MyMillion Medical Plan – Superior Plan

Contents

1 Definitions

Accident and **Accidental** refers to a sudden, unexpected and unintentional external event which causes an Injury to the Insured, and occurs while he or she is insured by this Policy. An Accident does not include an Illness, degenerative process or any other naturally occurring condition.

Age refers to the age next birthday of the Insured of this Policy, unless otherwise specified.

Anaesthetist, Physician, Surgeon or **Specialist** refers to a person who is licensed and registered under in the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) and/or registered in the Specialist Register of the Medical Council of Hong Kong to practice western medical and surgical services, or is otherwise legally authorized to practice such services in the region of his or her practice. An Anaesthetist, Physician, Surgeon or Specialist cannot be an Interested Party unless We pre-approve in writing. An Anaesthetist cannot be an attending Physician or Surgeon operating on the Insured.

Annual Deductible refers to a fixed amount of Eligible Expenses that, in a Policy Year, You must pay before We will reimburse the remaining Eligible Expenses.

Annual Limit refers to the maximum amount of benefits We pay to You in a Policy Year irrespective of whether any limits of any benefit items stated in the Policy Schedule or any Endorsement have been reached. The Annual Limit is counted afresh in a new Policy Year.

Asia refers to 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.

Balance of Annual Deductible refers to the remaining amount of Annual Deductible to be borne by You or the Insured within the relevant Policy Year under this Policy.

Beneficiary refers to a person chosen by You to receive the death benefits under this Policy at the death of the Insured.

Chinese Medicine Practitioner refers to a person registered under the Chinese Medicine Ordinance of Hong Kong (Cap. 549 of the Laws of Hong Kong) as an herbalist or an acupuncturist, or registered with the local medical authorities at the place of treatment if the treatment is received outside Hong Kong. A Chinese Medicine Practitioner cannot be an Interested Party unless We pre-approve in writing.

Chiropractor, Physiotherapist or **Dentist** refers to a person who is legally recognised to perform services in the specialist area of their titled profession by the relevant government-recognised registration body in Hong Kong, or in the region in which he or she operates. This person cannot be an Interested Party unless We pre-approve in writing.

Commencement Date refers to the date the first premium is due and is the date used for calculating the Insured's Age at the start of the Policy, as shown on the Policy Schedule.

Confinement or **Confined** refers to an admission of the Insured to a Hospital that is recommended by a Physician for Medical Service and as an In-Patient as a result of a Medically Necessary condition. Confinement will be evidenced by a daily room charge invoiced by the Hospital and the Insured must stay in the Hospital continuously for the entire period of Confinement.

Congenital Conditions refers to (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 refers to a Medically Necessary surgical procedure for investigation or treatment listed in the Appendix 1 to the Insured performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.

Day Patient refers to an Insured receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured is not in Confinement.

Disability refers to an Illness or Injury, including Disabilities arising from the same cause, and any complications arising from that Illness or Injury.

Eligible Expenses refers to the Reasonable and Customary charges for Medically Necessary treatment or services for a Disability.

Emergency refers to an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured 's health.

Emergency Treatment refers to 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.

Endorsement refers to an additional document attached to this Policy that outlines any adjustments that We may make to this Policy.

Expiry Date refers to the Policy Anniversary immediately following the Insured's 100th birthday.

Family Member refers to a person's spouse, children, parents, parents-in-law, brothers or sisters, grandparents, grandchildren, other relatives or legal guardian.

First Symptoms refers to the first time that the Insured experiences a physical symptom that would cause a reasonable and prudent person to seek medical advice, diagnosis or treatment, or where a medical examination or investigation shows the likely presence of a medical condition.

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

Hospital refers to a medical facility that meets all of the following requirements:

1. is licensed as a hospital under the laws of the country where it operates;
2. is supervised by Physicians and provides 24-hour care by Qualified Nurses;
3. is operated mainly to diagnose and treat injuries or illnesses on an In-Patient basis;
4. has diagnostics and major surgery facilities; and
5. is not primarily a clinic, nursing facility, nursing home, convalescence home, psychiatric facility, drug and alcohol rehabilitation facility, preventative medicine facility, homeopathic facility or hospice care.

Illness refers to 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 and whether or not any diagnosis is confirmed.

Injury refers to bodily harm to the Insured caused solely and directly by an Accident that occurs on or after the Policy Date.

In-Patient refers to when the Insured is admitted to a Hospital on the written recommendation of a

Physician or Specialist to receive Medically Necessary treatment that cannot be provided safely outside the Hospital premises.

Insured refers to the person insured by this Policy and shown on the Policy Schedule as the "Insured".

Intensive Care Unit refers to the unit in a Hospital that has one-to-one nursing care, where patients undergo specialized resuscitation, monitoring and treatment procedures. The unit must be staffed twenty-four (24) hours a day with highly trained Qualified Nurses, technicians and Physicians, and be equipped with life-saving medical equipment to continuously assess vital body functions.

Interested Party refers to You or the Insured (if different people) and their insurance agent or representative, Family Member, business partner, employer or employee.

Medical Services refer to 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 refers to a medical recommendation by a Physician, Surgeon or Specialist as part of his or her diagnosis and/or treatment of an Illness or Injury. The medical recommendation must meet each of the following criteria:

1. the Insured's medical condition will be adversely affected if the medical recommendation is not followed;
2. The recommendation is widely accepted within the medical profession in Hong Kong or the country of treatment as being effective, appropriate and essential to diagnose, relieve or cure the Insured's Illness or Injury based on recognised western medical standards of the specialty involved;
3. The recommended medical management and/or treatment is not experimental in nature; and
4. The recommended diagnosis and/or treatment is not preventative, investigational or screening in nature, is not opted or selected by the Insured alone, nor is it for the personal convenience or comfort of the Insured or any medical service provider. This precludes:
   - general check-up unrelated to an Illness or Injury;
   - preventative screening or check-up looking for the presence of an Illness or Injury where there are no symptoms or history of that Illness or Injury;
   - vaccinations for the prevention of an Illness or Injury;
   - convalescence, custodial or rest care unrelated to an Illness or Injury;
   - cosmetic surgery for aesthetic purposes, including gender identity treatment or procedures of any kind (even if not for aesthetic purposes);
   - dental treatment, eye tests and/or optical treatment and surgery, unless this treatment is directly related to an Illness or Injury covered by this Policy.

Policy Anniversary refers to the same date each year as the Commencement Date.

Policy Date refers to the date when coverage under this Policy begins as shown in the Policy Schedule or the date that We reinstate the coverage of this Policy under clause 3.5, whichever is later.

Policy Schedule refers to the document attached to this Policy which shows important information about this Policy, including the policy number, premium payable and the Policy benefits.

Policy Year refers to each twelve (12) month period from the Commencement Date.

Pre-existing Condition(s) refers to any Illness, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition of the Insured, that has existed prior to the Policy Date. An ordinary prudent person will be reasonably aware of a Pre-existing Condition, where –

1. it has been diagnosed;
2. it has manifested clear and distinct signs or symptoms; or
3. medical advice or treatment has been sought, recommended or received.

Prescribed Diagnostic Imaging Tests refers to 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 refers to chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.

Qualified Nurse refers to a person registered with the Nursing Council of Hong Kong under the Nurses Registration Ordinance of Hong Kong (Cap. 164 of the Laws of Hong Kong) to render Medical Service in Hong Kong, or is legally authorized to render such service in the region of this person's practice. A Qualified Nurse cannot be an Interested Party unless We pre-approve in writing.

