(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

TheOne Medical Solution

Contents

1 Definitions

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

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

Anaesthetist - shall mean an Independent Person (other than the attending Physician or Surgeon operating on the Insured), who is licensed and registered with the Health Bureau of Macau under Decree-Law 84/90/M or equivalent to perform anesthesiology services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

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

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

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

Chinese Medicine Practitioner - shall mean an Independent Person who is licensed and registered with the Health Bureau of Macau under Decree-Law 84/90/M or otherwise legally authorized and having at least equivalent qualifications to perform equivalent Chinese medicine treatment in accordance with the laws of that location where the Eligible Expenses are incurred, and who is acceptable to the Company.

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

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

Company, us or **our** – shall mean FWD Life Insurance Company (Macau) Limited.

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

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

Covered Illness – shall mean a physical condition marked by a pathological deviation from the normal healthy state which manifests and commences more than thirty (30) days after the Policy Date of this Policy. In this Policy, an illness is regarded as having occurred when it has been investigated,

diagnosed or treated or when its signs or symptoms have manifested which would cause an ordinary prudent person to seek diagnosis, care or treatment. In the event of any conflict or discrepancy of opinions relating to the signs or symptoms of an illness and their manifestation between a Physician and the Insured, the Company shall adopt and follow the Physician's professional opinion.

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

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

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

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

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

Macau – shall mean the Macau Special Administrative Region.

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

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

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

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

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

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

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

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

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

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

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

Physician or **Surgeon -** shall mean an Independent Person who is licensed and registered with the Health Bureau of Macau under Decree-Law 84/90/M or otherwise with equivalent qualifications and legally authorized to practice western medical and surgical services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

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

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

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

Policy Date – shall mean the date when coverage under this Policy becomes effective as shown in the Policy Schedule or the date of reinstatement, whichever is later.

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

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

Pre-existing Conditions - shall mean (1) any physical, medical or mental condition or (2) any illness or injury:
(a) that existed whether it was known or unknown to the Policy Owner or the Insured; or
(b) that was investigated, diagnosed, or treated by a Physician; or
(c) for which Physician was consulted; or
(d) the signs or symptoms of which commenced,
before the Policy Date.

Registered Dentist – shall mean an Independent Person who is qualified by a degree in dentistry and licensed and registered with the Health Bureau of Macau under Decree-Law 84/90/M or otherwise with equivalent qualifications and legally authorized to provide dental services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

Registered Nurse - shall mean an Independent Person who is licensed and registered with the Health Bureau of Macau under Decree-Law 84/90/M or otherwise with equivalent qualifications and legally authorized to render nursing services in accordance with the laws of the location where the Eligible Expenses are incurred, and who is acceptable to the Company.

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

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

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

2 General Provisions

2.1 The Contract

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

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

2.2 Alterations

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

2.3 Policy

Policy shall mean the terms and conditions of the TheOne Medical Solution mentioned herein.

2.4 Effective Date

The Policy Date specified in the Policy Schedule or the date of reinstatement, whichever is later.

2.5 Expiry Date

The Policy Anniversary immediately preceding the one hundredth (100th) birthday of the Insured.

2.6 Policy Owner

The Policy Owner is the person designated in the Policy Schedule. Only the Policy Owner can exercise all rights, privileges and options provided under this Policy while the Insured is alive and this Policy is in force.

Notwithstanding anything contained in this Policy, if the Policy Owner holds this Policy in exclusive benefit of the beneficiary, any rights, privileges and options to be exercised by the Policy Owner shall be deemed to be exercised by the Policy Owner with the consent of the beneficiary and exercised for the sole benefit of the Beneficiary.

2.7 Beneficiary

The Beneficiary is the person or persons entitled to the proceeds of this Policy upon the death of the Insured. During the lifetime of the Insured, a Beneficiary has no right to deal in any way with this Policy.

The proceeds under the death benefits of this Policy shall be paid to the nominated Beneficiary or, if there is no nominated Beneficiary, to the Policy Owner or, if the Policy Owner is deceased, to the appointed executor(s) or administrator(s) of the Policy Owner's estate, as the case may be.

The interest of any Beneficiary under this Policy who predeceases the Insured shall vest in the Policy Owner and the interest of any joint Beneficiary who predeceases the Insured shall accrue to the surviving Beneficiaries in such proportion as they are nominated or otherwise in equal proportion.

If any Beneficiary dies simultaneously with the Insured, the proceeds of this Policy shall, unless

otherwise provided in the application or in a written request, be paid to the same payee or payees and in the same manner as if the person who is older by age had died before the person who is younger by age.

2.8 **Changes of Policy Owner and Beneficiary**

The Policy Owner may, while the Insured is alive and this Policy is in force, change the Policy Owner or the Beneficiary of this Policy by filing written request satisfactory to the Company. Once received and recorded by the Company, the change shall be effective as of the date the notice was signed, regardless of whether the Insured or the Policy Owner is alive at the time the notice is received by the Company.

2.9 **Change of Place of Residence or Occupation**

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

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

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

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

2.10 **Assignment**

Notwithstanding anything to the contrary in this Policy, this Policy or the benefits hereunder cannot be assigned by the Policy Owner.

2.11 **Age and Sex**

This Policy is issued at the Insured's age on the next birthday following the Commencement Date as set out in the Policy Schedule. If the age and/or sex of the Insured was misstated in the application for this Policy, and the Policy Owner did not act intentionally in respect of the misstatement, any amount paid or payable or benefit accruing under the Policy shall be such as the premiums paid would have purchased at the time of the application on the basis of the correct age and/or sex, but not greater than the original benefit which is specified in the Policy Schedule or any subsequent endorsement thereto.

If the Insured's correct age when the Policy is issued is outside the age range pursuant to the Company's underwriting rules, this Policy shall be void from the Policy Date by the Company sending a notice to the Policy Owner at his/her last known address and the Company's liability shall be limited to the total amount of premium and contributions (if any) paid less any partial surrender as of the effective date specified in the Company's written notice to the Policy Owner regarding its avoidance of this Policy, less:

(i) any indebtedness under this Policy; and
(ii) any expenses incurred or to be incurred by the Company in relation to its avoidance of this

Policy.

