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Cigna HealthFirst DiaMedic Plan

Part I – Definitions

1.1 Unless otherwise stated, capitalized words or terms that appear in this Policy shall have the meaning as defined below:

"Accident" means a sudden, unforeseen, unexpected, external and visible event while the Policy is in force and **"Accidental"** shall be construed accordingly.

"Age" means the age at the last birthday upon the Commencement Date or any Anniversary Date thereafter.

"Anaesthetist" means a Physician who is licensed and registered under Anaesthesiology of Specialist Register of applicable medical council of a country or territory.

"Anniversary Date" means each anniversary date of the Commencement Date.

"Application Form" means the application submitted to us for applying for the Policy, including any evidence of insurability and documents or information submitted in relation thereto, whether in writing or verbal (through telephone or otherwise).

"Basic Medication" means medication, as prescribed by Network Doctor, legally registered by the pharmaceutical service of the applicable department of health in a country or territory rendering western medicine and surgical services. Network Doctor(s) reserves the right for extra charges on medication if, in the opinion of the Network Doctor, special and expensive prescription is required.

"Basic Policy" means the Hospitalization and Surgical Benefits and Extended Benefits of this Cigna HealthFirst DiaMedic Plan policy including any endorsement relating thereto, but excluding any rider or endorsement which is not related to the Hospitalization and Surgical Benefits and Extended Benefits of this Cigna HealthFirst DiaMedic Plan policy and any additional coverage, and terms and conditions of the Optional Insurance Benefit rider(s).

"Basic Premium" means premium payable for the Hospitalization and Surgical Benefits and Extended Benefits under this Basic Policy as specified in the Policy Schedule.

"Benefit Schedule" means the schedule attached hereto entitled "Benefit Schedule" which sets out the limits of the benefits payable under the Policy.

"Bodily Injury" means

(a) injury to the Person Insured on any part of his / her body resulting solely and directly from an Accident and independent of all other causes; and
(b) caused by external, violent and visible means while the Policy is in force.

"Calendar Month" means the period of time between any day in a month and the day immediately preceding the same day of the next succeeding month or, if there is no corresponding day in the next succeeding month, the last day of the next succeeding month.

"Chief Medical Officer"
A Physician appointed by us from time to time as medical consultant.

"Chinese Medicines" means the Chinese medicines legally registered in the Chinese Medicines Board under Chinese Medicine Council in Hong Kong pursuant to the Chinese Medicine Ordinance of Hong Kong or the equivalent legal authority of any other place rendering Chinese medicines treatment.
For the avoidance of doubt, this Policy does not cover the health supplements and all specialized Chinese herbs and/or tonic medicine such as but not limited to bird's nest, Lingzhi, ginseng, cordceps sinensis, agaricus blazei murill, deer antler and etc.

"Chinese Medicine Practitioner" means a person, other than the Person Insured or any relative of the Person Insured unless approved by the Company, who is practising Chinese medicine on the basis of traditional Chinese medicine in general practice; and is legally licensed and registered with the applicable medical council of a country or territory in which traditional Chinese medicine treatment is rendered by the Chinese Medicine Practitioner to the Person Insured.

"Cigna HealthFirst Medical Plan Series" means the series including "Cigna HealthFirst DiaMedic Plan", "Cigna HealthFirst Elite Medical Plan", "Cigna HealthFirst Choice Medical Plan", and any other policies that fall under the "Cigna HealthFirst Medical Plan Series" as defined and issued by the Company from time to time.

"Civil Commotion" means a disturbance, commotion or disorder created by civilians usually against a governing body or the policies of that body.

"Class of Risk" means the class of risk to which the Person Insured belongs as specified in the Policy Schedule and any subsequent endorsement of this Policy.

"Commencement Date" means the date (Hong Kong time) on which the Policy becomes effective, and referred to as such in the Policy Schedule.

"Company", "we", "our" and "us" mean Cigna Worldwide General Insurance Company Limited.

"Congenital Conditions" means medical abnormalities existing at the time of birth, regardless of whether they are known or unknown to the Person Insured. They shall include (but not limited to the exclusion of others which may medically be regarded as congenital conditions), strabismus (squint), hydrocephalus, undescended testicle, Meckel's diverticulum, flat foot, heart septal defect and indirect inguinal hernias.

"Developmental Conditions" means abnormal development compared to what is expected at the given age level or stage of development. These impairments or disabilities originate before the Age of eighteen (18), may be expected to continue indefinitely, and constitute a substantial impairment. Biological and nonbiological factors are involved in these disorders. They shall include (but not to the exclusion of others which may medically be regarded as developmental conditions) language and learning disorders, autism and mental retardation.

"Dietitian" means a person, other than the Person Insured or any relative of the Person Insured unless approved by the Company, who is legally qualified as a dietitian licensed and permitted to practice in the country or territory where treatment is received.

"Extended Benefits" means the Extended Benefits payable under Clause 4.4 of Part IV of this Policy.

"General Practitioner" means a Physician who is licensed and registered in the General Register of the applicable medical council of a country or territory.

"Grace Period" means a period of one (1) Calendar Month after any Premium Due Date excluding the Commencement Date.

"Hereditary Conditions" means medical conditions genetically transmitted from parent to offspring.

"Hong Kong" means Hong Kong Special Administrative Region of the People's Republic of China.

"Hospital" means a legally constituted establishment duly registered and legally authorized under the laws of the country or territory in which it is established and which meets all of the following requirements:
(a) it operates primarily for the reception and medical care and treatment of sick, ailing or injured persons on a resident inpatient basis;
(b) it admits resident in-patients only under the supervision of a Physician or Physicians one of whom is available for consultation at all times;
(c) it maintains organised facilities for medical diagnosis and treatment of such persons, and provides (where appropriate) facilities for major surgery within the confines of the establishment or in facilities controlled by the establishment;
(d) it provides full-time twenty-four (24) hours per day nursing service by and under the supervision of a staff of Nurses; and
(e) it maintains at least one (1) Physician in residence.

Notwithstanding the foregoing, "Hospital" shall not include any of the following:
(a) a mental institution, an institution engaged primarily in the treatment of psychiatric or psychological disease including subnormality, and the psychiatric department of a Hospital;
(b) a place for the aged, a rest home, a place for drug addicts or alcoholics; or
(c) a health hydro or nature cure clinic, a nursing or convalescent home, a special unit of a Hospital used primarily as a place for drug addicts or alcoholics, or as a nursing, convalescent, rehabilitation, extended-care facility or rest home.

If the diagnosis and Hospital Confinement is made in mainland China, it must be made in Tier 3 Class A or above Hospital or our designated Hospital from time to time, otherwise no benefit shall be payable by the Company.

"Hospital Confinement" means admission in a Hospital as a resident in-patient due to Bodily Injury or Sickness suffered by the Person Insured and a Medically Necessary condition under a written recommendation by a Physician.

"Hospitalization and Surgical Benefits" means the Hospitalization and Surgical Benefits payable under Clause 4.3 of Part IV of this Policy.

"Intensive Care Unit" means a part of a Hospital other than a post-operative recovery room which, in addition to providing room and board:
(a) is established by the Hospital for a formal intensive care program;
(b) is exclusively reserved for critically ill patients requiring constant audio-visual observation prescribed and performed by a Physician or by a specially trained registered graduate Nurse;
(c) provides all necessary life-saving equipment, drugs and supplies in the immediate vicinity on a stand-by basis; and
(d) a specific additional charge for daily Intensive Care Unit charges are made.

"Indebtedness" means any amounts owed to us in respect of the Policy, including without limitation any outstanding Premium and any accrued interest on the above mentioned amounts.

"Issue Date" means the date on which the Policy is issued by the Company (Hong Kong time), and referred to as such in the Policy Schedule.

"Maximum Limit" means the maximum amount that will be paid or reimbursed by the Company subject to the terms and conditions of this Policy with regard to the relevant benefit(s) as specified in the Benefit Schedule.

"Medically Necessary" means the necessity to have a medical service which is:
(a) consistent with the diagnosis and customary medical treatment for the condition at a Reasonable and Customary charge;
(b) in accordance with standards of good and prudent medical practice;
(c) necessary for such a diagnosis or treatment;
(d) not furnished primarily for the convenience of the Person Insured, Physician, Chinese Medicine Practitioner, Physiotherapist, Anaesthetist or any other medical service providers;
(e) furnished at the most appropriate level which can be safely and effectively provided to the Person Insured; and
(f) with respect to Hospital Confinement, not furnished primarily for diagnostic scanning purpose, imaging examination or physical therapy.

"Network Doctor" means the Chinese Medicine Practitioner(s) and Physician(s) in Hong Kong whose name is specified in the list provided by our designated medical service provider(s), subject to change from time to time.

"Nurse" means a person, other than the Person Insured or any relative of the Person Insured unless approved by the Company, who is a qualified or trainee nurse or general nurse legally licensed and registered and authorized pursuant to the laws of the country or territory in which he/she is employed for providing nursing services.

"Optional Insurance Benefit" means additional insurance benefit other than the benefits provided under this Basic Policy, namely Outpatient Benefits.

"Optional Insurance Benefit Issue Date" means the issue date of specific Optional Insurance Benefit (Hong Kong time).

"Optional Insurance Benefit Premium" means premium payable under this Policy for all Optional Insurance Benefit rider(s) as set out in the Policy Schedule.

"Outpatient Benefits" means the Outpatient Benefits payable under Clause 4.5 of Part IV of this Policy.

"Palliative Care" means treatment that does not cure and substantially improve a condition but is given in order to alleviate symptoms.

"Palliative Care Benefit Waiting Period" means a period of two (2) years from each of:
(a) the Issue Date or the Commencement Date (whichever is the later);
(b) the approval date of reinstatement (if the Policy has been reinstated); and
(c) the issue date or the effective date of increase in benefit, whichever is the later (if any benefit under this Policy has been increased).

"Period of Insurance" means the period during which the Policy shall remain in force (Hong Kong time).

"Person Insured" means the person who is named as "Person Insured" in the Policy Schedule.

"Physician" means unless otherwise determined by the Company, means a medical practitioner, other than the Person Insured or any relative of the Person Insured unless approved by the Company, who is qualified with a degree in western medicine and is legally licensed and registered with the applicable medical council of a country or territory in which medical or surgical services are rendered by that medical practitioner.

"Physiotherapist" means unless otherwise determined by the Company, means a person, other than the Person Insured or any relative of the Person Insured unless approved by the Company, who is legally licensed and registered with the applicable medical council of a country or territory where medical expenses are incurred to render assessment and treatment service on physical disabilities by means of remedial exercises, manual therapy and mechanical, thermal or electrical.

"Plan Level" means the plan level selected by the Policyholder in respect of the Policy and specified in the Policy Schedule or endorsement (if any), being one of the plan levels as set out in the Benefit Schedule.

"Policy" means this Basic Policy, the Optional Insurance Benefit rider(s) (if any), the Statements, the Policy Schedule, the Benefit Schedule, any endorsements attached to this Basic Policy and any other subsequent endorsements and amendments made to the Policy which are duly signed by the Company's authorized representative.

