vPrime Medical Plan
Policy Provisions

vPrime Medical Plan
Terms and Conditions

Contents

TERMS AND CONDITIONS

Part 1 Insuring Clause and The Policy

Insuring Clause

These Terms and Conditions together with the Benefit Schedule (including the Schedule of Surgical Procedures) and any related Supplement(s) (hereafter "Terms and Benefits") apply to the following Plan offered by the Company –

Name of the Plan - vPrime Medical Plan

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

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

The Policy

The Policy Holder and the Company agree that –

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

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

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

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

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

6. The Company acknowledges that, as part of the underwriting process, it is the obligation of the Company to ask the Policy Holder and the Insured Person in the Application all requisite information for the Company to make the underwriting decision. If the Company requires the Policy Holder and/or the Insured Person to disclose any updates of or changes to such requisite information after the time of submission of Application and before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Company must make such a request prominently to the Policy Holder and the Insured Person (including without

limitation in the application form), in which case the Policy Holder and/or the Insured Person shall have the obligation to inform the Company on such updates and changes. Each of the Policy Holder and the Insured Person shall have the obligation to respond to the questions, and to disclose such material facts as requested in the questions. The Company agrees that if any such questions are not included in the Application, the Company shall be deemed to have waived the disclosure obligation of the Policy Holder and the Insured Person in respect of the information that was not requested.

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

8. If the Policy Holder or the Insured Person fails to make the relevant disclosures under Section 6 or 7 of this Part 1, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right as provided in Sections 13 and 14 of Part 2.

Part 2 General Conditions

1. Interpretation

(a) Throughout these Terms and Benefits, where the context so requires, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.
(b) Headings are for convenience only and shall not affect the interpretation of these Terms and Benefits.
(c) A time of day is a reference to the time in Macau.
(d) Unless otherwise defined, capitalised terms used in these Terms and Benefits shall have the meanings ascribed to them under Part 8.

These Terms and Benefits have been prepared in both English and Chinese. The Chinese language version shall prevail in the event of any inconsistency.

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

2. Cancellation within cooling-off period

If Policy Holder is not completely satisfied with these Terms and Benefits, and Policy Holder has not made a claim, Policy Holder can cancel it within twenty-one (21) days after:

(i) the date the Company delivers these Terms and Benefits to the Policy Holder or Policy Holder's representative; or
(ii) the date the Company issues a notice to the Policy Holder or Policy Holder's representative informing Policy Holder or Policy Holder's representative about these Terms and Benefits and the right to cancel;

whichever is earlier.

This 21-day period is called the cooling-off period. Policy Holder can cancel these Terms and Benefits and receive premiums without interest back. The Company follows the cooling-off period principles set out by the Macau insurance regulator to protect customers.

The above cancellation right shall not apply at Renewal.

To exercise this cancellation right, the Policy Holder must –

(a) return the original of these Terms and Benefits and the Policy Schedule; and
(b) attach a letter, signed by the Policy Holder, requesting cancellation or in other forms acceptable by the Company.

These Terms and Benefits shall then be cancelled and the premium paid without interest shall be fully refunded. In such event, these Terms and Benefits shall be deemed to have been void from the Policy Effective Date and the Company shall not be liable to pay any benefit.

3. Cancellation

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

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

4. Benefit entitlement

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

5. Assignment

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

6. Clerical error

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

7. Currency

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

8. Interest

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

9. Company's obligation

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

10. Governing law

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

11. Dispute resolution

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

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

12. Liability

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

13. Misstatement of personal information

Without prejudice to the Company's right to declare this Policy void in the case of misrepresentation on health related information or fraud as provided in Section 14 of this Part 2, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or smoking habit) is

misstated in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1), the Company may adjust the premium, for the past, current or future Policy Years, on the basis of the correct information. Where additional premium is required, no benefits shall be payable unless the additional premium has been paid. If the additional required premium is not paid within a grace period of thirty (30) days after the due date as notified by the Company to the Policy Holder, the Company shall have the right to terminate this Policy with effect from such due date, in which case Section 15 of this Part 2 shall apply. Where there has been an overpayment of premium by the Policy Holder, the Company shall refund the overpaid premium.

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

(a) the right to demand refund of the benefits previously paid; and
(b) the obligation to refund the premium received,

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

14. Misrepresentation or fraud

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

(a) any material fact relating to the health related information of the Insured Person which may impact the risk assessment by the Company is incorrectly stated in, or omitted from, the Application or any statement or declaration made for or by the Insured Person in the Application or in any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1). The circumstances that a fact shall be considered "material" include, but not limited to, the situation where the disclosure of such fact as required by the Company would have affected the underwriting decision of the Company, such that the Company would have imposed Premium Loading, included Case-based Exclusion(s), or rejected the application. For the avoidance of doubt, this paragraph (a) shall not apply to non-health related information of the Insured Person, which shall be governed by Section 13 of this Part 2; or
(b) any Application or claim submitted is fraudulent or where a fraudulent representation is made.

The burden of proving (a) and (b) shall rest with the Company. The Company shall have the duty to make all necessary inquiries on all facts which are material to the Company for underwriting purpose as provided in Section 6 or 7 of Part 1.

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

(i) the right to demand refund of the benefits previously paid; and
(ii) the obligation to refund the premium received,

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

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

(iii) the right to demand refund of the benefits previously paid; and
(iv) the right not to refund the premium received.

15. Termination of Policy

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

(a) where this Policy is terminated due to non-payment of premiums after the grace period as specified in Section 13 of this Part 2 or Section 3 of Part 3; or
(b) the day immediately following the death of the Insured Person; or
(c) the Company has ceased to have the requisite authorisation under the Macau Insurance Companies Ordinance to write or continue to write this Policy;

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

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

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

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

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

If this Policy is terminated under (a) or (c) of this Section 15, in the case where the Insured Person is being Confined or is undergoing Prescribed Non-surgical Cancer Treatment for a Disability suffered before such termination, then, with respect to the Confinement or

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

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

(d) the Terms and Benefits of this Plan which shall continue to be in full force and effect; and
(e) the continuity of these Terms and Benefits, and shall not adversely affect the Company's compliance with the licensing requirement in order to continue to write these Terms and Benefits.

16. Notices to Company

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

17. Notices from Company

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

(a) if sent by post, two (2) working days after posting; or
(b) if sent by email, on the date and time transmitted.

18. Other insurance coverage

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

19. Ownership and discharge under this Policy

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

20. Change of ownership of the Policy

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

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

(a) the Insured Person if he has reached the Age of eighteen (18) years;
(b) the parent or the Guardian of the Insured Person if he is a Minor; or
(c) any person whose familial relationship with the Insured Person is accepted by the Company according to its prevailing underwriting practices which are readily accessible by the Policy Holder.

21. Death of Policy Holder

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

(a) the Insured Person if he has reached the Age of eighteen (18) years; or
(b) the parent or the Guardian if the Insured Person is a Minor. If the parent or the Guardian refuses the transfer, the ownership of this Policy shall be transferred to the administrator or executor of the Policy Holder's estate.

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

22. Subrogation

After the Company has paid a benefit under this Policy, the Company shall have the right to proceed at its own expense in the name of the Policy Holder and/or the Insured Person against any third party who may be responsible for events giving rise to such benefit claim under this Policy. Any amount recovered from any such third party shall belong to the Company to the extent of the amount of benefits which has been paid by the Company in respect of the relevant benefit claim under this Policy. The Policy Holder and/or the Insured Person must

provide full details in his possession or within his knowledge on the fault of the third party and fully cooperate with the Company in the recovery action. For the avoidance of doubt, the above subrogation right shall only apply if the third party is not the Policy Holder or the Insured Person.

23. Suits against third parties

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

24. Waiver

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

25. Compliance with law

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

26. Personal data protection

The Company shall comply with the Personal Data Protection Act and the related codes, guidelines and circulars.

Part 3 Premium Provisions

1. Premium payable

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

(a) the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company; and
(b) the Premium Loading, if applicable.

2. Payment of premiums

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

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

3. Grace period

The Company shall allow a grace period of thirty (30) days after the premium due date for payment of each premium. This Policy shall continue to be in effect during the grace period but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, this Policy shall be terminated immediately on the date on which the unpaid premium is first due.

Part 4 Renewal Provisions

These Terms and Benefits shall be effective from the Policy Effective Date in consideration of the payment of premium and is Renewable for each Policy Year in accordance with the terms of this Part 4. Renewal is up to the Age of one hundred (100) years of the Insured Person.

1. Renewal

Unless the Policy Holder decides not to Renew these Terms and Benefits by giving the Company not less than thirty (30) days prior notice in writing in accordance with Section 3 of Part 2, Renewal shall be arranged automatically by the Company. The Company reserves the right to revise, modify or adjust the Terms and Benefits upon renewal.

2. Adjustment of premium

Irrespective of whether the Company revises these Terms and Benefits upon Renewal, the Company shall have the right to adjust the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company on an overall basis. For the avoidance of doubt, if the Premium Loading is set as a percentage of the Standard Premium (i.e. rate of Premium Loading), the amount of Premium Loading payable shall be automatically adjusted according to the change in Standard Premium.

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

3. Notification of Renewal

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

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

4. No re-underwriting except in limited circumstances

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

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

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

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

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

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

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

The Company and Policy Holder acknowledge that –

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

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

Part 5 Claim Provisions

1. Submission of claims

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

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

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

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

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

2. Claimable amount estimate

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

3. Legal action

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

4. Medical examination

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

Part 6 Benefit Provisions

1. General

(a) Territorial scope of cover

Except for the psychiatric treatment as stated in Section 3(l) of this Part 6 and the cash benefit for room and board Confinement below entitled ward class in a private Hospital in Macau or Hong Kong as stated in Section 6 of the Supplement – Other benefits, all benefits described in these Terms and Benefits are subject to the geographical limitation for benefit coverage as stated in Sections 1 and 3 of Part 1 of the Supplement – Limitation of benefits of these Terms and Benefits.

