Manulife 宏利

TERMS AND CONDITIONS

Part 1 Insuring Clause and The Policy

Insuring Clause

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

Type of the Certified Plan – "Flexi Plan"
Name of the Certified Plan – Manulife First VHIS Flexi Plan

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

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

The Policy

The Policy Holder and the Company agree that –

1. No alteration to these Terms and Benefits shall be valid unless it is made in accordance with these Terms and Conditions.

2. All statements made by or for the Insured Person in the Application shall be treated as representations and not warranties.

3. All information provided and all statements made by or for the Insured Person as required under this Policy and the Application shall be provided to the best of his knowledge and in his utmost good faith.

4. These Terms and Benefits come into force on the Policy Effective Date as specified in the Policy Schedule on the condition that the Policy Holder has paid the first premium in full.

5. At the inception of these Terms and Benefits and at each Renewal, in the event of any inconsistency between –

   (a) the terms and benefits of this Policy; and

   (b) the Standard Plan Terms and Benefits of such version as may be determined by the Government and is referred to in Sections 1 (a) to (c) of Part 4,

   then –

(i) so far as the scope of Standard Plan Terms and Benefits is concerned, the terms and benefits which are more favourable to the Policy Holder or the Insured Person shall prevail to the extent of such inconsistency; and

(ii) so far as the scope of Standard Plan Terms and Benefits is concerned, the terms and benefits which impose additional restrictions or limitations to the Policy Holder or the Insured Person shall become ineffective.

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

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

6. At the inception of these Terms and Benefits and at each Renewal, if this Policy covers any benefits that exceed the Standard Plan Terms and Benefits and the terms and benefits applicable to such benefits differ from the terms and benefits applicable to the Standard Plan Terms and Benefits, the difference shall not amount to an inconsistency contemplated under Section 5 of this Part 1.

7. At the time these Terms and Benefits are first issued, the Company may apply Case-based Exclusion(s) due to a Pre-existing Condition or other factor that affects the insurability of the Insured Person notified to the Company in the Application.

8. The Company acknowledges that, as part of the underwriting process, it is the obligation of the Company to ask the Policy Holder and the Insured Person in the Application all requisite information for the Company to make the underwriting decision. If the Company requires the Policy Holder and/or the Insured Person to disclose any updates of or changes to such requisite information after the time of submission of Application and before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Company must make such a request prominently to the Policy Holder and the Insured Person (including without limitation in the application form), in which case the Policy Holder and/or the Insured Person shall have the obligation to inform the Company on such updates and changes. Each of the Policy Holder and the Insured Person shall have the obligation to respond to the questions, and to disclose such material facts as requested in the questions. The Company agrees that if any such questions are not included in the Application, the Company shall be deemed to have waived the disclosure obligation of the Policy Holder and the Insured Person in respect of the information that was not requested.

9. All questions and required information included in the Application must be sufficiently specific and unambiguous, and consistent with the rules and regulations of the VHIS, so as to allow the Policy Holder and the Insured Person (as the case may be) to understand the information being requested and to provide clear and unequivocal responses. In case of dispute, the burden of proving that the questions are sufficiently specific and unambiguous

shall rest with the Company.

10. If the Policy Holder or the Insured Person fails to make the relevant disclosures under Section 8 or 9 of this Part 1, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right as provided in Sections 13 and 14 of Part 2.

Part 2 General Conditions

1. Interpretation

(a) Throughout these Terms and Benefits, where the context so requires, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.

(b) Headings are for convenience only and shall not affect the interpretation of these Terms and Benefits.

(c) A time of day is a reference to the time in Hong Kong.

(d) Unless otherwise defined, capitalised terms used in these Terms and Benefits shall have the meanings ascribed to them under Part 8.

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

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

2. Cancellation within cooling-off period

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

(a) The request to cancel must be received directly by the Company within the cooling-off period. The cooling-off period is the period of twenty-one (21) days immediately following the day of the Delivery to the Policy Holder or the nominated representative of the Policy Holder, of –

(i) these Terms and Benefits and the Policy Schedule; or

(ii) the cooling-off notice;

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

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

The above cancellation right shall not apply at Renewal.

To exercise this cancellation right, the Policy Holder must –

(c) return the original of these Terms and Benefits and the Policy Schedule; and

(d) attach a letter, signed by the Policy Holder, requesting cancellation or in other forms acceptable by the Company.

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

3. Cancellation

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

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

4. Benefit entitlement

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

5. Assignment

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

6. Clerical error

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

7. Currency

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

8. Interest

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

9. Company's obligation

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

10. Governing law

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

11. Dispute resolution

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

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

12. Liability

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

13. Misstatement of personal information

Without prejudice to the Company's right to declare this Policy void in the case of misrepresentation on health related information or fraud as provided in Section 14 of this Part 2, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or smoking habit) is misstated in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1), the Company may adjust the premium, for the past, current or future Policy Years, on the basis of the correct information. Where additional premium is required, no benefits shall be payable unless the additional premium has been paid. If the additional required premium is not paid within a grace period of thirty-one (31) days after the due date as notified by the

Company to the Policy Holder, the Company shall have the right to terminate this Policy with effect from such due date, in which case Section 15 of this Part 2 shall apply. Where there has been an overpayment of premium by the Policy Holder, the Company shall refund the overpaid premium.

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

(a) the right to demand refund of the benefits previously paid; and

(b) the obligation to refund the premium received,

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

14. Misrepresentation or fraud

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

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

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

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

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

(i) the right to demand refund of the benefits previously paid; and

(ii) the obligation to refund the premium received,

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

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

(iii) the right to demand refund of the benefits previously paid; and

(iv) the right not to refund the premium received.

15. Termination of Policy

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

(a) where this Policy is terminated due to non-payment of premiums after the grace period as specified in Section 13 of this Part 2 or Section 3 of Part 3;

(b) the day immediately following the death of the Insured Person; or

(c) the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write or continue to write this Policy;

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

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

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

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

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

If this Policy is terminated under (a) or (c) of this Section 15, in the case where the Insured Person is being Confined or is undergoing Prescribed Non-surgical Cancer Treatment and/or outpatient kidney dialysis (as stated in Section 3 of Part 1 in the Supplement for Enhanced Benefits) for a Disability suffered before such termination, then, with respect to

the Confinement or treatment in relation to the same Disability, Eligible Expenses incurred shall continue to be covered under this Policy until (i) the Insured Person is discharged or the treatment is completed or (ii) thirty (30) days after the termination of this Policy, whichever is the earlier. The Terms and Benefits applicable shall be those prevailing as at the day immediately preceding the date of termination of this Policy. The Company shall have the right to deduct any outstanding premium under Section 13 of this Part 2 from any benefit payment.

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

(d) the Terms and Benefits of this Certified Plan which shall continue to be in full force and effect; and

(e) the continuity of these Terms and Benefits, and shall not adversely affect the Company's compliance with the licensing requirement in order to continue to write these Terms and Benefits.

16. Notices to Company

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

17. Notices from Company

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

(a) if sent by post, two (2) working days after posting; or

(b) if sent by email, on the date and time transmitted.

18. Other insurance coverage

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

19. Ownership and discharge under this Policy

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

20. Change of ownership of the Policy

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

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

(a) the Insured Person if he has reached the Age of eighteen (18) years;

(b) the parent or the Guardian of the Insured Person if he is a Minor; or

(c) any person whose familial relationship with the Insured Person is accepted by the Company according to its prevailing underwriting practices which are readily accessible by the Policy Holder.

21. Death of Policy Holder

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

(a) the Insured Person if he has reached the Age of eighteen (18) years; or

(b) the parent or the Guardian if the Insured Person is a Minor. If the parent or the Guardian refuses the transfer, the ownership of this Policy shall be transferred to the administrator or executor of the Policy Holder's estate.

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

22. Rights of third parties

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

23. Subrogation

After the Company has paid a benefit under this Policy, the Company shall have the right to proceed at its own expense in the name of the Policy Holder and/or the Insured Person

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

24. Suits against third parties

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

25. Waiver

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

26. Compliance with law

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

27. Personal data privacy

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

Part 3 Premium Provisions

1. Premium payable

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

(a) the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company; and

(b) the Premium Loading, if applicable.

2. Payment of premiums

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

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

3. Grace period

The Company shall allow a grace period of thirty-one (31) days after the premium due date for payment of each premium. This Policy shall continue to be in effect during the grace period but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, this Policy shall be terminated immediately on the date on which the unpaid premium is first due.

Part 4 Renewal Provisions

These Terms and Benefits shall be effective from the Policy Effective Date in consideration of the payment of premium and is Renewable for each Policy Year in accordance with the terms of this Part 4. Renewal is guaranteed during the lifetime of the Insured Person.

1. Renewal

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

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

(b) At the time of Renewal, if the Company shall cease or has ceased to maintain its registration with the Government as a VHIS provider while maintaining the requisite authorisation under the Insurance Ordinance to write these Terms and Benefits, Renewal shall be arranged automatically with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time when the Company ceased to maintain its registration as a VHIS provider, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.

(c) After the Company has ceased to maintain its registration with the Government, if the Company subsequently re-registers with the Government as a VHIS provider, then at the Renewal Date coinciding with or immediately following such re-registration, these Terms and Benefits shall be Renewed with the Terms and Benefits no less favourable than the latest version of the Standard Plan Terms and Benefits published by the Government at the time of the Renewal, save for the exceptions in Section 7 of Part 1, Sections 1(b) and 5 of Part 6 and any other exceptions as may be approved by the Government from time to time.

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

2. Adjustment of premium

Irrespective of whether the Company revises these Terms and Benefits upon Renewal, the Company shall have the right to adjust the Standard Premium according to the prevailing

Standard Premium schedule adopted by the Company on an overall Portfolio basis. For the avoidance of doubt, if the Premium Loading is set as a percentage of the Standard Premium (i.e. rate of Premium Loading), the amount of Premium Loading payable shall be automatically adjusted according to the change in Standard Premium.

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

3. Notification of Renewal

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

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

4. No re-underwriting except in limited circumstances

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

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

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

(a) Where the Policy Holder requests the Company to re-underwrite these Terms and Benefits at the time of Renewal for reduction in Premium Loading or removal of Case-based Exclusion(s) according to the Company's underwriting practices. For the avoidance of doubt, the Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;

(b) At any time where the Policy Holder requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits (in which cases the re-underwriting shall be limited to such upgrade or additional benefits).

(i) However, at any time where the Policy Holder requests to unsubscribe the additional benefits (if any) in these Terms and Benefits, or switch to another insurance plan which provides downgrade or reduction of benefits, the Company shall not have the right to re-underwrite these Terms and Benefits but shall have the discretion to accept or reject the request according to its prevailing practices in handling similar requests; and

(ii) The Company shall not have the right to terminate or not to Renew these Terms and Benefits if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;

The Company and Policy Holder acknowledge that –

(c) if under the terms of this Part 4, the Company has the right, or is required, to re-underwrite these Terms and Benefits based on certain factors at Renewal, the Company shall, in accordance with the terms of this Part 4 and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and

(d) as a result of re-underwriting, these Terms and Benefits may be terminated, new Premium Loading may be applied, existing Premium Loading may be adjusted upwards or downwards, new Case-based Exclusion(s) may be applied, and existing Case-based Exclusion(s) may be revised or removed.

Part 5 Claim Provisions

1. Submission of claims

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

(a) all original receipts and/or original itemised bills together with the diagnosis, type of treatment, procedure, test or service provided shall have been submitted to the Company; and

(b) all relevant information, certificates, reports, evidence, referral letter and other data or materials as reasonably required by the Company shall have been furnished to the Company for processing of such claim.

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

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

2. Claimable amount estimate

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

3. Legal action

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

4. Medical examination

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

Part 6 Benefit Provisions

1. General

(a) **Territorial scope of cover**

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

The geographical limitation related to the supplementary medical benefit as stated in Section 6 of Part 1 in the Supplement for Enhanced Benefits, if applicable, shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

(b) **Lifetime Benefit Limit**

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

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

Except for the Network Benefit described in the supplementary medical benefit as stated in Section 6 of Part 1 in the Supplement for Enhanced Benefits, if applicable, and the waiver of the Coinsurance for the benefit described in Section 3(i) of this Part 6, all benefits described in Sections 3(a) to (l) of this Part 6, and Sections 1 to 6 of Part 1 in the Supplement for Enhanced Benefits of these Terms and Benefits, if applicable, are not subject to any restriction in the choice of healthcare services providers, including but not limited to Registered Medical Practitioner and Hospital.

The Network Benefit described in the supplementary medical benefit as stated in Section 6 of Part 1 in the Supplement for Enhanced Benefits, if applicable, is subject to the restriction in the choice of healthcare services providers as stated in Section 6(b) of Part 1 in the Supplement for Enhanced Benefits and the Benefit Schedule of these Terms and Benefits.

The waiver of the Coinsurance for the benefit described in Section 3(i) of this Part 6 is subject to the restriction in the choice of healthcare services providers as stated in Part 2 in the Supplement for Enhanced Benefits and the Benefit Schedule of these Terms and Benefits.

The above restrictions shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

(d) **Choice of ward class**

All benefits described in Sections 3(a) to (l) of this Part 6 and Sections 1 to 5 of Part 1 in the Supplement for Enhanced Benefits of these Terms and Benefits are not subject to any restriction in the choice of ward class in Hospital.

The benefits described in the supplementary medical benefit as stated in Section 6 of Part 1 in the Supplement for Enhanced Benefits, if applicable, are subject to the restriction in the choice of ward class as stated in Section 6 of Part 1 in the Supplement for Enhanced Benefits of these Terms and Benefits. Such restriction shall not apply to the terms and benefits within the scope of the Standard Plan Terms and Benefits. For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall be the version as is referred to under Sections 1(a), (b) or (c) of Part 4.