Reasonable and Customary refers to a fee or expense which:
1. is actually charged for Medically Necessary treatment, supplies or Medical Services;
2. does not exceed the usual or reasonable average level of charges for similar treatment, supplies or Medical Services in the location where the expense is incurred;
3. does not include charges that would not have been made if no insurance existed.

We may adjust benefit(s) payable under this Policy for fees or expenses that We judge not to be Reasonable and Customary after comparing with fee schedules used by the government, relevant authorities or recognised medical association in the location where the fee or expense is incurred.

Standard Private Room refers to a standard single occupancy room with an adjoining bathroom for the Insured'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 refers to a single or double occupancy room in a Hospital, with a shared bath or shower room.

Standard Ward Room refers to a room type in a Hospital that is of a quality below a Standard Semi-Private Room.

We, **Us** or **Our** refers to FWD Life Insurance Company (Bermuda) Limited (incorporated in Bermuda with limited liability), the issuer of this Policy.

You, **Your** or **Policy Owner** refers to the person who owns this Policy as shown on the Policy Schedule or any Endorsement.

2 General Provisions

2.1 The Policy

This Policy is governed by the laws of Hong Kong and is proof of an insurance contract between You and Us. The contract is made up of this contract document, the Policy Schedule, application form and any Endorsements.

The Policy Owner and the Insured are required to provide truthful and accurate information during the application of this Policy. We issued this Policy after receiving Your payment of the premium shown in the Policy Schedule, and considering the information provided by You and the Insured (if different people) during the application process. This information provided is

considered representations and not warranties.

2.2 Cooling-off Period

The Policy Owner has the right to cancel this Policy by notice and obtain a full refund of any premium(s) paid by You and insurance levy paid by You without any interest, by giving a written notice to Us. Such notice must be signed by the Policy Owner and received directly by Us within twenty-one (21) calendar days immediately following either the day of delivery of the Policy or a Cooling-off Notice to You or Your nominated representative, whichever is the earlier as specified by cooling-off period principles set out by the Hong Kong insurance regulator. No refund can be made if a claim payment under the Policy has been made prior to Your request for cancellation.

2.3 Alterations and Company Notices

No alterations in the terms and conditions and provisions of this Policy will be valid unless made in a written Endorsement and / or any supplement to this Policy and issued by Us. No agent or other persons have the authority to change or waive any provision of this Policy.

We will send any written notices to Your latest address as shown on Our records. We will consider any such notice to have been successfully received forty-eight (48) hours by You after We post it.

2.4 Policy Owner

As the Policy Owner, You are the only person who can request changes to, and exercise the rights related to this Policy while this Policy is in force.

You are entitled to any proceeds of this Policy that do not result from the death of the Insured. If You die, the proceeds will be paid to the appointed executors or administrators of Your estate. If You are also the Insured, the proceeds will instead be paid to the Beneficiary.

2.5 Beneficiary

A Beneficiary is someone You nominate to receive proceeds of this Policy if the Insured dies. You can nominate multiple Beneficiaries as well as each Beneficiary's share of any proceeds.

During the Insured's lifetime, the Beneficiary cannot request any changes to, claim benefits from, or exercise any rights in relation to this Policy.

If no Beneficiaries are nominated, or if all of the Beneficiaries die before the Insured, We will pay the proceeds to You, or the Executors of Administrators of Your estate (if You die).

If a Beneficiary dies before the Insured, and You do not provide an update to Your Beneficiary nomination, his or her share of the Policy benefits will be redistributed to any surviving Beneficiaries in proportion to their nominated share (or equally if no nomination has been made).

If both the Insured and a Beneficiary die in the same incident and the official time of death is the same, any Policy proceeds will be paid as if the elder of the two (2) people had died first.

2.6 Change of Policy Owner and Beneficiary

You may change the Policy Owner or Beneficiary of this Policy while it is in force by submitting a written request to Us. We will register the change in Our records when We determine that all relevant information has been received, from which time the change will be effective.

2.7 Change of Place of Residence or Occupation

You must immediately inform Us if the Insured's occupation or country of residence changes and We will re-underwrite in respect of such changes based on Our then underwriting rules. If We need to reduce or increase the premium, We will inform you the amount of new premium and the due date in writing.

You also acknowledge that, We will carry out the re-underwriting solely in respect of the said change and the re-underwriting result may be more advantageous or adverse to You and the Insured.

If We consider the new occupation or country of residence to be subject to a higher premium rate, based on Our underwriting rules, We may increase the premium and collect any premium shortfall with interest and any additional insurance levy.

If We consider the new occupation or country of residence to be subject to a lower premium rate, based on Our underwriting rules, We may decrease the premium and refund the excess premium and insurance levy without interest.

If the new occupation or country of residence is unable to be insured based on Our underwriting rules, We may terminate this Policy or refuse Policy benefits that become payable after the change.

2.8 Assignment

You cannot assign this Policy or its benefits to any person or organisation.

2.9 Basis for offering this Policy

We have used the information, including but not limited to Age, gender and other material facts, provided by You and Insured (if different people) during the Policy application process to determine whether to offer this Policy. If the Insured's Age or gender shown in the Policy Schedule is incorrect, We have the right to:

i) require You to pay Us any difference in premiums, with interest determined by Us and any outstanding insurance levy, if the premiums paid up on or before the date which the mistake was discovered are lower than what should have been paid based on the Insured's correct Age or gender; or
ii) refund any difference in premiums and insurance levy, without interest, if the premiums paid up on or before the date which the mistake was discovered are higher than what should have been paid based on the Insured's correct Age or gender.

We may cancel this Policy and treat it as having never existed if (a) any information provided by You and the Insured during the Policy application process is incorrect and if, based on the correct information, We would not have offered this Policy, or (b) if any material facts were

not disclosed by You and the Insured during the Policy application process which may affect Our risk assessment. In this situation, We will refund any premium and insurance levy(ies) paid without interest after deducting any benefits that We have paid, and You upon demand to refund the benefits previously received from this Policy. We will send written notification of the cancellation to Your address in Our records.

2.10 Payment Currency

All amounts that We or You are required to pay in relation to this Policy are payable in Hong Kong Dollars, unless We nominate a different currency in the Policy Schedule or any Endorsement.

We will convert any amounts payable into Hong Kong Dollars at a reasonable foreign currency exchange rate that We choose. We are not legally responsible for any exchange rate-related losses incurred.

2.11 Non-Participating

This Policy does not participate in the divisible surplus of Our life insurance funds.

2.12 Contracts (Rights of Third Parties) Ordinance

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

2.13 Cancellation

After cooling-off period, You can request cancellation of this Policy by giving Us thirty (30) days prior written notice, provided that there has been no benefit payment under this Policy during the relevant Policy Year. The cancellation right will also apply after this Policy has been renewed upon expiry of its first (or subsequent) Policy Year.

2.14 General Interpretation and Application

Where the context requires, words importing one gender will include the other gender, and singular terms will include the plural and vice versa. Headings are for convenience only and will not affect the interpretation of this Policy. References to sections, clauses, provisions and schedules are to sections, clauses, provisions and schedules to this Policy. Should any conflict arise in respect of the interpretation of any provision in this Policy and any other material otherwise produced by Us, then the provisions of this Policy will prevail.