"Policy Schedule" means the document attached to the Policy and entitled "Policy Schedule" (as subsequently amended by any endorsement issued by the Company) which bears the policy number of the Policy and the particulars of the Person Insured for identification purposes.

"Policy Year" means each twelve (12) Calendar Months period commencing from the Commencement Date or any Anniversary Date thereafter.

"Policyholder" means the person who owns this Policy, and referred to as such in the Policy Schedule.

"Pre-existing Medical Conditions" means Bodily Injury or Sickness sustained or suffered by the Person Insured which has been diagnosed or has exhibited symptoms or has occurred or required medical advice and/or treatment and/or the prescriptions of drugs before each of:

(a) the Issue Date or the Commencement Date (whichever is the later);
(b) the approval date of reinstatement (if the Policy has been reinstated);
(c) the Optional Insurance Benefit Issue Date (if the Optional Insurance Benefit is added after the Issue Date); and
(d) the issue date or the effective date of increase in benefit, whichever is the later (if any benefit under this Policy has been increased).

Notwithstanding the foregoing, "Pre-existing Medical Conditions" shall not include Bodily Injury or Sickness including but not limited to diabetes which:

(a) has been fully disclosed in the Application Form; and
(b) the Company agrees not to classify as an exclusion under the Policy.

"Premium" means Basic Premium and Optional Insurance Benefit Premium (if any) payable under this Policy.

"Premium Due Date" means the Commencement Date, Anniversary Date, and (in case the payment frequency is not on an annual basis) such other payment dates which correspond to the payment frequency for Premium settlement.

"Reasonable and Customary" in relation to a fee, a charge or an expense, means any fee or expense which

(a) is charged for treatment, supplies (inclusive of medication) or medical services that are Medically Necessary and in accordance with standards of good medical practice for the care of an injured or ill person under the care, supervision or order of a Physician;
(b) does not exceed the usual level of charges for similar treatment, supplies (inclusive of medication) or medical services in the locality where the expense is incurred; and
(c) does not include charges that would not have been made if no insurance existed.

The Company reserves the right to determine whether any particular Hospital/medical charge is a reasonable and customary charge with reference but not limited to any relevant publication or information made available, such as schedule of fees, by the government, relevant authorities and recognized medical association in the locality. The Company reserves the right to adjust any and all benefits payable in relation to any Hospital/medical charges which in the opinion of the Chief Medical Officer is not a reasonable and customary charge.

"Rehabilitation Centre" means a registered institution (other than Hospital) which provides physiotherapy, occupational therapy and other rehabilitative treatment for physical injury, dysfunction or disability.

"Shortfall" means expenses incurred by a Person Insured who has used the Cigna HealthFirst DiaMedic Card for payment of such expenses, which is not covered by this Policy.

"Sickness" means the impairment of normal physiological function which affects part or all of the Person Insured.

"Simplified Schedule of Operations" means the schedule attached hereto entitled "Simplified Schedule of Operations" which sets out the Surgical Procedures and classifications of operations covered under this Policy.

"Specialist" means a Physician who is licensed and registered in the Specialist Register of the applicable medical council of a country or territory.

"Statements" means the Application Form, any declarations and personal statements made to and received by the Company in applying for this Policy.

"Surgical Procedure" means any surgical procedure listed in the Simplified Schedule of Operations.

"Terrorism" means the use or threatened use of force or violence against person or property, or commission of an act dangerous to human life or property, or commission of an act that interferes with or disrupts an electronic or communication system, undertaken by any person or group, whether or not acting on behalf of or in any connection with any organization, government, power, authority or military force, when the intent is to intimidate, coerce or harm a government, the civilian population or any segment thereof, or to disrupt any segment of the economy.

Terrorism shall also include any act which is verified or recognized by the relevant local government as an act of terrorism.

"War" means war, whether declared or not, or any warlike activities including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

"Western Medication" means western medication registered with Pharmaceutical Services of Department of Health in Hong Kong or equivalent legal authority of any other place.

"You, your, yours or yourself" means the "Policyholder" named in the Policy Schedule.

1.2 Unless the context otherwise provides, singular words shall include the plural form and masculine words shall include the feminine form and vice versa. General words shall not be given a restrictive meaning by reason of the fact that they are followed by particular examples intended to be embraced by the general words.

1.3 Reference to Clauses refers to clauses of this Policy. Headings are inserted for convenience of reference only and shall not affect the interpretation of this Policy.

1.4 If any provision of this Policy shall be determined by a court of competent jurisdiction to be illegal, invalid or unenforceable, it shall not affect the legality, validity or enforceability of any other provision of this Policy.

1.5 No failure or delay in exercising any right under this Policy by the Company shall operate as a waiver of any such right by the Company.

Part II – General Provisions

2.1 The Policy Contract

In consideration of the payment of the Premium and on the basis of the Statements submitted to the Company, the Company hereby agrees to issue this Policy to cover the Person Insured and provide for benefits in accordance with the terms and conditions appear herein. This Policy document, the Statements, the Policy Schedule, the Benefit Schedule, any endorsement, provision and document bearing the policy number of this Policy shall constitute the entire contract between you and us.

2.2 Governing Law and Jurisdiction

This Policy is governed by and shall be interpreted in accordance with the laws of Hong Kong. You and we both agree that the Hong Kong courts shall have exclusive jurisdiction to settle any claim, dispute or matter arising under or in connection with this Policy or the legal relationships it creates.

2.3 Policy Currency

Subject to Clause 2.4 of this Part II, all dollar amounts referred to in this Policy are expressed in the currency specified in the Policy Schedule.

2.4 Benefit Currency

Unless otherwise agreed by the Company, all benefits denominated under the Policy shall be based in the same currency as specified in the Policy Schedule.

2.5 Policy Changes

2.5.1 We reserve the right to amend the terms and conditions of this Policy at any time while this Policy is in force, as may be deemed necessary by the Company, or pursuant to any applicable legislation and/or regulatory requirements effective at the Commencement Date or during the term of the Policy.

2.5.2 No variation to the terms and conditions of this Policy (including its appendices), whether by endorsement or otherwise, shall be valid unless it is made in writing and signed by an authorized representative of the Company. The related endorsement and document would be sent to your last known address under our record.

2.5.3 You can inform the Company in writing at any time of any change of your or the Person Insured's personal particulars in a form prescribed by us. An endorsement effecting such changes or notice acknowledging receipt of your instructions will be sent to your last known address under our record.

2.6 Change Of Details

The Person Insured and the Policyholder shall give immediate notice to the Company of any change in any of their personal particulars, including but not limited to, names, occupation, resident country and addresses.

2.7 Change of Plan Level / Optional Insurance Benefits

Downgrade and upgrade of level of cover refer to any change in the Plan Level or the Optional Insurance Benefits.

2.7.1 On each Anniversary Date, the Policyholder may, subject to the Company's approval, upgrade or downgrade the level of cover specified in the Benefit Schedule by making a written application to the Company at least thirty (30) days prior to the Anniversary Date and by paying the relevant premium for such new level of cover. Such new level of cover shall then become the Plan Level or the Optional Insurance Benefits under the Policy.

2.7.2 Any increase of benefits resulting from upgrade of the Plan Level and/or the Optional Insurance Benefits under Clause 2.7.1 of this Part II shall only be applicable to:

(a) Bodily Injury sustained after the issue date or effective date of upgrade (whichever is the later); or

(b) Sickness which has been diagnosed or has exhibited symptoms or has occurred or requires medical treatment and/or prescriptions of drugs for the first time after the issue date or the effective date of upgrade (whichever is the later), subject to the terms of specified benefits under this Policy.

2.8 Renewal

2.8.1 Subject to Clause 2.15 of this Part II, the Basic Policy shall be effective for an initial period of twelve (12) Calendar Months and thereafter guaranteed and automatically renewable, for successive periods of twelve (12) Calendar Months each, provided that payment of the Premium has been made at the time of renewal and that we continue to issue new policy(ies) under the "Cigna HealthFirst DiaMedic Plan".

2.8.2 Subject to Clause 2.15 of this Part II, the Optional Insurance Benefits of this Policy (if applicable) shall be effective for an initial period of twelve (12) Calendar Months and thereafter guaranteed and automatically renewable, for successive periods of twelve (12) Calendar Months each provided that payment of the Premium has been made at the time of renewal, and that we continue to issue new policies under the Basic Policy and the respective Optional Insurance Benefits of "Cigna HealthFirst DiaMedic Plan".

2.8.3 The Company reserves the right to revise the terms of the Policy and/or the Premium and/or the Benefit Schedule upon each renewal.

2.8.4 If the Basic Policy and/or the respective Optional Insurance Benefit of "Cigna HealthFirst DiaMedic Plan" are not renewed by the Company, we will send a written notice to the latest address we have of yours, at least thirty (30) days before the next Anniversary Date, to notify you that the Basic Policy and/or the respective Optional Insurance Benefit of "Cigna HealthFirst DiaMedic Plan" will not be renewed.

2.9 Mis-statement

2.9.1 If the Age and/or the Class of Risk of the Person Insured has been mis-stated and the Person Insured would still be eligible for insurance coverage under this Policy, we shall adjust the Premiums payable under this Policy based on the correct Age and/or the Class of Risk. Any excess Premiums shall be refunded to the Policyholder without interest and any shortfall in Premiums shall be paid immediately upon our request, as the case may be.

2.9.2 If the Age and/or the Class of Risk of the Person Insured has been mis-stated and the Person Insured would not have been eligible for insurance coverage under this Policy, the coverage provided by this Policy to such Person Insured would be void for the period during which the Person Insured is ineligible for coverage under this Policy and the liability of the Company during the period within which the Person Insured is not eligible for coverage shall be limited to a refund, upon written request, of that part of Premium paid for such period without interest provided always that where there is fraud on the part of the Person Insured and/or the Policyholder, no Premiums paid shall be refunded. The Company retains the right to recover any relevant claims previously paid hereunder.

2.9.3 The Policy is issued based on the completeness and accuracy of information you and the Person Insured provided us the Statements and other relevant declaration. If there is any fraud, mis-statement, false statement or representation, serious negligence or concealment made by the Policyholder or the Person Insured in the Statements and/or the relevant declaration or if there is any fraud, mis-statement, false statement or representation or concealment made by the Policyholder or the Person Insured in relation to claims payable under the Policy, this Policy shall be deemed to be void as from the Commencement Date for all purposes at the sole and absolute discretion of the Company. Accordingly, the Company shall not be liable to pay any benefit under the Policy. The Company reserves the right in our sole and absolute discretion not to refund any Premium paid. If a policy payment including but not limited to claim payment has been paid in respect of the Person Insured, you are required to repay to us on demand the amount of that policy payment. For the purposes of this provision, "serious negligence" shall be deemed to be inexcusable failure to comply with the pre-contractual requirement to declare all the

circumstances which affect the risk assessment and which are determining factors for the Company in order to conclude the contract of this Policy.

2.10 Subrogation

The Company shall have the right to proceed at its own expense in the name of the Person Insured against any third party who may be responsible for causing directly or indirectly Bodily Injury or Sickness giving rise to a claim under this Policy. The Person Insured agrees to give the necessary consent and assistance to the Company in such proceedings.