(b) Lifetime Benefit Limit

All benefits described in these Terms and Benefits, except for the death benefit and accidental death benefit as stated in Sections 1 and 2 of the Supplement – Other benefits, are subject to the Lifetime Benefit Limit as stated in the Benefit Schedule of these Terms and Benefits.

(c) Choice of healthcare services providers

Except for the cash benefit for room and board Confinement below entitled ward class in a private Hospital in Macau or Hong Kong as stated in Section 6 of the Supplement – Other benefits, all benefits described in these Terms and Benefits are not subject to any restriction in the choice of healthcare services providers, including but not limited to Registered Medical Practitioner and Hospital.

The benefit described in the cash benefit for room and board Confinement below entitled ward class in a private Hospital in Macau or Hong Kong as stated in Section 6 of the Supplement – Other benefits of these Terms and Benefits is subject to the restriction in the choice of healthcare services providers as stated in Section 6 of the Supplement – Other benefits and the Benefit Schedule of these Terms and Benefits.

(d) Choice of ward class

The benefits described in these Terms and Benefits are subject to the restriction in the choice of ward class as stated in the Benefit Schedule and Section 2 of Part 1 of the Supplement - Limitation of benefits of these Terms and Benefits.

The above restriction shall not apply to the benefits described in Appendix – Non-emergency treatment outside Asia benefit schedule.

2. Coverage of Confinement and non-Confinement services

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

(a) is Confined in a Hospital; or
(b) undergoes any Day Case Procedure, Prescribed Diagnostic Imaging Test, Prescribed Non-surgical Cancer Treatment, Emergency outpatient accidental treatment or outpatient kidney dialysis (in a setting for providing Medical Services to a Day Patient),

the Company shall reimburse the Eligible Expenses which are Reasonable and Customary in accordance with benefit items under Section 3 of this Part 6 and the Supplement - Enhanced benefits of these Terms and Benefits.

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

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

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

3. Benefits covered

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

(a) Room and board

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

(b) Miscellaneous charges

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

(i) Road ambulance service to and/or from the Hospital;
(ii) Anaesthetic and oxygen administration;
(iii) Administration charges for blood transfusion;
(iv) Dressing and plaster casts;
(v) Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;

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

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

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

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

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

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

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

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

(c) Attending doctor's visit fee

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

(d) Specialist's fee

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

(e) Intensive care

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

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

(f) Surgeon's fee

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

This benefit shall be payable according to the relevant surgical category and the categorisation of such surgical procedure under the Schedule of Surgical Procedures as categorised and reviewed from time to time by the Company. If a surgical procedure performed is not included in the Schedule of Surgical Procedures, the Company may reasonably determine its surgical category according to relevant

publication or information including but not limited to the schedule of fees recognised by relevant authorities and medical association in the locality where the surgical procedure is performed.

(g) Anaesthetist's fee

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

(h) Operating theatre charges

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

For the avoidance of doubt, the Eligible Expenses for any additional surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be payable under Section 3(b) of this Part 6.

(i) Prescribed Diagnostic Imaging Tests

This benefit shall be payable for the Eligible Expenses charged on Prescribed Diagnostic Imaging Test performed during Confinement or in a setting for providing Medical Services to a Day Patient recommended in writing by the attending Registered Medical Practitioner for the investigation or treatment of a Disability.

(j) Prescribed Non-surgical Cancer Treatments

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

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

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

This benefit shall be payable for the Eligible Expenses for –

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

(ii) follow-up outpatient visit (including but not limited to consultation, western medication prescribed, dressings, physiotherapy, occupational therapy, speech therapy or diagnostic test) to, or recommended in writing by, the attending Registered Medical Practitioner, within the period stated in the Benefit Schedule after discharge from Hospital or the date of Day Case

Procedure, provided that such outpatient visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

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

(l) Psychiatric treatments

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

This benefit shall be payable in lieu of other benefit items under Sections 3(a) to (k) of this Part 6. For the avoidance of doubt, where a Confinement is not solely for the purpose of psychiatric treatments, this benefit shall only be payable for the Eligible Expenses charged on the Medical Services related to psychiatric treatments. Where the Eligible Expenses involve both psychiatric and non-psychiatric treatments and apportionment of the expenses is not available, the expenses in entirety shall be payable under this benefit if the Confinement is initially for the purpose of psychiatric treatments. If the Confinement initially is not for the purpose of psychiatric treatment, the expenses in entirety shall be payable under Sections 3(a) to (k) above.

4. Pre-existing Condition(s)

Eligible Expenses arising from Pre-existing Condition(s) that are notified to the Company in the Application and subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1), subject to the Case-based Exclusion(s) (if any), shall be payable in accordance with these Terms and Benefits. The Company may impose Case-based Exclusion(s) to these Terms and Benefits by reason of a Pre-existing Condition or other factor that affects the insurability of the Insured Person notified to the Company in the Application and any subsequent information or document submitted to the Company for the purpose of the application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1). After the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Company shall not have the right to impose any additional Case-based Exclusion(s), save for the limited circumstances stated in Section 4 of Part 4.

Eligible Expenses arising from Pre-existing Condition(s) that the Policy Holder and/or Insured Person was not aware and would not reasonably have been aware of at the time of submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 6 of Part 1), shall be payable in accordance with these Terms and Benefits, subject to the following waiting period and reimbursement arrangement –

First 30 days of the first Policy Year	no coverage
31st day of the first Policy Year onwards	full coverage

For the avoidance of doubt, the Company shall not have the right to re-underwrite or terminate these Terms and Benefits where the Policy Holder and/or Insured Person was not aware and would not reasonably have been aware of the Pre-existing Condition(s) at the time of submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 6 of Part 1).

If the Policy Holder or the Insured Person is requested but fails to disclose to the Company upon submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 6 of Part 1), that the Insured Person is suffering from a Pre-existing Condition, and such Pre-existing Condition has been treated or diagnosed or has manifested signs or symptoms of which the Policy Holder or the Insured Person is aware or should have reasonably been aware of at the time of submission of Application, including any updates of and changes to the required information (if so requested by the Company under Section 6 of Part 1), the Company has the right to declare these Terms and Benefits void, demand repayment of any benefits paid and/or refuse to provide coverage under these Terms and Benefits. In such event, the Company shall refund the premium in accordance with Section 14 of Part 2. The burden of proving the above shall rest with the Company.

5. Cost-sharing requirement

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

Part 7 General Exclusions

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

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

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

3. Expenses arising from Human Immunodeficiency Virus ("HIV") and its related Disability, which is contracted or occurs before the Policy Effective Date. Irrespective of whether it is known or unknown to the Policy Holder or the Insured Person at the time of submission of Application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1) such Disability shall be generally excluded from any coverage of these Terms and Benefits if it exists before the Policy Effective Date. If evidence of proof as to the time at which such Disability is first contracted or occurs is not available, manifestation of such Disability within the first five (5) years after the Policy Effective Date shall be presumed to be contracted or occur before the Policy Effective Date, while manifestation after such five (5) years shall be presumed to be contracted or occur after the Policy Effective Date.

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

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

5. Any charges in respect of services for –

   (a) except as otherwise specified in Sections 1 and 2 of Part 1 of the Supplement - Enhanced benefits, beautification or cosmetic purposes, unless necessitated by Injury caused by an Accident and the Insured Person receives the Medical Services within ninety (90) days of the Accident; or

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

6. Expenses incurred for prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests, screening procedures for asymptomatic conditions, screening or surveillance procedures based on the health history of the Insured Person and/or his family members, Hair Mineral Analysis (HMA), immunisation or health supplements. For the avoidance of doubt, this Section 6 does not apply to –
   (a) treatments, monitoring, investigation or procedures with the purpose of avoiding complications arising from any other Medical Services provided;
   (b) removal of pre-malignant conditions; and
   (c) treatment for prevention of recurrence or complication of a previous Disability.

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

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

9. Except as otherwise provided in Section 6(a) of Part 1 of the Supplement – Enhanced benefits, expenses incurred for the purchase of durable medical equipment or appliances including but not limited to wheelchairs, beds and furniture, airway pressure machines and masks, portable oxygen and oxygen therapy devices, dialysis machines, exercise equipment, spectacles, hearing aids, special braces, walking aids, over-the-counter drugs, air purifiers or conditioners and heat appliances for home use. For the avoidance of doubt, this exclusion shall not apply to rental of medical equipment or appliances during Confinement or on the day of the Day Case Procedure.

10. Except as otherwise provided in Sections 6(b) and 10 of Part 1 of the Supplement - Enhanced benefits, expenses incurred for traditional Chinese medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na, and other forms of alternative treatment including but not limited to hypnotism, qigong, massage therapy, aromatherapy, naturopathy, hydropathy, homeotherapy and other similar treatments.

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

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

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

14. Expenses incurred for treatment for Disability arising from war (declared or undeclared), civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power.

Part 8 Definitions

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

"Accident"	shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured Person and caused by violent, external and visible means.
"Age"	shall mean the attained age of the Insured Person.
"Annual Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder in a Policy Year irrespective of whether any limits of any benefit items stated in the Benefit Schedule have been reached. The Annual Benefit Limit is counted afresh in a new Policy Year.
"Application"	shall mean the application submitted to the Company in respect of this Plan, including the application form, questionnaires, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1).
"Benefit Schedule"	shall mean a schedule of benefits attached to these Terms and Benefits which sets out, among others, the benefit items and maximum benefits covered.
"Case-based Exclusion"	shall mean the exclusion of a particular Sickness or Disease from the coverage of these Terms and Benefits that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.
"Plan"	shall mean all the terms and benefits (including any Supplement(s)) that form an insurance plan. This Plan comprises these Terms and Conditions, the Benefit Schedule and the followings – (a) Supplement – Enhanced benefits; (b) Supplement – Other benefits; (c) Supplement – No claims premium discount; (d) Supplement – Change of Deductible; (e) Supplement – Limitation of benefits; and (f) Supplement – First-dollar coverage – Deductible waived for designated crises.
"Coinsurance"	shall mean a percentage of Eligible Expenses the Policy Holder must contribute after paying the Deductible (if any) in a Policy Year. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits under these Terms and Benefits.
"Company"	shall mean FWD Life Insurance Company (Macau) Limited.
"Confinement" or "Confined"	shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition.

	Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured Person must stay in the Hospital continuously for the entire period of Confinement.
"Congenital Condition(s)"	shall mean (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.
"Deductible"	shall mean a fixed amount of Eligible Expenses or expenses that, in a Policy Year, the Policy Holder must pay before the Company shall reimburse the remaining Eligible Expenses or remaining expenses.
"Disability"	shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.
"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Disability.
"Emergency"	shall mean an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.
"Emergency Treatment"	shall mean Medical Service required in an Emergency. The Emergency event or situation, and the required Medical Service cannot be and are not separated by an unreasonable period of time.
"Government"	shall mean the Macao Special Administrative Region Government.
"Guardian"	in respect of a Minor shall mean the person(s) appointed as the guardian(s) under or acting by virtue of the Macau Civil Code.
“MOP”	shall mean Macau Patacas.
"HKD"	shall mean Hong Kong dollars.
“Macau”	shall mean the Macao Special Administrative Region of the People’s Republic of China.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People’s Republic of China.

"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which – (a) has facilities for diagnosis and major operations; (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Injury"	shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.
"Inpatient"	shall mean an Insured Person who is Confined.
" Monetary Authority of Macao"	shall mean the Monetary Authority of Macao established pursuant to Decree-Law No. 39/89/M and amended by Decree-Law No. 14/96/M of Macau.
"Macau Insurance Companies Ordinance"	shall mean the Macau Insurance Companies Ordinance (Decree-Law No. 27/97/M, amended by Law No. 21/2020 and republished by the Macau Chief Executive Dispatch no. 229/2020).
"Insured Person"	shall mean any person whose risks are covered by these Terms and Benefits, and named as the "Insured Person" in the Policy Schedule.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
"Lifetime Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder cumulatively since the inception of these Terms and Benefits, irrespective whether any limits of any benefit items stated in the Benefit Schedule have been reached or whether the Annual Benefit Limit in a Policy Year has been reached.
"Medical Services"	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.
"Medically Necessary"	shall mean the need to have medical service for the purpose of investigating or treating the relevant Disability in accordance with the generally accepted standards of medical practice and such medical service must – (a) require the expertise of, or be referred by, a Registered Medical Practitioner; (b) be consistent with the diagnosis and necessary for the investigation and treatment of the Disability;

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

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

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

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

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

(ii) surgical procedures are performed under general anaesthesia;

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

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

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

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

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

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

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

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

"Minor" shall mean a person below the Age of eighteen (18) years.

"Policy"	shall mean this policy underwritten and issued by the Company, which is the contract between the Policy Holder(s) and the Company in respect of this Plan including but not limited to these Terms and Conditions, Benefit Schedule, Application, declarations, Policy Schedule and any Supplement(s) attached to this policy, if applicable. Where this Policy contains additional terms and benefits other than those of this Plan, the meaning of Policy shall also cover such additional terms and benefits.
"Policy Effective Date"	shall mean the commencement date of these Terms and Benefits which is specified as "Policy Effective Date" in the Policy Schedule.
"Policy Holder"	shall mean the person who is a legal holder of this Policy and is named as the "Policy Holder" in the Policy Schedule.
"Policy Issuance Date"	shall mean the date of first issuance of these Terms and Benefits.
"Policy Schedule"	shall mean a schedule attached to these Terms and Benefits, which sets out, among others, the Policy Effective Date, Renewal Date, the name and the relevant particulars of the Policy Holder and the Insured Person, the eligible benefits, premium and other relevant details in respect of these Terms and Benefits.
"Policy Year"	shall mean the period of time these Terms and Benefits are in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Renewal Date as specified in the Policy Schedule (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year period from each Renewal Date.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where – (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.
"Prescribed Diagnostic Imaging Tests"	shall mean computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

"Prescribed Non-surgical Cancer Treatments"	shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.
"Reasonable and Customary"	shall mean, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar Age, for a similar Disability, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred. In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable) – (a) treatment or service fee statistics and surveys in the insurance or medical industry; (b) internal or industry claim statistics; (c) gazette published by the Government; and/or (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.
"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"	shall mean a medical practitioner of western medicine, (a) who is duly qualified and is registered with the Health Bureau of Macau under Decree-Law No. 84/90/M, amended by Decree-Law No. 20/98/M and Law No. 18/2020, or a body of equivalent standing in jurisdictions outside Macau (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering relevant Medical Service in Macau or the relevant jurisdiction outside Macau where the Medical Service is provided to the Insured Person, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the practitioner is not duly qualified and registered under the laws of Macau or a body of equivalent standing in jurisdictions outside Macau (as reasonably determined by the Company in utmost good faith), the Company shall exercise reasonable judgment to determine whether such practitioner shall nonetheless be considered qualified and registered.
"Renewal", "Renew", "Renewed" or "Renewable"	shall mean renewal of these Terms and Benefits in accordance with their terms without any discontinuance.

"Renewal Date"	shall mean the effective date of Renewal. The first Renewal Date shall be the date as specified in the Policy Schedule (which shall not be later than the first anniversary of the Policy Effective Date) and the subsequent Renewal Date(s) shall be the anniversary(ies) of the first Renewal Date. The relevant Renewal Date shall be specified in the notification of Renewal in accordance with Section 3 of Part 4.
"Schedule of Surgical Procedures"	shall mean the list of surgical procedures attached to the Benefit Schedule which sets out the surgical category of different surgical procedures according to their relative degree of complexity, which is subject to regular review by the Company.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured Person and whether or not any diagnosis is confirmed.
"Standard Premium"	shall mean the basic premium for the coverage under this Plan, as charged by the Company to the Policy Holder on an overall basis, which may be adjusted in accordance with the Age, gender and/or lifestyle factors of the Insured Person.
“Supplement(s)”	shall mean any document which may add, delete, amend or replace the terms and benefits of this Policy. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Policy.
"Terms and Benefits"	shall mean the Terms and Conditions together with the Benefit Schedule (including the Schedule of Surgical Procedures) and any related Supplement(s) under this Plan.
"Terms and Conditions"	shall mean Part 1 to Part 8 of this Plan.

Supplement – Enhanced benefits

vPrime Medical Plan

(This is to supplement Part 6 Benefit Provisions of the Terms and Benefits)

Part 1 - Enhanced benefits

Subject to the following terms and conditions and during the period while these Terms and Benefits are in force, the Company shall reimburse the Eligible Expenses or expenses which are Reasonable and Customary in accordance with benefit items 1 to 10 under this Supplement – Enhanced benefits.

The amount of Eligible Expenses or expenses payable under this Supplement – Enhanced benefits shall be subject to the limits as stated in the Benefit Schedule and further reduced by any remaining balance of Deductible of the relevant Policy Year, if applicable. The amount of expenses shall not exceed the actual costs for services provided, if applicable**.**

1. Reconstructive surgery benefit

(a) This benefit shall be payable for the Eligible Expenses charged on the Surgeon's fee, Anaesthetist's fee and operating theatre charges including additional surgical appliances, equipment and devices used in the operating theatre in relation to the reconstructive surgery performed on the Insured Person during Confinement or in a setting for providing Medical Services to a Day Patient, recommended in writing by the Insured Person's attending Registered Medical Practitioner, provided that such reconstructive surgery –

(i) is performed for beautification or cosmetic purposes;

(ii) is necessitated by Injury caused by an Accident; and

(iii) is received within twelve (12) months but more than ninety (90) days from the date of such Accident.

For the avoidance of doubt, Eligible Expenses charged on the reconstructive surgery which is necessitated by Injury caused by an Accident, provided that the Insured Person receives the relevant Medical Services within ninety (90) days from the date of Accident, shall be payable under Section 3 of Part 6 of these Terms and Benefits.

(b) If an Insured Person sustains a Sickness or Disease and undergoes mastectomy, this benefit shall also be payable for the Eligible Expenses charged on the Surgeon's fee, Anaesthetist's fee and operating theatre charges including additional surgical appliances, equipment and devices used in the operating theatre in relation to the breast reconstruction surgery performed on the Insured Person during Confinement or in a setting for providing Medical Services to a Day Patient, which is recommended in writing by the Insured Person's attending Registered Medical Practitioner, provided that such breast reconstruction surgery –

(i) is performed for beautification or cosmetic purposes; and

(ii) is received within twelve (12) months from the date of the mastectomy.

2. Medical appliances benefit for reconstructive surgery

If reconstructive surgery benefit is payable under Section 1 of Part 1 of this Supplement - Enhanced benefits, this benefit shall be payable for the expenses charged on the cost of the external, prosthetic device or reconstructive materials in relation to and within twelve (12) months immediately after such reconstructive surgery.

3. Donor's benefit

Notwithstanding the last paragraph of Section 2 of Part 6 of these Terms and Benefits, if the Insured Person receives any transplantation of heart, kidney, liver, lung or bone marrow from a legally certified and verified source of donation at a Hospital as recommended in writing by the Insured Person's attending Registered Medical Practitioner, this benefit shall be payable for the following expenses;

(a) the expenses charged by the Surgeon and Anaesthetist for the surgical procedure of removing the organ or bone marrow from the donor; and

(b) the expenses charged for the use of operating theatre during such procedure.

For the avoidance of doubt, this benefit shall not be payable for any costs of organs or bone marrow.

This benefit is subject to the limitation that only up to thirty percent (30%) of the total transplantation cost (the sum of the surgical expenses charged for removing the organ or bone marrow from the donor and the Eligible Expenses of the surgical procedure performed on the Insured Person as a recipient payable in accordance with the Terms and Benefits) shall be payable.

For the avoidance of doubt, this benefit is in addition to any other benefits payable under Section 3 of Part 6 of these Terms and Benefits.

4. Emergency outpatient accidental treatment

This benefit shall be payable for the Eligible Expenses the Insured Person incurred for outpatient Emergency Treatment provided by a Registered Medical Practitioner at the outpatient or emergency department of a Hospital or in the Registered Medical Practitioner's clinic within seventy-two (72) hours of an Accident.