2. Coverage of Confinement and non-Confinement services

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

(a) is Confined in a Hospital; or

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

the Company shall reimburse the Eligible Expenses which are Reasonable and Customary in accordance with benefit items under Section 3 of this Part 6, Sections 1, 3 to 5 and Section 6 (if applicable) of Part 1 of the Supplement for Enhanced Benefits.

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

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

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

3. Benefits covered

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

(a) **Room and board**

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

(b) **Miscellaneous charges**

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

(i) Road ambulance service to and/or from the Hospital;

(ii) Anaesthetic and oxygen administration;

(iii) Administration charges for blood transfusion;

(iv) Dressing and plaster casts;

(v) Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;

(vi) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;

(vii) Additional surgical appliances, equipment and devices other than those inclusively paid under Section 3(h) of this Part 6, and implants, disposables and consumables used during surgical procedure;

(viii) Medical disposables, consumables, equipment and devices;

(ix) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Section 3(i) of this Part 6;

(x) Intravenous ("IV") infusions including IV fluids;

(xi) Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;

(xii) Rental of walking aids and wheelchair for Inpatients; and

(xiii) Physiotherapy, occupational therapy and speech therapy during Confinement.

(c) **Attending doctor's visit fee**

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

(d) **Specialist's fee**

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

(e) **Intensive care**

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

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

(f) **Surgeon's fee**

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

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

(g) **Anaesthetist's fee**

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

(h) **Operating theatre charges**

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

For the avoidance of doubt, the Eligible Expenses for any additional surgical appliances, equipment and devices used in the operating theatre that are separately charged shall

be payable under Section 3(b) of this Part 6.

(i) **Prescribed Diagnostic Imaging Tests**

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

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

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

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

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

This benefit shall be payable for the Eligible Expenses for –

(i) outpatient visit or Emergency consultation resulting in a Confinement or Day Case Procedure (including but not limited to consultation, western medication prescribed or diagnostic test); and

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

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

(l) **Psychiatric treatments**

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

This benefit shall be payable in lieu of other benefit items under Sections 3(a) to (k) of this Part 6. For the avoidance of doubt, where a Confinement is not solely for the purpose of psychiatric treatments, this benefit shall only be payable for the Eligible Expenses charged on the Medical Services related to psychiatric treatments. Where

the Eligible Expenses involve both psychiatric and non-psychiatric treatments and apportionment of the expenses is not available, the expenses in entirety shall be payable under this benefit if the Confinement is initially for the purpose of psychiatric treatments. If the Confinement initially is not for the purpose of psychiatric treatment, the expenses in entirety shall be payable under Sections 3(a) to (k) above.

4. Pre-existing Condition(s)

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

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

First thirty (30) days of the first Policy Year	no coverage
Thirty-first (31st) day of the first Policy Year onwards	full coverage

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

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

5. Cost-sharing requirement

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

Part 7 General Exclusions

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

1. Expenses incurred for treatments, procedures, medications, tests or services which are not Medically Necessary.

2. Expenses incurred for the whole or part of the Confinement solely for the purpose of diagnostic procedures or allied health services, including but not limited to physiotherapy, occupational therapy and speech therapy, unless such procedure or service is recommended by a Registered Medical Practitioner for Medically Necessary investigation or treatment of a Disability which cannot be effectively performed in a setting for providing Medical Services to a Day Patient.

3. Expenses arising from Human Immunodeficiency Virus ("HIV") and its related Disability, which is contracted or occurs before the Policy Effective Date. Irrespective of whether it is known or unknown to the Policy Holder or the Insured Person at the time of submission of Application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1) such Disability shall be generally excluded from any coverage of these Terms and Benefits if it exists before the Policy Effective Date. If evidence of proof as to the time at which such Disability is first contracted or occurs is not available, manifestation of such Disability within the first five (5) years after the Policy Effective Date shall be presumed to be contracted or occur before the Policy Effective Date, while manifestation after such five (5) years shall be presumed to be contracted or occur after the Policy Effective Date.

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

4. Expenses incurred for Medical Services as a result of Disability arising from or consequential upon the dependence, overdose or influence of drugs, alcohol, narcotics or similar drugs or agents, self-inflicted injuries or attempted suicide, illegal activity, or venereal and sexually transmitted disease or its sequelae (except for HIV and its related Disability, where Section 3 of this Part 7 applies).

5. Any charges in respect of services for –

   (a) beautification or cosmetic purposes, unless necessitated by Injury caused by an Accident and the Insured Person receives the Medical Services within ninety (90) days of the Accident; or

   (b) correcting visual acuity or refractive errors that can be corrected by fitting of spectacles or contact lens, including but not limited to eye refractive therapy, LASIK and any related tests, procedures and services.

6. Expenses incurred for prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests, screening procedures for asymptomatic conditions,

screening or surveillance procedures based on the health history of the Insured Person and/or his family members, Hair Mineral Analysis (HMA), immunisation or health supplements. For the avoidance of doubt, this Section 6 does not apply to –

(a) treatments, monitoring, investigation or procedures with the purpose of avoiding complications arising from any other Medical Services provided;

(b) removal of pre-malignant conditions; and

(c) treatment for prevention of recurrence or complication of a previous Disability.

7. Expenses incurred for dental treatment and oral and maxillofacial procedures performed by a dentist except for Emergency Treatment and surgery during Confinement arising from an Accident. Follow-up dental treatment or oral surgery after discharge from Hospital shall not be covered.

8. Expenses incurred for Medical Services and counselling services relating to maternity conditions and its complications, including but not limited to diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction or pre-mature ejaculation, regardless of cause.

9. Expenses incurred for the purchase of durable medical equipment or appliances including but not limited to wheelchairs, beds and furniture, airway pressure machines and masks, portable oxygen and oxygen therapy devices, dialysis machines, exercise equipment, spectacles, hearing aids, special braces, walking aids, over-the-counter drugs, air purifiers or conditioners and heat appliances for home use. For the avoidance of doubt, this exclusion shall not apply to rental of medical equipment or appliances during Confinement or on the day of the Day Case Procedure.

10. Expenses incurred for traditional Chinese medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na, and other forms of alternative treatment including but not limited to hypnotism, qigong, massage therapy, aromatherapy, naturopathy, hydropathy, homeotherapy and other similar treatments.

11. Expenses incurred for experimental or unproven medical technology or procedure in accordance with the common standard, or not approved by the recognised authority, in the locality where the treatment, procedure, test or service is received, except to the extent where a Medical Service which the Insured Person is being treated has been approved by a Designated Regulatory Authority in use according to the approved indications stipulated by the Designated Regulatory Authority.

12. Expenses incurred for Medical Services provided as a result of Congenital Condition(s) which have manifested or been diagnosed before the Insured Person attained the Age of eight (8) years.

13. Eligible Expenses which have been reimbursed under any law, or medical program or insurance policy provided by any government, company or other third party.

14. Expenses incurred for treatment for Disability arising from war (declared or undeclared),

civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power.

Part 8 Definitions

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

"Accident"	shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured Person and caused by violent, external and visible means.
"Age"	shall mean the attained age of the Insured Person
"Annual Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder in a Policy Year irrespective of whether any limits of any benefit items stated in the Benefit Schedule have been reached. The Annual Benefit Limit is counted afresh in a new Policy Year.
"Application"	shall mean the application submitted to the Company in respect of this Certified Plan, including the application form, questionnaires, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such application, including any updates of and changes to such requisite information (if so requested by the Company under Section 8 of Part 1).
"Benefit Schedule"	shall mean a schedule of benefits attached to these Terms and Benefits which sets out, among others, the benefit items and maximum benefits covered.
"Case-based Exclusion"	shall mean the exclusion of a particular Sickness or Disease from the coverage of these Terms and Benefits that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.
"Certified Plan"	shall mean all the terms and benefits (including any Supplement(s)) that form an insurance plan certified by the Government to be compliant with the requirements of the VHIS. This Certified Plan comprises these Terms and Conditions and the Benefit Schedule and the followings – (a) Supplement for Enhanced Benefits; (b) Supplement for Other Benefits; (c) Supplement for Health Discount; (d) Supplement for Inclusion of VAT and GST as Eligible Expenses;

(e) Supplement for Inclusion of public hospitals and private hospitals in Hong Kong in the definition of Hospital; and

(f) Supplement for Layered Benefits (if applicable).

"Coinsurance"	shall mean a percentage of Eligible Expenses the Policy Holder must contribute after paying the Deductible (if any) in a Policy Year. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits under these Terms and Benefits.
"Company"	shall mean Manulife (International) Limited.
"Confinement" or "Confined"	shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition. Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured Person must stay in the Hospital continuously for the entire period of Confinement.
"Congenital Condition(s)"	shall mean (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.
"Deductible"	shall mean a fixed amount of Eligible Expenses that, in a Policy Year, the Policy Holder must pay before the Company shall reimburse the remaining Eligible Expenses.
“Delivery”	shall mean the delivery of these Terms and Benefits and the Policy Schedule or the cooling-off notice as stated in Section 2(a) of Part 2 to the Policy Holder, or to nominated representative of the Policy Holder, by any the following means: (a) by hand; (b) by post (including registered post); or (c) by electronic means.

	Regardless of the means of delivery is used, it is the responsibility of the Company, to have sufficient proof of delivery and the timing of delivery.
"Designated Regulatory Authority"	shall mean the authorities as stated under the list of designated regulatory authorities applicable to this Certified Plan, as published on the Company's website (www.manulife.com.hk). The list of designated regulatory authorities may be varied, updated and amended from time to time at the Company's discretion. Any change shall be deemed as effective as of the effective date as stated on the list, and Policy Holder and/or Insured Person is recommended to refer to the Company's website set out above for the latest list before receiving any Medical Services.
"Disability"	shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.
"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Disability.
"Emergency"	shall mean an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.
"Emergency Treatment"	shall mean Medical Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.
"Flexi Plan"	shall mean any individual indemnity hospital insurance plan under the VHIS framework with enhancement(s) to any or all of the protections or terms and benefits that the Standard Plan provides to the Policy Holder and the Insured Person, subject to certification by the Government. Such plan shall not contain terms and benefits which are less favourable than those in the Standard Plan, save for the exception as may be approved by the Government from time to time.
"Government"	shall mean the Hong Kong Special Administrative Region Government.
"Guardian"	in respect of a Minor shall mean the person(s) appointed as the guardian(s) under or acting by virtue of the Guardianship of Minors Ordinance (Cap 13. of the Laws of Hong Kong).
"HKD"	shall mean Hong Kong dollars.

"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which – (a) has facilities for diagnosis and major operations; (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Injury"	shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.
"Inpatient"	shall mean an Insured Person who is Confined.
"Insurance Authority"	shall mean the Insurance Authority of Hong Kong established pursuant to section 4AAA of the Insurance Ordinance.
"Insurance Ordinance"	shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).
"Insured Person"	shall mean any person whose risks are covered by these Terms and Benefits, and named as the "Insured Person" in the Policy Schedule.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
"Lifetime Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder cumulatively since the inception of these Terms and Benefits, irrespective whether any limits of any benefit items stated in the Benefit Schedule have been reached or whether the Annual Benefit Limit in a Policy Year has been reached.
"Medical Services"	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.

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

(a) require the expertise of, or be referred by, a Registered Medical Practitioner;

(b) be consistent with the diagnosis and necessary for the investigation and treatment of the Disability;

(c) be rendered in accordance with standards of good and prudent medical practice, and not be rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner;

(d) be rendered in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice for the medical services; and

(e) be furnished at the most appropriate level which, in the prudent professional judgment of the attending Registered Medical Practitioner, can be safely and effectively provided to the Insured Person.

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

(i) the Insured Person is having an Emergency that requires urgent treatment in Hospital;

(ii) surgical procedures are performed under general anaesthesia;

(iii) equipment for surgical procedure is available in Hospital and procedure cannot be done on a Day Patient basis;

(iv) there is significantly severe co-morbidity of the Insured Person;

(v) taking into account the individual circumstances of the Insured Person, the attending Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, the medical service should be conducted in Hospital;

(vi) in the prudent professional judgment of the attending Registered Medical Practitioner, the length of Confinement of the Insured Person is appropriate for the medical service concerned; and/or

(vii) in the case of diagnostic procedures or allied health services prescribed by a Registered Medical Practitioner, such Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, such procedures or services should be conducted in Hospital.

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

(aa) is in accordance with standards of good and prudent medical practice in the locality for the medical service rendered, and, in the prudent professional judgment of the attending Registered Medical Practitioner, not rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner; and

(bb) is in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice in the locality for the medical service rendered.

"Minor"	shall mean a person below the Age of eighteen (18) years.
"Policy"	shall mean this policy underwritten and issued by the Company, which is the contract between the Policy Holder(s) and the Company in respect of this Certified Plan including but not limited to these Terms and Conditions, Benefit Schedule, Application, declarations, Policy Schedule and any Supplement(s) attached to this policy, if applicable. Where this Policy contains additional terms and benefits other than those of this Certified Plan, the meaning of Policy shall also cover such additional terms and benefits.
"Policy Effective Date"	shall mean the commencement date of these Terms and Benefits which is specified as "Policy Effective Date" in the Policy Schedule.
"Policy Holder"	shall mean the person who is a legal holder of this Policy and is named as the “Policy Holder” in the Policy Schedule.
"Policy Issuance Date"	shall mean the date of first issuance of these Terms and Benefits.

