團 體 醫 療 保 險 保 單
GROUP MEDICAL INSURANCE POLICY

日期 Date	：	18 April, 2023
投保單位 Policyholder	：	中國科學院香港創新研究院有限公司
地 址 Address		5/F BUILDING 15W, 15 SCIENCE PARK WEST AVENUE, HK SCIENCE PARK, SHATIN, NT
保單編號 Policy No.	：	MD230336804
保單起保日 Policy Effective Date	：	15 April, 2023
保單滿期日 Policy Expiry Date	：	14 April, 2024
保 費 Premium	：	

*此保費並未包括由保險業監管局(「保監局」)徵收的保費徵費。
This premium does not include premium levy which is collected by the Insurance Authority ("IA").
(應付總額請參考付帳通知單。Please refer to the Debit Note for the Total Payable.)

中銀集團保險有限公司(以下簡稱「本保險公司」)茲根據投保單位的要保書簽發本保單，其承保責任範圍均按要保書、保單正文、保單規章、承保表、附加條款、團體受保人名單及批單批文辦理。
Bank of China Group Insurance Company Limited (hereinafter called "the Company") hereby agrees, in accordance with and subject to the terms, provisions and exclusions of this Policy, to pay the Benefits as provided by this Policy to the person or persons entitled thereto. The terms, provisions and exclusions, underwriting table, rider, group names list, and endorsements on the subsequent pages hereof form a part of this Policy.

For and on behalf of
Bank of China Group Insurance Co. Ltd.

_____
Authorized Signature

Examiner:

本保單英文譯本只供參考之用，如與中文原文有歧異，概以中文本為準。(第二部份-保單規章 第十二章-制裁限制條款以英文本為準)
The English version of this Policy is for reference purpose only. In the event of any inconsistency between the Chinese version and the English version, the Chinese version shall prevail. (The English version of PART II – POLICY CONDITIONS Section 12-Sanction Limitation Clause is prevail)

承 保 表
Benefit Schedule

一、住 院 醫 療 保 險 HOSPITALIZATION BENEFIT

	計劃一Plan 1 (港幣HKD)	計劃二Plan 2 (港幣HKD)	計劃三Plan 3 (港幣HKD)
(1) 每日住院膳宿費 Daily Room & Board Fees	450	600	1,000
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	182天 Days	182天 Days	182天 Days
(2) 醫院服務費 Hospital Services Charges			
每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	6,000	10,000	14,000
(3) 每日醫生巡房費 Daily Doctor's Visit Fees	450	600	1,000
每年每一傷病最高賠償天數 Maximum Days per Disability Per Year	182天 Days	182天 Days	182天 Days
(4) 專科醫生診療費 Specialist Fees			
每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	2,500	3,500	5,500
(5) 外科手術費 Surgeon's Fee			
每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year			
複雜手術 Complex	45,000	57,000	69,000
大型手術 Major	15,750	20,050	25,000
中型手術 Intermediate	8,000	10,020	12,070
小型手術 Minor	3,200	3,990	4,830
(6) 麻醉師費 Anaesthetist Fees			
每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year			
複雜手術 Complex	13,500	17,100	20,700
大型手術 Major	5,000	6,200	7,500
中型手術 Intermediate	2,500	3,200	3,800
小型手術 Minor	1,200	1,500	1,800
(7) 手術室費 Operation Theatre Fees			
每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year			
複雜手術 Complex	13,500	17,100	20,700
大型手術 Major	5,000	6,200	7,500
中型手術 Intermediate	2,500	3,200	3,800
小型手術 Minor	1,200	1,500	1,800
(8) 每日深切治療費 Daily Intensive Care	900	1,200	2,000
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	20天 Days	20天 Days	20天 Days

承 保 表
Benefit Schedule

	計劃一Plan 1 (港幣HKD)	計劃二Plan 2 (港幣HKD)	計劃三Plan 3 (港幣HKD)
(9) 每日政府醫院住院現金津貼 Daily Public Hospital In-patient Cash Allowance	200	300	500
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	60天 Days	60天 Days	60天 Days
(10) 每日私家護士護理費 In-hospital Private Nursing	200	300	500
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	60天 Days	60天 Days	60天 Days
(11) 雙重保險住院現金 Hospital Income for Double Benefit	225	300	500
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	30天 Days	30天 Days	30天 Days
(12) 三重保險現金保障 Cash Benefit for Triple Insurance	315	420	700
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	30天 Days	30天 Days	30天 Days
(13) 指定門診手術現金津貼 Designated Clinical Surgery Cash Allowance			
每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	225	300	500

如受保人在海外(中國大陸及澳門除外)因意外受傷入住醫院，則基本住院保障獲自動提升百份之一百。
For hospitalization overseas (except Mainland China and Macau) due to accidental cause, basic hospitalization benefit would be increased by 100% automatically.

承 保 表
Benefit Schedule

		計劃四Plan 4 (港幣HKD)	計劃五Plan 5 (港幣HKD)	計劃五/M Plan 5/M (港幣HKD)
(1)	每日住院膳宿費 Daily Room & Board Fees	1,500	2,500	2,500
	每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	182天 Days	182天 Days	182天 Days
(2)	醫院服務費 Hospital Services Charges			
	每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	20,000	30,000	30,000
(3)	每日醫生巡房費 Daily Doctor's Visit Fees	1,500	2,500	2,500
	每年每一傷病最高賠償天數 Maximum Days per Disability Per Year	182天 Days	182天 Days	182天 Days
(4)	專科醫生診療費 Specialist Fees			
	每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	7,500	11,000	11,000
(5)	外科手術費 Surgeon's Fee			
	每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year			
	複雜手術 Complex	87,000	108,000	108,000
	大型手術 Major	30,450	37,800	37,800
	中型手術 Intermediate	15,220	18,900	18,900
	小型手術 Minor	6,090	7,560	7,560
(6)	麻醉師費 Anaesthetist Fees			
	每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year			
	複雜手術 Complex	26,100	32,400	32,400
	大型手術 Major	10,000	13,000	13,000
	中型手術 Intermediate	4,800	6,000	6,000
	小型手術 Minor	2,200	2,500	2,500
(7)	手術室費 Operation Theatre Fees			
	每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year			
	複雜手術 Complex	26,100	32,400	32,400
	大型手術 Major	10,000	13,000	13,000
	中型手術 Intermediate	4,800	6,000	6,000
	小型手術 Minor	2,200	2,500	2,500
(8)	每日深切治療費 Daily Intensive Care	3,000	5,000	5,000
	每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	20天 Days	20天 Days	20天 Days

承 保 表
Benefit Schedule

	計劃四Plan 4 (港幣HKD)	計劃五Plan 5 (港幣HKD)	計劃五/M Plan 5/M (港幣HKD)
(9) 每日政府醫院住院現金津貼 Daily Public Hospital In-patient Cash Allowance	750	1,000	1,000
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	60天 Days	60天 Days	60天 Days
(10) 每日私家護士護理費 In-hospital Private Nursing	600	700	700
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	60天 Days	60天 Days	60天 Days
(11) 雙重保險住院現金 Hospital Income for Double Benefit	750	1,250	1,250
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	30天 Days	30天 Days	30天 Days
(12) 三重保險現金保障 Cash Benefit for Triple Insurance	1,050	1,750	1,750
每年每一傷病最高賠償天數 Maximum Days Per Disability Per Year	30天 Days	30天 Days	30天 Days
(13) 指定門診手術現金津貼 Designated Clinical Surgery Cash Allowance			
每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	750	1,250	1,250

如受保人在海外(中國大陸及澳門除外)因意外受傷入住醫院，則基本住院保障獲自動提升百份之一百。
For hospitalization overseas (except Mainland China and Macau) due to accidental cause, basic hospitalization benefit would be increased by 100% automatically.

承 保 表
Benefit Schedule

二、 重 病 住 院 醫 療 保 險 SUPPLEMENTARY MAJOR MEDICAL BENEFIT

		計劃一Plan 1 (港幣HKD)	計劃二Plan 2 (港幣HKD)	計劃三Plan 3 (港幣HKD)
(1)	每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	50,000	60,000	70,000
	自付額 Deductible	1,000	1,000	1,000
	賠償率 Reimbursement Percentage〔私家病房 Private〕	25%	25%	50%
	〔半私家病房 Semi-Private〕	50%	50%	100%
	〔普通病房 Ward〕	100%	100%	100%

		計劃四Plan 4 (港幣HKD)	計劃五Plan 5 (港幣HKD)	計劃五/M Plan 5/M (港幣HKD)
(1)	每年每一傷病最高賠償限額 Maximum Limit Per Disability Per Year	85,000	100,000	100,000
	自付額 Deductible	1,000	1,000	1,000
	賠償率 Reimbursement Percentage〔私家病房 Private〕	50%	100%	100%
	〔半私家病房 Semi-Private〕	100%	100%	100%
	〔普通病房 Ward〕	100%	100%	100%

承 保 表
Benefit Schedule

三、 門 診 醫 療 保 險 OUT-PATIENT BENEFIT

		計劃一Plan 1 (港幣HKD)	計劃二Plan 2 (港幣HKD)	計劃三Plan 3 (港幣HKD)
(1)	註冊西醫診療費 General Practitioner Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	120	150	180
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	95	65	35
(2)	疫苗注射 Vaccination			
	每次最高賠償金額 Maximum Limit Per Visit	120	150	180
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	1次 Once	1次 Once	1次 Once

上述(1)至(2)項每年合共最高賠償50次。 For benefit items (1) to (2), the maximum annual visits for these items is 50 visits.

(3)	專科醫生診療費 Specialist Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	240	300	360
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	220	160	100
(4)	精神科相關治療/心理醫生診療費 Psychiatric-related treatment/Psychological Counselling			
	每次最高賠償金額 Maximum Limit Per Visit	240	300	360
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	10次 Times	10次 Times	10次 Times

上述(3)至(4)項每年合共最高賠償50次。For benefit items (3) to (4), the maximum annual visits for these items is 50 visits

(5)	中醫師 / 跌打醫師 / 針灸醫師診療費 Chinese Herbalist / Bonesetter / Acupuncturist Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	120	150	180
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	130	100	70

承 保 表
Benefit Schedule

		計劃一Plan 1 (港幣HKD)	計劃二Plan 2 (港幣HKD)	計劃三Plan 3 (港幣HKD)
(6)	物理治療/脊骨神經科醫生診療費 Physiotherapist/Chiropractor Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	240	300	360
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	70	10	0

上述(1)至(6)項每年合共最高賠償50次。 For benefit items (1) to (6), the maximum annual visits for these items is 50 visits.

(7)	X光及化驗費 Out-Patient X-Ray and Diagnostic Laboratory Test			
	每年最高賠償金額 Maximum Limit Per Year	1,200	1,500	1,800
	賠償百份率 Reimbursement Percentage	100%	100%	100%
(8)	註冊牙科醫生診療費 Dental Treatment			
	每年最高賠償金額 Maximum Limit Per Year	1,000	2,000	3,000
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	項目包括：牙科 X 光檢查、藥物治療、脫牙、補牙、膿瘡排放、補留牙峰的牙冠釘、齒根管治療、洗牙/口腔檢查及牙冠及假牙(只適用於因意外導致)。 (Includes: X-Ray, Medication, Extraction, Fillings, Drainage of abscess, Pins for Cusp Restoration, Root Canal Treatment and Scaling & Oral Examination but excluding Crown & Denture except caused by accident).			
(9)	身體健康檢查費 Annual Body Checkup			
	每年最高賠償金額 Maximum Limit Per Year	6,000	6,000	6,000
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	1次 Once	1次 Once	1次 Once

承 保 表
Benefit Schedule

		計劃四Plan 4 (港幣HKD)	計劃五Plan 5 (港幣HKD)	計劃五/M Plan 5/M (港幣HKD)
(1)	註冊西醫診療費 General Practitioner Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	300	400	400
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	0	0	0
(2)	疫苗注射 Vaccination			
	每次最高賠償金額 Maximum Limit Per Visit	300	400	400
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	1次 Once	1次 Once	1次 Once

上述(1)至(2)項每年合共最高賠償50次。 For benefit items (1) to (2), the maximum annual visits for these items is 50 visits.

(3)	專科醫生診療費 Specialist Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	550	750	750
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	0	0	0
(4)	精神科相關治療/心理醫生診療費 Psychiatric-related treatment/Psychological Counselling			
	每次最高賠償金額 Maximum Limit Per Visit	550	750	750
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	10次 Times	10次 Times	10次 Times

上述(3)至(4)項每年合共最高賠償50次。 For benefit items (3) to (4), the maximum annual visits for these items is 50 visits.

(5)	中醫師 / 跌打醫師 / 針灸醫師診療費 Chinese Herbalist / Bonesetter / Acupuncturist Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	300	400	400
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	0	0	0

承 保 表
Benefit Schedule

		計劃四Plan 4 (港幣HKD)	計劃五Plan 5 (港幣HKD)	計劃五/M Plan 5/M (港幣HKD)
(6)	物理治療/脊骨神經科醫生診療費 Physiotherapist/Chiropractor Consultation			
	每次最高賠償金額 Maximum Limit Per Visit	550	750	750
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	50次 Times	50次 Times	50次 Times
	每次醫療網絡應診自付額 Co-Payment	0	0	0

上述(1)至(6)項每年合共最高賠償50次。 For benefit items (1) to (6), the maximum annual visits for these items is 50 visits.