2.12 **Incorrect Disclosure or Non-Disclosure**

Incorrect disclosure or non-disclosure in bad faith of any material facts which, in our opinion, may affect our risk assessment, including but not limited to, age, gender and other material facts declared on the relevant application form, may render this Policy voidable from the Policy Date,if the Company declares such intention within one (1) month from the date of the knowledge of the incorrect disclosure or non-disclosure of the facts.

If the incorrect disclosure or non-disclosurb e is not in bad faith, the Company may, within two (2) months from the date of the knowledge of the incorrect disclosure or non-disclosure of the facts, either rescind this Policy by giving an advance notice of fifteen (15) days, or propose a new premium to the Policy Owner.

2.13 **Freedom from Restriction**

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

2.14 **Suicide**

If the Insured dies by suicide, whether sane or insane, within twelve (12) calendar months from the later of the Policy Date or the date of reinstatement, the Company's liability shall be limited to the amount of the premiums paid without interest, less any indebtedness and any benefit payment under this Policy.

All amounts payable by the Company under this clause shall be paid (i) to the Policy Owner or to his or her estate (as the case may be) if such suicide takes place within twelve (12) calendar months from the later of the Policy Date or the date of reinstatement, or (ii) to the Beneficiary if such suicide takes place outside the period set out in (i).

2.15 **Currency of Payment**

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

2.16 **Notices from the Company**

Any notice to be given under this Policy will be sent to the Policy Owner's latest address as notified to us, and will be deemed to have been received by the Policy Owner after forty-eight (48) hours of posting. The Policy Owner must immediately notify the Company of any change of address and must take all necessary measures to ensure that the notifications sent by the Company are received at its latest address as notified to the Company, even in case of prolonged absence. The content of all notices received at the Policy Owner's latest address as notified to the Company is deemed to have been made known to the Policy Owner immediately upon receipt.

All notices sent to the Policy Owner's latest address as notified to the Company which are not received by breach of the Policy Owner's obligations under the previous paragraph are deemed to not have been received by reasons exclusively imputable to the Policy Owner, and the contents thereto will be immediately effective, for all purposes under this Policy, as if said notices had been received by the Policy Owner.

2.17 **Interpretation**

Throughout this Policy, where the context so admits, words embodying the masculine gender

shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.

Any doubts as to the interpretation of any provisions in this Policy and any other material otherwise produced by the Company shall be resolved in accordance with Article 970 of the Macau Commercial Code.

2.18 **Cooling-off Period**

If the Policy Owner is not completely satisfied with this Policy, and the Policy Owner has not made a claim, the Policy Owner can cancel it by giving a written notice to the Company. Such notice must be signed by the Policy Owner and received directly by the Company together with this Policy (if received) within twenty-one (21) calendar days immediately following:

1. the day the Company delivers this Policy to the Policy Owner or Policy Owner's nominated representative; or
2. the day the Company delivers a cooling-off notice (separate from the Policy) to the Policy Owner or Policy Owner's nominated representative informing the Policy Owner about this Policy and the right to cancel within the stated twenty-one (21) calendar day period;

whichever is earlier.

This twenty-one (21) calendar day period is called the Cooling-off Period. The Policy Owner can cancel this Policy and receive premiums without interest back. The Company follows the Cooling-off Period principles set out by Monetary Authority of Macao to protect customers.

2.19 **Language**

This Policy appears in the Chinese and English languages. In the event of any conflict between these two versions, the Chinese language version shall govern and prevail.

2.20 **Governing Law**

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

2.21 **Obligation to Provide Information**

The Policy Owner acknowledges that the Company and/or its affiliates are obliged to comply with legal and/or regulatory requirements in various jurisdictions as promulgated and amended from time to time, such as the United States Foreign Account Tax Compliance Act, and the automatic exchange of information regime ("AEOI") followed by the Financial Services Bureau (the "Applicable Requirements"). These obligations include providing clients' information (including personal information) to relevant local and international authorities and/or to verify the identity of its clients. In addition, our obligations under the AEOI are to:

1. identify accounts as non-excluded "financial accounts" ("NEFDs");
2. identify the jurisdiction(s) in which NEFA-holding individuals and NEFA-holding entities reside for tax purposes;
3. determine the status of NEFA-holding entities as "passive NFEs" and identify the jurisdiction(s) in which their controlling persons reside for tax purposes;
4. collection information on NEFAs which is required by various authorities; and
5. furnish this information to the Financial Services Bureau.

The Policy Owner agrees that from time to time the Company shall have the right to request from the Policy Owner, and disclose to relevant authority(ies), various information about the Policy Owner, the Beneficiary and this Policy as required under Applicable Requirements for the following purposes:

1. for the Company to issue this Policy to the Policy Owner;

2. for the Company to provide benefits available to the Policy Owner and / or the Beneficiary under the terms of this Policy; and / or
3. for this Policy to remain in force in accordance with its terms.

In addition, the Policy Owner agrees to notify the Company in writing within 30 days if there is any change to any of the information previously provided to the Company that relates to the Company's legal obligations under this clause (whether at time of application or at any other time).

If the Policy Owner does not provide such information within the time period as reasonably requested by the Company, notwithstanding any other provisions of this Policy, the Company shall be entitled to, to the extent permitted by Applicable Requirements,

1. report this Policy and/or information about the Policy Owner and/or the Beneficiary to relevant authority(ies);
2. terminate this Policy and return to the Policy Owner the surrender value (if any) without interest which shall be calculated pursuant to applicable terms and conditions under this Policy net of any outstanding amounts relating to this Policy; or
3. take any such other action as may be reasonably required including but not limited to making adjustments to the values, balances, benefits or entitlements under this Policy.

