ZURICH

Zurich HealthMultiple Medical Insurance Plan

Please read this policy carefully upon receipt and promptly request for any necessary amendments.

This policy together with the enclosed *schedule* and any endorsements subsequently issued should be read as if they are one document and form the contract between *you* and *us*, and no variations shall be admitted except those acknowledged in writing by *us*. The enrollment form and declaration which *you* completed and provided to *us*, either verbal (if recorded by *us* or by *our* appointed authorized agent) or written are the basis of this contract.

We agree, in consideration of *your* payment of the premium and in reliance upon the statements, warranties or declarations and subject to the terms and conditions of this policy and the attached *schedule*, *we* will insure *the insured person(s)* under those sections shown in the *schedule* during any *period of insurance* to pay the benefits defined to the *insured person* who sustain(ed) *sickness* or *injury* or incurs charges within the scope of coverage provided hereinafter upon recommendation of a *medical practitioner*.

This policy is an annual medical policy which will be renewed subject to subsequent premium payments and *our* acceptance. *You* are required to settle the annual premium for the concurrent policy year.

Should *you* change any information given on *your* enrollment form (regardless verbally or in written format), please inform *us* of the changes immediately as the changes may affect the *insured person*'s insurance cover.

This policy is a legal document and should be kept in a safe place.

PART 1 – DEFINITIONS

Certain words in this policy have specific meanings. These meanings are given below. To help *you* identify these words in this policy *we* have printed them in italics throughout this policy. Words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.

Accident/Accidental
A sudden and unforeseen event that happens unexpectedly and causes *injury* to the *insured person* during the *period of insurance.*

Activities of Daily Living
Daily self-care activities including:
(i) Dressing – the ability to put on and take off clothing without assistance.
(ii) Mobility – the ability to move from room to room without physical assistance.
(iii) Transfer – the ability to get in and out of bed or a chair without assistance.
(iv) Continence – the ability to control bowel and bladder function.
(v) Feeding – the ability to get food from a plate into the mouth without assistance.
(vi) Bathing or showering – the ability to bathe or shower without assistance.

Age/Aged
Age at last birthday.

Anaesthetist
A *medical practitioner* other than *you*, the *insured person* or *immediate family member,* legally registered under the Specialist Register of Anaesthesiology of the Medical Council of *Hong Kong* or the equivalent. In the event of emergency treatment or surgical operation received outside *Hong Kong*, it shall mean a *medical practitioner* who can legally practise anaesthesiology and to render medical and surgical services in accordance with the equivalent specialty law in the geographical area of his/her practice.

Civil War
An internecine war or a *war* carried on between or among opposing citizens of the same country or nation.

Computer Virus
A set of corrupting, harmful or otherwise unauthorized instructions or code including a set of maliciously introduced unauthorized instructions or code, programmatic or otherwise, that propagate themselves through a computer system or network of whatsoever nature. Computer virus includes but is not limited to "Trojan Horses", "worms" and "time or logic bombs".

Confined/Confinement(s)
The *insured person* is admitted to a *hospital* as a result of *sickness* or *injury* with *medical necessity* upon the recommendation of a *medical practitioner* and continuously stays in the *hospital* prior to his/her discharge from the *hospital. Hospital confinement* will be evidenced by a daily room and board charge by the *hospital.*

Critical Illness(es)
The disease or incapacity or surgery as defined under Section 6 – *Critical Illness* Cover of Part 3 – Benefits, of which the symptoms first occurred during the *period of insurance* and is *diagnosed* after ninety (90) days immediately following the *policy inception date*, or the *upgrade effective date*, or last reinstatement date, whichever is the later. A *critical illness* is considered *diagnosed* under this policy only if the *insured person* has been examined by one (1) or more *specialist* in respect of such *critical illness*, and a written report(s) prepared by each of the *insured person*'s treating *specialist* or under his/her supervision satisfies each and every diagnostic requirement specified in the policy corresponding to that *critical illness*.

Cyber Act
Any unauthorized, malicious or criminal acts, regardless of time and place, involving access to, processing, use or operation of any computer system, computer software programme, malicious code, *computer virus* or process or any other electronic system.

Day Patient
A patient who is admitted to a day patient unit of a *hospital* for the purpose of undergoing a surgical procedure, but does not require an overnight stay.

Deductible
The *deductible* amount as stated in the *schedule* which is the portion of expenses for which the *insured person* is liable for each and every claim made under Section 1 to Section 3 of Part 3 – Benefits of the policy. *We* are only liable to pay the remaining balance of the medical expense of a covered *disability* if such expense exceeds the *deductible* amount, up to the Maximum Benefits as shown under the selected plan in Part 2 - Table of benefits.

Diagnosis/Diagnose/Diagnosed
The definitive *diagnosis* made in writing by the *insured person*'s treating *specialist* based upon such specific evidence, radiological, clinical, histological and/or laboratory evidence, as referred to in the definition of the particular *critical illnesses* concerned (as set out under Section 6 – *Critical Illness* Cover of Part 3 – Benefits of this policy) which are acceptable to *us*.

Disability/Disabilities
A *sickness* or *injury*. All *injuries* sustained in any one (1) *accident* shall be considered one (1) *disability*. All *sickness* existing simultaneously which are due to the same or related causes including any and all complications therefrom shall be considered as one (1) *disability* as well. If a *disability* is due to causes which are the same or related to the causes of a prior *disability* including complications arising therefrom, the *disability* shall be considered a continuation of the prior *disability* and not a separate *disability* except that after ninety (90) days following the latest discharge from *hospital* or prior curative treatment/surgical operation or the last consultation or the latest date receiving medical treatment or prescribed drugs or special diet for the condition and no further treatment for the said *disability* is required, any subsequent *disability* from the same cause shall be considered a separate *disability*.

Domestic Partner
An unmarried adult *aged* eighteen (18) or above who has chosen to live with the *insured person* in an intimate and committed relationship, and has resided with the *insured person* for at least three (3) years, intends to do so indefinitely and is able to provide such proof of residence. *Domestic Partner* does not include roommates or any *immediate family member*.

Hong Kong
Hong Kong Special Administrative Region of the People's Republic of China.

Hospital
An institution which
(i) is licensed in accordance with the applicable laws of the jurisdiction in which it is located,
(ii) is primarily engaged in providing, for compensation from its patients, diagnostic, medical and surgical facilities for the care and *treatment* of injured or sick person,
(iii) has staff of one (1) or more *medical practitioner* available at all times,
(iv) has 24 hour-a-day nursing service by registered graduate nurses under the permanent supervision of the *medical practitioner* in charge,
(v) maintains well-equipped inpatient facilities, and
(vi) maintains a daily medical record for each of its patients.

Hospital does not include any institution which is primarily a clinic, a nature care clinic, a health hydro, a rest or convalescent facility, a place for custodial care, a facility for the elderly or alcoholics or drug addicts or for *treatment* of mental disorders, or a nursing home, or similar establishment.

Immediate Family Members
Your or the *insured person*'s spouse, parent, parent-in-law, grandparent, son or daughter, brother or sister, grandchild, or legal guardian.

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Injury
Bodily injury sustained in an *accident* solely and independently of all other cause.

Insured Person
The persons who are being insured under this policy.

Intensive Care Unit
A part of a *hospital* which is designated as an *intensive care unit* by the *hospital* providing one-to-one nursing care, in which patients undergo specialized resuscitation, monitoring and *treatment* procedures. The part or unit must be staffed twenty-four (24) hours a day with highly trained nurses, technicians and *medical practitioners*, and be equipped with resuscitative equipment and monitoring devices that allow continuous assessment of vital body functions such as heart rate, blood pressure and blood chemistry.

Loss of Sight
The entire and *permanent* irrecoverable *loss of sight*.

Loss of Use
Permanent total functional disablement or complete and *permanent* physical separation at or above the wrists or ankle joints.

Medically Necessary/ Medical necessity
The necessity to have a medical service which is
(i) consistent with the *diagnosis* and is the customary medical treatment for the condition; and
(ii) in accordance with standards of good and prudent medical practice ; and
(iii) not furnished primarily for the convenience of *medical practitioner* or any other medical service providers; and
(iv) furnished at the most appropriate level sufficient to safely and adequately treat the *insured person*'s *disability* and are performed in the least costly setting required for treatment of a covered *disability*; and
(v) not rendered primarily for diagnostic tests, diagnostic scanning purpose, imaging examination, laboratory test or physiotherapy in the event of a *confinement*.

Medical Practitioner
A person other than *you,* the *insured person*, or *immediate family member,* who is a registered medical practitioner under Medical Registration Ordinance, Chapter 161, Laws of *Hong Kong*. In the event of treatment or surgical operation received outside *Hong Kong*, it shall mean a person other than *you,* the *insured person*, or *immediate family member,* who is qualified by degree in western medicine, legally authorized in the geographical area of his/her practice to render medical and surgical services.

Outpatient
An *insured person* who receives medical services and medicines in connection with treatment for a covered *sickness* or *injury* given in the clinic or office of a *medical practitioner* or a *specialist*, *outpatient* department or emergency treatment room of a *hospital*.

Period of Insurance
The period of time as stated in the *schedule* during which this policy is effective and *we* have accepted *your* premium.

Permanent
Lasting not less than twelve (12) consecutive months from the date of an *accident* and at the expiry of that period being beyond hope of improvement.

Policy Effective Date
The effective date of the policy as stated in the *schedule*, or the latest date of renewal, whichever is the later, provided that the premium has been paid.

Policy Inception Date
It shall mean:-
(i) the first effective date of this policy as stated in the *schedule* upon application of this policy, and for the avoidance of doubt does not include any date of renewal; or
(ii) policy reinstatement date, whichever is the later.

Pre-existing Condition
Any *injury, sickness* or condition and/or directly related conditions for which the *insured person* showed symptoms or has received medical consultation, *diagnosis*, treatment or advice by a *medical practitioner* or took prescribed drugs or medicine for a period of time during which the *insured person* was aware of or could reasonably be expected to be aware of prior to the *policy inception date* or the date of reinstatement or *upgrade effective date*, whichever is later, unless such conditions have been fully disclosed on the application form and accepted by *us* in writing and the policy document does not expressly exclude treatment relating to such pre-existing condition.

Public Hospital
A *hospital* which is listed within the seven (7) *hospital* clusters in *Hong Kong* as defined by the Hospital Authority of *Hong Kong*.

Qualified Nurse
A *qualified nurse* other than *you*, the *insured person*, or *immediate family member*, legally authorized to render nursing services by the government of the geographical area of his/her practice.

Reasonable and Customary Charges
In relation to a fee, a charge or an expense, means any fee or expense which:
(i) is 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 injured or ill person under the care, supervision or order of a *medical practitioner*;
(ii) does not exceed the usual level of charges for similar treatment, supplies or medical services in the locality where the expense is incurred; and
(iii) does not include charges that would not have been made if no insurance existed.

We reserve the right to determine whether any particular *hospital/* medical charge is a *reasonable and customary charge* with reference including 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 in the locality. *We* also reserve the right to adjust any or all benefits payable in relation to any *hospital*/medical charges which is not a *reasonable and customary charge* based on the above mentioned reference.

Relevant Documents
Relevant documents include *schedule*, enrollment form, declaration, riders, endorsements, attachments and amendments (regardless verbally or in written format).

Schedule
The *schedule* attached to and incorporated in this policy of insurance.

Schedule of Surgical Operations
The attachment to this policy entitled "Schedule of Surgical Operations" which contains a list of surgical operations covered by this policy.

Sickness
A physical condition marked by a pathological deviation from the normal healthy state during the *period of insurance*.

Specialist
A *medical practitioner* other than *you,* the *insured person*, or *immediate family member,* who is legally registered in the Specialist Register of the Medical Council of *Hong Kong*. In the event of treatment or surgical operation received outside *Hong Kong*, it shall mean a *medical practitioner* who can legally practise specialist care in accordance with the equivalent specialty law in the geographical area of his/her practice to render medical and surgical services.

Terrorism
An act of *terrorism* includes any act, preparation or threat of action including the intention to influence any government de jure or de facto of any nation or any political division thereof and/or to intimidate the public or any section of the public of any nation, of any person or group(s) of persons whether acting alone or on behalf of or in connection with any organization(s) or government(s) de jure or de facto committed for political, religious, ideological, or similar purposes, and which
involves violence against one (1) or more persons;
(i) involves damage to property;
(ii) endangers life other than that of the person committing the action;
(iii) creates a risk to the health or safety of the public or a section of the public; or
(iv) is designed to interfere with or disrupt an electronic system.

Total Disablement
When as the result of *injury* and commencing within twelve (12) consecutive months from the date of an *accident* in which the *insured person* is totally and *permanent*ly disabled and prevented from engaging in each and every occupation or employment for compensation or profit for which the *insured person* is reasonably qualified by reason of the *insured person*'s education, training or experience, or if the *insured person has no business or occupation, it means the inability of the insured person to perform any activities which would normally be carried out in the insured person's daily life.*

Upgrade
An increase in the level of benefit and/or plan level.

Upgrade Effective Date
00:00 *Hong Kong* Time on the date *we* agree to provide an *upgrade* of *your* policy and such date is shown on *your* policy *schedule* or endorsement recording that *upgrade*.

Waiting Period
For Sections 1 to 5 of Part 3 – Benefits, thirty (30) days from the *upgrade effective date* or effective date of any additional benefit(s) which is subsequently added (applicable to the *upgraded* portion or additional benefit(s) only), or last reinstatement date, whichever is the later. During such period, no benefit will be payable for any cause, other than in respect of an *accident*. For Section 6 of Part 3 – Benefits, any *critical illness* of which, the signs or symptoms first occurred within ninety (90) days from the *policy inception date*, or *upgrade effective date* for this section (applicable to the upgraded portion only), or last reinstatement date, whichever is the later. During such period, no benefit will be payable for any cause, other than in respect of an *accident*.

War
A contest by force between two (2) or more nations, carried on for any purpose; or armed conflict of sovereign powers; or declared or undeclared and open hostilities; or the state of nations among whom there is i) an interruption of peaceful relations and ii) a general contention by force, both authorized by the sovereign.

We, Us or Our
Zurich Insurance Company Ltd.

You or Your or Yours
The owner of this policy

PART 2 – TABLE OF BENEFITS

Plans and sections contained hereunder are only applicable if it is shown as being operative in the *schedule.*

		Maximum benefit per *insured person* per *disability* (HKD)		
		Essential Plan	**Advanced Plan**	**Deluxe Plan**
Section 1 – Room and Board				
1.1 Room and Board				
Maximum no. of days		182	182	182
Maximum limit per day		750	1,580	3,100
1.2 Room and Board for *Intensive Care Unit*				
Maximum no. of days		15	15	15
Maximum limit per day		2,000	3,000	4,000
1.3 Accompanying Bed Benefit				
Maximum no. of days		60	60	60
Maximum limit per day		400	500	600
Section 2 – Surgical Cover				
2.1 In-*hospital* Doctor's Call Fees				
Maximum no. of days		182	182	182
Maximum limit per day		650	1,200	2,000
2.2 *Hospital* Special Services Charges				
Maximum limit per *disability*		12,000	18,000	30,000
2.3 Surgical Charges				
	Complex	46,000	62,000	93,000
	Major	27,000	36,000	54,000
	Intermediate	11,250	15,000	22,500
	Minor	5,625	7,500	11,250
2.4 *Anaesthetist's* Fee				
	Complex	15,750	21,000	31,500
	Major	9,450	12,600	18,900
	Intermediate	3,938	5,250	7,875
	Minor	1,969	2,625	3,938
2.5 Operating Theatre Charges				
	Complex	15,750	21,000	21,500
	Major	9,450	12,600	18,900
	Intermediate	3,938	5,250	7,875
	Minor	1,969	2,625	3,938
2.6 In-*hospital Specialist* Consultation Fees				
		6,000	8,000	10,000
2.7 Cancer Treatment and Kidney Dialysis Benefit				
(including chemotherapy, radiotherapy, cyberknife, gamma knife or targeted cancer therapy for cancer treatment or kidney dialysis upon recommendation by the *medical practitioner*)		To be covered under Section 2.2 - *Hospital* Special Services Charges of Part 2 - Table of benefits		
2.8 *Day Patient* or *Outpatient* Surgery				
		To be covered under: Section 2.2 - *Hospital* Special Services Charges, &/or Section 2.3 - Surgical Charges, &/or Section 2.4 - *Anaesthetist's* Fee, &/or Section 2.5 - Operating Theatre Charges. of Part 2 - Table of benefits		
2.9 Hospital Cash (for *Confinement* in *Public Hospital*)				
Maximum no. of days		90	90	90
Maximum limit per day		300	450	600
(applicable only to *confinement* in general ward of *public hospital* in *Hong Kong*.)				
2.10 Medical Negligence Benefit				
		30,000	60,000	80,000
Section 3 – Pre-admission and Post-hospitalization Cover				
3.1 Pre-admission and Post-hospitalization *Outpatient* Benefit				
(including two pre-admission visits and all post- hospitalization follow-up visits on *outpatient* basis within 45 days after discharge from *hospital*)		1,500	2,500	4,500
3.2 Home Nursing Fees				
Maximum no. of days		90	90	90
Maximum limit per day		500	600	700
3.3 *Specialist* Treatment due to Specified *Critical Illness** (including all follow-up *outpatient specialist* visits within 90 days from the first date of *diagnosis*)				
Maximum limit per visit		1,500	2,000	3,000
Maximum limit per specified *critical illness*		20,000	30,000	50,000

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	Maximum benefit per *insured person* per *disability* (HKD)		
*applicable to the following *critical illness(es)* only: item 5 - benign brain tumour, item 9 - cancer, item 17 - end stage liver disease, item 19 - heart attack, item 21 - kidney failure and item 27 - major organ transplant defined under Section 6 – *Critical Illness* Cover of Part 3 – Benefits.			
3.4 Artificial Prosthesis and Rental of Wheel Chairs Benefit			
(up to 30 consecutive days immediately after discharge from *hospital*)	10,000	20,000	30,000
3.5 Psychology and Psychiatry Expenses			
(up to 180 consecutive days immediately after discharge from *hospital*)	10,000	15,000	20,000
3.6 Rehabilitation and Physical Therapy Expenses			
(up to 180 consecutive days immediately after discharge from *hospital*)	10,000	15,000	20,000
Complementary Benefits			
a. *Accidental* Death and Disablement Benefit	100,000		
b. Compassionate *Accidental* Death Cash Benefit	10,000		
c. Emergency *Outpatient* Benefit	Maximum 3,000 per policy year		
Optional Benefits (Section 4 – Section 6)			
Section 4a – Supplementary Major Medical Cover			
Maximum limit per *disability*	100,000	200,000	300,000
Reimbursement % of the remaining balance	80%	80%	80%
Section 4b – Voluntary *Deductible*			
As stated in the *schedule* if applicable			
Section 5 – Hospital Cash			
Maximum no. of days	182	182	182
Maximum limit per day	500	750	1,000
Section 6 – *Critical Illness* Cover			
Maximum limit per *disability*	150,000	250,000	500,000

PART 3 – BENEFITS

If the *insured person* is *confined* in a *hospital* (unless otherwise specified under Section 2.8 of this Part) on the recommendation of an attending *medical practitioner* due to *sickness* or *injury* occurring during the *period of insurance* which is *medically necessary*, upon receipt of proof acceptable to *us* and subject to the terms and conditions of this policy, *we* will pay up to the Maximum Benefits shown in the *schedule*. In no event shall the maximum amount payable for any one (1) *disability* exceed the Maximum Benefit as stated under the plan selected in Part 2 – Table of benefits.
If the *medically necessary hospital confinement* of the *insured person* is incurred in a place outside of *Hong Kong*, benefit entitlement stated in Part 2 – Table of benefits shall be adjusted as follows:-

- should the optional benefit(s) under Section 5 is shown as being operative in the *schedule*, *we* will pay the hospital cash under Section 5 for each and every day of *confinement* up to a maximum of thirty (30) days per *disability*.

Section 1 – Room and Board

The maximum amount *we* will pay for any one (1) day is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability* and the maximum amount *we* will pay for any one (1) day for such same *confinement* is the Maximum Benefit shown under the selected plan in Part 2 - Table of benefits.

1.1 Room and Board

We will pay for the actual *reasonable and customary charges* for room and board incurred for the period during which the *insured person* is *confined* in a *hospital* up to maximum of one hundred and eight-two (182) days per *disability*.

1.2 Room and Board for *Intensive Care Unit*

We will pay for the actual *reasonable and customary charges* for room and board incurred for the period during which the *insured person* is *confined* in the *intensive care unit* up to maximum of fifteen (15) days per *disability*.

1.3 Accompanying Bed Benefit

If the *insured person* is *confined* in a *hospital*, *we* shall pay the actual *reasonable and customary charges* charged by the *hospital* for any accompanying bed occupied by one (1) of the *immediate family members* or the *domestic partner*, up to maximum of sixty (60) days per *disability*.

Section 2 – Surgical Cover

2.1 In-*hospital* Doctor's Call Fees

Where the *insured person* is *confined* in a *hospital*, *we* will pay the attending *medical practitioner*'s actual *reasonable and customary charges* for treatment during such *confinement,* up to maximum of one hundred and eighty-two (182) days per *disability*. The maximum amount *we* will pay for any one (1) day is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability* and the maximum amount *we* will pay for any one (1) day for such same *confinement* is the Maximum Benefit shown under the selected plan in Part 2 - Table of benefits.

2.2 *Hospital* Special Services Charges

Where the *insured person* is *confined* in a *hospital*, *we* will pay the actual *reasonable and customary charges* charged by the *hospital* in respect of:

(i) western medication prescribed by the attending *medical practitioner* and consumed during the *confinement* as well as medicines prescribed on the date of discharge for treatment of the same *disability* up to a period of seven (7) days, but excluding medicines for treatment of chronic illnesses, for prophylactic purposes, for recurrent courses after the immediate course of treatment upon discharge and for long term treatment; or
(ii) dressings, ordinary splints and plaster casts but excluding special braces and appliances equipment; or
(iii) implants which is *medically necessary*; or
(iv) physical therapy done during the *confinement* as recommended by the attending *medical practitioner;* or
(v) oxygen and its administration; or
(vi) x-rays, electrocardiograms and other laboratory examinations and tests and diagnostic procedures, the immediate purpose of which is the cure of *disability* as a result of *medical necessity*; or
(vii) intravenous infusions; or
(viii) blood transfusion, blood or plasma and their administration; or
(ix) ambulance service to or from the *hospital*.

This Section 2.2 is not applicable to instruments and other hardware used in an operation including but not limited to anaesthesia machine, gastroscope, colonoscope, lithotripter, x-knife, cyberknife and gamma knife.