2.11 Notice and Proof of Claims

2.11.1 Notification of a claim

Written notification of a claim must be given to the Company within thirty (30) days after the occurrence of the event giving rise to the claim. Such notification shall include information sufficient to identify the Person Insured and the nature of the claim.

2.11.2 Proof of claim

(a) Original receipts for all Medically Necessary charges and documentary proof of the Age of the Person Insured must be submitted with a fully completed claim form prescribed by the Company and signed by the relevant Physician and/or Specialist. In the event that the Policyholder opts to make a claim in respect of the same medical expenses under an insurance policy issued by another insurer, a copy of the claim form which has already been submitted to that insurer shall also be submitted to the Company.

(b) The Person Insured shall at his / her own expense provide to the Company or our designated medical service providers such certificates, information and evidence as the Company or our designated medical service providers may from time to time require in connection with any claim under this Policy and all claims requests shall be made in the form prescribed by the Company.

(c) For the purpose of assessing a claim, the Person Insured shall make available to the Company or our designated medical service providers all medical records and reports and, where required, shall sign all authorization forms necessary to authorize the Company or our designated medical service providers to obtain a full and complete medical history of the Person Insured.

(d) The Company reserves the right to require that the Person Insured under this Policy be examined by the Chief Medical Officer and/or Physician(s) and/or a Specialist(s) of our choice when and as often as it may be required for the purpose of assessing the validity of the proof of claim submitted hereunder.

(e) Proof of claim must be given within ninety (90) days after the Person Insured has been discharged from the Hospital or the event giving rise to the claim, whichever is the later. If proof of claim is not given within the prescribed period, it must be shown that proof of claim has been given as soon as reasonably possible; otherwise, the Company shall have the right not to pay the claim.

(f) If the diagnosis and Hospital Confinement is made in mainland China, it must be made in Tier 3 Class A or above Hospital or our designated Hospital from time to time, otherwise no benefit shall be payable by the Company.

(g) It is a condition precedent to the Company's liability to make any payment under this Policy that the Person Insured, the claimant and the Policyholder fully comply with the terms and conditions of this Policy. The Company or our designated medical service providers will not issue any guarantee of payment or be liable for any credit facility unless the Policyholder has completed the Hospital pre-admission form and submit to us for approval.

(h) The Company shall not be liable to pay any benefit under this Policy unless the Chief Medical Officer, at the Company's expense, is allowed to examine the Person Insured. In case of any conflict between the medical opinion of the Chief Medical Officer and that of another Physician, the opinion of the Chief Medical Officer shall prevail.

2.11.3 Deduction of claim payment

The Company shall have the right to deduct any outstanding Indebtedness arising from the Person Insured from any benefit payable under the Policy.

2.12 Co-ordination Of Benefits

If any Medically Necessary charges shall be reimbursed by another party or by us under another insurance plan, we shall only be liable for the difference between such reimbursement and the total amount of benefits which would otherwise be payable in respect of such medical expenses under the Policy.

2.13 Payment

We shall pay the benefit amount to you or if you are not living at the time of payment, to your estate, in Hong Kong dollar without interest.

Notwithstanding any provision in this Policy, all payments under this Policy shall be conditional upon production of valid documents verifying the identity of the Policyholder and/or the Person Insured and/or the executor or administrator of your estate (as the case may be) to our reasonable satisfaction. The receipt given by you or the executor or administrator of your estate as the case may be, shall be valid and be treated as a full and final discharge of all liabilities of the Company under this Policy.

2.14 Interest

Unless otherwise provided in the Policy, all amounts payable by the Company under the Policy shall not carry any interest.

2.15 Termination

2.15.1 Cancellation by Policyholder

The Policyholder may cancel this Policy by giving not less than thirty (30) days' notice in writing to the Company. Termination of the Policy caused by such cancellation shall become effective on the date specified in such written notice or the date approved by us, whichever is later. There shall be no refund of Premium paid and the Company reserves the right to charge the Premium until the end of such Policy Year after the termination.

2.15.2 Cancellation by the Company

(a) The Company shall be entitled to cancel this Policy at any time with immediate effect in the event of fraud, material mis-statement, concealment or breach of utmost good faith or any claim made be fraudulent or exaggerated on the part of the Policyholder or the Person Insured in respect of a claim or any other matter affecting or in connection with the underwriting of this Policy or any other Policy(ies) held by the Policyholder or the Person Insured and issued by the Company. In such event, the Company reserves the right in our sole and absolute discretion not to refund any Premium paid. If a policy payment including but not limited to claim payment has been paid in respect of the Person Insured, you are required to repay to us on demand the amount of that policy payment.

(b) The Company reserves the right to cancel this Policy when Shortfall referred to in Clause 2.18 of this Part II is not settled within fourteen (14) days period after receipt of a shortfall advice from the Company or the Company's designated medical service providers to the Policyholder as referred to Clause 2.18 of this Part II (and where the Shortfall continues not to be settled, any delay by the Company in cancelling this Policy pursuant to this provision shall not constitute a waiver of its right to cancel at a later time).

2.15.3 Automatic Termination

This Policy shall terminate immediately upon the occurrence of the earliest of the following events:

(a) the death of the Person Insured;
(b) this Policy is cancelled by the Policyholder or the Company pursuant to Clause 2.15.1 or Clause 2.15.2 of this Part II respectively;
(c) this Policy is not renewed due to any reasons provided under Clause 2.8.4 of this Part II; or
(d) at the end of a Grace Period when the Premium payable or any part thereof remains unpaid.

2.16 Clerical Error

Clerical errors by the Company shall not invalidate insurance otherwise validly in force, nor continue insurance otherwise not validly in force, and this Policy shall be construed as if any such clerical errors have not been committed.

2.17 Limitations

No action at law shall be brought against the Company for the recovery of any claim under this Policy within the first sixty (60) days from the date on which proof of claim has been submitted to the Company in accordance with the requirements of this Policy or after two (2) years from the date on which the written proof of claim is required to be submitted under this Policy.

2.18 The Cigna HealthFirst DiaMedic Card

(a) The Company shall issue a Cigna HealthFirst DiaMedic Card to the Person Insured who has enrolled in this Policy upon policy issue.

(b) The Person Insured who has enrolled in this Policy may use the Cigna HealthFirst DiaMedic Card together with the guarantee of payment letter (GOP) issued by the Company or the Company's designated medical service providers to pay the medical expenses for Hospital Confinement at any private Hospitals subject to the acceptance of the Hospitals.

(c) All expenses charged to the Cigna HealthFirst DiaMedic Card remain the responsibility of the Policyholder until settlement of eligible expenses has been notified by the Company or the Company's designated medical service providers to the Policyholder.

(d) If the Person Insured incurs any expenses that are excluded items, in excess of the credit limit specified in the GOP or not approved by the Company or the Company's designated medical service providers, the Policyholder/Person Insured is liable and agrees to settle such charges by himself/herself before discharge from the Hospital.

(e) In the event that the Person Insured using the Cigna HealthFirst DiaMedic Card incurs a cost which has exceeded the applicable Maximum Limit; or is not eligible under this Policy (including but not limited to the use of the Cigna HealthFirst DiaMedic Card by the Person Insured after the termination of the Policy or benefits), the Policyholder agrees to reimburse the Company in full for the Shortfall within fourteen (14) days of receipt of a shortfall advice from the Company or the Company's designated medical service providers. The Company reserves the right to charge the Policyholder interest on the Shortfall outstanding for more than fourteen (14) days.

(f) Use of Cigna HealthFirst DiaMedic Card constitutes acceptance of the conditions under which it is issued and in the event of theft or loss, the Policyholder is responsible for any transactions involving its use until such theft or loss is reported to the Company in writing.

(g) The Cigna HealthFirst DiaMedic Card shall remain the property of the Company and the Person Insured to whom it is issued shall keep it safe at all times. It may only be used by the Person Insured to whom it is issued and it shall not be transferable. The Cigna HealthFirst DiaMedic Card shall immediately cease to be valid upon the earliest of the following events and the Policyholder undertakes to return any physical Cigna HealthFirst DiaMedic Card(s) to the Company within seven (7) days after it becomes invalid:
  (i) the Policy is terminated in accordance with the terms herein; or
  (ii) the Company so demands.

(h) The Policyholder is liable to pay the Company or the Company's designated medical service providers the Shortfall and ensure that the Cigna HealthFirst DiaMedic Card will be used properly.

(i) The Company shall not be liable to the Person Insured/Policyholder in any respect for any loss, damage, expense, suit, action or proceeding suffered or incurred by the Person Insured/Policyholder, whether directly or indirectly arising from or in connection with the use of the Cigna HealthFirst DiaMedic Card.

(j) The Company has the right to offset any refund or claim to the Policyholder against any Shortfall outstanding and arising from the Person Insured.

(k) The Company or the Company's designated medical service providers has the right to hold the credit limit and collect the Shortfall from the Policyholder's authorized credit card.

2.19 Guarantee of Payment Letter (GOP)

(a) The Company or the Company's designated medical service providers has the absolute right in accepting or declining the GOP application based on the information the Person Insured / Policyholder provides.

(b) If the Person Insured / Policyholder fails to provide valid, sufficient and complete information for credit card authorization while submitting GOP application, the Company or the Company's designated medical service providers has the absolute discretion to decline the GOP application.

(c) The giving of GOP or subsequent GOP from the Company or the Company's designated medical service providers under this clause shall not be deemed as admission of the Company's liability to pay and/or reimburse the Policyholder under this Policy or a waiver of any breach of the terms and conditions of the Policy.

2.20 Incontestability

Except for fraudulent misrepresentation or fraudulent non-disclosure, this Policy shall be incontestable after it has been in force during the lifetime of the Person Insured for two (2) years from any of (i) the Issue Date of the Basic Policy, (ii) the Commencement Date of the Basic Policy, (iii) the approval date of any reinstatement of the Basic Policy (whichever is the later). If the Company contests this Policy, we shall have the discretion to forfeit any and all the monies paid to us under this Policy.

However, this incontestability clause shall not apply to any Optional Insurance Benefit contract of this Policy.

2.21 Policy Ownership

While this Policy is in force, the Policyholder can exercise all rights, privileges and options provided under this Policy. You may change the ownership of this Policy during the lifetime of the Person Insured. Such change is valid only if recorded by us and approved by us and an endorsement has been issued by us in relation thereto.

2.22 Third Party Rights

This Policy is excluded from the application of the Contracts (Rights of Third Parties) Ordinance (the "Ordinance"). Other than the Company and the Policyholder, a person who is not a party to the Policy (including, but not limited to, the Person Insured or any beneficiary) shall have no right under the Ordinance to enforce any term of this Policy.

2.23 English and Chinese Versions

The English version of the Policy is the official version and the Chinese version is provided for reference only. In the event of any inconsistency or conflict between the English version and the Chinese version, the English version of the Policy shall prevail.

Part III – Premium Provisions

3.1 Premium payment under this Policy includes the following:

(a) Basic Premium

Under the Basic Policy, you are required to pay the Basic Premium regularly on Premium Due Date in the frequency as specified in the Policy Schedule.