(7)	X光及化驗費 Out-Patient X-Ray and Diagnostic Laboratory Test			
	每年最高賠償金額 Maximum Limit Per Year	2,600	3,600	3,600
	賠償百份率 Reimbursement Percentage	100%	100%	100%
(8)	註冊牙科醫生診療費 Dental Treatment			
	每年最高賠償金額 Maximum Limit Per Year	4,000	5,000	5,000
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	項目包括：牙科 X 光檢查、藥物治療、脫牙、補牙、膿瘡排放、補留牙峰的牙冠釘、齒根管治療、洗牙/口腔檢查及牙冠及假牙(只適用於因意外導致)。 (Includes: X-Ray, Medication, Extraction, Fillings, Drainage of abscess, Pins for Cusp Restoration, Root Canal Treatment and Scaling & Oral Examination but excluding Crown & Denture except caused by accident).			
(9)	身體健康檢查費 Annual Body Checkup			
	每年最高賠償金額 Maximum Limit Per Year	6,000	6,000	6,000
	賠償百份率 Reimbursement Percentage	100%	100%	100%
	每年最高賠償次數 Maximum No. of Visits Per Year	1次 Once	1次 Once	1次 Once

承 保 表
Benefit Schedule

四、 女性住院分娩醫療保險 MATERNITY BENEFIT

	計劃四Plan 4 (港幣HKD)	計劃五Plan 5 (港幣HKD)	計劃五/M Plan 5/M (港幣HKD)
(1) 自然分娩 Normal Delivery Per Pregnancy	--	--	50,000
流產 Miscarriage Per Pregnancy	--	--	50,000
剖腹分娩 Caesarean Section Per Pregnancy	--	--	30,000

第一部份　定 義

1.　本保單
意指投保單位簽署的要保書、受保單位任何員工所申報的資料、保單正文、規章條款、承保表、附加條款、團體受保人名單及所有連同本保單簽發的附件、批單批文。

2.　本計劃
意指本保單所提供之保險計劃，各受保人之保險內容詳列於承保表、團體受保人名單及各利益保障條款中。

3.　保單年度
意指由本保單中明列之保單起保日至保單滿期日。

4.　受保人
意指在投保單位內任職的正式員工及其家屬或任何經本保險公司發出的批單中確認受保的員工及其家屬，該等員工或家屬乃根據本保單規章第一條規定參加本保險計劃。

5.　家屬
意指受保員工的合法配偶，其年齡必須在七十歲或以下；及受保員工的子女，其年齡由出生日起至二十五歲止。

6.　醫院
意指於其經營地區提供醫院服務之合法註冊醫院；但不包括復康院、療養院、戒毒所及養老院。若該醫院經營地方為中國境內，則指縣級或以上並以西醫診治為依歸的醫院，但不包括中醫院。

7.　深切治療
意指須入住醫院轄下深切治療部病房接受之治療。

8.　麻醉師
意指完成麻醉科課程及獲頒認可麻醉科醫生資格證書，並於其執業地區獲當地政府核准合法執業之麻醉科醫生，唯麻醉科醫生為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。

9.　私家護士
意指完成專業護理課程及獲頒認可資格證書，並於其執業地區獲當地政府核准合法執業之護士，唯執業之護士為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。

10.　註冊西醫
意指獲頒西醫醫學位並於其行醫地區獲當地政府核准合法執業之醫生，唯執業之醫生為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。

11.　專科醫生
意指完成西醫專科課程及獲頒認可專科醫生資格證書，並於其行醫地區獲當地政府核准以其專科資格合法執業之專科醫生，唯執業之專科醫生為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。

12.　中醫師、跌打醫師、針灸醫師
意指於其行醫地區領有合法執業登記之中醫師、跌打醫師、針灸醫師（如在香港特別行政區執業意指已被列入香港中醫藥管理委員會中醫組備存的表列中醫名單內或經註冊可作中醫執業之中醫師、跌打醫師、針灸醫師），唯執業登記之中醫師、跌打醫師、針灸醫師為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。其簽發之收據，需列明主診醫師姓名及其註冊或表列編號、醫館名稱、醫館地址及電話。

13.　註冊牙科醫生
意指獲頒牙科醫學學位並於其行醫地區獲當地政府核准合法執業之牙科醫生，唯執業之牙科醫生為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。

14.　物理治療師
意指獲頒物理治療師並於其行醫地區獲當地政府核准合法執業之物理治療師，唯執業之物理治療師為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。

15.　脊骨神經科醫生
意指獲頒脊骨神經科醫生學位並於其行醫地區獲當地政府核准合法執業之脊骨神經科醫生，唯執業之脊骨神經科醫生為受保人本人、保險經紀及代理、商業伙伴、受保人之僱主或僱員，及受保人的親屬除外。

16.　每年每一傷病
意指在同一保單年度內之同一傷患或疾病又或因同一意外事故引致的身體受傷及上述傷病引起之併發症。在同一保單年度內，倘因上述傷病及其引致之併發症須接受治療一次以上，而每次治療時間相隔在九十天以內者，應視為一次傷病處理，一切保險給付的金額計算將依照承保表規定辦理。

17.　意外事故
意指因身體遭受外來因素作用，致成突然的、直接的、可見的、非受保人意願的傷害事故。

18.　合理及慣常費用
意指其醫療服務費不能超過具有同等經驗及專業資格之人士在同一地區所提供之服務；或在同一地區所提供之物料、器材或服務而其質量在相若之經濟考慮情況下所收取之合理平均數。

19.　自付費
意指受保人接受醫療網絡服務後，必須自行承擔的固定費用或醫療服務費用的百份比。

20.　海外
意指非香港特別行政區之地區。

21.　必要的醫療
意指有關的治療：
(1)　須符合病情的診斷及慣常治療；
(2)　須符合良好和謹慎的行醫標準；
(3)　並非為方便投保人、受保人、或安排治療的醫生；
(4)　須在治療受保傷病所需最低收費的環境下進行。

第二部份　保 單 規 章

第一章 受保人加入/轉換投保計劃/退出本計劃的規定

1.　本保單生效日前，投保單位提供之受保人名單，均可於本保單生效日起參加本保險計劃。
2.　所有新增正式員工加入本計劃，須由投保單位於該員工受聘日起計三十一日內填具批改申請書送交本保險公司，經本保險公司同意後加簽批單始行生效。
3.　任何新增正式員工於獲得資格參加本計劃時，必須在從事正常工作。如該員工因疾病、休假或其他事故於該日未能正常工作者，其參加本計劃日期應於該員工恢復全日正常工作日開始。
4.　符合參加本計劃資格的受保人，應於獲得參加資格日起三十一日內參加計劃，並填具批改申請書送交本保險公司，

否則日後必須自費提出可保性之證明，並經本保險公司同意後，始得參加。

5. 所有員工轉換投保計劃，須由投保單位於該員工轉換投保計劃日起計三十一日內填具批改申請書送交本保險公司，經本保險公司同意後加簽批單始行生效。
6. 所有正式員工退出本計劃，須由投保單位於該員工離職日起計三十一日內填具批改申請書送交本保險公司，經本保險公司同意後加簽批單始行生效。

第二章 保單生效及保費

1. 投保單位繳交保費後，本保單方為有效。
2. 任何受保人加入或退出本計劃，即自加入或退出本計劃起增收或退還部分保費，其保費均按日子比例計算，全部批改保費待每一保單年度末一併結算及清妥。
3. 任何受保人加入本計劃，所有以每年限制之保障即自加入日期起按日子比例計算。
4. 本保險公司在每一個保單年度終結時，保留調整保險費率及承保的權利。

第三章 續保

本保險公司給予投保單位由保單滿期日起一個月（不超過三十一天）的續保通知。如投保單位超過續保通知限期仍未遞交續保通知書，本保單即行失效。

第四章 資料

1. 投保單位必須搜集各受保人的資料，包括中、英文姓名、出生日期、性別、參與的保險計劃、保險生效日及其他與本保險有關的資料給予本保險公司；本保險公司將根據該資料簽發本保單。
2. 投保單位提供的文件繕打錯漏如不影響本保險公司的承保責任範圍者，則不會影響利益給付，任何文書錯漏都應在發現時立即以書面通知本保險公司更正。
3. 如因投保單位提供的受保人資料有誤而影響本保險公司的承保決定，得盡快聲明更正，在更正前該受保人所發生每一傷病，本保險公司不予負責。
4. 如因投保單位提供的受保人資料有誤而影響受保人的利益給付，得盡快聲明更正，在更正前該受保人所發生每一傷病，本保險公司只能按更正前的資料處理。

第五章 保單更改

如投保單位欲更改本保單內容，須書面填具批改申請書，經本保險公司同意及加簽批單，方能生效。本保單內所訂規章條款，非經本保險公司加簽批單同意，不得更改或增刪。

第六章 終止受保人保險效力

在下列任何一種情況下，受保人的保險即行終止：

1. 受保人於本保單起保日之前已為投保單位的正式員工，並於本保單起保日開始已參加本計劃，其年齡在保單年度內超過 70 歲，該受保人的保險在保單年度末正式終止。
2. 受保人於本保單起保日後根據保單規章第一章第 2 點規定參加本保險計劃，其年齡在保單年度內超過 70 歲，該受保人及其家屬之保險在保單年度末正式終止。
3. 正式員工的受保配偶及子女，其年齡在保單年度內已達到本保單所規定的歲數限制，其保險在保單年度末正式終止。
4. 保單到達保單滿期日或保單已被終止。
5. 投保單位書面通知取消受保人的保險效力。
6. 投保單位與受保人(意指正式員工)終止僱傭合約或受保員工終止替投保單位服務。
7. 受保人加入任何國家或地區之陸、海、空軍服役。

第七章 保單終止

在每一保單年度末，投保單位或本保險公司均有權終止本合約。

第八章 幣制

本保單的賠償幣制按港幣結算。外幣兌換價按處理賠償手續當天本保險公司參考銀行所定的兌換率折算港幣賠付。

第九章 訴訟

本保險公司有權在收到投保單位或受保人索賠申請書後九十天內進行調查，決定是否在本保單承保責任範圍內，在此期間，投保單位不得採取任何訴訟行為。如本保險公司依保單規章或條款決定拒賠，投保單位須在拒賠後一年內提出訴訟。

第十章 合約(第三者權利)條例

任何不是本保單某一方的人士或實體，不能根據《合約(第三者權利)條例》(香港法例第 623 章)強制執行本保單的任何條款。

第十一章 收集個人資料聲明

您提供的資料，為中銀集團保險有限公司("本公司")提供保險業務所需，並可能使用於下列目的:

(i) 處理及審批您的保險申請或您將來提交的保險申請；
(ii) 執行您保單的行政工作及提供與您保單相關的服務；
(iii) 分析或調查、處理及支付您保單有關的索償；
(iv) 發出繳交保費通知及向您收取保費及欠款；
(v) 任何與保險有關的產品或服務的任何更改、變更、取消或續期；
(vi) 就以上用途聯絡您；
(vii) 本公司行使任何代位權；
(viii) 其它與上述用途有直接關係的附帶用途；及
(ix) 遵循適用法律，條列及業內守則及指引。

本公司亦可因應上述用途將您的個人資料移轉予下列各方：

(a) 就上述用途，向本公司提供行政、通訊、電腦、付款、保安及其它服務的第三方代理、承包商及顧問（包括：醫療服務供應商、緊急救援服務供應商、電話促銷商、郵寄及印刷服務商、資訊科技服務供應商及數據處理服務商）；
(b) 處理索賠個案的理賠師、理賠調查員及醫療顧問；
(c) 追討欠款的收數公司或索償代理；
(d) 保險資料服務公司及信貸資料服務公司；
(e) 再保公司及再保經紀；
(f) 您的保險經紀（若有）；
(g) 本公司的法律及專業業務顧問；
(h) 本公司的關連公司(以《公司條例》內的定義為準)；
(i) 現存或不時成立的任何保險公司協會或聯會或類同組織(「聯會」)及其會員，以達到任何上述或有關目的，或以便「聯會」執行其監管職能，或其他基於保險業或任何「聯會」會員的利益而不時在合理要求下賦予「聯會」的職能；
(j) 透過「聯會」移轉予任何「聯會」的會員，以達到任何上述或有關目的；
(k) 任何有關的公司，或任何其他從事與保險或再保險業務有關的公司，或與保險業務有關的中介人或索償或調查或其他服務提供者，以達到任何上述或有關目的；
(l) 保險索償投訴局及同類的保險業機構；及
(m) 法例要求或許可的政府機關。

您在此授權本公司可向「聯會」從保險業內收集的資料中查閱及/或核對您任何資料。

此外，經您同意，本公司可能會以其它方式使用及披露您的個人資料。

您有權查閱及要求更正由本公司持有有關您的個人資料。如有需要，可向本公司法律與合規部提出 (電話：2867 0888，傳真：3906 9939)。

第十二章 制裁限制條款

根據聯合國決議或歐盟、英國、美國的貿易或經濟制裁、法律及規定，如果（再）保險人承保、支付賠款或向被保險人提供其它任何利益的行為，將會導致（再）保險人受到任何制裁、禁令或

限制的，則在上述保險範圍內（再）保險人將不予承諾。

第十三章 適用法律

本保單須受香港特別行政區之司法管轄權約束，並根據香港特別行政區之法律解釋。

第三部份 利 益 保 障 條 款

除非另外註明，保單下列所有之保障內容並未受地域限制。

第一章 住院醫療保險

1. 利益保障

受保人的住院醫療保險金額及保險計劃詳列於本保單之承保表及受保人名單表內。任何受保人加入本計劃後，在保單年度內，倘因疾病或意外受傷，經主診註冊西醫證明，須入住醫院接受必要的醫療治療，本保險公司將按下列規定給予賠償受保人在醫院接受治療所產生的費用:

1.1 每日住院膳宿費

受保人於住院期間內，每日病房及相關房租與基本膳食費用，賠償額以實際開支為準，但不能超過承保表中規定每天最高賠償額及最高賠償天數。

1.2 每日醫生巡房費

受保人於住院期間內,接受主診註冊西醫每日巡房診查之費用。若保險計劃未有投保入院前診治及出院後覆診費之保障,每日醫生巡房費將延伸保障一次入院前診症費及出院後八星期內所有與住院治療有關之門診費用。此延伸保障同樣適用於受保人在註冊西醫書面證明下,在其醫務所或醫院門診部內所接受手術的一次手術前診症費及手術後八星期內所有手術治療有關之門診費用。本保險公司按其主診註冊西醫診查所收取之實際費用賠償,但不能超過承保表中規定每天最高賠償額及最高賠償天數。

1.3 每日私家護士護理費

倘主診註冊西醫認為受保人在住院期間需接受私家護士特別護理，本保險公司按其私家護士所收取之實際護理費用賠償，但不能超過承保表中規定每天最高賠償額及最高賠償天數。唯私家護士必須由主診註冊西醫書面轉介。

1.4 醫院服務費

受保人住院期間，本保險公司按醫院收取之雜項服務費用賠償。醫院服務費包括院內醫藥費、敷料、普通外科夾板及石膏整形、化驗室檢驗、心電圖及電腦掃描、基礎代謝率檢查、物理治療、麻醉藥、氧氣及其處理、X光、靜脈輸注、血液或血漿之服務費用（但不包括血液或血漿之費用）、救護車費用（但不能超過每日住院膳宿費）、手術用品(包括但不限於人造器官、晶體、心臟起搏器、心臟支架等)、於門診作先進類型之造影或專科 X 光檢驗，例如鋇餐造影、腎盂造影等先進影像包括但不限於電腦素描、磁力素描、正離子核磁素描、涉及放射性物質的化驗及於門診進行之電療、化療、腎透析治療等費用。醫院服務費的賠付總額以不超過承保表之規定為限。

若保險計劃未有投保手術室費、麻醉師費，該兩項費用，均作醫院服務費賠償，唯每項賠償不能超過外科手術分類表或外科手術保障項目表內指定的支付百份率中外科手術費賠償額的百份之三十。

1.5 外科手術費

倘受保人於住院期間需接受外科手術，或受保人在註冊西醫書面證明下，在其醫務所或醫院門診部內所接受手術、麻醉注射、及藥物等治療，本保險公司將給付外科手術費，其保險給付按其外科醫生所收取之實際手術費用及本保單所附的『外科手術項目表』(見附表)規定該項手術之分類計算，但以不超過承保表所規定該項手術分類的最高賠償限額為限。

如在每一傷病需接受超過一項以上手術項目，所有手術項目的總賠償額將只根據所接受的各項手術項目當中在『外科手術項目表』內規定賠償額分類最高的該項手術項目計算，而總賠付金額不能超過外科醫生所收取之實際的手術費用或承保表所規定該項分類最高的手術所獲的最高賠償限額為限，兩者以較低數額者為準。

1.6 手術室費

倘受保人於住院期間需接受外科手術，本保險公司按其租用手術室所收取之實際費用及本保單所附的『外科手術項目表』內規定該項手術之分類計算，並以不超過承保表所規定該項手術分類的最高賠償限額為限，兩者以較低數額者為準。