2.3 Surgical Charges

Where the *insured person* is *confined* in a *hospital*, *we* will pay the actual *reasonable and customary charges* for surgical operation charged by a *medical practitioner.* The maximum amount payable for any one (1) *disability* shall be the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits subject to the classification of the relevant surgical operation stated in the *schedule of surgical operations*.

(i) If two (2) or more surgical operations are performed for the same *disability* during the same *confinement* period, only the surgical operation with the highest classification as stated on the *schedule of surgical operations* will be reimbursed.
(ii) If two (2) or more surgical operations are performed for the same *disability* or different *disabilities* through the same incision, only the surgical operation with the highest classification as stated on the *schedule of surgical operations* will be reimbursed.
(iii) If two (2) or more surgical operations are performed in the same operation session for the same *disability* or different *disabilities* through different incisions, or if two (2) or more surgical operations are performed for different *disabilities* during the same *confinement* period, the reimbursements for all of the surgical operations are as follows:

(a) 100% of the Maximum Benefit corresponding to the classification, for the surgical operation with the highest classification as stated on the *schedule of surgical operations;*
(b) 50% of the Maximum Benefit corresponding to the classification, for the surgical operation with the second (2nd) highest classification as stated on the *schedule of surgical operations*, or for the second (2nd) surgical operation with the same classification as the first (1st) one;
(c) 25% of the Maximum Benefit corresponding to the classification, for the surgical operation with the third (3rd) highest classification as stated on the *schedule of surgical operations*, or for the third (3rd) surgical operation with the same classification as the first (1st) one.

The maximum number of surgical operations *we* will pay for each and every same *confinement* shall be three (3) only.
If any alternative procedures including X-ray, radium or any other radioactive substances are used for treatment in place of any cutting operation listed in the *schedule of surgical operations*, *we* will, subject to the terms and conditions of this policy, pay the actual *reasonable and customary charges* for such treatment up to the maximum amount payable for the replaced cutting operation stated in the *schedule of surgical operations*.

2.4 *Anaesthetist*'s Fee
Provided that *we* agree to pay the benefit under Section 2.3 – Surgical Charges, *we* will pay the actual *reasonable and customary charges* for anaesthetic fees charged by an *anaesthetist* other than the *medical practitioner* who operates on the *insured person* during the same surgical operation. The maximum amount payable for any one (1) *disability* shall be the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits subject to the classification of the relevant surgical operation stated in the *schedule of surgical operations*.
If two (2) or more surgical operations are performed for the same *disability* or different *disabilities* during the same *confinement* period, benefit entitlement shall be calculated in accordance with clause (i), (ii) and (iii) of Section 2.3 of Part 3 – Benefits above.

2.5 Operating Theatre Charges
Provided that *we* agree to pay the benefit under Section 2.3 – Surgical Charges, *we* will pay the actual *reasonable and customary charges* for the use of the operating theatre or treatment room and the consumables or equipments used for the surgical operation(s) in the operating theatre or treatment room charged by the *hospital.* The maximum amount payable for any one (1) *disability* shall be the Maximum Benefit shown under the plan selected in Part 2 – Table of benefits in accordance with the classification of the relevant surgical operation stated in the *schedule of surgical operations*.
If two (2) or more surgical operations are performed for the same *disability* or different *disabilities* during the same *confinement* period, benefit entitlement shall be calculated in accordance with clause (i), (ii) and (iii) of Section 2.3 of Part 3 – Benefits above.

2.6 In-*hospital Specialist* Consultation Fees
Where the *insured person* is *confined* in a *hospital*, *we* will pay the actual *reasonable and customary charges* for consultation of a *specialist* during the *confinement* as a result of the *sickness* or *injury* for which the *insured person* is admitted provided that such consultation of the *specialist* was recommended by the attending *medical practitioner* in writing.
The maximum amount *we* will pay for any one (1) *disability* is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability* and the maximum amount *we* will pay for such same *confinement* is shown under the selected plan in Part 2 – Table of benefits.

2.7 Cancer Treatment and Kidney Dialysis Benefit
This is an extension of the cover under Section 2.2 of Part 2 – Table of benefits. *We* will pay the actual *reasonable and customary charges* incurred for the following special treatment and any medical expenses arising directly therefrom, recommended in writing by the *insured person*'s attending *medical practitioner* regardless of whether the special treatment is performed during *confinement* or on *outpatient* or *day patient* basis, upon the first *diagnosis* of any kind of cancer or chronic and irreversible kidney failure, including any and all complications arising therefrom or closely related thereto:
(i) Chemotherapy;
(ii) Radiotherapy;
(iii) Cyberknife and/or gamma knife for cancer treatment;
(iv) Renal Dialysis (haemodialysis or peritoneal dialysis); or
(v) Targeted Cancer Therapy.

The maximum aggregate amount payable for treatment specified in this Section 2.7 which may also be payable under Sections 1, 2 and/or 3 in respect of any one (1) *disability* shall be the Maximum Benefit shown in Section 2.2 and Section 2.7 under the selected plan in Part 2 – Table of benefits.
The *insured person* will not be entitled to this benefit if the *insured person* suffers from cancer within ninety (90) days from the *upgrade effective date* or the last reinstatement date, whichever is the later.

2.8 Day Patient/Outpatient Surgery
This is an extension of the cover under Sections 2.2 to 2.5 of Part 2 – Table of benefits. *We* will pay the actual *reasonable and customary charges* for the following items provided that they are in connection with the surgical operation which is actually undertaken on *outpatient* or *day patient* basis by a *medical practitioner*:
(i) Pathological study provided it is (a) directly associated with the surgical operation performed; and (b) performed on the same date as the surgical operation, up to the Maximum Benefit payable under Section 2.2 – Hospital Special Services Charges. The maximum aggregate amount payable for any one (1) disability under Sections 2.2 and 2.8 shall be the Maximum Benefit shown in respect of Section 2.2 under the selected plan in Part 2 – Table of benefits; and/ or
(ii) Surgical charges up to the Maximum Benefit payable under Section 2.3 – Surgical Charges. The maximum aggregate amount payable for any one (1) *disability* under Sections 2.3 and 2.8 shall be the Maximum Benefit shown in respect of Section 2.3 under the selected plan in Part 2 – Table of benefits, subject to the classification of the relevant surgical operation stated in the *schedule of surgical operations*; and/or
(iii) Anaesthetist's fee up to the Maximum Benefit payable under Section 2.4 – Anaesthetist's Fee. The maximum aggregate amount payable for any one (1) *disability* under Sections 2.4 and 2.8 shall be the Maximum Benefit shown in respect of Section 2.4 under the selected plan in Part 2 – Table of benefits, subject to the classification of the relevant surgical operation stated in the *schedule of surgical operations*; and/or
(iv) Operating theatre or treatment room and the consumables or equipments used for the surgical operation, up to the Maximum Benefit payable under Section 2.5 – Operating Theatre Charges. The maximum aggregate amount payable for any one (1) disability under Sections 2.5 and 2.8 shall be the Maximum Benefit shown in respect of Section 2.5 under the plan selected in Part 2 – Table of benefits, subject to the classification of the relevant surgical operation stated in the *schedule of surgical operations*.

2.9 Hospital Cash for *Confinement* in *Public Hospital*
If the *insured person* is *confined* in the general ward of a *public hospital* during the *period of insurance* due to *sickness* or *injury*, *we* will pay the hospital cash for each and everyday of *confinement* up to a maximum of ninety (90) days per *disability*. The maximum amount *we* will pay for any one (1) day is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability* and the most *we* will pay for any one (1) day for such same *confinement* is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

2.10 *Medical Negligence Benefit*
If during the *period of insurance*, due to the *medical practitioner*'s medical negligence in the surgical operation, the *insured person* has suffered from *permanent total disablement* and such negligence is being certified by the registered medical authority in the geographical area of the registered *medical practitioner*'s practice, *we* shall pay the medical negligence benefit to the *insured person* as shown under the selected plan in Part 2 – Table of benefits.

Section 3 – Pre-admission and Post-hospitalization Cover
The benefits payable under this Section 3 are applicable only if the relevant surgical operation is covered by this policy and performed during the *confinement* in a *hospital*.

3.1 Pre-admission and Post-hospitalization *Outpatient* Benefit
We will pay the actual *reasonable and customary charges* charged by the same *medical practitioner* who has operated on the *insured person* for:
(i) two (2) pre-admission *outpatient* visits in connection with such surgical operation (*outpatient* visit includes consultation, medication prescribed, physiotherapy and diagnostic tests); and
(ii) all *medically necessary* follow-up *outpatient* visits directly relating to and as a result of the surgical operation and which are incurred by the *insured person* within forty-five (45) consecutive days immediately after his/her discharge from the *hospital* following the relevant surgical operation for any one (1) *disability*.

The maximum amount *we* will pay for any one (1) *disability* is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all

disabilities during the same *confinement* shall be considered as one (1) *disability* and the aggregate charges for the pre-admission and posthospitalization follow-up *outpatient* treatments as a result to such same *confinement* shall not exceed the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

3.2 Home Nursing Fees

We will pay the actual *reasonable and customary charges* charged by a *qualified nurse* in respect of care service, which is *medically necessary* after the surgical operation, provided to the *insured person* at the *insured person*'s usual residence (not being a nursing or convalescent home). Such service must be recommended in writing by the attending *medical practitioner* and the maximum benefit period shall be ninety (90) consecutive days immediately after the *insured person*'s discharge from the *hospital* following the relevant surgical operation.

The maximum amount *we* will pay for any one (1) day is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

3.3 Specialist* Treatment due to Specified *Critical Illness

We will pay the actual *reasonable and customary charges* charged by the *specialist* for the *insured person*'s follow-up *outpatient* visit for the *critical illnesses* specified in this Section 3.3 which is *medically necessary* within ninety (90) consecutive days immediately following the first date of *diagnosis* of any one (1) of the following *critical illnesses* as defined under Section 6 – *Critical Illness* Cover of this policy. Such *specialist* treatment must be recommended in writing by the attending *medical practitioner*:

(i) Benign Brain Tumour (as defined in clause 5 of Section 6)
(ii) Cancer (as defined in clause 9 of Section 6)
(iii) End Stage Liver Disease (as defined in clause 17 of Section 6)
(iv) Heart Attack (as defined in clause 19 of Section 6)
(v) Kidney Failure (as defined in clause 21 of Section 6)
(vi) Major Organ Transplant (as defined in clause 27 of Section 6)

In the event that the attending *medical practitioner* and the *specialist* is the same person, we will be liable only to pay either the benefits payable under Section 3.1 – Pre-admission and Post-hospitalization *Outpatient* Benefit, or the benefits payable under Section 3.3 – *Specialist* Treatment due to Specified *Critical Illness*, whichever is the higher.

The maximum amount *we* will pay for any one (1) of the *critical illnesses* listed above is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

3.4 Artificial Prosthesis and Rental of Wheel Chairs Benefit

We will pay the actual *reasonable and customary charges* for artificial prosthesis for artificial limb(s) and eyeball(s) only; and rental costs of wheel chairs directly relating to and as a result of the surgical operation of the *insured person* which is recommended in writing by the attending *medical practitioner* provided such charges are incurred during such same *confinement* or within thirty (30) consecutive days immediately after the *insured person*'s discharge from the *hospital* following the surgical operation.

The maximum amount *we* will pay for any one (1) *disability* is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability*. The aggregate costs of prosthesis and rental of wheel chairs incurred in connection with such same *confinement* to be paid by *us* shall not exceed the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

3.5 Psychology and Psychiatry Expenses

We will pay the *medically necessary* costs of the psychological and psychiatric treatments on *outpatient* basis directly relating to and as a result of the surgical operation of the *insured person* which is recommended in writing by the attending *medical practitioner* provided such charges are incurred within one hundred and eighty (180) consecutive days immediately after the *insured person*'s discharge from the *hospital* following the surgical operation.

The maximum amount *we* will pay for any one (1) *disability* is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability* and the aggregate costs of the psychological and psychiatric treatments incurred subsequent to and in connection with such same *confinement* to be paid by *us* shall not exceed the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

3.6 Rehabilitation and Physical Therapy Expenses

We will pay the *medically necessary* costs of the rehabilitation and physical therapy treatments on *outpatient* basis rendered by registered physiotherapist or registered occupational therapist or registered speech therapist or registered prosthetist-orthotist or registered podiatrist directly relating to and as a result of the surgical operation which are recommended in writing by the attending *medical practitioner* provided such charges are incurred within one hundred and eighty (180) consecutive days after the *insured person*'s discharge from the *hospital* following the surgical operation for any one (1) *disability*.

The maximum amount *we* will pay for any one (1) *disability* is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability* and the aggregate costs of the rehabilitation and physical therapy treatments incurred subsequent to and in connection with such same *confinement* to be paid by *us* shall not exceed the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

Complementary Benefits (applicable to *insured person* provided that Sections 1 to 3 of Part 2 – Table of benefits are operative)

a. *Accidental* Death and Disablement Benefit

If during the *period of insurance*, an *insured person* sustains *injury* as a result of an *accident* covered under this policy which results in death or one of the Events in the following Compensation Table within twelve (12) consecutive months of the *accident*, *we* shall pay to the *insured person* the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.

Compensation Table

Events	
Events	
1.	Death
2.	*Permanent Total Disablement*
3.	*Permanent* and Incurable Paralysis of all Limbs
4.	*Permanent* Total *Loss of Sight* of both Eyes
5.	*Permanent* Total *Loss of Sight* of one Eye
6.	Loss of or the *Permanent* Total *Loss of Use* of two Limbs
7.	Loss of or the *Permanent* Total *Loss of Use* of one Limb
8.	Loss of Speech and Deafness (as defined in clauses 24 and 14 of Section 6)

<u>Compensation:</u>

(i) If a limb or organ which had been partially disabled prior to an *injury* becomes totally disabled as a result of such *injury*, the percentage of Maximum Benefit payable shall be determined by *us* having regard to the extent of disablement caused by the *injury*. The *insured person* shall not be entitled to any benefit under this Section in respect of the loss of a limb or organ which was totally disabled prior to the *injury*.

(ii) Benefit shall not be payable for more than one (1) of the Events set out in the Compensation Table above in respect of the same *accident*. Should the *insured person* sustains more than one (1) of the Events as a result of the same *accident*, *we* are liable to pay for one (1) Event only, whichever is the higher, up to the Maximum Benefit payable under this Section.

b. Compassionate *Accidental* Death Cash Benefit

We will pay the Maximum Benefit as stated in Part 2 – Table of benefits to the estate of the *insured person* as emergency cash or for funeral expenses in the event that the *insured person* dies as a result of, and within twelve (12) consecutive calendar months of the date of, an *accident* during the *period of insurance*.

c. Emergency *Outpatient* Benefit

We will pay the actual *reasonable and customary charges* charged by the *hospital* or *medical practitioner* in respect of the emergency treatment given in the *hospital outpatient* department for an *injury* of the *insured person* provided that the emergency treatment is given within forty-eight (48) hours of such *injury*. The maximum amount *we* will pay to any *insured person* in one (1) policy year is set out in Part 2 – Table of benefits.

<u>Special Condition applicable to Complementary Benefits</u>

1. The Complementary Benefits (a) to (c) are only applicable to the *insured person* if all of the Sections 1 to 3 of Part 2 – Table of benefits of this policy are shown as being operative in the *schedule* at the time when any claim is made pursuant to this Section – Complimentary Benefits (a) to (c).
2. The Complimentary Benefits (a) to (c) shall terminate immediately upon payment of any compensation pursuant to Complementary Benefits (a).

Section 4a – Supplementary Major Medical Cover

This benefit is only applicable if it is shown as being operative in the *schedule*. This benefit will provide supplementary cover in respect of the following sections under this policy:

<u>In respect to Section 1.1 – Room and Board and Section 2.1 – In-*hospital* Doctor's Call Fees</u>

If the *insured person* is *confined* in a *hospital* for more than one hundred and eighty-two (182) days, *we* will pay the actual *reasonable and customary charges* for the room and board and in-*hospital* doctor's call

fees subject to the daily limit set out in sections 1.1 and 2.1 of Part 2 under the selected plan in Part 2 – Table of benefits.
In respect to Section 2.2 – *Hospital* Special Services Charges, Section 2.3 – Surgical Charges, Section 2.4 – *Anaesthetist*'s Fee, Section 2.5 – Operating Theatre Charges, Section 2.6 – In*hospital Specialist* Consultation Fees and Section 2.7 – Cancer Treatment and Kidney Dialysis Benefit
When the amount of the actual *reasonable and customary charges* for the medical services incurred in respect of a *disability* exceed the limit of the selected plan as shown in Part 2 – Table of benefits, *we* will pay up to eighty percent (80%) of the remaining balance of such actual *reasonable and customary charges* in excess of such limit. The maximum amount *we* will pay in aggregate for any one (1) *disability* under this Section 4a is the Maximum Benefit as shown under the selected plan in Part 2 – Table of benefits.
Special Conditions applicable to Section 4a only
1. The plan level selected in respect of Section 4a must be the same as the one selected in respect of Sections 1 to 3 of Part 2 – Table of benefits.
2. This section is only available to the *insured person* if all of the Sections 1 to 3 of Part 2 – Table of benefits are shown as being operative in the *schedule*.

Section 4b - Voluntary *Deductible*
A discount on the policy premium payable in respect of sections 1 to 3 of Part 2 – Table of benefits will be offered to the *insured person* who voluntarily accepts a *deductible* for each and every claim made under Sections 1 to 3 of this policy. The amount of *deductible* selected is set out in the *schedule*.
In the event that the *insured person* has received, or is entitled to receive, a reimbursement of the medical expenses under other policy(s) from *us* or other insurer(s) for a *disability* covered by this policy, the maximum amount *we* pay under this policy will be the remaining balance of the medical expenses after deducting either the *deductible*, or the reimbursement paid under other policy(s), whichever deducted amount is the higher, up to the Maximum Benefit as shown under the selected plan in Part 2 – Table of benefits.
The *insured person* can apply to reduce or remove the *deductible* once before Termination of Policy pursuant to clause 15 under Part 6 – General provisions without the need to provide health declaration only upon one of the following circumstances:
- anniversary of the *policy effective date* immediately subsequent to the *insured person*'s birthday of 50, 55, 60 or 65 years old. Removal or reduction of *deductible* will be effective on the anniversary of the *policy effective date* immediately subsequent to the *insured person*'s birthday of 50, 55, 60 or 65 years old; or
- anniversary of the *policy effective date* immediately subsequent to the *insured person*'s new employment date or marriage date or the date(s) of birth of his/her child(ren) or the date of his/her university graduation. Removal or reduction of *deductible* will be effective on the anniversary of the *policy effective date* immediately subsequent to the date of occurrence of the above event for which the *insured person* applied removal or reduction of *deductible*. For the avoidance of doubt, the event for which the *insured person* applied removal or reduction of *deductible* must occur within the policy year immediately before the anniversary of the *policy effective date* on which the reduction or removal of *deductible* is effective.

To reduce or remove the *deductible*, the *insured person* must give no less than thirty (30) days' notice in writing to *us* and provide the proof accepted by *us* before such anniversary of the *policy effective date*.
Special Conditions applicable to Section 4b only
1. The plan level selected in respect of Section 4b must be the same as the one selected in respect of Sections 1 to 3 of Part 2 – Table of benefits.
2. If the *insured person* is insured under other medical policy(s) underwritten by other insurer(s) (including group medical cover provided by the *insured person*'s employer) with same or similar medical benefits as those under Sections 1 to 3 of Part 2 – Table of benefits of this policy, the *insured person* must make a claim against such other policy(s) before making any claim against this policy.
3. This section is only available to the *insured person* if all of the Sections 1 to 3 of Part 2 – Table of benefits of this policy are shown as being operative in the *schedule*.

Section 5 – Hospital Cash
This benefit is only applicable if it is shown as being operative in the *schedule*.
If the *insured person* is *confined* in *hospital* during the *period of insurance* due to *sickness* or *injury, we* will pay the hospital cash for each and every day of *confinement* evidenced by the full day room and board charges made by the *hospital.*
The maximum amount *we* will pay for any one (1) day is the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits. The maximum number of days payable in respect of each *disability* is also shown under the selected plan in Part 2 – Table of benefits. In the event that the *insured person* is *confined* in the *hospital* for surgical operation or treatment of more than one (1) *disability*, all *disabilities* during the same *confinement* shall be considered as one (1) *disability* and the maximum amount *we* will pay for any one (1) day during such same *confinement* is shown under the plan selected in Part 2 – Table of benefits.
Special Condition applicable to Section 5 only
This section is only available to the *insured person* if all of the Sections 1 to 3 of Part 2 Table of benefits of this policy are shown as being operative in the *schedule*.

Section 6 – *Critical Illness* Cover
This benefit is only applicable if it is shown as being operative in the *schedule*. Each *critical illness* is defined in the relevant paragraph of this Section 6. For the purpose of claiming a benefit, the *diagnosis* of a *critical illness* must correspond to the definition of the relevant *critical illness.*
We will pay the Maximum Benefit as shown under the selected plan in Part 2 – Table of benefits to the *insured person* if the *insured person* is *diagnosed* by a *specialist* during the *period of insurance* to be suffering from, or if the *insured person* undergoes a surgical operation in respect of, any one (1) of the following *critical illnesses*:

1. HIV due to Blood Transfusion
The *insured person* being infected by Human Immunodeficiency Virus (HIV) provided that:
(i) The infection is due to a blood transfusion, transfusion with blood products or an organ transplant to the *insured person* received after *policy inception date*;
(ii) The institution which provided the transfusion admits liability or there is a final court verdict that cannot be appealed indicating such liability; and
(iii) The infected *insured person* is not a haemophiliac.

This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS.
Infection in any other manner, including but not limited to infection as a result of sexual activity or intravenous drug use is excluded. *We* must have open access to all blood samples and be able to perform independent testing of such blood samples.

2. Alzheimer's Disease
The *insured person* must be *aged* seventy (70) or below at the time of first *diagnosis*. Alzheimer's Disease is a progressive degenerative disease of the brain characterised by diffuse atrophy throughout the cerebral cortex with distinctive histopathologic changes.
The *diagnosis* must be confirmed in writing by a registered *specialist* in neurology, and all of the following conditions must be fulfilled:
(i) Permanent irreversible failure of brain function;
(ii) Standardized tests must prove a significant cognitive impairment due to Alzheimer's Disease;
(iii) Diffuse atrophy throughout the cerebral cortex confirmed by Magnetic Resonance Imaging (MRI) or Computerised Tomography (CT), and other pathology like brain tumor or blood clot has been ruled out; and
(iv) The severity of the disease shall be such that there will be at least three (3) of the *activities of daily living* which the *insured person* will, for a continuous period of not less than one hundred and eighty (180) days, have been unable to perform without the assistance of another person.