2.15 Obligation to Provide Information

You acknowledge that We and/or Our affiliates are obliged to comply with legal and/or regulatory requirements in various jurisdictions as promulgated and amended from time to time, such as the United States Foreign Account Tax Compliance Act, and the automatic exchange of information regime ("AEOI") followed by the Inland Revenue Department (the "Applicable Requirements"). These obligations include providing information of clients and related parties (including personal information) to relevant local and international authorities

and/or to verify the identity of its clients and related parties. In addition, Our obligations under the AEOI are to:

i) identify accounts as non-excluded "financial accounts" (NEFAs);
ii) identify the jurisdiction(s) in which NEFA-holding individuals and NEFA-holding entities reside for tax purposes;
iii) determine the status of NEFA-holding entities as "passive non-financial entities (NFEs)" and identify the jurisdiction(s) in which their controlling persons reside for tax purposes;
iv) collect information on NEFAs ("Required Information") which is required by the authorities; and
v) furnish Required Information to the Inland Revenue Department.

You agree that from time to time We will have the right to request from You, and disclose to relevant authority(ies), various information about You, the Beneficiary and this Policy as required under Applicable Requirements for the following purposes:

i) for Us to issue this Policy to You;
ii) for Us to provide benefits available to You and / or the Beneficiary under the terms of this Policy; and / or
iii) for this Policy to remain in force in accordance with its terms.

In addition, You agree to notify Us in writing within thirty (30) days if there is any change to any of the information previously provided to Us that relates to Our legal obligations under this clause (whether at time of application or at any other time).

If You do not provide such information within the time period as reasonably requested by Us, notwithstanding any other provisions of this Policy, We will be entitled to, to the extent permitted by Applicable Requirements,

i) report this Policy and/or information about You and/or the Beneficiary to relevant authority(ies);
ii) terminate this Policy and refund any premium and any insurance levy paid, after deducting any benefits We have paid, and any amounts owed to Us; or
iii) take any such other action as may be reasonably required including but not limited to making adjustments to the values, balances, benefits or entitlements under this Policy.

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

3 Premiums and Reinstatement Provisions

3.1 Payment of Premiums

The first premium is due on the Commencement Date. If this is not paid within thirty (30) days of the Policy Date, this Policy will be automatically cancelled and considered as having never existed. In this situation, We will not be legally obliged to pay any benefits from this Policy.

Subsequent premiums must be paid until the Expiry Date. Premiums must be paid at a frequency We agree with You.

3.2 Renewal

We will automatically renew this Policy at each Policy Anniversary until the Expiry Date. This automatic renewal is only applicable if the Policy premiums are paid when due without the requirement of evidence of insurability.

We have the right to review and adjust the Policy's premium each Policy Anniversary. We determine the premium rates for each renewal based on factors including but not limited to the Age of the Insured at the time of renewal, claims experience, medical inflation and policy persistency, provided any premium review will be applied to all other policies of the same kind, and these premium rates are not guaranteed.

3.3 Deduction of Unpaid Premium and outstanding insurance levy

If You are paying the premium at a frequency which is other than in annual (for example, monthly), We will deduct from any death benefit payment the amount of unpaid premiums and/or outstanding insurance levy(ies) (if any) for the Policy Year in which the Insured died, as well as any other money which You owe to Us before paying the death benefits. Any due and unpaid premium and outstanding insurance levy will be deducted from any benefit otherwise payable.

3.4 Grace period

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

3.5 Reinstatement

We may agree to reinstate this Policy if it was terminated because of unpaid premiums. In order to reinstate this Policy, You must:

i) apply to Us in writing within one (1) year the date of termination of this Policy;
ii) provide Us with satisfactory evidence that the Insured still qualifies for this Policy based on the same factors that We used when assessing the initial application; and
iii) repay all unpaid premiums (with interest at an interest rate that We set) and any outstanding insurance levy(ies).

We may refuse the application for reinstatement or may adjust the terms of this Policy. If We accept the application for reinstatement, this Policy will recommence from a date that We determine. No coverage is provided under this Policy during the period starting from the date on which the Policy lapses and ending on the date of reinstatement.

4 <u>Annual Deductible and Geographical Limitation</u>

We offer this Policy with different amount of Annual Deductible. The Annual Deductible of this Policy You chose is set out in the Policy Schedule or any Endorsement.

Except the Psychiatric Treatments as stated in clause 5.1.8, and Cash Benefit for Confinement in General Ward of Public Hospital in Hong Kong as stated in clause 5.8; all benefits described in this Policy are subject to geographical limitation for benefit coverage as below:

i) for non-Emergency Treatment, We offer coverage for the Eligible Expenses incurred within Asia in accordance with this Policy;
ii) for Emergency Treatment, there is no geographical limitation and We cover for the Eligible Expenses for Emergency Treatment incurred in accordance with this Policy.

5 Benefit Provisions

We will reimburse the Eligible Expenses in accordance with the terms and conditions of this Policy.

The final amount paid and payable under clauses 5.1, 5.2 and 5.3 is subject to Annual Limit, Annual Deductible (if any) and other limits set out in Policy Schedule or any Endorsement.

5.1 Hospitalisation Benefits

We will reimburse the Eligible Expenses described below but subject to Annual Limit, Annual Deductible (if any) and other limits set out in the Policy Schedule or any Endorsement:

5.1.1 Room and Board

We will reimburse the Eligible Expenses for room and board when the Insured is Confined in a Hospital or undergoes any Day Case Procedure or Prescribed Non-surgical Cancer Treatment.

5.1.2 Intensive Care Unit Charges

We will reimburse the Eligible Expenses if the Insured is Confined in an Intensive Care Unit on the written recommendation of the Insured's attending Physician or Surgeon.

If We make the reimbursement under this clause, We will not pay the benefit under clause 5.1.1.

5.1.3 Physician's Hospital Visit and Specialist's Fee

While the Insured is Confined, We will reimburse the Eligible Expenses charged:

i) by the Insured's attending Physician to visit the Insured; and
ii) for Specialist treatment recommended in writing by the Insured's attending Physician.

5.1.4 Miscellaneous Medical Charges

We will reimburse the Eligible Expenses charged on the miscellaneous charges where the Insured is Confined in a Hospital, or on the day the Insured undergoes any Day Case Procedure or receiving Medical Services. These charges cover the following items:

- Drugs and medicines required by the Insured;
- Dressing, ordinary splints and plaster casts but excluding special braces, artificial limbs, appliances and equipment;
- Laboratory examinations;
- Electrocardiograms;
- Physiotherapy;
- Basal metabolism tests;
- X-ray examinations;
- Medical report charges as a result of tests and examinations;
- Administration of blood and blood plasma but excluding costs of blood or blood plasma;
- Local ambulance service to or from where the Insured is Confined;
- Use of post-operative recovery room.

For clarity, We will not cover:

i) non-medical miscellaneous charges, such as guest meals, personal wi-fi, telephone, photocopying, taxis and personal items;
ii) items that have not been recommended in writing by the Insured's attending Physician;
iii) narcotics used by the Insured (unless taken as prescribed by the attending Physician); or
iv) any genetic testing, medical services, procedures or supplies which are not Medically Necessary.

Apart from the abovementioned items, We have the right to determine whether a particular service or charge will be reimbursed under this clause.

5.1.5 **Hospital Companion Bed**

We will reimburse the Reasonable and Customary fees charged by the Hospital for a companion bed for one (1) of the Insured's Family Members while the Insured is Confined.

5.1.6 **Private Nursing Care's Fee**

We will reimburse the Eligible Expenses for private nursing services provided by a Qualified Nurse during the Insured's Confinement if the services have been recommended in writing by the Insured's attending Physician following the Insured's surgery or after the transfer from an Intensive Care Unit to another ward within the Hospital.

