Policy Year as specified in the Benefit Schedule regardless of the number of eligible Confinements, and the Insured must be Confined in the same or lower room level during the whole Confinement period.

This benefit shall not be paid in conjunction with the Daily Hospital Cash Benefit under this Policy.

This benefit is not applicable to the "Standard Plan" and "Advance Plan" under this Policy.

4.1.10 Psychiatric Treatment Benefit (Applicable to "Prestige Plan" only)

The Company shall reimburse the Reasonable and Customary charges for the Confinement of the Insured in a Mental/Psychiatric Hospital for the Medically Necessary treatment of mental, behavioral, psychiatric or psychological disorder during such Confinement, up to the maximum number of days per Policy Year and per lifetime of the Insured as specified in the Benefit Schedule, provided that such Confinement and treatment are recommended in writing by a Specialist in psychiatry.

Once this benefit is paid, no other benefit will be payable in respect of such Confinement and treatment under this Policy.

This benefit is not applicable to the "Standard Plan" and "Advance Plan" under this Policy.

The benefits under clauses 4.1.2, 4.1.3, 4.1.4, 4.1.5, 4.1.7, 4.1.9 shall only be payable if the Room and Board Benefit under clause 4.1.1 or the Intensive Care Benefit under clause 4.1.6 is payable.

4.2 Surgical Benefits

If the Insured undergoes Medically Necessary surgical procedures due to Covered Illness or Covered Injury:

4.2.1 Surgery Fee Benefit

The Company shall reimburse the Reasonable and Customary charges for Medically Necessary procedures performed on the Insured during his/her Confinement in Hospital, including the actual charges of the Surgeon's fee, Anaesthetist's fee and operating theatre fee and the Eligible Expenses in respect of items and equipment used during the use of operating theatre charged to the Insured.

The Company shall also reimburse the Reasonable and Customary charges for Medically Necessary Clinical Surgery performed on the Insured including the actual charges of consultation, medication, the Surgeon's fee, Anaesthetist's fee and operating theatre fee and the Eligible Expenses in respect of items and equipment used during the use of the operating theatre or the room for operation charged to the Insured for that surgical operation.

4.2.2 Organ and Bone Marrow Transplantation Benefit

If the Insured requires organ transplant or bone marrow transplant from a legally certified and verified source of donation on the written recommendation of the Insured's attending Physician, the Company shall reimburse the Reasonable and Customary charges for such surgical procedure or operations performed on the Insured as a recipient and in Confinement as an In-Patient. Expenses incurred in identifying, procuring, and transporting the organ is not reimbursable.

4.2.3 Medical Appliances Benefit

The Company shall reimburse the Reasonable and Customary charges for the following medical materials or appliances implanted in the Insured during surgery or used in replacement procedures, which are Medically Necessary and required to perform the surgery:

(i) Pace maker;
(ii) Stents for Percutaneous Transluminal Coronary Angioplasty;
(iii) Intraocular lens;
(iv) Artificial cardiac valve;
(v) Metallic or artificial joints for joint replacement;
(vi) Prosthetic ligaments for replacement or implantation between bones; and
(vii) Prosthetic intervertebral disc.

The Company shall reimburse the Reasonable and Customary charges for any other Medically Necessary prosthetic device implanted during surgery or Medically Necessary replacement of any other body organ or part inside the Insured's body up to the limit per item and per lifetime of the Insured for this benefit as specified in the Benefit Schedule for each such device, organ or part.

This benefit shall only be payable if a claim under clause 4.2.1 above is also payable in respect of the same surgical procedures.

4.3 Pre- & Post-Hospitalization Benefits

4.3.1 Pre-Hospitalization Outpatient Benefit

When benefit is payable under Hospitalization Benefits or Surgical Benefits, the Company shall reimburse the Reasonable and Customary charges for pre-admission Out-Patient consultation, subject to one (1) visit per day within thirty-one (31) days immediately before the Insured's Confinement or Clinical Surgery, if such consultation results in the Insured's Confinement or Clinical Surgery. This benefit shall not be payable for any Chinese medicine treatment, chiropractic consultation, podiatry consultation or physiotherapy, regardless whether such consultation results in the Insured's Confinement or Clinical Surgery.

If two (2) or more Confinements or Clinical Surgeries are due to the same or related Covered Injury or Covered Illness, or to any complications arising therefrom, such Confinements or Clinical Surgeries shall be regarded as one (1) Confinement or Clinical Surgery if each of them is not separated by more than ninety (90) days. The Company shall only reimburse the Reasonable and Customary charges for pre-admission Out-Patient consultation incurred within thirty-one (31) days immediately before the Insured's first Confinement or Clinical Surgery.

For the avoidance of doubt, and notwithstanding anything else contained herein, a subsequent Confinement or Clinical Surgery due to the same or related Covered Injury or Covered Illness as the first Confinement or Clinical Surgery shall only be regarded as a separate Confinement or Clinical Surgery for the purposes of this Policy where no treatment, consultation or investigation of the said Covered Illness or Covered Injury is required within the ninety (90) days period.

The medical expenses covered under this benefit shall include consultation fee, prescribed medication for the Insured's consumption within thirty-one (31) days immediately before the Insured's Confinement or Clinical Surgery, and diagnostic tests which are directly related to the same cause of Covered Illness or Covered Injury that necessitated the Insured's Confinement or Clinical Surgery.

4.3.2 Post-Hospitalization Outpatient Benefit

When benefit is payable under Hospitalization Benefits or Surgical Benefits, the Company shall reimburse the Reasonable and Customary charges for related follow-up Out-Patient consultations, subject to one (1) visit per day for the same Covered Injury or Covered Illness and recommended in writing by the Insured's attending Physician and within sixty (60) days immediately after the Insured's Discharge or Clinical Surgery. This benefit shall not be payable for any Chinese medicine treatment or podiatry consultation, regardless whether such consultation relates to the follow-up Out-Patient consultations of the Insured.

If two (2) or more Confinements or Clinical Surgeries are due to the same or related Covered Injury or Covered Illness, or to any complications arising therefrom, such Confinements or Clinical Surgeries shall be regarded as one (1) Confinement or Clinical Surgery if each of them is not separated by more than ninety (90) days. The Company shall only reimburse the Reasonable and Customary charges for related follow-up Out-Patient consultations incurred within sixty (60) days immediately after the Insured's Discharge from the first Confinement or Clinical Surgery.

For the avoidance of doubt, and notwithstanding anything else contained herein, a subsequent Confinement or Clinical Surgery due to the same or related Covered Injury or Covered Illness as the first Confinement or Clinical Surgery shall only be regarded as a separate Confinement or Clinical Surgery for the purposes of this Policy where no treatment, consultation or investigation of the said Covered Illness or Covered Injury is required within the ninety (90) day period.

The medical expenses covered under this benefit shall include consultation fee, prescribed medication for the Insured's consumption within sixty (60) days immediately after the Insured's Confinement or Clinical Surgery, and diagnostic tests which are directly related to the same cause of Covered Illness or Covered Injury which necessitated the Insured's Confinement or Clinical Surgery.

4.3.3 Post-Hospitalization Home Nursing Benefit

When benefit is payable under Hospitalization Benefits or Surgical Benefits, the Company shall reimburse the Reasonable and Customary charges for Medically Necessary nursing services provided to the Insured by a Registered Nurse in the Insured's home within thirty-one (31) days immediately after the Insured's Discharge following surgery or admission to ICU.

If two (2) or more Confinements are due to the same or related Covered Injury or Covered Illness, or to any complications arising therefrom, such Confinements shall be regarded as one (1) Confinement if each of them is not separated by more than ninety (90) days. The Company shall only reimburse the Reasonable and Customary charges for Medically Necessary nursing services provided to the Insured within thirty-one (31) days immediately after the Insured's Discharge from the first surgery or admission to ICU .

For the avoidance of doubt, and notwithstanding anything else contained herein, a subsequent Confinement due to the same or related Covered Injury or Covered Illness as the first Confinement shall only be regarded as a separate Confinement for the purposes of this Policy where no treatment, consultation or investigation of the said Covered Illness or Covered Injury is required within the ninety (90) day period.