"Policy Schedule"	shall mean a schedule attached to these Terms and Benefits, which sets out, among others, the Policy Effective Date, Renewal Date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, premium and other relevant details in respect of these Terms and Benefits.
"Policy Year"	shall mean the period of time these Terms and Benefits are in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Renewal Date as specified in the Policy Schedule (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year period from each Renewal Date.
"Portfolio"	shall mean all policies of the same terms and conditions and the benefit schedule as certified by the Government as a Certified Plan under VHIS.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre- existing Condition, where – (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.
"Prescribed Diagnostic Imaging Tests"	shall mean computed tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.
"Prescribed Non-surgical Cancer Treatments"	shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.
"Reasonable and Customary"	shall mean, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and

	similar Age, for a similar Disability, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred. In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable) – (a) treatment or service fee statistics and surveys in the insurance or medical industry; (b) internal or industry claim statistics; (c) gazette published by the Government; and/or (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.
"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"	shall mean a medical practitioner of western medicine, (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the practitioner is not duly qualified and registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith), the Company shall exercise reasonable judgment to determine whether such practitioner shall nonetheless be considered qualified and registered.
"Renewal", "Renew", "Renewed" or "Renewable"	shall mean renewal of these Terms and Benefits in accordance with their terms without any discontinuance.
"Renewal Date"	shall mean the effective date of Renewal. The first Renewal Date shall be the date as specified in the Policy Schedule (which shall not be later than the first anniversary of the Policy

	Effective Date) and the subsequent Renewal Date(s) shall be the anniversary(ies) of the first Renewal Date. The relevant Renewal Date shall be specified in the notification of Renewal in accordance with Section 3 of Part 4.
"Schedule of Surgical Procedures"	shall mean the list of surgical procedures attached to the Benefit Schedule which sets out the surgical category of different surgical procedures according to their relative degree of complexity, which is from time to time published and subject to regular review by the Government.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured Person and whether or not any diagnosis is confirmed.
"Standard Plan"	shall mean the insurance plan with terms and conditions and the benefit schedule equivalent to the minimum compliant product requirements of VHIS, which are from time to time published and subject to regular review by the Government.
"Standard Plan Terms and Benefits"	shall mean the terms and conditions and the benefit schedule of the Standard Plan, which are from time to time published and subject to regular review by the Government. https://www.vhis.gov.hk/doc/en/information_centre/e_standard_plan_template.pdf
"Standard Premium"	shall mean the basic premium for the coverage under this Certified Plan, as charged by the Company to the Policy Holder on an overall Portfolio basis, which may be adjusted in accordance with the age, gender and/or lifestyle factors of the Insured Person.
“Supplement(s)”	shall mean any document which may add, delete, amend or replace the terms and benefits of this Policy. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Policy.
"Terms and Benefits"	shall mean the Terms and Conditions together with the Benefit Schedule (including the Schedule of Surgical Procedures) and any related Supplement(s) as certified by the Government under this Certified Plan.
"Terms and Conditions"	shall mean Part 1 to Part 8 of this Certified Plan.

Manulife 宏利

SUPPLEMENT FOR ENHANCED BENEFITS

This Supplement for Enhanced Benefits is attached to and forms part of this Policy. For the avoidance of doubt, the provisions herein are deemed to supplement the Terms and Benefits.

Part 1 Enhanced Benefits Provisions

This Part 1 is supplementing Part 6 of the Terms and Conditions. Sections 1, 3 to 5 and Section 6 (if applicable) of this Part 1 shall form part of the benefit items that are payable for the Eligible Expenses covered under Section 2 of Part 6 of the Terms and Conditions. The Company shall also reimburse the expenses in accordance with Section 2 of this Part 1.

1. Isolation room

If on any day of Confinement, the Insured Person is admitted to an isolation room in a Hospital due to any of the following infectious illnesses diagnosed by the attending Registered Medical Practitioner, and if room and board under Section 3(a) of Part 6 of the Terms and Conditions is payable, this benefit shall be payable for the Eligible Expenses charged by the Hospital on the cost of accommodation and meals for the isolation room in excess of the daily limit of room and board as stated in the Benefit Schedule.

(a) Acute poliomyelitis
(b) Amoebic dysentery
(c) Anthrax
(d) Bacillary dysentery
(e) Botulism
(f) Chickenpox
(g) Cholera
(h) Community-associated methicillin-resistant Staphylococcus aureus infection
(i) Creutzfeldt-Jakob disease
(j) Diphtheria
(k) Ebola Virus Disease
(l) Enterovirus 71 infection
(m) Haemophilus influenzae type B infection (invasive)
(n) Hantavirus infection
(o) Invasive pneumococcal disease
(p) Legionnaires' disease
(q) Leprosy
(r) Leptospirosis
(s) Listeriosis
(t) Malaria
(u) Measles
(v) Meningococcal infection (invasive)
(w) Middle East Respiratory Syndrome
(x) Mumps
(y) Novel influenza A infection
(z) Paratyphoid fever
(aa) Plague
(bb) Psittacosis
(cc) Q fever
(dd) Rabies
(ee) Relapsing fever
(ff) Rubella
(gg) Scarlet fever
(hh) Severe Acute Respiratory Syndrome
(ii) Shiga toxin-producing Escherichia coli infection
(jj) Streptococcus suis infection
(kk) Tetanus
(ll) Tuberculosis
(mm) Typhoid fever
(nn) Typhus and other rickettsial diseases
(oo) Viral haemorrhagic fever
(pp) Whooping cough
(qq) Yellow fever

2. Hospital companion bed

If room and board under Section 3(a) or intensive care under Section 3(e) of Part 6 of the Terms and Conditions is payable, this benefit shall be payable for the expenses charged on one (1) extra bed for one (1) person who accompanies the Insured Person in the Hospital during the Confinement, provided that these expenses do not exceed the general range of charges being charged by the Hospital in the locality for providing similar services, as reasonably

determined by the Company in utmost good faith.

3. Outpatient kidney dialysis

This benefit shall be payable for the Eligible Expenses charged on haemodialysis or peritoneal dialysis performed in a setting for providing Medical Services to a Day Patient recommended in writing by the attending Registered Medical Practitioner if the Insured Person is diagnosed with chronic and irreversible kidney failure.

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

4. Post-Confinement home nursing

This benefit shall be payable for the Eligible Expenses charged for nursing services rendered by one (1) Registered Nurse during a home visit to the Insured Person as recommended in writing by the attending Registered Medical Practitioner, within the period stated in the Benefit Schedule after discharge from the Hospital following a surgical procedure performed during a Confinement or admission to an Intensive Care Unit, provided that such home visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or admission to an Intensive Care Unit.

5. Emergency outpatient care

This benefit shall be payable for the Eligible Expenses charged by a Hospital for Emergency Treatment received in the outpatient unit of the Hospital within twenty-four (24) hours of an Accident, provided that the Injury sustained by the Insured Person was caused by the Accident.

Where Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Conditions, such Eligible Expenses shall not be payable under this benefit.

6. Supplementary medical benefit (only applicable if this benefit is available according to the Policy Schedule and Benefit Schedule)

This benefit shall be payable according to the following formula and the terms and conditions for Network Benefit and Non-network Benefit below, subject to the limits of this benefit for each Disability in a Policy Year (as defined in Section 6(d) of this Part 1) as stated in the Benefit Schedule –

$$\left(\text{Eligible Excess Expenses} \times (1 - \text{supplementary medical Coinsurance})_{\text{(if applicable)}} \times \text{Ward Class Adjustment Factor}_{\text{(if applicable)}} \times \text{Location Adjustment Factor}_{\text{(if applicable)}}\right)$$

(a) Non-network Benefit

When the Insured Person receives Medical Services performed by a non-Healthcare Network Medical Practitioner or at a non-Healthcare Network Facility, or in the event where the Network Benefit is not payable as a result of the requirements set out in Section 6(b) of this Part 1 not being fully fulfilled, the Company shall reimburse the Policy Holder

for Eligible Excess Expenses under Non-network Benefit, subject to supplementary medical Coinsurance, Ward Class Adjustment Factor (if applicable), Location Adjustment Factor (if applicable) and the benefit limits below as specified in the Benefit Schedule:
(i) the Non-network Benefit limit;
(ii) the respective benefit limits of the benefit items of Non-network Benefit; and
(iii) the total aggregate supplementary medical benefit limit.

(b) Network Benefit

Network Benefit shall only be payable if all of the requirements set out in items (aa) to (hh) of Section 6(b) of this Part 1 are fully satisfied. Upon fulfillment to these requirements, the Company shall reimburse the Policy Holder for Eligible Excess Expenses with no supplementary medical Coinsurance applied under Network Benefit, subject to Ward Class Adjustment Factor (if applicable), Location Adjustment Factor (if applicable) and the benefit limits below as specified in the Benefit Schedule:
(i) the Network Benefit limit; and
(ii) the total aggregate supplementary medical benefit limit.

(aa) The Insured Person must be Confined, receive the Day Case Procedure, Prescribed Non-surgical Cancer Treatment and/or Prescribed Diagnostic Imaging Test at a Healthcare Network Facility;

(bb) The Confinement, Day Case Procedure and Prescribed Non-surgical Cancer Treatment must be attended and/or performed by a Healthcare Network Medical Practitioner;

(cc) The Healthcare Network Medical Practitioner as stated in item (bb) above must correspond to and practice at the Healthcare Network Facility as stated in item (aa) above, as specified in the list of Healthcare Network Provider;

(dd) The Prescribed Diagnostic Imaging Test must be referred by a Healthcare Network Medical Practitioner;

(ee) The following documents and information must be presented at the Healthcare Network Facility upon registration, including but not limited to the initial registration for consultation with the Healthcare Network Medical Practitioner:
1. Health Card issued by the Company, the Policy Schedule of this Policy or a proof of being the Insured Person of this Policy displayed at the Company's online application(s) or website after appropriate authentication, and
2. An identity card or passport of the Insured Person (or other valid identification document(s) reasonably required by the Healthcare Network Facility);

(ff) Healthcare Network Medical Practitioners are required to submit the pre-approval request on behalf of the Policy Holder and/or Insured Person to the Company for the relevant Medical Services, which shall be approved by the Company before the Healthcare Network Medical Practitioner provides the relevant Medical Services to the Insured Person. If there is any variation in the approved Medical Services covered by the pre-approval, the Healthcare Network Medical Practitioner should inform the Company before providing the relevant Medical Services and the Policy Holder and/or Insured Person must obtain the pre-approval result of such change before receiving the relevant Medical Services;

(gg) The Company shall approve the pre-approval request based on the Medical Services to be provided to the Insured Person and the benefit limits of this Policy. The Policy Holder and/or Insured Person must obtain the pre-approval result with pre-approval amount before the Insured Person receives the relevant Medical Services; and

(hh) Notwithstanding the requirements set out in items (ff) and (gg) above, if it is not feasible to obtain the pre-approval result before the Insured Person receives the relevant Medical Service where Emergency Treatment is needed due to Accident or Emergency, the Healthcare Network Medical Practitioner shall submit the pre-approval request for such Emergency Treatment to the Company on the next working day immediately after the day on which the Insured Person receives such Emergency Treatment.

The Network Benefit shall not be payable and any Eligible Excess Expenses shall be payable under Non-network Benefit if –

(i) the terms and conditions set out in items (aa) to (hh) above have not been fully fulfilled; or

(ii) in any event, where a pre-approval request has not been submitted, or where a pre-approval request has been submitted but has been rejected.

For the avoidance of doubt, approval of the pre-approval request by the Company does not constitute admission of its liability and/or responsibility for all of the charges and expenses incurred for the Medical Services to which the Company's approval relates.

In case of any Shortfall paid by the Company to the Healthcare Network Facility in respect of any Medical Services, the Company shall notify the Policy Holder in writing of such Shortfall, and the Policy Holder shall upon demand by the Company immediately pay the Shortfall in full to the Company.

In the event such Shortfall remains unpaid, the Company reserves the right to deduct the Shortfall amount from any subsequent benefit(s) payable to the Policy Holder under this Policy.

The Company shall be responsible for ensuring that the Healthcare Network Medical Practitioners are aware of their obligations hereunder and the required information to be included when processing the pre-approval request.

When the Insured Person receives Medical Services from Healthcare Network Provider and other medical service providers separately for the same Disability within the same Policy Year, the Eligible Excess Expenses incurred shall be subject to one (1) total aggregate supplementary medical benefit limit (i.e., the total benefit limit which comprises both Network Benefit and Non-network Benefit, subject to benefit limit as stated in the Benefit Schedule). All the respective benefit limits of benefit items (if any) shall still apply.

Healthcare Network Medical Practitioners and Healthcare Network Facilities are not operated by the Company nor the Company's agents or employees. The Company is not the agent of the Healthcare Network Medical Practitioners or Healthcare Network Facilities; and accepts no liability and/or responsibility for the quality and availability of the services, or for any advice provided through the services. The Company shall not be liable and/or responsible for any acts or omissions of a Healthcare Network Medical Practitioner or Healthcare Network Facility in the provision of such services.

The Company is not responsible for maintaining any medical information of the Insured Person in relation to services provided by Healthcare Network Medical Practitioners or

Healthcare Network Facilities. Any information disclosed to the Healthcare Network Medical Practitioners or Healthcare Network Facilities by the Policy Holder or Insured Person shall not constitute any actual, constructive, or deemed knowledge of the Company of the same, and shall not affect the Company's right to contest this Policy and any other policies the Company issued/to be issued to the Insured Person, unless such information has actually been disclosed to the Company or the Company has actual knowledge of such information.

The list of Healthcare Network Provider is available on the Company's online application(s) or website after appropriate authentication. The list may be varied, updated and amended from time to time at the Company's discretion without prior notification. Any change shall be deemed as effective as of the effective date as stated on the list.