(b) Optional Insurance Benefit

You may apply for additional benefits or coverage under the Policy. The Optional Insurance Benefit Premium required for such benefit or coverage will be set out in the Policy Schedule and paid on Premium Due Date.

3.2 Payment Frequency

This Policy is an annual policy. Any Premium payable under this Policy shall be paid on an annual or monthly basis. Subject to the approval of the Company, you may request in writing to alter the payment frequency during the term of the Policy.

3.3 Premium Payment

3.3.1 The Premium is determined based on the Age and Class of Risk of the Person Insured on the Commencement Date and at the time of renewal of this Policy.

3.3.2 If you fail to pay the initial premium for the Policy, the Policy shall be deemed to be void as from the Commencement Date for all purposes. Accordingly, we shall not be liable to pay any benefit under the Policy. Except for the initial premium payment, a Grace Period of one (1) Calendar Month after any Premium Due Date will be allowed for payment of Premium or any part thereof. The coverage of this Policy will remain in force during this Grace Period. If the Premium or any part thereof remains unpaid at the end of the Grace Period, the Policy shall terminate on the Premium Due Date.

3.3.3 The Company reserves the right to revise the Premium of this Policy on the Anniversary Date or upon renewal at its sole discretion by taking into account such factors as the Company determines to be relevant for the purpose of revising the Premium.

3.3.4 There shall be no refund of Premiums paid upon termination of the Policy in case of (i) cancellation of the Policy by the Company due to fraud, material mis-statement or concealment or breach of utmost good faith or any claim made be fraudulent or exaggerated on the part of the Policyholder or the Person Insured in respect of a claim or any other matter affecting or in connection with the underwriting of this Policy or any other Policy(ies) held by the Policyholder or the Person Insured and issued by the Company or (ii) cancellation of the Policy by the Policyholder.

3.3.5 If the Policy is cancelled by the Policyholder during a Policy Year, the Company reserves the right to charge the Premium until the end of the same Policy Year.

3.4 Reinstatement

3.4.1 If the Policy lapses due to non-payment of Premium, subject to the approval of the Company, the Policy may be reinstated within three (3) Calendar Months from the date on which the unpaid Premium was first due subject to all of the following:

(a) submission of a written application for reinstatement in a form prescribed by us;

(b) submission of evidence of insurability of the Person Insured to the satisfaction of the Company; and

(c) receipt of the payment of all the arrears of Indebtedness (if any).

3.4.2 For the avoidance of doubt, the Company shall not be liable to pay any benefits for Bodily Injury or Sickness which has been diagnosed or which has exhibited symptoms or which has occurred or required medical advice and/or treatment and/or the prescription of drugs prior to the date when the Policy is reinstated.

3.4.3 Subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement, the Policyholder shall have the same rights under this Policy as existing immediately before the date of termination. However, the Company shall not be liable for any claims for events occurred during the period from the date of termination of this Policy prior to reinstatement to the approval date of reinstatement.

Part IV – Benefit Provisions

4.1 Extent Of Benefits

While this Policy is in effect and subject to the terms of the Policy, the Basic Policy shall be payable by the Company according to the Plan Level selected on the earlier of (i) the admission date of Hospital and (ii) the date of surgery in the Physician's clinic. Outpatient Benefits shall be payable only if the Optional Insurance Benefit is covered under the Policy and specified in the Policy Schedule. The Company reserves the right to request the Person Insured to obtain pre-approval from the Company before incurring the relevant expense.

4.2 Plan Level

4.2.1 The coverage of the Basic Policy is worldwide but the Optional Insurance Benefit only covers consultation occurring / tests performed / treatment provided / medication prescribed in Hong Kong.

4.2.2 Unless otherwise specified, all benefits covered under this Policy are subject to the Plan Level and Maximum Limits including but not limited to day limit and annual limit as set out in the Benefit Schedule of this Policy.

4.2.3 For the Basic Policy, the Company shall reimburse the Reasonable and Customary expenses actually incurred due to the insured event. The amount payable shall be calculated in accordance with the formula as follows provided that the amount payable for any one Policy Year does not exceed the applicable Maximum Limit of the relevant benefits:

{Amount of eligible medical expenses incurred **LESS (-)** (the medical expenses of same insured event reimbursed by another party or by us under another insurance plan

Please note that:

(a) the benefits under the Basic Policy shall not be payable for Hospital Confinement in class of suite / VIP/ deluxe room of a Hospital.

4.3. Hospitalization and Surgical Benefits

4.3.1 Hospital Room & Board

The Company shall reimburse the Reasonable and Customary of the actual expenses charged by a Hospital for accommodation and meals of the Person Insured in the event of the Hospital Confinement for receiving Medically Necessary western medicine treatment or services. The number of days covered and the amount payable under this benefit should not exceed the Maximum Limit as specified under Hospital Room & Board section in the Benefit Schedule.

4.3.2 Intensive Care Unit Expenses

The Company shall reimburse the actual Reasonable and Customary expenses charged by a Hospital for Intensive Care Unit. The services shall be rendered upon recommendation by the attending Physician for Medically Necessary western medicine treatment for the Person Insured. The number of days covered and the amount payable under this benefit should not exceed the Maximum Limit as specified under Intensive Care Unit Expenses section in the Benefit Schedule.

4.3.3 Inpatient Doctor's Call

The Company shall reimburse the Reasonable and Customary charges of the actual attendance fee charged by a Physician(s) for Hospital Confinement for Medically Necessary western medicine treatment of the Person Insured. It covers no more than one visit per day and payable for one Physician a day. Attendance shall be incurred inside the Hospital and Person Insured shall be examined by the Physician in person. The number of days covered and the amount payable under this benefit should not exceed the Maximum Limit as specified under as specified under Inpatient Doctor's Call section in the Benefit Schedule.

4.3.4 Surgical Benefit

The Company shall reimburse the Reasonable and Customary actual charges of the surgeon's fee, Anaesthetist's fee, operating theatre fee and the consultation fee (the consultation fee is limited to surgical procedures performed in the Physician's clinic only) for Medically Necessary Surgical Procedure for treatment of Bodily Injury or Sickness of the Person Insured. The Surgical Procedure is to be performed either in Hospital or in a Physician's clinic. The amount payable under this benefit should not exceed the Maximum Limit as specified under Surgical Benefit section in the Benefit Schedule for the relevant class of Surgical Procedure in accordance with the Simplified Schedule of Surgical Operations, provided that:

(a) for Surgical Procedure performed during the Hospital Confinement, the Company shall reimburse under this benefit the actual surgeon fee for such Surgical Procedure performed by one or more Physicians; and
(b) for Surgical Procedure performed in the Physician's clinic, the Company shall also reimburse the Physician's consultation fees, if any, charged on the same day as the surgery and the ancillary services (such as instruments, operating room time, anaesthetist's expenses) are provided to the Person Insured.

4.3.5 Inpatient Specialist's Fee

The Company shall reimburse the Reasonable and Customary charges of the actual fee charged by a Specialist, other than the attending Physician or the surgeon, for Hospital Confinement for Medically Necessary western medicine treatment of the Person Insured. Services rendered by Specialist shall be incurred inside the Hospital and Person Insured shall be treated by them in person. Written referral shall be obtained by the attending Physician for the service. The amount payable under this benefit should not exceed the Maximum Limit as specified under Inpatient Specialist's Fee section in the Benefit Schedule.

4.3.6 Companion Bed

The Company shall reimburse the Reasonable and Customary of the actual expenses charged by a Hospital for accommodation and meals for the Person Insured's direct family member for occupying one (1) extra bed, provided that the Hospital Room & Board expenses are payable for the same Hospital Confinement under this Policy. The number of days covered and the amount payable under this benefit should not exceed the Maximum Limit as specified under Companion Bed section in the Benefit Schedule.

4.3.7 Private Nurse's Fees

The Company shall reimburse Reasonable and Customary charges of the actual expenses for Medically Necessary services provided by a Nurse for special nursing care at time during the Hospital Confinement and the written referral shall be obtained by the attending Physician for this service.

The number of days covered and the amount payable under this benefit shall not exceed the Maximum Limit as specified under Private Nurse's Fees section in the Benefit Schedule.

4.3.8 Other Medical Expenses

The Company shall reimburse the Reasonable and Customary actual expenses charged by a Hospital in the event of Hospital Confinement for receiving Medically Necessary western medicine treatment for the Person Insured, provided that the Hospital Room & Board expenses are payable for the same Hospital Confinement under this Policy. The amount payable under this benefit should not exceed the Maximum Limit as specified under Other Medical Expenses section in the Benefit Schedule.
It covers the following services:

(a) ambulance services immediately preceding the admission to and following the discharge from Hospital;
(b) diagnostic imaging services including X-ray, magnetic resonance imaging (MRI), computed tomography (CT) scan, PET scan and nuclear medicine. It covers diagnostic imaging services performed on the Person Insured either in

a Hospital or in a Physician's clinic or in a imaging centre provided that the services are rendered upon recommendation by the attending Physician as western medicine treatment which is considered Medically Necessary for the Person Insured. It covers only if a claim is made in relation to the incurred expenses for diagnostic imaging services which are performed on the Person Insured within thirty (30) days immediately prior to the admission date of the latest Hospital Confinement or within thirty (30) days immediately after the discharge date of the latest Hospital Confinement and provided that such expenses must be directly related to the diagnosis or medical conditions of the Person Insured during such Hospital Confinement;

(c) laboratory and pathological examinations;
(d) drugs and medication, intravenous fluid and curative material consumed at time of Hospital Confinement;
(e) dressing, splints and plaster casts;
(f) blood transfusion, excluding the cost of blood and blood plasma;
(g) physiotherapy and emergency expenses;
(h) general nursing care, excluding services payable under private nursing care;
(i) implants including but not limited to stent and pacemaker;
(j) surgical appliance used by the Physician during surgery, except all external prosthesis, special braces, equipment or appliances; and
(k) Medically Necessary western medicine services, medical disposals and consumable, excluding items being covered under the other benefits of Hospitalization and Surgical Benefits.

4.3.9 Cancer Treatment and Dialysis

The Company shall reimburse Reasonable and Customary charges of the actual expenses of a covered Sickness incurred for:

(a) treatment of cancer includes radiotherapy, chemotherapy, target therapy, gamma knife and cyberknife; or
(b) treatment of chronic and irreversible kidney failure includes peritoneal dialysis and regular hemodialysis

The treatment can be performed in Hospital or in a Physician's clinic under the recommendation from a Physician for Medically Necessary western medicine treatment of the Person Insured. The amount payable under this benefit should not exceed the Maximum Limit as specified under Cancer Treatment and Dialysis section in the Benefit Schedule.

4.3.10 Organ Transplantation

The Company shall reimburse Reasonable and Customary charges of the actual cost of Medically Necessary operation for heart, kidney, liver or bone marrow transplantation if the Person Insured is a recipient of the said organ transplant. This benefit covers the entire costs incurred to perform an organ transplant including Hospital Room & Board expenses, Intensive Care Unit Expenses, Inpatient Doctor's Call, Inpatient Specialist's Fee, Companion Bed, Other Medical Expenses and Surgical Benefit. All the other costs including the cost of acquisition and transportation of the organ are not covered.