This benefit shall only be payable for the Eligible Expenses for outpatient visit or Emergency consultation (including but not limited to consultation, western medication prescribed or diagnostic test) not resulting in a Confinement or Day Case Procedure.

5. Outpatient kidney dialysis

This benefit shall be payable for the Eligible Expenses incurred for haemodialysis or peritoneal dialysis performed on the Insured Person in a setting for providing Medical Services to a Day Patient recommended in writing by the Insured Person's attending Registered Medical Practitioner. This benefit shall also be payable for the rental cost of a kidney dialysis machine for use on the Insured Person at home as recommended in writing by the Insured Person's attending Registered Medical Practitioner.

6. Stroke rehabilitation treatment

If the Insured Person is discharged from Hospital after Confinement following a diagnosis of Stroke, the following benefits shall be payable in respect of each Incident –

(a) Home facility enhancement benefit

This benefit shall be payable for the expenses charged on home facility enhancement recommended by an occupational therapist for the purpose of assisting the Insured Person in his/her daily life. Home facility enhancement includes but is not limited to:

(i) Adapting bathroom facilities (for example, raising toilet, installing a back rest against the toilet cistern, installing a level deck shower, installing a bath with hoist and installing hand basin at appropriate height);
(ii) Installing a stair lift or elevator;
(iii) Installing grab rails for support;
(iv) Installing ramps to avoid using steps;
(v) Locating bathroom or bedroom facilities at ground-floor level;
(vi) Moving light switches, door handles, doorbells and entry phones to convenient heights;
(vii) Provision of specialized furniture, like adjustable beds and mattresses or support chairs;
(viii) Setting up alert devices; and
(ix) Widening doorways and passageways.

(b) Stroke ancillary benefit

This benefit shall be payable for the Eligible Expenses or expenses incurred for any of the following rehabilitation treatments provided to the Insured Person, subject to the limits as stated in the Benefit Schedule:

(i) Consultation with, medical treatment performed and western medication prescribed by a Neurologist, which is recommended in writing by the Insured Person's attending Registered Medical Practitioner who diagnoses the Insured Person to be suffering from Stroke;
(ii) Consultation with, medical treatment performed and medication prescribed by a Chinese Medicine Practitioner; and
(iii) Physiotherapy, occupational therapy, speech therapy, chiropractic treatment or medical treatment performed by a Neurosurgeon and its related consultation, which is recommended in writing by the Insured Person's attending Registered Medical Practitioner who diagnoses the Insured Person to be suffering from Stroke.

Where Eligible Expenses or expenses under this benefit are also covered under Section 3 of Part 6 of these Terms and Benefits, or under Section 10 of Part 1 of this Supplement - Enhanced benefits, such Eligible Expenses or expenses shall be payable in the following order:

(iv) Section 3 of Part 6 of these Terms and Benefits;
(v) Section 10 of Part 1 of this Supplement - Enhanced benefits;
(vi) this Stroke ancillary benefit.

(c) Disability subsidy benefit

The benefit shall be payable if the Insured Person, in the opinion of a Registered Medical Practitioner-

(i) is disabled such that he/she is unable to perform three (3) or more Activities of Daily Living as a direct result of Stroke; and

(ii) such disability continues uninterruptedly for at least six (6) months from the date when the Stroke is diagnosed.

The benefit payable for the first six (6) months period shall only be paid by the Company in a single lump sum, which sum shall be equal to six (6) months of benefits as stated in the Benefit Schedule upon receipt of the evidence from the Registered Medical Practitioner and other information as reasonably required by the Company.

Save for the first six (6) months period as mentioned above, this benefit shall be payable on a monthly basis and shall continue as long as the Insured Person remains disabled due to such Stroke and the Terms and Benefits remains in force, subject to the limits as stated in the Benefit Schedule.

For the purpose of determining the maximum period payable per Incident (including, for the avoidance of doubt, the above-mentioned six (6) months period), the date of entitlement for this disability subsidy benefit (i.e. the date the Company shall start to pay this benefit) is based on the date on which the Insured Person is diagnosed with the Stroke, subject to the requirements set out above and limits stated in the Benefit Schedule. The Company reserves the right to require proof of survival, such disability and/or all relevant information of the Insured Person as reasonably required by the Company.

7. Private nurse's fee

In addition to the general nursing services provided by the Hospital to the Insured Person during Confinement, this benefit shall be payable for the Eligible Expenses the Insured Person incurred for private nursing service provided by a Registered Nurse recommended in writing by the Insured Person's attending Registered Medical Practitioner during the Insured Person's Confinement following –

(a) a surgical procedure performed on the Insured Person for which the Eligible Expenses incurred are payable under Section 3(f) of Part 6 of these Terms and Benefits; or

(b) the Insured Person's discharge from an Intensive Care Unit for which the Eligible Expenses incurred are payable under Section 3(e) of Part 6 of these Terms and Benefits,

subject to the limits as stated in the Benefit Schedule.

This benefit is subject to a maximum of one (1) nursing visit on each day of such eligible Confinement. In the event that more than one (1) Registered Nurse provides nursing services at the same visit, only the one with the highest Eligible Expenses shall be payable; or if the Insured Person has received more than one (1) nursing visit on the same day, only the one (1) nursing visit with the highest Eligible Expenses shall be payable. For the avoidance of doubt, regardless of whether nursing service(s) is/are provided for all or part of a day on a particular day, the day on which the nursing service(s) is/are provided shall be counted as one (1) day for the purpose of counting the maximum number of days per Policy Year allowed for this benefit as specified in the Benefit Schedule.

8. Post-Confinement home nursing

This benefit shall be payable for the Eligible Expenses the Insured Person incurred for home nursing service provided by a Registered Nurse recommended in writing by the Insured Person's attending Registered Medical Practitioner within one hundred and ninety-six (196) days after the Insured Person's discharge from Hospital following a surgical procedure performed during a Confinement or admission to an Intensive Care Unit for which the Eligible Expense incurred are payable under Section 3(e) or 3(f) of Part 6 of these Terms and Benefits, subject to the limits as stated in the Benefit Schedule.

This benefit is subject to a maximum of one (1) nursing visit on each day. In the event that more than one (1) Registered Nurse provides nursing services at the same visit, only the one with the highest Eligible Expenses shall be payable; or if the Insured Person has received more than one (1) nursing visit on the same day, only the one (1) nursing visit with the highest Eligible Expenses shall be payable. For the avoidance of doubt, regardless of whether nursing service(s) is/are provided for all or part of a day on a particular day, the day on which the nursing service(s) is/are provided shall be counted as one (1) day for the purpose of counting the maximum number of days per Policy Year allowed for this benefit as specified in the Benefit Schedule.

9. Companion bed

This benefit shall be payable for expenses charged by the Hospital in which the Insured Person is Confined for an extra companion bed for one (1) person who accompanies the Insured Person in Hospital during his/her Confinement.

10. Post-Confinement/Day Case Procedure Chinese medicine treatment

Notwithstanding Section 10 of Part 7 of the Terms and Benefits, this benefit shall be payable for the expenses of the follow-up outpatient visit provided by a Chinese Medicine Practitioner within the period stated in the Benefit Schedule after discharge from Hospital or the date of Day Case Procedure, provided that such outpatient visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

Where expenses under this benefit are also covered under Section 6(b) of Part 1 of this Supplement - Enhanced benefits, such expenses shall be payable in the following order:

(a) this Post-Confinement/Day Case Procedure Chinese medicine treatment benefit;
(b) Section 6(b) of Part 1 of this Supplement - Enhanced benefits.

Part 2 Definitions

Terms defined below and any other terms defined in this Supplement – Enhanced benefits shall only be applicable to this Supplement – Enhanced benefits, the Supplement – First dollar coverage – Deductible waived for designated crises, the Supplement – Limitation of benefits and the Benefit Schedule, and shall have the same meaning wherever used within these Supplements and Benefit Schedule unless the context otherwise requires.

"Activities of Daily Living"	shall mean the following: 1. Bathing/Washing: The ability to wash oneself in the bath or shower (including getting in or out of the bath or shower) or wash oneself by any other means; 2. Continence: The ability to voluntarily control bladder and bowel functions so as to maintain personal hygiene; 3. Dressing: The ability to put on and take off all necessary items of clothing without requiring assistance of another person; 4. Eating: The ability to perform all tasks of getting food into the body once it has been prepared; 5. Mobility: The ability to move from room to room without requiring any physical assistance; and 6. Transfer: The ability to get in and out of a chair or bed without requiring any physical assistance.
"Chinese Medicine Practitioner"	shall mean any person other than the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or Insured Person (unless approved in advance by the Company in writing) who is duly qualified and is registered with the Health Bureau of Macau under Decree-Law No. 84/90/M, amended by Decree-Law No. 20/98/M and Law No. 18/2020, or a body of equivalent standing in jurisdictions outside Macau (as reasonably determined by the Company in utmost good faith) and legally authorised for rendering relevant Chinese medical service in Macau or the relevant jurisdiction outside Macau where the Chinese medical service is provided to the Insured Person.
"Incident"	shall mean a Stroke that occurs in the Insured Person. For the purpose of counting per Incident as specified in the Benefit Schedule, a new Incident shall mean – (a) A first-time Stroke that occurs in the Insured Person who never has had a stroke before; or (b) A recurrent Stroke occurs in the Insured Person who has a history of a previous Stroke, provided that such subsequent Stroke is diagnosed more than one (1) year immediately following the date of diagnosis of the previous Stroke.

For the avoidance of doubt, if the Insured Person is diagnosed with Stroke within one (1) year following the date of diagnosis of a previous Stroke, this subsequent Stroke event shall not be counted as a new Incident.

"Neurologist"	shall mean a Registered Medical Practitioner specialising in the diagnosis and treatment of Diseases or conditions of the brain and other parts of the nervous system.
"Neurosurgeon"	shall mean a Registered Medical Practitioner specialising in surgical procedures on the brain and other parts of the nervous system.
"Registered Nurse"	shall mean any person other than the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing) who is duly qualified and is registered with the Health Bureau of Macau under Decree-Law No. 84/90/M, amended by Decree-Law No. 20/98/M and Law No. 18/2020, or a body of equivalent standing in jurisdictions outside Macau (as reasonably determined by the Company in utmost good faith) and legally authorised for rendering relevant Medical Service in Macau or the relevant jurisdiction outside Macau where the Medical Service is provided to the Insured Person.
"Stroke"	shall mean a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis, infarction of brain tissue, haemorrhage and embolism from an extra-cranial source resulting in neurological deficit. The diagnosis of Stroke must be based on changes seen in a CT scan or MRI and must be confirmed by a Neurologist.