(c) Eligible Excess Expenses

For the purpose of the calculation of this benefit, the Eligible Excess Expenses covered under this benefit shall be limited to the following benefit items –

I. For Non-network Benefit

(i) Room and board as stated in Section 3(a) of Part 6 of the Terms and Conditions;
(ii) Miscellaneous charges as stated in Section 3(b) of Part 6 of the Terms and Conditions;
(iii) Attending doctor's visit fee as stated in Section 3(c) of Part 6 of the Terms and Conditions;
(iv) Specialist's fee as stated in Section 3(d) of Part 6 of the Terms and Conditions;
(v) Intensive care as stated in Section 3(e) of Part 6 of the Terms and Conditions;
(vi) Surgeon's fee as stated in Section 3(f) of Part 6 of the Terms and Conditions;
(vii) Anaesthetist's fee as stated in Section 3(g) of Part 6 of the Terms and Conditions;
(viii) Operating theatre charges as stated in Section 3(h) of Part 6 of the Terms and Conditions; and
(ix) Emergency outpatient care as stated in Section 5 of this Part 1.

The Eligible Excess Expenses in respect of the benefit items (ii), (iv), (vi), (vii), (viii) and (ix) above include the Eligible Expenses incurred exceeding the respective benefit limits as stated in the Benefit Schedule (which means the Eligible Expenses incurred less the respective benefit limits as stated in the Benefit Schedule).

The Eligible Excess Expenses in respect of the benefit items (i), (iii) and (v) above include the Eligible Expenses incurred on days exceeding the respective limits on the number of days as stated in the Benefit Schedule for the benefit items payable under Sections 3(a), 3(c) or 3(e) of Part 6 of the Terms and Conditions, subject to the respective "per day" limits of this supplementary medical benefit as stated in the Benefit Schedule.

II. For Network Benefit

(i) Room and board as stated in Section 3(a) of Part 6 of the Terms and Conditions;
(ii) Miscellaneous charges as stated in Section 3(b) of Part 6 of the Terms and Conditions;
(iii) Attending doctor's visit fee as stated in Section 3(c) of Part 6 of the Terms and

Conditions;

(iv) Specialist's fee as stated in Section 3(d) of Part 6 of the Terms and Conditions;
(v) Intensive care as stated in Section 3(e) of Part 6 of the Terms and Conditions;
(vi) Surgeon's fee as stated in Section 3(f) of Part 6 of the Terms and Conditions;
(vii) Anaesthetist's fee as stated in Section 3(g) of Part 6 of the Terms and Conditions;
(viii) Operating theatre charges as stated in Section 3(h) of Part 6 of the Terms and Conditions;
(ix) Prescribed Diagnostic Imaging Tests performed during Confinement or during the course of Prescribed Non-surgical Cancer Treatments recommended in writing by the attending Healthcare Network Medical Practitioner for the investigation or treatment of a Disability. For the avoidance of doubt, both the Coinsurance and the Eligible Expenses incurred for Prescribed Diagnostic Imaging Tests performed on the Insured Person as a Day Patient but not during the course of Prescribed Non-surgical Cancer Treatments will not be counted as Eligible Excess Expenses;
(x) Prescribed Non-surgical Cancer Treatments as stated in Section 3(j) of Part 6 of the Terms and Conditions; and
(xi) Isolation room as stated in Section 1 of this Part 1.

The Eligible Excess Expenses in respect of the benefit items (ii), (iv), (vi), (vii), (viii) and (x) above include the Eligible Expenses incurred exceeding the respective benefit limits as stated in the Benefit Schedule (which means the Eligible Expenses incurred less the respective benefit limits as stated in the Benefit Schedule).

The Eligible Excess Expenses in respect of the benefit item (ix) above include the Coinsurance and the Eligible Expenses incurred exceeding the respective benefit limit as stated in the Benefit Schedule (which means the Eligible Expenses incurred less the respective benefit limit as stated in the Benefit Schedule).

The Eligible Excess Expenses in respect of the benefit items (i), (iii), (v) and (xi) above include the Eligible Expenses incurred exceeding the respective benefit limits as stated in the Benefit Schedule (which means the Eligible Expenses incurred less the respective benefit limits as stated in the Benefit Schedule), starting from the first day of Confinement in a Policy Year.

(d) The "per Disability per Policy Year" benefit limits as stated in Benefit Schedule

<u>Eligible Excess Expenses incurred in different Policy Years</u>

(i) For the Eligible Excess Expenses incurred in different Policy Years, the supplementary medical benefit ("SMM") benefit limits for each Disability shall be counted anew every Policy Year, regardless of whether the Eligible Excess Expenses relate to the same or different Disability(ies).

<u>Eligible Excess Expenses incurred within the same Policy Year</u>

(ii) For the Eligible Excess Expenses incurred within the same Policy Year concerning different Disabilities, the SMM benefit limits shall be counted anew for each Disability in the same Policy Year, except where the Insured Person receives a Medical Service involving more than one (1) Disability, then the Eligible Excess Expenses incurred for all Disabilities involved in the same Medical Service shall be subject to one (1) benefit limit for SMM benefit.

(iii) For the Eligible Excess Expenses incurred within the same Policy Year concerning more than one (1) Medical Service for the same Disability (regardless of whether there are any other Disability(ies) involved in the Medical Service(s)), the SMM benefit limits shall be counted anew for each Medical Service concerning the same Disability in the same Policy Year provided that the relevant Medical Service performed on the Insured Person does not occur within ninety (90) consecutive days following the Last Date (as defined below) of the previous Medical Service in relation to the same Disability.

(iv) For the purpose of Section 6(d)(iii) of this Part 1 and the Benefit Schedule, the Last Date of a Medical Service in relation to the same Disability shall mean the following date –

(aa) the discharge date of Confinement; or
(bb) the date on which the Medical Service is performed on the Insured Person as a Day Patient,

whichever is later.

(e) Supplementary medical Coinsurance

Supplementary medical Coinsurance as stated in the Benefit Schedule shall be applied to the calculation of benefit under Section 6 of this Part 1. However, in the event that:

(i) Non-network Benefit is payable when the Medical Services are received in Hong Kong and Preliminary Assessment is issued by the Company; or
(ii) Network Benefit is payable when all of the requirements set out in items (aa) to (hh) of Section 6(b) of this Part 1 are fully satisfied;

no supplementary medical Coinsurance shall be applied to the calculation of the benefit under Section 6 of this Part 1.

(f) Preliminary Assessment (applicable to Non-network Benefit only)

The Policy Holder may request the Company to provide a Preliminary Assessment upon complying with the following conditions -

(i) Completion and submission of the prescribed form for Preliminary Assessment to the Company at least five (5) working days before the Insured Person receives the Medical Services;
(ii) in the event of any variations on the Medical Services stated in the Preliminary Assessment (e.g. cost and treatment to be received) before the Insured Person receives the Medical Services, resubmission of the revised prescribed form for Preliminary Assessment to the Company before the Insured Person receives the Medical Services; and
(iii) the Preliminary Assessment (and any subsequent Preliminary Assessment under subparagraph (ii) above) is issued by the Company before the Insured Person receives the Medical Services;

except that where Emergency Treatment is needed due to Accident or Emergency, the Policy Holder, the Insured Person or the Insured Person's authorised representative

must complete the prescribed form for a Preliminary Assessment of such Emergency Treatment and submit it to the Company within a reasonable period of time after such Emergency Treatment was received by the Insured Person.

The issuance of a Preliminary Assessment by the Company shall not be deemed to constitute the Company's admission of its liability and/or responsibility for any of the expenses incurred in receiving such Medical Services.

In the event that the actual expenses incurred exceed the claimable amount stated in the Preliminary Assessment, the Company shall request the attending Registered Medical Practitioner to make a written statement on the relevant claim form setting out the reason for (a) the excess; and (b) any differences between the Medical Services actually received and those for which the Preliminary Assessment was issued. In the event that the written statement is not available or the reason is not accepted by the Company based on reasonable assessment, such Preliminary Assessment shall become invalid and supplementary medical Coinsurance shall be applied.

(g) Ward Class Adjustment Factor

If the ward class of the Confinement is of a class higher than the Designated Ward Class, the following Ward Class Adjustment Factor shall be applied to the calculation of the benefit under Section 6 of this Part 1 –

Designated Ward Class	Ward class of the Confinement	Ward Class Adjustment Factor
Ward	Private Room or above	25%
Ward	Semi-private Room	50%
Semi-private Room	Private Room or above	50%
Private Room	Above Private Room	50%

If the reason of the Confinement in a ward class higher than the Designated Ward Class does not involve personal preference of the Policy Holder and/or the Insured Person, and is due to (1) the absence of available room of the Designated Ward Class because of room shortage in case of Emergency Treatment; (2) medical condition(s) that require a specific class of room for isolation reasons; or (3) any other Medically Necessary reasons, the Ward Class Adjustment Factor shall not be applied to the calculation of this benefit. The Company shall have the right to ask for proof of ward class availability in the Hospital to establish whether or not the Ward Class Adjustment Factor applies (e.g. testimony issued by the Hospital; or the isolation reasons as stated on the relevant claim form by the attending Registered Medical Practitioner).

(h) Location Adjustment Factor

The following Location Adjustment Factor shall be applied to the calculation of the benefit under Section 6 of this Part 1 –

- Eligible Excess Expenses incurred outside Asia (excluding the United States of America): 75%
- Eligible Excess Expenses incurred in the United States of America: 50%

Part 2 Waiver of Coinsurance for Prescribed Diagnostic Imaging Tests performed at a Designated Diagnostic Imaging Centre

This Part 2 is supplementing Section 3(i) of Part 6 of the Terms and Conditions.

The Coinsurance as stated in benefit item I(i) of the Benefit Schedule shall not be applied for Prescribed Diagnostic Imaging Test payable under Section 3(i) of Part 6 of the Terms and Benefits if all of the following conditions are fulfilled:

(a) The Prescribed Diagnostic Imaging Test is performed at a Designated Diagnostic Imaging Centre; and

(b) Below documents/information are presented at the Designated Diagnostic Imaging Centre upon registration:

  (i) Health Card issued by the Company, the Policy Schedule of this Policy or a proof of being the Insured Person of this Policy displayed at the Company's online application(s) or website after appropriate authentication;

  (ii) An identity card or passport of the Insured Person (or other valid identification document(s) reasonably required by the Designated Diagnostic Imaging Centre); and

  (iii) A referral letter issued by the attending Registered Medical Practitioner.

Designated Diagnostic Imaging Centres are not operated by the Company nor the Company's agents or employees. The Company is not the agent of the Designated Diagnostic Imaging Centres, and accepts no liability and/or responsibility for the quality and availability of the services, or for any advice provided through of the services. The Company shall not be liable and/or responsible for any acts or omissions of a Designated Diagnostic Imaging Centre in the provision of such services.

The Company is not responsible for maintaining any medical information of the Insured Person in relation to services provided by Designated Diagnostic Imaging Centres. Any information disclosed to the Designated Diagnostic Imaging Centres by the Policy Holder or Insured Person shall not constitute any actual, constructive, or deemed knowledge of the Company of the same, and shall not affect the Company's right to contest this Policy and any other policies the Company issued/to be issued to the Insured Person, unless such information has actually been disclosed to the Company or the Company has actual knowledge of such information.

The list of Designated Diagnostic Imaging Centre is available on the Company's online application(s) after appropriate authentication or the Company's website. The list may be varied, updated and amended from time to time at the Company's discretion without prior notification. Any change shall be deemed as effective as of the effective date as stated on the list.

Part 3 Definitions

This Part 3 is supplementing Part 8 of the Terms and Conditions. Words and expressions used in the Policy Schedule and the Terms and Benefits shall have the following meanings -

"Asia"	shall mean Afghanistan, Australia, Bangladesh, Bhutan, Brunei, Cambodia, Chinese Mainland, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, New Zealand, North Korea, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan and Vietnam.
"Designated Diagnostic Imaging Centre"	shall mean an imaging centre included in the list of Designated Diagnostic Imaging Centre available on the Company's online application(s) after appropriate authentication or the Company's website. The list may be varied, updated and amended from time to time at the Company's discretion without prior notification. Any change shall be deemed as effective as of the effective date as stated on the list.
"Designated Ward Class"	shall mean the ward class selected in the Application or any application made after the issuance of this Policy for a subsequent upgrade or downgrade in any of the benefits under this Certified Plan. The Designated Ward Class is specified as "Designated Ward Class" in the Benefit Schedule and the Policy Schedule or in the latest endorsement (if any).
"Eligible Excess Expenses"	shall mean the Eligible Expenses as stated in Section 6(c) of Part 1 of this Supplement for Enhanced Benefits.
"Health Card"	shall mean the digital health card issued by the Company to the Insured Person. The use of the card is subject to the terms and conditions set out in Section 6(b) of Part 1 and Part 2 of this Supplement for Enhanced Benefits.
"Healthcare Network Facility"	shall mean Hospitals, cancer centres, day case centres and medical service providers who have entered into credit facility arrangements with the Company to provide services to the Insured Persons under this Policy on the Company's undertaking to pay for the services so provided and have included in the list of Healthcare Network Provider available on the Company's online application(s) or website after appropriate authentication. The list may be varied, updated and amended from time to time at the Company's discretion without prior notification. Any change shall be deemed as effective as of the effective date as stated on the list.