Prior to the expiry of such time period and notwithstanding any other provisions of this Policy, the Company shall have the sole discretion to suspend or defer any transaction or provision of any services to the Policy Owner under this Policy, including the payment of any benefit, if any information reasonably requested by the Company under Applicable Requirements remains outstanding.

3 Premiums and Reinstatement Provisions

3.1 Payment of Premiums

Premiums are payable during the lifetime of the Insured. The first year premium is specified in the Policy Schedule or any endorsement attached thereto. Premiums shall be paid on a yearly basis or with such other frequency as the Company permits.

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

After payment of the first premium, failure to pay a premium on or before its due date shall constitute default in payment of premium.

3.2 Renewal

This Policy shall be automatically renewed at each Policy Anniversary for another Policy Year until the Expiry Date based on then applicable terms and conditions of this Policy, provided that premiums under this Policy are paid when due and the Plan is continually offered by the Company. The premium rates for each renewal are determined based on the age of the Insured at the next birthday, are not guaranteed and are subject to change at the sole discretion of the Company.

3.3 No re-underwriting except in limited circumstances

While this Policy is in force, the Company shall not have the right to re-underwrite this Policy irrespective of any change in health conditions of the Insured after the Commencement Date or the Policy Date, whichever is the earlier.

The Company shall not have the right to re-underwrite this Policy irrespective of any change. 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 this Policy, regardless of where they are set out in this Policy.

The Company shall have the right to re-underwrite this Policy only under the following circumstances –

1. Where the Policy Owner requests the Company to re-underwrite this Policy 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 this Policy if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Owner;

2. At any time where the Policy Owner 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 Owner requests to unsubscribe the additional benefits (if any) in this Policy, or switch to another insurance plan which provides downgrade or reduction of benefits, the Company shall not have the right to re-underwrite this Policy 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 this Policy if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Owner;

The Company and Policy Owner acknowledge that –

3. if under the terms of this clause, the Company has the right, or is required, to re-underwrite this Policy based on certain factors including but not limited to health conditions, smoking status, occupations, residency and financial conditions at renewal, the Company shall, in accordance with the terms of this clause and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and

4. as a result of re-underwriting, this Policy 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.

3.4 Grace Period

After payment of the first premium, the Company shall allow a Grace Period of thirty (30) days after the premium due date for payment of each premium. If a premium is still unpaid at the expiration of the Grace Period, this Policy shall cease to be in force from the date of the first unpaid premium without prejudice to any claim arising prior to the date the Policy ceases to be in force. Any due and unpaid premium shall be deducted from any benefit otherwise payable.

3.5 Deduction of Unpaid Premium

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

3.6 Reinstatement

Within one (1) year from the date of a default in payment of premium pursuant to which this Policy was terminated, this Policy may be reinstated at the Company's absolute discretion, provided that the Insured is still alive and insurable by the Company's underwriting rules.

Subject to the terms of this Policy, the Company's rules and regulations from time to time, the Policy Owner may apply for reinstatement of this Policy if:

1. a written application for reinstatement is furnished to the Company; and
2. the Policy Owner provides evidence of insurability satisfactory to the Company that the Insured is insurable on the same basis as when this Policy was issued; and
3. the Policy Owner pays all the unpaid premiums with interest, at a rate determined by the Company from time to time, from the date of termination.

The Policy will be reinstated only from such date as notified in writing by the Company ("date of reinstatement"). The reinstated Policy shall cover only medical fees or expenses caused by Covered Illness or Covered Injury that occurs after the date of reinstatement.

3.7 Non-Participating

This Policy is non-participating and shall not share in the divisible surplus of the Company's life insurance funds.

4 Benefit Provisions

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

1. it is Medically Necessary for Covered Illness or Covered Injury; and
2. the fees and expenses incurred are Reasonable and Customary charges; and
3. the fees and expenses do not exceed the maximum limits set out in the Policy Schedule or any endorsement attached thereto.

4.1 Death Benefit and Accidental Death Benefit

While this Policy is in force and, subject to the terms of this Policy, if the Insured dies before the Expiry Date, the Company shall, upon receipt of due proof of the death and any other documents as required by the Company, pay to the Beneficiary the death benefit, as specified in the Policy Schedule or any endorsement attached thereto.

In addition to the death benefit as specified in the Policy Schedule or any endorsement attached thereto (herein referred to as "Death Benefit"), if the cause of death is an Accident, the Company shall, upon receipt of due proof of the death and any other documents as required by the Company, pay to the Beneficiary the accidental death benefit, as specified in the Policy Schedule or any endorsement attached thereto (herein referred to as "Accidental Death Benefit").

The payment of the Balance of Annual Deductible (if any) is waived for this benefit.

4.2 Hospitalization Benefits

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

4.2.1 Room and Board Benefit

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

4.2.2 Companion Bed Benefit

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

4.2.3 Private Nursing Care's Fee Benefit

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

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

4.2.4 **Specialist's Fee Benefit**

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

4.2.5 **Physician's Hospital Visit Benefit**

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

4.2.6 **Charges for Intensive Care Benefit**

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

Payment under this benefit shall be in lieu of any Room and Board Benefit payable under clause 4.2.1 for such Confinement.

4.2.7 **Miscellaneous Hospital Charges Benefit**

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

- Drugs and medicines consumed by the Insured in the Hospital during his/her Confinement;
- Dressing, ordinary splints and plaster casts but excluding special braces, artificial limbs, appliances and equipment;
- Laboratory examinations;
- Electrocardiograms;
- Physiotherapy;
- X-ray examinations;
- Intravenous injections and solutions;
- Administration of blood and blood plasma but excluding costs of blood or blood plasma;
- Local ambulance service to or from the Hospital of Confinement.

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

4.2.8 **Daily Hospital Cash for Voluntary Room and Board Stay Below Private Room Benefit**

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

4.2.9 **Psychiatric Treatment Benefit**

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

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

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

The benefits under clauses 4.2.2, 4.2.3, 4.2.4, 4.2.5, 4.2.7, 4.2.8 shall only be payable if the Room and Board Benefit under clause 4.2.1 or the Intensive Care Benefit under clause 4.2.6 is payable.