This benefit is restricted to nursing services recommended by the Insured's attending Physician in writing and relating directly to the Covered Illness or Covered Injury for which the Insured was Confined in Hospital. This benefit is restricted to nursing services provided by a maximum of one (1) Registered Nurse during any given time slot, up to the maximum number of days, during which nursing services are provided for all or part of the day, per Policy Year as specified in the Benefit Schedule regardless of the number of eligible Confinements.

4.4 Extended Benefits

4.4.1 First-dollar Coverage – Deductible Waived for Designated Critical Illness Benefit

While this Policy is in force, if the Insured suffers the following Designated Crises (as defined herein below) and is Confined in a Hospital as a direct result of the Designated Crises, in calculation of benefits payable under clause 4 of this Policy, the payment of the Balance of Annual Deductible (if any) will be waived in respect of such Confinement and/or treatment.

The definition of the following Designated Crises is provided in a document named "Definition of Designated Crises" attached to this Policy. The Designated Crises must be confirmed by the Insured's attending Physician in writing and supported by clinical, radiological, histological and laboratory evidence acceptable to the Company.

1. Cancer
2. Fulminant Hepatitis
3. Chronic Liver Disease
4. End Stage Lung Disease
5. Cardiomyopathy
6. Heart Valve Surgery
7. Primary Pulmonary Arterial Hypertension
8. Coronary Artery Disease Surgery
9. Stroke
10. Kidney Failure
11. Surgery to Aorta
12. Major Organ Transplantation
13. Severe Rheumatoid Arthritis
14. Heart Attack
15. Parkinson's Disease
16. Terminal Illness

The Company shall not waive the payment of any Balance of Annual Deductible if the Confinement is related to one of the Designated Crises whose symptoms appear or relevant diagnosis or surgery occurs within the first ninety (90) days from the Policy Date.

This benefit is applicable to the Plan with Annual Deductible only.

4.4.2 Chemotherapy and Radiotherapy Benefit

The Company shall reimburse the Reasonable and Customary charges for Medically Necessary chemotherapy and radiotherapy treatment, including immunotherapy, target therapy, cancer hormonal therapy and proton therapy, oncology drugs prescribed by the Insured's attending Physician and performed on the Insured, whether as an In-Patient or Out-Patient, due to Covered Illness or Covered Injury.

4.4.3 Kidney Dialysis Benefit

The Company shall reimburse the Reasonable and Customary charges for Medically Necessary haemodialysis or peritoneal dialysis performed on the Insured, whether as an In-Patient or Out- Patient, due to Covered Illness or Covered Injury, provided that the Insured is suffering from chronic and irreversible kidney failure, and haemodialysis or peritoneal dialysis is prescribed by the Insured's attending Physician.

4.4.4 Additional Annual Limit for Organ and Bone Marrow Transplantation, Chemotherapy, Radiotherapy and Kidney Dialysis Benefit

When the benefit is payable under clauses 4.2.2, 4.4.2, or 4.4.3, the Company shall increase the Annual Limit for such benefits by the amount specified in the Policy Schedule for that Policy Year. This benefit is only applicable once per Policy Year. The amount of Lifetime Limit as specified in the Policy Schedule shall remain unchanged.

4.4.5 HIV/AIDS Treatment Benefit

If the Insured is Confined in a Hospital for Covered Illness or Covered Injury, the Company shall reimburse the Reasonable and Customary charges for Medically Necessary treatment of the Insured during such Confinement for any HIV Infection related illness including AIDS. This benefit is only payable if the signs or symptoms of such illness first occur after the Policy has been effective for five (5) consecutive years from the Policy Date. This benefit is only payable once per lifetime of the Insured and the maximum amount payable is specified in the Benefit Schedule. Payment of this benefit shall be in lieu of all benefits provided by this Policy in respect of such Confinement and treatment.

4.4.6 Traditional Chinese Medicine Benefit (Applicable to "Prestige Plan" only)

When the benefit is payable under Hospitalization Benefits or Surgical Benefits, the Company shall reimburse the Reasonable and Customary charges for consultation fee, cost of medicine, Chinese bone-setting and acupuncture within sixty (60) days immediately after the Insured's Discharge or Clinical Surgery for the same cause of Covered Illness or Covered Injury by a Chinese Medicine Practitioner as part of the Insured's rehabilitation treatment up to one (1) visit under any items of this category per day and subject to the maximum limit per visit and maximum number of visits per Policy Year as specified in the Benefit Schedule.

If two (2) or more Confinements or Clinical Surgeries are due to the same or related Covered Injury or Covered Illness, or to any complications arising therefrom, such Confinements or Clinical Surgeries shall be regarded as one (1) Confinement or Clinical Surgery if each of them is not separated by more than ninety (90) days. The Company shall only reimburse the Reasonable and Customary charges for Chinese medicine treatment incurred within sixty (60) days immediately after the Insured's Discharge from the first Confinement or Clinical Surgery only

For the avoidance of doubt, and notwithstanding anything else contained herein, a subsequent Confinement or Clinical Surgery due to the same or related Covered Injury or Covered Illness as the first Confinement or Clinical Surgery shall only be regarded as a separate Confinement or Clinical Surgery for the purposes of this Policy where no treatment, consultation or investigation of the said Covered Illness or Covered Injury is required within the ninety (90) day period.

The medical expenses covered in this benefit shall include consultation fee and prescribed medication for consumption within sixty (60) days after the Insured's Discharge or Clinical Surgery.

This benefit is not applicable to the "Standard Plan" and "Advance Plan" under this Policy.

4.4.7 Pregnancy Complications Benefit

The Company shall reimburse the Reasonable and Customary charges for the Insured's Confinement and surgical procedure in a Hospital due to covered pregnancy complications as recommended in writing by the Insured's attending Physician provided that the date of diagnosis must be after twelve (12) policy months after the Policy Date. The covered pregnancy complications are ectopic pregnancy, molar pregnancy, disseminated intravascular coagulopathy, pre-eclampsia, miscarriage, threatened abortion, medically prescribed induced abortion, foetal death, postpartum hemorrhage requiring hysterectomy, eclampsia, amniotic fluid embolism and pulmonary embolism of pregnancy.

4.5 Emergency Dental Treatment Benefit

The Company shall reimburse the Reasonable and Customary charges for emergency dental treatment provided by a Registered Dentist to the Insured and necessitated solely and directly by Covered Injury to the Insured's sound natural teeth.

The charges covered in this benefit shall include consultation, staunch bleeding, tooth extraction and X- Ray, provided that such treatment is provided within two (2) weeks of the Accident and in a legally registered dental clinic or Hospital. Notwithstanding the foregoing, this benefit shall not cover any restorative or remedial work, prostheses, the use of any precious metals, orthodontics or periodontics of any kind, or dental surgery performed in a Hospital unless dental surgery is Medically Necessary. This benefit shall not cover any treatment for: (i) injury caused by eating or drinking; (ii) damage caused by normal wear and tear; and (iii) damage caused by tooth brushing or any other oral hygiene procedure.

4.6 Health Screening Benefit (Applicable to "Advance Plan" and "Prestige Plan" only)

The Company shall reimburse the Reasonable and Customary charges for health screening received by the Insured up to the latest limit specified in the Benefit Schedule or any subsequent endorsement provided that:-

(a) the Insured must have been continuously covered for two (2) years from the Policy Date (hereinafter refer to as "Initial Period"); and

(b) the date of health screening received is after the Initial Period.

While this Policy is in force, this benefit is payable once every two (2) years after the Initial Period regardless of whether there is any subsequent change of this benefit. Unused benefit cannot be carried forward to the next policy year.

While this Policy is in force, if the eligible benefit under this clause 4.6 is increased, such increased benefit shall not be effective until the expiry of two (2) years calculated from the respective date when the benefit is increased. The amount of benefit payable before the expiry of the said two (2) years shall be that amount which was applicable before the benefit was increased.

Whilst this Policy is in force, if the eligible benefit under this clause 4.6 is decreased, such decreased benefit shall be effective immediately.

This benefit is not available to an Insured who is aged below 18 and is not available under the "Standard Plan" of this Policy.

The Company shall waive the payment of any Balance of Annual Deductible (if any) for this benefit.