"Healthcare Network Medical Practitioner"	shall mean a Registered Medical Practitioner of designated specialty(ies) (if any) included and specified in the list of Healthcare Network Provider available on the Company's online application(s) or website after appropriate authentication. The list may be varied, updated and amended from time to time at the Company's discretion without prior notification. Any change shall be deemed as effective as of the effective date as stated on the list.
"Healthcare Network Provider"	shall mean Healthcare Network Medical Practitioner and Healthcare Network Facility.
"Location Adjustment Factor"	shall mean the adjustment percentage specified in Section 6(h) of Part 1 of this Supplement for Enhanced Benefits to be applied to the calculation of the benefit under Section 6 of Part 1 of this Supplement for Enhanced Benefits for any Eligible Excess Expenses incurred outside Asia.
"Network Benefit"	shall mean the network benefit payable according to the applicable calculation and requirements as set out in Section 6(b) of Part 1 of this Supplement for Enhanced Benefits and the limits as stated in the Benefit Schedule.
"Non-network Benefit"	shall mean the non-network benefit payable according to the applicable calculation and requirements as set out in Section 6(a) of Part 1 of this Supplement for Enhanced Benefits and the limits as stated in the Benefit Schedule.
"Preliminary Assessment"	shall mean the written notice issued by the Company to the Policy Holder which sets out the claimable amount estimate on Eligible Expenses in respect of the relevant Medical Services which are Reasonable and Customary, provided that the request for Preliminary Assessment fulfills the conditions as set out in Section 6(f) of Part 1 of this Supplement for Enhanced Benefits.
"Private Room"	shall mean a Hospital room for the Insured Person's private use during the Confinement with its own private facilities including a bedroom and bath/shower room(s) only, but excluding a room of any higher ward class with its own kitchen, dining or sitting room(s) or otherwise.
"Registered Nurse"	shall mean a nurse, (a) who is duly qualified and is registered as a registered nurse with the Nursing Council of Hong Kong pursuant to the Nurses Registration Ordinance (Cap. 164 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering relevant nursing service in Hong Kong or the relevant jurisdiction outside Hong Kong where the nursing service is provided to the Insured Person,

	but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the nurse is not duly qualified and registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith), the Company shall exercise reasonable judgment to determine whether such nurse shall nonetheless be considered qualified and registered.
"Semi-private Room"	shall mean a Hospital room for the Insured Person's use during the Confinement that is a twin or double occupancy room with two (2) patient beds (not including any companion bed) and one (1) adjoining bathroom.
"Shortfall"	shall mean any expenses for Medical Services provided to the Insured Person which are not covered hereunder or which exceed the benefit coverage of this Policy, and which have been paid to a Healthcare Network Facility(ies) by the Company on behalf of the Insured Person.
"Ward"	shall mean a Hospital room for the Insured Person's use during the Confinement that is a multi-bed room with more than two (2) patient beds (not including any companion bed).
"Ward Class Adjustment Factor"	shall mean the adjustment percentage specified in Section 6(g) of Part 1 of this Supplement for Enhanced Benefits to be applied to the calculation of the benefit under Section 6 of Part 1 of this Supplement for Enhanced Benefits where the ward class of the Confinement is of a class higher than the Designated Ward Class.

SUPPLEMENT FOR OTHER BENEFITS

This Supplement for Other Benefits is attached to and forms part of this Policy. For the avoidance of doubt, the provisions herein are deemed to supplement the Terms and Benefits.

Part 1 Other Benefits Provisions

This Part 1 is supplementing Part 6 of the Terms and Conditions. Other benefits shall be payable according to the following benefit items and are subject to the maximum limits as stated in the Benefit Schedule.

1. Special bonus

This benefit shall be payable as an extra cash bonus in the amount specified in the Benefit Schedule for each day of such Confinement, if a claim in respect of the Eligible Expenses incurred during a Confinement is payable under these Terms and Benefits and either one of the conditions set out in item (a) or item (b) below is satisfied –

(a) such Eligible Expenses have been fully reimbursed under any other hospital reimbursement plans provided by any insurance company(ies) other than the Company; or

(b) the Company reimburses such Eligible Expenses after any reimbursement has been paid under any other hospital reimbursement plans provided by any insurance company(ies) other than the Company.

This benefit is subject to the limit on the number of days as stated in the Benefit Schedule.

2. Compassionate death benefit

This benefit shall be payable to the beneficiary upon the death of the Insured Person.

Any amount payable under this benefit shall be regarded as death benefit proceeds.

3. Accidental death benefit

This benefit shall be payable to the beneficiary upon the death of the Insured Person as a result of Injury caused by an Accident, where such death occurs within ninety (90) days of the Accident.

Any amount payable under this benefit shall be regarded as death benefit proceeds.

4. Medical negligence benefit

This benefit shall be payable to the beneficiary if the Insured Person dies as a direct consequence of any negligence of a healthcare professional of a Hospital during the course of any medical procedure or treatment, provided that –

(i) such death occurs within thirty (30) days of such recorded and proven incident constituting such negligence;

(ii) a public admission of such negligence and liability therefore is made by the Hospital concerned, and is verified and confirmed by the relevant government authority, a court of law (including by way of a coroner's inquest) or the relevant healthcare professional regulator; and

(iii) such death is independent of any other cause.

Any amount payable under this benefit shall be regarded as death benefit proceeds.

Part 2 Beneficiary Provisions

The Policy Holder may designate beneficiaries by providing the names of such beneficiaries to the Company together with such other particulars assisting the identification process, and in such a format prescribed by the Company (in the application or in a form provided by the Company). Any such beneficiary designation must be signed by the Policy Holder and filed with the Company.

Unless otherwise provided in this Policy or in a beneficiary designation in effect under this Policy, the following terms and conditions apply –

1. Beneficiary classifications

The beneficiary for any death benefit proceeds under this Policy will be classified as a primary, secondary or final beneficiary as designated by the Policy Holder. Such classification will determine the interest of that beneficiary with respect to such death benefit proceeds. Beneficiaries surviving at the time of the Insured Person's death and in the same beneficiary classification will share equally in the death benefit proceeds payable to the beneficiaries in that classification. If allocation in percentage or proportion is provided in respect of the various beneficiaries of the same beneficiary classification, the said surviving beneficiaries in the said beneficiary classification will then share the death benefit proceeds payable to the beneficiaries in that classification in accordance with the said allocation, and on a pro rata basis (in accordance with the ratio of the allocated percentage or proportion of each of the said surviving beneficiaries) if one (1) or more than one (1) of the beneficiaries predecease the others of the same beneficiary classification at the time of payment of the said proceeds. If only one (1) beneficiary in the same beneficiary classification is surviving at the time of the Insured Person's death, such a beneficiary will be solely entitled to the death benefit proceeds payable to the beneficiaries in that classification.

For the avoidance of doubt, if a beneficiary and the Insured Person die at the same time, or in circumstances rendering it uncertain which of them survived the other, such beneficiary is, for purpose of this Policy, considered to have died before the death of the Insured Person.

2. Payment to beneficiaries

Death benefit proceeds under this Policy will be paid –

(a) to any primary beneficiaries surviving at the time of the Insured Person’s death; or

(b) if no primary beneficiary is surviving at the time of the Insured Person’s death, to any secondary beneficiaries surviving at the time of the Insured Person’s death; or

(c) if no primary or secondary beneficiary is surviving at the time of the Insured Person’s death, to any final beneficiaries surviving at the time of the Insured Person’s death.

3. Death of beneficiary or failure to designate a beneficiary

If no beneficiary under this Policy is surviving at the time of death of the Insured Person or if the Policy Holder fails to designate a beneficiary in accordance with this Part 2, the death benefit proceeds under this Policy will be paid to –

(a) the Policy Holder if the Insured Person is not the Policy Holder; or

(b) the Policy Holder's estate if the Insured Person is also the Policy Holder.

4. Change of beneficiary and appointment and change of trustee

During the Insured Person's lifetime, the Policy Holder, without the consent of any beneficiary or trustee, can from time to time by a declaration in writing in a form prescribed by the Company signed by the Policy Holder and sent to the Company –

(a) change any prior beneficiary designation or appointment.

(b) appoint a trustee to receive the proceeds for any beneficiary if the beneficiary is under Age eighteen (18), and change or revoke any prior trustee designation or appointment.

Once the request for change has been received and successfully recorded by the Company, the Company shall notify the Policy Holder, and the change shall be effective as of the date of the prescribed form signed by the Policy Holder.

5. Receipt a good discharge

A receipt for any death benefit proceeds under this Policy, signed by the beneficiary, beneficiaries, trustee or trustees designated either in this Policy or in accordance with this Part 2, or anyone lawfully entitled to the death proceeds, will be a good and valid discharge of the death benefit proceeds paid by the Company. Such a receipt, which is duly signed will be final and conclusive evidence that such death benefit proceeds have been duly paid to and received by those lawfully entitled to them and that all claims and demands against the Company with respect to them have been fully satisfied.

Part 3 Suicide Provisions

This Part 3 is supplementing Part 7 of the Terms and Conditions. No death benefit will be payable under this Policy if the Insured Person commits suicide, whether sane or insane, within one (1) year of the Policy Effective Date.

SUPPLEMENT FOR HEALTH DISCOUNT

This Supplement for Health Discount is attached to and forms part of this Policy. For the avoidance of doubt, the provisions herein are deemed to supplement the Terms and Benefits. It is supplementing Part 3 of the Terms and Conditions.

Health Discount

If no benefit (except Health Discount) under these Terms and Benefits has been paid in relation to medical expenses which were incurred during the Relevant Period as defined in the table below, the Company will provide a discount ("Health Discount") on the premium due and payable for these Terms and Benefits for the Policy Year immediately after the Relevant Period. The Health Discount will be equal to the premium due and payable for these Terms and Benefits in the Policy Year immediately after the Relevant Period times the Health Discount Percentage as set in the following table –

Relevant period during which this Policy must remain in force and effective ("Relevant Period")	**Health Discount Percentage (%)**
Two (2) to four (4) consecutive Policy Years immediately prior to the Renewal Date ("Relevant Period A")	8%
Five (5) or more consecutive Policy Years immediately prior to the Renewal Date ("Relevant Period B")	16%

In the event that any benefit under these Terms and Benefits for a Policy Year that falls in a Relevant Period becomes payable after the Health Discount has been applied to the premium, the Health Discount shall be recalculated for all Policy Years subsequent to the incurrence of medical expenses in relation to such benefit. The Policy Holder shall repay to the Company the difference between the Health Discount actually provided by the Company and the recalculated Health Discount to be entitled immediately upon the Company's demand.

For the avoidance of doubt, the determination of Health Discount makes reference to the Policy Year in which the medical expenses are incurred, but not the Policy Year in which an admission to or a discharge from Hospital occurs.

The Health Discount is only offered in respect of either the Relevant Period A or the Relevant Period B, but not both.

Manulife 宏利

SUPPLEMENT

Inclusion of VAT and GST as Eligible Expenses

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

This Supplement shall take effect from 1 March 2022 **("Effective Date")**.

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

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

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

Definition

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

Manulife 宏利

SUPPLEMENT

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

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

This Supplement shall take effect from the Policy Effective Date.

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

Definition

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

Manulife 宏利

SUPPLEMENT FOR LAYERED BENEFITS

<<Product name>>

A. This Supplement for Layered Benefits shall only be applicable to a Policy where benefit layering has been applied on specified health condition(s) as a result of <<underwriting/ re-underwriting>>.

B. This Supplement for Layered Benefits is attached to and forms part of the Terms and Benefits and shall be read in conjunction with Part 6 of the Terms and Benefits of <<Product name>>.

C. Eligible Expenses or other expenses arising from the specified health condition(s) <<(Letter number of the Specified Health Conditions)>> listed in the document "Specified Health Conditions" shall be payable subject to the terms and benefits of <<Product name (the layered benefit)>> <<(Certification number)>> in lieu of the Terms and Benefits.
Please refer to the {terms and conditions, supplement(s), }benefit schedule {and schedule of surgical procedures} of <<Product name (the layered benefit)>> <<(Certification number)>> attached to this Supplement for Layered Benefits for details.

Where the Eligible Expenses or other expenses involve both specified health conditions and non-specified health conditions and apportionment of the expenses is not available, the expenses in entirety shall not be subject to benefit layering specified in this Supplement.

D. All Eligible Expenses or other expenses payable in accordance with this Supplement for Layered benefits shall be counted towards the Annual Benefit Limit and respective benefit limits of the relevant Policy Year as stated in the Benefit Schedule of the Terms and Benefits.

E. For the avoidance of doubt, the amount of benefit payable for all specified health conditions listed in the document "Specified Health Conditions" shall not be lower than that calculated according to the prevailing Standard Plan Terms and Benefits as referred to under Section 1 of Part 4 of the Terms and Benefits.

Manulife 宏利

SPECIFIED HEALTH CONDITIONS

Policy Number	:	<<Policy Number>>
Policyowner	:	<<Name of Policyowner>>
Life Insured	:	<<Name of Life Insured>>
Product Name and Certification Number	:	<<Product name>> <<(Certification number)>>
Print Date	:	<<Print Date>>

Specified Health Conditions:

A. <<Specified Health Condition(s) under the layered benefit>> and complications thereof
B. <<Specified Health Condition(s) under the layered benefit>> and complications thereof
C. <<Specified Health Condition(s) under the layered benefit>> and complications thereof

Manulife 宏利

The benefit payable for the specified health condition(s) <<(Letter number of the Specified Health Conditions)>> shall be subject to the terms and conditions of <<Product name (the layered benefit)>> <<(Certification number)>> on the next page.

{TERMS AND CONDITIONS}

Manulife 宏利

The benefit payable for the specified health condition(s) <<(Letter number of the Specified Health Conditions)>> shall be subject to the supplement of <<Product name (the layered benefit)>> <<(Certification number)>> on the next page.