4.3 **Surgical Benefits**

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

4.3.1 **Surgery Fee Benefit**

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

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

4.3.2 **Organ and Bone Marrow Transplantation Benefit**

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

4.3.3 **Medical Appliances Benefit**

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

(i) Pace maker;
(ii) Stents for Percutaneous Transluminal Coronary Angioplasty;
(iii) Intraocular lens;
(iv) Artificial cardiac valve;
(v) Metallic or artificial joints for joint replacement;

(vi) Prosthetic ligaments for replacement or implantation between bones; and

(vii) Prosthetic intervertebral disc.

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

This benefit shall only be payable if a claim under clause 4.3.1 above is also payable in respect of the same surgical procedures.

4.4 Pre- & Post-Hospitalization Benefits

4.4.1 Pre-Hospitalization Outpatient Benefit

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

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

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

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

4.4.2 Post-Hospitalization Outpatient Benefit

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

If two (2) or more Confinements or Clinical Surgeries are due to the same or related

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

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

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

4.4.3 **Post-Hospitalization Home Nursing Benefit**

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

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

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

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

4.5 **Extended Benefits**

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

While this Policy is in force, if the Insured suffers the following Designated Crises (as defined herein below) and is Confined in a Hospital as a direct result of the Designated Crises, in calculation of benefits payable under clause 4 of this Policy, the payment of

the Balance of Annual Deductible (if any) will be waived in respect of such Confinement and/or treatment.

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

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

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

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

4.5.2 **Chemotherapy and Radiotherapy Benefit**

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

4.5.3 **Kidney Dialysis Benefit**

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

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

When the benefit is payable under clauses 4.3.2, 4.5.2, or 4.5.3, the Company shall increase the Annual Limit for such benefits by the amount specified in the Policy Schedule for that Policy Year. This benefit is only applicable once per Policy Year. The amount of Lifetime Limit as specified in the Policy Schedule shall remain unchanged.

4.5.5 HIV/AIDS Treatment Benefit

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

4.5.6 Traditional Chinese Medicine Benefit

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

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

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

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

This benefit is not available under the "Standard Plan" of this Policy.

4.5.7 Pregnancy Complications Benefit

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

4.6 **Emergency Dental Treatment Benefit**

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

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

4.7 **Health Screening Benefit**

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

(a) the Insured must have been continuously covered for two (2) years from the Policy Date (hereinafter refer to as "Initial Period"); and
(b) the date of health screening received is after the Initial Period.

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

While this Policy is in force, if the eligible benefit under this clause 4.7 is increased, such increased benefit shall not be effective until the expiry of two (2) years calculated from the respective date when the benefit is increased. The amount of benefit payable before the expiry of the said two (2) years shall be that amount which was applicable before the benefit was increased.

Whilst this Policy is in force, if the eligible benefit under this clause 4.7 is decreased, such decreased benefit shall be effective immediately.

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

The payment of the Balance of Annual Deductible (if any) is waived for this benefit.

4.8 **Entitlement of Refund from Other Sources**

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

4.9 **Revision of Benefits and Limitations**

The Company reserves the right to revise, amend or modify the benefits payable, restrictions, limitations, exclusions under this Policy and any supplementary benefits, if attached hereto.

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

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

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

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

(i) for any benefit payable under clause 4.1, the increased benefit shall be payable from the date when the benefit is increased;
(ii) for any benefit payable under clauses 4.2, 4.3, 4.4 and 4.5 (except 4.5.1, 4.5.5 and 4.5.7), if the benefit is payable as a result of Covered Illness, the increased benefit shall only be payable to a Covered Illness which manifests and commences more than thirty (30) days after the day when the benefit is increased. If the benefit is payable as a result of Covered Injury, the increased benefit shall be payable from the date when the benefit is increased;
(iii) for any benefit payable under clause 4.5.1, the increased benefit shall only be applicable to Confinement which relates to a Designated Crises of which symptoms appear or relevant diagnosis or surgery occurs ninety (90) days after the date when the benefit is increased;
(iv) for any benefit payable under clause 4.5.5, the increased benefit shall only be payable if the signs or symptoms of the illness listed under clause 4.5.5 first occur after the Policy has been effective for five (5) consecutive years calculated from the date when the benefit is increased;
(v) for any benefit payable under clause 4.5.7, the increased benefit shall only be payable if the date of diagnosis of the covered pregnancy complications is after twelve (12) months after the date when the benefit is increased.

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

4.10 **Revision of the Plan**

This clause is only applicable for choosing Premier Plan under this Policy as specified in the Policy Schedule, or the latest endorsement (if any).

The Company reserves the absolute right to change the Plan from Premier Plan to Standard Plan at any time if the Insured has taken up residence in the USA for at least one hundred and eighty-three (183) days (including the days of arrival and departure) in the past twelve (12) months.

4.11 **Deduction from Benefits**

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

4.12 **No Interest on Benefits**

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

4.13 **Aggregate Benefits Limit**

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

4.14 **Benefit Calculation**

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

All Eligible Expenses of each claim minus the higher of:
(a) The Balance of Annual Deductible (if any); and
(b) The actual amount(s) reimbursed from other sources;
subject to any limitations of each benefit including the Annual Limit and the Lifetime Limit as specified in the Policy Schedule.