4.7 Entitlement of Refund from Other Sources

If the Insured is entitled to a refund of all or part of expenses specified in clause 4 of this Policy from any other sources, the Policyholder shall notify the Company. The Company shall only be liable for the excess, if any, of such expenses over the amount recoverable from such other sources. However, such compensation or reimbursement from any other sources will count towards the Balance of Annual Deductible provided that certified copy(s) of all the bills are submitted to the Company as evidence. If the Company shall have paid the amount recoverable from such other sources, the same shall be refunded to the Company. The maximum amount payable under each item of benefits shall not exceed the limit of this benefit as stated in the Benefit Schedule.

4.8 Revision of Benefits and Limitations

The Company reserves the right to revise, amend or modify the benefits payable, restrictions, limitations, exclusions under this Policy and any supplementary benefits, if attached hereto. The Company shall notify the Policyholder in writing at least thirty (30) days before the Policy Anniversary effecting such revision specifying, among others, the new premium rate and its due date. The premium(s) shall be adjusted accordingly based on the rate as determined by the Company for the Plan. If the Policyholder refuses to take the revised benefits, with such restrictions, limitations, or exclusions or does not pay the revised premiums when they are due, then the Company has the right to terminate this Policy and any benefits and/or supplementary benefits, if attached hereto, when the new premiums have been due for thirty (30) days.

While this Policy is in force, the Policyholder may request increase of benefits by changing the Plan or changing the Annual Deductible at the time of renewal or at such time as approved by the Company at its sole discretion. Such increase of benefits shall be subject to such terms and conditions as determined by the Company from time to time. The Policyholder should use the prescribed form supplied by the Company and provide satisfactory evidence of insurability which is satisfactory to the Company. The Company shall have the sole discretion to approve or decline any such application for increase of benefits.

The additional benefit shall not be payable in respect of any Pre-existing Conditions which occur before the date of increase of benefit.

In case of increase of benefits, subject to other terms and conditions of this Policy, the calculation of the respective benefits under clause 4 of this Policy shall be adjusted as follows:-

(i) for any benefit payable under clauses 4.1, 4.2, 4.3 and 4.4 (except 4.4.1, 4.4.5 and 4.4.7), if the benefit is payable as a result of Covered Illness, the increased benefit shall only be payable to a Covered Illness which manifests and commences more than thirty (30) days after the day when the benefit is increased. If the benefit is payable as a result of Covered Injury, the increased benefit shall be payable from the date when the benefit is increased;

(ii) for any benefit payable under clause 4.4.1, the increased benefit shall only be applicable to Confinement which relates to a Designated Crises of which symptoms appear or relevant diagnosis or surgery occurs ninety (90) days after the date when the benefit is increased;

(iii) for any benefit payable under clause 4.4.5, the increased benefit shall only be payable if the signs or symptoms of the illness listed under clause 4.4.5 first occur after the Policy has been effective for five (5) consecutive years calculated from the date when the benefit is increased;

(iv) for any benefit payable under clause 4.4.7, the increased benefit shall only be payable if the date of diagnosis of the covered pregnancy complications is after twelve (12) months after the date when the benefit is increased.

For the avoidance of doubt, subject to the above, before the increased benefit is payable or applicable, the benefit payable or applicable immediately before the date of increase shall apply.

4.9 Deduction from Benefits

Any outstanding premiums related to this Policy and other amounts due to the Company under this Policy will be deducted from any and all benefits when payable under this Policy.

4.10 No Interest on Benefits

The benefits payable under this Policy shall not carry any interest.

4.11 Aggregate Benefits Limit

The maximum of total benefits payable under clause 4 of this Policy shall be subject to the Annual Limit and Lifetime Limit of this Policy.

4.12 Benefit Calculation

Subject to other terms and conditions of this Policy, the Company shall calculate the amount of the benefit payable of each claim in accordance with the following formula:

All Eligible Expenses of each claim minus the higher of:

(a) The Balance of Annual Deductible (if any); and

(b) The actual amount(s) reimbursed from other sources;

subject to any limitations of each benefit including the Annual Limit and the Lifetime Limit as specified in the Policy Schedule.

Where a Confinement spans two (2) Policy Years, the applicable Annual Deductible for such Confinement shall be the Annual Deductible of the Policy Year in which the date of admission falls and it shall apply to the calculation of the whole amount of benefit payable with respect of such Confinement. If a Confinement spans more than two (2) Policy Years, this calculation method shall not apply and the Company shall reserve the right to calculate the applicable Annual Deductible based on the then claims policies of the Company.

In deciding the applicable Annual Limit, the benefit payable will be apportioned to the respective Policy Years on the basis of the date on which the actual itemized expenses are incurred. In the event that no breakdown of daily expenses is available, such expenses shall be apportioned on the basis of the percentage of the actual days of Confinement in each respective Policy Year. The expenses so apportioned for the respective Policy Years shall be subject to the applicable Annual Limit of that Policy Year.

4.13 Supplementary Outpatient Benefits (if applicable)

4.13.1 Consultation at Physician's Office

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges incurred by the Insured for the consultation fee and cost of medicine in respect of Medically Necessary treatment provided by the Physician subject to a maximum of one visit per day, but not to exceed the Cover Limit per visit and the maximum number of visits per Policy Year applicable to such charges as specified in the Benefit Schedule.

4.13.2 Physiotherapist's and Chiropractor's Treatment

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges incurred by the Insured for the Medically Necessary treatment provided by a Physiotherapist or Chiropractor subject to a maximum of one visit per day, but not to exceed the Cover Limit per visit and the maximum number of visits per Policy Year applicable to such charges as specified in the Benefit Schedule provided that the Insured was referred to such Physiotherapist or Chiropractor by the attending Physician in writing.

4.13.3 Specialist's Consultation

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges incurred by the Insured for the consultation fee and cost of medicine in respect of Medically Necessary treatment provided by a Specialist subject to a maximum of one visit per day, but not to exceed the Cover Limit per visit and the maximum number of visits per Policy Year applicable to such charges as specified in the Benefit Schedule provided that the Insured was referred to such Specialist by the attending Physician in writing.

4.13.4 Diagnostic X-Ray and Laboratory Tests

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges incurred by the Insured for Medically Necessary X-Ray examinations or laboratory tests that are referred by the attending Physician in writing for diagnostic purpose, but not to exceed the Cover Limit per Policy Year applicable to such charges as specified in the Benefit Schedule.

4.13.5 Prescribed Western Medicines and Drugs

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges, other than when confined in a Hospital, incurred by the Insured for Medically Necessary western medicines and drugs as prescribed on a written basis by the attending Physician and purchased from a pharmacy or dispensary (not being the one within the attending Physician's clinic), but not to exceed the Cover Limit per Policy Year applicable to such charges as specified in the Benefit Schedule.

4.13.6 Chinese Medicine Practitioner's Treatment

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges incurred by the Insured for:

(a) consultation fee;

(b) cost of medicine; and

(c) treatment fee in respect of Chinese bone-setting and acupuncture,

which are deemed Medically Necessary and provided by a Chinese Medicine Practitioner subject to a maximum of one visit under any items of this category per day, but not to exceed the Cover Limit per visit and the maximum number of visits per Policy Year applicable to such charges as specified in the Benefit Schedule.

4.13.7 Consultation at Patient's Home

The Company shall reimburse subject to Benefit Schedule the Reasonable and Customary charges incurred by the Insured for the consultation fee and cost of medicine in respect of Medically Necessary treatment provided by the Physician subject to a maximum of one visit per day, but not to exceed the Cover Limit per visit and the maximum number of visits per Policy Year applicable to such charges as specified in the Benefit Schedule.

4.13.8 Psychiatric Outpatient Treatment

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges incurred by the Insured for the consultation fee and cost of medicine in respect of Medically Necessary treatment provided by a Specialist in psychiatry subject to a maximum of one visit per day, but not to exceed the Cover Limit per visit and the maximum number of visits per Policy Year applicable to such charges as specified in the Benefit Schedule provided that the Insured was referred to such Specialist by the attending Physician in writing.

4.13.9 Dietetic Guidance or Speech Therapy or Occupational Therapy

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary charges incurred by the Insured for the consultation fee and cost of medicine in respect of Medically Necessary treatment provided by a Dietitian, Speech Therapist or Occupational Therapist subject to a maximum of one visit per day, but not to exceed the Cover Limit per visit and the maximum number of visits per Policy Year applicable to such charges as specified in the Benefit Schedule provided that the Insured was referred to such Specialist by the attending Physician in writing.