{SUPPLEMENT FOR OTHER BENEFITS}

The benefit payable for the specified health condition(s) <<(Letter number of the Specified Health Conditions)>> shall be subject to the supplement of <<Product name (the layered benefit)>> <<(Certification number)>> on the next page.

{SUPPLEMENT FOR HEALTH DISCOUNT}

Manulife 宏利

The benefit payable for the specified health condition(s) <<(Letter number of the Specified Health Conditions)>> shall be subject to the benefit schedule of <<Product name (the layered benefit)>> <<(Certification number)>> on the next page.

BENEFIT SCHEDULE

Manulife 宏利

The benefit payable for the specified health condition(s) <<(Letter number of the Specified Health Conditions)>> shall be subject to the schedule of surgical procedures of <<Product name (the layered benefit)>> <<(Certification number)>> on the next page.

{SCHEDULE OF SURGICAL PROCEDURES}

Manulife 宏利

BENEFIT SCHEDULE

Manulife First VHIS Flexi Plan (Ward) with Major Medical	
Designated Ward Class [1]	**Ward**
Benefit items [2]	**Benefit limit (in HKD)**
I. Basic benefits	
(a) Room and board	$1,200 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	$15,000 per Policy Year
(c) Attending doctor's visit fee	$900 per day Maximum 180 days per Policy Year
(d) Specialist's fee [3]	$4,300 per Policy Year
(e) Intensive care	$4,200 per day Maximum 25 days per Policy Year
(f) Surgeon's fee	Per surgery, subject to surgical category for the surgery/ procedure in the Schedule of Surgical Procedures – • Complex $52,500 • Major $26,250 • Intermediate $13,125 • Minor $5,250
(g) Anaesthetist's fee	35% of Surgeon's fee payable [4]
(h) Operating theatre charges	35% of Surgeon's fee payable [4]
(i) Prescribed Diagnostic Imaging Tests [3] [5]	$25,000 per Policy Year Subject to 30% Coinsurance [6]
(j) Prescribed Non-surgical Cancer Treatments [7]	$100,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care [3]	$1,100 per visit, up to $16,000 per Policy Year • 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure • 10 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	$30,000 per Policy Year
II. Other benefits	
(a) Special bonus	$300 per day of Confinement Maximum 180 days per Policy Year
(b) Compassionate death benefit	$10,000
(c) Accidental death benefit	$10,000
(d) Medical negligence benefit	$100,000
III. Enhanced benefits	
(a) Isolation room [8]	$1,100 per day Maximum 180 days per Policy Year
(b) Hospital companion bed [9]	Full cover per day

The content on this page is part of the Terms and Benefits of Certified Plan (No. F00019).

	Maximum 180 days per Policy Year	
(c) Outpatient kidney dialysis [3]	$90,000 per Policy Year	
(d) Post-Confinement home nursing [3]	$660 per visit, up to $13,000 per Policy Year • 15 follow-up nursing visits at home per Confinement (within 90 days after discharge from Hospital)	
(e) Emergency outpatient care	$6,600 per Policy Year	
(f) Supplementary medical benefit [10] [11] [12] Supplementary medical benefit shall be payable for the Eligible Excess Expenses of the following benefit items – I. Basic benefits (a) – (j); and III. Enhanced benefits (a) and (e)		
	Network Benefit [13]	**Non-network Benefit**
Network Benefit limit and Non-network Benefit limit	• Before Age 76: $120,000 per Disability[14] per Policy Year • On or after Age 76: $126,000 per Disability[14] per Policy Year	• Before Age 76: $100,000 per Disability[14] per Policy Year • On or after Age 76: $105,000 per Disability[14] per Policy Year
Total aggregate supplementary medical benefit limit [15] (The total benefit limit of Network Benefit and Non-network Benefit)	• Before Age 76: $120,000 per Disability[14] per Policy Year • On or after Age 76: $126,000 per Disability[14] per Policy Year	
Supplementary medical Coinsurance	Not applicable (i.e. full cover[16])	20% supplementary medical Coinsurance[17]
(i) Room and board	Payable after exceeding the benefit limit as stated under I. Basic benefits (a), starting from the 1st day of Confinement in a Policy Year	Payable after exceeding the limit on the number of days (i.e. 180 days per Policy Year) as stated under I. Basic benefits (a), subject to $1,200 per day
(ii) Miscellaneous charges	Payable after exceeding the benefit limit as stated under I. Basic benefits (b)	
(iii) Attending doctor's visit fee	Payable after exceeding the benefit limit as stated under I. Basic benefits (c), starting from the 1st day of Confinement in a Policy Year	Payable after exceeding the limit on the number of days (i.e. 180 days per Policy Year) as stated under I. Basic benefits (c), subject to $900 per day
(iv) Specialist's fee [3]	Payable after exceeding the benefit limit as stated under I. Basic benefits (d)	
(v) Intensive care	Payable after exceeding the benefit limit as stated under I. Basic benefits (e), starting from the 1st day of Confinement in a Policy Year	Payable after exceeding the limit on the number of days (i.e. 25 days per Policy Year) as stated under I. Basic benefits (e), subject to $4,200 per

		day
(vi) Surgeon's fee	Payable after exceeding the benefit limit as stated under I. Basic benefits (f)	
(vii) Anaesthetist's fee	Payable after exceeding the benefit limit as stated under I. Basic benefits (g)	
(viii) Operating theatre charges	Payable after exceeding the benefit limit as stated under I. Basic benefits (h)	
(ix) Prescribed Diagnostic Imaging Tests (3) (5) (18)	Payable for: • the Coinsurance; and • after exceeding the benefit limit as stated under I. Basic benefits (i)	Nil
(x) Prescribed Non-surgical Cancer Treatments (7)	Payable after exceeding the benefit limit as stated under I. Basic benefits (j)	Nil
(xi) Isolation room (8)	Payable after exceeding the benefit limit as stated under III. Enhanced benefits (a), starting from the 1st day of Confinement in a Policy Year	Nil
(xii) Emergency outpatient care	Nil	Payable after exceeding the benefit limit as stated under III. Enhanced benefits (e)
Other limits		
Annual Benefit Limit for benefit items I. Basic benefits (a) – (l), II. Other benefits (a) – (d) and III. Enhanced benefits (a) – (f)	Nil	
Lifetime Benefit Limit for benefit items I. Basic benefits (a) – (l), II. Other benefits (a) – (d) and III. Enhanced benefits (a) – (f)	Nil	

Notes –

(1) Hospitals offer various accommodation options with different facilities, and the categorisation used by the Hospitals may be different from the definitions as stated in Part 3 in the Supplement for Enhanced Benefits of these Terms and Benefits. If you are unsure of whether a particular accommodation option meets the Ward, Semi-private Room and Private Room definitions under these Terms and Benefits, please contact the Company before Confinement.

(2) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one (1) benefit item in the table above, except the excess amount eligible under supplementary medical benefit and isolation room.

(3) The Company shall have the right to ask for proof of recommendation e.g. written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner.

(4) The percentage here applies to the Surgeon's fee actually payable or the benefit limit for the

Surgeon's fee according to the surgical categorisation, whichever is the lower.

(5) Tests covered here only include computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

(6) No Coinsurance for this benefit item shall be applied if the Prescribed Diagnostic Imaging Test is performed at a Designated Diagnostic Imaging Centre and all other conditions stated in Part 2 in the Supplement for Enhanced Benefits are satisfied.

(7) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.

(8) Provided that room and board under Section 3(a) of Part 6 of the Terms and Conditions is payable.

(9) Provided that room and board under Section 3(a) or intensive care under Section 3(e) of Part 6 of the Terms and Conditions is payable.

(10) For details, please refer to Section 6 of Part 1 of the Supplement for Enhanced Benefits.

(11) The Ward Class Adjustment Factor shall be applied to the calculation of the benefit when the ward class of the Confinement is of a class higher than the Designated Ward Class.

(12) The Location Adjustment Factor shall be applied to the calculation of the benefit for any Eligible Excess Expenses incurred outside Asia.

(13) Network Benefit is subject to terms and conditions. For details, please refer to Section 6(b) of Part 1 of the Supplement for Enhanced Benefits.

(14) a. Any Medical Service involving more than one (1) Disability within the same Policy Year shall be subject to one (1) benefit limit for supplementary medical benefit.
b. The benefit limit shall be counted anew for each Medical Service concerning the same Disability in the same Policy Year provided that the relevant Medical Service performed on the Insured Person does not occur within ninety (90) consecutive days following the Last Date (as defined in Section 6(d)(iv) of Part 1 of the Supplement for Enhanced Benefits) of the previous Medical Service in relation to the same Disability.
For details, please refer to Section 6(d) of Part 1 of the Supplement for Enhanced Benefits.

(15) In no event shall the total aggregate amount of benefits payable per Disability per Policy Year under both the Network Benefit and Non-network Benefit exceed the total aggregate supplementary medical benefit limit.

(16) Full cover refers to the Network Benefit under supplementary medical benefit only, and shall mean that no supplementary medical Coinsurance shall be applied and the benefit payable for each benefit item shall be subject to Network Benefit limit and total aggregate supplementary medical benefit limit.

(17) No supplementary medical Coinsurance shall be applied if the Medical Services are received in Hong Kong and Preliminary Assessment is issued by the Company. For details, please refer to Sections 6(e) and 6(f) of Part 1 of the Supplement for Enhanced Benefits.

(18) Only applicable to the Prescribed Diagnostic Imaging Tests performed during Confinement or during the course of Prescribed Non-surgical Cancer Treatments. For the avoidance of doubt, both the Coinsurance and the Eligible Expenses incurred for Prescribed Diagnostic Imaging Tests performed on the Insured Person as a Day Patient but not during the course of Prescribed Non-surgical Cancer Treatments will not be counted as Eligible Excess Expenses. For details, please refer to Section 6(c)(II) of Part 1 of the Supplement for Enhanced Benefits.

SCHEDULE OF SURGICAL PROCEDURES

Procedure / Surgery		Category
ABDOMINAL AND DIGESTIVE SYSTEM		
Oesophageal / stomach / duodenum	Excision of oesophageal lesion / destruction of lesion or tissue of oesophagus, cervical approach	Major
	Highly selective vagotomy	Major
	Laparoscopic fundoplication	Major
	Laparoscopic repair of hiatal hernia	Major
	Oesophagogastroduodenoscopy (OGD) +/- biopsy and/or polypectomy	Minor
	OGD with removal of foreign body	Minor
	OGD with ligation / banding of oesophageal/ gastric varices	Intermediate
	Oesophagectomy	Complex
	Total oesophagectomy and interposition of intestine	Complex
	Percutaneous gastrostomy	Minor
	Permanent gastrostomy / gastroenterostomy	Major
	Partial gastrectomy +/- jejunal transposition	Major
	Partial gastrectomy with anastomosis to duodenum / jejunum	Major
	Partial gastrectomy with anastomosis to oesophagus	Complex
	Proximal gastrectomy / radical gastrectomy / total gastrectomy +/- intestinal interposition	Complex
	Suture of laceration of duodenum / patch repair, duodenal ulcer	Major
	Vagotomy and / or pyloroplasty	Major
Jejunum, ileum and large intestine	Appendicectomy, open or laparoscopic	Intermediate
	Anal fissurectomy	Minor
	Anal fistulotomy / fistulectomy	Intermediate
	Incision & drainage of perianal abscess	Minor
	Delorme operation for repair of prolapsed rectum	Major
	Colonoscopy +/- biopsy	Minor
	Colonoscopy with polypectomy	Minor
	Sigmoidoscopy	Minor
	Haemorrhoidectomy, internal or external	Intermediate
	Injection / banding of haemorrhoid	Minor
	Ileostomy or colostomy	Major
	Anterior resection of rectum, open or laparoscopic	Complex
	Abdominoperineal resection, open or laparoscopic	Complex

Procedure / Surgery		Category
	Colectomy, open or laparoscopic	Complex
	Low anterior resection of rectum , open or laparoscopic	Complex
	Reduction of volvulus or intussusception	Intermediate
	Resection of small intestine and anastomosis	Major
Biliary tract	Cholecystectomy, open or laparoscopic	Major
	Endoscopic retrograde cholangio-pancreatography (ERCP)	Intermediate
	ERCP with papilla operation, stone extraction or other associated operation	Intermediate
Liver	Fine needle aspiration (FNA) biopsy of liver	Minor
	Liver transplantation	Complex
	Marsupialization of lesion / cyst of liver or drainage of liver abscess, open approach	Major
	Removal of liver lesion, open or laparoscopic	Major
	Sub-segmentectomy of liver, open or laparoscopic	Major
	Segmentectomy of liver, open or laparoscopic	Complex
	Wedge resection of liver, open or laparoscopic	Major
Pancreas	Closed biopsy of pancreatic duct	Intermediate
	Excision / destruction of lesion of pancreas or pancreatic duct	Major
	Pancreaticoduodenectomy (Whipple's Operation)	Complex
Abdominal wall	Exploratory laparotomy	Major
	Laparoscopy / peritoneoscopy	Intermediate
	Unilateral repair of inguinal hernia, open or laparoscopic	Intermediate
	Bilateral repair of inguinal hernia, open or laparoscopic	Major
	Unilateral herniotomy / herniorrhaphy, open or laparoscopic	Intermediate
	Bilateral herniotomy / herniorrhaphy, open or laparoscopic	Major
BRAIN AND NERVOUS SYSTEM		
Brain	Brain biopsy	Major
	Burr hole(s)	Intermediate
	Craniectomy	Complex
	Cranial nerve decompression	Complex
	Irrigation of cerebroventricular shunt	Minor
	Maintenance removal of cerebroventricular shunt, including revision	Intermediate
	Creation of ventriculoperitoneal shunt or subcutaneous cerebrospinal fluid reservoir	Major
	Clipping of intracranial aneurysm	Complex
	Wrapping of intracranial aneurysm	Complex