1.7 麻醉師費

倘受保人於住院期間接受外科手術及需接受麻醉師服務，本保險公司按麻醉師所收取之實際費用及本保單所附的『外科手術項目表』內規定該項手術之分類計算，並以不超過承保表所規定該項手術分類的最高賠償限額為限，兩者以較低數額者為準。

1.8 專科醫生診療費

倘受保人於住院期間需接受認可專科醫生診查，本保險公司按其認可專科醫生診查所收取之實際費用賠償，並以不超過承保表之規定為限。唯專科醫生必須由主診註冊西醫書面轉介。

1.9 每日深切治療費

倘受保人於住院期間需在醫院轄下的深切治療部接受特別治療，本保險公司按其實際治療費用賠償，但不能超過承保表中規定每天最高賠償額及最高賠償天數。唯必須由主診註冊西醫書面轉介。

1.10 意外受傷額外賠償

倘受保人因意外事故引致受傷入住醫院接受治療，而上列各項住院項目最高賠償金額不足以支付其實際各項醫療費用，本保險公司按其不足之數，作出額外賠償，並以不超過承保表之規定為限。

1.11 每日政府醫院住院現金津貼

倘受保人因疾病或意外受傷，經主診註冊西醫證明，入住香港政府醫院、醫院管理局或政府津貼的公益團體醫院之公眾病房接受治療，而其每天住院所收取之實際費用合共不超過港幣一百二十元（不包括入院登記費及因手術所需額外收取的醫療用品費用）。本保險公司將根據承保表內訂明之每天入住政府醫院現金津貼金額之規定，按實際住院天數計算賠償金額，但不能超過承保表中規定的最高賠償天數。

1.12 政府醫院手術醫療用品賠償

倘受保人因疾病或意外受傷，經主診註冊西醫證明，入住香港政府醫院、醫院管理局或政府津貼的公益團體醫院之公眾病房接受治療，而其每天住院所收取之實際費用合共不超過港幣一百二十元（不包括入院登記費及因手術所需而額外收取的醫療用品費用），並在住院期間需接受外科手術，本保險公司將按醫院實際額外收取的手術醫療用品費用賠償，並以不超過承保表之規定為限。

1.13 入院前診治及出院後覆診費

倘受保人因受保疾病或意外受傷，經主診註冊西醫證明，須入住醫院接受必要的醫療治療，其入院前的一次註冊西醫的診治費用，及經住院接受治療並離開醫院後的三個月內，因應住院主診註冊西醫建議需前往該主診註冊西醫醫務所、或主診註冊西醫轉介至其他必要的醫療治療或相關政府醫院屬下門診接受相關傷病的跟進診查、X光及治療的

費用。本保險公司按主診註冊西醫所收取之實際費用賠償，並以不超過承保表之規定為限。

1.14 意外緊急門診費

倘受保人因意外事故，在意外發生後二十四小時內需要接受註冊西醫緊急治療，本保險公司按其所收取之實際治療費用賠償，並以不超過承保表之規定為限。

1.15 意外身故額外賠償

倘受保人因意外事故入住醫院接受治療，並在住院期間不幸身故，本保險公司除給付上列各項有關醫療費用賠償外，本保險公司額外賠償承保表規定之金額給予法定之受益人。

1.16 放射性治療費

倘受保人於住院期間接受放射性治療，本保險公司按其放射性治療所收取之實際費用賠償，並以不超過承保表之規定為限。

1.17 家居康復護理費

倘受保人因疾病或意外受傷入住醫院接受治療，並連續七十二小時或以上，經主診註冊西醫確認可出院並且在家中或由保險公司認可之康復機構繼續接受有關傷病的康復護理服務，本保險公司會按其所產生在醫療上的合理及慣常費用賠償，但賠付總額以不超過承保表之規定為限。倘受保人未能獲得主診註冊西醫書面推薦，則不會獲得此項賠償。有關家居康復護理服務包括：

1. 護士服務；
2. 醫生診症服務；
3. 血液、尿液及其他體液化驗、心電圖、病理學化驗、以流動儀器進行之肺部功能測試；
4. 藥物；
5. 傷口護理、消毒手套、消毒藥水、針、針筒、醫療利器棄置箱、棉花、失禁護墊、床墊、枴杖、支架、石膏、耐用物品(只限醫療床、物理治療器材、供氧機及靜脈注射用具)之租金；
6. 物理治療、言語治療及職業治療；
7. 氧氣及其處理；
8. 血液或血漿及其處理；
9. 往返醫院之救護車服務。

1.18 雙重保險住院現金

倘受保人是次住院先在其他醫療保險計劃索償(不包括住院現金保障計劃)，而本保單作為第二賠償者，將根據承保表內訂明之每天雙重保險住院現金金額之規定，按實際住院天數計算賠償金額，但不能超過承保表中規定的最高賠償天數。

1.19 三重保險現金保障

倘受保人是次住院先在其他兩份醫療保險計劃索償(不包括住院現金保障計劃)，而本保單作為第三或以上賠償者所賠償之金額不超過是次住院總費用金額百分之三十，本保險公司將根據承保表內訂明之金額規定作出賠償。此保障與本章1.18(雙重保險住院現金)將不能連同一起支付賠償。

1.20 指定門診手術現金津貼

倘受保人在註冊西醫書面證明下，因醫療需要在其醫務所或醫院門診部(醫院沒有收取病房收費)內接受胃部內窺鏡或大腸內窺鏡檢查，本保險公司將根據承保表內訂明之金額之規定作出賠償。

2. 索償手續

受保人因疾病或意外受傷入院接受治療，必須於出院後90日內向本保險公司遞交下列文件申請索賠，否則即視為放棄索賠權論：

1. 住院醫療保險索賠申請書；
2. 住院醫療保險主診註冊西醫證明書；
3. 住院醫療費用正式單據及帳單明細表。

除已獲本保險公司特別豁免外，如受保人未能按要求提供【住院醫療保險主診註冊西醫證明書】辦理索償手續，本保險公司可協助代辦。唯投保單位及受保人需辦理授權手續及承擔索取有關文件之費用。

3. 其他索償文件

在辦理利益保障給付時，投保單位或受保人除上述第2點所列文件外，亦須按本保險公司要求提供其他有關的證明文件，倘投保單位或受保人未能提供所需證明文件，本保險公司可延遲發給其應所得的賠償，直至所有證明文件在指定期限具備為止。如在指定期限內未能提供所需證明文件，則作視為放棄索賠權論。

第二章 重病住院醫療保險

1. 利益保障

受保人的重病住院醫療保險金額及保險計劃詳列於本保單之承保表及受保人名單表內。受保人自加入本計劃的生效日期起至本保單年度期滿日止的期間內，倘因疾病或意外受傷入住醫院接受治療，或在註冊西醫書面證明下，在其醫務所或醫院門診部內所接受手術，或於門診作先進類型之造影或專科X光檢驗而所產生的醫療費用超過基本住院醫療保險利益中的每一傷病最高賠償金額或最高賠償天數時，本保險公司將按下列第二條條款『合資格費用』利益保障範圍給付賠償利益。

賠償利益金額將按下列公式計算：
重病住院醫療賠償金額＝(醫療總支出 － 基本住院醫療保險利益 － 自付額) × 賠償百份率

註：

1. 醫療總支出意指每一傷病住院醫療總『合資格費用』，但不包括受保人於其他保險計劃中已獲賠償的費用，及在基本住院醫療保險利益中受保人須承擔的賠償率以外費用及除外責任條款中不保障項目之費用。
2. 基本住院醫療保險利益意指承保表內第一項住院醫療保險對是次住院費用之總賠償金額。
3. 自付額意指訂於承保表內之自付金額。
4. 賠償百份率意指訂於承保表內之賠償率。
5. 重病住院醫療賠償金額以不超過承保表內該項最高賠償限額為限。

2. 合資格費用

合資格費用意指在住院期間所接受下列住院服務，其服務收費則按 『合理及慣常費用』收費標準。

合資格費用項目：

2.1 住院膳宿費

已超過基本住院醫療保險利益中的最高賠償天數，並由醫院提供之病房房租及膳食費用。但每天的住院膳宿費若超過基本住院醫療保險利益中的每天最高賠償限額，所超額費用則不能在此項目獲得賠償。

2.2 醫生巡房費

已超過基本住院醫療保險利益中的最高賠償天數，並在住院期間內接受主診註冊西醫治療之費用。但每天的醫生巡房費若超過基本住院醫療保險利益中的每天最高賠償限額，所超額費用則不能在此項目獲得賠償。

2.3 私家護士護理費

已超過基本住院醫療保險利益中的最高賠償天數，並在住

院期間內經主診註冊西醫轉介需接受私家護士特別護理之費用。但每天的私家護士護理費若超過基本住院醫療保險利益中的每天最高賠償限額，所超額費用則不能在此項目獲得賠償。

2.4 深切治療費

已超過基本住院醫療保險利益中的最高賠償天數，並在醫院轄下的深切治療部接受特別治療之費用。但每天的深切治療費若超過基本住院醫療保險利益中的每天最高賠償限額，所超額費用則不能在此項目獲得賠償。

2.5 醫院雜項醫療費

醫院雜項醫療費包括：醫院服務費、手術室費、麻醉師費、專科醫生費。

2.6 外科手術費

在住院期間內接受外科手術之治療費用。

3 索償手續

按此保單第三部份第一章第2及第3條辦理。

第三章 女性住院分娩醫療保險

1. 利益保障

受保人的住院分娩醫療保險金額及保險計劃詳列於本保單之承保表及受保人名單表內。任何受保人加入本保障計劃後，在保險有效期內倘經註冊西醫證明因懷孕(包括分娩、流產)須接受醫療服務，本保險公司會根據本條款的條文規定作出賠償。分娩利益的保障範圍亦包括一切產前及產後(分娩後十四天內)所須的檢查、藥物治療及婦產科醫生所收取之實際費用和新生嬰兒剛出生七天內之住院費用。賠償金額將以醫院所收取之實際費用乘以承保表中所列的賠付比率計算。唯最高賠償金額應以承保表中所列的每年最高賠償金額為限。

2. 索償手續

受保人因懷孕(包括分娩、流產)須接受治療，必須於出院後90日內向本保險公司遞交下列文件申請索賠，否則即視為放棄索賠權論：

1. 住院分娩醫療保險索賠申請書；
2. 住院分娩醫療保險主診註冊西醫證明書；
3. 住院醫療費用正式單據及帳單明細表。

如受保人未能提供上述第2項的醫生證明書，本保險公司可協助代辦。唯投保單位及受保人需辦理授權手續及負責索取該醫生證明書之費用。

3. 附加除外責任

除本保單的“一般除外責任條款”所訂明之外，本保險公司亦將不予負責由於下列原因所引致之任何醫療費用：

1. 受保人在參加本保障計劃時距離預產期不足六個月的分娩索償（包括產前及產後所須的門診檢查和有關的藥物治療費用），但如受保人於本保單起保日前已在受保名單之列，則可豁免此限制；
2. 受保人自參加本保障計劃當日起計不足90天的流產索償（包括產前及產後所須的門診檢查和有關的藥物治療費用），但如受保人於本保單起保日前已在受保名單之列，則可豁免此限制；

第四章 門診醫療保險

1. 利益保障

受保人的門診醫療保險金額及保險計劃詳列於本保單之承保表及/或使用醫療網絡協議及受保人名單表內。受保人使用醫療網絡服務，不論任何原因而導致超出承保表及/或使用醫療網絡協議所列的最高賠償金額及自付費，受保人須將超出的醫療費用直接支付有關醫療網絡機構；而本保險公司將不會承擔此等醫療費用。

1.1 註冊西醫診療費

倘受保人因疾病或意外受傷，接受註冊西醫治療，注射或藥物等項目，本保險公司按其所收取之實際診查，注射及藥物等費用賠付。每次賠償金額應以實際收取金額乘以承保表中所列的賠付比率計算。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

1.2 醫療網絡轄下註冊西醫診療費

倘受保人因疾病或意外受傷，前往由投保單位所安排的醫療網絡轄下診療所接受註冊西醫治療，須出示醫療咭及身份證並即時繳付承保表及/或使用醫療網絡協議中所列的自付費，其餘診金及藥費以不超過承保表及/或使用醫療網絡協議中所列的每次最高賠償金額為限，以掛帳方式由本保險公司代為支付。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

1.3 中醫師/跌打醫師/針灸醫師診療費

倘受保人因疾病或意外受傷，接受中醫師 / 跌打醫師 / 針灸醫師的診治，本保險公司按其所收取之實際診查及藥物等費用賠付。每次賠償金額應以實際收取金額乘以承保表中所列的賠付比率計算賠償金額。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

1.4 醫療網絡轄下中醫師/跌打醫師/針灸醫師診療費

倘受保人因疾病或意外受傷，前往由投保單位所安排的醫療網絡轄下診療所接受中醫師 / 跌打醫師 / 針灸醫師的診治，須出示醫療咭及身份證並即時繳付承保表及/或使用醫療網絡協議中所列的自付額，其餘診金及藥費以不超過承保表及/或使用醫療網絡協議中所列的每次掛帳額為限，以掛帳方式由本保險公司代為支付。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

1.5 物理治療/脊骨神經科醫生診療費

倘受保人因疾病或意外受傷，經註冊西醫書面轉介，接受物理治療師 / 脊骨神經科醫生之治療，本保險公司將按其所收取之實際物理治療或整脊診查及治療費用賠付。每次賠償金額應以實際收取金額乘以承保表中所列的賠付比率計算。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。倘受保人未能獲得註冊西醫書面轉介，則不會獲得此項利益保障賠償。

1.6 醫療網絡轄下物理治療/脊骨神經科診療費

倘受保人因疾病或意外受傷，經註冊西醫書面轉介，前往由投保單位所安排的醫療網絡轄下診療所接受物理治療師 / 脊骨神經科醫生之物理治療或整脊治療，須出示醫療咭及身份證並即時繳付承保表及/或使用醫療網絡協議中所列的自付額，其餘診療費以不超過承保表及/或使用醫療網絡協議中所列的每次掛帳額為限，以掛帳方式由本保險公司代為支付。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。倘受保人未能獲得註冊西醫書面轉介，則不會獲得此項利益保障賠償。

1.7 專科醫生診療費

倘受保人因疾病或意外受傷，接受專科醫生之醫學意見或特別治療，本保險公司按其所收取之實際診查、注射及藥物等費用賠付。每次賠償金額應以實際收取金額乘以承保表中所列的賠付比率計算。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

若保險計劃未有投保物理治療或脊骨神經科醫生診療費，有關費用可在專科醫生診療費的保障項目下賠付。唯受保人需獲得註冊西醫之書面轉介。唯賠償次數以專科醫生、

物理治療師及脊骨神經科醫生診療費合計，但不可超過承保表中專科醫生診療費所列的最高賠償次數及每次最高賠付金額。

1.8 醫療網絡轄下專科醫生診療費

倘受保人因疾病或意外受傷，前往由投保單位所安排的醫療網絡轄下診療所接受專科醫生的專科治療，須出示醫療咭及身份證並即時繳付承保表及/或使用醫療網絡協議中所列的自付費，其餘診金及藥費以不超過承保表及/或使用醫療網絡協議中所列的每次最高賠償金額為限，以掛帳方式由本保險公司代為支付。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