The amount payable under this benefit shall not exceed the Maximum Limit as specified under the Organ Transplantation section in the Benefit Schedule and in no event shall be paid in addition to any other benefits payable under Hospitalization and Surgical Benefits.

The benefits under Inpatient Doctor's Call, Surgical Benefit, Inpatient Specialist's Fee, Companion Bed, Private Nurse's Fees and Other Medical Expenses shall not be payable if Hospital Room & Board expenses and/or Intensive Care Unit Expenses are not payable (except the treatment done in the Physician's clinic).

4.4 Extended Benefits

4.4.1 Pre-admission and Post-Hospitalization Outpatient Expenses

The Company shall reimburse Reasonable and Customary charges of the actual expenses for the outpatient consultation, prescribed Western Medication and diagnostic tests, provided that the Hospital Room & Board expenses are payable for the same Hospital Confinement under this Policy, or the Surgical Benefit are payable for the same surgery in the Physician's clinic under this Policy:

(a) within thirty (30) days immediately preceding the Hospital Confinement or performance of the surgery in the Physician's clinic. The services shall be rendered or recommended by the Physician for Medically Necessary western medicine treatment for the Person Insured and consistent with the diagnosis or medical conditions of the subsequent Hospital Confinement or surgery in the Physician's clinic; and
(b) within one hundred and eighty (180) days after discharge from Hospital or after the performance of surgery which are directly related to the diagnosis or medical conditions for the Hospital Confinement or the performance of surgery in the Physician's clinic.

The amount payable under this benefit shall not exceed the Maximum Limit as specified under Pre-admission and Post-Hospitalization Outpatient Expenses section in the Benefit Schedule.

4.4.2 Rehabilitation Benefit

The Company shall reimburse Reasonable and Customary charges of the actual expenses for confinement of a Rehabilitation Centre and for Medically Necessary rehabilitation treatment provided to the Person Insured during such confinement at time within ninety (90) days after discharge from Hospital for which such claim had been paid under Hospitalization and Surgical Benefits. The services shall be rendered upon recommendation by the attending Physician for Medically Necessary western medicine treatment for the Person Insured.

The amount payable under this benefit shall not exceed the Maximum Limit as specified under Rehabilitation Benefit section in the Benefit Schedule and in no event shall be paid in addition to any other benefits payable under Hospitalization and Surgical Benefits.

4.4.3 Palliative Care Benefit

The Company shall reimburse Reasonable and Customary charges of the actual expenses for confinement of a registered hospice and for Medical Necessary care and nursing service provided to the Person Insured during such confinement following a diagnosis of terminal illness confirmed after the Palliative Care Benefit Waiting Period, which in the opinion of a Physician, is highly likely to lead to the Person Insured's death within twelve (12) Calendar Months of such diagnosis. The services shall be rendered upon recommendation by the attending Physician for Medically Necessary western medicine treatment for the Person Insured. The benefit is only payable once per lifetime and only payable if the signs or symptoms of such terminal illness first occur after the Palliative Care Benefit Waiting Period.

The amount payable under this benefit shall not exceed the Maximum Limit as specified under Palliative Care Benefit section in the Benefit Schedule and in no event shall be paid in addition to any other benefits payable under Hospitalization and Surgical Benefits.

4.5 Outpatient Benefits (if applicable)

The number of visits covered and amount payable under these benefits shall not exceed the Maximum Limit as specified under the Outpatient Benefits section in the Benefit Schedule.

4.5.1 General Practitioner Outpatient Consultation

The Person Insured is eligible for the outpatient consultation with three-day (3-day) Basic Medications provided by a General Practitioner at the Network Doctor's clinic, subject to the number of visits covered as specified under General Practitioner Outpatient Consultation section in the Benefit Schedule.

4.5.2 Specialist Outpatient Consultation

The Person Insured is eligible for the outpatient consultation with five-day (5-day) Basic Medications provided by a Specialist at the Network Doctor's clinic, subject to the number of visits covered as specified under Specialist Outpatient Consultation section in the Benefit Schedule.

4.5.3 Chinese Medicine Practitioner Consultation (if applicable)

The Person Insured is eligible for the outpatient consultation with two (2) packs of basic Chinese Medicines, excluding bonesetting and acupuncture treatment, provided by a Chinese Medicine Practitioner at the Network Doctor's clinic, subject to the number of visits covered as specified under Chinese Medicine Practitioner Consultation section in the Benefit Schedule.

4.5.4 Acupuncture (if applicable)

The Person Insured is eligible for the acupuncture treatment, provided by a Chinese Medicine Practitioner at the Network Doctor's clinic, subject to the number of visits covered as specified under Acupuncture section in the Benefit Schedule.

4.5.5 Dietetic Guidance (if applicable)

The Company shall reimburse Reasonable and Customary charges of the actual outpatient consultation fee charged by a Dietitian in providing Medically Necessary treatment for the Person Insured. The number of visits covered and the amount payable under this benefit shall not exceed the Maximum Limit as specified under Dietetic Guidance section in the Benefit Schedule, provided that a written referral from a Physician shall be made and the referral letter shall be valid for six (6) Calendar Months from the date of issuance.

4.5.6 Prescribed Western Medicine

The Company shall reimburse Reasonable and Customary charges of the actual cost of Medically Necessary Western Medication prescribed to the Person Insured. Written prescription from a Physician shall be presented at time of claim and the Western Medication must be obtained from legitimate sources, including registered drugstore or pharmacy. The amount payable under this benefit shall not exceed the Maximum Limit as specified under Prescribed Western Medicine section in the Benefit Schedule.

4.5.7 Diagnostic Imaging and Laboratory Tests

The Company shall reimburse Reasonable and Customary charges of the actual outpatient expenses for imaging and laboratory examination for diagnostic purpose. The examination(s) must be Medically Necessary and consistent with the symptom(s) and diagnosis of the Person Insured and a written referral from a Physician is required to undergo the examination(s). The amount payable under this benefit shall not exceed the Maximum Limit as specified under Diagnostic Imaging and Laboratory Tests section in the Benefit Schedule.

4.6 Health Reward

4.6.1 On condition that the Premium for a Policy Year has been fully paid, the Policyholder will be eligible for a cash reward as specified under the Health Reward section in the Benefit Schedule at the next Anniversary Date provided that the following conditions are met at the end of the Policy Year:

(a) the Person Insured submits the latest evidence of insurability of the Person Insured before the deadline as specified in the written notice sent by the Company; and

(b) the Person Insured whose Age is eighteen (18) or above and who meets the Company's Health Reward Criteria whereby all five (5) underwriting criteria set out in the below respective table are met; and

(c) the Person Insured whose Age is less than eighteen (18) and who meets the Company's Health Reward Criteria whereby all four (4) underwriting criteria set out in the below respective table are met.

For Person Insured whose Age is eighteen (18) or above and who has been diagnosed by a Physician as having type 1 diabetes mellitus:

Examination Type	Examination Name	Reading	Acceptable or not
Blood Sugar Level	HbA1c	Less than 7%	Yes
		7% or above	No
Blood Pressure	Systolic Blood Pressure	Less than 90	No
		90 – 140	Yes
		Above 140	No
	Diastolic Blood Pressure	Less than 60	No
		60 – 80	Yes
		Above 80	No
Body Build	Body Mass Index (BMI)	Less than 17	No
		17 – 25	Yes
		Above 25	No
Cholesterol	Cholesterol Low-density Lipoprotein	<116 mg/dl or <3 mmol/l	Yes
		≥116 mg/dl or ≥3 mmol/l	No
Presence of Protein / Albumin in Random Urine Sample	Protein Concentration in Urine	<0.02g/l or <2mg/dl	Yes
		≥0.02g/l or ≥2mg/dl	No

For Person Insured whose Age is less than eighteen (18) and who has been diagnosed by a Physician as having type 1 diabetes mellitus:

Examination Type	Examination Name	Reading	Acceptable or not
Blood Sugar Level	HbA1c	Less than 7.5%	Yes
		7.5% or above	No
Blood Pressure	Systolic Blood Pressure	Refer to the following Table #1	
	Diastolic Blood Pressure		
Body Build	Body Mass Index (BMI)	Refer to the following Table #2	
Cholesterol	Cholesterol Low-density Lipoprotein	<110 mg/dl or <2.8 mmol/l	Yes
		≥110 mg/dl or ≥2.8 mmol/l	No

For Person Insured whose Age is eighteen (18) or above and who has never been diagnosed by a Physician as having type 1 diabetes mellitus:

Examination Type	Examination Name	Reading	Acceptable or not
Blood Sugar Level	HbA1c	Less than 8%	Yes
		8% or above	No
Blood Pressure	Systolic Blood Pressure	Less than 90	No
		90 – 140	Yes
		Above 140	No
	Diastolic Blood Pressure	Less than 60	No
		60 – 90	Yes
		Above 90	No
Body Build	Body Mass Index (BMI)	Less than 17	No
		17 – 30	Yes
		Above 30	No
Cholesterol	Cholesterol Low-density Lipoprotein	<129 mg/dl or <3.3 mmol/l	Yes
		≥129 mg/dl or ≥3.3 mmol/l	No
Presence of Protein / Albumin in Random Urine Sample	Protein Concentration in Urine	<0.66g/l or <66mg/dl	Yes
		≥0.66g/l or ≥66mg/dl	No

For Person Insured whose Age is less than eighteen (18) and who has never been diagnosed by a Physician as having type 1 diabetes mellitus:

Examination Type	Examination Name	Reading	Acceptable or not
Blood Sugar Level	HbA1c	Less than 8%	Yes
		8% or above	No
Blood Pressure	Systolic Blood Pressure	Refer to the following Table #1	
	Diastolic Blood Pressure		
Body Build	Body Mass Index (BMI)	Refer to the following Table #2	
Cholesterol	Cholesterol Low-density Lipoprotein	<110 mg/dl or <2.8 mmol/l	Yes
		≥110 mg/dl or ≥2.8 mmol/l	No

Table #1 – Blood Pressure Level (Acceptable range)

Attained Age	Boys		Girls	
	Systolic Blood Pressure	Diastolic Blood Pressure	Systolic Blood Pressure	Diastolic Blood Pressure
1	83 – 100	36 – 53	85 – 101	39 – 55
2	87 – 104	41 – 58	87 – 103	44 – 60
3	89 – 107	45 – 62	88 – 104	48 – 64
4	91 – 109	49 – 66	90 – 106	51 – 67
5	93 – 110	52 – 69	91 – 107	53 – 69
6	94 – 111	54 – 71	93 – 109	55 – 70
7	95 – 113	56 – 73	95 – 111	56 – 72
8	97 – 114	58 – 74	96 – 113	57 – 73
9	98 – 115	59 – 76	98 – 114	58 – 74
10	100 – 117	60 – 76	100 – 116	59 – 75
11	102 – 119	60 – 77	102 – 119	60 – 77
12	104 – 121	61 – 77	104 – 121	61 – 77
13	106 – 124	61 – 78	106 – 124	61 – 78
14	109 – 126	61 – 79	109 – 126	63 – 79
15	112 – 129	63 – 80	112 – 129	63 – 80
16	114 – 131	64 – 81	114 - 131	64 – 81
17	116 – 134	66 – 83	116 – 134	66 - 83

Table #2 – Body Build (Acceptable range)

Attained Age	Height (in cm)	Weight (in kg)
1	63 – 93	6.3 – 15.1
2	75.4 – 101.4	8.9 – 17.3
3	83 – 109	10 – 20.4
4	89 – 116.3	11.3 – 24
5	95 – 98.1	12.6 – 28
6	101.2 – 130.9	14.1 – 32.8
7	107.1 - 138	15.5 – 38.4
8	112.2 – 144.6	17.1 – 44.9
9	116.6 – 150.6	18.8 – 52
10	120.5 – 156.4	20.7 – 59.1
11	124.6 – 162.8	23.1 – 66.2
12	130.8 – 170.2	25.8 – 72.7
13	137.8 – 177.5	28.9 – 79.1
14	142.1 – 182.9	31.9 – 85.1
15	143.9 – 186.0	34.7 – 91.2
Attained Age	**BMI for Boys**	**BMI for Girls**
16	20.4 - 23.7	20.4 - 23.1
17	20.8 - 23.9	20.4 - 23.2

4.7 Duplicated policy

4.7.1 Any Person Insured shall not subscribe more than one single "Cigna HealthFirst Medical Plan Series" policy issued by the Company. If the Person Insured is covered under more than one "Cigna HealthFirst Medical Plan Series" policy, the Company shall consider and treat the Person Insured to be covered only under the one single policy which:

(a) provides the highest benefit amount; or

(b) was issued first if the benefit amount under each policy is the same.