Procedure / Surgery		Category
	Excision of arteriovenous malformation, intracranial	Complex
	Excision of acoustic neuroma	Complex
	Excision of brain tumour or brain abscess	Complex
	Excision of cranial nerve tumour	Complex
	Radiofrequency thermocoagulation of trigeminal ganglion	Intermediate
	Closed trigeminal rhizotomy using radiofrequency	Major
	Decompression of trigeminal nerve root/ open trigeminal rhizotomy	Complex
	Excision of brain, including lobectomy	Complex
	Hemispherectomy	Complex
Spine	Lumbar puncture or cisternal puncture	Minor
	Decompression of spinal cord or spinal nerve root	Major
	Cervical sympathectomy	Intermediate
	Thoracoscopic or lumbar sympathectomy	Major
	Excision of intraspinal tumour, extradural or intradural	Complex
CARDIOVASCULAR SYSTEM		
Heart	Cardiac catheterization	Intermediate
	Coronary artery bypass graft (CABG)	Complex
	Cardiac transplantation	Complex
	Insertion of cardiac pacemaker	Intermediate
	Pericardiocentesis	Minor
	Pericardiotomy	Major
	Percutaneous transluminal coronary angioplasty (PTCA) and related procedures, including use of laser, stenting, motor-blade, balloon angioplasty, radiofrequency ablation technique, etc.	Major
	Pulmonary valvotomy, Balloon / Transluminal laser / Transluminal radiofrequency	Major
	Percutaneous valvuloplasty	Major
	Balloon aortic / mitral valvotomy	Major
	Closed heart valvotomy	Complex
	Open heart valvuloplasty	Complex
	Valve replacement	Complex
Vessels	Intra-abdominal venous shunt/ spleno-renal shunt / portal-caval shunt	Complex
	Resection of abdominal vessels with replacement / anastomosis	Complex

Procedure / Surgery		Category
ENDOCRINE SYSTEM		
Adrenal Gland	Unilateral adrenalectomy, laparoscopic or	Major
	Bilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Complex
Pineal Gland	Total excision of pineal gland	Complex
Pituitary Gland	Operation of pituitary tumour	Complex
Thyroid Gland	Fine needle aspiration (FNA) of thyroid gland +/- imaging guidance	Minor
	Hemithyroidectomy / partial thyroidectomy / subtotal thyroidectomy / parathyroidectomy	Major
	Total thyroidectomy / complete parathyroidectomy / robotic-assisted total thyroidectomy	Major
	Excision of thyroglossal cyst	Intermediate
EAR / NOSE / THROAT / RESPIRATORY SYSTEM		
Ear	Canaloplasty for aural atresia / stenosis	Major
	Excision of preauricular cyst / sinus	Minor
	Haematoma auris, drainage / buttoning / excision	Minor
	Meatoplasty	Intermediate
	Removal of foreign body	Minor
	Excision of middle ear tumour via tympanotomy	Major
	Myringotomy +/- insertion of tube	Minor
	Myringoplasty / tympanoplasty	Major
	Ossiculoplasty	Major
	Labyrinthectomy, total / partial excision	Major
	Mastoidectomy	Major
	Operation on cochlea and / or cochlear implant	Complex
	Operation on endolymphatic sac / decompression of endolymphatic sac	Major
	Repair of round window or oval window fistula	Intermediate
	Tympanosympathectomy	Major
	Vestibular neurectomy	Intermediate
Nose, mouth and pharynx	Antral puncture and lavage	Minor
	Cauterization of nasal mucosa / control of epistaxis	Minor
	Closed reduction for fracture nasal bone	Minor
	Closure of oro-antral fistula	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lesion of nose	Minor

Procedure / Surgery		Category
	Nasopharyngoscopy / rhinoscopy +/- including rhinoscopic biopsy +/- removal of foreign body	Minor
	Polypectomy of nose	Minor
	Caldwell-Luc operation / Maxillary sinusectomy with Caldwell-Luc approach	Intermediate
	Endoscopic sinus surgery on ethmoid / maxillary / frontal / sphenoid sinuses	Intermediate
	Extended endoscopic frontal sinus surgery with trans-septal frontal sinusotomy	Major
	Frontal sinusotomy or ethmoidectomy	Intermediate
	Frontal sinusectomy	Major
	Functional endoscopic sinus surgery (FESS)	Major
	Functional endoscopic sinus surgery (FESS) bilateral	Complex
	Maxillary / sphenopalatine / ethmoid artery ligation	Intermediate
	Other intranasal operation, including use of laser (excluding simple rhinoscopy, biopsy and cauterisation of vessel)	Intermediate
	Rhinoplasty	Intermediate
	Resection of nasopharyngeal tumour	Intermediate
	Sinoscopy +/- biopsy	Minor
	Septoplasty +/- submucous resection of septum	Intermediate
	Submucous resection of nasal septum	Intermediate
	Turbinectomy / submucous turbinectomy	Intermediate
	Adenoidectomy	Minor
	Tonsillectomy +/- adenoidectomy	Intermediate
	Excision of pharyngeal pouch / diverticulum	Intermediate
	Pharyngoplasty	Intermediate
	Sleep related breathing disorder – hyoid suspension, maxilla / mandible / tongue advancement, laser suspension / resection, radiofrequency ablation assisted uvulopalatopharyngoplasty, uvulopalatopharyngoplasty	Intermediate
	Marsupialization / excision of ranula	Intermediate
	Parotid gland removal, superficial	Intermediate
	Parotid gland removal / parotidectomy	Major
	Removal of submandibular salivary gland	Intermediate
	Submandibular duct relocation	Intermediate
	Submandibular gland excision	Intermediate

Procedure / Surgery		Category
Respiratory system	Arytenoid subluxation – laryngoscopic reduction	Minor
	Bronchoscopy +/- biopsy	Minor
	Bronchoscopy with foreign body removal	Minor
	Laryngoscopy +/- biopsy	Minor
	Laryngeal / tracheal stenosis – endolaryngeal / open operation with stenting / reconstruction	Major
	Laryngeal diversion	Intermediate
	Laryngectomy +/- radical neck resection	Complex
	Microlaryngoscopy +/- Biopsy +/- excision of nodule / polyp / Reinke's edema	Minor
	Partial / total resection of laryngeal tumour	Intermediate
	Removal of vallecular cyst	Intermediate
	Repair of laryngeal fracture	Major
	Injection for vocal cord paralysis	Minor
	Tracheoesophageal puncture for voice rehabilitation	Minor
	Thyroplasty for vocal cord paralysis	Intermediate
	Vocal cord operation, including use of laser (excluding carcinoma)	Minor
	Tracheostomy, temporary / permanent / revision	Minor
	Lobectomy of lung / pneumonectomy	Complex
	Pleurectomy	Major
	Segmental resection of lung	Major
	Thoracocentesis / insertion of chest tube for pneumothorax	Minor
	Thoracoscopy +/- biopsy	Intermediate
	Thoracoplasty	Major
	Thymectomy	Major
EYE		
Eye	Excision / curettage / cryotherapy of lesion of eyelid	Minor
	Blepharorrhaphy / tarsorrhaphy	Minor
	Repair of entropion or ectropion +/- wedge resection	Minor
	Reconstruction of eyelid, partial-thickness	Intermediate
	Excision / destruction of lesion of conjunctiva	Minor
	Excision of pterygium	Minor
	Corneal grafting, severe wound repair and keratoplasty, including corneal transplant	Major
	Laser removal / destruction of corneal lesion	Intermediate

Procedure / Surgery		Category
	Removal of corneal foreign body	Minor
	Repair of cornea	Intermediate
	Suture / repair of corneal laceration or wound with conjunctival flap	Intermediate
	Aspiration of lens	Intermediate
	Capsulotomy of lens, including use of laser	Intermediate
	Extracapsular / intracapsular extraction of lens	Intermediate
	Intraocular lens / explant removal	Intermediate
	Chorioretinal lesion operations	Intermediate
	Phacoemulsification and implant of intraocular lens	Intermediate
	Pneumatic retinopexy	Intermediate
	Retinal Photocoagulation	Intermediate
	Repair of retinal detachment / tear	Intermediate
	Repair of retinal tear / detachment with buckle	Major
	Scleral buckling / encircling of retinal detachment	Major
	Cyclodialysis	Intermediate
	Trabeculectomy, including use of laser	Intermediate
	Surgical treatment for glaucoma including insertion of implant	Intermediate
	Diagnostic aspiration of vitreous	Minor
	Injection of vitreous substitute	Intermediate
	Mechanical vitrectomy / removal of vitreous	Major
	Biopsy of iris	Minor
	Excision of lesion of iris / anterior segment of eye / ciliary body	Intermediate
	Excision of prolapsed iris	Intermediate
	Iridotomy	Intermediate
	Iridectomy	Intermediate
	Iridoplasty +/- coreoplasty by laser	Intermediate
	Iridencleisis and iridotasis	Intermediate
	Scleral fistulization +/- iridectomy	Intermediate
	Thermocauterization of sclera +/- iridectomy	Intermediate
	Diminution of ciliary body	Intermediate
	Biopsy of extraocular muscle or tendon	Minor
	Operation on one extraocular muscle	Intermediate
	Eyeball, perforating wound of, with incarceration or prolapse of uveal tissue repair	Major
	Enucleation of eye	Intermediate

Procedure / Surgery		Category
	Evisceration of eyeball / ocular contents	Intermediate
	Repair of eyeball or orbit	Intermediate
	Conjunctivocystorhinostomy	Intermediate
	Conjunctivorhinostomy with insertion of tube / stent	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lacrimal sac and passage	Minor
	Excision of lacrimal gland / dacryoadenectomy	Intermediate
	Probing +/- syringing of lacrimal canaliculi / nasolacrimal duct	Minor
	Repair of canaliculus	Intermediate
	Coreoplasty	Intermediate
FEMALE GENITAL SYSTEM		
Cervix	Amputation of cervix	Intermediate
	Colposcopy +/- biopsy	Minor
	Conization of cervix	Minor
	Destruction of lesion of cervix by excision/ cryosurgery / cauterization / laser	Minor
	Endocervical curettage	Minor
	Loop electrosurgical excision procedure (LEEP)	Minor
	Marsupialization of cervical cyst	Minor
	Repair of cervix	Minor
	Repair of fistula of cervix	Intermediate
	Suture of laceration of cervix / uterus / vagina	Intermediate
Fallopian tubes and ovaries^	Dilatation / insufflation of fallopian tube	Minor
	Excision / destruction of lesion of fallopian tube, open or laparoscopic	Major
	Repair of fallopian tube	Major
	Salpingostomy / salpingotomy	Intermediate
	Total or partial salpingectomy	Intermediate
	Tuboplasty	Intermediate
	Aspiration of ovarian cyst	Minor
	Ovarian cystectomy, open or laparoscopic	Major
	Wedge resection of ovary, open or laparoscopic	Major
	Oophorectomy	Intermediate
	Oophorectomy, laparoscopic	Major
	Salpingo-oophorectomy, open or laparoscopic	Major
	Drainage of tubo-ovarian abscess, open or laparoscopic	Intermediate

Procedure / Surgery		Category
	^ *The category applies to both unilateral and bilateral procedures unless otherwise specified.*	
Uterus	Dilatation and curettage of Uterine (D&C)	Minor
	Hysteroscopy +/- biopsy	Minor
	Hysteroscopy with excision or destruction of uterus and supporting structures	Intermediate
	Hysterotomy	Major
	Laparoscopic assisted vaginal hysterectomy (LAVH)	Major
	Vaginal hysterectomy +/- repair of cystocele and/or rectocele	Major
	Total / subtotal abdominal hysterectomy +/- bilateral salpingo- oophorectomy, open or laparoscopic	Major
	Radical abdominal hysterectomy	Complex
	Myomectomy, open or laparoscopic	Major
	Uterine myomectomy, vaginal or hysteroscopic	Intermediate
	Laparoscopic drainage of female pelvic abscess	Intermediate
	Colposuspension	Major
	Pelvic floor repair	Major
	Pelvic exenteration	Complex
	Uterine suspension	Intermediate
Vagina	Destruction of lesion of vagina by excision / cryosurgery / cauterization / laser	Minor
	Insertion / removal of vaginal supportive pessaries	Minor
	Marsupialization of Bartholin's cyst	Minor
	Vaginal stripping of vaginal cuff	Minor
	Vaginotomy	Intermediate
	Partial vaginectomy	Intermediate
	Vaginectomy, complete	Major
	Radical vaginectomy	Complex
	Anterior colporrhaphy +/- Kelly plication	Intermediate
	Posterior colporrhaphy	Intermediate
	Obliteration of vaginal vault	Intermediate
	Sacrospinous ligament suspension or fixation of the vagina	Intermediate
	Sacral colpopexy	Intermediate
	Vaginal repair of enterocoele	Intermediate
	Closure of urethro-vaginal fistula	Intermediate
	Repair of rectovaginal fistula, vaginal approach	Intermediate
	Repair of rectovaginal fistula, abdominal approach	Major