Supplement – Other benefits

vPrime Medical Plan

(This is to supplement Part 6 Benefit Provisions of the Terms and Benefits)

1. Death benefit

While this Policy is in force, this benefit shall be payable to the beneficiary in the amount as specified in the Benefit Schedule upon the death of the Insured Person, provided that due proof of the death and any other documents as reasonably required by the Company (including all relevant certificates, reports, evidence and other data or materials) are provided to the Company. All such documents which can be reasonably provided by the Policy Holder shall be furnished at the expenses of the Policy Holder. The Company shall bear all expenses incurred in obtaining further certificates, information and evidence for the purposes of verification of the claim after the Policy Holder has submitted all required information.

The beneficiary is the person or persons entitled to the death benefit of this Policy upon the death of the Insured Person. During the lifetime of the Insured Person, a beneficiary has no right to deal in any way with this Policy. The death benefit of this Policy shall be paid to the nominated beneficiary or, if there is no nominated beneficiary, to the Policy Holder or, if the Policy Holder is deceased, to the appointed executor(s) or administrator(s) of the Policy Holder's estate, as the case may be.

If a beneficiary predeceases the Insured Person, the interest of the beneficiary under this Policy shall vest in the Policy Holder; if there is more than one (1) beneficiary and any beneficiary predeceases the Insured Person, the interest of the deceased beneficiary shall accrue to the surviving beneficiaries in such proportion as they are nominated or otherwise in equal proportion.

If the Insured Person and a beneficiary die in the same incident and the official time of death is recorded as being the same time, the Company shall decide the distribution of this benefit as if the older person had died first.

2. Accidental death benefit

In addition to the death benefit payable as specified in the Benefit Schedule, if the cause of death of the Insured Person is an Accident, this benefit shall be payable in the amount as specified in the Benefit Schedule.

If the Insured Person and a beneficiary die in the same incident and the official time of death is recorded as being the same time, the Company shall decide the distribution of this benefit as if the older person had died first.

<u>Exclusion on accidental death benefit:</u>
No accidental death benefit is payable under this Policy when the death of the Insured Person is directly or indirectly caused by the willful participation of the Policy Holder, the Insured Person or the beneficiary in an illegal or unlawful act.

3. Emergency outpatient dental treatment

Notwithstanding Section 7 of Part 7 of the Terms and Benefits, this benefit shall be payable for the Reasonable and Customary charges of Emergency Treatment to the Insured Person's sound natural teeth solely as a direct result of an Injury, if such treatment is provided within three (3) months of the Accident causing such Injury by a registered dentist in a legally registered dental clinic.

The Company shall not pay any benefits for any restorative or remedial work (for the purpose other than Emergency Treatment), prostheses, the use of any precious metals or any kind of orthodontics, or other dental surgery performed in a legally registered dental clinic unless the dental surgery is medically necessary. For the purpose of this benefit, medically necessary shall mean the medical service, procedure or supply which are necessary and is (a) consistent with the diagnosis and customary dental treatment; (b) recommended by a Registered Medical Practitioner, Surgeon or registered dentist for such emergency dental treatment and must be widely accepted professionally in Macau or the relevant jurisdictions outside Macau where the medical service is provided to the Insured Person, as effective, appropriate and essential based upon recognised standards of the health care specialty involved; and (c) not furnished primarily for the personal comfort or convenience of the Insured Person or any medical service provider. Experimental, screening and preventive services or supplies shall not be considered as medically necessary for the purpose of this benefit.

4. Cash benefit for Day Case Procedure

In an event that an Insured Person undergoes a Day Case Procedure which is payable in accordance to these Terms and Benefits, this benefit shall be payable in the amount as specified in the Benefit Schedule irrespective of the amount of Eligible Expenses reimbursed under any other benefit items of the Terms and Benefits, subject to the limits as specified in the Benefit Schedule.

5. Cash benefit for top-up subsidy

For the Insured Person covered by any other hospital reimbursement plans offered by a licensed insurance company other than the Company, regardless of whether it is an individual or group policy, if the Eligible Expenses incurred for any Confinement of the Insured Person are payable under these Terms and Benefits after any reimbursement has been paid by such other licensed insurance companies, this benefit shall be payable for each day of Confined period in Hospital, subject to the limits as specified in the Benefit Schedule.

6. Cash benefit for room and board Confinement below entitled ward class in a private Hospital in Macau or Hong Kong

This benefit shall be payable in the amount as specified in the Benefit Schedule for each day when the Insured Person is Confined in a room of a private Hospital in Macau or Hong Kong where the ward class is below the entitled ward class as specified in the Benefit Schedule during the whole Confinement period, provided that:

(a) such Confinement is considered Medically Necessary upon the recommendation of the Insured Person's attending Registered Medical Practitioner; and

(b) the Eligible Expenses incurred for such Confinement are payable under these Terms and Benefits.

Supplement – No claims premium discount

vPrime Medical Plan

(This is to supplement Part 3 Premium Provisions of the Terms and Benefits)

1. No claims premium discount

If:

(a) this Policy has been in force for two (2) or more consecutive Policy Years; and

(b) no claims have been incurred under these Terms and Benefits during two (2) or more consecutive Policy Years immediately prior to the Policy's Renewal and no claims have been settled by the Company. For the purpose of this clause, a claim is considered as incurred on

(i) the first date of admission if the Insured Person is Confined in a Hospital; or

(ii) the date on which the Medical Service is performed on the Insured Person as a Day Patient;

then the Policy Holder shall be eligible for a no claims premium discount on the Renewal premium of these Terms and Benefits at the following rate:

No claims period immediately prior to the Policy's Renewal	No claims premium discount (Discount rate on Renewal premium)
Two (2) consecutive Policy Years	10%
Three (3) consecutive Policy Years	10%
Four (4) consecutive Policy Years	10%
Five (5) or more consecutive Policy Years	15%

2. Extra no claims premium discount

The Policy Holder shall be eligible for this extra no claims premium discount if the Policy Holder is eligible for the relevant no claims premium discount as stated in Section 1 of this Supplement – No claims premium discount under these Terms and Benefits and other in-force vPrime Medical Plan policy (policies) on any Renewal Date.

In addition to the relevant no claims premium discount applicable on the Renewal premium specified in Section 1 of this Supplement – No claims premium discount, the Policy Holder shall be eligible for an extra no claims premium discount on the Renewal premium of these Terms and Benefits at the following rate:

Number of in-force policies (including these Terms and Benefits) issued to the Policy Holder which are eligible for the no claims premium discount as stated in Section 1 of this Supplement – No claims premium discount on any Renewal Date	Extra no claims premium discount under these Terms and Benefits (Discount rate on Renewal premium)
Two (2) or Three (3)	2.5%
Four (4)	5%
Five (5) or above	10%

3. For the avoidance of doubt, if a claim under these Terms and Benefits is incurred prior to the Renewal Date but is not made or settled until after the Renewal Date, and the Policy Holder has already received the no claims premium discount, the Policy Holder shall upon demand immediately repay the Company the difference between the no claims premium discount amount already received and the eligible discount amount under these Terms and Benefits as recalculated according to Sections 1 and 2 of this Supplement – No claims premium discount.

Supplement – Change of Deductible

vPrime Medical Plan

(This is to supplement Part 4 Renewal Provisions of the Terms and Benefits)

1. General provisions

The Policy Holder may apply to the Company in writing at least thirty (30) days before the Renewal Date for a variation of the Deductible under the Terms and Benefits. If the Company approves the application for variation of Deductible, claims for expenses incurred after variation of the Deductible shall be subject to the varied Deductible from the relevant Renewal Date.

2. Increasing Deductible

The Company shall approve the application for increasing Deductible without any re-underwriting.

3. Reducing or removing Deductible

(a) Except for exercising the right under Section 3(b) of this Supplement – Change of Deductible below, all applications for reducing or removing Deductible are subject to re-underwriting of the Company. Approval shall be given subject to the prevailing underwriting guideline of the Company.

(b) The Policy Holder can exercise a one-off right to reduce or remove the Deductible without re-underwriting, provided that:

  (i) the request is made not less than thirty (30) days prior to the Renewal Date on or immediately following the date that the Insured Person attains the Age of fifty (50), fifty-five (55), sixty (60), sixty-five (65), seventy (70), seventy-five (75) or eighty (80);

  (ii) such right to reduce or remove the Deductible without re-underwriting can only be exercised once during the lifetime of the Insured Person; and

  (iii) the Insured Person has been covered under the Policy continuously for two (2) consecutive Policy Years.

The Policy Holder can choose whether or not to exercise such right and the Age to exercise such right.

Supplement – Limitation of benefits

vPrime Medical Plan

(This is to supplement Part 6 Benefits Provisions of the Terms and Benefits, Supplement – Enhanced benefits and Supplement – Other benefits)

Part 1 - General

1. **Geographical limitation**

(a) Eligible Expenses and/or other expenses incurred within Asia shall be payable in accordance with these Terms and Benefits.

(b) The benefits under Section 3(I) of Part 6 of the Terms and Benefits and in Section 6 of the Supplement – Other benefits shall only be payable for Confinement in Macau or Hong Kong.