4.7.2 Other than the one single policy under "Cigna HealthFirst Medical Plan Series" which is considered to validly cover the Person Insured under Clause 4.7.1, any other "Cigna HealthFirst Medical Plan Series" policy or policies for that Person Insured issued by the Company ("Void Policies") shall be null and void with effective from the commencement date(s) of those Void Policies, and no coverage shall be provided under the Void Policies. You are required to immediately return to us any money paid by us under the Void Policies in full, and upon receipt of all your payment, we will then refund to you the premium paid in respect of the Void Policies.

Part V –Exclusion Provisions

5.1 Exclusions

5.1.1 The Company shall not be liable to pay any claim under this Policy or expenses incurred directly or indirectly resulting from or consequent upon or contributed by:

(a) Pre-existing Medical Conditions and any special exclusion(s) set out under this Policy ;

(b) War, invasion, act of foreign enemy, hostilities (whether war is declared or not), Civil Commotion, rebellion, revolution, insurrection, military or usurped power or Terrorism;

(c) The Person Insured's engaging in or taking part in:

(i) Naval, military or air force service or operations, armed force or service with the police of any nation;

(ii) Professional sports or hazardous activities such as but not limited to rock climbing or mountaineering, parachuting, hang-gliding (whether powered or not), para-gliding, bungi-jumping or any kind of race other than by foot;

(iii) Cave, wreck or free diving, professional diving, diving without holding the correct diving certification such as a Professional Association of Diving Instructors (PADI) and diving at depths below 40 meters;

(iv) professional, semiprofessional or competitive winter sports, cross country skiing or snowboarding, ski or snowboard jumping, heli-skiing, off piste skiing or snowboarding, Speed Skiing;

(v) Working at height (over 20 feet);

(vi) Operating heavy machinery;

(vii) Aviation or aerial activities except air travel as a fare-paying passenger in or as a member of the aircrew of a properly licensed, fixed-wing multi-engined aircraft constructed to carry passengers and operated by a licensed commercial air carrier or in a helicopter owned and operated by a commercial concern which is licensed for the regular transportation of fare-paying passengers provided such helicopter is operating only between commercial airports and/or licensed commercial heliports and provided further that in either event such travel is not for the purpose of any trade or technical operation in or on the aircraft; or

(viii) Manufacture, storage, filling, breakdown, handling and transport of any explosive (including but not limited to firework or firecracker) or chemical material;

(d) The Person Insured's suicide, attempted suicide or intentionally self-inflicted injuries, whether sane or insane;

(e) The Person Insured being under the influence of alcohol or drugs unless, in the case of drug consumption, it is proven that such drug was taken in accordance with proper medical prescription by a Physician other than for the treatment of drug addiction;

(f) The Person Insured's driving any kind of vehicle while the alcohol content of his / her blood exceeds the level permitted by the laws of the country or territory where the Accident resulting in Bodily Injury or Sickness occurs;

(g) Any act of the Person Insured being contrary to the law of the country or territory in which the Bodily Injury or Sickness occurs as a result of such act;

(h) Pregnancy, childbirth and miscarriage of or abortion by the Person Insured, including complications resulting therefrom notwithstanding that such incident may have been accelerated or induced by Bodily Injury or Sickness;

(i) Infection with Human Immunodeficiency Virus (HIV) or variants including Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related complex (ARC);

(j) Sexually-transmitted diseases or treatment thereof;

(k) Infertility or sterilization or any type of fertility;

(l) Birth defects, Congenital Conditions, Hereditary Conditions or any disabilities arising therefrom;

(m) Cosmetic and elective surgery including but not limited to:
(i) facelifts (rhytidectomy);
(ii) nose reshaping (rhinoplasty);
(iii) liposuction and other procedures which remove fat tissue;
(iv) hair transplants; and
(v) surgery to change the shape of, enhance or reduce breast (other than breast reconstruction following treatment for breast cancer);

(n) Eye refraction error and the treatment(s) of which involve but not limited to, laser treatment, refractive keratotomy or photorefractive keratectomy, except due to Bodily Injury. The Company shall pay for treatment to correct or restore eyesight if it is Medically Necessary as a result of a Sickness or Bodily Injury, such as cataracts or a detached retina;

(o) Routine eye/ear examinations, cost of spectacles, contact lenses, hearing aids and artificial lens;

(p) Vaccination and immunisation injections;

(q) All dental treatment prescribed by dentist except emergency treatments by a Physician during Hospital Confinement due to Bodily Injury. No claims shall be payable for any follow up treatment from such Hospital Confinement;

(r) Mental, psychiatric or nervous illness, personality disorder and character disorders;

(s) Organ transplantation except such occurrence is covered under the "Organ Transplantation" section;

(t) Footcare by a chiropodist or podiatrist;

(u) Developmental Conditions including but not limited to:

(i) learning difficulties such as dyslexia;
(ii) behavioral problems such as autism or attention deficit disorder (ADHD); or
(iii) physical development problems such as short height.

(v) Treatment for obesity, or which is necessary because of obesity. This includes, but is not limited to, slimming class, aids and drugs. The Company shall only pay for gastric banding or gastric bypass surgery if the Person Insured;
(i) has a body mass index (BMI) of 40 or over and had been diagnosed as being morbidly obese; and
(ii) can provide documented evidence of other methods of weight loss which have been tried over the past twenty-four (24) Calendar Months;

(w) Artificial life maintenance including mechanical ventilation, where such treatment will not or is not expected to result in the Person Insured's recovery, or

restore the Person Insured to his/her previous state of health;

(x) Fetal surgery or treatment;

(y) Treatment for a related condition resulting from addictive conditions and disorders, including but not limited to smoking cessation; or

(z) Sleep disorders including insomnia, snoring, sleep-related breathing problems unless there are medical proofs that the Person Insured is suffering from sleep apnoea. In these circumstances, we will only pay the expenses incurred for Hospital Confinement for:

(i) One sleep study/year; and
(ii) Surgery, only if Medically Necessary;

(aa) Not Medically Necessary; or

(bb) The Person Insured's voluntarily exposing himself/herself to any hazard or danger.

5.1.2 The Company shall not be liable to reimburse any expenses and/or charges incurred by the Person Insured in respect of the following:

(a) Convalescence accommodation or treatment or services rendered in any sanatorium or similar establishment;

(b) Donor organs:
(i) Mechanical or animal organs, except where a mechanical appliance is temporarily used to maintain bodily function whilst awaiting transplant;
(ii) Purchase of a donor organ from any source; or
(iii) Harvesting and storage of stem cells, when a preventative measure against possible future disease.

(c) Medical treatment received after termination of this Policy or the expiry of the Period of Insurance notwithstanding that such expense may arise from Bodily Injury or Sickness occurring during the Period of Insurance;

(d) Routine medical examinations or health screening checks;

(e) Subject to Clause 2.11 of General Provisions, any Bodily Injury or Sickness for which compensation is payable under any laws or regulations or any other insurance plan except to the extent that such charges are not reimbursed by such laws or regulations or other insurance plan;

(f) Alternative treatment including but not limited to Chinese Medicines treatment, acupuncture, acupressure, Tui Nai, hypnotism, rolfing, massage therapy, aromatherapy (unless it is payable under the Chinese Medicine Practitioner Consultation or Acupuncture);

(g) Experimental and/or new medical technology/procedure not yet approved by the Company;

(h) Non-medical services, including but not limited to guest meals, radio, telephone, photocopy, taxes, medical report charges, fax and the like;

(i) Treatment for or in connection with speech therapy that is not restorative in nature, or if such therapy:
(i) is used to improve speech skills that have not fully developed;
(ii) can be considered custodial or educational; or
(iii) is intended to maintain speech communication.

(j) Sex change operations or any treatment needed to prepare for or recover from these operations (such as psychological counselling) including complications arising out of such treatment;

(k) Treatment for sexual dysfunction disorders (such as impotence) or other sexual problems regardless of underlying cause;

(l) any loss, damage, Sickness and/or Bodily Injury that may occur as a result of receiving medical treatment at a Hospital or from a medical professional, even when we have approved the treatment as being covered; and

(m) Treatment which is provided by anyone who lives at the same address as the Person Insured or who is a member of Person Insured's family.