No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses. Dementia relating to alcohol, drug abuse or AIDS are excluded.

3. Apallic Syndrome
Universal necrosis of the brain cortex with the brainstem remaining intact. The *diagnosis* should be in permanent nature and must be confirmed by a *specialist* in neurology and this condition must be documented for at least thirty (30) days.

4. Aplastic Anaemia
I r reversible bone marrow failure resulting in anaemia, neutropenia and thrombocytopenia. The *diagnosis* must be confirmed by a *specialist* in hematology and based on a bone marrow biopsy. Two (2) out of the following three (3) values should be presented in blood test:
(i) Absolute neutrophil count of five hundred (500) per cubic millimeter or less;
(ii) Absolute reticulocyte count of twenty thousand (20,000) per cubic millimeter or less; and

(iii) Platelet count of twenty thousand (20,000) per cubic millimeter or less.

5. Benign Brain Tumour

A benign tumour in the brain where all of the following conditions are met:

(i) It is life threatening;
(ii) It has caused damage to the brain;
(iii) It has undergone surgical removal by crainiotomy or, if inoperable, has resulted in the permanent inability to perform, without assistance, at least three (3) of the activities of daily living for a continuous period of at least one hundred and eighty (180) days. This has to be confirmed by a specialist in neurology; and
(iv) Its presence must be confirmed by a *specialist* in neurology or neurosurgeon and supported by findings on Magnetic Resonance Imaging MRI, Computerised Tomography (CT), or other reliable imaging techniques.

The following are excluded:

(i) Cysts;
(ii) Granulomas;
(iii) Vascular Malformations;
(iv) Haematomas;
(v) Tumours of the pituitary gland or spinal cord; and
(vi) Meningioma

6. Blindness

Total and irreversible *loss of sight* in both eyes as a result of disease or *accident*. The *diagnosis* must be confirmed by a *specialist* in ophthalmology. No benefit will be payable if in general medical opinion a device or implant could result in the partial or total restoration of sight.

7. Brain Damage

Permanent neurological impairment or loss of intellectual capacity as a result of Brain Damage sustained through *accident* or *injury*. Permanent neurological impairment must be *diagnosed* by a neurology *specialist*.

8. Brain Surgery

The actual undergoing of surgery to the brain under general anaesthesia during which a keyhole surgery is performed but brain surgery as a result of an *accident* is excluded. The procedure must be *diagnosed* and considered *medically necessary* by a qualified *specialist*.

9. Cancer

Cancer shall mean a malignant tumour characterized by progressive, uncontrolled growth, spread of malignant cells with invasion and destruction of normal and surrounding tissue. Major interventionist treatment or major surgery must be considered *medically necessary* or palliative care must have been initiated. The cancer must be positively *diagnosed* with histopathological confirmation. Cancer includes Leukaemia, but the following are excluded:

(i) All cancers which are histologically classified as any of the following:
    (a) pre-malignant, for example essential thrombocythaemia and polycythaemia rubra vera;
    (b) non-invasive;
    (c) having either borderline malignancy; or
    (d) having low malignant potential.
(ii) Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia, cervix intra-epithelial neoplasia CIN-1, CIN-2 & CIN-3) or which are histologically described as pre-malignant conditions or non-invasive cancers;
(iii) Tumours of the ovary classified as T1aN0M0, T1bN0M0 or FIGO 1A, FIGO 1B;
(iv) Duke's A colo-rectal cancer;
(v) Prostate cancers which are histologically described as TNM Classification T1 (including T1a,T1b or T1c) or another equivalent or lesser classification;
(vi) Chronic lymphocytic leukaemia less than RAI Stage 3;
(vii) Papillary micro-carcinoma of the thyroid;
(viii) Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification;
(ix) All skin cancers, unless there is evidence of metastases or the tumour is a malignant melanoma of greater than 1.5 mm in thickness as determined by a histological examination using the Breslow method; and
(x) All tumours in the presence of Human Immunodeficiency Virus (HIV) infection.

10. Chronic/End Stage Lung Disease

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

(i) A consistent forced expiratory volume (FEV1) test value of less than one (1) liter (during the first second of a forced exhalation);
(ii) Requiring permanent supplementary oxygen therapy for hypoxemia for at least eight (8) hours per day;
(iii) Arterial blood gas analyses repeatedly showing partial oxygen pressures of 50mmHg or less (PaO2 < 50mmHg); and
(iv) Dyspnea at rest.

The *diagnosis* must be confirmed by a pulmonary *specialist*.

11. Chronic Relapsing Pancreatitis

More than three (3) medically documented attacks of pancreatitis resulting in pancreatic dysfunction causing malabsorption needing enzyme replacement therapy. The *diagnosis* must be made by a gastroenterologist and confirmed by Endoscopic Retrograde Cholangio Pancreatography (ERCP).

Chronic Relapsing Pancreatitis caused by alcohol abuse is excluded.

12. Coma

A state of unconsciousness with no reaction to external stimuli or internal needs and all of the following conditions must be fulfilled:

(i) Rated three points on the Glasgow Coma Scale;
(ii) Requires the use of life support systems for a continuous period of at least ninety six (96) hours; and
(iii) Results in permanent neurological deficit with persisting clinical symptoms lasting for at least a continuous period of thirty (30) days.

The *diagnosis* must be confirmed by a *specialist*. Coma caused by alcohol or drug abuse are excluded.

13. Coronary Artery By-pass Surgery

The actual undergoing of sternotomy and 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 *specialist* in cardiology.

Angioplasty and all other intra arterial, catheter based techniques or laser procedures are excluded from this definition.

14. Deafness

Total, irreversible loss of hearing in both ears for all sounds as a result of *sickness* or *injury*. Medical evidence to be supplied by a *specialist* in Ear, Nose and Throat (ENT) and to include audiometric and sound-threshold test for the *diagnosis*.

No benefit will be payable if in general medical opinion a hearing aid, device, or implant could result in the partial or total restoration of hearing.

15. Elephantiasis

End stage lymphatic filariasis, characterized by massive enlargement and disfiguration of the infected tissues of the body (legs, genitals or breasts) as a result of obstructed circulation in lymphatic system by filariae parasites.

Unequivocal *diagnosis* of elephantiasis with permanent lymphatic obstruction must be clinically confirmed by an appropriate *specialist*, including laboratory confirmation showing circulating filariae antigen or microfilariae in a blood smear (Wuchereria bancrofti or Brugia malayi). Other forms of lymphoedema or acute lymphangitis are specifically excluded.

16. Encephalitis

Severe inflammation of the brain (cerebral hemisphere, brainstem or cerebellum). The disease must result in significant complications lasting a continuous period of at least one hundred and eighty (180) days, which include permanent neurological deficit. The resultant significant Permanent Neurological Deficit must be confirmed in writing by a *specialist* in neurology.

Encephalitis caused by Human Immunodeficiency Virus (HIV) infection is excluded.

17. End Stage Liver Disease

End stage liver disease or cirrhosis means chronic end-stage liver failure that causes all of the following:

(i) Ascites;
(ii) Renal impairment;
(iii) Oesophageal or gastric varices or variceal haemorrhage; and
(iv) Hepatic encephalopathy.

Liver disease caused directly or indirectly, wholly or partly by alcohol or drug abuse is excluded.

18. Fulminant Viral Hepatitis

A sub-massive to massive necrosis of the liver due to the hepatitis virus, leading to rapid liver failure. The *diagnosis* must be evidenced as secondary to the hepatitis virus, and all of the following must be demonstrated:

(i) Rapid decrease in liver size;
(ii) Rapid deterioration of liver function tests;
(iii) Deepening jaundice; and
(iv) Necrosis of entire liver lobules, leaving only a collapsed reticular framework. Evidence of the following must be produced:
(i) Liver function test to show massive parenchymal liver disease; and
(ii) Objective signs of portasystemic encephalopathy. Liver failure caused directly or indirectly, wholly or partly, by attempted suicide, poisoning or drug or alcohol abuse is excluded.

19. eart Attack
A definite first occurrence and *diagnosis* of the 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 of myocardial infarction (for example, characteristic chest pain);
(ii) New characteristic electrocardiographic changes indicating myocardial infarction; and
(iii) The characteristic rise of cardiac enzymes or Troponins recorded at the following levels or higher:
  (a) Troponin T > 1.0 ng/ml
  (b) AccuTnI > 0.5 ng/ml or equivalent threshold with other Troponin I methods.
The evidence must show a definite acute myocardial infarction. Other acute coronary syndromes including but not limited to angina are excluded. The *diagnosis* must be confirmed by a *specialist* in cardiology.

20. Heart Valve Surgery
The first occurrence of open-heart surgery via thoracotomy, performed to replace or repair one (1) or more heart valves, as a consequence of defects that cannot be repaired by intra arterial catheter procedures alone. The surgery must be considered *medically necessary* with recommendation by a *specialist* in cardiology and supported by appropriate investigations. Catheter based techniques including but not limited to balloon valvotomy or valvuloplasty are excluded from this definition.

21. Kidney Failure
A definite *diagnosis* of chronic and irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The *diagnosis* must be confirmed by a *specialist*.

22. Loss of Independent Existence
The *insured person* must be *aged* eighteen (18) or above and up to seventy (70) years old at the time of first *diagnosis*.
Confirmation by a *specialist* of the loss of independent existence, resulting in a permanent inability to perform any three (3) of the *activities of daily living* (either with or without the use of mechanical equipment, special devices or other aids or adaptations in use for disabled persons) for a continuous period of at least six (6) months.
Loss of Independent Existence caused by psychological or psychiatric related causes are excluded.

23. Loss of Limb
Complete severance of two (2) or more limbs at or above the wrist or ankle through *sickness* or *accident*. The *diagnosis* of loss of limbs must be confirmed by a *specialist*.

24. Loss of Speech
Total and irrecoverable loss of the ability to speak which must be established for a continuous period of three hundred and sixty five (365) days. Medical evidence is to be supplied by an Ear, Nose and Throat (ENT) *specialist* for the *diagnosis* and to confirm *sickness* or *injury* to the vocal cords.
The condition must not be able to be corrected by medical procedure. No benefit will be payable if in general medical opinion any aid, device, treatment or implant could result in the partial or total restoration of speech. Loss of speech caused by psychological or psychiatric related causes are excluded.

25. Major Burns
Third degree burns covering at least twenty percent (20%) of the total body surface of the *insured person* as measured by The Rule of Nines or the Lund and Browder Body Surface Chart and the *diagnosis* of severe burns must be confirmed by a *specialist*.

26. Major Head Trauma
Accidental head *injury* resulting in significant and permanent neurological deficit which has lasted for a minimum period of ninety (90) days from the date of the trauma or *injury*. The condition must cause permanent and irreversible inability of the *insured person* to perform at least three (3) of the *activities of daily living* without the assistance of another person.
This *diagnosis* must be confirmed by a *specialist* in neurology and supported by unequivocal findings on Magnetic Resonance Imaging (MRI), Computerised Tomography (CT), or other reliable imaging techniques.

27. Major Organ Transplant
A definite *diagnosis* of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow. The *insured person* as a recipient must actually undergo a transplant of one or more of the below organs:
(i) One of the following whole human organs: heart, lung, liver, kidney or pancreas; or
(ii) Human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation.
In respect of this contract, liver means at least one lobe of the liver, lung means at least two lobes of a lung, haemopoietic stem cells include bone marrow stem cells, peripheral blood stem cells and umbilical blood stem cells.
The transplant must be *medically necessary* and based on objective confirmation of organ failure made by a *specialist*. Other than the above, the transplantation of any other organs, part of an organ, tissues or cells, stem cell transplants and islet cell transplants are excluded.

28. Motor Neurone Disease
A progressive degenerative disorder of the motor neurons of the cerebral cortex resulting in widespread weakness on an upper motor neuron basis. Clinically it is characterised by progressive spastic weakness of the limbs, preceded or followed by spastic dysarthria and dysphagia, indicating combined involvement of the corticospinal and corticobulbar tracts. The *diagnosis* must be confirmed by a *specialist* in neurology and supported by appropriate neuromuscular testing such as Electromyogram (EMG).

29. Multiple Sclerosis
A disease due to demyelination of neurological brain tissue. A *specialist* in neurology must make a *diagnosis* of clinically definite Multiple Sclerosis. The *diagnosis* must be supported by all of the following:
(i) Investigations which unequivocally confirm the *diagnosis* to be Multiple Sclerosis;
(ii) Multiple neurological deficits involving any combination of deficit in the optic nerves, brain stem, spinal cord, co-ordination or sensory function, which occurred over a continuous period of at least one hundred and eighty (180) days; and
(iii) Well documented history of exacerbations and remissions of said symptoms or neurological deficits.
Other causes of neurological damage such as Systemic Lupus Erythematosus (SLE) and Human Immunodeficiency Virus (HIV) are excluded.

30. Muscular Dystrophy
Muscular Dystrophies are a group of genetic degenerative myopathies characterized by weakness and atrophy of muscle without involvement of the nervous system. The *diagnosis* must be made by a *specialist* in neurology and supported by all of the following:
(i) Neurological deficit resulting in the permanent and irreversible inability of the *insured person* to move indoors from room to room on level surfaces (whether aided or unaided).
(ii) Clinical presentation including absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction;
(iii) Confirmed by appropriate neuromuscular testing such as Electromyogram (EMG); and
(iv) Confirmed by muscle biopsy.

31. Occupationally Acquired HIV
Infection with the Human Immunodeficiency Virus (HIV) where the virus is acquired as the result of:
(i) An *injury* occurring during the course of the *insured person*'s normal occupation; or
(ii) Occupational handling of blood or other body fluids.
All of the following conditions must be fulfilled for a valid claim:
(i) The infection must have incurred while the *insured person* worked in his/her profession and the profession must be on the list below;
(ii) The *accident* must involved a definite source of the HIV infected fluids;
(iii) The *accident* giving rise to the HIV Infection must be reported to *us* within thirty (30) days of the *accident* ; and
(iv) The *insured person* must provide proof of sero-conversion from HIV negative to HIV positive occurring within the one hundred and eighty (180) days after the reported incident. This proof must include a negative HIV antibody test within five (5) days of the *accident*.
The list is restricted to the following professions:
(i) Doctors and dentists;

(ii) Nurses;
(iii) Laboratory personnel;
(iv) Ancillary *hospital* workers;
(v) Medical and dental assistants;
(vi) Ambulance personnel;
(vii) Midwives;
(viii) Fire brigades;
(ix) Policemen/-women; or
(x) Prison officers.

This benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS.
Infection in any other manner, including but not limited to infection as a result of sexual activity or intravenous drug use is excluded.
We must have open access to all blood samples and be able to perform independent testing of such blood samples.

32. Paralysis
Paralysis means the total and irreversible loss of function of two (2) or more limbs as a result of *injury* to, or disease of the spinal cord or brain. Limb is defined as the complete arm (including both upper arm and forearm) or the complete leg (including both upper leg and lower leg).
Such functional loss is considered to be permanent by a *specialist* in neurology and has been present for at least one hundred and eighty (180) consecutive days.
Paralysis due to self-infliction, partial paralysis, temporary post-viral paralysis, or paralysis due to psychological causes are excluded.

33. Parkinson´s Disease
The *insured person* must be *aged* seventy (70) or below at the time of first *diagnosis*. A slowly progressive degenerative disease of the central nervous system with degeneration of neurones in a region of the brain that causes a reduction of dopamine levels in parts of the brain. The disease must be unequivocally *diagnosed* by a *specialist* in neurology and all the following conditions must be fulfilled:
(i) The disease cannot be controlled with medication;
(ii) The disease shows definite signs of progressive and permanent neurological impairment; and
(iii) At least three (3) of the *activities of daily living* which the *insured person* will, for a continuous period of at least one hundred and eighty (180) days, have been unable to perform without the assistance of another person.

All other types of Parkinsonism are excluded.

34. Permanent Total Disablement
The *insured person* has become totally and irreversibly disabled as a result of *sickness* or *injury*. The *insured person* must be totally incapable of being employed or engaged in any work or any occupation whatsoever for remuneration or profit. The *disability* must have lasted without interruption for at least six (6) consecutive months. Permanent total *loss of use* of both hands or both feet or both eyes, or a combination of any two (2), is included.

35. Poliomyelitis
Unequivocal *diagnosis* by a *specialist* in neurology of infection by the poliovirus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. This condition has to be medically documented for a continuous period of at least ninety (90) days. Cases not involving paralysis will not be eligible for this. Other causes of paralysis are specifically excluded.

36. Primary Pulmonary Arterial Hypertension
Primary Pulmonary Arterial Hypertension is the pathological increase of pulmonary artery pressure due to structural, functional or circulatory disturbances of the lung leading to right heart strain and failure. The disease must result in permanent and irreversible physical impairment to the degree of at least Class 4* of the New York Heart Association Classification of cardiac impairment. The *diagnosis* must be confirmed by a *specialist* and needs to be supported by data provided at cardiac catheterization. The *diagnosis* must be made by a *specialist* supported by data provided at cardiac catheterization and all of the following must be demonstrated:
(i) Mean pulmonary artery pressure > 40mmHG;
(ii) Pulmonary vascular resistance > 3(mmHG/L)/min; and
(iii) Normal pulmonary wedge pressure < 15mmHg.

Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, diseases of the left side of the heart and congenital heart disease specifically excluded.
*Class 4 of the New York Heart Association 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.

37. 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) Hips
(vi) Knees
(vii) Ankles

The *diagnosis* must be confirmed by a *specialist* and supported by all of the following:
(i) The diagnostic criteria of The American College of Rheumatology;
(ii) Permanent inability to perform at least two (2) of the *activities of daily living* which the *insured person* will have been unable to perform without the assistance of another person; and
(iii) All of the above conditions have been present for a continuous of at least one hundred and eighty (180) days.

38. Stroke
A cerebrovascular incident resulting in irreversible death of brain cells due to infarction of brain tissue, haemorrhage or embolisation from an extra-cranial source. This *diagnosis* must be supported by all of the following conditions:
(i) Evidence of permanent neurological damage confirmed by a *specialist* in neurology at least ninety (90) days after the event; and
(ii) Findings on Magnetic Resonance Imaging (MRI), Computerised Tomography (CT), 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 including infarction of the optic nerve or retina;
(iv) Ischaemic disorders of the vestibular system;
(v) Asymptomatic silent stroke found on imaging; or
(vi) Lacunar infarction.

39. Surgery to Aorta
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. The surgery must be considered *medically necessary* by a *specialist*.
Surgery to treat peripheral vascular disease of the aortic branches is excluded even if a portion of aorta is removed during the operative procedure. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

40. Systemic Lupus Erythematosus
Systemic Lupus Erythematosus with Lupus Nephritis means an autoimmune disease in which tissues and cells are damaged by deposition of pathogenic autoantibodies and immune complexes.
The *diagnosis* of Systemic Lupus Erythematosus with Lupus Nephritis must be confirmed by a *specialist* and based on all of the following criteria:
(i) Clinically there must be at least four (4) out of the following presentations suggested by The American College of Rheumatology:
  (a) Malar rash
  (b) Discoid rash
  (c) Photosensitivity
  (d) Oral ulcers
  (e) Arthritis
  (f) Serositis
  (g) Renal disorder
  (h) Leukopenia (<4,000/mL);
  or Lymphopenia (<1,500/mL);
  or Haemolytic anaemia,
  or Thrombocytopenia (<100,000/mL)
  (i) Neurological disorder
(ii) Two (2) or more of the following tests being positive:
  (a) Anti-nuclear Antibodies
  (b) L.E. cells
  (c) Anti-DNA
  (d) Anti-Sm (Smith IgG Autoantibodies)
(iii) There is lupus nephritis causing impaired renal function with a creatinine clearance rate of thirty (30)ml per minute or less.

41. Terminal Illness
The *insured person* must be *aged* seventy (70) or below at the time of first *diagnosis*. The conclusive *diagnosis* of an illness other than the *critical illnesses* as defined in Section 6 – *Critical Illness* Cover of Part 3 – Benefits that is expected to result in the death of the *insured person* within three hundred and sixty five (365) days. The *insured person* must no longer be receiving active treatment other than that for pain relief or other conservative palliative measures and the *diagnosis* must be supported by a specialist and confirmed by *our* appointed *medical practitioner*. Terminal Illness in the presence of Human Immunodeficiency Virus (HIV) infection is excluded.

Special Conditions applicable to Section 6 only

1. The amount payable to the *insured person* upon the *diagnosis* of a *critical illness* shall be one hundred percent (100%) of the Maximum Benefit shown under the selected plan in Part 2 – Table of benefits.
2. *Our* liability to pay and *your* entitlement to the benefit under Section 6 shall cease once one hundred percent (100%) of the Maximum Benefit for Section 6 – *Critical Illness* Cover is paid by *us* to the *insured person* under this policy. *Your* liability to pay the premium for Section 6 will cease accordingly.
3. This section is only available to the *insured person* if all of the Sections 1 to 3 of Part 2 – Table of benefits are shown as being operative in the *schedule*.

Exclusions applicable to Section 6 only
This policy shall not cover any *critical illness* which is caused directly or indirectly by any one (1) or more of the following:-

1. Failure to seek or follow any medical advice of a *medical practitioner*.
2. Any *sickness* or *injury* other than those defined as *critical illness* in this Section 6.
3. Any *critical illness* of which, the signs or symptoms first occurred within ninety (90) days from the *policy inception date*, or *upgrade effective date* for this section (applicable to the *upgraded* portion only), or last reinstatement date, whichever is the later (this exclusion shall not apply if the *critical illness* is caused by an *accident*).
4. Any *critical illness* from which the *insured person* dies within thirty (30) days after the *diagnosis* (this exclusion shall not apply if the *critical illness* is caused by an *accident*).

PART 4 – ZURICH EMERGENCY ASSISTANCE

The service provider of Zurich Emergency Assistance will provide the following services in the event that the *insured person* sustains *sickness* or *injury* during the *period of insurance* whilst the *insured person* is travelling outside of *Hong Kong* for a period not exceeding ninety (90) days:

1. Home Nursing Care Referral (Applicable in *Hong Kong*)
Upon the request of the *insured person*, the service provider of Zurich Emergency Assistance shall arrange to send a baby sitter, domestic helper or *qualified nurse* to the *insured person*'s residence in *Hong Kong* to provide care services to the *insured person*'s child(ren), *family member(s)* or *domestic partner*. The cost of this service shall be borne solely by the *insured person*.