(c) For any non-Emergency Treatment received outside Asia, the final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 3(a)(i) of Part 1 of this Supplement – Limitation of benefits, and in so doing,

(i) the amount of benefits under Sections 3(a) to (k) of Part 6 of the Terms and Benefits shall be payable up to the benefit limits as stated in Appendix – Non-emergency treatment outside Asia benefit schedule;

(ii) no benefit shall be payable under Sections 3(I) of Part 6 of the Terms and Benefits, under Sections 1 to 3 and 5 to 10 of Part 1 of the Supplement – Enhanced benefits and Sections 4 to 6 of the Supplement – Other benefits;

(iii) the restriction as stated in Section 2 of Part 1 of this Supplement – Limitation of benefits shall not apply;

(iv) the benefit payable shall further be reduced by the remaining balance of Deductible in the relevant Policy Year (if applicable); and

(v) any actual benefits reimbursed (i.e. after deduction of any applicable Deductible as stated in Section 1(c)(iv) of Part 1 above) in accordance with Appendix – Non-emergency treatment outside Asia benefit schedule shall be counted towards the applicable Annual Benefit Limit and the Lifetime Benefit Limit as specified in the Benefit Schedule.

(d) For any Emergency Treatment received outside Asia, any Eligible Expenses and/or other expenses incurred shall be payable in accordance with these Terms and Benefits.

2. Restriction in the choice of ward class

(a) If on any day of Confinement, the Insured Person is voluntarily Confined in a ward class of Hospital accommodation higher than his/her entitled ward class as specified in the Benefit Schedule, the ward class adjustment factor set out below shall be applied to the Eligible Expenses and/or expenses which are Reasonable and Customary incurred on that day.

Ward class adjustment factor

(i) Insured Person's Confinement in Hong Kong, Macau and Mainland China

Entitled ward class as specified in the Benefit Schedule	Actual ward class occupied by the Insured Person during Confinement	Ward class adjustment factor
Standard Semi-private Room	Standard Private Room	50%
Standard Semi-private Room	Above the Standard Private Room	25%

(ii) Insured Person's Confinement in other regions of Asia (excluding Hong Kong, Macau and Mainland China) and for Emergency Treatment outside Asia

Entitled ward class as specified in the Benefit Schedule	Actual ward class occupied by the Insured Person during Confinement	Ward class adjustment factor
Standard Private Room	Above the Standard Private Room	25%

(b) The ward class adjustment factor shall not be applied under the following circumstances:

(i) unavailability of accommodation at the specified ward class due to ward or room shortage for Emergency Treatment;

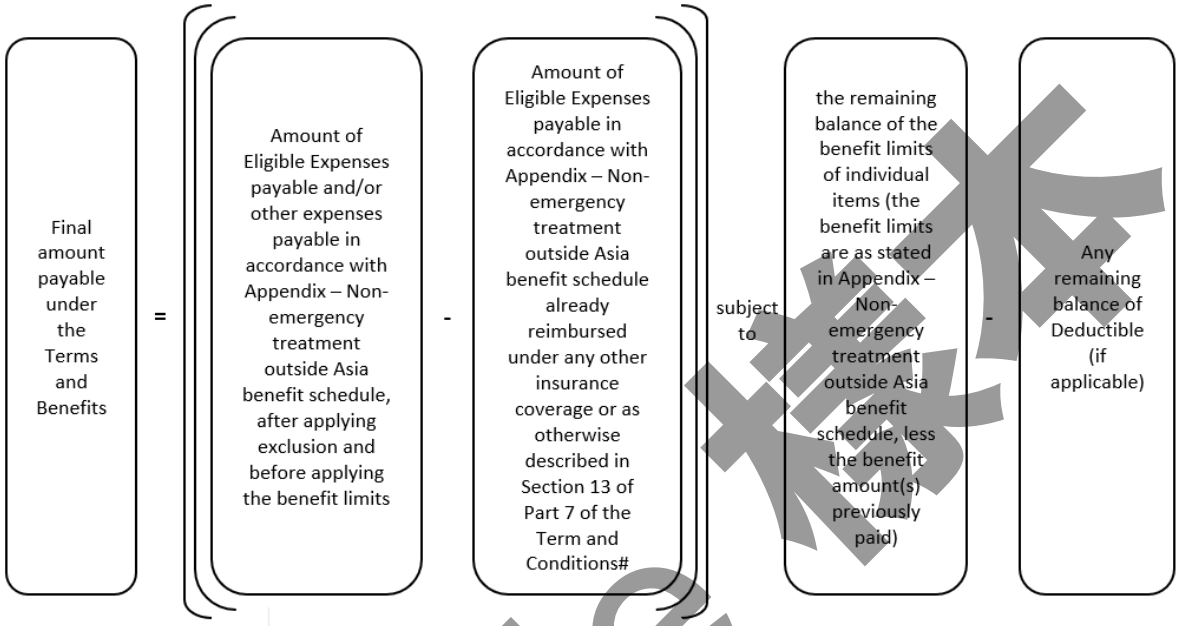
(ii) isolation reasons that require a specific class of accommodation; or

(iii) other reasons not involving personal preference of the Policy Holder and/or the Insured Person.

3. **Overall benefit limit and benefit payable**

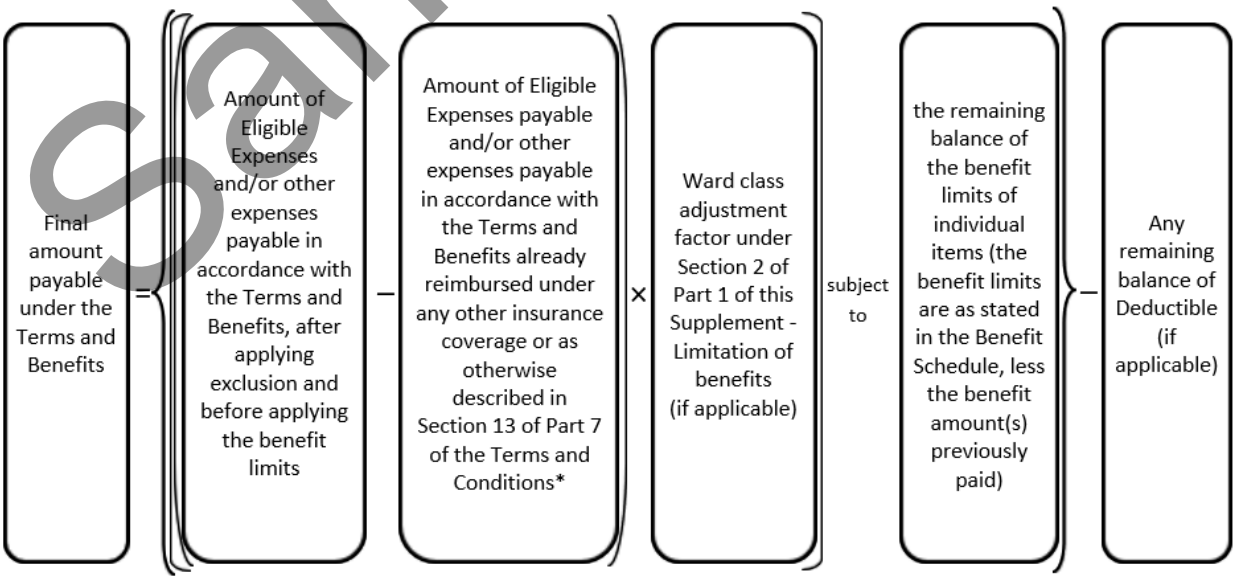
(a) The final amount payable under the Terms and Benefits shall be calculated according to the formula below:

(i) Expenses incurred outside Asia (for any non-Emergency Treatment) as stated in Section 1(c) of Part 1 of this Supplement – Limitation of benefits



If there are any Eligible Expenses payable in accordance with Appendix – Non-emergency treatment outside Asia benefit schedule already reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of the Terms and Conditions, such amount shall be reduced from the remaining balance of Deductible in the relevant Policy Year, if applicable.

(ii) Expenses incurred within Asia or for any Emergency Treatment received outside Asia as stated in Sections 1(a) and 1(d) of Part 1 of this Supplement – Limitation of benefits



* If there are any Eligible Expenses and/or other expenses payable under the Terms and Benefits already reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of the Terms and Conditions, such amount shall be reduced from the remaining balance of Deductible in the relevant Policy Year, if applicable.

(b) Any paid benefits shall be counted towards the corresponding benefit limits as stated in the Benefit Schedules of these Terms and Benefits (including Appendix – Non-emergency treatment outside Asia benefit schedule).

(c) All benefits payable in accordance with the Terms and Benefits (including Appendix – Non-emergency treatment outside Asia benefit schedule, if applicable), shall be subject to the application of any applicable remaining balance of Deductible.

(d) The final amount payable under the Terms and Benefits (i.e. after the application of any applicable remaining balance of Deductible) shall be counted towards the Annual Benefit Limit of the relevant Policy Year and the Lifetime Limit as specified in the Benefit Schedule.

Part 2 Definitions

Terms defined below and any other terms defined in this Supplement – Limitation of benefits shall only be applicable to this Supplement – Limitation of benefits and shall have the same meaning wherever used within this Supplement – Limitation of benefits unless the context otherwise requires.

"Asia"	shall include Afghanistan, Australia, Bangladesh, Bhutan, Brunei, Cambodia, Mainland China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, New Zealand, North Korea, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan and Vietnam.
"Standard Private Room"	shall mean a standard single occupancy room with an adjoining bathroom for the Insured Person's use during his or her Confinement, but does not include any Hospital room that has its own kitchen, dining or sitting room.
"Standard Semi-private Room"	shall mean a single or double occupancy room in a Hospital, with a shared bath or shower room.

Appendix – Non-emergency treatment outside Asia benefit schedule

Benefit items[1]	**Benefit limit (in HKD)**
(a) Room and board	$750 per day Maximum 180 days per Policy Year
(b) Miscellaneous charges	$14,000 per Policy Year
(c) Attending doctor's visit fee	$750 per day Maximum 180 days per Policy Year
(d) Specialist's fee[2]	$4,300 per Policy Year
(e) Intensive care	$3,500 per day Maximum 25 days per Policy Year
(f) Surgeon's fee	Per surgery, subject to surgical category for the surgery/procedure in the Schedule of Surgical Procedures* – • Complex $50,000 • Major $25,000 • Intermediate $12,500 • Minor $5,000
(g) Anaesthetist's fee	35% of Surgeon's fee payable [5]
(h) Operating theatre charges	35% of Surgeon's fee payable [5]
(i) Prescribed Diagnostic Imaging Tests[2] [3]	$20,000 per Policy Year Subject to 30% Coinsurance
(j) Prescribed Non-surgical Cancer Treatments[4]	$80,000 per Policy Year
(k) Pre- and post-Confinement/Day Case Procedure outpatient care [2]	$580 per visit, up to $3,000 per Policy Year • 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure • 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
(l) Psychiatric treatments	$30,000 per Policy Year
Other limit	
Annual Benefit Limit for benefit items (a) – (l)	$420,000 per Policy Year

* same as the Schedule of Surgical Procedures

Notes -

(1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above.