1.9 X光及化驗費

倘受保人因疾病或意外受傷，經註冊西醫、中醫師、物理治療師或脊醫書面轉介，接受診斷性化驗或檢查，如X光檢查、電腦掃瞄、磁力共震檢測等，本保險公司將按其所收取之實際費用賠付。每次賠償金額應以實際收取金額乘以承保表中所列的賠付比率計算賠償金額。唯最高賠償金額應以承保表中所列的每年或每一傷病最高賠償金額為限。倘受保人未能獲得註冊西醫、中醫師、物理治療師或脊醫書面轉介，則不會獲得此項利益保障賠償。

1.10 註冊牙科醫生診療費

倘受保人因洗牙及口腔檢查(每年一次)、牙科疾病或意外受傷，接受註冊牙科醫生治療、洗牙、補牙、脫牙、X光、膿瘡排放、補留牙峰的牙冠釘、齒根管治療、注射或藥物、因意外導致之牙冠及假牙等治療項目，本保險公司將按其所收取之實際費用賠付，每次賠償金額應以實際收取金額乘以承保表中所列的賠付比率計算賠償金額。此項索償以承保表中所列的最高賠償金額及最高賠償次數為限。

1.11 註冊西醫處方購買藥物費

倘受保人因疾病或意外受傷，經註冊西醫書面處方於藥房購買藥物之費用，本保險公司將按其實際收取費用賠付。每次賠償金額應以實際支出金額乘以承保表中所列的賠付比率計算。唯最高賠償金額應以承保表中所列的每年或每一傷病最高賠償金額為限。倘受保人未能獲得註冊西醫書面轉介，則不會獲得此項利益保障賠償。

1.12 身體健康檢查費

身體健康檢查費用包括註冊西醫門診診查、常規化驗及胸肺片檢查之費用。唯最高賠償金額應以承保表中所列的每年最高賠償金額及次數為限。

1.13 私家註冊西醫上門診療費

倘受保人因疾病或意外受傷，並由註冊西醫親往受保人家中提供治療，注射或藥物等服務，本保險公司按其所收取之實際診查、注射及藥物等費用賠付。每次賠償金額應以實際收取金額乘以承保表中所列的賠償比率計算。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

1.14 私家專科醫生上門診療費

倘受保人因疾病或意外受傷，並由專科醫生親往受保人家中提供治療，注射或藥物等服務。本保險公司按其所收取之實際診查、注射及藥物等費用賠付。每次賠償金額應以實際收取金額乘以承保表中所列的賠償比率計算。此項索償，每天只賠付一次並以承保表中所列的每次最高賠償金額及每年最高賠償次數為限。

2. 索償手續

受保人因疾病或意外受傷接受治療，必須於引致之有關醫療費用後90日內向本保險公司遞交下列文件申請索賠，否則即視為放棄索賠權論：

1. 已填妥的【門診醫療索賠申請書】；
2. 門診收據正本，該收據必須具備下列內容：診症日期、病症(若中醫師單據索償，單據上須註明主診醫師名稱、其註冊或表列編號) 、病人姓名、診治費用、醫生的蓋章及簽署。如門診收據欠缺上述任何一項內容者，本保險公司將不予受理；
3. 受保人如要求索取X光及化驗費賠償，除需提供收據正本外，還需提供註冊西醫、中醫師、物理治療師或脊醫推薦信正本(推薦信由簽發日起計90天內有效)，否則本保險公司不予受理；
4. 受保人如要求索取註冊西醫處方購買藥物費，除需提供收據正本外，還需提供註冊西醫推薦信正本(推薦信由簽發日起計90天內有效)，否則本保險公司不予受理；
5. 受保人如要求索取專科醫生診療費的賠償，除需提供上述門診收據正本外，還需在【門診醫療索賠申請書】上選擇索賠專科醫生診療費，否則本保險公司只能按本利益保障條款的“註冊西醫診療費”所規定辦理該筆賠償；
6. 受保人如要求索取物理治療/脊骨神經科醫生診療費的賠償，除需提供上述門診收據正本外，還需提供註冊西醫推薦信正本 (推薦信由簽發日起計一年內有效，若屬跟進診治，在每次索償時仍需附上推薦信副本作參考)，否則本保險公司不予受理。

3. 其他索償文件

在辦理利益保障給付時，投保單位或受保人除上述第2點所列文件外，亦須按本保險公司要求提供其他有關的證明文件，倘投保單位或受保人未能提供所需證明文件，本保險公司可延遲發給其應所得的賠償，直至所有證明文件在指定期限具備為止。如在指定期限內未能提供所需證明文件，則視為放棄索賠權論。

第四部份 除 外 責 任

本保險公司將不予負責由於下列原因所引致之任何醫療費用：

1. 與就診病無關之住院膳宿費、陪人費、特別看護費、客人膳食費、額外病床、非醫療性的個人服務及其他特殊費用包括但不限於器官、輪椅、拐杖等費用。
2. 非因意外引起的矯視包括但不限於近視、遠視、散光、老花、斜視、驗眼、配鏡、聽覺測驗或助聽器等輔助費用；義肢和施行美容治療或整容手術費用。
3. 一切牙齒護理包括但不限於每年例行檢查、洗牙、鑲牙、箍牙、牙齒矯正等及牙科手術(唯正常牙齒因意外受傷而引起的必要牙科手術或牙肉感染治療，或於承保表上註明之項目除外)。
4. 因戰爭(不論宣戰與否)、罷工、暴亂、革命、叛變、恐怖主義活動或其他類似戰爭的行為或參加軍警工作直接或間接引致的傷害或疾病。
5. 精神病包括但不限於生理或心理失調所引起的精神紊亂、神經衰弱、厭食、失眠等。
6. 因懷孕(包括產前產後檢查)、流產、分娩(包括自然分娩及剖腹產)、墮胎、絕育、避孕、不育及其併發症或一切有關的治療費用，唯於於承保表上註明之項目除外。
7. 自加傷害、自殺(不論其清醒與否)、酒醉、精神錯亂或吸食軟性藥物(包括吸食毒品)。
8. 觸犯或參與不合法行為所致之傷害。
9. 先天異常，即出生時存在的疾病並在 12 歲前出現，包括但不限於遺傳病如兔唇、畸形足、胎記、骨或肌肉不正常生長、腦麻痺等；發展異常包括但不限於偏平足、隱睪症等；嬰兒黃疸病。
10. 定期、例行常規健康檢查或休養之醫療費用。
11. 接受預防注射疫苗之費用。
12. 有關性能力、性病、愛滋病及其併發症引起的治療費用。
13. 受保人可依例申請僱員補償保險的賠償或其他保險計劃可支付的賠償。唯賠償不足之醫療費用，本保險公司將按本

保單條款及承保表內所列的最高賠償金額規定給予適當的賠償。

14. 因參與或從事危險活動包括但不限於吊索跳、滑翔風箏、滑翔飛機、跳傘、激流、水肺潛水、攀山、攀石等。
15. 在水療中心、天然治療中心、復康院、療養院、老人院或類似機構提供的醫療服務費用。
16. 另類治療包括但不限於中醫的冬病夏治、夏病冬治、三伏天灸、艾灸、按摩、推拿、催眠、香薰治療、自然療法、瑜珈、足部治療、語言治療、職業治療或營養治療等。
17. 未經本公司同意之實驗治療。
18. 屬補養性質的藥物索償，包括但不限於保健產品如靈芝、人參、燕窩、商業健康補健包、滋養的草本植物或補品等。
19. 預防及調理性質之治療。
20. 體重控制及其相關之治療。
21. 醫療報告之費用。

第五部份　附加海外緊急救援服務條款

本緊急救援服務乃由“國際救援(亞洲)公司(以下稱為“國際救援”)”提供予本保單列明之受保人。

第一章 定義

1. 原居地

意指香港特別行政區(除非在投保申請書上另有列明)。

2. 緊急情況

意指受保人因意外事故或急病所致情理上無法防止且急需外來援助之嚴重醫療情況或災難。

3. 急病

意指於本保單起保日後所發生及不可預知、必須入院接受治療的疾病。

第二章 有效期，限制及責任

1. 有效期

以下第三章所述之緊急救援服務保障有效期將由本保單生效日期起至保單周年終止。唯受保障之事故發生逾兩年後，將終止提供由該事故而引致的緊急支援服務。

2. 地域及時期限制

以下第三章所述之緊急救援服務保障適用於受保人的原居地以外之地區所發生之緊急情況，而該緊急情況須發生於離開原居地180日內。

3. 本保險公司及國際救援的責任

獲推介的專業人士、醫生、診所及醫院，均非本保險公司或國際救援的職員、代理或僱員，這些專業人士、醫生、診所及醫院乃獨立人士或機構而需對自己所作的行為負責。在推介前，國際救援將查核這些專業人士、醫生、診所及醫院是否具備資格，並確實其獲當地政府的認可。如遇這些專業人士、醫生、診所及醫院之行為不當，本保險公司及國際救援概不負責。

第三章 緊急醫療救援服務及保障

如受保人在原居地以外地方旅行或公幹時因意外嚴重受傷、急病或死亡，又或在此期間需要法律、行程折回之緊急服務(旅遊諮詢服務可在任何情況下查詢)而該旅程或公幹並非在罔顧醫療人員的勸止下進行，或/及該旅程或公幹並非為接受或尋求海外醫療或手術治療，則受保人或其代表可致電國際救援及要求提供下列服務及保障。求救電話號碼：(852)28619235。任何受保人自行支付之有關費用，將不會獲發還。

1. 電話醫療建議、評估及轉介約見

當需要醫療建議時，受保人或其代表可致電國際救援的緊急中心向中心內當值醫生索取醫療建議及評估，但該項電話對話只屬建議性質，並不能視作對受保人之診斷。若醫療上有需要，受保人可轉介至合適之醫生或專科醫生，以獲取其個人評估；而國際救援可代為預約有關醫生。但所有醫療費用及相關之費用需由受保人自行支付。

2. 緊急護送

若受保人身體受傷或患上急病，而國際救援中心的醫療隊伍及受保人的主診醫生均建議受保人需要於其他醫院接受所需之適當治療，國際救援會安排並支付：

1. 運送受保人至最就近的醫院；
2. 如站在醫療的角度上有需要：
   i) 利用一切方法(包括但不限於救護機，固定班次之商務客機及救傷車)以運送受保人至一所在設備上就該項身體受傷或急病更為適合的醫院。
   ii) 直接運返受保人至其原居地的醫院。

以上安排須由國際救援中心的醫療隊伍及受保人的主診醫生共同決定。這決定包括運送時間表、運輸工具及目的地。

國際救援會根據情況作出以下安排：

- 安排救護車連接醫院及機場
- 安排離境及入境手續
- 提供醫療器材
- 提供合適醫務人員護送受保人
- 安排救護車於機場接載受保人和護送的醫務人員
- 安排合適專科醫生在目的地候診
- 安排入住醫院
- 跟進病人入院後病情
- 與家屬聯絡並知會運送進展

3. 治療後之護送服務

於接受第 2 項之緊急護送服務後，並在受保人的主診醫生及國際救援緊急中心的醫生的共同診斷下，受保人仍需被護送回原居地，而其機票並不能用於護送服務，則國際救援將妥善安排受保人乘坐固定班次之航機或其他運輸方法(以經濟客位為準)返回其原居地，一切護送費用包括往來機場的附加費用將由國際救援支付，唯受保人須把原有機票之未使用部份交回國際救援。

4. 運返遺體/骨灰回國

如受保人不幸因意外或急病身故，國際救援將支付並安排 1)運返其遺體或骨灰至受保人原居地內之安葬地點，或 2)應受保人之繼承人或代表之要求，安排當地安葬，但該費用不得超過運送受保人遺體返回原居地之費用。棺木費用於任何情況下都不受保障。

5. 跟進病情

當受保人身在原居地以外地方接受住院治療，國際救援將會跟進受保人的醫療狀況，並在有需要時向受保人或其家屬代表提供有關治療的意見。

6. 旅遊諮詢

受保人可在旅程前或旅程期間，向國際救援諮詢以下資料或服務：

- 最新的免疫及防疫要求及需要
- 世界各地天氣
- 機場稅
- 海關條例
- 護照/簽證要求
- 領事館/大使館之地址及聯絡電話
- 貨幣兌換率
- 銀行工作日
- 當地語言及翻譯服務
- 護送小童回國
- 因醫療緣故需轉遞緊急訊息

7. 代尋行李

如運送機構遺失或誤送受保人的行李，國際救援可代為向

有關機構包括但不限於航空公司、海關及政府機關查詢代尋。若尋回行李將轉送到受保人之指定地點。

8. 更改行程之緊急安排

若受保人遇緊急事故需更改原先行程，國際救援將會協助受保人重新安排所乘坐之飛機班次。

9. 護照補發遞送

當受保人旅程所需之文件或個人證件(如護照、簽證等)遺失或被盜竊，國際救援將向受保人提供所需資料，以便受保人向有關當局補辦證件。

10. 法律轉介

應受保人要求，國際救援可提供律師及律師行的地址及電話。

11. 親友探病費用

若受保人在原居地以外地方，因嚴重之身體損傷或急病，住院連續十天以上，國際救援將安排受保人一名親屬或其指定人士，由受保人原居地乘坐固定航班之客機(經濟艙)前往探望受保人，並代其支付來回機票及最長連續五天，每天不超越港幣 1,200 元之酒店普通房間之合理住宿費，但膳食費及額外房間服務費將不予負責。

12. 護送隨行之未成年子女返回原居地

若受保人在原居地以外地區，因嚴重之身體損傷或急病而住院或不幸去世，遺下同行而未滿十六歲受供養之子女，在其子女之回程機票失效時，國際救援將安排該名(或多名)子女乘坐固定航班之客機(經濟艙)返回原居地，並支付有關機票費用(包括往返機場之附加交通費)。而該子女未被使用且未能用於此次護送服務之機票須退給國際救援緊急支援中心處理。如有需要，國際救援亦會聘請符合資格人士，陪同受保人子女返回原居地。

13. 住院按金保證

當國際救援緊急支援中心之醫生及當地主診醫生均同意受保人因意外受傷或患上急病須入住醫院時，國際救援可在受保人無法即時支付住院按金的情況下，提供達港幣 40,000 元之住院按金保證。國際救援緊急支援中心有權在替受保人支付住院按金前，索取有效之信用保證。

14. 出院後療養住宿

若受保人之主診醫生及國際救援之醫生均認為受保人於出院後需即時進行療養，國際救援將會為受保人安排及支付出院後之酒店住宿費用，每天上限則為港幣 1,200 元，並最長可達連續 5 天。

15. 安排緊急回國料理親人後事

當受保人身在海外(不包括移民)而獲悉其直系親屬身故，須立即折返其原居地，國際救援將安排受保人乘坐客機(單程經濟客位)返回原居地及支付有關的機票費用。

16. 任中橫服務

若受保人在中國大陸身體受傷或患上急病，必須入院接受治療，受保人可致電國際救援。國際救援會根據情況安排受保人至最就近的任中橫服務旗下醫院，及提供掛帳服務，受保人不需要交付入院定金。當受保人出院後必須繳交全部住院費用包括入院定金給國際救援。