2. Telephone Medical Advice (Applicable outside *Hong Kong*)
Medical advice to assist in stabilizing the *insured person*'s medical condition can be provided over the telephone whilst the *insured person* travels outside of *Hong Kong*. Such advice shall not be construed as a diagnosis.

3. Medical Service Provider Referral (Applicable outside *Hong Kong*)
Details of medical service providers' including name, address, telephone number of medical practitioners, *hospitals*, clinics can be provided upon *insured person*'s request. Any medical services used and expenses incurred, if any, shall be borne solely by the *insured person*.

4. Arrangement of *Hospital* Admission Deposit (Applicable outside *Hong Kong*)
If the *insured person,* whilst travelling outside of *Hong Kong,* is admitted to a *hospital* which requires *hospital* admission deposit, an *hospital* admission deposit up to a maximum of HKD 39,000 can be provided subject to prior approval by *us*. This deposit shall be fully refunded to *us* and any medical services used and expenses incurred, if any, shall be borne solely by the *insured person*.

Zurich Emergency Assistance is rendered by a service provider which is nominated by Zurich Insurance Company Ltd. Please call *our* 24-hour emergency hotline in *Hong Kong* at +852 2886 3977 for assistance.

PART 5 - EXCLUSIONS

This policy will not cover any claim arising directly or indirectly from:

1. any *pre-existing condition*;
2. any treatment or expenses incurred within the *waiting period*;
3. any condition resulting from childbirth, miscarriage, abortion, pregnancy, including but not limited to pregnancy test, pre-natal care as well as post-natal care and other complications arising from pregnancy, contraceptive or contraceptive devices, infertility or any other method of inducing pregnancy, sterilization of either sex; venereal diseases;
4. cosmetic surgery or plastic surgery for purposes of beautification except as necessitated by an *accident;* elective treatment; treatment for the purpose of weight reduction or gain regardless of the existence of morbid or comorbid conditions;
5. any dental surgery of any nature whatsoever except for necessary procedure on the damage to sound and natural teeth as a result of an *accident* occurring during the *period of insurance*; benefit is payable purely for emergency condition and to alleviate the pain and in a legally registered dental clinic or *hospital* but in all circumstances shall not cover any restorative or remedial work, the use of any precious metals, orthodontic treatment of any kind, replacement of natural teeth, denture and prosthetic services such as bridges and crowns, their replacement and related expenses;
6. *hospital confinement* for the purpose of convalescence, custodial, rest care, palliative care, sanitaria care or rehabilitation; or medical expenses incurred not in accordance with the diagnosis and treatment of the condition for which the *confinement* is required;
7. acquisition of the organ to be used for organ transplantation and all expenses incurred by the donor, who is someone other than the *insured person*, including all costs related to organ donation as the donor;
8. congenital abnormalities existing at the time of birth or neo-natal abnormalities developing before the *insured person* attains the *age* of eight (8), including but not limited to hernias of all types (except when caused by a trauma after commencement of this policy), epilepsy, strabismus, hydrocephalus, undescended testicle, hypospadias and Meckel's diverticulum;
9. vaccination or inoculations, general check-up, screening and preventive care; expenses relating to sleep test for sleep apnoea; routine eye test, refractive errors of the eyes or their corrective measures;
10. procurement or use of appliances, equipment (unless specified otherwise in this policy), including but not limited to hearing aids, brace, crutch, spectacle or any other similar kind;
11. suicide, attempted suicide, intentional self-injury, insanity or any functional disorder or psychiatric condition of the mind, including but not limited to psychoses, neuroses, depression of any kind, anorexia nervosa, bulimia, gender reassignment, schizophrenia and other behavioral disorders (except under the circumstance covered by Section 3.5 – Psychology and Psychiatry Expenses of Part 3 – Benefits of this policy); or under the influence of alcohol or drugs other than as prescribed by *medical practitioner*;
12. participation in any illegal activity, including but not limited to robbery, drug abuse or assault;
13. air travel except as a fare-paying passenger in a properly licensed aircraft operated by a licensed commercial air carrier; riding or driving in any kind of motor racing, or engaging in a sport in a professional capacity or where the *insured person* would or could earn income or remuneration from engaging in such sport, trekking at an altitude greater than 5,000 meters above sea level or diving to a depth greater than 40 meters below sea level;
14. any *disabilities* for which compensation is payable under any law, regulation or for which benefits are payable under any other insurance policies underwritten by any other insurer(s) except to the extent that such claim is not fully reimbursed under or pursuant to such law, regulation or other policies;
15. HIV (Human Immunodeficiency Virus) and/or HIV-related illness including AIDS (Acquired Immune Deficiency Syndrome) and/or any mutant derivative or variations thereof however caused or however named. This exclusion shall not apply if the *diagnosis* is item 1– AIDS due to Blood Transfusion and/or item 31– Occupationally Acquired HIV of Section 6 – *Critical Illness* Cover of Part 3 – Benefits of this policy;
16. *war*, invasion, act of foreign enemy, hostilities (whether *war* has been declared or not), *civil war*, rebellion, revolution, insurrection, military or usurped power, direct participation in strike, riot or civil commotion or any kinds of participation in any act of *terrorism*; and/or

17. ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel, or from any nuclear weapons material.
18. Any *cyber act* that results in any *accident*, *disability*, *sickness* and/or *injury*.

PART 6 – GENERAL PROVISIONS

1. Entire Contract

This policy including all the *relevant documents* will constitute the entire contract between the parties. No agent or other person has the authority to change or waive any provision of this policy. No changes in this policy shall be valid unless approved by *our* authorized officer and evidenced by endorsement of such amendment. For avoidance of doubt, the *relevant documents* will form part of the renewed policy contract and information contained are deemed to remain true and valid as at the time of renewal unless otherwise instructed by *you.*

2. *Age* Limit and Eligibility

Unless otherwise specified, for Sections 1 to 5 under Part 3 – Benefits of this policy, the *age* of the *insured person* must be between fifteen (15) days and sixty-four (64) years old (both inclusive) at the *policy inception date* and Sections 1 to 5 of this policy is renewable up to the *age* of one hundred (100) years old. All benefits under Sections 1 to 5 of this policy shall terminate on the anniversary of the *policy effective date* following the *insured person*'s 101st birthday. For Section 6 – *Critical Illness* Cover under Part 3 – Benefitsof this policy, the *age* of the *insured person* must be between fifteen (15) days to sixty-four (64) years old (both inclusive) at the *policy inception date* and this Section 6 is renewable up to seventy-five (75) years of *age.* All benefits under Section 6 shall terminate on the anniversary of the *policy effective date* following the *insured person*'s 76th birthday.

The *insured person* must be a *Hong Kong* citizen or resident in *Hong Kong* holding a valid *Hong Kong* identity card with a permanent address and live in *Hong Kong* as a usual country of residence. *Insured person* under *age* of eighteen (18) years old shall hold a valid *Hong Kong* birth certificate or proof of dependent visa.

3. Status Change

You must take full responsibility to inform *us* forthwith of any change in respect of the information provided in the enrollment form for this policy (regardless verbally or in written format), otherwise *we* reserve the right to refuse or invalidate all claims under this policy.

4. Notice of Claims

Written notice must be given to *us* within thirty (30) days upon the first treatment of any *disability* likely to give rise to a claim under this policy and within ninety (90) days upon the *diagnosis* of any *critical illness*. All certificates, information and evidences required by *us* shall be furnished at the expense of *you* or the *insured person* or the personal representative of *yours* or the *insured person's* and shall be in such form and of such nature as *we* may prescribe. *We* shall be entitled to call for examination(s) by a medical referee at *our* expense. If *you* or the *insured person* do(es) not comply with this condition, *we* shall have the sole discretion to decide not to pay any benefits under this policy.

5. Proof of Loss

Written proof of loss, including receipts and itemized bills with the *diagnosis* in original in support of a claim, together with a fully completed claim form supplied by *us*, must be furnished to *us* within thirty (30) days from the completion and/or termination of the treatment for which the claim is being made. Failure to furnish such proof within the prescribed time shall not invalidate any claims if it was not reasonably practicable to give proof within such time, provided that such proof is furnished as soon as reasonably practicable, and in no event later than one hundred and eighty (180) days from the time such proof is required. All certificates information and evidence in such form and of such nature and within such time as *we* may reasonably require shall be furnished without expense to *us*.

If the supporting documents of a claim are in a language other than Chinese or English. The *insured person* must undertake to obtain certified translation of the documents in Chinese or English at the expense of *you* or the *insured person.*

6. Claims Admittance

In no case shall *we* be liable in respect of any claim after the expiry of twelve (12) months from the occurrence of the *disability* giving rise to it unless the claim has been admitted or is the subject of a pending legal action or arbitration.

7. Medical Examination

We shall be entitled in the case of non-fatal *injury* to call for examination by a medical referee appointed by *us* if we deem necessary and in the event of death of the *insured person* to have a post-mortem examination at *our* expense.

8. Payment of Claims

All payment of claims in this policy shall be in *Hong Kong* dollars and are payable to *you* after the receipt of due proof. In the event of *your* death, the benefit will be paid to *your* estate.

9. Misrepresentation, Non-disclosure or Fraud

We have the right to declare this policy void as from the *policy effective date* and notify *you* that no cover shall be provided for the *insured person* in case of any of the following events :

(a) any material fact relating to the health related information of the *insured person* which may impact the risk assessment by *us* is incorrectly stated in, or omitted from the enrolment form or any statement or declaration made for or by the *insured person* in the enrolment or in any subsequent information or document submitted to *us* for the purpose of the application, including any updates of and changes to such information, failure to disclose *pre-existing conditions* or failure to act in utmost good faith. The circumstances that a fact shall be considered "material" include, but are not limited to, the situation where the disclosure of such fact would have affected *our* underwriting decision, such that *we* would have imposed premium loading, added exclusion(s), rejected the application or considered it as a pending application.

(b) any enrolment form or claim submitted is fraudulent or where a fraudulent representation is made.

In the event of (a):

(i) *we* shall refund the applicable premiums and insurance levy (if any) received after offsetting against all past claim payments and necessary expenses incurred by *us* including, but not limited to, *our* reasonable administration charge and service fees incurred in relation to this policy (if any).

(ii) if the total amount of the above offsetting items exceeds the applicable premiums received by *us*, *you* must repay such excess to *us* within fourteen (14) working days from the date *we* issue a notice to *you* requiring such payment.

In the event of (b), *we* shall have the right:

(i) not to refund the applicable premiums paid; and

(ii) to demand that all past claim payments previously paid to *you* be repaid to *us* within fourteen (14) working days from the date *we* issue a notice to *you* requiring such payment.

10. Premium Charge

(i) This policy is an annual medical policy. *You* may pay the premium to *us* on an annual or monthly basis. All premiums after the first premium are payable to *us* on or before the due date. The validity of the policy is subject to *your* settlement of the full premium for the entire policy year and *you* are required to settle the annual premium for the concurrent *period of insurance* when there is a claim made or service used in such policy year. *We* will not be liable to refund any premium paid.

(ii) *We* reserve the right to revise or adjust the premium under the following circumstances:

   (a) According to *our* applicable premium rate at the time of renewal (which will be based on several factors, including but not limited to medical price inflation, projected future medical costs, claims experience and expenses incurred by *you* and/ or in relation to this product, and any changes in benefit) by giving thirty (30) days' advance written notice to *you*.

   (b) The premium rate should be adjusted automatically according to the attained *age* of the *insured person* at the time of renewal.

11. No Claim Discount

No claim discount on the renewal premium of any policy year of this policy may be available in respect of Sections 1 to 3 of Part 2 – Table of benefits and is calculated as follows:

(i) If no claim has been made by the *insured person* within the policy year prior to the concurrent anniversary of the *policy effective date*, the no claim discount on the renewal premium of the policy year following such anniversary of the *policy effective date* will be increased by five percent (5%). The maximum percentage of the no claim discount is fifteen percent (15%).

(ii) If a claim has been made by the *insured person* within the policy year prior to the concurrent anniversary of the *policy effective date*, the no claim discount on the renewal premium of the policy year following such anniversary of the *policy effective date* will be decreased by five

percent (5%). The minimum percentage of the no claim discount is nil percent (0%).

(iii) The no claim discount of any *policy* year shall be invariably deducted from the originally chargeable renewal premium of such *policy* year (without taking into account any no claim discount) and shall not be calculated on the basis of the renewal premiums paid for any of the previous *policy* years.

12. Grace Period

We will allow *you* thirty-one (31) days for the payment of each premium after the first premium. During that time *we* will keep this policy in force. If after that time the premium remains unpaid, this policy will be deemed to have lapsed from the date that the unpaid premium was due.

13. Reinstatement

If *we* terminate this policy due to non-payment of premium, *we* may allow this policy to be reinstated if *you* provide *us* with a satisfactory written application for reinstatement including proof of insurability and subject to *our* approval. The reinstated policy shall only provide coverage to the *insured person* due to *accident* after the date of reinstatement and shall only cover *sickness* of the *insured person* which begins no sooner than thirty (30) days after the date of reinstatement.

14. Cancellation

(i) *We* have the right to cancel this policy or any section or part of it by giving thirty (30) days' advance notice in writing by post to *your* last known address. Under no circumstances *we* will be obligated to reveal *our* reasons for cancellation. Whenever this policy is cancelled, pro-rata premium for the period starting at the time of cancellation to the last date of the *period of insurance* shall be refunded provided that no claim has been made during such *period of insurance* of this policy.
The payment or acceptance of any premium subsequent to such termination shall not create any liability on *us* but *we* shall refund any such premium received by *us*.

(ii) *You* have the right to cancel this policy by giving thirty (30) days' advance notice in writing to *us*. In such event, *we* will refund the unearned premium actually paid by *you* provided that no claim has been made during the period starting from the *policy effective date* to the date on which the cancellation takes effect ("Policy Period"), the earned premium shall be calculated in accordance with the table below but in no event shall the earned premium be less than *our* customary minimum premiums. If this policy is pay on monthly payment mode, *we* have the right to charge *you* the remaining balance of the annual premium for the current policy year in accordance with the charges indicated below.

In both cases above, if there is a claim or service used during the current policy period, there will be no refund of premium on the unexpired period and *you* are liable to settle the annual premium of the policy year.

Policy period	Percentage of premium earned by us
2 months (our customary minimum premiums)	40%
3months	50%
4months	60%
5 months	70%
6 months	75%
Over 6 months	100%

Notwithstanding the above, if *you* are not satisfied with this policy, *you* may within twenty-one (21) days immediately following the day of delivery of this policy, cancel the policy by returning the policy to us and attaching a notice signed by *you* requesting cancellation. In the event that no claim payment has been or is to be made, *we* will refund to *you* all the premiums you have paid without interest. In the event that a benefit payment has been made or is to be made, no refund of premium shall be made.

15. Termination of Policy

This policy shall automatically terminate on the earliest of:

(i) the *insured person* is no longer eligible for the benefits under this policy in view of Clause 2 – *Age* Limit and Eligibility of this Part;

(ii) cover under this policy ceases pursuant to the Clause 9 – Misrepresentation, Non-disclosure or Fraud of this Part;

(iii) *you* fail to pay after expiry of the 31-day grace period in accordance with Clause 12 – Grace Period of this Part; or

(iv) either party cancel this policy by giving thirty (30) days written advance notice pursuant to Clause 14 – Cancellation of this Part.

16. Renewal

The policy shall remain in force for a period of one (1) year from the *policy effective date* and this policy will be automatically renewed at *our* discretion. *We* reserve the right to alter the terms and conditions, including but not limited to the premiums, benefits, benefits amount or exclusions of this policy at the time of renewal of any period of insurance by giving thirty (30) days' written notice to *you*. *We* will not be obligated to reveal *our* reasons for such amendments and such renewal will not have to take place if before the *policy effective date* of any *period of insurance*, *you* have indicated to *us* that such amendments are not acceptable to *you*.

17. Change of Benefits

You may apply for change of benefits or *upgrade* by giving thirty (30) days' notice in writing before the anniversary of the *policy effective date*. A health declaration with details on any *injury*, *sickness*, symptoms or conditions which are then known to exist by *you* or the *insured person* or any treatment or medication the *insured person* is having or will be having shall be submitted to *us*. Such application shall be subject to *our* approval and *we* reserve *our* right to amend any terms and conditions, including but not limited to the premium rates or benefits or exclusions (applicable to the *upgrade* portion only) of this policy. Any change accepted by *us* shall be effective on the next policy renewal date.
If such *insured person* showed symptoms or has received medical consultation, *diagnosis*, treatment or advice by a *medical practitioner* or took prescribed drugs or medicine prior to the said written notice is received by *us*, the limit of benefits payable in respect of such *disability(ies)* shall not exceed the limit of benefits before or after the change in benefit level whichever is lower.

18. Misstatement of *Age* or Sex

If the *insured person*'s *age* or sex has been misstated, the premium difference would be returned or charged according to the correct *age* or sex. In the event the *insured person*'s *age* has been misstated and if, according to the correct *age*, the coverage provided by this policy would not have become effective, or would have ceased prior to the acceptance of each premium or premiums, then *our* liability, under all circumstances, shall be limited to the refund of the premiums paid for such period covered by this policy.

19. Other Insurance

If an *insured person* is entitled to a compensation or reimbursement of all or part of the expenses covered under this policy (except for Complementary Benefits (a) and (b) and Section 5) under any other insurance policy(ies) or from any other source(s) (such as government scheme), *we* will only be liable for the remaining balance of *your* expenses after deducting the amount recoverable from such other policies or sources. In all situations, the total amount recoverable from all relevant policies or sources shall not exceed the actual medical expense paid by the *insured person*.

20. Zurich Emergency Assistance

The service provider of Zurich emergency assistance is an independent service provider providing services to the *insured person* upon the *insured person's* request. *We* or any of *our* affiliates, agents, or employees of any of them has no responsibility or liability of any act, default, negligence, error or omission of the relevant service provider of Zurich emergency assistance or any of its employees, agents or representatives.

21. Clerical Error

Our clerical errors shall not invalidate insurance otherwise valid nor continue insurance otherwise not valid.

22. Legal Action

No legal action shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of claims has been filed in accordance with the requirements of this policy, nor shall such action be brought at all unless commenced within one (1) years from the expiration of the time within which proof of claims is required.

23. Subrogation

We have the right to proceed at *our* own expense in the name of the *insured person* against third parties who may be responsible for an occurrence giving rise to a claim under this policy.

24. Alternative Dispute Resolution

In the event of a dispute arising out of this policy, the parties may settle the dispute through mediation in good faith in accordance with the relevant Practice Direction on civil mediation issued by the Judiciary of *Hong Kong* and applicable at the time of dispute. All unresolved disputes shall be determined by arbitration in accordance with the Arbitration Ordinance (Chapter 609), Laws of *Hong Kong* as amended from time to

time. The arbitration shall be conducted in *Hong Kong* by a sole arbitrator to be agreed by the parties. It is expressly stated that the obtaining of an arbitral award is a condition precedent to any right of legal action arising out of this policy. Irrespective of the status or outcome of any form of alternative dispute resolution, if *we* deny or reject liability for any claim under this policy and *you* do not commence arbitration in the aforesaid manner within twelve (12) calendar months from the date of the *our* disclaimer, *your* claim shall then for all purposes be deemed to have been withdrawn or abandoned and shall not thereafter be recoverable under this policy.

25. Rights of Third Parties
Other than *you* or as expressly provided to the contrary, a person who is not a party to this policy has no right to enforce or to enjoy the benefit of any term of this policy. Any legislation in relation to third parties' rights in a contract shall not be applicable to this Policy. Notwithstanding any terms of this policy, the consent of any third party is not required for any variation (including any release or compromise of any liability under) or termination of this policy.

26. Compliance with Policy Provisions
Failure to comply with any of the provisions contained in this policy shall invalidate all claims hereunder.

27. Governing Law and Jurisdiction
This policy shall be governed by and interpreted in accordance with the laws of *Hong Kong* and subject to the exclusive jurisdiction of the *Hong Kong* courts.

28. Statement of Purpose for Collection of Personal Data
All personal data collected and held by us will be used in accordance with our privacy policy, as notified to you from time to time and available at this website: https://www.zurich.com.hk/en/services/privacy.
The policyholder and/or *insured person* shall, and shall procure all other *insured persons* covered under the policy to, authorize us to use and transfer data (within or outside Hong Kong), including sensitive personal data as defined in the Personal Data (Privacy) Ordinance (Cap.486), Laws of Hong Kong, for the obligatory purposes as set out in our privacy policy as applicable from time to time.
When information about a third party is provided by the *insured person* to us, the *insured person* warrants that proper consents from the relevant data subjects have been obtained before the personal data are provided to us, enabling us to assess, process, issue and administer this policy, including without limitation, conducting any due diligence, compliance and sanction checks on such data subjects.

29. Sanctions
Notwithstanding any other terms under this policy, no insurer shall be deemed to provide coverage or will make any payments or provide any service or benefit to any *insured person* or other party to the extent that such cover, payment, service, benefit and/or any business or activity of the *insured person* would violate any applicable trade or economic sanctions law or regulation.

The above clause shall also apply for any trade or economic sanction law or regulation that the insurer deems applicable or if the *insured person* or other party receiving payment, service or benefit is a sanctioned person.

PART 7 – CLAIMS PROCEDURE

Step 1: Notify *us in writing* within thirty (30) days upon the first treatment of any *disability*;
Step 2: Complete and submit a claim form and provide the following original documents required for the corresponding claim to *us* within thirty (30) days from the completion and/or termination of the treatment for which the claim is being made.