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

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

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

(5) The percentage here applies to the Surgeon's fee actually payable or the benefit limit for the Surgeon's fee according to the surgical categorisation, whichever is the lower.

(6) All benefits described in this appendix is not subject to any restriction in the choice of ward class in Hospital.

Supplement – First-dollar coverage – Deductible waived for designated crises

vPrime Medical Plan

(This is to supplement Part 6 Benefit Provisions of the Terms and Benefits)

Part 1 General

1. First-dollar coverage – Deductible waived for designated crises

The terms and conditions stated in this Supplement – First-dollar coverage – Deductible waived for designated crises are not applicable to vPrime Medical Plan with zero dollar ($0) Deductible option shown in the Benefit Schedule.

While this Policy is in force, under the circumstances where the Insured Person suffers the following (a) to (p) designated crises (as defined in Part 2 of this Supplement – First-dollar coverage – Deductible waived for designated crises) and, upon the recommendation of the attending Registered Medical Practitioner in writing, receives any Medical Services as a direct result of the designated crises, in calculation of the final amount payable under the Terms and Benefits according to the formula as stated in Section 3 of Part 1 of the Supplement – Limitation of benefits, the remaining balance of Deductible (if any and if applicable) for such Medical Services shall be reduced to zero (0). The Company shall pay the Eligible Expenses and/or other expenses charged on such Medical Services for designated crises before the entire Deductible is met.

In the event that the Deductible is waived for a claim of Eligible Expenses and/or other expenses incurred for one (1) of the designated crises in accordance with the terms of this Supplement – First-dollar coverage – Deductible waived for designated crises (i.e. the Policy Holder is not required to pay the Deductible amount for such claim), the amount of Eligible Expenses and/or other expenses payable shall still count towards the remaining balance of Deductible in the relevant Policy Year, if any and if applicable.

For the avoidance of doubt, the "first-dollar coverage – Deductible waived for designated crises" under this Supplement – First-dollar coverage – Deductible waived for designated crises shall only be applicable to the Medical Services arising from any designated crisis defined under Parts 1 and 2 of this Supplement– First-dollar coverage – Deductible waived for designated crises. Where the Eligible Expenses and/or other expenses involve Medical Services for both designated crises and any Disabilities other than such designated crises, and apportionment of the expenses is not available, the expenses in entirety shall be regarded as Eligible Expenses and/or other expenses charged on Medical Services for designated crises.

The definition of the following designated crises is provided in Part 2 of this Supplement – First-dollar coverage – Deductible waived for designated crises. The designated crises must be confirmed by the Insured Person's attending Registered Medical Practitioner in writing and supported by clinical, radiological, histological or laboratory evidence reasonably acceptable to the Company.

Designated crises shall include:

(a) Cardiac Impairment Caused By Cardiomyopathy;

(b) Cardiac Impairment Due To Primary Pulmonary Arterial Hypertension;
(c) Chronic Liver Disease;
(d) Coronary Artery Bypass Operation;
(e) End Stage Lung Disease;
(f) Fulminant Hepatitis;
(g) Heart Attack (Acute Myocardial Infarction);
(h) Kidney Failure;
(i) Major Organ Transplantation;
(j) Open Heart Valve Surgery;
(k) Parkinson's Disease;
(l) Severe Rheumatoid Arthritis;
(m) Specified Cancer;
(n) Stroke;
(o) Surgery to Aorta; and
(p) Terminal Illness.

The "first-dollar coverage – Deductible waived for designated crises" under this Supplement – First-dollar coverage – Deductible waived for designated crises shall not be applicable to the Medical Services arising from any designated crisis that the Policy Holder or Insured Person is aware of, or shall be reasonably aware of within the first ninety (90) days from the Policy Effective Date of the Policy. The Policy Holder or Insured Person shall be reasonably aware of a designated crisis where–

(q) the designated crisis has been diagnosed;
(r) the designated crisis has manifested clear and distinct signs or symptoms; or
(s) medical advice or treatment has been sought, recommended or received for the designated crisis.

For the avoidance of doubt, the "first-dollar coverage – Deductible waived for designated crises" under this Supplement – First-dollar coverage – Deductible waived for designated crises shall not be applicable to any Policies where the selected Deductible option is zero dollar ($0).

Part 2 Definitions

Terms defined below and any other terms defined in this Supplement – First dollar coverage – Deductible waived for designated crises shall only be applicable to the Benefit Schedule and this Supplement – First dollar coverage – Deductible waived for designated crises, and shall have the same meaning wherever used within the Benefit Schedule and this Supplement – First dollar coverage – Deductible waived for designated crises unless the context otherwise requires.

"Cardiac Impairment Caused By Cardiomyopathy"	Impaired ventricular function of variable aetiology, resulting in permanent and irreversible physical impairments to the degree of Functional Class IV under the New York Heart Association Functional Classification of cardiac impairment, despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination and laboratory studies. The diagnosis must also be confirmed by a Specialist in cardiology and supported by the appropriate test results including echocardiography.

	Class IV under the New York Heart Association Classification of cardiac impairment means that the patient is symptomatic during ordinary daily activities.
"Cardiac Impairment Due To Primary Pulmonary Arterial Hypertension"	The pathological increase of pulmonary pressure due to structural, functional or circulatory disturbances of the lung leading to right ventricular enlargement. The disease must result in permanent irreversible physical impairment to the degree of Class IV under the New York Heart Association Classification of cardiac impairment, despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination and laboratory studies. Class IV under the New York Heart Association Classification of cardiac impairment means that the patient is symptomatic during ordinary daily activities.
"Chronic Liver Disease"	End stage liver failure with increasing jaundice that in general medical opinion will not improve in future and resulting in either ascites or encephalopathy.
"Coronary Artery Bypass Operation"	The actual undergoing of open-chest surgery to correct or treat coronary artery disease (CAD) by way of coronary artery by-pass grafting. Angioplasty and all other intra-arterial, catheter-based techniques, keyhole or laser procedures, are excluded.
"End Stage Lung Disease"	The final or end stage of lung disease, causing chronic respiratory failure, as demonstrated by all of the following: 1. "Forced expiratory volume in 1 second" test ("FEV1 test") results consistently less than one (1) litre; 2. Requiring permanent supplementary oxygen therapy for hypoxemia; 3. Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO_2 \leq 55mmHg$); and 4. Dyspnea at rest. The diagnoses must be confirmed by a Specialist in pulmonology
"Fulminant Hepatitis"	A sub-massive to massive necrosis of the liver by a Hepatitis virus, leading precipitously to liver failure. The diagnosis in respect of this illness must be supported by evidence or clinical findings and be based on the meeting of all of the following criteria: 1. A rapidly decreasing liver size; 2. Necrosis involving entire lobules, leaving only a collapsed reticular framework;

3. Rapid deterioration of liver function tests;
4. Liver function test to show massive parenchymal liver disease; and
5. Objective signs of portosystemic encephalopathy.

"Heart Attack (Acute Myocardial Infarction)"	The death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis of a definite acute myocardial infarction must be supported by all of the following evidences: 1. typical chest pain; 2. new ischemic electrocardiographic (ECG) changes indicating acute myocardial infarction; and 3. elevation of cardiac enzymes CK-MB or cardiac troponin T or I > 0.5 ng/ml. In the event that only evidences (1) and (2) above are provided but evidence (3) is not available, echocardiographic proof of death of a portion of the heart muscle with the evidence of reduction in left ventricular ejection fraction of less than fifty percent (50%) or significant hypokinesia, akinesia, or wall motion abnormalities consistent with a heart attack having occurred will be considered.
"Kidney Failure"	End stage renal failure presenting chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated, or renal transplant is carried out.
"Major Organ Transplantation"	The actual undergoing of a transplant of the heart, kidney, liver, lung, pancreas or bone marrow as a recipient, or the inclusion on an official organ transplant waiting list, for any of the above organs. The transplant must be based on objective confirmation of organ failure.
"Open Heart Valve Surgery"	Open heart valve surgery requiring median sternotomy, performed to replace or repair one (1) or more heart valves, as a consequence of defects that cannot be repaired by intra arterial catheter procedures alone. The surgery must be performed after a recommendation by a Specialist in cardiology.
"Parkinson's Disease"	Unequivocal diagnosis of Parkinson's Disease by a consulting Neurologist where the condition: 1. cannot be controlled with medication; 2. shows signs of progressive impairment; and 3. must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living, definition of which is stated in Part 2 of the Supplement – Enhanced benefits.

The "first-dollar coverage – Deductible waived for designated crises" is applicable to idiopathic Parkinson's Disease only.

"Severe Rheumatoid Arthritis"

Widespread joint destruction as a result of Severe Rheumatoid Arthritis with major clinical deformity of three (3) or more of the following joint areas:

1. joint of fingers;
2. wrists;
3. elbows;
4. cervical spine;
5. knees; or
6. ankles.

For the purpose of counting the number of affected joint areas with major clinical deformity to qualify Severe Rheumatoid Arthritis –

7. If both left and right hands, wrists, elbows, knees or ankles (as the case may be) are diagnosed with major clinical deformity, the Company shall consider the right side and left side as two (2) joint areas;
8. if two (2) or more finger joints of one (1) hand are diagnosed with major clinical deformity, the Company shall consider them as one (1) joint area only;
9. if two (2) or more joints of the cervical spine are diagnosed with major clinical deformity, the Company shall consider them as one (1) joint area only.

The diagnosis must be supported by all the following:

10. Morning stiffness;
11. Symmetric arthritis;
12. Presence of rheumatoid nodules;
13. Elevated titres of rheumatoid factors; and
14. Radiographic evidence of severe involvement.