<u>任中橫服務之程序</u>

當受保人需要至任中橫服務旗下醫院，受保人可以 1) 致電國際救援求救電話號碼：(852)2861 9235 尋找協助或 2)出示印有任中橫標識的緊急救援咭，及提供以下文件或資料給急診室之醫院員工：

(a) 身份証號碼/住宅電話號碼/護照號碼
(b) 如有需要請提供保單編號或員工編號
(c) 聯絡方法，例如手提電話

第四章 遇事通知程序/責任

若受保人在通知國際救援之前遇上身體受傷或患上急病而需住院，受保人或其代表應盡可能於緊急事故發生後三日內聯絡國際救援。在未有收到上述通知情況下，國際救援將不會承擔有關事件的救援責任。

第五章 代位追償權

如國際救援因提供支援予受保人而需支付任何費用，其將取代受保人的權利向任何在法律上須承擔責任的第三者取回因有關支援而支付了的款項，唯金額將不超過國際救援及其他保險或支援計劃就是項救援所支付的費用或賠償。

第六章 除外責任

受保人若因下列情況導致身體損傷或患上疾病，國際救援將不提供緊急支持服務及支付任何費用。

1. 在旅程出發前已存在的疾病或損傷, 不論受保人察覺與否。
2. 故意自傷、神經錯亂、神智不清、濫用酒精或藥物所引致的損傷、長期休養或療養、及患有可傳染而按法律規定需隔離的疾病。
3. 先天的疾病及異常。
4. 所有與懷孕及分娩有關的費用或情況。
5. 間接或直接由於參與職業運動或競賽運動(競走除外)、水上或水內運動、冬季運動、賽車、越野賽車、探穴、攀石、需輔以繩索或由嚮導帶領的登山活動、跳降傘、綁繩跳、武術或搏擊運動。
6. 由於參與非法活動所致的損傷。
7. 並未經國際救援授權或介入提供的服務。
8. 在無國際救援介入的情況下，受保人理應支付或早已產生的費用。
9. 任何更適當地由其他保險承保的費用。
10. 根據國際救援醫生的意見，受保人在當地獲妥當的治療後，便能繼續旅程或返回工作的輕微疾病或損傷。
11. 經國際救援之醫生意見認為受保人在無醫療人員陪同下，仍能如一般乘客可乘坐普通航班返回原居地，國際救援將不負責所支出的費用。除非國際救援的醫生認為有需要的則除外。
12. 一切與精神病有關的個案。
13. 受保人參與任何空中飛行活動。如以持票乘客身份，乘坐固定航班或領有飛行執照及固定航線的包機則除外。

第七章 不可抗力之免責事由

本保險公司及國際救援將不負責因罷工、戰爭、敵國入侵、武裝衝突(不論是否正式宣戰)、內戰、內亂、叛亂、恐怖行動、政變、暴動、群眾騷擾、政治或行政干預、輻射或自然災難等的不可抗力事項或不可歸責於國際救援之事由所導致救助行動延誤、無法提供或進行而產生的任何責任。

第八章 合約

國際救援乃本海外緊急救援服務保障的服務提供者，不論本保單其他保障條款所定，如遇有國際救援之行為不當，本保險公司概不負責。

PART I – GENERAL DEFINITIONS

1. Policy
means proposal signed by the Policyholder together with details declared by any employee of the Policyholder, the Policy wordings, terms and conditions, Benefit Schedule, Supplementary clauses, group Insured Person's name list, attachments and endorsements signed and issued with the Policy.

2. Scheme
means insurance scheme under this Policy. Cover for the Insured Person is mentioned in detail in the Benefit Schedule, the group Insured Person's name list and the various benefit clauses.

3. Policy Year
means starting from the Policy Effective Date to the Policy Expiry Date as stated in the Policy.

4. Insured Person
means the confirmed employees of the Policyholder, the eligible Family Member of any employees, and / or any employees approved to be covered by the endorsement, who participate in the Scheme under Policy Conditions 1.

5. Family Member
means legal spouse of the insured employee, whose age is 70 or below, the children of the insured employee, whose ages are from birth day to 25.

6. Hospital
means legally registered Hospitals which provide Hospital services in their areas of operation but excluding rehabilitation Hospitals or homes, convalescent Hospitals or homes, rehabilitation institutions for drug addicts and homes for the aged. If such Hospitals operate in Mainland China, "Hospital" means institutions licensed as Hospitals at or above the country level and using western medicine for medical treatment, but does not include any institution which is below the country level or uses traditional Chinese medicine for medical treatment.

7. Intensive Care
means all medical treatment or care required under the intensive care unit of a Hospital.

8. Anaesthetists
means Anaesthetists who have completed course of Anaesthetist and been granted a certificate of qualified Anaesthetist and are licensed to legally practise as Anaesthetists by the Governments of the areas where they conduct anaesthetic practice but excluding Anaesthetist who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives.

9. Private Nursing
means nurses who have completed professional nursing course and been granted a qualified nursing certificate and are legally registered and qualified to practice nursing by the Governments of the area where they conduct their practice but excluding nurse who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives.

10. Registered Medical Practitioner
means doctors who are licensed to legally practise as medical practitioners by the Governments of the areas where they conduct medical practice, and are granted a western medical degree but excluding doctor who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives.

11. Specialist Doctors
means doctors who have completed western specialist course and been granted a qualified specialist certificate and are licensed to legally practise as particular medical specialists by the Governments of the areas where they conduct medical practice, and are granted a specialist qualification but excluding doctor who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives.

12. Chinese Herbalist, Bonesetter, Acupuncturist
means Chinese herbalists, bonesetters, acupuncturists who have obtained a legal registration certificate for their practice as Chinese herbalists, bonesetters, acupuncturists in their areas of practice (If practice in Hong Kong means persons who have been entered on the list of listed Chinese medicine practitioners maintained by the Chinese Medicine Practitioners Board of the Chinese Medicine Council of Hong Kong). but excluding Chinese herbalist, bonesetter, acupuncturist who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives. In their receipts, the name of the practitioners, the registered or listed number, address and telephone number of their working place must be shown.

13. Registered Dental Surgeon
means dentists who are legally registered and practise as dental surgeon by the Government of the area where they conduct dental practice and are granted a recognized degree of dental surgery but excluding dentist who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives.

14. Physiotherapist
means physiotherapists who are licensed to legally practise as physiotherapists by the Governments of the areas where they conduct their practice but excluding physiotherapist who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives.

15. Chiropractor
means chiropractors who are licensed to legally practise as chiropractors by the Governments of the areas where they conduct their practice but excluding chiropractor who is the Insured himself, an Insurance agent, business partner(s) or employer / employee of the Insured or a member of the Insured's relatives.

16. Each and every disability per policy year
means injury, sickness, disease, or illness and shall including all disabilities arising from the same cause including any and all complications arising therefrom in the same policy year. Treatment for more than once within 90 days in the same policy year arising from same disability and their complications, will be regarded as one disability for the purpose of all insurance payments in accordance with the provisions of the Benefit Schedule.

17. Accident
means sudden, direct and visible incident of bodily injury caused by external factors, which is not the will of the Insured Person.

18. Reasonable and customary charges
means medical charges not more expensive than the services provided by persons of similar experience and professional qualifications in the same area or as a matter of economics, the reasonable average sums receivable for the supply of materials, equipments or services of similar quality and quantity in the same area.

19. Co-payment
The coverage for certain services requires the insured person to share the costs.

20. Overseas
means territories other than Hong Kong Special Administrative Region.

21. Medically Necessary
means treatment incurred which is:
(1) consistent with the diagnosis and customary medical treatment for the condition;
(2) in accordance with standards of good and prudent medical practice;
(3) not for the convenience of the Insured, the Insured Person, or the doctor who arrange the treatment;
(4) performed in the least costly form required for treatment of a covered Disability.

PART II – POLICY CONDITIONS

Section 1 Provisions for employees participating / changes / termination in the Scheme

1. All employees in the Insured Person's name list provided by the Policyholder before the effective date of the Policy are eligible to joining this insurance scheme from the effective date of the Policy.
2. For all newly recruited and confirmed employees to join this Scheme, the Policyholder should within 31 days from the date of employment complete an endorsement application and sends it to the Company. Benefit for such an Insured Person shall not become effective until the Company accepts his application by signing an endorsement.
3. When any newly recruited and confirmed employees have been given approval to join this Scheme, they should return to normal work activity on the date on which the benefit become effective. If the employees have not return to normal work activity due to illness, leave or any other reasons, benefits for such an Insured Person shall not become effective until the day they return to normal work activity.
4. For employees who are eligible to joining this Scheme, they should join the Scheme within 31 days from the date of approval to join. Failing which the Insured shall furnish at his own expense evidence of insurability to the Company in addition to a properly completed written Application, and cover for the benefits shall not become effective until the date of Registration by the Company pursuant to such Application.
5. For employees who are eligible to amend this Scheme, the Policyholder should within 31 days from the date of movement complete an endorsement application and sends it to the Company. Amendment for such an Insured Person shall not become effective until the Company accepts his application by signing an endorsement.
6. For employees who are eligible to terminate this Scheme, the Policyholder should within 31 days from the date of termination complete an endorsement application and sends it to the Company. Termination for such an Insured Person shall not become effective until the Company accepts his application by signing an endorsement.

Section 2 Validity of Policy and Premium

1. This policy is valid only after premium has been paid by the Policyholder.
2. Additional or refund premium on daily pro-rata basis will be calculated for any in-coming or out-going employees from their dates of joining or leaving the Scheme. All premium adjustments will be settled at the end of each Policy year.
3. Benefits on per year basis will be calculated on daily pro-rata basis from their dates of joining for any in-coming employees from their dates of joining the Scheme.
4. The Company reserves the right to underwrite and adjust premium rate prospectively at the end of each Policy year.

Section 3 Renewal

The Company will provide the Policyholder (1) month (not exceeding 31 days) grace period for Renewal Notice for each Renewal Policy Year. If Renewal Notice is not made within the grace period, this Policy shall become invalid from the Policy expiry date that provides for the said grace period.

Section 4 Information

1. The Policyholder shall collect and give to the Company the information of each Insured Person, including Chinese and English name, date of birth, sex, class of insurance benefits, effective date of cover and other information relevant to this insurance. This Policy will be signed and issued by the Company in accordance with the information given.
2. Typing errors and omissions in the documents provided by the Policyholder that do not affect the scope of underwriting responsibility of the Company will not have any bearing on benefit payments. But all clerical errors and omissions must be notified to the insurance company in writing for correction immediately upon discovery.
3. If the information of Insured Persons provided by the Policyholder is wrong, and has affected the underwriting decision of the insurance company, a declaration to correct must be made as quickly as possible. Before correction, the Company will not be liable for each and every disability of the Insured Person.
4. If the information of Insured Person provided by the Policyholder is wrong and has affected the benefit payments of the Insured Person, a declaration to correct must be made as quickly as possible. But before correction, the Company can only deal with each and every disability of the Insured Person in accordance with the information before correction.

Section 5 Policy Endorsement

If the Policyholder wants to amend the contents of this Policy, an endorsement application must be completed in writing and such amendments will not be effective until and unless agreed by the Company and an endorsement duly signed. The provisions and clauses of this Policy cannot be amended or deleted without the consent of the Company by endorsement duly signed.

Section 6 Termination of cover for Insured Person

Under any one of the following circumstances, cover for the Insured Person terminates:

1. In case of the Insured Person's age over 70 during the period of insurance, who was the confirmed employee of the Policyholder before the commencement date of the Policy and participate in the Scheme at the commencement date of the Policy, the cover for the Insured Person and his Family Member will formally cease at the end of the Policy year.
2. In case of the Insured Person's age over 70 during the period of insurance who participate in the Scheme after the commencement date of the Policy under the item 2 of Section 1 of Policy Conditions, the cover for the Insured Person and his Family Members will formally cease at the end of the Policy year.
3. In case of the insured spouse and children of the confirmed employee reaching the maximum cover age as mentioned herein the Policy during the period of insurance, their cover will formally cease at the end of the Policy year.
4. The Policy has reached expiry date or has been terminated.
5. The effectiveness of insurance is cancelled by written notice from the Policyholder.
6. The employment contract between the Policyholder and the Insured Person (meaning confirmed employee) is terminated or the insured employee has stopped serving for the Policyholder.
7. The Insured Person serves in the military, naval or air force of any country or area.

Section 7 Termination of Policy
Both Policyholder and the Company have the right to terminate this contract at the end of each Policy year.

Section 8 Currency
Claims under this Policy will be settled in Hong Kong currency. Exchange rates for foreign currencies quoted by banks on the day when the claim is processed will be used as a reference for arriving at the payment value in Hong Kong currency in respect of foreign currency claims.

Section 9 Legal Proceedings
The Company has the right to conduct investigations within 90 days after receiving a claim from the Policyholder or the Insured Person so as to determine whether the claim is within the scope of underwriting responsibility of the Policy. During this period of time, the Policyholder should not take any legal action. If the Company decides to reject a claim in accordance with the terms and conditions or clauses of the Policy, legal proceedings by the Policyholder must be instituted within one year after the claim is rejected.

Section 10 Contracts (Rights of Third Parties) Ordinance
Any person or entity who is not a party to this Policy shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap 623 of the Laws of Hong Kong) to enforce any terms of this Policy.

Section 11 Personal information collection statement
The information you provide to Bank of China Group Insurance Company Limited ("the Company") is collected to enable the Company to carry on insurance business and may be used for the purpose of:

(i) processing and evaluating your insurance application and any future insurance application you may make;
(ii) administering your insurance policy and providing services in relation to your insurance policy;
(iii) analysis or investigating, processing and paying claims made under your insurance policy;
(iv) invoicing and collecting premiums and outstanding amounts from you;
(v) any alterations, variations, cancellation or renewal of any insurance related product or service;
(vi) contacting you for any of the above purposes;
(vii) exercising any right of subrogation;
(viii) other ancillary purposes which are directly related to the above purposes; and
(ix) complying with applicable laws, regulations or any industry codes or guidelines.

The Company may disclose your personal data for the above purposes to the following classes of transferees:
(a) third party agents, contractors and advisors who provide administrative, communications, computer, payment, security or other services which assist us to carry out the above purposes (including medical service providers, emergency assistance service providers, telemarketers, mailing houses, IT service providers and data processors);
(b) in the event of a claim, loss adjudicators, claims investigators and medical advisors;
(c) in the event of default, debt collectors and recovery agents;
(d) insurance reference bureaus or credit reference bureaus;
(e) reinsurers and reinsurance brokers;
(f) your insurance broker (if you have one);
(g) the Company's legal and professional advisors;
(h) the Company's related companies (as that term is defined in the Companies Ordinance);
(i) any association, federation or similar organization of insurance companies ("Federation") and its members that exists or is formed from time to time for any of the above or related purposes or to enable the Federation to carry out its regulatory functions or such other functions that may be assigned to the Federation from time to time and are reasonably required in the interest of the insurance industry or any member(s) of the Federation;
(j) any member(s) of the "Federation" by the "Federation" for any of the above or related purposes;
(k) any related company or any other company carrying on insurance or reinsurance related business or an intermediary or a claims or investigation or other service provider providing services relevant to insurance business for any of the above or related purposes;
(l) the Insurance Claims Complaints Bureau and similar industry bodies; and
(m) government agencies and authorities as required or permitted by law.