Sections 1 and 2 (unless otherwise specified below) of Part 2 – Table of benefits: Hospitalization and Surgical Benefits

- *Hospital* statement showing
  - name of the patient
  - period of *confinement*
  - itemised charges
- Receipts issued by all attending *medical practitioner/ specialists/ anaesthetists/* surgeons/ physical therapists showing:
  - name of the patient
  - date of consultation
  - *diagnosis* and/or treatment given
  - amount charged

Section 3.1 of Part 2 – Table of benefits: Pre-admission and Post-hospitalization *Outpatient* Benefit/Complementary Benefit (c) : Emergency *Outpatient* Benefits
Attending *medical practitioner* 's receipt showing:

- name of the patient
- date of consultation
- *diagnosis* and/or treatment given
- amount charged

Section 3.2 of Part 2 – Table of benefits: Home Nursing

- Written referral letter from the attending *medical practitioner*
- Receipt of *qualified nurse* for services showing:
  - name of the patient
  - period of services
  - amount charged (per day and total)

Section 2.9 of Part 2 – Table of benefits: Hospital Cash (for *Confinement* in *Public Hospital*)/Section 5 of Part 2 – Table of benefits: Hospital Cash

- *Hospital* statement showing:
  - name of the patient
  - name of the *hospital*
  - period of *confinement*
  - *diagnosis* and/or treatment given

Section 2.7 of Part 2 – Table of benefits: Cancer Treatment and Kidney Dialysis Benefit/Section 3.3 of Part 2 – Table of benefits: *Specialist* Treatment due to Specified *Critical Illness*/Section 3.4 of Part 2 – Table of benefits: Artificial Prosthesis and Rental of Wheel Chairs Benefit/Section 3.5 of Part 2 – Table of benefits: Psychology and Psychiatry Expenses/Section 3.6 of Part 2 – Table of benefits: Rehabilitation and Physical Therapy Expenses

- Written referral letter from the attending *medical practitioner* for the related benefit/service required
- Receipts of *specialist* or *medical practitioner* or all relevant service provider showing:
  - name of the patient
  - date of consultation
  - *diagnosis* and/or treatment given
  - amount charged

Sections 6 of Part 2 – Table of benefits: *Critical Illness*

- Receipts of all attending *specialist*(s) showing:
  -name of the patient
  - date of consultation 11
  - *diagnosis* and/or treatment given
- Certificates and reports by the *specialist*(s) as specified in the definition of the relevant *critical illness* in Section 6 of Part 3 of this policy.

There are two versions of this policy, one in English and one in Chinese. If there is any discrepancy between the English and the Chinese versions, the English version shall prevail.

蘇黎世「智樂人生」自選醫療保險計劃

ZURICH 蘇黎世

請細閱本保單，如有任何修正請求，並請盡快提出。

本保單連同「附表」及嗣後發出的任何附帶批單應以整體文件形式一併閱讀，並構成「閣下」與「本公司」之間的合約。除非獲「本公司」書面同意，否則合約內容不得更改。而「閣下」的投保表格及聲明，不論以口述(若是由「本公司」或「本公司」授權之代理錄音)或書面形式提供，均會構成本合約的依據。

「本公司」現與 「閣下」協議，鑒於 「閣下」支付保費及信賴各陳述、保證或聲明，以及遵從本保單及隨附之「附表」的條款與規章，「本公司」將於「保險期」內以「附表」所載之保障項目承保「受保人」，如「受保人」因「疾病」或「損傷」而招致在下文所訂承保範圍內由「醫生」建議之費用，「本公司」將支付指定的保障。

此乃全年醫療保險保單，將於「本公司」接受及收訖「閣下」繳交隨後的保費後而續保。 「閣下」必須繳付同年度之全年保費。

「閣下」於投保表格內填報的資料如有任何更改（不論以口述或書面形式），請盡早通知「本公司」，以免影響「受保人」於本保單的保障內容。

此乃一份有法律效力的文件，敬請妥為保存。

第一部份 – 定義

本保單內某些詞彙具有指定含意，釋義已分別列明如下。為方便「閣下」識別有關詞彙，「本公司」特將此等詞彙全部加上引號。本保單內容用詞如有性別或單複之分，均應視為概括性的描述，並無區別。

「意外」
於「保險期」內，任何不可預見或預料並導致「受保人」蒙受身體「損傷」之突發事件。

「日常活動」
日常自理活動包括：
(i) 更衣：無須他人扶助，自行穿上及脫下衣物；
(ii) 行動：無須他人扶助，能夠自行由一間房移動到另一間房；
(iii) 移動：無須他人扶助，上落床或椅子；
(iv) 自制：自行控制大小便；
(v) 進食：無須他人扶助，能夠自行進行一切進食程序；及
(vi) 沐浴或淋浴：無須他人扶助，自行沐浴或淋浴。

「年齡」
上次生日的年齡。

「麻醉科醫生」
「麻醉科醫生」指「香港」醫務委員會以麻醉科專科登記或具其他同等資歷的「醫生」。惟 「閣下」、「受保人」或「直系親屬」除外。如在「香港」以外地區接受緊急治療或手術，則指該註冊「醫生」已於其執業的地區以同等麻醉科專科登記法律合法地獲准授權提供醫療及外科手術的人士。

「內戰」
相同國家的公民或民族互相對抗而發生互相攻擊的戰爭或「戰 爭」。

「電腦病毒」
是指一組損壞的、有害的或未經授權的指令或代碼，包括一組通過程序或其他方式惡意傳播的未經授權指令或代碼，並通過電腦系統或任何性質的網絡傳播。電腦病毒包括但不限於"特洛伊木馬"、"蠕蟲"和"時間或邏輯炸彈"。

「住院」
「受保人」必須因為「疾病」或「損傷」而遵照「醫生」建議及基 於「醫療必需」下入住「醫院」及「受保 人」在出院前，必須一直 逗留在「醫院」內。「受保人」須出示「醫院」發出的每日房間及 膳食費用單據，以作證明。

「危疾」
指第三部份-保障第 6 節-「危疾」保障內所定義之「疾病」或能力喪失或手術，必須於「保險期」內首次出現徵狀及在「首個保單生效日」、「提升保障生效日」或復效日「（以較遲者為準）90 日之後「確診」。於本保單中，危疾之「確診」必須為「受保人」已就該「危疾」接受一位或以上「專科醫生」檢查，並由「受保人」之每位主診「專科醫生」或由其監督下所預備之書面醫療報告證明，而所有診斷結果必須符合本保單就該「危疾」的所有診斷條件。

「網絡行為」
是指在任何時間和地點所做的任何未經授權、惡意或犯罪行為。而該行為涉及進入、處理、使用或操作任何電腦系統、電腦軟體程式、惡意代碼、「電腦病毒」或流程或任何其他電子系統。

「日症病人」
在「醫院」的日症手術部門進行手術，但不需要過夜的病人。

「自負額」
列明於「附表」內，「受保人」於本保單第三部 - 保障第 1 至 3 節內，就每次及每宗索償所必需承擔之自負金額。如受保「傷疾」之合共醫療費用超過訂明之自負金額，「本公司」只會負責賠償該受保「傷疾」的醫療費用扣除自負金額後所剩餘之費用，而有關醫療費用中的每項保障會根據列載於本保單第二部份 - 保障表已選擇的計劃內的最高賠償限額為上限。

「確診」
必須由「受保人」之主診「專科醫生」根據載於本保單的第三部份 - 保障的第 6 節 - 「危疾」保障內所保障的有關「危疾」之定義中所指定的跡象証明，並通過放射結果、臨床病歷、細胞組織分析或試驗分析所作出的明確診斷並以書面形式確認，所有上述之證明均需要被「本公司」接受方可成立。

「傷疾」
一宗「疾病」或「損傷」。由同一次「意外」所引致之所有「損傷」都被視為同一「傷疾」。所有因為相同原因或相關原因引致的同時存在的「疾病」及所有由此發生的併發症均會被視為同一次「傷疾」。若「傷疾」是與先前「傷疾」的相同原因或相關原因引致，包括所有由此發生的併發症均會被視為先前「傷疾」的延續而不是另一「傷疾」，除非最近的出院日期，或最後一次治療性手術，或最後一次到「醫生」診所接受診斷或治療，或領取藥物之日期，或接受特別餐單（以較遲為準）之日期已相隔最少 90 天且無須再就該「傷疾」接受治療，其後的「傷疾」將被視為另一「傷疾」。

「同居伴侶」
一名「年齡」18 歲或以上、選擇以親密和忠誠的關係與「受保人」共同生活的未婚成年人，與「受保人」同居於一起最少三年或以上並以此為長遠目標，以及能提供相關住址證明。「同居伴侶」並不包括室友或任何「直系親屬」。

「香港」
中華人民共和國香港特別行政區。

「醫院」
符合下列條件的機構：
(i) 根據所在國家或司法管轄區規定領取牌照之持牌「醫院」；

(ii) 主要業務為收取報酬的情況下為受傷或患病人士提供診斷、醫療護理及外科手術設備服務；
(iii) 有一名或以上的「醫生」時刻駐院；
(iv) 在負責「醫生」監督下，駐有註冊護士每天 24 小時提供看護服務；
(v) 具有完善的住院病人設備；及
(vi) 保存所有病人的每日醫療記錄。

「醫院」並不包括主要業務為診所、照料類別的診所、自然療法診所、健康水療院、療養院或復康院、保管照料的地方、照顧長者或嗜酒者或吸毒者或精神病患者的機構，或護理院，或類似的機構。

「直系親屬」
「閣下」或「受保人」的配偶、父母、配偶父母、祖 / 外祖父母、兒女、兄弟姊妹、孫兒女或合法監護人。

「損傷」
純粹因「意外」而非任何其他事故所蒙受之身體損傷。

「受保人」
受保於此保單中的人士。

「深切治療部」
在「醫院」內特定以提供護士病人一對一護理，向病人提供專門的 復甦、觀察及治療的單位。此單位必須 24 小時駐有經驗護士、護理 人員及「醫生」，同時備有復甦工具、觀察儀器，以容許持續地評 估病人的重要身體機能，例如心跳、血壓、血液化驗等。

「喪失視力」
視力完全喪失及「永久」無法復原。

「殘廢」
「永久」完全喪失功能或手腕或足踝或其以上的肢體部份「永久」 完全分離。

「醫療必需」
以下列各項作為接受醫療服務的必要性：
(i) 因應有關診斷及有關狀況的治療所需；及
(ii) 符合良好及謹慎的行醫標準；及
(iii) 非純為「醫生」或任何其他醫療服務供應商之方便；及
(iv) 以最適合的程度有效地為「受保人」之「傷疾」作出安全及足夠的治療及以最經濟之設備進行治療受保「傷疾」；及
(v) 在「住院」的情況下，其主要的目的並非純為診斷檢查、診斷掃瞄、影像檢查、化驗檢查或物理治療。

「醫生」
已根據《醫生註冊條例》「香港」法例第 161 章規定，註冊為「醫生」之人士，惟「閣下」、「受保人」或「直系親屬」除外。如於「香港」以外之地區接受治療或手術，則指擁有合格西醫學位，並已獲授權在其執業的地區合法提供醫療及外科手術服務的人士，惟「閣下」、「受保人」或「直系親屬」除外。

「門診」
「受保人」因本保單承保的「疾病」或「損傷」在「醫生」或「專科醫生」的診所或辦事處、或「醫院」門診部或急症室接受醫療服務或藥物治療。

「保險期」
「附表」內所訂明之保險有效期，而「本公司」已接納「閣下」在「附表」內所訂明該保險期間之保費。

「永久」
「意外」事故發生之日起計，損害情況持續至少 12 個月，並於此段時間終結時沒有好轉之跡象。

「保單生效日」
在收妥保費的前提下，列明於「附表」上之生效日期或最近的一個續保日，以較後者為準。

「首個保單生效日」
是指：
(i) 申請此保單時列明於「附表」上的首個「保單生效日」；為免生疑，續保日除外；或
(ii) 保單復效日，以較遲者為準。

「投保前已存在之傷疾」
在「首個保單生效日」、復效日或「提升保障生效日」（以較遲者為準）之前已存在之任何「損傷」、「疾病」或病況及 / 或「受保人」已呈現病徵或已接受「醫生」診療、「確診」、治療或醫療意見，或已服用處方藥物一段時間而「受保人」懂悉或理應知道之相關病況，除非「受保人」已於申請表格全面披露此等病況並獲「本公司」書面接受，而保單文件無明文規定不承保之前已存在之病況的治療，則屬除外。

「公立醫院」
列明在「香港」醫院管理局所定義之七個「醫院」聯網內之「醫院」。

「合資格護士」
合資格護士指合法批准及獲准資格在其執業地區合法提供護理服務的人士，惟 「閣下」、「受保人」或「直系親屬」除外。

「合理及慣常收費」
就任何費用、收費或開支而言，指符合以下規定的費用或開支：
(i) 受傷或患病人士在「醫生」按照良好醫療守則的護理標準下所提供「醫療必需」的照顧，監管或指示而收取的治療、用品或醫療服務費用；
(ii) 不超過當地同類治療、用品或醫療服務的正常收費水平；及
(iii) 並不包括如非有投購保險便不會招致的費用。

「本公司」保留權利釐定個別「醫院」 / 醫療費用是否屬於「合理及慣常收費」，參考的基準包括但不限於任何可取得的相關刊物或資料，例如當地政府、相關部門及認可醫療協會公佈的收費表。如根據上述參考資料，任何「醫院」 / 醫療費用並非「合理及慣常收費」，「本公司」保留權利調整任何或所有應付賠償的金額。

「有關文件」
有關文件包括「附表」、投保表格、聲明、附加契約、批單、附件及修訂本（不論以口述或書面形）。

「附表」
隨附本保單並構成保單一部份之附表。

「手術項目表」
附帶在本保單上，標示為「手術項目表」的一份文件，它包括一系列受保於本保單內的手術。

「疾病」
在「保險期」內健康出現不正常之病理癥狀。

「專科醫生」
除 「閣下」、「受保人」或「直系親屬」外，在「香港」醫務委員會以專科登記為「醫生」之人士。若於「香港」以外之地區接受治療或手術時，則指根據當地相關的專科醫務法律，該「醫生」已登記在當地合法從事專科治療或手術服務。

「恐怖活動」
「恐怖活動」包括任何人或團體為達到政治、宗教、思想或同類目的作出的行動、策劃或威脅活動，包括意圖影響任何國家法律上或實際上的政府或其政治部門，及 / 或威脅任何國家的公眾或部份公眾，不論是獨自行動又或代表或聯同任何組織或法律上或實際上的政府亦然；並且：
(i) 涉及以暴力對待一人或多人；
(ii) 涉及財物損毀；
(iii) 危害生命但不包括執行行動的人；
(iv) 對公眾或部份公眾的健康或安全造成風險；或
(v) 設計去干擾或破壞某電子系統。

「完全傷殘」
「受保人」遭遇「意外」而導致「損傷」，並且於「意外」日期後 12 個月內「受保人」出現完全及「永久」性的傷殘及不能從事任何根據「受保人」的學歷、專業訓練或經驗而可賺取酬勞或利益的工作。如「受保人」並無從事任何職業或工作，則指「受保人」喪失應付任何日常生活事務的能力。

「提升」
指「提升」保障及或計劃級別。

「提升保障生效日」
指「本公司」同意 「閣下」保單「提升」保障當日之「香港」時間 00:00 時，而「本公司」發予 「閣下」訂明「提升」保障詳情之保單「附表」或批單所註明的日期。

「等候期」
就第三部份 - 保障的第 1 至 5 節而言，指在「提升保障生效日」或任何新增保障的有效日（僅適用於提升保障或新增的保障）或復效日（以較遲者為準）起的 30 日內。在該段時期內，「本公司」不會就任何原因提供保障，「意外」則除外。
就第三部份 - 保障的第 6 節而言，指在「首個保單生效日」或「提升保障生效日」（僅適用於「提升」保障的部份）或復效日（以較遲者為準） 起的 90 日內，首次出現之病徵及徵狀的任何「危疾」。在該段時期內，「本公司」不會就任何原因提供保障，「意外」則除外。

「戰爭」
兩國或多國因任何目的交戰，或主權國家之間的武裝衝突，又或正式宣戰或未正式宣戰的公開軍事衝突，又或國與國之間經主權國正式授權而終止和平關係並陷入武裝敵對的局面。

「本公司」
蘇黎世保險有限公司。

「閣下」
本保單持有人之人士。

第二部份 - 保障表

以下各項計劃及保障必須於「附表」內訂明為有效，方為適用。

		每名「受保人」就每宗「傷疾」之最高賠償額（港元）		
		精選計劃	**特級計劃**	**尊貴計劃**
第 1 節 - 房租及膳食費用				
1.1 房租及膳食費				
最高日數		182	182	182
每日最高限額		750	1,580	3,100
1.2 「深切治療部」房租及膳食費				
最高日數		15	15	15
每日最高限額		2,000	3,000	4,000
1.3 陪伴床位保障				
最高日數		60	60	60
每日最高限額		400	500	600
第 2 節 - 手術費用保障				
2.1 「醫生」巡房費				
最高日數		182	182	182
每日最高限額		650	1,200	2,000
2.2 「醫院」雜費				
每宗「傷疾」最高限額		12,000	18,000	30,000
2.3 手術費				
	複雜	46,000	62,000	93,000
	大型	27,000	36,000	54,000
	中型	11,250	15,000	22,500
	小型	5,625	7,500	11,250
2.4 「麻醉科醫生」費				
	複雜	15,750	21,000	31,500
	大型	9,450	12,600	18,900
	中型	3,938	5,250	7,875
	小型	1,969	2,625	3,938
2.5 手術室費				
	複雜	15,750	21,000	21,500
	大型	9,450	12,600	18,900
	中型	3,938	5,250	7,875
	小型	1,969	2,625	3,938
2.6 住院「專科醫生」診症費				
		6,000	8,000	10,000
2.7 癌症及腎透析治療保障				
（包括由「醫生」建議用於癌症治療的化療、電療、數碼導航刀、伽傌刀或標靶治療；或腎透析）		包括在第二部份 - 保障表內第 2.2 節 - 「醫院」雜費之內		
2.8 「日症病人」或「門診」手術				
		包括在第二部份 - 保障表內下列所訂明的項目 第 2.2 節 - 「醫院」雜費 第 2.3 節 - 手術費用		

	每名「受保人」就每宗「傷疾」之最高賠償額（港元）		
	第 2.4 節 - 「麻醉科醫生」費用 第 2.5 節 - 手術室費用		
2.9 於「公立醫院」「住院」的住院現金			
最高日數	90	90	90
每日最高限額	300	450	600
（適用於在「香港」之「公立醫院」內之大房內「住院」）			
2.10 醫療失誤保障			
	30,000	60,000	80,000
第 3 節 - 入院前及出院後之保障			
3.1 入院前及出院後之「門診」保障			
（包括兩次入院前「門診」及所有出院後 45 日內之「門診」覆診）	1,500	2,500	4,500
3.2 家居看護費用			
最高日數	90	90	90
每日最高限額	500	600	700
3.3 指定「危疾」*之「專科醫生」治療費用 （包括在「確診」首日後起計 90 日內之所有「專科醫生」「門診」）			
每次診症上限	1,500	2,000	3,000
每宗「危疾」之最高限額	20,000	30,000	50,000
*只適用於下列「危疾」：根據第三部份 - 保障中第 6 節 - 「危疾」保障所定義的第 5 項 - 腦部良性腫瘤、第 9 項 - 癌症、第 17 項 - 末期肝病、第 19 項 - 心臟病、第 21 項 - 腎衰竭及第 27 項 - 主要器官移植。			
3.4 人造義肢及輪椅租用保障			
（出院日起計連續 30 日內）	10,000	20,000	30,000
3.5 心理科及精神科治療費用			
（出院日起計連續 180 日內）	10,000	15,000	20,000
3.6 復康及物理治療費用			
（出院日起計連續 180 日內）	10,000	15,000	20,000
額外保障			
a. 「意外」死亡及傷殘保障	100,000		
b. 「意外」身故恩恤保障	10,000		
c. 緊急「門診」保障	每保單年度最高限額 3,000		
自選保障（第 4 節至第 6 節）			
第 4a 節 - 附加醫療保障			
每宗「傷疾」最高限額	100,000	200,000	300,000
餘下費用之賠償百分比	80%	80%	80%
第 4b 節 - 自願性「自負額」			
如適用，已訂明於「附表」之內			
第 5 節 - 住院現金保障			
最高日數	182	182	182
每日最高限額	500	750	1,000
第 6 節 - 「危疾」保障			
每宗「傷疾」最高限額	150,000	250,000	500,000

第三部份 - 保障

若「受保人」在「保險期」內，因「疾病」或「損傷」，由主診「醫生」建議有「醫療必需」地在「醫院」「住院」（除本部份第 2.8 節所註明外），「本公司」將會按「附表」所示之最高限額支付有關之保障，惟必須向「本公司」提交「本公司」認為可接納的證明及受本保單之條款所限制。在任何情況下，「本公司」就每宗「傷疾」之最高賠償額將不會超過訂明於第二部份 - 保障表內所選擇的計劃之最高賠償限額。

若「受保人」因「醫療必需」在「香港」以外地區之「醫院」「住院」，「受保人」按第二部份 - 保障表內所享有之保障將會作出以下調整：

- 若「附表」列明第 5 節的自選保障適用時，「本公司」會按第 5 節支付每日住院現金之保障，而每宗「傷疾」之最高賠償日數為三十(30)日。

第1節 - 房租及膳食費用

「本公司」就每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就同一次「住院」之每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。

第1.1節 - 房租及膳食費

「本公司」會支付「受保人」在「醫院」「住院」期間實際收取的房租及膳食「合理及慣常收費」，每宗「傷疾」之最高賠償日數為 182 日。

第1.2節 - 「深切治療部」房租及膳食費

「本公司」會支付「受保人」在「深切治療部」「住院」期間實際收取的房租及膳食「合理及慣常收費」，每宗「傷疾」之最高賠償日數為 15 日。

第1.3節 - 陪伴床位保障

若「受保人」在「醫院」「住院」，「本公司」將會就「醫院」向任何一位「直系親屬」或「同居伴侶」所收取之陪床位費用，支付實際收取的「合理及慣常收費」，每宗「傷疾」之最高賠償日數為 60 日。

第2節 - 手術費用保障

第 2.1 節 - 「醫生」巡房費

若「受保人」在「醫院」「住院」，「本公司」將會就主診「醫生」因應「住院」期內之治療所收取之巡房費，支付實際收取的「合理及慣常收費」，每宗「傷疾」之最高賠償日數為 182 日。

「本公司」就每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」而在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同

一宗「傷疾」，而「本公司」就同一次「住院」之每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。

第 2.2 節 - 「醫院」雜費

若「受保人」在「醫院」「住院」，「本公司」將會就「醫院」所收取之下列費用，支付實際收取的「合理及慣常收費」：

(i) 由主診「醫生」處方，並在「住院」期間服用之西藥，並就同一宗「傷疾」所處方及在治療完成後七日內服用的西藥，惟不包括治療慢性病、預防性質、為出院後即時療程之後的複發性療程、長期治療之藥物；或

(ii) 包敷物料、普通夾板及石膏費，惟不包括特別支架、器具及設備費；或

(iii) 有「醫療必需」的植入物；或

(iv) 由主診「醫生」建議並在「住院」期間進行之物理治療；或

(v) 氧氣及施用費；或

(vi) X - 光片、心電圖及其他化驗室檢查及測試費用及診斷過程，其即時目的為有「醫療必需」的「傷疾」治療；或

(vii) 靜脈注射費；或

(viii) 輸血、血或血漿及施用費；或

(ix) 來往「醫院」的救護車服務費。

本 2.2 節不適用於手術時使用之儀器或其他器材，包括但不限於麻醉機、胃鏡、腸鏡、碎石機、X 光刀、數碼導航刀及伽傌刀。

第 2.3 節 - 手術費

若「受保人」在「醫院」「住院」，「本公司」將會就「醫生」所收取之手術費用，支付實際收取的「合理及慣常收費」。「本公司」就每一宗「傷疾」會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內，並同時受有關手術在「手術項目表」上之分類賠償額所限。