4.13.10 Vaccination

The Company shall reimburse subject to the Benefit Schedule the Reasonable and Customary fee actually charged for necessary vaccinations of the Insured, but not to exceed the Cover Limit per Policy Year applicable to such fee as specified in the Benefit Schedule.

4.14 Supplementary Dental Benefits (if applicable)

The Company shall reimburse the dental charges incurred by the Insured for the following treatments as a result of Covered Illness or damage to sound natural teeth (and/or dentures/ bridges when applicable) caused solely and directly by an Accident while this Policy is in force or the oral service provided by a Registered Dentist, but not to exceed the Cover Limit applicable to such charges as specified in the Benefit Schedule.

(i) Routine Oral Examination & Scaling
(ii) Dental X-Ray
(iii) Abscesses
(iv) Fillings
(v) Extraction
(vi) Root canal fillings
(vii) Dentures, Crowns and bridges (due to accident)

5 Convertibility Option to Reduce Annual Deductible at Specified Ages

Policyholder has the right to apply for lowering the Annual Deductible of this Policy upon the Policy Anniversary which immediately comes on or after the respective ages of the fiftieth (50), fifty-fifth (55), sixtieth (60) or sixty- fifth (65) of the Insured. The application should be made within thirty-one (31) days immediately before or after the relevant Policy Anniversary without providing further evidence of insurability on the Insured. The application of this benefit shall be subject to the Annual Deductible options available at that time and such terms and conditions as determined by the Company from time to time. This right can only be exercised once during the lifetime of the Insured and is irrevocable.

If the eligible benefits under this Policy are increased by the Policyholder pursuant to this clause 5, and if the Insured was afflicted with Covered Illness or Covered Injury before the lowering of Annual Deductible was approved by the Company, the limit of benefits payable in respect of such Covered Illness or Covered Injury shall be that limit which was applicable prior to the date the benefits were increased.

6 Exclusions (applicable to all benefits except dental benefits)

Despite anything stated in this Policy and/or supplementary benefits (if any), the Company shall not be liable to pay any benefits under this Policy if:

1) the Insured's illness or injury is a Pre-existing Condition or results from the complications of a Pre-existing Condition;
2) the Insured's sickness, disease or illness occurs during the first thirty (30) days from the Policy Date;
3) in case of medical treatment in Mainland China, the subject hospital is not a Grade 3A hospital as recognized by the National Health Commission of the People's Republic of China at the time of admission.
4) the Confinement, treatment or charges incurred relate to or arise as a direct or indirect result of:

   (1) the Insured's pregnancy, surrogacy, childbirth or termination of pregnancy (except for the Pregnancy Complications Treatment under clause 4.4.7 of this Policy), birth control, infertility or human assisted reproduction, or sterilisation of either sexes;
   (2) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, riot, strike, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, terrorist act, nuclear reactions, nuclear radiation, nuclear contamination, biological contamination or chemical contamination;
   (3) naval, military or air-force services, or any operation or combat duty with any armed force of any country, territory, or organization;
   (4) the Insured's participation in any criminal offence or illegal acts;
   (5) attempted suicide or self-inflicted injuries while sane or insane, or under any condition caused by chronic alcoholism or drug addiction;
   (6) cosmetic or plastic surgery, dental treatment or surgery of any kind, oral or oro-surgical care, eye refraction, eye tests or fitting of glasses, or surgical correction of nearsightedness (such as but not limited to radial keratomoty and keratectomy), unless such a treatment is explicitly covered by this Policy.
   (7) procurement or use of medical appliances and medical devices for the benefit of the Insured including but not limited to spectacles, contact lenses, hearing aids or wheelchairs (unless such medical appliances and medical devices are explicitly covered by this Policy);
   (8) preventive treatments, preventive medicines, convalescence, physical examinations, or health checks (with or without any positive finding) on the Insured; vaccination and immunisation received by the Insured; genetic testing or counselling on the Insured; or any treatment which is not deemed Medically Necessary by the Company; (unless explicitly covered by this Policy)
   (9) treatment or tests carried out in relation to the Insured's illness or injury are not consistent with customary medical treatment or diagnosis in Hong Kong;
   (10) narcotics used by the Insured unless taken as prescribed by a Physician, or the Insured's abuse of drugs or alcohol;
   (11) health supplements and all specialized Chinese herbs and/or tonic medicine including bird's nest, lingzhi, gingseng, agaricus blazei murill, antelope horn powder, antler, cordyceps sinensis, donkey- hide gelatin, hippocampus, moschus, pearl powder, placenta hominis and any other Chinese herbs and/or tonic medicine determined by the Company in its absolute discretion from time to time;
   (12) scuba diving or engaging in or taking part in any kind of race other than on foot, mountaineering involving the use of ropes or guides by the Insured or other professional or hazardous sports or pastimes including but not limited to skydiving, parachuting, hang-gliding, parasailing, hunting, aviation or aeronautics (other than as fare paying passenger on a duly licensed commercial aircraft), ice or water ski-jumping, show jumping;
   (13) AIDS or any complications associated with HIV Infection except for the HIV / AIDS Treatment Benefit under clause 4.4.5 of this Policy;

(14) transplant service for which the cost incurred in connection with identifying service and procuring a replacement organ or any costs incurred for removal of the organ from the donor, all associated transportation costs and administrative costs;

(15) donation of organ;

(16) mental disorder, psychological or psychiatric conditions, behavioural problems or personality disorder of the Insured unless such occurrence is covered by the Psychiatric Treatment Benefit under clause 4.1.10 of this Policy;

(17) birth defects, genetic disorders, Congenital Conditions, or inherited disorders or developmental conditions (only applicable if the disorder gives rise to signs or symptoms or was diagnosed before the Insured attains sixteenth (16th) years of age) of the Insured;

(18) any Confinement primarily for physiotherapy or for the investigation of signs and/or symptoms with diagnostic imaging, laboratory investigation or other diagnostic procedures as determined by the Company;

(19) rest cures and services or treatment received in any home, spa, health hydro, nature cure clinic, sanatorium or long term care facility that is not a registered acute treatment hospital;

(20) any treatment, investigation, services or supplies which are not Medically Necessary; any charges which exceed the Reasonable and Customary Charges as determined by the Company;

(21) non-medical services, including but not limited to guest meals, radio, telephone, television, photocopy, telex, personal items, and medical report charges;

(22) experimental and / or unconventional medical technology / procedure / therapy performed on the Insured; novel drugs / medicines / stem cell therapy not yet approved by the government, relevant authorities and recognised medical association in the locality, or treatment and procedures carried out by a facility not recognized as an acute treatment hospital, or services performed by a relative of the insured or a person who ordinarily resides in the insured's home.

(23) sleep disorders (except for the treatment of sleep apnoea which is life-threatening as confirmed by a Specialist and approved by the Company in advance), treatment for learning difficulties in children, such as dyslexia or behavioural problems, attention deficit hyperactivity disorder, or development problems such as shortness of stature;

(24) treatment of obesity (including morbid obesity), weight control programmes or bariatric surgery (except when bariatric surgery is necessary as confirmed by a Specialist after failure of conventional treatments and approved by the Company in advance);

(25) treatment of sexually transmitted diseases; venereal diseases, sexual problems, such as impotence, whatever the cause, gender issues or gender re-assignment except for the HIV/AIDS Treatment Benefit under clause 4.4.5 of this Policy;

(26) treatment whilst staying in Hospital for more than ninety (90) consecutive days if the Insured is in a persistent vegetative state characterized by wakefulness without awareness for more than four (4) weeks;

(27) care or treatment for which payment is not required or is waived or is recoverable from a third party or under any other insurance including (without limitation) employees' compensation insurance;

(28) any activity or disease which falls under the exclusion(s) as shown on the endorsement(s) (if any) of this Policy.

6.1 Dental Exclusions

Despite anything stated in this Policy and/or supplementary benefits (if any), the Company shall not be liable to pay any benefits under this Policy if:

(1) Care or treatment for which payment is not required or is waived or is recoverable from a third party or under any other insurance including (without limitation) Employees' Compensation Insurance;

(2) Self-inflicted injury;

(3) Cosmetic treatment (including but not limited to orthodontic treatment and bleaching);

(4) Conditions or injury arising out of consumption of alcohol or narcotics or similar drugs or agents;

(5) Conditions or injury caused by declared or undeclared war, civil commotions, rebellion, revolution conspiracy, military, riot, strikes or illegal acts;

(6) Oral hygiene instructions, plaque control program and dietary instructions.