Simplified Schedule of Operations

Surgical Procedure	Classification of Operation
Abdomen	
Appendectomy	Intermediate
Removal of, or other operation on gall bladder	Major
Gastro-enterostomy	Major
Resection of stomach, bowel or rectum	Major
Oesophagogastrostomy	Complex
Pancreatectomy	Complex
Total Gastrectomy	Complex
Biliary Tract	
Hepaticodudenostomy	Complex
Partial Hepatectomy or Resection (liver)	Complex
Amputations	
Thigh, leg	Major
Upper arm, forearm, entire hand or foot	Intermediate
Fingers or toes, each	Minor
Breast	
Removal of benign tumor or cyst	Minor
Simple amputation	Intermediate
Radical amputation	Major
Chest/Heart	
Complete thoracoplasty, transthoracic approach to stomach, diaphragm, esophagus, sympathectomy or laryngectomy	Major
Cardiac Catheterisation	Intermediate
Angiocardiography	Intermediate
Insertion of Cardiac pacemaker	Intermediate
Coronary Angioplasty	Major
Removal of lung or portion of lung	Major
Bronchoscopy, esophagoscopy	Minor
Induction of artificial pneumothorax, initial refills each (not more than 12)	Minor
Any operation on the heart and great vessels including Coronary Artery Bypass	Complex
Portocaval Anastomosis	Complex
Dislocation, Reduction of	
Hip, vertebra or vertebrae, ankle joint, elbow or knee joint (patella excepted)	Minor
Shoulder	Minor
Lower jaw, collar bone, wrist or patella	Minor
Any dislocation involving an open operation	Intermediate
Excision or Fixation by Cutting	
Hip joint	Major
Shoulder, knee joint, semilunar cartilage, wrist or ankle joint	Intermediate
Removal of diseased portion of bone, including curettage (alveolar process excepted)	Intermediate
Revision hip replacement	Complex
Revision knee replacement	Complex

Surgical Procedure	Classification of Operation
Ear, Nose or Throat	
Fenestration, one or both sides	Major
Mastoidectomy, simple, one side or both sides	Intermediate
Mastoidectomy, radical, one side or both sides	Major
Tonsillectomy, Adenoidectomy or both	Minor
Antrum puncture	Minor
Sinus operation by cutting, intranasal or extranasal	Intermediate
Excision of nasal polyp	Minor
Submucous resection of nasal septum	Intermediate
Tracheotomy	Intermediate
Cauterization of turbinate	Minor
Pharyngectomy	Complex
Pharyngolaryngectomy	Complex
Laryngectomy	Major
Laryngectomy with radical neck dissection	Complex
Eye	
Laser Coagulation or photo Coagulation of detached retina	Intermediate
Operation for detached retina	Major
Squint correction	Major
Cataract, removal of	Major
Any other cutting operation into the eyeball (through the cornea or sclera) or cutting operation on eye muscles	Intermediate
Removal of eyeball	Intermediate
Incision and Curettage of stye or chalazion	Minor
Fractures	
Treatment of Thigh, vertebra or vertebrae, pelvis	
- Simple Fracture	Intermediate
- Compound fracture or fracture requiring an open operation	Major
Treatment of leg, kneecap, upper arm, ankle (Potts)	
- Simple fracture, compound fracture or fracture requiring an open operation	Intermediate
Treatment of lower jaw (alveolar process excepted), collar bone, shoulder blade, forearm, wrist (colles), skulls	
- Simple or compound fracture	Minor
- fracture requiring an open operation	Intermediate
Treatment of hand, foot, fingers or toes, nose, rib or ribs	
- Simple, compound or fracture requiring an open operation	Minor
Removal of pins and screws from old fractures	Minor

Simplified Schedule of Operations (Continued)

Surgical Procedure	Classification of Operation
Genito-urinary Tract	
Removal of or cutting into kidney	Major
Fixation of kidney	Major
Removal of tumors or stones in ureter or bladder	
- By cutting operation	Major
- By endoscopic means	Minor
- By extracorporel shock wave lithotripsy treatment	Intermediate
Cystoscopy	Minor
Total Cystectomy	Complex
Prostatectomy	
- simple punch for median bar	Minor
- partial resection via cystoscope	Intermediate
- complete removal, any approach	Major
Circumcision	Minor
Varicocele, hydrocele, orchidectomy or epididymectomy	
- Single or bilateral	Intermediate
Hysterectomy or panhysterectomy	Major
Hysterotomy	Major
Excision of ovarian cyst	Intermediate
Oophorectomy, Salpingectomy or Salpingostomy	Major
Cervix amputation	Intermediate
Dilatation and curettage (non-puerperal), cervix cauterization or conization, polypectomy, or any combination of these	Minor
Vaginal plastic, operation for cystocele or rectocele	Intermediate
Goitre	
Removal of thyroid, total or subtotal	Major
Removal of adenoma or benign tumor of thyroid	Intermediate
Hernia	
Single hernia	Intermediate
More than one hernia	Major
Joint	
Incision into, tapping excepted	Minor
Ligaments and Tendons	
Cutting or transplant, single or multiple	Intermediate
Suturing of tendon, single	Minor
Suturing of tendon, multiple	Intermediate
Paracentesis	
Tapping	Minor
Rectum	
Sclerotherapy of Piles	Minor
Hemorrhoidectomy, external, internal or both	Intermediate
Cutting operation for fissure	Minor
Cutting operation for thrombosed hemorrhoids	Minor
Cutting operation for fistula-in-ano single or multiple	Intermediate

Surgical Procedure	Classification of Operation
Skin and Subcutaneous Tissues	
Burns and scalds, treatment under anaesthesia	Intermediate
Free graft	Minor
Skin grafting	Intermediate
Suture or excision and suture of wounds	Minor
Removal of Pilonidal Sinus or Cyst	Intermediate
Skull	
Trephine	Minor
Carotid Aneurysm	Complex
Carotid Endarterectomy	Complex
Craniotomy for brain abscess, excision of brain tumor (cerebral glioma), meningioma, posterior fossa craniectomy for aneurysm, acoustic neuroma, trigeminal rhizotomy	Complex
Operation for fractured skull including compound and depressed fracture	Complex
Burr Holes for abscess, evacuation of hematoma, tumor biopsy	Major
Operation on Trigeminal nerve root	Major
Cranioplasty	Major
Spine or Spinal Cord	
Operation for spinal cord tumor	Major
Operation with removal of portion of vertebra or vertebrae	Major
Removal of part or all of coccyx, or of transverse or spinous process	Intermediate
Manipulation or traction of the lumbar spine	Minor
Cordotomy	Complex
Cervical decompression of spinal nerve root for disc lesions	Complex
Spinal stenosis	Complex
Decompression of Spinal Cord	Complex
Exploration of Spinal Cord with removal of lesion	Complex
Spinal meningioma	Complex
Tumors	
Benign or Superficial tumor and cysts, warts, corns or abscesses requiring hospital confinement or not requiring hospital confinement	Minor
Malignant tumors of face, lip or skin	Intermediate
Varicose Veins	
Injection treatment, complete procedure, one or both legs	Minor
Cutting operation, complete procedure	
- one leg	Minor
- both legs	Intermediate

Remarks:

If the operation performed is not shown in the Simplified Schedule of Operations and is not expressly excluded by any of the terms of this Policy, the Company shall determine the classification for such operation. An operation of equivalent gravity and severity will be used as a basis for the Company's settlement. The Company reserve the right to amend the classification of operation from time to time.

信諾糖路同行醫療保

第一部份 - 釋義

1.1 除非另有述明，否則在本保單出現的定義詞語，將具有以下的特定釋義：

「意外」
指於「本保單」生效期間，突發性、不可預見、意料之外、外來及可見的事件，而**「意外地」**應作相應解釋。

「年齡」
指於「生效日」或其後的任何「周年日」時上一個生日的年齡。

「麻醉科醫生」
指在當地合適的醫務委員會以麻醉科專科登記或註冊的「醫生」。

「周年日」
指「生效日」的每個周年日。

「申請書」
指提交予「本公司」以用作申請「本保單」的申請書，包括任何可保證明及文件或所提交的相關資料，不論是書面的或口頭的（透過電話或其他方式）。

「基本藥物」
指由「網絡醫生」處方經當地政府提供西藥或外科手術治療服務的衛生署藥劑部合法註冊的藥物。如根據「網絡醫生」的意見須處方特別及昂貴的藥物，「網絡醫生」保留收取額外藥費的權利。

「基本保單」
指此信諾糖路同行醫療保保單之「住院及手術保障」及「延伸保障」，及其有關之背書，但不包括任何與此信諾糖路同行醫療保保單之「住院及手術保障」及「延伸保障」無關的附加條款或背書及任何附加保障，也不包括「自選保障」附加條款的條款及條件。

「基本保費」
指本「基本保單」之「住院及手術保障」及「延伸保障」應付的保費，列於「保單承保表」內。

「保障賠償表」
指隨附於「本保單」並標題為保障賠償表的附表，列明「本保單」應付保障的限額。

「身體損傷」
指
(a) 在不受其他因素的影響下，完全因「意外」直接導致「受保人」蒙受身體損傷；及
(b) 於「本保單」生效期間，因外來、猛烈及可見方式引致的身體損傷。

「日曆月」
指由某一月份內某一日子至下一個緊接著的月份內相同的日子之前一天為止或下一個緊接著的月份內最後一日（如下一個緊接著的月份內沒有對應的相同日子）的期間。

「首席醫學顧問」
由我們不時委任作為醫學顧問的「醫生」。

「中藥」
指按照「香港」《中醫藥條例》於「香港」中醫藥管理委員會中藥組或按照提供中藥治療之任何其他地方之同等法定機構合法註冊之中藥材。
為免存疑，「本保單」並不保障保健品及所有特別中草藥及／或補藥，包括但不限於燕窩、靈芝、人參、冬蟲夏草、姬松茸、鹿茸等。

信諾糖路同行醫療保

「中醫」
指從事以傳統全科中醫藥學為基礎的中醫，並有向「受保人」提供傳統全科中醫藥治療的當地政府註冊及登記執業；除非經「本公司」批准，否則「受保人」或其任何親屬則屬例外。

「信諾醫療保系列」
指此系列包括「信諾糖路同行醫療保」、「信諾尊尚醫療保」、「信諾自選醫療保」及任何其他由「本公司」不時簽發及列入「信諾醫療保系列」的保單。

「內亂」
指國民反對管治組織或其政策時產生的騷亂、動亂或混亂。

「風險類別」
指「保單承保表」及「本保單」的任何其後背書內所列，「受保人」所屬的風險類別。

「生效日」
指「保單承保表」內所列，「本保單」開始生效的日子（「香港」時間）。

「本公司」、「我們」或「我們的」
指信諾環球保險有限公司。

「先天性疾病」
指自出生已存在之醫學異常，不論「受保人」知道與否。這包括（但不排除在醫學上被視為先天性疾病之其他病症）斜視、腦積水、睪丸未降、美克爾氏憩室、扁平足、心間隔缺損及腹股溝斜疝（小腸氣）。

「發育異常」
指相較於同年齡或同發育階段之預期發育情況而出現之發育異常。這些缺陷或殘障出現於十八(18)歲之前，並可能預期會無限期延續下來，從而造成實質上的損害。這些障礙情況包含生物學及非生物學的因素在內。這包括（但不排除醫學上被視為發育異常的其他病症）語言及學習障礙、自閉症及智力遲鈍。

「營養師」
指在法律上有資格的營養師，並根據其提供服務的當地政府註冊及登記執業；除非經「本公司」批准，否則「受保人」或其任何親屬則屬例外。

「延伸保障」
指「本保單」第四部份條款4.4應付的延伸保障。

「普通科醫生」
指在當地合適的醫務委員會以普通科註冊及登記執業的「醫生」。

「寬限期」
指「生效日」除外之任何「保費到期日」後一(1)個「日曆月」的期間。

「遺傳性疾病」
指通過基因由父母遺傳給子女的疾病。

「香港」
指中華人民共和國香港特別行政區。

「醫院」

指一間合法成立的醫院，並根據其成立所在國家或地區的法律正式註冊及獲合法認可，及符合下列規定：

(a) 其主要運作乃接收及治療及治理「住院」的病人、病者及傷者；
(b) 在一名或多名「醫生」(其中一人必須可隨時聯絡)的監督下收容住院病人；
(c) 保持分工完善的設施，為該等人士診斷及醫治，並於醫院範圍或於醫院所控制的設施內提供(如適用)進行主要手術的設施；
(d) 由「護士」及在其監督下提供全日二十四(24)小時的護理服務；及
(e) 留駐至少一名「醫生」。