We will only pay for the Eligible Expenses charged on one (1) Qualified Nurse on each day to provide the services subject to other limits set out in Policy Schedule or any Endorsement.

5.1.7 **Prescribed Diagnostic Imaging Tests**

We will pay 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 Physician for the investigation or treatment of a Disability.

5.1.8 **Psychiatric Treatments**

We will pay for the Eligible Expenses charged on the psychiatric treatments during Confinement in Hong Kong as recommended by a Specialist subject to other limits set out in Policy Schedule or any Endorsement.

We will pay this benefit in lieu of other benefit items under clauses 5.1.1 to 5.1.4, 5.1.6 to 5.1.7, 5.2, 5.3.1 and 5.3.2. For the avoidance of doubt, where a Confinement is not solely for the purpose of psychiatric treatments, this benefit will 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 will 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 will be payable under clauses 5.1.1 to 5.1.4, 5.1.6 to 5.1.7, 5.2, 5.3.1 and 5.3.2.

We will only pay benefits under clauses 5.1.3 to 5.1.6 if We have paid a benefit under clause 5.1.1 or 5.1.2.

5.2 Surgical Benefits

We will reimburse the Eligible Expenses charged to the Insured during his or her Confinement in a Hospital or Day Case Procedure for treatment for a Disability, including the charges for consultation, medication, the Surgeon's fee, Anaesthetist's fee, operating theatre fee and other Eligible Expenses for items and equipment used during the procedures.

This reimbursement is subject to the Annual Limit and Annual Deductible (if any) as set out in the Policy Schedule or any Endorsement.

5.3 Other Benefits

We will reimburse the Eligible Expenses described below subject to Annual Limit, Annual Deductible (if any) and other limits set out in the Policy Schedule or any Endorsement:

5.3.1 **Pre- Confinement / Day Case Procedure Out-Patient Care**

We will reimburse the Eligible Expenses charged for pre-admission out-patient visits or Emergency consultations for a Disability before being Confined or undergoing Day Case Procedure for that Disability subject to the other limits set out in the Policy Schedule or any Endorsement. This benefit is subject to a maximum of:

- one (1) out-patient visit or Emergency consultation on each day which results in the relevant Confinement or Day Case Procedure; and
- three (3) prior out-patient visits or Emergency consultations per Confinement or Day Case Procedure.

We will also reimburse the Eligible Expenses charged on any prescribed western medication that needs to be taken during such out-patient visits or Emergency consultations that are necessary for the Confinement or Day Case Procedure.

We will not pay a benefit under this clause for any treatment from a Chinese Medicine

Practitioner, Chiropractor treatment, podiatry consultation or physiotherapy, even if the Insured's Confinement or Day Case Procedure follows that treatment or consultation.

For the benefits payable under this clause, Prescribed Diagnostic Imaging Tests and Prescribed Non-surgical Cancer Treatments will be respectively payable under clauses 5.1.7 and 5.3.6.

We will only pay this benefit if We have paid a benefit under clause 5.1.1, 5.1.2 or 5.2, and is subject to the Annual Limit, Annual Deductible (if any) and other limits set out in the Policy Schedule or any Endorsement.

5.3.2 **Post-Confinement / Day Case Procedure Out-Patient Care**

If the Insured's attending Physician recommends the Insured undergo follow-up out-patient consultations after the Confinement or Day Case Procedure for a Disability, We will reimburse the Eligible Expenses charged within ninety (90) days following the Insured's discharge from Hospital or the completion of Day Case Procedure. This benefit is subject to a maximum of:

- one (1) follow up out-patient visit on each day; and
- twenty (20) follow-up out-patient visits per Confinement or Day Case Procedure.

We will also reimburse the Eligible Expenses of any prescribed western medication given in that ninety (90) day period which relate to the Confinement or the completion of Day Case Procedure.

We will only pay this benefit if the Insured's attending Physician has made the recommendation in writing, and We will not pay any benefit under this clause for any treatment from a Chinese Medicine Practitioner, Chiropractor treatment, podiatry consultation or physiotherapy, regardless whether such consultation relates to the follow-up out-patient consultations.

For the benefits payable under this clause, Prescribed Diagnostic Imaging Tests and Prescribed Non-surgical Cancer Treatments will be respectively payable under clauses 5.1.7 and 5.3.6.

We will only pay this benefit if We have paid a benefit under clause 5.1.1, 5.1.2 or 5.2, and is subject to the Annual Limit and Annual Deductible (if any) and other limits set out in the Policy Schedule or any Endorsement.

5.3.3 **Post-Confinement Home Nursing**

If the Insured's attending Physician makes a written recommendation that it is Medically Necessary to have nursing support after being Confined for a Disability, We will reimburse the Eligible Expenses for a Qualified Nurse to attend the Insured's home within the thirty (30) days immediately after the Insured's discharge from Hospital following a surgery or Intensive Care Unit admission, subject to the other limits set out in the Policy Schedule or any Endorsement. This benefit is subject to a maximum of one (1) Qualified Nurse visit on each day and thirty (30) days per Policy Year. In the event that more than one (1) Qualified Nurse provides nursing services at the same visit, only the Qualified Nurse with the highest Eligible Expenses will be payable; or if the Insured has received more than one (1) Qualified Nurse visit on the same day, only the one (1) Qualified Nurse visit with the highest Eligible Expenses will be payable.

We will only pay this benefit if We have paid a benefit under clause 5.1.2 or 5.2 and the Insured's attending Physician has made a recommendation in writing, and the services relate directly to a Disability. This benefit is subject to the Annual Limit, Annual Deductible (if any) and other limits set out in the Policy Schedule or any Endorsement.

5.3.4 **Emergency Out-Patient Accident Treatment Charges**

If the Insured is involved in an Accident that requires Emergency Treatment provided by a Physician, Surgeon or Specialist at the out-patient or emergency department of a Hospital or in the Physician, Surgeon or Specialist's clinic within seventy-two (72) hours after the Accident, We will reimburse the Eligible Expenses charged on that treatment.

This benefit will only be payable for the Eligible Expenses for out-patient visit or Emergency consultation not resulting in a Confinement or Day Case Procedure.

5.3.5 **Emergency Dental Treatment**

We will reimburse the Eligible Expenses charged on Emergency dental treatment to the Insured's sound natural teeth as a direct result of an Injury caused by an Accident, if the treatment is provided within three (3) months of the Accident by a Dentist in a registered dental clinic or Hospital.

We will not pay any benefits for:

i) any restorative or remedial work, prostheses, the use of any precious metals, orthodontics or periodontics of any kind, or other dental surgery unless the dental surgery is Medically Necessary;
ii) treatment relating to an Injury caused by eating or drinking;
iii) treatment for damage caused by normal wear and tear; or
iv) treatment for damage caused by tooth brushing or any other oral hygiene procedure.

5.3.6 **Prescribed Non-surgical Cancer Treatments**

We will reimburse the Eligible Expenses charged on the Prescribed Non-surgical Cancer Treatments performed during Confinement or in a setting for providing Medical Services to a Day Patient, out-patient 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 will be payable under clause 5.1.7 of this provisions.

5.3.7 **Kidney Dialysis**

We will reimburse the Eligible Expenses incurred for haemodialysis or peritoneal dialysis performed on the Insured during Confinement or in a setting for providing Medical Services to a Day Patient recommended in writing by the Insured's attending Physician. We will also reimburse rental cost of a kidney dialysis machine for use on

the Insured at home as recommended in writing by the Insured's attending Physician.