(i) 若於同一次「住院」中，因同一宗「傷疾」進行兩項或以上的手術，「本公司」只會賠償在「手術項目表」內有較高賠償分類的一項手術。

(ii) 若因同一宗或不同「傷疾」而需於同一個切口進行兩項或以上的手術，「本公司」只會賠償在「手術項目表」內有較高賠償分類的一項手術。

(iii) 若因同一宗或不同「傷疾」而需於同一個手術過程中涉及不同切口以進行兩項或以上的手術，或於同一次「住院」中因不同「傷疾」進行兩次或更多次手術，所有手術會按以下方法賠償：

  (a) 於「手術項目表」中，最高賠償分類的一項手術可獲該手術分類的最高賠償額的 100%；

  (b) 於「手術項目表」中，第二最高賠償分類的一項手術，或其賠償額與上述第一項手術相同之第二項手術，可獲該手術分類的最高賠償額的 50%；

  (c) 於「手術項目表」中，第三最高賠償分類的一項手術，或其賠償額與上述第一項手術相同之第三項手術，可獲該手術分類的最高賠償額的 25%。

「本公司」只會就每一次及同一次「住院」期間，就最多三次手術作出賠償。若列於「手術項目表」中之切割手術可以其他形式取代，包括 X 光、鐳射或任何其他放射性物質治療，「本公司」將根據保單條款與規章賠償其實際收取的「合理及慣常收費」，最高賠償額為「手術項目表」訂明該項被取代之切割手術的費用。

第 2.4 節 - 「麻醉科醫生」費

在「本公司」已同意就第 2.3 節 - 手術費作出賠償之前提下，「本公司」會就有關手術由「麻醉科醫生」（如「麻醉科醫生」同為「受保人」進行手術之「醫生」，則不包括在內）所收取之費用，支付實際收取的「合理及慣常收費」。「本公司」就每一宗「傷疾」所支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內，並同時受有關手術在「手術項目表」上之分類賠償額所限。

若於同一次「住院」中，因同一宗或不同「傷疾」進行兩項或以上的手術，保障則根據上述第三部份 - 保障內第 2.3 節的條款(i)，(ii)及(iii) 計算。

第 2.5 節 - 手術室費

在「本公司」已同意就第 2.3 節 - 手術費作出賠償之前提下，「本公司」會就有關手術由「醫院」所收取之使用手術室或治療室及手術時使用的物料或儀器費用，支付實際收取的「合理及慣常收費」。「本公司」就每一宗「傷疾」所支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內，並同時受有關手術在「手術項目表」上之分類賠償額所限。

若於同一次「住院」中，因同一宗或不同「傷疾」進行兩項或以上的手術，保障則根據上述第三部份 - 保障內第 2.3 節的條款(i)，(ii)及(iii) 計算。

第 2.6 節 - 住院「專科醫生」診症費

若「受保人」在「醫院」「住院」，並按主診「醫生」的書面建議於「住院」期間接受註冊「專科醫生」就該「疾病」或「損傷」而入院的診治，「本公司」將支付該名「專科醫生」實際收取的「合理及慣常收費」。

「本公司」就每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」而在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就同一次「住院」之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。

第 2.7 節 - 癌症及腎透析治療保障

這是第二部份 - 保障表第 2.2 節的延伸保障。「本公司」將會就首次「確診」之癌症或慢性及不可逆轉之腎衰竭引起（包括任何及所有因其引起或有緊密關係的併發症）由「受保人」之主診註冊「醫生」書面建議，不論在「住院」或以「門診」或「日症病人」方式進行下列特別治療，支付有關之實際收取的「合理及慣常收費」及其直接引致之醫療費用：

(i) 化療；

(ii) 電療；

(iii) 癌症治療之數碼導航刀及 / 或伽傌刀；

(iv) 腎透析（血液透析治療或腹膜透析治療）；或

(v) 癌症標靶治療。

就第 2.7 節列明的治療而言，若有關同一宗「傷疾」可根據第 1、2 及 / 或 3 節獲得賠償，最高賠償額將根據第二部份 - 保障表內就第 2.2 節及第 2.8 節所選擇之計劃所限。若「受保人」在「提升保障生效日」或復效日（以較遲者為準）90 日之內「確診」癌症，則「受保人」將不受本節保障。

第 2.8 節 - 「日症病人」或「門診」手術

這是第二部份 - 保障表第 2.2 節及第 2.5 節的延伸保障。「本公司」將會就註冊「醫生」因應「受保人」以「門診」」或「日症病人」方式進行下列手術實際所收取之手術費用，支付實際收取的「合理及慣常收費」：

(i) 病理學報告，但必須(a) 直接跟該次手術有關；及(b)跟該次手術同日進行，最高賠償額受第 2.2 節 - 「醫院」雜費之最高限額所限。就同一宗「傷疾」而言，根據第 2.2 節及第 2.8 節下作出的最高總賠償額，將會按第二部份 - 保障表內就第 2.2 節所選擇之計劃之賠償額所限。

(ii) 手術費，最高賠償額受第 2.3 節 - 手術費用之最高限額所限。就同一宗「傷疾」而言，根據第 2.3 節及第 2.8 節下作出的最高總賠償額，將會按第二部份 - 保障表內就第 2.3 節所選擇之計劃，並同時受有關手術在「手術項目表」上之分類賠償額所限。

(iii) 「麻醉科醫生」費，最高賠償額受第 2.4 節 - 「麻醉科醫生」費用之最高限額所限。就同一宗「傷疾」而言，根據第 2.4 節及第 2.8 節下作出的最高總賠償額，將會按第 2 節 - 保障表內就第 2.4 節所選擇之計劃，並同時受有關手術在「手術項目表」上之分類賠償額所限。

(iv) 於手術時使用手術室或治療室及物料或儀器費用，最高賠償額受第 2.5 節 - 「麻醉科醫生」費用之最高限額所限。就同一宗「傷疾」而言，根據第 2.5 節及第 2.8 節下作出的最高總賠償額，將會按第二部份 - 保障表內就第 2.5 節所選擇之計劃，並同時受有關手術在「手術項目表」上之分類賠償額所限。

第 2.9 節 - 於「公立醫院」「住院」的住院現金

若「受保人」在「保險期」內，因「疾病」或「損傷」，於「公立醫院」之大房內「住院」，「本公司」將會就每日「住院」賠償住院現金，每宗「傷疾」之最高賠償日數為 90 日。

「本公司」就每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就同一次「住院」之每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。

第 2.10 節 - 醫療失誤保障

若在「保險期」內，「受保人」因「醫生」在手術中之醫療失誤而導致「永久及完全傷殘」，而該醫療失誤亦得到該「醫生」所註冊當地的授權醫療監管機構所證明，「本公司」將會按第二部份 - 保障表內所選擇之計劃賠償「受保人」醫療失誤保障。

第3節 - 入院前及出院後之保障

本第三節保障只適用於在「醫院」「住院」期間進行之有關手術索償，而有關手術索償已獲本保單接納及符合本保單之所有條款與規章。

第 3.1 節 － 入院前及出院後之「門診」保障

「本公司」將會向為「受保人」施行手術之「醫生」，支付下列項目之實際收取的「合理及慣常收費」：

(i) 入院前有關該入院手術的兩次「門診」（「門診」包括診症費、處方西藥、物理治療或診斷測試）；及

(ii) 所有「受保人」在有關同一「傷疾」的手術後在出院當日起計連續 45 日內屬「醫療必需」的「門診」覆診，而此等跟進療程必須與「住院」的手術有直接關係。

「本公司」就每一宗「傷疾」會支付之最高賠償額已列載於第二部份 － 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就同一次「住院」之入院前及出院後之「門診」保障之總最高賠償額已列載於第二部份 － 保障表內所選擇之計劃內。

第 3.2 節 － 家居看護費用

如「受保人」於手術出院後因「醫療必需」而聘請一名「合資格護士」到「受保人」的慣常之住所（並不包括任何復康院或療養院）提供看護服務，「本公司」會支付由手術後出院當日起計連續 90 天內該「合資格護士」實際收取的「合理及慣常收費」。有關之服務必需由「受保人」之主診「醫生」以書面建議。

「本公司」就每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。

第 3.3 節 － 指定「危疾」之「專科醫生」治療費用

如「受保人」因患上本第 3.3 節所指定並符合本保單第 6 節 － 「危疾」保障所列明之有關定義的「危疾」，「本公司」將會就「受保人」因有關首次「確診」「危疾」後連續 90 日內有「醫療必需」的「專科醫生」「門診」跟進治療，支付有關之實際收取的「合理及慣常收費」。有關「專科醫生」治療必須由「受保人」之主診「醫生」書面建議：

(i) 腦部良性腫瘤〔第 6 節 － 「危疾」保障所定義的第 5 項〕

(ii) 癌症〔第 6 節 － 「危疾」保障所定義的第 9 項〕

(iii) 末期肝病〔第 6 節 － 「危疾」保障所定義的第 17 項〕

(iv) 心臟病〔第 6 節 － 「危疾」保障所定義的第 19 項〕

(v) 腎衰竭〔第 6 節 － 「危疾」保障所定義的第 21 項〕

(vi) 主要器官移植〔第 6 節 － 「危疾」保障所定義的第 27 項〕

若「受保人」之主診「醫生」及「專科醫生」為同一人，「本公司」只會就第 3.1 節 - 入院前及出院後之「門診」保障或第 3.3 節 － 指定「危疾」之「專科醫生」治療費用之中有較高保障的一項提供保障。

「本公司」就每一宗「危疾」會支付之最高賠償額已列載於第二部份 － 保障表內所選擇之計劃內。

第 3.4 節 － 人造義肢及輪椅租用保障

「本公司」會支付由主診「醫生」以書面建議的，直接因「受保人」有關手術導致的，就使用人造義肢或人造眼球或租用輪椅而實際收取的「合理及慣常收費」，該費用必須在「受保人」就有關手術的同一次「住院」其間或於該手術後出院當日起計連續三十(30)日內招致。

「本公司」就每一宗「傷疾」會支付之最高賠償額已列載於第二部份 － 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」而在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就相關同一次「住院」之人造義肢及輪椅租用保障之總最高賠償額已列載於第二部份 － 保障表內所選擇之計劃內。

第 3.5 節 － 心理科及精神科治療費用

「本公司」會支付由主診「醫生」以書面建議的，直接因「受保人」有關手術導致的，就心理科或精神科「門診」治療而實際收取的「合理及慣常收費」，該費用必須在「受保人」出院當日起計連續 180 日內招致。

「本公司」就每一宗「傷疾」會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」而在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就相關同一次「住院」其後招致及與其有關之心理科及精神科治療之總最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。

第 3.6 節 － 復康及物理治療費用

「本公司」會支付由主診「醫生」以書面建議的，直接因「受保人」有關手術導的，就致需接受註冊物理治療師、註冊職業治療師、註冊語言治療師、註冊義肢矯形師或註冊足部治療師所提供的「門診」復康治療之實際收取的「合理及慣常收費」，該費用必須在「受保人」出院當日起計連續 180 日內招致。

「本公司」就每一宗「傷疾」會支付之最高賠償額已列載於第二部份 － 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」而在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就相關同一次「住院」其後招致及與其有關之復康及物理治療之總最高賠償額已列載於第二部份 － 保障表內所選擇之計劃內。

額外保障（適用於第二部份 － 保障表內第 1 節至第 3 節同時為有效之「受保人」）

a. **「意外」死亡及傷殘保障**若

「受保人」在「保險期」內遭遇「意外」而蒙受本保單保障範圍內之「損傷」，並於「意外」日起計連續 12 個月內導致死亡或以下賠償表內所載的任何一項保障項目，則「本公司」將按第二部份 － 保障表內所選擇之計劃內之最高限額賠償予「受保人」。

賠償表

保障項	
1.	死亡
2.	「永久及完全傷殘」
3.	「永久」及無法痊癒之四肢癱瘓
4.	雙眼「永久」完全「喪失視力」
5.	單眼「永久」完全「喪失視力」
6.	任何兩肢「永久」完全「殘廢」
7.	任何單肢「永久」完全「殘廢」
8.	喪失說話能力及失聰〔第 6 節 －「危疾」保障所定義的第 24 項及第 14 項〕

賠償：

(i) 如蒙受「損傷」前手足或器官已喪失部份功能，而在「損傷」後變成全部「殘廢」，「本公司」會就該次「損傷」引致的傷殘程度決定最高賠償百分比以計算賠償該「損傷」所引致的「殘廢」部份。若「受保人」於「損傷」前該手足或器官已完全喪失功能，則不能就本節獲得任何賠償。

(ii) 在同一宗「意外」事件中，「本公司」不會就上列保障項目作出多於一次賠償。若「受保人」就同一次「意外」中遭受多於一項上列保障項目，「本公司」亦只會就有較高保障額的一項項目，按照本節訂明之最高賠償額作出賠償。

b. 「意外」身故恩恤保障

若「受保人」在「保險期」內遇上「意外」，並在該「意外」後連續 12 個月內直接因此而死亡，「本公司」將會根據第二部份 － 保障表內所訂明之最高賠償額，支付一筆過身故恩恤金予「受保人」之遺產承繼人以用作緊急現金或殮葬費用。

c. 緊急門診保障

若「受保人」在蒙受「損傷」後 48 小時內到「醫院」「門診」部門接受緊急治療，「本公司」將會支付「醫院」或「醫生」就該緊急治療所收取之實際的「合理及慣常收費」。「本公司」於每保單年度對「受保人」之最高賠償額已列載於第二部份 － 保障表內。

只適用於額外保障之特別條款

1. 就本部分（a） － （c）項之額外保障發生任何索償時，本部分（a） － （c）項之額外保障必須於當時「附表」內訂明本保單第二部份 － 保障表內之第一節至第 3 節同時為有效之「受保人」。
2. 在獲得本部分額外保障（a）項的任何賠償後，本部分（a） － （c）項之額外保障將會即時終止。

第 4a 節 － 附**加醫療保障**

本保障只在「附表」上訂明為有效時才適用。

本節就本保單內下列之項目提供附加醫療保障：

就第 1.1 節 － 房租及膳食費及第 2.1 節 － 「醫生」巡房費而言

若「受保人」在「醫院」「住院」超過 182 日，「本公司」會支付房租及膳食、及「醫生」巡房之實際收取的「合理及慣常收費」，惟需受第二部份 － 保障表第 1.1 節及第 2.1 節所選擇之計劃之每日保障額所限。

就第 2.2 節 － 「醫院」雜費、第 2.3 節 － 手術費、第 2.4 節 － 「麻醉科醫生」費、第 2.5 節 － 手術室費、第 2.6 節 － 住院「專科醫生」診症費及第 2.7 節 － 癌症及腎透析治療保障而言

若就同一宗「傷疾」，其實際收取的「合理及慣常收費」超出第二部份 － 保障表所選擇之計劃之最高保障額，「本公司」將會賠償此實際收取的「合理及慣常收費」超出最高保障額的餘額部分的 80%。

「本公司」就每一宗「傷疾」於本 4a 節會支付之最高總賠償額已列載於第二部份 － 保障表內所選擇之計劃內。

只適用於第 4a 節之特別條款

1. 就第 4a 節所選擇之計劃級別必須與第二部份 - 保障表內之第 1 節至第 3 節所選擇的計劃級別相同。
2. 「受保人」只能夠在「附表」內訂明本保單第二部份 - 保障表內之第 1 節至第 3 節同時為有效時，才可選用本節。

第 4b 節 - 自願性「自負額」

若「受保人」自願地接受於每次及每宗有關本保單第二部份 - 保障表內之第 1 節至第 3 節保障之索償附加「自負額」，則可就第二部份 - 保障表內之第 1 節至第 3 節之應繳保費獲得折扣優惠。有關之「自負額」已列載於「附表」上。

若「受保人」已就受保「傷疾」從「本公司」或其他保險公司所簽發的醫療保單獲得賠償，「受保人」從本保單中可獲得的賠償，將會是實際醫療費用扣減從其他保單中已獲得的賠償後，或是扣減「自負額」後，之餘額（以扣減額較高者為準），惟需受第二部份 - 保障表內所選擇之計劃之最高限額所限。

在本保單所定義第六部份 - 一般保障第 15 項 - 保障終止之前，「受保人」可在以下其中一個情況提出減少或免除「自負額」一次而不需提交健康申報表：

- 緊隨「受保人」50 歲、55 歲、60 歲或 65 歲生日後之「保單生效日」的周年日。有關已減少或免除的「自負額」將於緊隨其 50 歲、55 歲、60 歲或 65 歲生日後之「保單生效日」的周年日起生效；或
- 緊隨「受保人」新工作的入職日期、結婚日期、子女出生日期或其本人的大學畢業日期後之「保單生效日」的周年日。有關已減少或免除的「自負額」將於緊隨其就申請減少或免除「自負額」的事件發生後之「保單生效日」的周年日起生效。為免生疑，有關就申請減少或免除「自負額」的事件必須在減少或免除生效之「保單生效日」的周年日前一年以內發生。

「受保人」必須就有關減少或免除的申請，於「保單生效日」的周年日前不少於三十(30)天向「本公司」提供書面申請，並提供我們認為可接受的證明。

只適用於第 4b 節之特別條款

1. 就第 4b 節所選擇之計劃級別必須與第二部份 - 保障表內之第 1 節至第 3 節所選擇的計劃級別相同。
2. 若「受保人」受保於由其他保險公司承保之醫療保險計劃（包括由「受保人」僱主提供之團體醫療保險計劃），且該保險計劃提供跟本保單第二部份 - 保障表內之第 1 節至第 3 節相同或類似之保障，「受保人」必須在向本保單提出索償前，先從該其他保險計劃申請索償。
3. 「受保人」只能夠在「附表」內訂明本保單第二部份 - 保障表內之第 1 節至第 3 節同時為有效時，才可選用本節。

第 5 節 - 住院現金保障

本保障只在「附表」上訂明為有效時才適用。

若「受保人」在「保險期」內因「疾病」或「損傷」於「醫院」「住院」，「本公司」將會就「醫院」收取之每一整日「住院」之房租及膳食費支付住院現金保障。

「本公司」就每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。就每一宗「傷疾」會支付之最高保障日數亦已列載於第二部份 - 保障表內所選擇之計劃內。若「受保人」因多於一宗「傷疾」在「醫院」「住院」並進行手術或治療，在同一次「住院」內之所有「傷疾」將被視為同一宗「傷疾」，而「本公司」就同一次「住院」之每一日會支付之最高賠償額已列載於第二部份 - 保障表內所選擇之計劃內。

只適用於第 5 節之特別條款

「受保人」只能夠在「附表」內訂明本保單第二部份 - 保障表內之第 1 節至第 3 節同時為有效時，才可選用本節。

第 6 節 - 「危疾」保障

本保障只在「附表」上訂明有效時才適用。

每一宗「危疾」都在本第 6 節按名定義。任何「危疾」必須按照有關之定義「確診」為「危疾」，方可索償。

若「受保人」在「保險期」內，根據以下任何一項「危疾」之定義被「專科醫生」「確診」患有「危疾」或進行下列定義之手術，「本公司」將會按照第二部份 - 保障表內所選擇之計劃之最高限額作出賠償：

1. 因輸血而感染人類免疫力缺乏病毒

「受保人」感染人類免疫力缺乏病毒（HIV），並符合下列所有條件：

(i) 感染由於輸血引起，且導致感染的輸血日期在「首個保單生效日」之後；
(ii) 提供輸血的單位承認責任或者法院終審庭裁定此醫療責任，而且不准上訴；及
(iii) 「受保人」並非血友病患者。

如果醫學上出現能夠治癒愛滋病或人類免疫力缺乏病毒的方法，或者出現能夠預防愛滋病的方法，本保障將不再適用。

由於其他方式導致的感染，包括經性行為或靜脈注射藥物導致的感染均不在保障範圍內。「本公司」有權取得「受保人」任何的血液樣本，並且使用該血液樣本進行獨立測試。

2. 亞爾茲默氏病

「受保人」在首次「確診」時「年齡」必須為 70 歲或以下。

亞爾茲默氏病是一種進行性腦變性疾病，表現為瀰漫性大腦皮質萎縮並具有特徵性組織病理學改變。必須由神經科「專科醫生」「確診」，並符合以下所有條件：

(i) 不可逆轉的永久性腦功能衰退；
(ii) 由標準測試證實因亞爾茲默氏病導致明顯的認知功能損害；
(iii) 由磁力共振掃瞄或電腦掃瞄證實存在大腦皮層瀰漫性萎縮，而腦腫瘤或血栓等其它病變不在保障範圍內；及
(iv) 「受保人」必須連續不少於 180 日無法在沒有他人協助的情況下完成最少三項「日常活動」。

其他精神錯亂腦功能失調及精神病都不受保障。因濫用酒精或藥物引致之痴呆並不在保障範圍之內。

3. 植物人

指腦皮質廣泛壞死，惟腦幹仍保持完整。有關診斷必須由神經科「專科醫生」「確診」而損壞性質屬永久性的，且此狀態須已持續最少三十(30)日。

4. 再生障礙性貧血

是指不可逆轉的骨髓功能衰竭導致的貧血、中性粒細胞減少和血小板減少。再生障礙性貧血必須由血科「專科醫生」基於骨髓穿刺細胞檢查「確診」。血象檢查必須符合下列三項條件中的兩項：

(i) 中性粒細胞絕對計數相等或低於 500 / mm3；
(ii) 網織紅細胞絕對計數相等或低於 20,000 / mm3；及
(iii) 血小板計數相等或低於 20,000 / mm3。

5. 腦部良性腫瘤

良性的腦部腫瘤，並且符合以下所有條件：

(i) 腫瘤對生命構成威脅；
(ii) 腫瘤對腦部造成損害；
(iii) 腫瘤已經通過顱骨切開手術切除或如果腫瘤不能通過顱骨切開手術切除，它已經導致會員在沒有協助的情況下，永久性失去進行「日常活動」六項中最少三項的能力。此狀況須已持續最少 180 日，並得到神經科「專科醫生」的證明；及
(iv) 必須由神經科「專科醫生」或神經外科「專科醫生」證明腫瘤的存在，並且提供磁力共振、電腦掃瞄或其他可靠的影像技術的報告為證明。