The Company is hereby authorized to obtain access to and/or to verify any of your data with the information collected by the Federation from the insurance industry.

Moreover, the Company may also use and disclose your personal data otherwise with your consent.

You have the right to obtain access to and to request correction of any personal information concerning yourself held by the Company. Requests for such access can be made to the Company's Legal and Compliance Department (Tel: 2867 0888 / Fax: 3906 9939).

Section 12 Sanction Limitation Clause
No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover; payment of such claim or provision of such benefit would expose that (re)insurer to any sanction; prohibition or restriction under United Nations resolutions or the trade or economic sanctions; laws or regulations of the European Union; United Kingdom or United States of America. LMA3100

Section 13 Laws applicable
This Policy shall be subject to the jurisdiction of Hong Kong Special Administrative Region and construed in accordance with the laws of Hong Kong Special Administrative Region.

PART III - BENEFITS

Unless otherwise specified, all benefits indicated in the following sections are applicable without geographical limitation.

Section 1 Hospitalization Benefits Provisions

1. Benefits covered
The amount of Hospitalization benefits for the Insured Person and the types of insurance are set out in detail in the Benefit Schedule and on the Insured Person's name list. In the event of any Insured Person after joining this Scheme and during the Policy year requiring Medically Necessary Hospitalization treatment, proven by a Registered Medical Practitioner, and due to illness or accidental injury, the Company will, according to the following rules, pay to the Insured Person the fees which arise from treatments received in a Hospital.

1.1 Daily room and board fees
The amount of the benefit shall be equal to the actual charges made by the Hospital in respect of Room and Board during the Insured Person's Hospital confinement but in no event shall the benefits payable under this benefit exceeds the daily limit or maximum limits as specified in the Benefit Schedule.

1.2 Daily doctor visit fees
The daily visits fee by a Registered Medical Practitioner during hospitalization. If Pre-hospital and Post-hospital consultation benefit has not been insured in the Insurance Scheme, the Daily doctor visit fees will extend coverage to one time consultation or treatment before admission to the hospital

and the post-hospital or post-clinical surgery consultation or treatment within eight weeks after discharge from hospital. This extended coverage also applicable to the clinical surgery referred by a registered Medical Practitioner for the one time consultation or treatment before the clinical surgery and post consultation or treatment within eight weeks after the clinical surgery. The Company will pay an amount equal to the charges made in respect of Physician's Fees but in no event shall the benefit payable exceed the daily limit or maximums as specified in the Benefit Schedule.

1.3 In-Hospital private nursing

If the Insured Person requires in-Hospital private nursing during Hospital confinement, the Company will pay the fees actually incurred for such visits by the in-Hospital nurse, but will not exceed the maximum limit per day and the maximum number of days provided in the Benefit Schedule. No benefit shall be payable if there is not a written recommendation from the Registered Medical Practitioner in- charge.

1.4 Hospital services charges

During Insured Person's Hospital Confinement, the Company will pay for miscellaneous Hospital services charges incurred during the Hospitalization, and the amount of benefit shall be equal to the normal, proper and actual charges made by the Hospital in respect of Hospital Services during the Insured Person's Hospital Confinement but in no event shall the benefits payable under this provision exceed the limits or maximums as specified in the Benefit Schedule. The miscellaneous Hospital services charges include charges for drugs or medicines consumed in the Hospital, dressings, ordinary surgical splints and plaster casts, laboratory examinations, electrocardiograms and CT scanning, basal metabolism tests, physiotherapy, anaesthesia, oxygen gas and its administration, X-ray examinations, intravenous infusions, blood or blood plasma administration fees (excluding the cost of blood or blood plasma), ambulance fees (not exceeding the daily room and board fees), materials and surgical appliances to be used in an operation (Including but not limited to artificial organ, lens, pacemaker and stent), those Advanced imaging (X-ray investigations, using contrast media such as Ba Meal, intravenous pyelogram etc.) done in out-patient setting. Radiotherapy, Chemotherapy and Renal Dialysis done in out-patient setting. Advanced imaging including but not limited to computerised axial tomography scan, magnetic resonance imagingscan, positron emission tomography scan, investigations involving radioactive substance, but shall not exceed the limits and maximums as specified in the Benefit Schedule.

If the operation theatre fees and the anesthesia fees have not been insured in the Insurance Scheme, these two items will be payable under hospital service charges, but for each item, payment will not exceed 30% of the maximum limit per disability under the Surgeon's fees in the Benefit Schedule.

1.5 Surgeon's fees

If the Insured Person requires surgical operation during Hospital confinement, or the Insured Person obtain a written referral from a Registered Medical Practitioner and Surgical Fees for Operation, charged of anaesthetic drugs, or medication incurred by the Insured Person in an Outpatient Setting, such as at doctor's clinic or Outpatient Department of a Hospital, the Company will pay for the surgical fees. The insurance payment is based on the surgical fees actually charged by the surgeon and the classification of relevant surgical operation specified in the Classification Schedule or Surgical Operations ("the Classification Schedule"), but not exceeding the maximum limit provided for the relevant classification of operation in the Benefit Schedule. If there are two or more operations to be performed in one disability, the amount payable for all such operations will be calculated on the basis of these operations amongst which only the largest surgical operation according to the "Classification Schedule", but the sum amount payable will not exceed the fees actually charged or the maximum limit in the Benefit Schedule provided for the relevant classification of such the largest surgical operation, whichever is the lesser.

1.6 Operation theatre fees

If the Insured Person requires surgical operation during Hospital confinement, the Company will pay for the operation theatre fees. The amount payable for the use of operation theatre and the classification of relevant surgical operation specified in the "The Classification Schedule", but shall not exceed the limits or maximums provided for the relevant classification of operation in the Benefit Schedule.

1.7 Anaesthetist fees

If the Insured Person requires surgical operation during Hospital confinement, the Company will pay for the anaesthetist fees. The amount payable for the actual charges made by the Anaesthetist and the classification of relevant surgical operation specified in the "The Classification Schedule", but shall not exceed the limits or maximums provided for the relevant classification of operation in the Benefit Schedule.

1.8 Specialist fees

A benefit shall be paid in an amount equal to the actual charges made by a Specialist to whom the Insured Person has been referred by a Registered Medical Practitioner with a written referral letter during an Insured Person's Hospital Confinement but in no event shall exceed the limits or maximums as specified in the Policy Schedule. No benefit shall be payable if there is not a written recommendation from the Registered Medical Practitioner in-charge.

1.9 Daily Intensive Care

If during the period of Hospitalization the Insured Person requires special treatment under the Intensive Care Unit of the Hospital, a benefit is payable for the actual Hospital charges incurred for Intensive Care Unit recommended by the doctor in charge. The amount of the benefit payable shall not exceed daily maximum limit and the maximum number of days as specified in the Benefit Schedule. No benefit shall be payable if there is not a written recommendation from the Registered Medical Practitioner in-charge.

1.10 Accidental Injury Benefit

If the Insured sustains Covered injury as a result of Accident and the actual medical expenses exceeds the maximum limits covered in the above benefits, the Company will pay a benefit of exceeded expenses subject to the maximum limits as specified in the Benefit Schedule provided proof of such injury is furnished to the Company.

1.11 Daily Public Hospital In-patient Cash Allowance

A daily Hospital cash allowance shall be payable on a daily basis when upon recommendation of a Registered Medical Practitioner an Insured Person is registered as an Inpatient in a Public ward or third class ward only of a Public Hospital in Hong Kong (Hong Kong Government Hospital, a Hospital Authority Hospital or a subsidized charity Hospital) for the treatment of a covered Disability and incurs charges therefore. The actual daily fee charged by the Hospital should not exceed HK$120 (excluding admission fee or extra charges for medical items incurred from an operation). The Company shall grant cash allowance to the insured person in accordance with the amount as laid down in the Schedule and in accordance with the actual period of Hospitalization, but it shall not exceed the maximum number of days as specified in the Benefit Schedule.

1.12 Public Hospital Surgical Consumable Expenses

A benefit shall be paid for the actual charge for surgical consumable expenses made by the Hospital when upon

recommendation of a Registered Medical Practitioner an Insured Person is registered as an inpatient in a General ward or third class ward only of a Public Hospital for surgical procedure. The actual daily fee charged by the Hospital should not exceed HK$120 (excluding admission fee or extra charges for medical items incurred from an operation). The amount of the benefit payable shall not exceed the limits or maximums or limits as specified in the Benefit Schedule.

1.13 Pre-hospital and Post-hospital consultation

In the event that the Insured Person is referred by Registered Medical Practitioner to receive Medically Necessary treatment on a covered sickness / injury in Hospital, the charges of one pre-hospital consultation, and if the Insured Person on the advice of the Registered Medical Practitioner in-charge requires post-hospital consultation or treatment at the clinic of the Registered Medical Practitioner in-charge, or referred to other Medically Necessary treatment by the Registered Medical Practitioner in–charge or at the out-patient clinics of Hong Kong Government Hospitals within three months after discharge from hospital, the Company will pay the charges actually incurred for such consultation or treatment, but will not exceed the maximum amount provided in the Benefit Schedule.

1.14 Emergency Consultation for Accidental Injury

A benefit shall be paid in an amount equal to the actual charges made by a Medical Practitioner for emergency consultation within 24 hours of the accidental injury but in no event shall exceed the limits or maximums as specified in the Policy Schedule.

1.15 Accidental Death Cash benefit

If the Insured Person requires Hospitalization for treatment due to Accident and dies during the Hospital confinement, in addition to the above medical expenses reimbursements, the Company will pay an extra amount as stated in the Benefit Schedule to the legal beneficiary.

1.16 Radiotherapy Treatment

If the Insured Person requires treatment for radiotherapy during Hospital confinement, a benefit is payable for the actual charges made by the treatment subject to the maximum or limits provided in the Benefit Schedule.

1.17 Home Health Care

If the Insured Person requires Hospitalization for treatment over a minimum period of seventy-two (72) consecutive hours due to illness or accident and recommended by the Registered Medical Practitioner in-charge to leave the Hospital and then immediately stay at home or a home health care agency suitable for recovery approved by the insurance company, the insurance company will pay the medically necessary, reasonable and customary charges actually incurred for the following services, but will not exceed the maximum amount provided in the Benefit Schedule. No benefit shall be payable if there is not a written recommendation from the Registered Medical Practitioner in-charge.

1. Nursing services;
2. Doctor's consultation fee;
3. laboratory examination limited to blood, urine and other body fluids examinations, electrocardiogram, pathological examination and lung function test by portable machine;
4. medicine and drugs;
5. dressings, sterile gloves, antiseptics, needles, syringes, sharp boxes, cotton wool, incontinence pad, mattress cover, braces, supports, splints, plaster casts and rental of durable medical equipments limited to hospital beds, physiotherapy equipments, oxygen administration equipment and intravenous infusion equipment;
6. physiotherapy , speech and occupational therapy;
7. oxygen and its adminstration;
8. blood or blood plasma and their adminstration;
9. ambulance service to and from the hospital.

1.18 Hospital Income for Double Benefit

The Hospital Income for Double Benefit shall be paid up to the maximum limit as specified in the Benefits schedule when this policy is the second payer for coordination of benefit. This benefit shall be applicable only if the Insured is covered by another insurance plan which is the first payer of the medical benefits (not include Hospital Cash Benefit Plan).

1.19 Cash Benefit for Triple Insurance

The cash benefit shall be paid in the amount specified in the Benefits schedule when the Company is the third payer or above which the total claim paid amount for coordination of benefit is less than 30% of the total incurred amount. This benefit shall be applicable only if the Insured is covered by another two insurance plan which are the first and second payer of the medical benefits (not include Hospital Cash Benefit Plan) This Benefit shall not be paid in conjunction with 1.18 of this Section (Hospital Income for Double Insurance) under this Policy.

1.20 Designated Clinical Surgery Cash Allowance

If the Insured Person undergo Gastroscopy or Colonscopy in an Outpatient Setting, such as at doctor’ s clinic or Outpatient Department of a Hospital and no ward charges from the hospital, due to medically necessary reason with written referral from a Registered Medical Practitioner, the Company will pay the amount specified in the Benefits schedule.

2 Claims procedure

The Insured Person must submit the following information to the Company within 90 days from date of treatment received, failing which, the right to claim is considered abandoned.

1. completed Hospitalization claim form;
2. attending physician’s statement completed by the physician in-charge;
3. all original receipts and itemized bills in respect of Hospitalization charges and fees

Attending Physician’s Statement must be provided except the Company agreed to waive. The Company may assist the Insured Person in obtaining attending physician’s statement from the physician in-charge (item 2 above). However, the Policyholder and the Insured Person have to provide a letter of authorization and be responsible for the collection charges.

3 Other claim documents

In addition to the documents mentioned in Condition 2 above, the Policyholder or Insured Person shall provide relevant documents of proof as required by the Company for reimbursement. If such documents cannot be provided on claims submission, payment of benefits may be deferred until all documents of proof are available within the prescribed time limit, failing which, the right to claim is considered abandoned.

Section 2 Supplementary Major Medical Benefits Provisions

1. Benefits covered

The supplementary major medical benefits amount for the Insured Person and the types of cover in detail are specified in the Benefit Schedule of the Policy. If during the period between the effective date of participating in this Scheme and the expiry date of the Policy year, the Insured Person is admitted in a Hospital for treatment of illness or injury caused by an accident, or the Insured Person obtain a written referral from a Registered Medical Practitioner and Surgical Fees for Operation in an Outpatient Setting, such as at doctor’s clinic or Outpatient Department of a Hospital, or those advanced diagnostic scanning done in out-patient setting, and the medical expenses thus incurred exceed the maximum

insurance amount for each disability under the basic Hospitalization cover, the Company will pay benefits in accordance with the "Eligible expenses" within the scope of benefits covered and provided in Condition II hereunder.

The amount of benefits payable will be calculated in accordance with the following formula:
Amount payable under the benefit = (Total medical expenses − Basic Hospitalization benefits − Deductible) × percentage of reimbursement

Remarks
1. Total medical expenses means total "Eligible expenses " of Hospitalization for each disability but excluding claim payment recovered from other insurance plans of the Insured Person, fees outside the percentage which the Insured Person must bear in the basic Hospitalization benefit and fees for non-covered items as specified in "Exclusions".
2. Basic Hospitalization benefit means the total amount of benefits payable in respect of fees incurred for the particular Hospitalization under the first section of benefits covered in the Benefit Schedule.
3. Deductible means the amount to be borne by the Insured Person as specified in the Benefit Schedule.
4. Percentage of reimbursement means the rate of reimbursement specified in the Benefit Schedule.
5. The amount of insurance for major medical treatment is limited to the maximum amount for that item as specified in the Benefit Schedule.

2. Eligible expenses
Eligible expenses means fees for the following Hospital services rendered during Hospitalization, such service fees being charged in accordance with the standard of "reasonable and customary charges".

Items of eligible expenses

2.1 Room and board fees
Fees in respect of room and board services provided by a Hospital which exceed maximum days per disability, but if the daily room and board fees exceed the daily maximum limit of cover in the basic Hospitalization benefits, the excess will not be recoverable under this item.