5.3.8 **Pregnancy Complications**

We will pay You for the Eligible Expenses incurred for the benefit items described in clauses 5.1.1 to 5.1.4, 5.1.7 and 5.2 where a surgical procedure is performed by a Surgeon during Confinement or in a setting for providing Medical Services to a Day Patient as a result of the following pregnancy related complications arising during antepartum stages of pregnancy or childbirth:

i) ectopic pregnancy;
ii) molar pregnancy;
iii) disseminated intravascular coagulopathy;
iv) pre-eclampsia;
v) miscarriage;
vi) threatened abortion;
vii) medically prescribed induced abortion;
viii) foetal death;
ix) postpartum hemorrhage requiring hysterectomy;
x) eclampsia;
xi) amniotic fluid embolism; or
xii) pulmonary embolism of pregnancy.

This benefit will only be payable provided that the date of diagnosis of such pregnancy complication is at least one (1) year after the Policy Date.

If You have made a change to the Annual Deductible according to clause 5.14, We will reimburse the benefit amount subject to the latest Annual Deductible approved by Us one (1) year after the date the approved Annual Deductible takes effect. For clarity, We will only pay the benefit amount subject to the original Annual Deductible under this clause during this one (1)-year period.

Except as otherwise provided above, We will not cover the 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.

5.3.9 **Post-Confinement/ Day Case Procedure Chinese Medical Treatment**

If We have paid a benefit under clause 5.1.1, 5.1.2 or 5.2, and the Insured receives the follow-up out-patient treatment provided by a Chinese Medicine Practitioner within ninety (90) days after the Insured's discharge from Hospital or the completion of Day Case Procedure for treatment for the same Disability, We will reimburse the Eligible Expenses (including any prescribed medicine for Chinese medicine treatment) subject to a maximum of:

- one (1) visit to the Chinese Medicine Practitioner on each day; and
- ten (10) visits to the Chinese Medicine Practitioner after each Confinement or Day Case Procedure.

This benefit is further subject to the other limits as set out in the Policy Schedule or any Endorsement.

5.3.10 **Post-Confinement/ Day Case Procedure Physiotherapist or Chiropractic Consultation**

If We have paid a benefit under clause 5.1.1, 5.1.2 or 5.2, and the Insured receives the follow-up out-patient treatment provided by a Physiotherapist or Chiropractor recommended in writing by the Insured's attending Physician, within ninety (90) days after the discharge from Hospital or the date of completion of Day Case Procedure for treatment for the same Disability, We will reimburse the Eligible Expenses subject to a maximum of:

- one (1) visit to the Physiotherapist or Chiropractor on each day; and
- ten (10) visits to the Physiotherapist or Chiropractor after each Confinement or Day Case Procedure.

This benefit is further subject to other limits as set out in the Policy Schedule or any Endorsement.

5.4 Limitation of Claim

i) If on any day of Confinement, the Insured is voluntarily Confined in a ward class of Hospital accommodation higher than his/her entitled ward class as specified in the Policy Schedule or any Endorsement, the ward class adjustment factor set out below will be applied to the Eligible Expenses incurred on that day.

Entitled Ward Class	Actual Ward Class	Ward Class Adjustment Factor
Standard Ward Room	Standard Ward Room	100%
	Standard Semi-Private Room	50%
	Standard Private Room	25%
	Above Standard Private Room	12.5%

The ward class adjustment factor will not be applied under the following circumstances:

a) unavailability of accommodation at the specified ward class due to ward or room shortage for Emergency Treatment;
b) isolation reasons that require a specific class of accommodation; or
c) other reasons not involving personal preference of You and the Insured.

ii) If the Insured requires Confinement or treatment or incurs charges for a Disability that is directly or indirectly related to, arises from or is caused by attempted suicide, self-inflicted Injuries or under any condition caused by chronic alcoholism or drug addiction, the most We will pay for Eligible Expenses will be limited to HKD10,000 per Policy Year under clauses 5.1, 5.2 and 5.3.

5.5 Additional Benefit for Prescribed Non-surgical Cancer Treatments, Kidney Dialysis and Organ or Bone Marrow Transplantation

Subject to the limit of this benefit set out in the Policy Schedule or any Endorsement, this benefit will be payable for the Eligible Expenses in excess of the amounts payable under –

i) Clause 5.3.6 for Prescribed Non-surgical Cancer Treatments;
ii) Clauses 5.1.4 and 5.3.7 for kidney dialysis; or
iii) Clauses 5.1.1 to 5.1.7 and 5.2 for organ or bone marrow transplantation.

5.6 Cash Benefit for Day Case Procedure

If the Insured undergoes a Day Case Procedure for a Disability which is payable in accordance with this Policy, We will pay this benefit irrespective of the amount of Eligible Expenses reimbursed under any other benefit items of this Policy, subject to a maximum of one (1) Day Case Procedure on each day and other limits set out in the Policy Schedule or any Endorsement.

5.7 Cash Benefit for Top-up Subsidy

For the Insured covered by any other hospital and surgical reimbursement plan issued by a licensed insurance company other than Us, regardless of whether it is an individual or group policy, if the Eligible Expenses incurred for any Confinement of the Insured are payable under this Policy after any reimbursement has been paid by such other licensed insurance companies, this benefit will be payable for each day of Confined period in Hospital, subject to the limits as specified in the Policy Schedule or any Endorsement.

5.8 Cash Benefit for Confinement in General Ward of Public Hospital in Hong Kong

We will pay a benefit for each day the Insured is Confined in a general ward of a government Hospital in Hong Kong for Medically Necessary treatment of a Disability, up to the other limits set out in the Policy Schedule or any Endorsement.

5.9 Compassionate Death Benefit and Accidental Death Benefit

We will pay to the Beneficiary the compassionate death benefit as set out in the Policy Schedule or any Endorsement if the Insured dies while this Policy is in force and before the Expiry Date, provided that due proof of the death and other documents (including all relevant certificates, reports, evidence and other data or materials) are provided to Us six (6) months from the date of death of the Insured. All such documents which can be reasonably provided by You will be furnished at Your expenses. We will bear all expenses incurred in obtaining further certificates, information and evidence for the purposes of verification of the claim after You have submitted all required information.

In addition to the Compassionate Death Benefit, if the Insured's death is caused by an Accident, We will pay to the Beneficiary the Accidental Death Benefit as set out in the Policy Schedule or any Endorsement.

5.10 Special Benefit for Infant

While this Policy is in force, if the Insured or Insured's spouse gives birth to a child after the Policy has been in force for two (2) Policy Years from the Policy Date ("Covered Child"), a one (1) - year coverage by a designated medical insurance plan for the Covered Child will be offered without further evidence of insurability and at no additional charge.

Once the coverage for the Covered Child is in effect and if the Covered Child suffers from Disability during the coverage period, We will pay the benefits based on the terms and benefits of the designated medical insurance plan. The benefit amount will not be deducted from this Policy and will not affect the coverage available to the Insured under this Policy.

This benefit is subject to the following conditions:

i) You have to inform Us in writing of the birth of the Covered Child within one hundred and

eighty (180) days of the birth and provide the birth certificate of the Covered Child issued by the relevant competent authority of a lawful jurisdiction; and

ii) the terms and conditions of the designated medical insurance plan and Our prevailing rules and regulations which are determined by Us from time to time at its sole discretion will apply.

For the avoidance of doubt, this benefit is not available to children of the Insured who were born during or before the two (2) Policy Years period mentioned above.