以下的情況不在保障範圍內：

(i) 囊腫；
(ii) 肉芽腫；
(iii) 脈管畸形；
(iv) 血腫；
(v) 腦下垂體或脊椎腫瘤；及
(vi) 腦膜瘤。

6. 失明

因患病或「意外」導致的永久性雙目完全失去視力。必須由眼科「專科醫生」基於骨髓穿刺細胞檢查「確診」。如一般的醫療建議認為儀器或植入手術可以恢復完全或部分視力，則不在保障範圍內。

7. 腦部受損

腦部因「意外」或「損傷」導致永久性神經機能缺陷或喪失智力。永久性神經機能缺陷必須由神經病「專科醫生」「確診」。

8. 腦外科手術

在全身麻醉的情況下實際進行了腦部手術，期間進行顱骨鎖孔手術，但「意外」引致的腦部手術並不在此保障範圍之內。手術必須被合資格「專科醫生」「確診」並視為有「醫療必需」的。

9. 癌症

癌症指惡性腫瘤。其特徵為惡性細胞漸進地不受控制地生長及擴散，侵入及破壞正常及周邊組織。主要的介入性治療或大型手術被認為是「醫療必需」的，或已經進行紓緩治療。癌症必須由組織病理學報告「確診」腫瘤呈陽性。本項癌症包括白血病，但以下所列並不在保障範圍之內：

(i) 組織病理學中以下癌症分類：
  - (a) 癌前病變，比如血小板增生症以及真性紅細胞增多症；
  - (b) 非侵入性腫瘤；
  - (c) 交界性腫瘤；或
  - (d) 低惡性腫瘤。

(ii) 原位癌（包括子宮頸上皮內贅瘤 CIN-1、CIN-2 及 CIN-3）或組織學上被界定為癌前病變的情況；

(iii) 分類為 T1aN0M0、T1bN0M0 或 FIGO1A、FIGO1B 的卵巢腫瘤；

(iv) Duke's A 大腸癌；

(v) 在組織學上 TNM 分級標準級別為 T1a、T1b、T1c 或其他分級標相當或較低的級別之前列腺癌；

(vi) RAI 級別 3 以下的慢性淋巴性性白血病；

(vii) 微小甲狀腺乳頭狀癌；

(viii) 非侵入性膀胱乳頭狀癌，組織學上被界定為 TaN0M0 或更低的分級；

(ix) 所有皮膚癌，除非能夠證實腫瘤已經轉移或是利用 Breslow 組織學檢驗方法證明最高厚度超過 1.5 毫米之惡性黑色素瘤；及

(x) 與人體免疫力缺乏病毒同時存在的所有腫瘤。

10. 慢性及末期肺病

最後或末期階段肺病導致慢性呼吸系統衰竭，並且出現以下所有情況：

(i) 在第一秒最大呼氧量（FEV1）測試中的呼氧量每秒持續少於一公升（即在用力呼氣的第一秒期間）；

(ii) 低血氧症導致每天需要接受至少八小時或以上的永久性吸氧治療；

(iii) 動脈血液氣體分析重複顯示動脈血氧分壓低於 55mgHg （PaO2< 50mmHg）；及

(iv) 休息時呼吸困難。

此「確診」必須由肺科「專科醫生」確定。

11. 復發性慢性胰臟炎

根據醫療紀錄，胰臟炎發生超過三次，導致胰臟功能紊亂，引致吸收不良，須要接受酵素替代療法。復發性慢性胰臟炎必須由腸胃病「專科醫生」「確診」，並且由內窺鏡逆行性膽胰造影術（ERCP）證明。

任何因酗酒引起的再發性慢性胰臟炎並不在保障範圍之內。

12. 昏迷

處於完全喪失知覺狀態，對所有外界的刺激或內部需求完全沒有反應，並須符合下列所有條件：

(i) 格拉斯哥氏昏迷指數表三分；

(ii) 須要使用生命維持系統最少連續 96 小時或以上；及

(iii) 造成永久性神經損害，出現持續的臨床症狀連續最少三十(30)日。

必須由「專科醫生」「確診」。由於酒精或濫用藥物引起的昏迷不在保障範圍內。

13. 冠狀動脈手術

實際接受了胸骨切開手術及搭橋手術，以矯正一條或以上之冠狀動脈狹窄或阻塞。必須提供血管造影以證實冠狀動脈阻塞情況嚴重，以及經心臟「專科醫生」證實手術是有「醫療必需」。冠狀動脈血管成形手術及所有其他動脈內導管技術或激光治療手術並不在保障範圍之內。

14. 失聰

因「疾病」或「意外」導致雙耳完全及不可逆轉地失去聽覺。必須由耳、鼻、喉科「專科醫生」通過進行聽力及聲域測試「確診」。如一般的醫療意見認為助聽器、儀器或植入裝置可以恢復部分或全部的聽覺，則不在保障範圍內。

15. 象皮病

末期絲蟲病，其特徵為身體受感染組織部位（腿部、生殖器官或乳房）因淋巴管受絲蟲堵塞而明顯地增大或變形。象皮病必須由適當的「專科醫生」「確診」患有永久性淋巴堵塞，及同時經化驗證實循環性絲蟲病原或微絲蚴血液塗片確認（班氏吳策絲蟲或馬來絲蟲）。其他淋巴水腫或急性淋巴管炎並不在保障範圍之內。

16. 腦炎

腦部物資（大腦半球、腦幹或小腦）嚴重發炎。該疾病必須導致嚴重併發症及同時引起永久性神經損害，並且持續至少達 180 日。該永久性神經損害必須由神經科「專科醫生」書面證明。

因人類免疫力缺乏病毒（HIV） 引起之腦炎並不在保障範圍之內。

17. 末期肝病

末期肝病或肝硬化指導致以下所有情況之慢性末期肝衰竭：

(i) 腹水；

(ii) 腎功能損害；

(iii) 食管或胃靜脈曲張；及

(iv) 肝性腦病。

任何因酗酒或濫用藥物直接或間接地、完全或部分地導致之肝病並不在保障範圍之內。

18. 暴發性病毒性肝炎

由肝炎病毒引致部份或整個肝臟壞死而導致肝臟迅速衰竭。診斷必須經證實為肝炎病毒引致，並且出現以下所有症狀：

(i) 肝臟迅速萎縮；

(ii) 肝功能測試顯示肝功能急速退化；

(iii) 黃疸症狀加劇；及

(iv) 全部肝葉壞死，只存留萎陷的肝臟網狀支架。

必須提供以下的證明：

(i) 肝功能顯示大面積的肝實質病變；及

(ii) 肝性腦病的客觀徵狀。

任何因自殺、服毒、濫用藥物或酗酒而直接或間接地、完全或部分地導致之肝病並不在保障範圍之內。

19. 心臟病

因血液供應不足而首次出現及被「確診」心肌壞死，導致以下所有急性心肌梗塞之症狀：

(i) 心肌梗塞的典型臨床症狀 （例如： 典型胸痛）；

(ii) 新近的心電圖變化顯示出現心肌梗塞之形成；及

(iii) 典型心臟酵素提升或心肌鈣蛋白達到以下或更高水平：
  - (a) Troponin T > 1.0 ng / ml
  - (b) AccuTnI > 0.5 ng / ml 或其他 Troponin I 的檢驗方法同等的閾值。

報告必須明確證明有急性心肌梗塞。 其他急性冠狀動脈綜合，包括但不限於心絞痛並不在保障範圍之內。必須由心臟「專科醫生」「確診」。

20. 心瓣手術

因無法單獨通過動脈內插管手術進行修補心瓣膜缺陷而須首次進行的胸廓切開和心臟切開手術，為一個或多個心瓣進行置換或修復手術。進行此手術前必須經適當的檢查證明並由心臟「專科醫生」建議及證實手術為有「醫療必需」的。基於插管的技術（包括但不限於球囊分離術或瓣膜成形手術）並不在保障範圍之內。

21. 腎衰竭

被「確診」為慢性及不可逆轉性腎衰竭，雙腎出現慢性不可逆轉的功能喪失，導致定期需要接受血液透析、腹膜透析或已展開腎臟移植的治療。此「確診」必需由「專科醫生」確定。

22. 喪失獨立能力

「受保人」在首次「確診」時「年齡」必須為 18 歲或以上及最高至 70 歲。

經「專科醫生」「確診」為永久無法完成任何三項「日常活動」（無論有否使用機械設備，特殊裝置或專為殘疾人士而設的其他輔助和調整設備），並已持續最少六個月。因精神或心理因素導致之喪失獨立能力並不在保障範圍內。

23. 失肢

因「疾病」或「意外」導致於腕骨或踝骨部位或以上之兩肢或以上肢體完全切斷。必須由「專科醫生」「確診」失肢。

24. 喪失說話能力
完全及不可治癒地失去說話能力並持續 365 日或以上。必須由耳、鼻、喉「專科醫生」「確診」及提供醫學證明及確認聲帶器質性「疾病」或「損傷」。
有關喪失說話能力將不可能由醫學方法根治。如一般的醫療意見認為任何的輔助、儀器、治療或植入裝置可以恢復部分或全部的語言能力，則不在保障範圍內。因精神或心理因素導致之喪失說話能力並不在保障範圍內。

25. 嚴重燒傷
「受保人」身體皮膚面積最少達 20%以上受到三級燒傷。燒傷面積根據九分法或體表面積表（Lund and Browder Body Surface Chart）來量度並必須由「專科醫生」「確診」。

26. 嚴重頭部創傷
由「意外」造成的頭部創傷導致嚴重的永久性神經損害，並且由創傷或受傷日起計已維持最少 90 日。病情必須導致「受保人」在沒有他人協助的情況下，永久性和不可逆轉的失去進行最少三項「日常活動」的能力。必須由神經科「專科醫生」「確診」並必須有掃瞄、磁力共振掃瞄或其他可靠的造影證明。

27. 主要器官移植
心臟、兩邊肺部、肝臟、兩個腎臟或骨髓被「確診」為不可逆轉性衰竭。「受保人」作為器官受贈者必須已實際進行以下任何一個或多個器官移植手術：
(i) 以下任何整個器官：包括心臟、肺部、肝臟、腎臟或胰臟；或
(ii) 清除所有骨髓後利用造血幹細胞製造人類骨髓。
本定義內的肝臟移植不得少於一葉，肺移植不得少於兩葉，造血幹細胞可包括骨髓幹細胞、外周血幹細胞或臍帶血幹細胞。
移植手術必須為「醫療必需」，並且由「專科醫生」作出器官衰竭的客觀證明。除上述之外，任何其他器官、組織或細胞移植、部分器官移植、幹細胞移植及胰島細胞移植並不在保障範圍之內。

28. 運動神經原疾病
大腦皮質運動神經元進行性變性病症，引致以上運動神經元（受損）為基礎的廣泛性無力。臨床特徵為肢體進行性強直性無力，伴有發音障礙和吞嚥困難，顯示皮質脊髓束和皮質延髓束受損。必須由神經科「專科醫生」「確診」，並有適當的神經肌肉檢查（如肌電圖）證實。

29. 多發性硬化
是一種神經性腦組織的脫髓鞘疾病。必須由神經科「專科醫生」「確診」證實為臨床定義的多發性硬化症。「確診」必須符合下列所有條件：
(i) 檢查必須明確「確診」為多發性硬化症；
(ii) 連續最少 180 日反復發作之神經性損害涉及視覺神經、腦幹、脊髓、協調或感官功能的任何功能缺損組合；及
(iii) 必須有清楚記錄的病歷顯示以上病徵或神經性損害的惡化及緩解的情況。
因紅斑性狼瘡（SLE）及人類免疫力缺乏病毒（HIV）引致之神經性損害並不在保障範圍之內。

30. 肌營養不良症
肌營養不良症是一組遺傳性肌肉變性病變，特徵為不涉及神經系統的肌肉無力和肌肉萎縮。必須由神經科「專科醫生」「確診」及符合以下所有條件：
(i) 病情必須導致「受保人」出現神經功能損害，永久性不可逆轉的喪失在室內房間之間平地行走能力；
(ii) 臨床檢驗包括：無官感神經紊亂、正常腦脊液及輕微腱反射的減退；
(iii) 經適當的神經肌肉檢查例如肌電圖（EMG）檢查證實；及
(iv) 經肌肉活組織檢查證實。

31. 因職業而感染人類免疫力缺乏病毒
由於下列原因感染人類免疫力缺乏病毒（HIV）：
(i) 「受保人」在其常規職業工作過程中受「損傷」引起；或
(ii) 職業須要處理血液或者其他體液。
有效的賠償必須符合以下所有條件：
(i) 感染必須是在「受保人」正在從事的職業工作時發生，該職業必須屬於以下列表內的職業；
(ii) 必須在該「意外」中牽涉有確切來源的受感染的人類免疫力缺乏病毒（HIV）體液；
(iii) 必須在該「意外」當日起計天內將引致人類免疫力缺乏病毒（HIV）感染的「意外」向「本公司」報告；及
(iv) 「受保人」必須證明人類免疫力缺乏病毒（HIV）之抗體呈陰性反應而在該「意外」發生後 180 日內轉變為陽性之血清轉變證明。
該證明必須包括「意外」發生後五日內所做的人類免疫力缺乏病毒（HIV）抗體測試呈陰性反應的結果。
只有下列之職業在受保範圍之內：
(i) 醫生及牙科醫生；
(ii) 護士；
(iii) 實驗室工作人員；
(iv) 醫院內輔助工作人員；
(v) 醫生及牙科醫生助理；
(vi) 救護員；
(vii) 助產士；
(viii) 消防員；
(ix) 警察；或
(x) 監獄工作人員。
如果醫學上出現能夠治癒愛滋病或人類免疫力缺乏病毒的方法，或者出現能夠預防愛滋病的方法，本保障將不再適用。
由於其他方式導致的感染，包括經性行為或靜脈注射藥物導致的感染均不在保障範圍內。「本公司」有權取得「受保人」任何的血液樣本，並且使用該血液樣本進行獨立測試。

32. 癱瘓
因脊髓或腦部「損傷」或疾病導致完全及不可逆轉性喪失兩個或以上的肢體功能。肢體定義為完整的上肢（包括上臂和前臂）或下肢（包括大腿和小腿）。有關之功能損失必須由神經科「專科醫生」確定為永久及已持續最少 180 日。
因自殘、部分癱瘓、病毒感染後暫時性癱瘓或因心理因素引致的癱瘓並不在保障範圍之內。

33. 柏金遜症
「受保人」在首次「確診」時「年齡」必須為 70 歲或以下。一種緩慢進行性中樞神經系統變性疾病，是由於腦實質某區域神經元變性引起腦內部分區域多巴胺水準下降而導致的。柏金遜症必須由神經科「專科醫生」「確診」並且符合下列所有條件:
(i) 症狀無法用藥物控制；
(ii) 呈進行性及永久性神經損害徵兆；及
(iii) 「受保人」連續最少 180 日無法在沒有他人協助的情況下進行最少三項「日常活動」。
其他任何類型的柏金遜綜合症並不在保障範圍之內。

34. 永久及完全傷殘
「受保人」因「疾病」或「損傷」導致完全及不可復原的傷殘，並無法受僱或從事任何職業，不論酬勞或利益多寡亦然。有關之傷殘必須於事發後維持最少連續六個月。而完全及永久喪失雙手、雙足或雙眼，或綜合任何兩項，亦包括在此保障之內。

35. 脊髓灰質炎
由神經科「專科醫生」「確診」受脊髓灰質炎病毒的感染而導致癱瘓，出現運動功能障礙或呼吸功能損害。此症狀表現必須已記存在醫學文件證明並持續出現最少 90 日。而不涉及癱瘓的個案則不在保障範圍之內。其他任何因素形成的癱瘓並不在保障範圍之內。

36. 肺動脈高血壓（原發性）
指因肺結構、肺功能或循環障礙引致肺動脈壓力病理性增高，造成右心室負荷過重及衰竭。肺動脈高壓必須已經造成永久性和不可逆轉的體力活動能力受限，心臟功能損害達到美國紐約心臟病學會心功能分級四級*或以上。必須由「專科醫生」通過心導管檢查「確診」。必須由「專科醫生」透過心臟導管檢查之資料「確診」並符合以下所有條件：
(i) 肺動脈平均壓力> 40mmHG；
(ii) 肺血管循環阻力 > 3（mmHG / L）/ 分鐘； 及
(iii) 正常肺楔壓 < 15mmHg。
與肺病關聯的肺高壓、慢性肺通氣不足、肺動脈血管栓塞性疾病、有關左邊心臟之疾病、左心病變及先天性心臟病並不在保障範圍之內。

*美國紐約心臟病學會心功能分級四級指病人已經接受藥物治療及調節飲食後仍然在日常生活活動中出現症狀，而且在身體檢查及實驗室檢驗證實心室功能異常。

37. 嚴重類風濕性關節炎

因嚴重類風濕關節炎，而導致廣泛性的關節受損，且在下列關節中有三個或以上出現嚴重畸形：

(i) 手指關節
(ii) 腕關節
(iii) 肘關節
(iv) 頸椎關節
(v) 髖關節
(vi) 膝關節
(vii) 踝關節

必須由「專科醫生」「確診」並必須符合以下所有條件：

(i) 美國類風濕病理學院（The American College of Rheumatology）的診斷標準；
(ii) 永久不能在沒有他人協助的情況下進行最少兩項「日常活動」；及
(iii) 以上所有狀況持續最少 180 日。

38. 中風

因腦血管的梗塞、出血或因顱外原因的栓塞而導致不可治癒的腦細胞死亡的任何腦血管疾病。此「確診」必須符合以下所有條件：

(i) 必須由神經科「專科醫生」證明永久性神經損害由事故發生後持續至少９０日；及
(ii) 磁力共振或電腦掃描的報告或其他可靠的影像技術證明此為新「確診」的中風事故。

下列所有項目均不在保障之內：

(i) 短暫性腦缺血發作；
(ii) 由「意外」、「損傷」、感染、血管炎或其他炎症性疾病引起的腦部損害；
(iii) 因血管病引起之眼部問題，包括視覺神經或視網膜梗塞；
(iv) 前庭系統的缺血性功能障礙；
(v) 由造影檢查發現之無症狀性中風；或
(vi) 腔隙性梗塞。

39. 主動脈手術

經胸廓切開或剖腹實際進行修補或矯正主動脈瘤或主動脈阻塞、縮窄或破裂的情況。本定義內主動脈指胸主動脈和腹主動脈，不包括其分支。

手術必須由「專科醫生」證實為有「醫療必需」的。手術治療主動脈周圍分支的血管病，即使手術過程中主動脈的一部分被移除不在保障範圍內。利用微創手術或動脈穿刺技術進行的手術不在保障範圍內。

40. 有狼瘡性腎炎的系統性紅斑狼瘡症

有狼瘡性腎炎的系統性紅斑狼瘡症為自體免疫性疾病，是由於病理性的自生抗體及免疫綜合體出現沉積，而導致身體組織及細胞受損。

有狼瘡性腎炎的系統性紅斑狼瘡症必須由「專科醫生」根據以下所有條件「確診」：

(i) 經臨床證實，最少有其中以下四項由美國類風濕病理學院（The American Collegeof Rheumatology）建議的情況：
  (i) 頰皮疹
  (ii) 盤狀疹
  (iii) 光線敏感
  (iv) 口腔潰瘍
  (v) 關節炎
  (vi) 漿膜炎
  (vii) 腎病
  (viii) 白血球減少（<4,000 微升）；
  或淋巴球減少（<1,500 微升）；
  或溶血性貧血；
  或血小板減少（<100,000 微升）
  (ix) 神經系統病
(ii) 下列兩項或以上的測試呈陽性結果：
  (a) 抗細胞核抗體測試
  (b) 狼瘡細胞測試
  (c) 抗脫氧核糖核酸測試
  (d) 抗 SM（史密夫 IgG 自體抗體）測試
(iii) 有導致腎功能受損的狼瘡性腎炎，其中腎功能的肌酸肝清除率必須為每分鐘 30 毫升或以下。

41. 末期危疾

「受保人」在首次「確診」時「年齡」必須為 70 歲或以下。

除了在此第三部份 - 保障第 6 節 - 「危疾」保障所定義之「疾病」外，「受保人」被「確診」其他「疾病」並將會因此而導致「受保人」於 365 日內死亡。「受保人」必須已不再接受任何積極性治療，惟緩解疼痛或其他舒緩性的措施則除外。必須由適當的「專科醫生」「確診」。

因感染人類免疫力缺乏病毒（HIV）感染導致之末期疾病不在保障範圍內。

只適用於第 6 節之特別條款

1. 若「受保人」被「確診」「危疾」，「本公司」將按第二部份 - 保障表內所選擇之計劃支付 100%的最高限額。
2. 若「本公司」就本保單第六部份 -「危疾」保障已對「受保人」作出 100%的最高保障額賠償，則「本公司」就此第六部份之責任及「閣下」就此第六部份之保障將會即時終止。 「閣下」就第六部份 - 「危疾」保障繳付保費的責任亦會終止。
3. 「受保人」只能夠在「附表」內訂明本保單第二部份 - 保障表內之第 1 節至第 3 節同時為有效時，才可選用本節。

第 6 節之不保事項

本保單將不承保由下列任何一項或多項事故直接或間接引致之「危疾」：

1. 未能尋求或遵從「醫生」之醫學意見。
2. 並非本第 6 節內所定義之「危疾」的任何「疾病」或「損傷」。
3. 在「首個保單生效日」或「提升保障生效日」（僅適用於「提升」保障的部份)或復效日（以較後者為準）起的 90 日內，首次出現病徵及徵狀之任何「危疾」（此項不保事項不包括由「意外」引致之「危疾」）。
4. 「受保人」在首次「確診」後三十(30)日內死亡之有關「危疾」（此項不保事項不包括由「意外」引致之「危疾」）。

第四部份 - 蘇黎世緊急支援

蘇黎世緊急支援將會在「保險期」內，於「受保人」離開「香港」外遊不超過 90 日之情況下，因「疾病」或「損傷」提供以下服務：

1. 轉介家庭護士（適用於「香港」境內）

若「受保人」提出要求，蘇黎世緊急支援的服務供應商可安排保姆、傭人或「合資格護士」到「受保人」在「香港」之住處為「受保人」的孩子、家人或「同居伴侶」提供照顧服務，惟所有費用一律由「受保人」獨自支付。