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

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

5 Convertibility Option to Reduce Annual Deductible at Specified Ages

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

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

6 Exclusions

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

1. the Insured's illness or injury is a Pre-existing Condition or results from the complications of a Pre-existing Condition;
2. in case of medical treatment in Mainland China, the subject Hospital is not a designated Hospital approved by the Company;
3. the Insured's sickness, disease or illness occurs during the first thirty (30) days from the Policy Date or the date of reinstatement of the Policy;
4. the Confinement, treatment or charges incurred relate to or arise as a direct or indirect result of:
   (1) the Insured's pregnancy, surrogacy, childbirth or termination of pregnancy (except for the Pregnancy Complications Treatment under clause 4.5.7 of this Policy), birth control, infertility or human assisted reproduction, or sterilisation of either sexes;
   (2) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, riot, strike, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, terrorist act, nuclear reactions, nuclear radiation, nuclear contamination, biological contamination or chemical contamination;
   (3) naval, military or air-force services, or any operation or combat duty with any armed force of any country, territory, or organization;
   (4) the Insured's participation in any criminal offence or illegal acts;
   (5) attempted suicide or self-inflicted injuries while sane or insane, or under any condition caused by chronic alcoholism or drug addiction;
   (6) cosmetic or plastic surgery, dental treatment or surgery of any kind, oral or oro-surgical care, eye refraction, eye tests or fitting of glasses, or surgical correction of nearsightedness (such as but not limited to radial keratomoty and keratectomy), unless such a treatment is explicitly covered by this Policy.
   (7) procurement or use of medical appliances and medical devices for the benefit of the Insured including but not limited to spectacles, contact lenses, hearing aids or wheelchairs (unless such medical appliances and medical devices are explicitly covered by this Policy);
   (8) preventive treatments, preventive medicines, convalescence, physical examinations, or health checks (with or without any positive finding) on the Insured; vaccination and immunisation received by the Insured; genetic testing or counselling on the Insured; or any treatment which is not deemed Medically Necessary by the Company;
   (9) treatment or tests carried out in relation to the Insured's illness or injury are not consistent with customary medical treatment or diagnosis in Macau;
   (10) narcotics used by the Insured unless taken as prescribed by a Physician, or the Insured's abuse of drugs or alcohol;
   (11) health supplements and all specialized Chinese herbs and/or tonic medicine including bird's nest, lingzhi, gingseng, agaricus blazei murill, antelope horn powder, antler, cordyceps sinensis, donkey-hide gelatin, hippocampus, moschus, pearl powder, placenta hominis and any other Chinese herbs and/or tonic medicine determined by the Company in its absolute discretion from time to time;
   (12) scuba diving or engaging in or taking part in any kind of race other than on foot, mountaineering involving the use of ropes or guides by the Insured or other professional or hazardous sports or pastimes including but not limited to skydiving, parachuting, hang-gliding, parasailing, hunting, aviation or aeronautics (other than as fare paying passenger on a duly licensed commercial aircraft), ice or water ski-jumping, show jumping;
   (13) AIDS or any complications associated with HIV Infection except for the HIV / AIDS Treatment Benefit under clause 4.5.5 of this Policy;
   (14) transplant service for which the cost incurred in connection with identifying service and procuring a replacement organ or any costs incurred for removal of the organ from the donor, all associated transportation costs and administrative costs;
   (15) donation of organ;

(16) mental disorder, psychological or psychiatric conditions, behavioural problems or personality disorder of the Insured unless such occurrence is covered by the Psychiatric Treatment Benefit under clause 4.2.10 of this Policy;
(17) birth defects, genetic disorders, Congenital Conditions, or inherited disorders or developmental conditions (only applicable if the disorder gives rise to signs or symptoms or was diagnosed before the Insured attains sixteenth (16th) years of age) of the Insured;
(18) any Confinement primarily for physiotherapy or for the investigation of signs and/or symptoms with diagnostic imaging, laboratory investigation or other diagnostic procedures as determined by the Company;
(19) rest cures and services or treatment received in any home, spa, health hydro, nature cure clinic, sanatorium or long term care facility that is not a registered acute treatment hospital;
(20) any treatment, investigation, services or supplies which are not Medically Necessary; any charges which exceed the Reasonable and Customary Charges as determined by the Company;
(21) non-medical services, including but not limited to guest meals, radio, telephone, television, photocopy, telex, personal items, and medical report charges;
(22) experimental and / or unconventional medical technology / procedure / therapy performed on the Insured; novel drugs / medicines / stem cell therapy not yet approved by the government, relevant authorities and recognised medical association in the locality, or treatment and procedures carried out by a facility not recognized as an acute treatment hospital, or services performed by a relative of the insured or a person who ordinarily resides in the insured's home.
(23) sleep disorders (except for the treatment of sleep apnoea which is life-threatening as confirmed by a Specialist and approved by the Company in advance), treatment for learning difficulties in children, such as dyslexia or behavioural problems, attention deficit hyperactivity disorder, or development problems such as shortness of stature;
(24) treatment of obesity (including morbid obesity), weight control programmes or bariatric surgery (except when bariatric surgery is necessary as confirmed by a Specialist after failure of conventional treatments and approved by the Company in advance);
(25) treatment of sexually transmitted diseases; venereal diseases, sexual problems, such as impotence, whatever the cause, gender issues or gender re-assignment except for the HIV/AIDS Treatment Benefit under clause 4.5.5 of this Policy;
(26) treatment whilst staying in Hospital for more than ninety (90) consecutive days if the Insured is in a persistent vegetative state characterized by wakefulness without awareness for more than four (4) weeks;
(27) expenses that are recoverable from any other source;
(28) any activity or disease which falls under the exclusion(s) as shown on the endorsement(s) (if any) of this Policy.

No Accidental Death Benefit is payable under this Policy when the death of the Insured is directly or indirectly caused by:

1. Disease or infection (except infections which occur through an accidental cut or wound).
2. Pregnancy, childbirth (in any form), miscarriage and abortion irrespective of whether such event is accelerated or induced by an injury.
3. Intentional self-inflicted injury or attempted suicide, while sane or insane and while intoxicated or not.
4. Any drug unless taken in accordance with the lawful directions and prescription of a qualified and registered Physician.
5. Accident occurring while or because the Insured is under the influence of alcohol/ drugs.
6. Poison, gas or fumes, voluntarily or otherwise taken, absorbed or inhaled, other than as a result of an Accident arising from a hazardous incident in relation to the Insured's occupation.
7. War or any act of war, terrorism or terroristic activities, declared or undeclared, hostilities, rebellion, revolution, insurrection, coup or usurped power or active duty in the military, naval or air forces of any country or international authority.
8. Aviation or aeronautics other than as a fare paying passenger on a duly licensed commercial aircraft.
9. The participation in any criminal event.