5.11 Guaranteed Convertibility to Reduce or Remove Annual Deductibles at Specified Age

If the Policy has been in force for two (2) consecutive Policy Years from the Policy Date, You have the right to reduce or remove the Annual Deductible of this Policy once during the Insured's lifetime without re-underwriting, upon the Policy Anniversary on or immediately following the date that the Insured attains the age of fifty (50), fifty-five (55), sixty (60), sixty-five (65), seventy (70), seventy-five (75) or eighty (80).

It is necessary for You to apply for this benefit within thirty-one (31) days immediately before or after the relevant Policy Anniversary subject to the Annual Deductible options available at that time and the terms and conditions determined by Us from time to time.

You can only exercise this right without re-underwriting once during the Insured's lifetime and such Annual Deductible reduction or removal is irreversible.

5.12 First-dollar Coverage – Annual Deductible Waived for Designated Crises

While this Policy is in force, if the Insured suffers the following designated crises (as defined herein below and Appendix 2) and is upon the recommendation of the attending Physician, Surgeon and Specialist in writing, receives any Medical Services as a direct result of the designated crises, in calculation of benefits payable under clauses 5.1 to 5.3 of this Policy, the payment of the Balance of Annual Deductible (if any and if applicable) will be reduced to zero (0). We will pay the Eligible Expenses charged on such Medical Services for designated crises before the entire Annual Deductible is met.

In the event that the Annual Deductible is waived for a claim of Eligible Expenses incurred for one (1) of the designated crises (i.e. You are not required to pay the amount of Annual Deductible for such claim), such amount of Eligible Expenses payable will still be reduced from the Balance of Annual Deductible in the relevant Policy Year, if any and if applicable.

For the avoidance of doubt, this benefit is only applicable to the Medical Services arising from any designated crisis defined under Appendix 2. Where the Eligible 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 will be regarded as Eligible Expenses charged on Medical Services for designated crises.

The designated crises must be confirmed by the Insured's attending Physician, Specialist or Surgeon in writing and supported by clinical, radiological, histological and laboratory evidence which We accept.

For the purpose of claiming this benefit, designated crises refer to the below crises and must fulfill the terms and conditions stated under the heading of such designated crisis in Appendix 2:

i) Cardiac Impairment Caused By Cardiomyopathy;

ii) Cardiac Impairment Due To Primary Pulmonary Arterial Hypertension;
iii) Chronic Liver Disease;
iv) Coronary Artery Bypass Operation;
v) End Stage Lung Disease;
vi) Fulminant Hepatitis;
vii) Heart Attack (Acute Myocardial Infarction);
viii) Kidney Failure;
ix) Major Organ Transplantation;
x) Open Heart Valve Surgery;
xi) Parkinson's Disease;
xii) Severe Rheumatoid Arthritis;
xiii) Specified Cancer;
xiv) Stroke;
xv) Surgery to Aorta; and
xvi) Terminal Illness.

This benefit will not be applicable to the Medical Services arising from any designated crisis that You or Insured is aware of, or will be reasonably aware of within the first ninety (90) days from the Policy Date. You or the Insured will be reasonably aware of a designated crisis where:

i) the designated crisis has been diagnosed;
ii) the designated crisis has manifested clear and distinct signs or symptoms; or
iii) medical advice or treatment has been sought, recommended or received for the designated crisis.

This benefit is not applicable if You have chosen to remove the Annual Deductible according to clause 5.11 .

5.13 Refund from Other Sources

If You can obtain a refund of any expenses in clause 5 from any other sources, We will only pay for any excess costs of these expenses up to the limit set out in the Policy Schedule or any Endorsement.

You must tell Us if You or the Insured can obtain a refund of all or part of expenses specified in clause 5 from any other sources. The reimbursement from those other sources will count towards the Balance of Annual Deductible (if any and if applicable) provided that required documents including but not limited to the original receipts are submitted to Us. If We have paid a benefit which is recoverable from another source, You must refund this amount to Us.

5.14 Revision of Benefits and Limitations

We can revise, amend or modify this Policy, including the premium, once We notify You in writing at least thirty (30) days before the Policy Anniversary after which the revisions will take effect.

While this Policy is in force, You may request an increase to the benefits by reducing the Annual Deductible and such reduction of Annual Deductible will be effective from the Policy Anniversary after We approve Your request. Such increase of benefits will be subject to re-underwriting such terms and conditions as determined by Us from time to time. We may require You to provide evidence of insurability which is acceptable to Us and any increase of benefits is subject to Our rules and policies.

Any increase in benefits by reducing the Annual Deductible will be adjusted as follows after

considering the latest rules and exclusions which will take effect on the same date with the benefit increase:

i) for any benefit payable under clauses 5.1 to 5.8 (except 5.3.8), if the benefit is payable as a result of Illness, the increased benefit will only be payable for an Illness if the First Symptoms appear, the condition occurs and the diagnosis or surgery related to the relevant Illness occurs after the day when the benefit is increased. If the benefit is payable as a result of an Injury, the increased benefit will only be payable if the Accident occurs from the day when the benefit is increased;

ii) for any benefit payable under clause 5.3.8, the increased benefit will be payable if the date of diagnosis of the covered pregnancy complications occurs after one (1) year from the date when the benefit is increased;

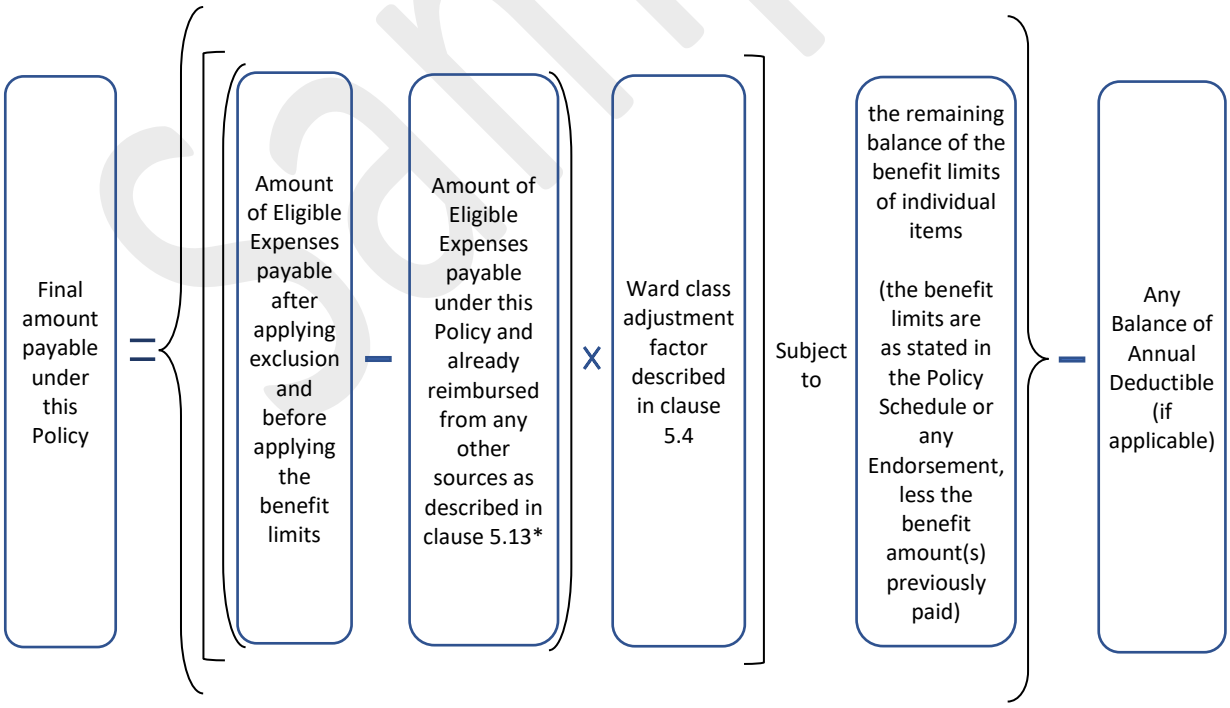
iii) for any benefit payable under clause 5.9, the increased benefit will be payable if the death occurs from the date when the benefit is increased.