Procedure / Surgery		Category
	Culdocentesis	Minor
	Culdotomy	Minor
	Excision of transverse vaginal septum	Minor
	McCall's culdeplasty / culdoplasty	Intermediate
	Vaginal reconstruction	Major
Vulva and introitus	Destruction of lesion of vulva by excision / cryosurgery / cauterization / laser	Minor
	Wide local excision of vulva with cold knife or LEEP	Minor
	Excision of vestibular adenitis	Minor
	Excision biopsy of vulva	Minor
	Incision and drainage of vulva and perineum	Minor
	Lysis of vulvar adhesions	Minor
	Repair of fistula of vulva or perineum	Minor
	Suture of lacerations / repair of vulva and/or perineum	Minor
	Vulvectomy	Intermediate
	Radical vulvectomy	Major
HEMIC AND LYMPHATIC SYSTEM		
Lymph Nodes	Drainage of lesion / abscess of lymph node	Minor
	Biopsy / excision of superficial lymph nodes / simple excision of lymphatic structure	Minor
	Incisional biopsy of cervical lymph node / fine needle aspiration (FNA) biopsy of lymph nodes	Minor
	Excision of deep lymph node / lymphangioma / cystic hygroma	Intermediate
	Bilateral inguinal lymphadenectomy	Intermediate
	Cervical lymphadenectomy	Intermediate
	Inguinal and pelvic lymphadenectomy	Major
	Radical groin dissection	Major
	Radical pelvic lymphadenectomy	Major
	Selective / radical / functional neck dissection	Major
	Wide excision of axillary lymph node	Major
Spleen	Splenectomy, open or laparoscopic	Major
MALE GENITAL SYSTEM		
Prostate	External drainage of prostatic abscess	Minor
	Photoselective vaporization of prostate	Major
	Plasma vaporization of prostate	Major
	Prostate biopsy	Minor

Procedure / Surgery		Category
	Transurethral microwave therapy	Intermediate
	Transurethral prostatectomy or TURP	Major
	Prostatectomy, open or laparoscopic	Major
	Radical prostatectomy, open or laparoscopic	Complex
Penis	Circumcision	Minor
	Release of chordee	Major
	Repair of buried / avulsion of penis	Intermediate
Testicles^	Epididymectomy	Intermediate
	Exploration of testis	Intermediate
	Exploration for undescended testis, laparoscopic	Major
	Orchidopexy	Intermediate
	Orchidectomy or orchidopexy, laparoscopic	Major
	Reduction of torsion of testis and fixation	Intermediate
	Testicular biopsy	Minor
	High ligation of hydrocoele	Intermediate
	Tapping of hydrocele	Minor
	Excision of varicocoele and hydrocoele of spermatic cord	Intermediate
	Varicocelectomy (microsurgical)	Major
	^ *The category applies to both unilateral and bilateral procedures unless otherwise specified.*	
Spermatic cord	Vasectomy	Minor
MUSCULOSKELETAL SYSTEM		
Bone	Amputation of finger(s) / toe(s) of one limb	Intermediate
	Amputation of one arm / hand / leg / foot	Intermediate
	Bunionectomy	Intermediate
	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal	Major
	Excision of radial head	Intermediate
	Mandibulectomy for benign disease	Intermediate
	Patellectomy	Major
	Partial ostectomy of facial bone	Intermediate
	Sequestrectomy of facial bone	Intermediate
	Wedge osteotomy of bone of wrist / hand / leg	Major
	Wedge osteotomy of bone of upper arm / lower arm / thigh	Major
	Wedge osteotomy of scapula / clavicle / sternum	Major
Joint	Arthroscopic drainage and debridement	Intermediate

Procedure / Surgery		Category
	Arthroscopic removal of loose body from joints	Intermediate
	Arthroscopic examination of joint +/- biopsy	Intermediate
	Arthroscopic assisted ligament reconstruction	Major
	Arthroscopic Bankart repair	Major
	Arthroscopic repair for superior labral tear from anterior to posterior of shoulder	Major
	Arthroscopic rotator cuff repair	Major
	Acromioplasty	Major
	Arthrodesis of shoulder	Major
	Arthrodesis of Elbow / Triple arthrodesis	Major
	Arthrodesis of knee / hip	Complex
	Arthroplasty of hand / finger / foot / Toe joint with implant	Major
	Fusion of wrist	Major
	Synovectomy of wrist	Intermediate
	Interphalangeal joint fusion of toes	Intermediate
	Interphalangeal fusion of finger	Major
	Excisional arthroplasty shoulder / hemiarthroplasty of shoulder	Major
	Excisional arthroplasty of hip / knee / Wrist / Elbow	Major
	Excisional arthroplasty of hip / knee with local antibiotic delivery	Complex
	Temporomandibular arthroplasty +/- autograft	Major
	Joint aspiration / injection	Minor
	Manipulation of joint under anesthesia	Minor
	Metal femoral head insertion	Major
	Anterior cruciate ligament reconstruction	Major
	Meniscectomy, open or arthroscopic	Major
	Posterior cruciate ligament reconstruction	Major
	Repair of the collateral ligaments	Major
	Repair of the cruciate ligaments	Major
	Suture of capsule or ligament of ankle and foot	Major
	Total shoulder replacement	Complex
	Total knee replacement	Complex
	Total hip replacement	Complex
	Partial hip replacement	Major
Muscle/ Tendon	Achilles tendon repair	Intermediate
	Achillotenotomy	Intermediate

Procedure / Surgery		Category
	Change in muscle or tendon length (except hand) / excision of lesion of muscle	Intermediate
	Change in muscle or tendon length of hand	Major
	Excision of lesion of muscle	Intermediate
	Lengthening of tendon, including tenotomy	Intermediate
	Open biopsy of muscle	Minor
	Release of De Quervain's disease	Minor
	Release of trigger finger	Minor
	Release of tennis elbow	Minor
	Transfer / transplantation / reattachment of muscle	Major
	Tendon repair / Suture of tendon not involving hand	Intermediate
	Tendon repair / Suture of tendon of hand	Major
	Tenosynovectomy / synovectomy	Intermediate
	Transposition of tendon of wrist / hand	Major
	Secondary repair of tendon, including graft, transfer and / or prosthesis	Major
Fracture/ dislocation	Closed reduction of dislocation of temporomandibular / interphalangeal / acromioclavicular joint	Minor
	Closed reduction of dislocation of shoulder / elbow / wrist / ankle	Intermediate
	Closed reduction for Colles' fracture with percutaneous k-wire fixation	Major
	Closed reduction for fracture of arm / leg / patella / pelvis with internal fixation	Major
	Close reduction for mandibular fracture with internal fixation	Intermediate
	Closed reduction for fracture of clavicle / scapula / phalanges / patella without internal fixation	Minor
	Closed reduction for fracture of upper arm / lower arm / wrist / hand / leg / foot bone without internal fixation	Intermediate
	Closed reduction for fracture of clavicle / hand / ankle / foot with internal fixation	Intermediate
	Closed reduction for fracture of femur +/- internal fixation	Major
	Closed / open reduction of fracture of acetabulum with internal fixation	Complex
	Open reduction for mandibular fracture with internal fixation	Major
	Open reduction for clavicle / hand / foot (except carpal / talus / calcaneus) +/- internal fixation	Intermediate
	Open reduction for arm / leg / patella / scapula +/- internal fixation	Major

Procedure / Surgery		Category
	Open reduction for femur / calcaneus / talus/ +/- internal fixation	Major
	Operative treatment of compound fracture with external fixator and extensive wound debridement	Intermediate
	Removal of screw, pin and plate, and other metal for old fracture except fracture femur	Minor
Spine	Artificial cervical disc replacement	Complex
	Anterior spinal fusion, cervical / cervicothoracic/ C4/5 and C5/6 and locking plate	Major
	Anterior spinal fusion (excluding cervical / cervicothoracic/ C4/5 and C5/6 and locking plate)	Complex
	Anterior spinal fusion with instrumentation	Complex
	Laminoplasty for cervical spine	Major
	Laminectomy / diskectomy	Major
	Laminectomy with diskectomy	Complex
	Posterior spinal fusion, thoracic / cervico-thoracic / thoracolumbar / T5 to L1/ atlas-axis	Major
	Posterior spinal fusion, (excluding thoracic / cervico-thoracic / thoracolumbar / T5 to L1 / atlas-axis)	Complex
	Posterior spinal fusion with instrumentation	Complex
	Spinal biopsy	Minor
	Spinal fusion +/- foraminotomy +/- laminectomy +/- diskectomy	Complex
	Spine osteotomy	Complex
	Vertebroplasty / kyphoplasty	Intermediate
Others	Excision of ganglion / bursa	Minor
	Closed/ Percutaneous needle fasciotomy for Dupuytren disease	Minor
	Radical (or total) fasciectomy for Dupuytren disease	Major
	Release of carpal / tarsal tunnel, open or endoscopic	Intermediate
	Release of peripheral nerve	Intermediate
	Transposition of ulnar nerve	Intermediate
	Sliding / reduction genioplasty	Intermediate
SKIN AND BREAST		
Skin	Curettage / cryotherapy / cauterization / laser treatment of lesion of skin	Minor
	Drainage of subungual haematoma or abscess	Minor
	Excision of lipoma	Minor
	Excision of skin for graft	Minor

Procedure / Surgery		Category
	Incision and /or drainage of skin abscess	Minor
	Incision and /or removal of foreign body from skin and subcutaneous tissue	Minor
	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue	Minor
	Suture of wound on skin	Minor
	Surgical toilet and suturing	Minor
	Wedge resection of toenail	Minor
Breast	Breast tumour/ lump excision +/- biopsy	Intermediate
	Fine needle aspiration (FNA) of breast cyst	Minor
	Incisional breast biopsy	Minor
	Modified radical mastectomy	Major
	Partial or simple mastectomy	Intermediate
	Partial or radical mastectomy with axillary lymphadenectomy	Major
	Total or radical mastectomy	Major
	Duct papilloma excision	Intermediate
	Gynaecomastia excision	Intermediate
URINARY SYSTEM		
Kidney	Extracorporeal shock wave lithotripsy for urinary stone (ESWL)	Intermediate
	Nephrolithotomy / pyelolithotomy	Major
	Nephroscopy	Major
	Percutaneous insertion of nephrostomy tube	Minor
	Renal biopsy	Minor
	Nephrectomy, open or laparoscopic or retroperitoneoscopic	Major
	Nephrectomy, partial/ lower pole	Complex
	Kidney transplant	Complex
Bladder, ureter and urethra	Cystoscopy +/- biopsy	Minor
	Cystoscopy with catheterization of ureter/ transurethral bladder clearance	Minor
	Cystoscopy with electro-cauterisation/ laser lithotripsy	Intermediate
	Excision of urethra caruncle	Minor
	Insertion of urethral/ureter stent	Intermediate
	Diverticulectomy of urinary bladder, open or laparoscopic	Major
	Transurethral resection of bladder tumour	Major
	Partial cystectomy, open or laparoscopic	Major

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

Manulife 宏利

POLICY SCHEDULE

LIFE INSURED	AGE NEAREST BIRTHDAY
POLICY NUMBER	SEX
POLICY YEAR DATE	
ISSUE DATE	
FIRST RENEWAL DATE	
IDENTIFICATION NO	
POLICYOWNER	
BENEFICIARY	
BASIC PLAN NAME	MANULIFE FIRST VHIS FLEXI PLAN
DESIGNATED WARD CLASS	
SUPPLEMENTARY MEDICAL BENEFIT LEVEL	
PLAN CERTIFICATION NO	

SCHEDULE OF PREMIUMS

TOTAL <ANNUAL/SEMI-ANNUAL/QUARTERLY/MONTHLY> PREMIUM IS MADE UP AS FOLLOWS:

	PAYABLE TO	STANDARD PREMIUM	EXTRA PREMIUM	COVERED PERIOD
BASIC PLAN	LIFETIME			

(I) STANDARD PREMIUM AND EXTRA PREMIUM ARE NOT GUARANTEED AND WILL VARY WITH THE AGE NEAREST BIRTHDAY WHERE APPLICABLE. THE STANDARD PREMIUM AND EXTRA PREMIUM STATED ABOVE ARE ONLY APPLICABLE TO THE FIRST POLICY YEAR.

(II) THE ONE-YEAR COVERED PERIOD STATED ABOVE ASSUMES THAT THE SHOWN STANDARD PREMIUM AND EXTRA PREMIUM ARE PAID BY EACH DUE DATE ACCORDING TO THE APPLICABLE PAYMENT MODE (I.E. MONTHLY, QUARTERLY, SEMI-ANNUAL OR ANNUAL) DURING THE COVERED PERIOD.

(III) ACTUAL PREMIUMS PAYABLE, PREMIUM DISCOUNT (IF APPLICABLE) AND LEVY FOR THE FIRST POLICY YEAR WILL BE SHOWN ON THE WELCOME LETTER. RENEWAL PREMIUMS ON EACH RENEWAL DATE WILL BE SHOWN ON THE RENEWAL NOTICE.

CURRENCY — ALL DOLLAR AMOUNTS STATED ON THIS PAGE AND THROUGHOUT THIS POLICY ARE IN HONG KONG DOLLARS. ALL AMOUNTS PAYABLE EITHER TO OR BY THE COMPANY WILL BE PAYABLE IN HONG KONG DOLLARS. ALL AMOUNTS PAYABLE BY THE COMPANY WILL BE PAID ONLY IN HONG KONG.

THIS POLICY IS ISSUED IN HONG KONG.

Manulife 宏利

GLOSSARY

THE WORDS AND EXPRESSIONS ON THE LEFT AND RIGHT COLUMNS SHALL CARRY THE SAME MEANINGS.

POLICY SCHEDULE	POLICY TERMS AND BENEFITS FOR THIS VHIS CERTIFIED PLAN
LIFE INSURED	INSURED PERSON
POLICYOWNER	POLICY HOLDER
POLICY YEAR DATE	POLICY EFFECTIVE DATE
ISSUE DATE	POLICY ISSUANCE DATE
EXTRA PREMIUM	PREMIUM LOADING