10. Racing of any kind other than on foot.
11. Nuclear radiation, or contamination or the use of ionization or combustion of any nuclear weapons.
12. Participation in all forms of professional sports competition with reward and income.

7 Claim Provisions

7.1 Notice of Claim

Written notice of a claim must be given to the Company within thirty (30) days from the date of Discharge or Clinical Surgery, or the date of death of the Insured, or in any case not beyond six (6) months from the date of discharge from Confinement or Clinical Surgery, or the date of death of the Insured. Any claims received after the said period shall not be accepted, unless the Company in its sole discretion decides otherwise.

7.2 Proof of Loss

Upon receipt of a notice of claim, the Company shall provide the claimant with such forms as it requires for filing proof of loss.

Written proof of loss satisfactory to the Company must be given to the Company within ninety (90) days after the time the proof is required or as soon thereafter as is reasonably possible, and in no event, except in the absence of legal capacity, later than six (6) months from the time the proof is required.

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

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

7.3 Claimable Amount Estimate

Before the Insured receives Medically Necessary services for a Covered Illness or Covered Injury, the Policy Owner may request the Company to provide an estimate on the amount that may be claimed under Benefit Provisions. The Policy Owner shall provide the Company with the estimated fees to be incurred as furnished by the Hospital and/or attending Physician as required by the laws and regulations regulating the private healthcare facilities in Macau at the time of request. Upon receiving the request, the Company shall inform the Policy Owner of the claimable amount estimate under Benefit Provisions based on the estimation furnished by the Hospital and/or attending Physician. The Company's estimate is for reference only, and the actual amount claimable by the Policy Owner shall be subject to the final expenses as evidenced required by the Company.

7.4 Limitation of Claim

In any case if the Insured is Confined, whether voluntarily or involuntarily, in a room of the class higher than Standard Private Room, the Company shall reduce the amount of the benefit incurred during the period of Confinement and payable under this Policy to 25% of the relevant benefit payable.

7.5 Limitation of Claim in the USA

This section is only applicable for choosing Premier Plan under this Policy as specified in the Policy Schedule, or the latest endorsement (if any).

Subject to other terms and conditions of this Policy, the Company shall reduce the amount of the benefit payable (except for Death Benefit and Accidental Death Benefit under the clause 4.1) under this Policy to fifty percent (50%) of the relevant benefit payable if:-

(a). at the time of Confinement, or receiving medical treatment and/or service in the USA, the Insured has taken up residence in the USA for at least one hundred and eighty-three (183) days (including the days of arrival and departure) in the past twelve (12) months; and / or

(b). the Insured is under Confinement or undergoes Clinical Surgeries in the USA without obtaining our preauthorization unless it is directly due to Accident or emergency.

The Company shall reserve the right to require any additional proof of the Insured's country of residence, including proof that the Insured has not taken up residence in USA, to our satisfaction at the time of processing any claim or payment of any benefit under this Policy.

This limitation is applicable in addition to clause 7.4.

7.6 **Payment of Claim**

The benefits of this Policy shall be payable to the Policy Owner or the nominated Beneficiary or any other person who is entitled to the benefits under this Policy, as the case may be, whose receipt shall constitute a sufficient discharge of all the Company's obligations under this Policy in respect of such benefit and conclusive evidence that the relevant claims under this Policy have been duly satisfied.

7.7 **Abandoned Claims**

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

7.8 **Legal Action**

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

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

8 Termination Provisions

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

1. The death of the Insured; or
2. The Expiry Date of this Policy; or
3. The date of Policy surrender. Such date is determined in accordance with the Company's applicable rules and regulations in relation to Policy surrender; or
4. The date the aggregate benefits paid under all relevant insurance policies reach the Lifetime Limit; or
5. Termination of this Policy in accordance with clauses 2.9, 3.2, 4.9 or 7.8; or
6. The end of the Grace Period of any premium due and not received by the Company.

Appendix – Clinical Surgery List

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

BONES AND JOINTS	Close reduction and fixation of fractures with or without the use of plaster of Paris
	Manipulation of joints under anaesthesia
	Halo-cast fixation for cervical spine fracture/dislocation
BRAIN AND CENTRAL NERVOUS SYSTEM	Lumbar puncture of cisternal puncture
BREAST	Biopsy of breast tissue
EAR	Insertion of grummet
	Operation on the external ear and/or pre-auricular sinuses
EYE	All conjunctival or corneal operations except corneal grafting, severe corneal wound repair and keratoplasty
	All eyelid operations except blepharoplasty and ptosis repair
	Surgical treatment for glaucoma
	Removal of corneal foreign body
	Lens operation including cataract removal and prosthetic lens insertion
	Phacoemulsification
	Laserphotocoagulation on retina
	Removal of pterygium (one or both sides)
	Incision of chalazion
	Open exploration of nasal lacrimal duct except simple probing
FEMALE GENITAL TRACT	Amputation of cervix, cervicectomy, cone biopsy or cauterisation of cervix
	Suture of cervix
	Marsupilisation of bartholin's cyst
	Operation for simple cyst or benign tumour of vulva and vagina, including simple repair and suturing
GASTRO-INTESTINAL TRACT OPERATION	Upper endoscopy up to the level of duodenum
	Colonoscopy, with or without biopsy or papilloma removal
	Haemorrhoidectomy
	Operation for anal fissure including radical excision
HEAD AND NECK	Lymph node biopsy
	Operation on lip and cheek benign tumour
MALE GENITAL TRACT	Circumcision
	Tapping of hydrocele
	Testicular biopsy
NOSE AND SINUSES	Antral puncture and lavage
	Removal of nasal polyp
	Cauterisation of nasal mucosa
	Rhinoscopy or nasopharyngoscopy including rhinoscopic biopsy and foreign body removal
HEPATO - BILIARY SYSTEM	Liver biopsy
SKIN	Lymph node biopsy or drainage of lymph node abscess
	Excision of skin lumps or tumour of subcutaneous tissue, including lipoma, neurofibroma or its variants, sebaceous cysts, malignant melanoma, and naevus etc.
	Incision and drainage of skin abscess
	Cauterisation of skin lesion with electricity or cryosurgery
	Removal of foreign body
	Excision of pilonidal cyst