2.2 Doctor visit fees
Fees for medical treatment by a Registered Medical Practitioner during Hospitalization which exceed maximum days per disability, but if the daily doctor visit fees exceed the daily maximum limit of cover in the basic Hospitalization benefits, the excess will not be recoverable under this item.

2.3 In-Hospital private nursing
Fees for in-Hospital private nursing during Hospitalization which exceed maximum days per disability, but if the daily private nursing expenses exceed the daily maximum limit of cover in the basic Hospitalization benefits, the excess will not be recoverable under this Plan.

2.4 Intensive care fees
Fees for the special treatment under the Intensive Care Unit of the Hospital which exceed maximum days per disability, but if the daily intensive care fees exceed the daily maximum limit of cover in the basic Hospitalization insurance benefits, the excess will not be recoverable under this item.

2.5 Miscellaneous Hospital medical fees
- Hospital service fees
- Operation theatre fees
- Anaesthetist fees
- Specialist fee

2.6 Surgeon's fees
Fees for receiving surgical treatments during Hospitalization

3 Claim procedure
To be handled in accordance with Part III Section 1 Point 2 and 3 of this Policy.

Section 3 Maternity Benefits Provisions

1. Benefits covered:
The amount of Maternity benefits for the Insured Person and the types of insurance are set out in detail in the Benefit Schedule and on the Insured Person's name list. In the event of any Insured Person after joining this Scheme and during the Policy year requiring treatment which conforms to the limitation of the provision herein, proven by a Registered Medical Practitioner and due to pregnancy (including normal delivery and miscarriage), the Company will, according to the maternity benefit, pay to the Insured Person the fees which arise from treatments received. Maternity benefit covers antenatal or postnatal care (14 days after childbirth), medications, obstetrician's fee, and any in-hospital expenses incurred for new born children within 7 days after birth. Each item of claim amount cannot exceed the fees actually received by the hospital and will be a combined calculation on the basis of the percentages provided in the Benefit Schedule, and the total sum of claims shall not exceed the maximum amount provided in the Benefit Schedule.

2. Claims procedure
The Insured Person must submit the following documents to the Company within 90 days from date of treatment received, failing which, the right to claim is considered abandoned.
1. completed Hospitalization claim form of Maternity;
2. attending obstetrician's statement completed by the obstetrician in-charge;
3. all original receipts and itemized bills in respect of Hospitalization charges and fees.

If the above item 2 cannot be provided, the Company may assist the Insured Person in obtaining attending physician's statement from the physician in-charge. However, the Policyholder and the Insured Person have to provide a letter of authorization and be responsible for the collection charges.

3. Additional Exclusion
Apart from the general exclusion of this policy, the Company shall not be liable for and shall not pay any claims or medical expenses in respect of:
1. If the Insured's expected date of confinement is within six (6) months from the effective date, no Maternity Benefit shall be payable in respect of such pregnancy. (Including antenatal or postnatal care and medication for such treatment). This exclusion is waived for the members who where insured under the Previous Policy as of the inception date of this policy.
2. If the Insured becomes miscarriage within ninety (90) days from the effective date, no Maternity Benefit shall be payable in respect of such miscarriage. (Including antenatal or postnatal care and medication for such treatment). This exclusion is waived for the members who where insured under the Previous Policy as of the inception date of this policy.

Section 4 Outpatient Benefits Provisions

1. Benefits covered
The amount of Outpatient benefits for the Insured Person and the types of insurance in detail are specified in the Benefit Schedule and/or Panel Service Agreement and on the Insured Person's name list.
In the event of the costs incurred by any Insured Person using the Medical Credit Facility exceeding the benefit to which that

Insured Person is entitled under the Benefits Schedule and/or Panel Service Agreement as stipulated in the Policy, the Insured Person is responsible for the payment of any Co-payment for Network Benefit directly to the Network Provider at the time of service or when billed by the Network Provider, the Company will not bear for the difference or shortfall.

1.1 General Consultation rendered by Registered Medical Practitioner "General Practitioner Consultation"

If the Insured Person suffers illness or accidental injury and has received medical treatment including consultation, examination, injection or medication from a Registered Medical Practitioner, the Company will pay the actual expenses incurred during the consultation. The amount payable under this benefit shall be according to the reimbursement percentage, and subject to the maximum amount per visit and maximum visits per year as specified in the Benefit Schedule.

1.2 General Consultation rendered by Network General Medical Practitioner "Network General Practitioner Consultation"

If the Insured Person suffers illness or accidental injury and has received medical treatment including consultation, examination, injection or medication from network Registered Medical Practitioner, the Company will pay the actual expenses incurred during the consultation. The insured person shall present his medical card and pay a co-payment fee during consultation. The amount of consultation and medication fee and benefit payable under this provision shall be subject to the limits and maximums as specified in the Benefit Schedule and/or Panel Service Agreement.

1.3 Consultation and medical treatment rendered by Registered Chinese herbalist or Bonesetter or Acupuncturist "Chinese Herbalist, Bonesetter or Acupuncturist Consultation"

If the Insured Person suffers illness or accidental injury and receives medical treatment from a Registered Chinese Herbalist / Bonesetter / Acupuncturist, the Company will pay for the expense of consultation, examination and medication actually incurred during the consultation. The amount payable in each visit shall be according to the reimbursement percentage, and subject to the maximum amount per visit and maximum visits per year as specified in the Benefit Schedule.

1.4 Consultation and medical treatment rendered by Network Chinese Herbalist or Bonesetter or Acupuncturist "Network Chinese Herbalist, Bonesetter or Acupuncturist Consultation"

If the Insured Person suffers illness or accidental injury and has received medical treatment including consultation, examination, injection or medication from network Registered Chinese Medical Practitioner, the Company will pay the actual expenses incurred during the consultation. The insured person shall present his medical card and pay a co-payment fee during consultation. The amount of consultation and medication fee and benefit payable under this provision shall be subject to the limits and maximums as specified in the Benefit Schedule and/or Panel Service Agreement.

1.5 Physiotherapy Treatment or Chiropractor Consultation

If the Insured Person suffers illness or accidental injury and receives treatment from a Physiotherapist or Chiropractor with a written referral from a Registered Medical Practitioner, the Company will pay the actual expenses incurred for the physiotherapy or chiropractic treatment. The amount payable under this benefit shall be according to the reimbursement percentage, and subject to the maximum amount per visit and maximum visits per year as specified in the Benefit Schedule. This provision is not admissible if the Insured Person fails to obtain a written referral from a Registered Medical Practitioner.

1.6 Network Physiotherapy Treatment or Chiropractor Consultation

If the Insured Person suffers illness or accidental injury and has received treatment from a network Physiotherapist or Chiropractor with a written referral from Registered Medical Practitioner, the Company will pay the actual expenses incurred for the physiotherapy or chiropractic treatment. The insured person shall present his medical card and relevant document (if required), and pay a co-payment fee during the visit. The amount of consultation and medication fee and benefit payable under this provision shall be subject to the limits and maximums as specified in the Benefit Schedule and/or Panel Service Agreement. This provision is not admissible if the Insured Person fails to obtain a written referral from a Registered Medical Practitioner.

1.7 Consultation and medical treatment rendered by Registered Specialists " Specialist Consultation"

If the Insured Person suffers illness or accidental injury and received treatment from a Registered Specialists, the Company will pay the actual expenses incurred for the specialist consultation, examination and medication. The amount payable under this benefit shall be according to the reimbursement percentage, and subject to the maximum amount per visit and maximum visits per year as specified in the Benefit Schedule.

If the Physiotherapy Treatment or the Chiropractor Consultation have not been insured in the insurance Scheme, it is hereby declared and agreed that the Specialist Consultation is hereby extended to cover treatments conducted by a registered Physiotherapist or a qualified Chiropractor provided that such treatment are recommended by the attending doctor in writing and that the total benefit payable for the normal Specialist Consultation, Physiotherapist and Chiropractor treatments altogether shall not exceed the maximum limits and the maximum numbers of visits payable under the Specialist Consultation Benefit set forth in the Insurance Schedule.

1.8 Consultation and medical treatment rendered by Network Specialists "Network Specialist Consultation"

If the Insured Person suffers illness or accidental injury and received treatment from a network Specialists, the Company will pay the actual expenses incurred from the specialist consultation, examination and medication. The insured person shall present his medical card and relevant document (if required), and pay a co-payment fee during the visit. The amount of consultation and medication fee and benefit payable under this provision shall be subject to the limits and maximums as specified in the Benefit Schedule and/or Panel Service Agreement.

1.9 X-ray and laboratory test

If the Insured Person suffers illness or accidental injury and receives diagnostic or laboratory tests such as x-ray test, computer tomography, magnetic resonance imaging test etc. with written referral from a Registered Medical Practitioner, Chinese Medical Practitioner, Physiotherapy or Chiropractor, the Company will pay the actual expenses incurred. The amount payable under this benefit shall be according to the reimbursement percentage, and subject to the maximum limit per year or per disability as specified in the Benefit Schedule. No benefit is payable if the Insured Person fails to obtain a written referral from a Registered Medical Practitioner, Chinese Medical Practitioner, Physiotherapy or Chiropractor.

1.10 Consultation and medical treatment fees of registered dental surgeon

If the Insured Person suffers dental disease or accidental injury, or scaling and oral examination (1 visit per year) and receives treatment, scaling and polishing, filling, extraction, x-ray,

drainage of abscess, pins for cusp restoration, root canal treatment, injection or medications crown and denture (caused by accident) from a Registered Dental Surgeon, the Company will pay the fees actually incurred. The amount payable in each time should be calculated by using the amount actually incurred times the reimbursement rate specified in the Benefit Schedule. But the maximum amount payable is limited to the maximum benefit per year specified in the Benefit Schedule.

1.11 Prescribed Medication

A benefit is payable for purchase of medicines at licensed Pharmacy and is prescribed by a registered medical practitioner specifically for the treatment of a covered injury or sickness, the Company shall pay a benefit equal to the actual expenses subject to the maximum limits and reimbursement percentage as stated in the Benefit Schedule. No benefit is payable if the Insured Person fails to obtain a written referral from a Registered Medical Practitioner.

1.12 Annual Health Checkup

The Company will pay actual medical expense, incurred for the routine health checkup, doctor's outpatient consultation, routine laboratory tests and Chest X-ray. The amount payable under this benefit shall be according to the reimbursement percentage, and subject to the maximum benefit per year as specified in the Benefit Schedule.

1.13 Home visit consultation and medical treatment fees rendered by Registered Medical Practitioner

If the Insured Person suffers illness or accidental injury and requires a Registered Medical Practitioner to provide medical treatment such as consultation, injection or medication etc. at home, the Company will pay the fees of such consultation, injection or medication etc. actually incurred. The amount payable in each time should be calculated by using the amount actually incurred times the reimbursement rate specified in the Benefit Schedule. But the maximum amount payable is limited to the maximum benefit per claim and the maximum number of claims per year specified in the Benefit Schedule. Under this item of claim, there is only one payment per day.

1.14 Home visit consultation and medical treatment fees rendered by Specialist Doctor

If the Insured Person suffers illness or accidental injury and requires a Specialist Doctor to provide medical treatment such as consultation, injection or medication etc. at home, the Company will pay the fees of such consultation, injection or medication etc. actually incurred. The amount payable in each time should be calculated by using the amount actually incurred times the reimbursement rate specified in the Benefit Schedule. But the maximum amount payable is limited to the maximum benefit per claim and the maximum number of claims per year specified in the Benefit Schedule. Under this item of claim, there is only one payment per day.

2 Claims procedure

The Insured Person must submitted the following documents to the Company within 90 days from date of treatment received, failing which, the right to claim is considered abandoned.

1. out-patient claim form duly completed;
2. original receipt(s) and the receipt must include the following details: date of consultation; diagnosis (for consultation or treatment rendered by Registered Chinese Practitioner, the receipt shall include name of the Practitioner, his registered or listed number); name of patient; consultation fees; clinic chop and signature of the attending physician or practitioner. If any of the above mentioned details missing in the outpatient receipts, claims will not be entertained by the Company;
3. if the insured Person claims for X-ray and laboratory test fees, the claim will not be entertained by the insurance company unless, other than receipts, the Insured Person can also provide a referral letter from the registered medical practitioner in-charge, Chinese Medical Practitioner, Physiotherapy or Chiropractor.(Referral letter is regarded valid for 90 days from date of issue);
4. if the insured Person claims for Prescribed Medication, the claim will not be entertained by the insurance company unless, other than receipts, the Insured Person can also provide a referral letter from the registered medical practitioner in-charge (Referral letter is regarded valid for 90 days from date of issue);
5. If the Insured Person claims for consultation and medical treatment fees of specialist doctor, other than providing the above-mentioned outpatient receipts, specialist consultation should be chosen on the out-patient claim form. . Otherwise, the Company will only pay on the basis of "General Practitioner Consultation" under the outpatient benefit.;
6. If the Insured Person claims for the benefit of physiotherapy or chiropractor treatment, other than providing the above-mentioned outpatient receipts, a referral letter of the registered medical practitioner must also be provided. If the Insured Person fails to provide the referral letter, benefit is not payable under the provision. (Referral letter is regarded valid for 1 year from date of issue. For follow-up consultation and treatments, a referral letter copy must be attached at each time of claim).

3 Other claim documents

In addition to the documents mentioned in Condition 2 above, the Policyholder or Insured Person shall provide relevant documents of proof as required by the Company for reimbursement. If such documents cannot be provided on claims submission, payment of benefits may be deferred until all documents of proof are available within the prescribed time limit, failing which, the right to claim is considered abandoned.

PART IV – GENERAL EXCLUSIONS

The Company shall not be liable for and shall not pay any claims or medical expenses in respect of:

1. Room and Board fees which is not related to the treatment of the disease. Non-medical expenses such as companion bed or seats, extra bed, private nurse, guest tray or charges for personal consumables, etc. Other expenses for organ, procurement or use of special braces, appliances, wheel chairs, medical accessories, walking frame, crutches or any other similar equipment.
2. Expenses in respect of eye refraction correction including but not limited to myopia, hyperopia, astigmatism, presbyopia, strabismus, eye examination, eyeglasses, contact lens, hearing test or aids (unless caused by an accident), etc.; prostheses; cosmetic or plastic surgery.
3. All dental care including but not limited to oral check-up, tooth braces, fillings, orthodontic, etc. or any dental surgery other than dental operation necessitated by damage to sound natural teeth as a result of injury in an accident and gum infection or treatment under the Benefit Schedule.
4. Injury, illness, sickness or disease directly or indirectly resulting from or consequent upon war or any act of war, declared or undeclared, invasion, strike, riot, revolution insurrection, acts of terrorism or participating in military service or police force.
5. Psychiatric conditions or mental illness including but not limited to psychoses, neurosis, or insanity, neurasthenia, anorexia, insomnia etc.
6. Any medical expenses related to pregnancy (including antenatal & postnatal care), miscarriage, childbirth (including vaginal delivery and caesarian section), abortion, birth control, contraception or infertility, sterilization and any complication therefrom or all relevant treatment, except explicitly stated on the Policy Schedule.