We will not pay the additional benefit in respect of any Pre-existing Condition which occurs before the date of the benefit increase.

You will not be subject to re-underwriting for requesting an increase of the Annual Deductible, provided that such increase of Annual Deductible will be effective from the Policy Anniversary after We approve your request. We will reimburse the decreased benefit subject to the increased Annual Deductible from the Policy Anniversary after We approve your request to increase the Annual Deductible.

5.15 Overall Benefit Limit and Benefit Payable

The final amount payable under this Policy for the expenses incurred within Asia or for any Emergency Treatment received outside Asia will be calculated according to the formula below:



* If there are any Eligible Expenses payable under this Policy already reimbursed under any other insurance coverage or as otherwise described in clause 5.13, such amount will be reduced from the Balance of Annual Deductible in the relevant Policy Year, if applicable.

i) Any paid benefits will be counted towards the corresponding benefit limits as stated in the Policy Schedule or any Endorsement.
ii) All benefits payable in accordance with this Policy will be subject to the application of any applicable Balance of Annual Deductible.
iii) The final amount payable under this Policy (i.e. after the application of any applicable Balance of Annual Deductible) will be counted towards the Annual Limit of the relevant Policy Year as specified in the Policy Schedule or any Endorsement.

6 Exclusions

Under this Policy, We will not pay any benefits in relation to or arising from the following expenses:

i) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, riot, strike, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, terrorist act, naval, military or air-force services, any operation or combat duty with any armed force of any country, territory, or organization, nuclear reactions, nuclear radiation, nuclear contamination, biological contamination or chemical contamination;
ii) the willful participation of the Insured in any criminal offence or illegal acts;
iii) AIDS or any complications associated with a HIV infection, unless the First Symptoms appear of a relevant Illness due to AIDS or any complications associated with HIV infection occur two (2) years or more after the Policy Date. HIV Infection refers to an infection where blood or other relevant test(s) indicate, in Our opinion, either the presence of any Human Immunodeficiency Virus, antigens or antibodies to such virus;
iv) Non-Emergency Treatment outside Asia; and
v) Pre-existing Condition(s) or any Eligible Expenses incurred for Pre-existing Condition(s) that You and/or Insured was not aware and would not reasonably have been aware on or before the 30th day of the Policy Date.

7 Suicide

If the Insured commits suicide (whether sane or insane at that time) within thirteen (13) calendar months from the Policy Date, Our liability under this Policy will be limited to the refund of premiums paid (without interest) less any outstanding insurance levy and any benefit which has been paid under this Policy.

8 Claim Provisions

8.1 Notice of Claim

You must inform Us in written as soon as possible, and no later than six (6) months of the Insured's discharge from Hospital, the date of completion of Day Case Procedure, the date the Medical Service is performed and completed, or the date of death of the Insured, for which a claim will be made on this Policy. We have the right to reject any written claims submitted after this six (6) month notice period.

8.2 Proof of Loss

Once We are notified of a potential claim, We will provide the forms needed to apply for a claim. The claim must be lodged using Our standard forms and We must be provided with any information and documents (including original receipts and proof of the Insured's country of residence) that We need to process the claim.

These forms and any supporting evidence must be submitted to Us within ninety (90) days from the date We first requested the proof, or as soon as is reasonably possible, but not exceeding one hundred and eighty (180) days from the date We first requested the proof (unless You are legally incapacitated from doing so).

You are legally responsible for all costs incurred in gathering any necessary documents to support this claim, including death certificates and other evidence. We may also require the Insured to undergo a medical examination, at Our expense, by a Physician of Our choice in Hong Kong.

8.3 Proof of Occurrence

Proof of occurrence of any insured event must be supported by:

i) a Physician;
ii) confirmatory investigations including but not limited to clinical, radiological, histological and laboratory evidence; and
iii) if the Insured event requires a surgical procedure to be performed, the procedure must be the usual treatment for the condition and be Medically Necessary.

We must be satisfied with the proof of the occurrence of any insured event. We reserve the right to require the Insured to undergo an examination or other reasonable tests to confirm the occurrence of an insured event.

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

The Insured will, at Our request and expense, submit to a medical examination by a designated Medical Practitioner in Hong Kong, when and so often as We may reasonably require.

8.4 Payment of Claim

We will pay benefits from this Policy to You or the Beneficiary in accordance with clauses 2.4 and 2.5. Our obligations for that benefit will be fulfilled and discharged once We have paid the benefits.

We will deduct any unpaid premiums owed to Us from any benefits that are payable. No interest will be payable on any benefits payable by this Policy.

8.5 Legal Action

If a claim is false, fraudulent, intentionally exaggerated or if any person has used fraudulent means to attempt to claim a benefit, We will terminate this Policy immediately without refunding the premiums and insurance levy paid. We will also recover any benefit which We paid but which should not have been paid because of this fraud.

Any legal action taken on this Policy cannot be pursued until three (3) months following the date We were given the proof of loss under clause 8.2, and cannot be pursued after three (3) years following that date.

If You do not take legal action to contest Our rejection of a claim within twelve (12) calendar months of being notified of Our rejection, We will consider the claim to be abandoned and it cannot be reinstated.

9 Termination

This Policy will automatically end on the earliest of the following:

i) The Insured dies;
ii) The Expiry Date of this Policy;
iii) You cancel the Policy. We will determine the cancellation date based on Our rules and regulations at that time;
iv) Termination under clauses 2.7 or 8.5 ; or
v) The premium grace period expires as described in clause 3.4 and We have not received the premium payment.

If this Policy is terminated pursuant to this clause, the termination will be effective at 00:00 hours of the effective date of termination.

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

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

Appendix 1 – Day Case Procedure List

We may revise the following list from time to time.

BONES AND JOINTS	Close reduction and fixation of fractures with or without the use of plaster of Paris
	Manipulation of joints under anaesthesia
	Halo-cast fixation for cervical spine fracture/dislocation
BRAIN AND CENTRAL NERVOUS SYSTEM	Lumbar puncture or cisternal puncture
BREAST	Biopsy of breast tissue
EAR	Insertion of grummet
	Operation on the external ear and/or pre-auricular sinuses
ENDOCRINE SYSTEM	Thyroid, various lesions, needle biopsy
EYE	All conjunctival or corneal operations except corneal grafting, severe corneal wound repair and keratoplasty
	All eyelid operations except blepharoplasty and ptosis repair
	Surgical treatment for glaucoma, goniotomy / trabeculotomy
	Removal of corneal foreign body
	Lens operation including cataract removal and prosthetic lens insertion
	Phacoemulsification
	Laser photocoagulation on retina
	Removal of pterygium (one or both sides)
	Incision of chalazion
	Open exploration of nasal lacrimal duct except simple probing
FEMALE GENITAL TRACT	Amputation of cervix, cervicectomy, cone biopsy or cauterisation of cervix
	Suture of cervix
	Hysteroscopy
	Marsupialisation of Bartholin's cyst
	Operation for simple cyst or benign tumour of vulva and vagina, including simple repair and suturing
	Removal or insertion of vaginal pessary
	Various lesions, dilatation and curettage of uterus
GASTRO-INTESTINAL TRACT OPERATION	Upper endoscopy up to the level of duodenum
	Gastroscopy
	Colonoscopy, with or without biopsy or papilloma removal
	Haemorrhoidectomy
	Sigmoidoscopy
	Operation for anal fissure including radical excision
HEAD AND NECK	Lymph node biopsy
	Operation on lip and cheek benign tumour
MALE GENITAL TRACT	Circumcision
	Tapping of hydrocele
	Testicular biopsy
NOSE AND SINUSES	Antral puncture and lavage
	Removal of nasal polyp
	Cauterisation of nasal mucosa
	Rhinoscopy or nasopharyngoscopy including rhinoscopic biopsy and foreign body removal
HEPATO - BILIARY	Liver biopsy