7 Sanction Exclusion

Notwithstanding anything to the contrary in the Policy the following shall apply:

If, by virtue of any law or regulation which is applicable to the Company at the inception of this Policy or becomes applicable at any time thereafter, providing coverage to the Insured is or would be unlawful because it breaches any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, United States of America or The People's Republic of China/Hong Kong SAR, that the Company shall provide no coverage or benefit or have no liability whatsoever to the Insured, to the extent that it would be in breach of such law or regulation.

8 Claim Provisions

8.1 Notice of Claim

Written notice of a claim must be given to the Company within thirty-one (31) days from the date of the Covered Illness or Covered Injury was first treated. Any claims received after the said period shall not be accepted, unless the Company in its sole discretion decides otherwise.

8.2 Proof of Loss

Written proof of loss including original receipts and itemized bills together with a fully completed claim form must be furnished to the Company within ninety (90) days after the Covered Illness or Covered Injury was first treated is required.

All certificates, information and evidence required by the Company shall be furnished at the expense of the claimant.

The Insured shall, at the Company's request and expense, submit to a medical examination by a Physician designated by the Company in Hong Kong, when and so often as the Company may reasonably require.

8.3 Limitation of Claim

In any case if the Insured is Confined, whether voluntarily or involuntarily, in a room of the class higher than the room level as specified in the Benefit Schedule, the Company shall reduce the amount of the benefit incurred during the period of Confinement and payable under this Policy equal to the amount of the original benefits payable multiplied by the adjustment factor as follows:

(1) If the Confinement in respect of which such charges have been incurred is at the Private Room and the Plan Level insured and specified in the Benefit Schedule is at the Semi-Private Room, an adjustment factor of 50% applies to benefits payable.

(2) If the Confinement in respect of which such charges have been incurred is at the Semi-Private Room and the Plan Level insured and specified in the Benefit Schedule is at the Ward, an adjustment factor of 50% applies to benefits payable.

(3) If the Confinement in respect of which such charges have been incurred is at the Private Room and the Plan Level insured and specified in the Benefit Schedule is at the Ward, an adjustment factor of 25% applies to benefits payable.

(4) If the Confinement in respect of which such charges have been incurred is at the Deluxe Room and the Plan Level insured and specified in the Benefit Schedule is at the Private

Room, an adjustment factor of 25% applies to benefits payable.

(5) If the Confinement in respect of which such charges have been incurred is at the Deluxe Room and the Plan Level insured and specified in the Benefit Schedule is at the Semi-Private Room, an adjustment factor of 12.5% applies to benefits payable.

(6) If the Confinement in respect of which such charges have been incurred is at the Deluxe Room and the Plan Level insured and specified in the Benefit Schedule is at the Ward, no benefits will be payable.

8.4 Payment of Claim

The benefits of this Policy shall be payable to the Policyholder, whose receipt shall constitute a sufficient discharge of all the Company's obligations under this Policy in respect of such benefit and conclusive evidence that the relevant claims under this Policy have been duly satisfied.

8.5 Abandoned Claims

If the Company declines any claim under this Policy and the Policyholder does not initiate any legal action in respect of such claim within twelve (12) calendar months from the date of such decline, the claim for all purposes shall be deemed abandoned and shall not thereafter be recoverable.

8.6 Legal Action

No suit or action against the Company, whether at law or in equity, shall be brought on a claim sooner than three (3) months after the date on which proof of loss satisfactory to the Company is given, nor later than three (3) years after the date on which proof of loss is required.

If a claim is, in any respect, false, fraudulent, intentionally exaggerated or if fraudulent means or devices or documentation has been used to obtain benefit under this Policy, the Company shall have the right to terminate this Policy immediately without refunding paid premiums. The Company shall also have the right to recover any benefit which have already paid to a claim which is not eligible.

9 Termination Provisions

This Policy shall terminate on the earliest of the following:-

1. The death of the Insured and no unearned premium paid of the deceased for the insurance period of this Policy shall be refunded; or
2. The last day of the Insurance Period immediately preceding the one hundredth (100th) birthday of the Insured; or
3. The date the aggregate benefits paid under all relevant insurance policies reach the Lifetime Limit; or
4. Termination of this Policy in accordance with clauses 2.6, 4.8 or 8.6; or
5. The end of the grace period of any premium due and not received by the Company.

10 Cancellation

The Policyholder may cancel this Policy at any time by giving notice to the Company by a letter sent by registered post addressed to the Company, specifying the effective date of cancellation of this Policy; and provided that no claims have been paid or are payable under this Policy, he shall be entitled to a refund of a proportionate amount of the annual premium paid by him corresponding to the unexpired portion of the Insurance Period less an administration charge of 10% of the annual premium in respect of this Policy. The Company shall refund the insurance levy paid by the Policyholder in accordance with the applicable laws and regulations, if any.

If the premium is paid by installment, no unearned premium paid for insurance period of this Policy shall be refunded. An administration charge of 10% of the annual premium shall be charged to the Policyholder.

No unearned premium shall be refunded in case of claims incurred during the insurance period.

Appendix – Clinical Surgery List

The Company shall have the sole discretion to revise the following list from time to time.

Bones And Joints	Close reduction and fixation of fractures with or without the use of plaster of Paris
	Manipulation of joints under anaesthesia
	Halo-cast fixation for cervical spine fracture/dislocation
Brain And Central Nervous System	Lumbar puncture of cisternal puncture
Breast	Biopsy of breast tissue
Ear	Insertion of grummet
	Operation on the external ear and/or pre-auricular sinuses
Eye	All conjunctival or corneal operations except corneal grafting, severe
	corneal wound repair and keratoplasty
	All eyelid operations except blepharoplasty and ptosis repair
	Surgical treatment for glaucoma
	Removal of corneal foreign body
	Lens operation including cataract removal and prosthetic lens insertion
	Phacoemulsification
	Laserphotocoagulation on retina
	Removal of pterygium (one or both sides)
	Incision of chalazion
Female Genital Tract	Open exploration of nasal lacrimal duct except simple probing
	Amputation of cervix, cervicectomy, cone biopsy or cauterisation of cervix
	Suture of cervix
	Marsupilisation of bartholin's cyst
	Operation for simple cyst or benign tumour of vulva and vagina, including simple repair and suturing
Gastro-Intestinal Tract Operation	Upper endoscopy up to the level of duodenum
	Colonoscopy, with or without biopsy or papilloma removal
	Haemorrhoidectomy
	Operation for anal fissure including radical excision
Head And Neck	Lymph node biopsy
	Operation on lip and cheek benign tumour
Male Genital Tract	Circumcision
	Tapping of hydrocele
	Testicular biopsy
Nose And Sinuses	Antral puncture and lavage
	Removal of nasal polyp
	Cauterisation of nasal mucosa
	Rhinoscopy or nasopharyngoscopy including rhinoscopic biopsy and foreign body removal
Hepato - Biliary System	Liver biopsy

Skin	Lymph node biopsy or drainage of lymph node abscess
	Excision of skin lumps or tumour of subcutaneous tissue, including lipoma, neurofibroma or its variants, sebaceous cysts, malignant melanoma, and naevus etc.
	Incision and drainage of skin abscess
	Cauterisation of skin lesion with electricity or cryosurgery
	Removal of foreign body
	Excision of pilonidal cyst
	Skin grafting or keloid operation : if total area less than or equal 1% of body surface area
	Drainage of subungual haematoma or abscess
	Skin suturing
Tendon, Nerve, Vessel, Muscle And Soft Tissue	Application of complete plaster cast, not for limb resting purpose
	Removal or avulsion of nail
	Excision of ganglion
	Operation on Dupuytren's Contracture
	Varicose vein sclerotherapy (one or two legs)
Thoracic Operations	Bronchoscopy
	Oesophagoscopy
	Thoracocentesis or insertion of chest tube for pneumothorax
Throat	Vocal cord operation including using laser techniques (carcinoma excluded)
	Tracheostomy
	Laryngoscopy with/without foreign body removal
	Tonsillectomy with or without other adenoid tissue removal
Urinary Tract	Cystoscopy
	Renal biopsy