7. Self-inflicted injury, suicide (whether sane or insane), intoxication, psychoses or wilful misuse of drugs (including the taking of narcotics).
8. Injury due to committing or participating in an illegal activity.
9. Congenital anomalies, which is medical abnormalities existing at the time of birth or neonatal physical abnormalities which become apparent within twelve (12) years of birth, including but not limited to genetic disease or deformities existing at the time of birth such as cleft lip or palate, clubfoot, birthmark, abnormal bone or muscles, cerebral palsy etc.; or developmental problem including but not limited to flat foot, undescended testis. Baby Jaundice.
10. Medical expenses for periodic, routine and regular medical examination or rest cures.
11. Expenses for inoculation or vaccination.
12. Medical expenses arising from sexual dysfunction, venereal disease or their sequelae; AIDS (Acquired Immune Deficiency Syndrome) and/or ARC (AIDS Related Complex) and its complications.
13. Insured Person is entitled to benefits payable under Employees' Compensation Ordinance or other insurance plans. For the balance of expenses not covered by the Ordinance or other insurance plans will be paid by the insurance company subject to the terms of exclusions and conditions of this Policy and will not exceed the maximum limit of cover as specified in the Benefits Schedule.
14. Participating or engaging in dangerous activities, including but not limited to Bungee jumping, Glide-Kite, Glider, Parachuting, Torrent Rafting, Diving with the use of breathing apparatus, Mountaineering, Rock Climbing, etc.
15. Any charges for accommodation, nursing and services received in health hydros, nature cure clinics, convalescent or rehabilitation home, rest home, home for aged or similar establishments.
16. Alternative treatment including but not limited to moxibustion therapy, massage therapy, Tui Nai, hypnotism, aromatherapy, naturopathy, yoga activities, podiatry, speech therapy, occupational therapy or dietitian consultation, etc.
17. Experimental procedure and / or treatment not yet approved by the Company.
18. All health supplements including but not limited to heathcare product such as lingzhi, ginzeng, swallow's nest, commercial healthcare pack, nutrient herbs and tonic.
19. Treatment of preventive and recuperative nature.
20. Treatment related to weight control.
21. Fees in relation to provision of medical reports.

PART V – SUPPLEMENTARY EMERGENCY ASSISTANCE SERVICES AND BENEFITS

These Emergency Assistance Services and Benefits are issued and provided by Inter Partner Assistance Hong Kong Limited (hereinafter called "IPA") to the Insured Person who is insured under the Policy with Bank of China Group Insurance Company Ltd.

Section 1 Definitions

1. Country of Residence
Shall mean Hong Kong Special Administrative Region, unless it is declared in the application form of the Policy.

2. Emergency
Shall mean a serious medical situation or distress which could not be reasonably prevented and for which specific external help is required.

3. Illness
Shall mean any unforeseen sickness, illness or disease first manifested after the effective date of the Policy.

Section 2 Duration of Cover, Limitations and Liabilities

1. Duration of Cover
The benefits mentioned in Section 3 are granted for a period of 12 consecutive months during the period of validity of the Policy. Every assistance cases in respect of a covered event shall be absolutely barred unless commenced within two years from the date of occurrence of such event.

2. Geographical and Time Limits
The benefits mentioned in Section 3 apply worldwide outside Country of Residence of the Insured Person and for the trips not exceeding 180 consecutive days.

3. Liability of the Company and IPA
It is understood that the physicians, Hospitals, clinics, any kind of professionals to whom the Insured Person will be referred by IPA are for most of them independent contractors responsible for their own acts and are not employees, agents or servants of the Company and IPA. Furthermore, the Company as well as IPA shall not be responsible for any act or failure to act on the part of those professionals such as, and not limited to, physicians, Hospitals, and clinics.

Section 3 Emergency Assistance Services and Benefits

If the Insured Person shall suffer serious Bodily Injury or Sudden Illness or death outside Country of Residence or require legal referral or emergency rerouting arrangements (travel information services can be obtained under any circumstances) while arising out of and in the course of his/her journey, provided that the trip is not undertaken against the advice of the physician, and/or for the purpose of obtaining or seeking any medical or surgical treatment abroad, the following emergency assistance services and benefits are available directly from IPA upon specific verbal notification by the Insured Person or his/her personal representative to any of the specified 24-hour alarm centre. The telephone number is (852)28619235. It shall be stressed that the Insured Person shall not be entitled to the reimbursement of any such expenses incurred or paid directly by him/her.

1. Medical Attention Telephone Medical Advice, Evaluation and Referral Appointment
When medical advice is needed, the Insured Person or his/her personal representative may telephone IPA's alarm centre for medical advice and evaluation from the attending physician. However, it shall be stressed that telephone conversation cannot establish a diagnosis and shall be considered as an advice only. If medically necessary, the Insured Person shall be referred to another physician or to a medical specialist for personal assessment and IPA will assist the Insured Person in making the medical appointment. All physician's fees and related charges shall be borne entirely and directly by the Insured Person without any reimbursement from IPA.

2. Medical Evacuation
Should the Insured Person suffer from Bodily Injury or Sudden Illness such that IPA's medical team and the attending physician recommend Hospitalization in a hospital or another medical facility where the Insured Person can be suitably treated, IPA will arrange and pay for:

1. The transfer of the Insured Person into one of the nearest Hospital and,
2. If necessary, on medical grounds:
   - The transfer of the Insured Person with necessary medical supervision by any means (including but not limited to air ambulance, scheduled commercial flight, and road ambulance) to an Hospital more appropriately equipped for the particular Bodily Injury or Sudden Illness, or
   - The direct repatriation of the Insured Person to an appropriate Hospital or other health care facility in his/her Country of Residence.

The IPA's medical team and attending physician will determine the necessary arrangements including timing, means of transfer, destination of evacuation according to the

circumstances. All decisions base on medical necessity.

To complete the Medical Evacuation, if medically necessary IPA will arrange for the following:

- ambulance to transfer the patient to the airport of departure
- emigration / immigration and customs clearances at the airport of departure / destination
- intensive care equipment
- qualified medical escort to stabilize the patient and monitor his/her condition during the transport
- ambulance on the tarmac to meet the patient and the medical escort at the airport of arrival
- immediate consultation by appropriate specialist upon arrival
- reservation of bed in Hospital
- constant monitoring of the medical condition of the Insured Person during his Hospitalization by IPA doctor
- liaison with the family of the Insured Person and updating of the evolution of the treatment.

3. Repatriation After Treatment

Following the Medical Evacuation in Section 2 above and if medically necessary, IPA will arrange and pay for the repatriation of the Insured Person to the medical facility in his Country of Residence by scheduled airline flight or any other appropriate means of transportation (on economy class), including any supplementary cost of transportation to and from the airport, if his/her original ticket is not valid for the purpose, provided that the Insured Person shall surrender any unused portion of his/her ticket to IPA. Any decision on the repatriation of the Insured Person shall be made jointly and exclusively by both the attending physician and IPA's alarm centre under constant medical supervision.

4. Repatriation of Mortal Remains/Ashes

Upon the death of the Insured Person due to Accident or Sudden Illness, IPA will arrange and pay for 1) the repatriation of the Insured Person's body or ashes to the place of burial in the Insured Person's Country of Residence, or 2) the local burial of the Insured Person at the request of the Insured Person's heirs or representative provided that the costs of local burial responsible will not exceed the equivalent costs of repatriation of the Insured Person's body or ashes to the place of burial in the Insured Person's Country of Residence. In no case shall IPA be responsible for the cost of coffin.

5. Medical Monitoring

In the event of the Insured Person being Hospitalized outside Country of Residence, IPA's medical team will monitor the Insured Person's condition as closely as possible with the attending doctor and IPA will give second opinion to the Insured Person or his/her representative in respect of treatment and medical charges, whenever possible.

6. Travel Information

The Insured Person may contact IPA to obtain the following information and services before starting or during his/her journey.

- Update immunizations and vaccinations requirement and needs
- Weather information worldwide
- Airport taxes
- Customs requirements
- Passport and Visa requirements
- Consulate and embassies addresses and contact numbers
- Exchange rates
- Banking days
- Language Information / Arrangement of interpreter services
- Arrangement of children escort
- Transmission of urgent messages for medical reasons

7. Luggage Retrieval

In the event of loss or misrouting of the Insured Person's luggage by a common carrier, IPA will liaise with the relevant entities such as but not limited to airline companies, customs officials, and will organize the dispatch of such luggage, if recovered, to such place as the Insured Person may direct.

8. Emergency Rerouting Arrangements

IPA will assist the Insured Person in reorganizing his/her flight schedule should an emergency oblige him/her to alter his/her original plan.

9. Assistance on Loss of Travelling Document

In case of loss or theft of essential documents or personal identification documents (e.g. passport, entry visa, etc.), IPA will provide the Insured Person with the necessary information regarding the formalities to be fulfilled with the appropriate local authorities or entities, in order to obtain the replacement of such lost or stolen documents.

10. Legal Referral

Upon the request of the Insured Person, IPA can provide the names, addressees, telephone numbers of lawyers and solicitors firms to the Insured Person.

11. Compassionate Visit

In the event of the Insured Person suffering from serious Bodily Injury or sudden Illness resulting in Hospital confinement outside his/her Country of Residence for more than 10 (ten) consecutive days, IPA will arrange and pay for the cost of a return scheduled airline (on economy fare basis) for a relative or designated person of the Insured Person to travel from the Insured Person 's Country of Residence to the Insured Person 's bedside, including the cost of an ordinary room accommodation in any reasonable hotel up to HKD1,200.00 per day for a maximum period of 5 (five) consecutive days, but excluding the cost of drinks, meals and other room services.

12. Return of Unattended Dependent Child(ren) to Country of Residence

If any of the Insured Person's travelling dependent child(ren) under 16 years of age is left unattended by reason of the Insured Person 's Bodily Injury or sudden Illness or the death of the Insured Person resulting in Hospital confinement outside his/her Country of Residence, IPA will organize and pay for the cost of a scheduled airline ticket (on economy fare basis), for such child(ren) to return to his/her home in the Insured Person's Country of Residence, including any supplementary cost of transportation to and from the airport, if the original ticket is not valid for the return, provided that the Insured Person shall surrender any unused portion of the return ticket to IPA. If necessary, IPA will also hire and pay for a qualified attendant to accompany any such dependent child(ren) for return journey.

13. Deposit Guaranteeing of Hospital Admission

In case of Hospital admission duly approved by both the attending physician and IPA's alarm centre doctor and the Insured Person is without means of payment of the required Hospital admission deposit, IPA will on behalf of the Insured Person guarantee or provide such payment up to HKD40,000.00. Prior to arranging the above service, IPA shall obtain the approval and confirmation for the reimbursement by the Company to IPA for the advanced sum of deposit.

14. Hotel Room Accommodation for Convalescence

IPA will arrange and pay for the cost of an ordinary room accommodation in any reasonable hotel up to HKD1,200.00 per day for a maximum of 5 (five) consecutive days, incurred

by the Insured Person for the sole purpose of convalescence immediately following his/her discharge from the Hospital, and if deemed medically necessary by the attending physician and IPA's doctor.

15. Unexpected Return to the Country of Residence

In the event of the death of the Insured Person's Immediate Relative in his/her Country of Residence while the Insured Person is travelling overseas (excluding the case of immigration) necessitating an unexpected return to his/her Country of Residence, IPA will arrange and pay for the cost of a scheduled return airline ticket (on economy class basis) for the return of the Insured Person.

16. China Hospitals Network Service

If the Beneficiary suffers from Bodily injury or sudden illness and needs to be hospitalized in PRC the Beneficiary may contact IPA. IPA will refer the nearest hospital under IPA's China Hospital Network to the Beneficiary and provide guarantee for the required admission deposit required by hospital. Under any circumstances the Beneficiary shall fully and directly settle the medical expenses including the hospital admission deposit guaranteed by IPA while the Beneficiary is discharged.

Procedure only applicable to Service 16

When the Beneficiary goes to the network hospital, the Beneficiary can either 1) call collect to IPA's Alarm Centre at (Hong Kong) 2861 9235 for the assistance of hospital admission or 2) present the emergency card will "MedPass" logo to the hospital staff of the Accident & Emergency Department and produce the following document and information to hospital staff:

- **(a)** I.D. number/ Home Permit number/ Passport number
- **(b)** If possible or applicable, policy number or certificate number
- **(c)** Contact i.e. phone number

Section 4 Failure to Notify IPA

In the event of a Bodily Injury or sudden Illness resulting in the Hospitalization of the Insured Person prior to notify IPA, the Insured Person or his representative, where possible, shall contact IPA within three days of the occurrence of such emergency or any complication directly relating to such emergency. In the absence of such notice, IPA may not be responsible for his/her assistance case.

Section 5 Subrogation

In the event that IPA makes any payment in connection with the provision of assistance to the Insured Person, IPA shall be subrogated to the rights of such Insured Person to obtain payments from any third party found legally responsible for the assistance, up to the amount of such payment made by IPA, and any other insurance or assistance plan which provides compensation to the assistance events.

Section 6 General Exclusions

IPA shall not be required to provide the assistance services in any form or manner to the Insured Person or his/her representative with respect to Bodily Injury or Sudden Illness of the Insured Person which is caused by the followings:

1. Pre-existing Illness or disabilities prior to the commencement of the trip during which the illness manifests, regardless the Insured Person is aware of the illness or not.
2. Injuries due to insanity or self-infliction or conditions related to functional disorders of the mind; rest cure or sanatorium care; drug addiction or alcoholism; communicable diseases requiring by law isolation or quarantine.
3. Congenital Abnormalities.
4. Pregnancy and Maternity.
5. Injuries arising directly or indirectly as a result of participation in any professional or competitive sports (other than on foot), water sports, winter sports, racing, rallies, potholing, rock climbing or mountaineering normally involving the use of ropes or guides, parachuting, bungee jumping or martial arts.
6. Injuries sustained contracted as a result of participation in illegal acts.
7. Services rendered without the authorization and/or intervention of IPA.
8. Costs which would have been payable if the event giving rise to the intervention of IPA had not occurred.
9. Any expense more specifically covered under any insurance policy.
10. Cases of minor Illness or injury which in the opinion of the IPA's doctor can be adequately treated locally and which do not prevent the Insured Person from continuing their travels or work.
11. Expenses incurred where the Insured Person in the opinion of the IPA's doctor is physically able to return to his/her Country of Residence sitting as a normal passenger and without medical escort, unless deemed necessary by the IPA's doctor.
12. Cases related to psychiatric disorders.
13. The Insured Person engaging in any form of aerial flight except as a fare paying passenger on a regular scheduled airline or licensed charter aircraft over an established route

Section 7 Force Majeure

The Company and IPA shall not be held responsible for delays or failures in providing assistance caused by any strike, war, invasion, act of foreign enemies, armed hostilities, (regardless of a formal declaration of war), civil war, rebellion, insurrection, terrorism, political coup, riot and civil commotion, administrative or political impediments or radioactivity or acts of God or any other event of force majeure which prevents IPA from providing such assistance services.

Section 8 Contract

Notwithstanding any other provisions in the Policy, IPA is the service provider of this emergency assistance program. The Company shall assume no liability in any default of the provision of the said benefits and service.