SYSTEM	
SKIN	Lymph node biopsy or drainage of lymph node abscess
	Excision of skin lumps or tumour of subcutaneous tissue, including lipoma, neurofibroma or its variants, sebaceous cysts, malignant melanoma, and naevus etc.
	Incision and drainage of skin abscess
	Cauterisation of skin lesion with electricity or cryosurgery
	Removal of foreign body
	Excision of pilonidal cyst
	Skin grafting or keloid operation: if total area less than or equal 1% of body surface area
	Drainage of subungual haematoma or abscess
	Skin suturing
TENDON, NERVE, VESSEL, MUSCLE AND SOFT TISSUE	Application of complete plaster cast, not for limb resting purpose
	Removal or avulsion of nail
	Excision of ganglion, bursa or villo-nodular synovitis
	Release of trigger finger
	Operation on Dupuytren's Contracture
	Varicose vein sclerotherapy (one (1) or two (2) legs)
THORACIC OPERATIONS	Bronchoscopy
	Oesophagoscopy
	Thoracocentesis or insertion of chest tube for pneumothorax
THROAT	Vocal cord operation including using laser techniques (carcinoma excluded)
	Microlaryngoscopy
	Tracheostomy
	Laryngoscopy with/without foreign body removal
	Tonsillectomy with or without other adenoid tissue removal
URINARY TRACT	Cystoscopy
	Renal biopsy

Appendix 2 – Definition of Designated Crisis

Part 1

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

Activities of Daily Living will 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.

Neurologist refers to a Physician specialising in the diagnosis and treatment of Illnesses or conditions of the brain and other parts of the nervous system.

Part 2

Unless otherwise specified, the following definitions will apply to the terms used in this Policy.

(i). 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.

(ii). 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.

(iii). 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.

(iv). 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.

(v). 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 ($PaO2 \leq 55mmHg$); and
4. Dyspnea at rest.

The diagnoses must be confirmed by a Specialist in pulmonology.

(vi). 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.

(vii). 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.

(viii). 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.

(ix). 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.

(x). 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.

(xi). 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 1 of this Appendix.

The "First-dollar Coverage – Annual Deductible Waived for Designated Crises" is applicable to idiopathic Parkinson's disease only.

(xii). 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, We will 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, We will 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, We will 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 will be such that there will be at least two (2) of the Activities of Daily Living, as defined in Part 1 of this Appendix, which the Insured will, for a continuous period of at least six (6) months, have been unable to perform without the assistance of another person.

(xiii). 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.

(xiv). Stroke

means 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.

(xv). 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.

(xvi). Terminal Illness

The conclusive diagnosis of an Illness that is expected to result in the death of the Insured within twelve (12) months. This diagnosis must be supported by a Specialist and confirmed by a Physician appointed by Us at the Our cost.

Health Assistance Services

1. PREMIER THE ONEcierge One Team Health Management

One Plan One Team One Stop Pan-Asia Health Solution

Everyone would like to be with a reliable partner to focus on their recovery and enjoy life even when facing any health problems. FWD Life Insurance Company (Bermuda) Limited (incorporated in Bermuda with limited liability) (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 a 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 that all aspects of your wellness have been taken care of.

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.

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 <note 4>, the team of specialists will arrange for you to be admitted to hospital and receive treatment promptly. Besides, the Service will provide you with personalized travel-related assistance <note 5> in flights, accommodation, ground transfers and visa application.

Efficient and Seamless Claims Resolution and Cashless Facility <note 6>

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 (if applicable) and pay the hospitalization fees and charges on your behalf, subject to respective benefit limits (if applicable). 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 7>:
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 the Company's Service Hotline at (852) 3123 3123.

Remarks:

- Any medical advice, opinion or services are provided by doctors of HealthMutual Group Limited ("HMG"), its healthcare team and Parkway, who are all external third-party service providers. They are independent contractors and are not employees or representatives of the Company. For any specific questions on medical matters or situations, please consult your doctor or other healthcare professionals. The Company shall not be responsible for any act, negligence or omission of medical advice, opinion, service or treatment on the part of them.
- You are required to consent to the Company, HMG, its healthcare network team and Parkway, recording, sharing, using and archiving your personal data in pursuance of the Service being offered to you as well as for their training and quality assurance purposes. 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 provided by external third party providers. It does not form a part of the policy or benefit item under the policy provisions and only applicable to the designated insurance plan. The Company reserves the right to suspend, terminate or vary the Service in its sole discretion without further notice. The Company is not the supplier of the Service and shall have no obligation or 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 the Company's Service Hotline at (852) 31233123 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 which are not employees and/or agents of the Company and this service offers inpatient medical advice for the Insured of the designated insurance plan. The Company shall not be responsible or liable to the Policy Owner or the Insured for anything in relation to such service given by HMG and its healthcare network team. Should the Insured be diagnosed with serious diseases and obtain a hospital admission letter, HMG will make an assessment based on the Insured'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. Please note that Inpatient Medical Advice shall not be considered as medical consultation. If the Insured would like to have medical consultation, all relevant costs will be borne by the Insured. The Company reserves the right to terminate or vary this service in its sole discretion without further notice.

4. The list of doctors of the Service may be revised from time to time without prior notice.

5. The Insured 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.

6. Cashless Facility ("Cashless Facility") is an administrative arrangement to pay the covered expenditures when the Insured is under confinement, but not a benefit item under policy provisions of the designated insurance plans 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 after successful arrangement of Cashless Facility. If there is deductible balance (if any) of the designated insurance plan, Policy Owners are required to pay such balance when admitted to the hospital. If the medical cost paid by the Company is higher than the maximum amount of benefit, the Company would seek reimbursement from Policy Owners for such amount.

7. This hotline is operated by HMG. Please note that this hotline is for non-emergency reservation of doctor consultation instead of for emergencies.

This benefit/service does not form part of the policy provisions of the MyMillion Medical Plan.

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 claim is approved and such claim is relevant to designated diseases. For the list of designated diseases, please call the International SOS at (852) 3122 2900 for details.

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 diseases. This is why the Company offers the Second Medical Opinion Service to our valuable Insured (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 designated disease made by your attending physician, plus any other relevant medical advice.

Panel of Second Medical Opinion 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 designated 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.

This benefit/service does not form part of the policy provisions of the MyMillion Medical Plan.

3. International SOS 24-hour Worldwide Assistance Services

General Benefits and Terms

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

The International SOS 24-hour 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/her 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.

This benefit/service does not form part of the policy provisions of the MyMillion Medical Plan.