Definition of Designated Crises
TheChoice Medical Insurance

The following crises are considered "Designated Crises" under TheChoice Medical Insurance:-

1. Cancer
2. Fulminant Hepatitis
3. Chronic Liver Disease
4. End Stage Lung Disease
5. Cardiomyopathy
6. Heart Valve Surgery
7. Primary Pulmonary Arterial Hypertension
8. Coronary Artery Disease Surgery
9. Stroke
10. Kidney Failure
11. Surgery to Aorta
12. Major Organ Transplantation
13. Severe Rheumatoid Arthritis
14. Heart Attack
15. Parkinson's Disease
16. Terminal Illness

General Term

Unless otherwise specified, the following definitions shall apply to the terms used in this "Definition of Designated Crises":

Activities of Daily Living

(i) Washing - The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;

(ii) Dressing - The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;

(iii) Transferring - The ability to move from a bed to an upright chair or wheelchair and vice versa;

(iv) Mobility - The ability to move indoors from room to room on level surfaces;

(v) Toileting - The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene; and

(vi) Feeding - The ability to feed oneself once food has been prepared and made available;

Permanent Neurological Deficit

Symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the Insured's life.

Symptoms that are covered include numbness, hyperaesthesia (increased sensitivity), paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, lethargy, dementia, delirium and coma.

The following are not covered:

(i) an abnormality seen on brain or other scans without definite related clinical symptoms;

(ii) neurological signs occurring without symptomatic abnormality, e.g. brisk reflexes without other symptoms; and

(iii) symptoms of psychological or psychiatric origin.

Designated Crises

Unless otherwise specified, the following definitions shall apply to the terms used in TheChoice Medical Insurance:

1. Cancer

Cancer means the presence of a malignant tumour that is characterised by progressive, uncontrolled growth, spread of malignant cells and invasion and destruction of normal and surrounding tissue. Major interventionist treatment or major surgery must be considered necessary or palliative care must have been initiated. Cancer must be positively diagnosed with histopathological confirmation.

The following tumours are excluded:

(i) leukaemia other than chronic lymphocytic leukaemia if there is no generalized dissemination of leukaemia cells in the blood-forming bone marrow;

(ii) tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant;

(iii) all skin cancers, unless there is evidence of metastases or the tumour is a malignant melanoma of greater than 1.5mm maximum thickness as determined by histological examination using the Breslow method;

(iv) non-life-threatening cancers, such as prostate cancers which are histologically described as TNM Classification T1 (a) or T1(b), or are of another equivalent or lesser classification;

(v) papillary micro-carcinoma of the thyroid;

(vi) non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification; and

(vii) chronic lymphocytic leukaemia less than RAI Stage I or Binet Stage A-I.

2. Fulminant Hepatitis

A sub-massive to massive necrosis of the liver by a Hepatitis virus, leading precipitously to liver failure. The diagnosis in respect of this illness must be based on the meeting of all of the following criteria:

(i) a rapidly decreasing liver size;

(ii) necrosis involving entire lobules, leaving only a collapsed reticular framework; and

(iii) rapid deterioration of liver function tests.

Evidence of the following must be produced:

(i) liver function test to show massive parenchymal liver disease; and

(ii) objective signs of portasystemic encephalopathy.

3. Chronic Liver Disease

End stage liver failure with increasing jaundice that in general medical opinion will not improve in future and resulting in either ascites or encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

4. End Stage Lung Disease

The final or end stage of lung disease, causing chronic respiratory failure, as demonstrated by all of the following:

(i) FEV1 test results consistently less than 1 litre;

(ii) requiring permanent supplementary oxygen therapy for hypoxemia;

(iii) arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO2 \leq 55mmHg$); and

(iv) dyspnea at rest.

The diagnoses must be confirmed by a pulmonologist.

5. Cardiomyopathy

Impaired ventricular function of variable aetiology, resulting in permanent and irreversible physical impairments to the degree of at least Class 4 of the New York Heart Association Functional Classification of Cardiac Impairment. The diagnosis must be confirmed by a consultant cardiologist and supported by the appropriate test results including echocardiography.

Cardiomyopathy caused by alcohol or drug abuse is specifically excluded.

Class 4 of the New York Heart Association Functional Classification of Cardiac Impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination and laboratory studies.

6. Heart Valve Surgery

The first occurrence of open heart valve surgery requiring median sternotomy, performed to replace or repair one or more heart valves, as a consequence of defects that cannot be repaired by intra arterial catheter procedures alone. The surgery must be performed after a recommendation by a consultant cardiologist.

7. Primary Pulmonary Arterial Hypertension

Primary Pulmonary Arterial Hypertension is the pathological increase of pulmonary pressure due to structural, functional or circulatory disturbances of the lung leading to right ventricular enlargement. The disease must result in permanent irreversible physical impairment to the degree of at least Class 4 of the New York Heart Association Functional Classification of Cardiac Impairment. There must be proof that pulmonary pressure has remained above 30mm Hg for a period of at least six months.

Class 4 of the New York Heart Association Functional Classification of Cardiac Impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination and laboratory studies.

8. Coronary Artery Disease Surgery

The actual undergoing of open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. Angiographic evidence of significant coronary artery obstruction must be provided and the procedure must be considered Medically Necessary by a consultant cardiologist. Angioplasty and all other intra arterial, catheter based techniques, minimally invasive, keyhole or laser procedures stent insertion are excluded.

9. Stroke

A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis. This diagnosis must be supported by all of the following conditions:

(i) evidence of Permanent Neurological Deficit confirmed by a neurologist at least 6 weeks after the event; and

(ii) findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke.

The following are excluded:

(i) transient ischaemic attacks;

(ii) brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease;

(iii) vascular disease affecting the eye or optic nerve; and

(iv) ischaemic disorders of the vestibular system.

10. Kidney Failure

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

11. Surgery to Aorta

Means the actual undergoing of surgery via thoracotomy or laparotomy to repair or correct an aortic aneurysm, an obstruction of the aorta, a coarctation of the aorta or a traumatic rupture of the aorta. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches.

Surgery performed using only minimally invasive or intra arterial techniques are excluded.

12. Major Organ Transplantation

The actual undergoing of a transplant of the lung, pancreas, liver, bone marrow, heart or kidney as a recipient. Inclusion on an official organ transplant waiting list, for any of the above organs, also qualifies for benefits. The transplant must be Medically Necessary and based on objective confirmation of organ failure.

13. Severe Rheumatoid Arthritis

Widespread joint destruction as a result of severe rheumatoid arthritis with major clinical deformity of three or more of the following joint areas:

(i) hands;
(ii) wrists;
(iii) elbows;
(iv) cervical spine;
(v) knees; and
(vi) ankles.

The diagnosis must be supported by all the following:

(i) morning stiffness;
(ii) symmetric arthritis;
(iii) presence of rheumatoid nodules;
(iv) elevated titres of rheumatoid factors; and
(iv) radiographic evidence of severe involvement.

The severity of the disease shall be such that there will be at least 3 of the Activities of Daily Living which the Insured will, for a continuous period of at least 6 months, have been unable to perform without the assistance of another person.

At bolttech Insurance's discretion, confirmation of the diagnosis and the degree of disability may be required through an independent medical examination by a specialist rheumatologist appointed by bolttech Insurance.

14. Heart Attack

Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction:

(i) typical clinical symptoms (for example, characteristic chest pain);
(ii) new characteristic electrocardiographic changes.; and
(iii) the characteristic rise of cardiac enzymes or troponins recorded at the following levels or higher:
- Troponin T > 1.0 ng/ml; and
- AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

Provided other criteria are met but cardiac enzymes is not available, echocardiographic proof of reduction in left ventricular function with a left ventricular ejection fraction of less than 50% or significant hypokinesia, akinesia, or wall motion abnormalities consistent with a heart attack having occured will be considered.

The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes including but not limited to angina are excluded.

15. Parkinson's Disease

Unequivocal diagnosis of Parkinson's Disease by a consulting neurologist where the condition:

(i) cannot be controlled with medication;
(ii) shows signs of progressive impairment; and
(iii) must result in the permanent inability to perform, without assistance, at least 3 of the 6 Activities of Daily Living.

Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinsonism are excluded.

16. Terminal Illness

The conclusive diagnosis of an illness that is expected to result in the death of the Insured within 12 months. This diagnosis must be supported by a specialist and confirmed by bolttech Insurance's appointed doctor.

Terminal illness in the presence of HIV Infection is excluded.

Emergency Assistance Services Agreement
(Medical Insurance)

These Emergency Assistance Services are provided by Assistance services provider to the Insured Members who are insured under the Policy with Bolttech Insurance (Hong Kong) Company Limited (hereinafter called "the Company").

1. Definitions

For the purpose of this Emergency Assistance Services Agreement ("this Agreement"):-

1.1 "Insured Member" refers to any person who is insured under the policy (hereinafter called "Policy"), whose name is specified in the Schedule / Policy Schedule or in an endorsement issued by the Company, and who is provided with the emergency assistance services as specified in the Schedule / Benefit Schedule of the Policy

1.2 "Act of Terrorism" refers to an act, including but not limited to the use of force or violence and/or threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or ethnic purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

1.3 "Close Relative" refers to the User's spouse, father, mother, his/her child(ren), brother(s) or sister(s).

1.4 "Home Country" refers to country of citizenship.

1.5 "Limit of Indemnity" refers to the maximum amount of third party expenses for which Assistance services provider shall be responsible in the provision of a Service to the Insured Member during any one event, subject to the terms and conditions as defined hereunder.

1.6 "Pre-Existing Condition" refers to any medical condition in respect of which the Insured Member has been hospitalised during the 12-month period immediately prior to the first day the Insured Member is included in the programme; or any medical condition that has been diagnosed or treated by a medical practitioner including prescribed drugs within the 6-month period immediately prior to the first day the Insured Member is included in the programme.

1.7 "Services" refers to the assistance services to be provided by Assistance services provider as set out in article 4 of this Agreement.

1.8 "Serious Medical Condition" refers to a condition which in the opinion of Assistance services provider constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the Insured Member's immediate or long-term health prospects. The seriousness of the medical condition will be judged within the context of the Insured Member's geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facilities.

1.9 "Usual Country of Residence" refers to Hong Kong unless it is agreed otherwise by the Company under the Policy.

2. Geographical Scope of Services

2.1 The Services provided by under article 4.4 of this Agreement are rendered on a worldwide basis. The Services provided by under article 4.5 of this Agreement are rendered within China. Assistance services provider shall endeavour on a best effort basis to provide the Services by any assistance service and intervention depends upon, and is subject to local and/or international resource availability and must remain within the scope of national and international law and regulations. Intervention may depend on Assistance services provider being able to attain the necessary authorizations issued by the various authorities concerned which is outside of the control or influence of Assistance services provider.

2.2 Assistance services provider shall not be required to provide Services to the Insured Member(s), who in the sole opinion of Assistance services provider are located in areas which represent conditions such as to make such Services impossible, reasonably impracticable or unsafe, including but not limited to geographical remoteness war risks or political unrest.

3. Limits of Indemnity

The Limit of Indemnity for any Insured Member during any one event shall be as follows:

Emergency Medical Evacuation, Emergency Medical Repatriation and Repatriation of Mortal Remains	-	Up to US$1,000,000
Compassionate Visit and Accommodation of	-	One Economy Class Return Airfare and Hotel
Hotel Accommodation	-	US$1,000 subject to a sub-limit of US$250 per day
Return of Minor Children	-	One Economy Class One Way Airfare
Convalescence Expenses	-	US$1,000 subject to a sub-limit of US$250 per day
Return of Insurance Member to Original Work Site	-	One Economy Class One Way Airfare
Unexpected Return to Home Country Or Usual Country of Residence	-	One Economy Class Return Airfare

4. Scope of Services

4.1 Assistance services provider shall maintain verified and updated information regarding service providers at all times. Assistance services provider shall review and update regularly its information regarding names, addresses, specialties, office hours and language proficiency. Assistance services provider shall instruct its agents to report newly obtained relevant information promptly upon its receipt, including information about the quality of services provided, new listings and updates of addresses and telephone numbers. In response to inquiries, Insured Members will be provided with the latest updated information on service providers and their services.

4.2 Assistance services provider shall provide Insured Members with 24 hours a day, 7 days a week access to Cantonese, Mandarin and English speaking Operations Coordinators via a fully-manned Assistance Centre in Hong Kong.

4.3 When immediately available, Assistance services provider shall provide the Services to the Insured Member whilst the Insured Member is on the telephone. In all other cases, Assistance services provider will provide the information by the quickest possible means.

4.4 Assistance services provider shall, subject to the terms and conditions as defined hereunder, provide the following Services to any Insured Member calling Assistance services provider when he/she travels outside the Home Country or Usual Country of Residence for periods not exceeding 90 consecutive days per trip:

(a) Medical Assistance

(i) Telephone Medical Advice

Assistance services provider will arrange for the provision of medical advice to the Insured Member over the telephone.

(ii) Arrangement of Hospital Admission and Guarantee of Hospital Admission Deposit

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

(iii) Delivery of Essential Medicine

Assistance services provider will arrange to deliver to the Insured Member essential medicine, drugs and medical supplies that are necessary for an Insured Member's care and/or treatment but which are not available at the Insured Member's location. The delivery of such medicine, drugs and medical supplies will be subject to the laws and regulations applicable locally. Assistance services provider will not pay for the costs of such medicine, drugs or medical supplies and any delivery costs thereof.

(iv) Arrangement and Payment of Emergency Medical Evacuation

Assistance services provider will arrange for the air and/or surface transportation and communication for moving the Insured Member when in a Serious Medical Condition to the nearest hospital where appropriate medical care is available. Assistance services provider shall pay for the medically necessary expenses of such transportation and communications and all usual and customary ancillary charges incurred in such services arranged by Assistance services provider.

Assistance services provider retains the absolute right to decide whether the Insured Member's medical condition is sufficiently serious to warrant Emergency Medical Evacuation. Assistance services provider further reserves the right to decide the place to which the Insured Member shall be evacuated and the means or method by which such evacuation will be carried out having regard to all the assessed facts and circumstances of which Assistance services provider is aware at the relevant time.

(v) Arrangement and Payment of Emergency Medical Repatriation

Assistance services provider will arrange for the return of the Insured Member to the Home Country or Usual Country of Residence by air and/or surface transportation following an Emergency Medical Evacuation where the Insured Member is evacuated to a place outside the Home Country or Usual Country of Residence for in-hospital treatment. Assistance services provider shall pay for the expenses necessarily and unavoidably incurred in the services so arranged by Assistance services provider.

Assistance services provider reserves the right to decide the means or method by which such repatriation will be carried out having regard to all the assessed facts and circumstances of which Assistance services provider is aware at the relevant time.

(vi) Arrangement and Payment of Transportation of Mortal Remains

Assistance services provider will arrange for transporting the Insured Member's mortal remains from the place of death to the Home Country or Usual Country of Residence and pay for all expenses reasonably and unavoidably incurred in the air and/or surface transportation so arranged by Assistance services provider or alternatively pay the cost of burial at the place of death as approved by Assistance services provider, subject to any governmental regulations.

(vii) Arrangement and Payment of Compassionate Visit and Hotel Accommodation

Assistance services provider will arrange and pay for one economy class return airfare and hotel accommodations for a relative or a friend of the Insured Member to join the Insured Member who, when travelling alone, is hospitalised outside the Home Country or Usual Country of Residence for a period in excess of seven (7) consecutive days, subject to the prior approval by the the assistance service provider and only when judged necessary by Assistance services provider on medical and compassionate grounds.

(viii) Arrangement and Payment of Return of Minor Children

Assistance services provider will arrange and pay for the economy class one-way airfare for the return of minor children [aged 18 years old and below, unmarried] to the Home Country or Usual Country of Residence if they are left unattended as a result of the accompanying Insured Member's illness, accident or Emergency Medical Evacuation. Escort will be provided, when required, at no charge.