	Skin grafting or keloid operation : if total area less than or equal 1% of body surface area
	Drainage of subungual haematoma or abscess
	Skin suturing
TENDON, NERVE, VESSEL, MUSCLE AND SOFT TISSUE	Application of complete plaster cast, not for limb resting purpose
	Removal or avulsion of nail
	Excision of ganglion
	Operation on Dupuytren's Contracture
	Varicose vein sclerotherapy (one or two legs)
THORACIC OPERATIONS	Bronchoscopy
	Oesophagoscopy
	Thoracocentesis or insertion of chest tube for pneumothorax
THROAT	Vocal cord operation including using laser techniques (carcinoma excluded)
	Tracheostomy
	Laryngoscopy with/without foreign body removal
	Tonsillectomy with or without other adenoid tissue removal
URINARY TRACT	Cystoscopy
	Renal biopsy

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

INTERNATIONAL SOS 24-HOUR WORLDWIDE ASSISTANCE PROGRAM

General Benefits and Terms

The following SOS benefits are available to the insureds ("Users") of FWD Life Insurance Company (Macau) Limited (the "Company") when travelling outside the Home Country or Usual Country of Residence for periods not exceeding 90 consecutive days per trip.

The Worldwide Assistance Program is provided as a benefit by International SOS ("Intl.SOS"), which does not form not part of the Policy or benefits under the Policy Provisions. The Company reserves the right to terminate or vary the Worldwide Assistance Program in its sole discretion without further notice.

Medical Assistance:

(1) Telephone Medical Advice
Intl.SOS will arrange for the provision of medical advice to the User over the telephone.

(2) Arrangement and Payment of Emergency Medical Evacuation
Intl.SOS will arrange and pay for the air and/or surface transportation and communication for moving the User to the nearest hospital where appropriate medical care is available.

(3) Arrangement and Payment of Emergency Medical Repatriation
Intl.SOS will arrange and pay for the return of the User to the Home Country or Usual Country of Residence following an Emergency Medical Evacuation for subsequent in-hospital treatment in a place outside the Home Country or Usual Country of Residence.

(4) Arrangement and Payment of Repatriation of Mortal Remains
Intl.SOS will arrange for transporting the User's mortal remains from the place of death to the Home Country or Usual Country of Residence and pay for all expenses reasonably and unavoidably incurred in such transportation so arranged by Intl.SOS or alternatively pay the cost of burial at the place of death as approved by Intl.SOS.

(5) Arrangement of Hospital Admission and Guarantee of Hospital Admission Deposit
If the medical condition of the User is of such gravity as to require hospitalisation, Intl.SOS will assist such User in the hospital admission. In case of hospital admission duly approved by Intl. SOS and the User is without means of payment of the required hospital admission deposit, Intl.SOS will on behalf of the User guarantee or provide such payment up to US$5,000. The provision of such guarantee by Intl.SOS is subject to Intl.SOS first securing payment from the User through the User's credit card or from the funds from the User's family. Intl.SOS shall not be responsible for any third party expenses which shall be solely the User's responsibility.

(6) Delivery of Essential Medicine
Intl.SOS will arrange to deliver to the User essential medicine, drugs and medical supplies that are necessary for a User's care and/or treatment but which are not available at the User's location. The delivery of such medicine, drugs and medical supplies will be subject to the laws and regulations applicable locally. Intl.SOS will not pay for the costs of such medicine, drugs or medical supplies and any delivery costs thereof.

(7) Arrangement and Payment of Compassionate Visit and Hotel Accommodation (US$1,000 subject to a sub-limit US$250 per day)
Intl.SOS will arrange and pay for one economy class return airfare and hotel accommodations for a relative or a friend of the User to join the User who, when travelling alone, is hospitalised outside the Home Country or Usual Country of Residence for a period in excess of seven (7) consecutive days, subject to Intl.SOS' prior approval and only when judged necessary by Intl.SOS on medical and compassionate grounds.

(8) Arrangement and Payment of Return of Minor Children

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

(9) Arrangement and Payment of Convalescence Expenses (US$1,000 subject to a sub-limit US$250 per day)

Intl.SOS will arrange and pay for the additional hotel accommodation expenses necessarily and unavoidably incurred by the User related to an incident requiring Emergency Medical Evacuation, Emergency Medical Repatriation or hospitalisation. Intl.SOS' prior approval, subject to its determination on medical grounds, is required in respect of such payment.

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

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

(11) Arrangement and Payment of Return of User to Original Work Site

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

Travel Assistance:

(1) Inoculation and Visa Requirement Information

Intl.SOS shall provide information concerning visa and inoculation requirements for foreign countries, as those requirements are specified from time to time in the most current edition of World Health Organization Publication "Vaccination Certificates Requirements and Health Advice for International Travel" (for inoculations) and the "ABC Guide to International Travel Information" (for visas). This information will be provided to the User at any time, whether or not the User is travelling or an emergency has occurred.

(2) Lost Luggage Assistance

Intl.SOS will assist the User who has lost his/her luggage while travelling outside the Home Country or Usual Country of Residence by referring the User to the appropriate authorities involved.

(3) Lost Passport Assistance

Intl.SOS will assist the User who has lost his/her passport while travelling outside the Home Country or Usual Country of Residence by referring the User to the appropriate authorities involved.

(4) Legal Referral

Intl.SOS will provide the Users with the name, address, telephone numbers, if requested by the User and if available, office hours for referred lawyers and legal practitioners. Intl.SOS will not give any legal advice to the User.

(5) Emergency Travel Service Assistance

Intl.SOS shall assist the User in making reservations for air ticket or hotel accommodation on an emergency basis when travelling overseas.