2. 電話醫療顧問（適用於「香港」境外）

於「受保人」離開「香港」外遊期間提供電話醫療顧問服務，以維持其身體狀況平穩。這類顧問服務並非診斷。

3. 轉介醫療服務供應商（適用於「香港」境外）

若「受保人」提出要求，可提供醫療服務供應商的資料，包括「醫生」、「醫院」及診所之名稱、地址、電話，惟所有診症及相關費用一律由「受保人」獨自支付。

4. 海外入院保證金（適用於「香港」境外）

若「受保人」於離開「香港」外遊期間需要入住「醫院」時繳付入院保證金，「受保人」將會獲得最高 39,000 港元之入院保證金，惟事前須先獲得「本公司」同意。有關入院保證金必須全數退還予「本公司」。其他所有診症及相關費用一律由「受保人」獨自支付。

蘇黎世緊急支援是由蘇黎世保險有限公司指定的服務供應商提供。如欲尋求協助，請致電「本公司」24 小時緊急支援熱線+852 2886 3977。

第五部份 - 一般不承保事項

本保單將不會承保因下列事故直接或間接引致之索償：

1. 任何「投保前已存在之傷疾」；
2. 任何在「等候期」內招致之治療或費用；
3. 任何因分娩、流產、墮胎、妊娠引致的狀況，包括但不限於妊娠測試，產前、產後護理及其他與妊娠、避孕、避孕儀器、不育或其他引致懷孕或絕育手術的方法有關之併發症；性病；
4. 以美容為目的之美容手術或整容手術，惟因「意外」導致而需要治療除外；選擇性的治療；所有目的為增加或減少體重之治療（無論是否病態或有並存病況）；
5. 任何性質之牙科療程或手術，惟因天然牙齒在「保險期」內因「意外」受損而需要治療則除外；保障只適用於緊急情況並用以減輕痛楚及必須在合法之牙科診所或「醫院」內進行治療，惟在任何情況

下均不保障修復或補救程序、任何貴金屬的應用、矯齒治療、補牙、假牙及假體服務（例如齒橋及假齒冠及其條補及相關費用）；

6. 於「醫院」「住院」的目的為療養、監護、休養、舒緩護理、衛生護理或復康；或與引致該次「住院」之診斷或治療無關之任何醫療費用；
7. 獲取器官以作器官移植或由捐贈者（非「受保人」）招致之任何費用，亦包括任何以捐贈者身份招致之費用；
8. 在出生時已存在之先天性缺陷或在「受保人」八歲前出現之新生兒之不正常狀況，包括但不限於所有性質之疝氣（在本保單起保後因創傷引起則除外）、腦癇症、斜視、腦積水、睪丸發育不健全、尿道下裂及梅克爾憩室；
9. 疫苗或預防接種、一般身體檢查、篩檢及預防性檢查；睡眠窒息症之睡眠測試之有關費用；例行眼部測試、眼部屈光不正或矯正視力措施；
10. 購置或使用器具或設備（除非訂明於本保單內），包括但不限於助聽器、支架、枴杖、眼鏡或其他類似項目；
11. 自殺、企圖自殺、蓄意自我傷害、精神失常或神經系統失調或精神疾病，包括但不限於精神病、神經官能症、任何類別抑鬱症、厭食症、暴食症、變性手術、精神分裂症及其他行為失常病症（受保於本保單第三部份 - 保障第 3.5 節 - 心理科及精神科治療費用的情況則除外）；受酒精或非由「醫生」處方之藥物之影響；
12. 參與任何違法行為，包括但不限於搶劫、濫用藥物或傷人；
13. 飛行，除非以付費乘客身份乘搭由持牌航空公司營運之正式持牌空中運載工具；以乘客或司機身份參與任形式的賽車，又或參加職業體育活動或「受保人」可能或可以賺取收入或報酬的體育活動；在海拔 5,000 米以上進行高山遠足，或在 40 米水深以下潛水；
14. 任何受法律、條例或受保於其他保險公司所簽發之保單所保障而獲得補償之「傷疾」索償，除非「受保人」並不能就該等法律、條例或其他保單獲得全數賠償；
15. 人類免疫力缺乏病毒及 / 或人類免疫力缺乏病毒有關「疾病」，包括愛滋病及 / 或其任何突變、衍生或變異所引致或因此而命名；此不承保事項不適用於本保單第三部份 - 保障第 6 節 - 「危疾」保障第 1 項 - 因輸血而感染人類免疫力缺乏病毒及 / 或第 31 項 - 因職業而感染人類免疫力缺乏病毒；
16. 「戰爭」、侵略、外敵入侵、敵對局面（不論正式宣戰與否）、「內戰」、叛亂、革命、暴亂、軍事政變或奪權行動、直接參與罷工、暴動或內亂或以任何形式參與「恐怖活動」；及 / 或
17. 任何核子燃料、核子燃料燃燒後所產生的核子廢料或任何核子武器所產生的電離子輻射或放射性污染。
18. 任何由「網絡行為」引致的「意外」、「傷疾」、「疾病」及 / 或「損傷」。

第六部份 - 一般條款

1. 整體協議

本保單，包括所有「有關文件」，乃立約各方之間之整體協議。任何代理或其他人士均無權更改或豁免本保單的任何條款。本保單如有任何修改，必須獲得「本公司」受權人員的批准並簽發批單作實，方始生效。為免生疑，「有關文件」亦會組成續保合約的部份並且所有資料會於續保時被視為真確及有效，除非收到 「閣下」在續約時另有通知。

2. 「年齡」及資格限制

除非另有說明，就本保單第三部 - 保障第 1 節至第 5 節而言，在「首個保單生效日」時，「受保人」「年齡」必須介乎 15 日至 64 歲（包括 15 日及 64 歲）及可續保至 100 歲。本保單第 1 節至第 5 節之所有保障將於「受保人」101 歲生日後緊隨的「保單生效日」的周年日結束。

就本保單第三部份 - 保障第 6 節而言，在「首個保單生效日」時，「受保人」「年齡」必須介乎 15 日至 64 歲（包括 15 日及 64 歲）及可續保至 75 歲。本保單第 6 節之所有保障將於「受保人」76 歲生日後緊隨的「保單生效日」的周年日結束。「受保人」必須為「香港」市民或居民及持有有效之「香港」身份證明文件，且有永久住址及以「香港」為經常居住地。18 歲以下之「受保人」應持有有效之「香港」出世紙或家屬簽證。

3. 現況改變

若「受保人」就申請表上所提供之資料（不論口頭或書面上提供）出現任何改變均須負上通知「本公司」的之全部責任，否則「本公司」有權拒絕所有賠償或使其失效。

4. 索償通知

若「受保人」因任何「傷疾」而接受治療及可能對本保單作出索償，須於首次接受治療三十(30)日內書面通知「本公司」，而任何「確診」為「危疾」的則須於首次確診後 90 日內書面通知「本公司」， 「閣下」或「受保人」或 「閣下」或「受保人」之代理人需自費提交「本公司」所需之證書、資料及證據，及任何「本公司」所定之形式及性質的各種證明。「本公司」有權自費要求聘用醫療公證人進行身體檢查。如 「閣下」或「受保人」不遵守本條款，「本公司」有權決定不支付本保單的任何保障。

5. 損失證明

必須在有關索償的治療完成及 / 或終止後三十(30)天內向「本公司」提交書面損失證明，包括收據和項目明細表單及診斷資料正本，連同由「本公司」提供並由 「閣下」填妥的索償表格，方可辦理索償。倘能合理解釋不能於限期內將有關證明文件送交「本公司」提供的緣由，並已盡可能於期限後立即送出有關文件，且不超過 180 日之限，則不會被視為放棄申請賠償的權利。「本公司」所需之證書、資料及證據，須依據「本公司」所定之形式及性質提交，「本公司」概不會負責任何費用。

若所提交的證明文件並非中文或英文。 「閣下」或「受保人」必須自費取得經核證的中文或英文證明文件譯本。

6. 索償時限

除索償已被「本公司」接納或為有待進行之未審結訴訟或仲裁外，於任何情況下，「本公司」概不會就「受保人」於任何「傷疾」出現後滿 12 個月方提出之有關索償支付賠償。

7. 身體檢查

如「受保人」蒙受非致命「損傷」，「本公司」有權按需要要求由「本公司」指定的醫療機構為「受保人」進行身體檢查。如「受保人」身故，「本公司」有權自費進行驗屍。

8. 支付索償

本保單之所有索償將以港元支付及將在收到所有必須之證明後支付予「閣下」。若 「閣下」已身故，索償則會支付予 「閣下」之遺產承繼人。

9. 失實陳述，漏報或欺詐

「本公司」有權在下列任何一項情況下，宣告本保單自「保單生效日」起無效，並通知「閣下」，本保單不會為「受保人」提供保障：

(a) 在投保表格或任何其後就相關申請提交予「本公司」的資料或文件（包括相關資料的任何更新及改動)，其所作出的陳述或聲明中，就「受保人」健康狀況的任何 “重要事實” 作出失實聲明或遺漏資料，未如實申報任何「投保前已存在之傷疾」或未能遵行最高誠信而影響「本公司」的風險評估。 “重要事實” 包括但不限於會影響「本公司」對「受保人」的核保決定的事實，若披露該事實「本公司」有可能因而徵收附加保費、增加不保項目、拒絕或待定投保申請。

(b) 在投保表格中或索償時，作出欺詐或有欺詐成分的申述。

在 (a) 的情況下，「本公司」將：

(i) 退還已繳交的相關保費及保費徵費（如有）但需扣除所有已支付的索償金額及「本公司」支付的必要費用，包括但不限於「本公司」的合理行政費及因本保單而招致的服務費（如有）。

(ii) 如上述抵銷事項總數超越已繳交的相關保費，「閣下」必須在「本公司」發出付款通知書後十四（14）個工作天內向「本公司」償還差額。

在 (b) 的情況下，「本公司」將有權:

(i) 不退還已繳交的相關保費；及

(ii) 追討所有過去已支付予「閣下」的賠償，並要求在「本公司」發出付款通知書十四（14）個工作天內把有關賠償償還「本公司」。

10. 保費

(1) 本保單為年度之醫療保單。「閣下」可以年繳或月繳方式付款予「本公司」。支付首期保費後，所有往後的保費必須在到期日或之前支付予「本公司」。如「閣下」曾提出索償或在「保險年度」內曾使用服務，「閣下」必須負責繳付同「保險期」之「保險年度」全年保費，保單方惟有效。「本公司」亦不會就任何已付保費作出退款。

(2) 「本公司」保留權利，在以下情況更改或調整保費：

(a) 「本公司」會根據續保時的適用保費率調整保費（將基於多個因素，包括但不限於醫療通脹，預期未來醫療費用，理賠紀錄及「閣下」及 / 或這產品招致之費用，及保障之更改），並於調整保費前三十(30)天以書面通知「閣下」。
(b) 於續保時，保費將按「受保人」之實際「年齡」自動調整。

11. 無索償折扣

在任何保單年度續保保費時可能適用的無索償折扣將（適用於第二部份 - 保障表內之第 1 節至第 3 節）計算如下：

(i) 如「受保人」於「保單生效日」的周年日前的一個保單年度並無任何索償紀錄，緊隨該「保單生效日」的周年日的續保保費便可享有5%的無索償折扣，最高折扣累積可至 15%。

(ii) 如「受保人」於「保單生效日」的周年日前的一個保單年度有任何索償紀錄，緊隨該「保單生效日」的周年日的無索償折扣會被扣減5%，或直至已沒有任何無索償折扣可被扣減。

(iii) 不論以往保單年度續保時已扣減無索償折扣後之保費多少，任何保單年度之無索償折扣均以原本保單應收取的保費來計算（即未有扣除任何無索償折扣之前之保費）。

12. 寬限期

在首期保費後，「本公司」將於每次保費到期後給予 「閣下」31 日寬限期。在寬限期內，本保單仍維持生效，如於寬限期屆滿後尚未繳清保費，本保單將於欠繳保費之日期起被視為逾時失效。

13. 重訂保單

若 「閣下」因欠繳保費而導致保單終止，惟事後 「閣下」向「本公司」提交令「本公司」滿意之重訂申請書，並提供可保性證明，「本公司」可能允許 「閣下」重訂保單。重訂保單只承保「受保人」於重訂日後開始蒙受之「意外」及重訂日後起計三十(30)日後開始呈現病徵之「疾病」。

14. 取消保單

(i) 「本公司」有權以三十(30)日書面通知 「閣下」取消保單或任何章節或部份，通知書將以郵件形式寄至 「閣下」最後登記地址。在任何情況下，「本公司」並無責任透露有關取消之原因。保障取消時，若在有關取消保單生效日至該「保險期」最後一天的期間沒有任何索償，保費會按比例退還。
在保障終止後，任何由「本公司」收取之有關保費將不對「本公司」構成任何責任，「本公司」亦會退還所收保費。

(ii) 「閣下」可於三十(30)日前向「本公司」提出書面通知以取消此保單，如在該「保單生效日」至取消保單生效日（保障期）期間無索償紀錄，「閣下」已繳交之全年但未到期之保費將根據下列適用之比率計算扣減並退還，但在任何情況下不可低於「本公司」慣常收取之最低保費。如保單以月繳方式繳付全年保費，「本公司」亦有權按以下比率向 「閣下」收取剩餘之全年保費。

於任何情況下，如該保單年度已獲得本保單賠償或接受服務，有關之未到期的保費將不獲退還及「閣下」必須繳交該保單全年之保費：

保障期	「本公司」應收取保費比率
兩個月（即慣常收取最低保費）	40%
三個月	50%
四個月	60%
五個月	70%
六個月	75%
超過六個月	100%

儘管有上述規定，如本保單未符合「閣下」需要，「閣下」有權在緊接保單交付予閣下之日起計的二十一（21）日內交還保單及附上「閣下」的簽署之書面通知書要求取消保單。若未曾獲賠償或沒有將獲發的賠償 ，「本公司」將會把「閣下」已付之保費無息全數退還。若「閣下」曾獲賠償或將獲得賠償，則不獲發還保費。

15. 保單終止

本保單之保障將會在遇到下列較早發生的一項時自動終止：

(i) 「受保人」根據本部份第 2 項 - 「年齡」及資格限制所述之情況，不再符合資格獲得本保單的保障；

(ii) 本保單的保障會根據本部份第 9 項 - 失實陳述，漏報或欺詐所述之情況終止；

(iii) 「閣下」未能根據本部份第 12 項 - 寬限期所述之情況，在 31 日寬限期內付款；

(iv) 任何一方根據本部份第 14 項 - 取消保單所述之情況，以三十(30)日內書面通知取消本保單。

16. 續訂保單

從「保單生效日」起計，本保單會維持生效一 (1) 年及由「本公司」酌情每年自動續保。惟「本公司」保留權利在任何「保險期」之續保前三十(30) 日向「閣下」提供書面通知以更改保單條款，包括但不限於保費、保障、保障額或不承保事項。「本公司」沒有責任透露有關更改之原因及如「閣下」於本保單任何一個「保險期」之「保單生效日」前表示「閣下」不接納相關更改,續保可以不實行。

17. 更改保障

「閣下」可於「保單生效日」的周年日前三十(30)日或之前提交書面申請更改或「提升」保障。申請必須連同健康聲明，詳列「受保人」於申請更改保障時已知或已有之「損傷」、「疾病」、病徵或身體狀況，或「受保人」正在或將會接受之治療或藥物。申請必須經「本公司」批核，「本公司」有權就此要求更改本保單內任何條款及條件，包括但不限於保費、保障或不承保事項（只適用於「提升」部份保障為準）。任何「本公司」接受之更改皆會在下一個保單續期日生效。

若「本公司」收到書面申請前「受保人」已出現病徵或正在接受「醫生」之咨詢、診症、治療或醫療意見、或正接受處方藥物，就有關「傷疾」之保障上限，將以更改保障申請前或後之較低保障為準。

18. 虛報「年齡」或性別

如「受保人」虛報「年齡」或性別，「本公司」會按其正確「年齡」或性別應付之保費退回或收回保費差額。倘「受保人」投保時虛報「年齡」而根據當時的正確「年齡」，本保單之保障應不能生效或應該在收取該次或每次保費前終止，「本公司」於任何情況下只會退回保費而不負責任何承保責任。

19. 其他保障

如「受保人」就受保於本保單內的保障範圍（額外保障 a 及 b 及第 5 節除外），能夠從其他保單或途徑（例如政府計劃）獲得部份或全部索償，「本公司」只會負責已扣除從有關之其他保單或途徑獲得之賠償之費用餘額。在任何情況下，從所有保單或途徑所得之賠償，將不應超過「受保人」實際支出之醫療費用。

20. 蘇黎世緊急支援

受委任提供服務之蘇黎世緊急支援的機構乃是一間獨立服務供應商，在「受保人」要求下為「受保人」提供服務。「本公司」、「本公司」的附屬機構、代理或旗下的員工不會就蘇黎世緊急支援的有關服務供應商、該機構之員工、代理或代表的任何行為、違責、疏忽錯誤或遺漏負責。

21. 筆誤

「本公司」的筆誤不會令生效之保單因而失效，或令失效之保單因而生效。

22. 法律訴訟

當書面索償證明文件根據本保單規定送交「本公司」後，60 日內不得進行法律訴訟以求賠償。此外， 「閣下」及「受保人」亦不得在「本公司」要求其提供索償證明之指定時限期屆滿一年後提出訴訟。

23. 代位權

「本公司」有權自費以 「閣下」或「受保人」名義對任何導致索償之承保事件之第三者進行追討。

24. 替代性爭議解決方案

如有任何關乎本保單之爭議出現，爭議各方可根據香港司法機構為民事調解所訂立及爭議時所適用之有關實務指示，真誠進行調解。所有未能解決之爭議，一律按照「香港」法例第六零九章《仲裁條例》及不時生效之修訂本以仲裁方式裁定。整個仲裁過程必須在「香港」進行，並由爭議各方同意之單一仲裁人裁定。現明文述明，在爭議各方根據本保單行使任何法律權利前，必須先取得仲裁決定。不論任何類型爭議解決方案之任何狀況或結果，如「本公司」否認或否決 「閣下」追索本保單之任何責任，而「閣下」並未能於「本公司」所發出之通知 12 個月內按以上規定展開仲

裁 「閣下」之賠償申請即被視作已被撤回或放棄，並且不能根據本保單再次進行追討。

25. 第三者權利

除 「閣下」或本保單以明示方式指明以外，任何人士如非本保單之一方並沒有權利執行或享有本保單條款的保障。任何有關合約第三者權益之法例將不適用於本保單。不論本保單任何條款所列，任何保單變更（包括任何解除責任或責任妥協）或終止均不須第三者同意。

26. 遵從保單條款

如違反本保單任何條款，所有就本保單提出之索償均告無效。

27. 管轄法律

本保單受「香港」法律管轄及按其詮釋，並且服從「香港」之專有司法裁判權。

28. 收集個人資料的目的

「本公司」將根據「本公司」不時通知 「閣下」的私隱政策使用所有已收集及持有個人資料，「閣下」亦可透過此網址查閱有關私隱政策：https://www.zurich.com.hk/zh-hk/services/privacy。

「閣下」及 / 或「受保人」會，及會促使保單內其他「受保人」，授權「本公司」根據「本公司」於不時適用之私隱政策所詳列的強制性用途，使用及轉發 （至「香港」境內或境外）包括屬敏感性如「香港」法例第486 章《個人資料（私隱）條例》中所定義之個人資料。

如「受保人」向「本公司」提供任何第三者資料，受保人」必須保證於提供此等個人資料予「本公司」前已獲得有關資料當事人之正式同意，使「本公司」可以評估、處理、簽發及執行管理本保單，包括但並不限於進行任何對有關資料當事人進行審慎調查、合規及製裁查核。

29. 制裁

若本保單提供的保險、款項、服務、保障及/或「受保人」的任何業務或活動會違反任何適用的貿易或經濟制裁法律或監管要求，不論本保單任何其他條款所列，保險公司則不得被視為向任何「受保人」或其他一方提供任何保險或將向「受保人」或任何其他一方支付任何款項或提供任何服務或保障。

以上條文亦適用於任何被保險公司視為適用的貿易或經濟制裁法律或監管要求，或若「受保人」或其他接受款項、服務或保障的一方是受制裁人士。

第七部份 - 索償程序

步驟1： 就任何「傷疾」於首次接受治療三十(30)日內書面通知「本公司」；

步驟2： 在有關索償的治療完成及 / 或終止後三十(30)天內向「本公司」提交填妥之賠償申報表、下列所需正本的證明文件。

第二部份 - 保障表內之第 1 節至第 2 節﹝除非下列訂明﹞：「住院」及手術保障

- 載明下列資料的「醫院」結單：
  - 病人姓名
  -「住院」期間及日數
  - 收費分類明細表
- 載明下列資料的所有主診「醫生」/「專科醫生」/「麻醉科醫生」/ 外科醫生 / 物理治療師收據：
  - 病人姓名
  - 診治日期
  - 提供的診斷及 / 或治療
  - 收費金額

第二部份 - 保障表內之第 3.1 節：入院前及出院後之「門診」保障 / 額外保障(c) ： 緊急「門診」保障

載明下列資料的主診「醫生」收據：

- 病人姓名
- 診治日期
- 提供的診斷及 / 或治療
- 收費金額

第二部份 - 保障表內之第 3.2 節：家居看護費用

- 主診「醫生」的書面轉介證明
- 載明提供下列服務的「合資格護士」收據：
  -病人姓名
  服務期間及日數
  - 收費金額（每天及總額）

第二部份 - 保障表內之第 2.9 節：於「公立醫院」「住院」的住院現金 / 第二部份 - 保障表內之第 5 節：住院現金保障

- 載明下列資料的「醫院」結單：
  - 病人姓名
  - 「醫院」名稱
  - 「住院」期間及日數
  - 提供的診斷及 / 或治療

第二部份 - 保障表內之第 2.7 節：癌症及腎透析治療保障 / 第二部份 - 保障表內之第 3.3 節：指定「危疾」之「專科醫生」治療費用 / 第二部份 - 保障表內之第 3.4 節：人造義肢及輪椅租用保障 / 第二部份 - 保障表內之第 3.5 節：心理科及精神科治療費用 / 第二部份 - 保障表內之第 3.6 節：復康及物理治療費用

- 主診「醫生」證明需要使用有關保障 / 服務的書面轉介證明
- 載明下列資料由「專科醫生」或「醫生」或有關提供服務機構或人仕所發出之收據：
  - 病人姓名
  - 診治日期
  - 提供的診斷及 / 或治療
  - 收費金額

第二部份 - 保障表內之第 6 節：「危疾」保障

- 載明下列資料的所有主診「專科醫生」收據：
  - 病人姓名
  - 診治日期
  - 提供的診斷及 / 或治療
- 由「專科醫生」簽發之證書及醫療報告且符合本保單第三部份第 6 節 - 「危疾」保障所定義的有關「危疾」。

此保單分別有英文及中文版本，如中文與英文版本有異，均以英文為準。