The severity of the disease shall be such that there will be at least two (2) of the Activities of Daily Living, as defined in Part 2 of the Supplement – Enhanced Benefits, which the Insured Person will, for a continuous period of at least six (6) months, have been unable to perform without the assistance of another person.

"Specified Cancer"

1. Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue; or
2. Any occurrence of histologically confirmed leukemia, lymphoma or sarcoma.

Notwithstanding the foregoing, the following cancers are excluded from the definition of "Specified Cancer":

3. Tumours showing the malignant changes of carcinoma in situ (including cervical dysplasia CIN-1, CIN-2 and CIN-3) or which are histologically described as pre-malignant;
4. All skin cancers, unless there is evidence of metastases or the tumour is a malignant melanoma of greater than 1.5mm maximum thickness as determined by histological examination using the Breslow method;
5. Prostate cancers which are histologically described as TNM Classification T1 (a) or T1(b) according to the 8th edition of the TNM staging system established by the American Joint Committee on Cancer (AJCC) and the Union for International Cancer Control (UICC), or a class (or stage) of equivalent or lower under other staging system;
6. Papillary micro-carcinoma of the thyroid;
7. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification according to the 8th edition of the TNM staging system established by the American Joint Committee on Cancer (AJCC) and the Union for International Cancer Control (UICC); and
8. Chronic lymphocytic leukaemia classified as less than Stage I under RAI staging system.

"Surgery to Aorta"

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

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

"Terminal Illness"

The conclusive diagnosis of a Sickness that is expected to result in the death of the Insured Person within twelve (12) months. This diagnosis must be supported by a Specialist and confirmed by a Registered Medical Practitioner appointed by the Company at the Company's cost.

Health Assistance Services

1. PREMIER THE ONEcierge One Team Health Management

One Plan One Team One Stop Pan-Asia Health Solutions

Everyone would like to be with a reliable partner to focus on their recovery and enjoy life even when facing any health problems. The Company, as your trusted partner, not only provides you with comprehensive medical protection coverage, but also customises dedicated health services especially for your needs. PREMIER THE ONEcierge One Team Health Management (the "Service") <Note 1> offers you priority and tailor-made treatment with an one-stop approach in the territories of the Pan-Asia Region (including Hong Kong, Mainland China, Taiwan, Singapore and Japan) (the "Pan-Asia Region") from a professional health management team, helping you when you need help most. You can relax with ease knowing the Company is there to take care of all aspects of your wellness.

Professional & Experienced Medical Specialist Team as your Partner

A professional medical service provider is undoubtedly your best assurance to receiving prompt and suitable medical advice and treatment. The Service provides you with a leading network of specialists so you can receive the most suitable treatment from the best-suited doctor and top-tiered network hospitals <Note 2> in the Pan-Asia Region.

The Service also provides you with extensive professional medical advice, through the Inpatient Medical Advice Service <Note 3>, so you can feel comfortable with the medical assessment and treatment. With our professional team of experts as your guardian angel, you will be hassle free even when facing any illness or disease.

Superior Hospitalization Arrangement where you prefer

The Service always puts your interest first. Should you require hospitalization as diagnosed by your consulting doctor of the Service, the team of specialists will arrange you to admit to hospital and receive treatment promptly. Besides, the Service arranges medical treatment for you in the Pan-Asia Region and provides you with personalized travel-related assistance <Note 4> in flights, accommodation, ground transfers and visa application. The medical team arranges what is needed in advance so you can rest assured that you will receive treatment and recover well.

Efficient and Seamless Claims Resolution <Note 5>

The team of specialists of the Service will assist you to apply for an efficient and seamless claims resolution arrangement with the Company prior to hospital admission. Upon the successful arrangement of the whole process of this resolution, the Company will then provide you with a Cashless Facility and pay the hospitalization fees and charges on your behalf. Payment and claim requests for such fees and charges can be dispensed with and you can focus on recovery and managing your cash reserve more effectively!

From now on, let the Service be your partner in safeguarding your health!

PREMIER THE ONEcierge One Team Health Management Hotline <Note 6>:
Macau: (853) 8988 6066
Hong Kong: (852) 8120 9066
Toll-free number for Mainland: 400 9303078
24-hour full support

For any enquiries about policy information, please contact your advisors or our Customer Service Hotline (853) 8988 6060.

Remarks:

- Please seek doctor's individual advice on appropriateness of any medical service to be provided. Doctors of HealthMutual Group Limited ("HMG") and its healthcare network team are all individual healthcare personnel instead of employees or representatives of the Company. The Company shall not be responsible for any act, negligence or omission of medical service or treatment on the part of them.

- You are required to consent to the Company, HMG and its healthcare network team and Parkway (whether within or outside Macau), recording, sharing, using and archiving your personal data in pursuance of the services being offered to you as well as for their training and quality assurance purposes. You hereby consent to the transfer of your personal data outside Macau. Failure to provide the relevant personal data may result in the said service providers being unable to provide the relevant services to you.

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

The service is currently provided by HMG and it is not guaranteed renewable. The Company shall not be responsible for any act or failure to act on the part of HMG and the professionals. The Company reserves the right to amend, suspend or terminate the PREMIER THE ONEcierge One Team Health Management Hotline and to amend the relevant terms and conditions at any time without prior notice.

Notes:

1. The Service, provided by HMG and its healthcare network team and Parkway Hospitals Singapore ("Parkway"), is not a part of the Policy or benefit item under the Policy provisions and only applicable to the Plan. The Company reserves the right to terminate or vary the Service in its sole discretion without further notice. The Company shall not be responsible for any act, negligence or failure to act on the part of HMG and its healthcare network team and Parkway. The Service is only applicable in the Pan-Asia Region.
2. Hospital means a variety of network hospitals in the Pan-Asia Region providing medical advice and treatment under the Service. Please contact our 24-hour Service Hotline (853) 8988 6060 to get more information about the list of hospitals in the Pan-Asia Region.
3. Inpatient Medical Advice Service is provided by HMG and its healthcare network team and this service offers inpatient medical advice for the Insured Person. Should the Insured Person be diagnosed with serious diseases and obtain a hospital admission letter, HMG will make an assessment based on the Insured Person's medical reports as appropriate, including explanations of the medical report, alternative medical treatment and associated estimated medical expenses in the Pan-Asia Region. A final decision on the medical treatment arrangement shall be made solely by the Insured Person. Please note that Inpatient Medical Advice shall not be considered as medical consultation. If the Insured Person would like to have medical consultation, all relevant costs will be borne by the Insured Person. The Company reserves the right to terminate or vary this service in its sole discretion without further notice.
4. The Insured Person is responsible for all relevant fees and charges required of the travel and accommodation related items. Travel related assistance is only applicable to Taiwan, Singapore & Japan.
5. Cashless Facility ("Cashless Facility") is an administrative arrangement to pay the covered expenditures when the Insured Person is under confinement, but not a benefit item under Policy provisions or a guaranteed successful arrangement. The Company reserves the right to terminate or vary the service in its sole discretion without further notice. The Company would pay the medical cost to the relevant hospital on behalf of the Insured Person after successful arrangement of Cashless Facility. If there is Deductible balance (if any) of Eligible Plan, Policy Holders are required to pay such balance when admission of hospitalization. If the medical cost paid by the Company is higher than the maximum amount of benefit, the Company would seek reimbursement from Policy Holders for such amount.
6. This hotline is operated by HMG. Please note that this hotline is for non-emergency reservation of doctor consultation instead of for emergencies.

2. Second Medical Opinion Service

As part of the Company's promise of care, you are given the access to some of the highest ranked medical institutions in the US through International SOS once your major disease claim 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 Person (the "member") via International SOS.

Understand this distinguished service, the member has access to a panel of world-class specialists at leading medical institutions in the US to obtain alternative advice on the member's medical condition and confirmation of the diagnosis in the event that the member has been diagnosed as suffering from major disease 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 member has been diagnosed with a major disease, the member is required to follow the instruction below to obtain the Second Medical Opinion Service. Call International SOS at (852) 3122 2900 and request for the Second Medical Opinion Service. Within 24 hours International SOS will confirm membership and whether medical condition is eligible for the Service.
Service Flow
1) Receive "Information Request Form" from International SOS via fax or email. 2) International SOS will assess the case and reply to the member if his/her case is eligible for the Service. The member 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 acknowledgement to International SOS after receipt. If additional medical information is required, the Panel of Second Medical Opinion will inform International SOS who in turn contact the member. 4) After evaluation, written Second Medical Opinion report and advice will be faxed/emailed to International SOS within 3-5 US working days depending on complexity of the report. 5) Upon receipt of the Second Medical Opinion report, International SOS will send it to the member and his/her treating physicians, 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 MEMBER.
*** 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 the Company or International SOS.

The service is currently provided by International SOS and it is not guaranteed renewable. The Company shall not be responsible for any act of failure to act on the part of International SOS and the professionals. The Company reserves the right to amend, suspend or terminate the Second Medical Opinion Service and to amend the relevant terms and conditions at any time without prior notice.

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 provides 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. International SOS, and/or its affiliates and the panel providing the medical opinion do not have any authority or responsibility to determine the benefits/amounts payable, its eligibility claim procedures etc.

3. International SOS 24-hour Worldwide Assistance Services

General Benefits and Terms

The following SOS benefits are available to the Company's Insured Persons ("Users") when travelling outside the Home Country or Usual Country of Residence for periods not exceeding 90 consecutive days per trip.

The Worldwide Assistance Services is provided as a benefit by International SOS ("Intl.SOS"). The Company is not an agent of Intl.SOS and shall not accept any liability for the services provided by Intl.SOS, or their availability. The contract between Intl.SOS and the Users is separate and independent to the Policy.

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.

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

The service is currently provided by International SOS and it is not guaranteed renewable. The Company shall not be responsible for any act or failure to act on the part of International SOS and the professionals. The Company reserves the right to amend, suspend or terminate the International SOS 24-hour Worldwide Assistance Services and to amend the relevant terms and conditions at any time without prior notice.