(ix) Arrangement and Payment of Convalescence Expenses

Assistance services provider will arrange and pay for the additional hotel accommodation expenses necessarily and unavoidably incurred by the Insured Member related to an incident requiring Emergency Medical Evacuation, Emergency Medical Repatriation or hospitalisation. Prior approval by the service provider, subject to its determination on medical grounds, is required in respect of such payment.

(x) Arrangement and Payment of Unexpected Return to the Home Country or Usual Country of Residence

In the event of the death of the Insured Member's close relative in his/her Home Country or Usual Country of Residence while the Insured Member is travelling overseas (save for in the case of migration) and necessitating an unexpected return to his Home Country or Usual Country of Residence, Assistance services provider will arrange and pay for one economy class return airfare for the return of the Insured Member to his/her Home Country or Usual Country of Residence.

(xi) Arrangement and Payment of Return of Insured Member to Original Work Site

Following the Insured Member's Emergency Medical Evacuation or Emergency Medical Repatriation and within one (1) month period, Assistance services provider will, upon the Insured Member's request, arrange and pay for a one-way economy class airfare to return the Insured Member to the original work location.

The above Service [item (i)] is purely on referral or arrangement basis. Assistance services provider shall not be responsible for any third party expenses which shall be solely the Insured Member's responsibility.

The above Services [items (ii) & (iii)] are charged on a case by case basis. The provision of financial guarantees by Assistance services provider is subject to Assistance services provider first securing payment from the Insured Member through the Insured Member's credit card or from the funds from the Insured Member's family. Assistance services provider shall not be responsible for any third party expenses which shall be solely the Insured Member's responsibility.

The above Services [items (iv) to (xi)] are subjected to the customary exclusions listed in article 5.

(b) Travel Assistance

(i) Inoculation and Visa Requirement Information

Assistance services provider shall provide information concerning visa and inoculation requirements for foreign countries, as those requirements are specified from time to time in the most current edition of World Health Organization Publication "Vaccination Certificates Requirements and Health Advice for International Travel" (for inoculations) and the "ABC Guide to International Travel Information" (for visas). This information will be provided to the Insured Member at any time, whether or not the Insured Member is travelling or an emergency has occurred. Assistance services provider shall inform the Insured Member requesting such information that Assistance services provider is simply communicating the requirements set forth in a document and Assistance services provider shall name the document.

(ii) Lost Luggage Assistance

Assistance services provider will assist the Insured Member who has lost his/her luggage while travelling outside the Home Country or Usual Country of Residence by referring the Insured Member to the appropriate authorities involved.

(iii) Lost Passport Assistance

Assistance services provider will assist the Insured Member who has lost his/her passport while travelling outside the Home Country or Usual Country of Residence by referring the Insured Member to the appropriate authorities involved.

(iv) Legal Referral

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

Although Assistance services provider shall make such referrals, it cannot guarantee the quality of the service provider and the final selection of a service provider shall be the decision of the Insured Member. Assistance services provider, however, will exercise care and diligence in selecting the service providers.

(v) Emergency Travel Service Assistance

Assistance services provider shall assist the Insured Member in making reservations for air ticket or hotel accommodation on an emergency basis when travelling overseas.

The above Services [items (i) to (v)] are purely on referral or arrangement basis. Assistance services provider shall not be responsible for any third party expenses which shall be solely the Insured Member's responsibility.

4.5 Assistance services provider shall, subject to the terms and conditions as defined hereunder, provide the following Services to any Insured Member calling Assistance services provider when he/she travels outside the Home Country or Usual Country of Residence to China for periods not exceeding 90 consecutive days per trip:-

China Medical Card Services

Guarantee of Hospital Admission Deposit

Assistance services provider will, upon the Insured Member's request, assist the Insured Member in the admission to designated hospitals in the People's Republic of China and will arrange and provide guarantee for any required hospital admission deposit. Assistance services provider shall not guarantee nor be responsible for the quality of such hospital and the services provided to the Insured Member. The final selection of a hospital shall be the decision of the Insured Member.

The provision of financial guarantees by Assistance services provider is subject to Assistance services provider first securing payment from the Insured Member through the Insured Member's credit card or from the funds from the Insured Member's family. Assistance services provider shall not be responsible for any third party expenses which shall be solely the Insured Member's responsibility.

5. Exclusions

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

(1) Any expenses incurred as a result of a Pre-Existing Condition unless such Pre-Existing Condition is covered under the relevant insurance Policy.

(2) More than one emergency evacuation and/or repatriation for any single medical condition of the Insured Member during the term of this Agreement, subject to a maximum of one year.

(3) Any costs or expenses not expressly covered by the program and not approved in advance and in writing by Assistance services provider and/or not arranged by Assistance services provider. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when Assistance services provider cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the Insured Member.

(4) Any event occurring when the Insured Member is within the territory of his/her Home Country and Usual Country of Residence.

(5) Any expenses for Insured Members who are travelling outside their Home Country or Usual Country of Residence contrary to the advice of a medical practitioner, or for the purpose of obtaining medical treatment or for rest and recuperation following any prior accident, illness or Pre-existing Condition.

(6) Any expenses for medical evacuation or repatriation if the Insured Member is not suffering from a Serious Medical Condition, and/or in the opinion of the Assistance services provider physician, the Group 1 Insured Member can be adequately treated locally, or treatment can be reasonably delayed until the Insured Member returns to his/her Home Country or Usual Country of Residence.

(7) Any expenses for medical evacuation or repatriation where the Insured Member, in the opinion of the Assistance services provider physician, can travel as an ordinary passenger without a medical escort.

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

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

(10) Any expenses incurred for emotional, mental or psychiatric illness.

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

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

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

(14) Any expenses related to the Insured Member engaging in the commission of, or the attempt to commit, an unlawful act.

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

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

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

(18) Any expenses incurred for or as a result of any activity required from an off-shore location.

(19) Any expenses in respect of the Insured Member more than 75 years old at the date of intervention.

(20) Any expenses which is a direct result of nuclear reaction or radiation.

6. Reasonable Precautions

The Insured Member shall take all reasonable precautions to prevent and minimise any accident, injury, death or expenses.

7. Request for Assistance

In case of any request for assistance, and prior to taking personal action where reasonable, the Insured Member or his representative shall call the assistance services Centre whose contact number is listed below:

HONG KONG: (852) 2456 5400
and should state:

- His name, the number of his policy and his I.D. card or passport number and,
- The name of the place and the telephone number where Assistance services provider can reach the Insured Member or his representative and,
- A brief description of the accident and the nature of help required.

8. Examinations

Assistance services provider shall have the right and opportunity through its medical representative to examine the Insured Member whenever and as often as may reasonably require.

9. Undertakings

9.1 Assistance services provider undertakes to exercise due care and diligence in the appointment and/or referral of any service provider to assist the Insured Member. Assistance services provider assumes no responsibility for any advice given by any service provider and the Insured Member shall not have any recourse against Assistance services provider by reason of its referral of or contact with a service provider or other determination resulting therefrom.

9.2 The Insured Member undertakes not to have any recourse against Assistance services provider or the Company for any indirect or consequential loss suffered by the Insured Member arising from the Services.

10. Force Majeure

Assistance services provider shall not be liable for failure to provide Services and/or delays caused by acts of God, strikes, or other conditions beyond its control, including but not limited to, flight conditions or situations where the rendering of Services is prohibited or delayed by local laws, regulators or regulatory agencies.

11. Contract

Notwithstanding any other provisions in the Policy, it is hereby declared by Assistance services provider that the above Services are made available to the Insured Member by the Company on behalf of Assistance services provider who is the principal party in providing the Services to the Insured Member under this Agreement. There is no privity of contract between the Company and the Insured Member in this Agreement and the Company shall assume no liability in any default of the provision of the Services or for any indirect or consequential loss suffered by the Insured Member arising from the Services.

12. Termination

This Agreement shall cease when the Policy is terminated.

Personal Information Collection Statement ("PICS")
收集個人資料聲明

Please scan the following QR code for review of Bolttech Insurance (Hong Kong) Company Limited's (the "Company") PICS. You can also request a copy of the PICS by calling the Company's Customer Service Hotline at 3123 3344.

請掃描以下二維碼查看保特保險 (香港) 有限公司 （「本公司」） 的收集個人資料聲明。您亦可致電本公司的客戶服務熱線 3123 3344 索取收集個人資料聲明副本。

English

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