Definitions:

(1) Serious Medical Condition
means a condition which in the opinion of Intl.SOS constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the User's immediate or long term health prospects. The seriousness of the medical condition will be judged within the context of the User's geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facilities.

(2) Pre-Existing Condition
means any medical condition in respect of which the User has been hospitalised during the 12-month period immediately prior to the 1st day the User is included in Intl.SOS program or any medical condition that has been diagnosed or treated by a medical practitioner including prescribed drugs within the 6- month period prior to the 1st day the User is included in Intl.SOS program.

Exclusions:

The following treatment, items, conditions, activities and their related or consequential expenses are excluded unless Intl.SOS has given its prior written approval and the Company has paid the designated fees:

(1) Any expense incurred as a result of a Pre-existing Condition.

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

(3) Any cost or expense not expressly covered by the program and not approved in advance and in writing by Intl.SOS and/or not arranged by Intl.SOS. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when Intl.SOS cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the User.

(4) Any event occurring when the User is within the territory of his/her home country or Usual Country of Residence.

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

(6) Any expense for medical evacuation or repatriation if the User is not suffering from a Serious Medical Condition, and/or in the opinion of the Intl.SOS physician, the User can be adequately treated locally, or treatment can be reasonably delayed until the User returns to his/her Home Country or Usual Country of Residence.

(7) Any expense for medical evacuation or repatriation where the User, in the opinion of the Intl.SOS physician, can travel as an ordinary passenger without a medical escort.

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

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

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

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

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

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

(14) Any expense related to the User engaging in the commission of, or the attempt to commit, an unlawful act.

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

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

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

(18) Any expense incurred for or as a result of any activity required from or on a ship or oil-rig platform, or at a similar off-shore location.

(19) Any expense in respect of the User under Group 1 (group insurance) more than 75 years old and User under Group 2 (individual insurance) more than 70 at the date of intervention.

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

Intl.SOS, at its sole discretion, will assist Users on a fee-for-service basis for interventions falling under the above exceptions, subject to Intl.SOS receiving additional financial guarantees or indemnification from the Company and/or its User(s) prior to rendering such services on a fee-for-service basis.

This is served for reference only.

(The English translation is for reference only. The Chinese language version shall govern and prevail in the event of any conflict.)

Second Medical Opinion Service

As part of the promise of care made by FWD Life Insurance Company (Macau) Limited (the "Company"), you are given the access to some of the highest ranked medical institutions in the US through International SOS once your claim as a result of a Covered Illness or a Covered Injury is approved.

What is Second Medical Opinion Service?
The objective of the Second Medical Opinion Service is to meet the public's increasing demands for the best possible medical treatment bearing in mind the continual development of leading edge treatments for major diseases. This is why we offer the Second Medical Opinion Service to our valuable Insured via International SOS.

Under this distinguished service, the Insured has access to a panel of world-class specialists at leading medical institutions in the US to obtain alternative advice on the Insured's medical condition and confirmation of the diagnosis in the event that the Insured has been diagnosed as suffering from a Covered Illness or a Covered Injury made by your attending physician, plus any other relevant medical advice.

Panel of Second Medical Advice Specialists
The Panel provides you access to some of the highest ranked medical institutions in the US, together with more than 15,000 leading specialists who practice there, including:

- Harvard Medical School
- Johns Hopkins Hospital, Baltimore
- Massachusetts General Hospital
- Brigham and Women's Hospital, Boston
- Dana-Faber Cancer Institute
- Cedars-Sinai Medical Center, Los Angeles

How to seek Second Medical Opinion Service?
When the Insured has been diagnosed with a Covered Illness or has been suffered from a Covered Injury, the Insured is required to follow the instructions below to obtain the Second Medical Opinion Service. Call International SOS at (852) 3122 2900 and request the Second Medical Opinion Service. Within 24 hours International SOS will confirm membership and whether the medical condition is eligible for the Service.
Service Flow
1) Receive "Information Request Form" from International SOS via fax or email. International SOS will advise the medical documents required. 2) International SOS will assess the case and reply to the Insured if his/her case is eligible for the Service. The Insured needs to complete the **Information Request Form** and send to International SOS together with the relevant medical documents for the Second Medical Opinion Report*. (via courier or registered mail) 3) The Panel of Second Medical Opinion will send an acknowledgement to International SOS after receipt. If additional medical information is required, the Panel of Second Medical Opinion will inform International SOS who will in turn contact the Insured. 4) After evaluation, the written Second Medical Opinion report and advice will be faxed/ emailed to International SOS within 3-5 US working days depending on the complexity of the report. 5) Upon receipt of the Second Medical Opinion report, International SOS will send it to the Insured and his/her treating physician, as required. If requested, International SOS will arrange transportation, accommodation and admission to the identified treating facility and with a medical escort, if medically necessary. ALL RELATED COSTS to International SOS WILL BE BORNE BY THE INSURED. *Second Medical Opinion Report is US$850. *(The cost may be reviewed from time to time)*

The information above is for reference only and none of the above is binding upon our Company or International SOS.

The service is provided by International SOS and it is not guaranteed renewable. It does not form part of the Policy or benefits under the Policy Provisions. Our Company shall not be responsible for any act or failure to act on the part of International SOS and the professionals. Details of the services may be revised from time to time without prior notice from the Company.

Note:

1) The Company, the medical panel, International SOS and/or any of its affiliates, record, share, use and archive your personal data in pursuance of the services being offered to you as well as for their training and quality assurance purposes. The failure to provide the relevant personal data may result in the said service providers being unable to provide the relevant services to you.
2) The Second Medical Opinion Service provided to you is purely advisory and recommendatory in nature and is not a substitute for medical services. It is for you and your physician or consulting hospital to decide the appropriate medical course of action to be pursued. The International SOS, and/or its affiliates and the panel providing the medical opinion do not have any authority or responsibility to determine the benefits or amounts payable, its eligibility, claim processing etc.