儘管前文所述，「醫院」不得包括以下各項：

(a) 精神病院、主要醫治精神病或心理病(包括弱智)的醫院和醫院的精神病科部；
(b) 收容老人的地方、休養院、收容吸毒者或酗酒者的地方；或
(c) 健康水力或自然療法診所、護理或療養院、「醫院」內主要收容吸毒者或酗酒者、或作為護理、療養、康復、延續護理設施或休養院的特別單位。

若在中國大陸確診及「住院」，必須要在三級甲等或以上的醫院或「本公司」不時指定的醫院內確診及「住院」，否則「本公司」不會支付任何保障。

「住院」

指「受保人」因「身體損傷」或「疾病」，經「醫生」以書面建議介定為「醫療必須」而轉介「受保人」入院，登記作為住院病人。

「住院及手術保障」

指「本保單」第四部份條款4.3應付的住院保障。

「深切治療部」

指除手術後康復病房外，「醫院」某部份內的供住院部份，除提供病房及床位外：

(a) 由「醫院」就正式深切治療計劃而設立；
(b) 僅收容經由「醫生」或曾接受專門訓練的註冊「護士」指示及進行持續視聽觀察的重病病人；
(c) 提供存放於就近位置隨時備用的一切生命搶救必須設備、藥物及補給品；及
(d) 入住深切治療部之每天，均須額外繳付附加費。

「欠款」

指就「本保單」而拖欠「本公司」的任何款項，包括但不限於任何未繳付的「保費」、以及因上述提及的款項而累計的任何利息。

「簽發日」

指「保單承保表」內所列，「本公司」簽發「本保單」的日子(「香港」時間)。

「最高賠償額」

指根據「本保單」條款關於「保障賠償表」中訂明之有關保障，經由「本公司」支付或賠償的最高限額。

「醫療必須」

指醫療上必需的醫療服務：

(a) 以「合理及慣常」費用對診斷作出相應及慣常之治療；
(b) 根據良好及謹慎的醫療標準；
(c) 就其診斷或治療而所需的；
(d) 非純為「受保人」、「醫生」、「中醫」、「物理治療師」、「麻醉科醫生」或任何其他醫療服務供應商提供方便；
(e) 以最合適之程度對「受保人」作安全及有效的治療；及
(f) 「住院」非純為診斷掃描目的、影像學檢驗或物理治療。

「網絡醫生」

指由「本公司」指定的醫療服務提供者提供的名單中所載在「香港」的「中醫」及「醫生」，名單將不時作出修訂。

「護士」

指根據其獲聘用提供護理服務所在的國家或地區的法律合法許可及註冊的合資格或受訓護士或普通科護士；除非「本公司」批准，否則該人士不能是「受保人」或其任何親屬。

「自選保障」
指本「基本保單」提供的保障以外的附加保障，如「門診保障」。

「自選保障簽發日」
指有關「自選保障」的簽發日（「香港」時間）。

「自選保障保費」
指根據「本保單」就所有「自選保障」附加條款而須繳付的保費，該保費列於「保單承保表」內。

「門診保障」
指「本保單」第四部份條款4.5應付的門診保障。

「善終服務」
指只能緩解症狀而不能治愈及大幅度改善身體狀況之治療服務。

「善終服務的等侯期」
指下列每一個日子起計兩(2)年的期間：
(a) 「簽發日」或「生效日」（以較遲者為準）；
(b) 批准復效日（如「本保單」已復效）；及
(c) 保障增加的簽發日或生效日，以較遲者為準（如「本保單」的任何保障有所增加）。

「保障期」
指在該期間內「本保單」維持有效（「香港」時間）。

「受保人」
指在「保單承保表」內列為受保人的人士。

「醫生」
指已獲得西方醫科學位的醫生，並根據其提供醫護或手術服務的當地政府註冊及登記執業；除非「本公司」批准，否則「醫生」不能是「受保人」或其任何親屬。

「物理治療師」
指引致醫療費用的當地政府註冊及登記執業的物理治療師，並從事以運動、人手治療及以機械能、熱能或電能就身體殘疾予以評估及醫治的具法定資格人士；除非經「本公司」批准，否則「受保人」或其任何親屬則屬例外。

「計劃級別」
指由「保單持有人」就「本保單」所選擇並列明於「保單承保表」或背書（如有）的一個計劃級別，其為列明於「保障賠償表」的其中一個計劃級別。

「本保單」
指本「基本保單」及「自選保障」附加條款（如有）、「陳述書」、「保單承保表」、「保障賠償表」，以及經「本公司」的授權代表正式簽署的附於本「基本保單」的任何背書及對「本保單」作出的任何其他其後的背書及修訂。

「保單承保表」
指隨附「本保單」並註明保單承保表的文件（其後由「本公司」簽發的任何背書修訂），當中載有作識別用途的「本保單」保單編號及「受保人」的個人資料。

「保單年度」
指由「生效日」或其後的任何「周年日」起計，每十二(12)個「日曆月」的期間。

「保單持有人」
指「保單承保表」內所列，並持有「本保單」的人士。

「之前已存在病症」

指下列每一個日子

(a) 「簽發日」或「生效日」(以較遲者為準);

(b) 批准復效日(如「本保單」已復效);

(c) 「自選保障簽發日」(如在「簽發日」後選取「自選保障);及

(d) 保障增加的簽發日或生效日,以較遲者為準(如「本保單」的任何保障有所增加)

前,「受保人」承受或蒙受、已被診斷、或已呈現徵狀、或已發生、或已尋求醫護意見及/或治療、及/或醫生藥物配方的任何「身體損傷」或「疾病」。

儘管上述如此規定,「之前已存在病症」不包括:

(a) 已在「申請書」全面披露;及

(b) 「本公司」同意不列為「本保單」的不保事項

的「身體損傷」或「疾病」(包括但不限於糖尿病)。

「保費」

指「本保單」應繳付的「基本保費」及「自選保障保費」(如有)。

「保費到期日」

指「生效日」、「保單周年日」及(倘繳款形式並非按年繳付)相對於「保費」結算的繳款形式的該等其他相應付款日。

「合理及慣常」

有關費用、收費或費用而言,指任何費用或開支::

(a) 乃根據良好的醫療標準,在「醫生」的護理、監督或命令下就其照顧受傷或患病的人所需的「醫療必須」療程、用品(包括藥物)或醫療服務而收取的;

(b) 不超過在引致有關開支的當地進行類似療程、用品(包括藥物)或醫療服務的正常水平;及

(c) 不包括若保險不存在則不會產生的費用。

「本公司」保留權利參考但不限於任何政府、當地的相關機構及認可的醫療協會所提供的任何相關出版物或已有的資料,而決定任何特定的「醫院」或醫療費用是否合理及慣常。倘「首席醫學顧問」認為該費用不是合理及慣常,「本公司」保留調整就「醫院」或醫療費用而支付任何及所有保障的權利。

「康復中心」

指「醫院」以外的註冊機構,並就物理損傷,功能障礙或殘疾而提供了物理治療,職業治療及其他康復治療服務。

「差額」

指使用信諾糖路同行醫療卡所支付但在「本保單」不受保障的醫療費用。

「疾病」

指「受保人」之正常生理功能損傷,並且影響整個「受保人」或「受保人」的一部份。

「簡明手術表」

指隨附於「本保單」並標題為"簡明手術表"的附表,列明「本保單」所保障的「外科手術程序」及手術類別。

「專科醫生」

指在當地政府以專科註冊及登記執業的「醫生」。

「陳述書」

指你就申請「本保單」而向「本公司」作出並經「本公司」收到的「申請書」、任何聲明及個人陳述。

「外科手術程序」

指「簡明手術表」所列明的任何外科手術程序。

「恐怖主義」

指任何人士或團體不論其是否代表或與任何組織、政府、力量、權力或軍事力量或有所關連,使用或威脅使用武力或暴力對付任何人或物,或進行對人命或財產構成危險的活動,或從事干擾或破壞電子或通訊系統之行為,其目的為恐嚇、強迫或傷害政府、平民社會或其任何部份,或破壞任何經濟部份。

「恐怖主義」亦包括任何有關地方政府可證實或確認之恐怖主義行為。

「戰爭」

指戰爭(正式宣戰與否亦然)或任何戰爭活動包括任何主權國家使用軍事力量以達致經濟、地緣、民族、政治、種族、宗教或其他目的。

「西藥」

指經「香港」衛生署藥劑部或任何其他地方之等同法定機構合法註冊的西方藥物。

「你」、「你的」或「你自己(的)」

指在「保單承保表」內列為保單持有人的人士。

1.2 除文意另有所指外,意含單數之詞語將包括複數,而所有陽性詞語亦包括陰性含意,反之亦然。一般詞彙不應因隨後列舉的例子如包含特定意義,而令該一般詞彙在涵義上受到限制。

1.3 凡提及條款,指「本保單」的條款。僅就方便參考起見,「本保單」已加入標題。有關標題應不影響「本保單」的詮釋。

1.4 如「本保單」的任何規定經具有司法管轄權的法院裁定為不合法、無效或不可強制執行,「本保單」的任何其他規定的合法性、有效性或可強制執行性將不會因此而受到影響。

1.5 「本公司」並未行使或遲延行使「本保單」的任何權利,均不應視為「本公司」放棄行使任何此權利。

第二部份 - 一般規定

2.1 保單合約

根據已支付的「保費」及提交予「本公司」的「陳述書」，「本公司」同意簽發「本保單」以承保「受保人」，並按「本保單」的條款及條件，支付有關的保障。「本保單」文件、「陳述書」、「保單承保表」、「保障賠償表」、任何附有「本保單」編號的背書、規定及文件，將構成「本公司」及你立約雙方的整體合約。

2.2 管轄法律及司法權

「本保單」將以「香港」法律為依據，並將按其詮釋。你及我們同意「香港」法庭享有專屬管轄權，以解決任何索償、爭議或由「本保單」或與此有關連的法律關係引起的事項。

2.3 「本保單」貨幣

在遵守本第二部份條款2.4的前提下，「本保單」的所有款項均以「保單承保表」內所列的貨幣為準。

2.4 保障貨幣

除「本公司」另有同意外，「本保單」的所有保障金額均以「保單承保表」內所列的相同貨幣支付。

2.5 更改保單條款

2.5.1 在「本保單」生效期間，我們有權在「本公司」認為必須或根據於「生效日」或「本保單」有效期間的適用法律或監管規定，隨時更改「本保單」的條款及條件。

2.5.2 除非是以書面作出及在有關更改上得到「本公司」的授權代表簽署，否則「本保單」的條款、條件（包括所有附錄）的任何更改，不論是以背書或其他形式作出，均屬無效。我們會依據我們記錄上你提供最近期的地址，發出有關背書及文件。

2.5.3 如你或「受保人」的個人資料有任何變更，你可隨時向我們提交指定的表格，以書面通知「本公司」。我們會依據我們記錄上你提供最近期的地址，發出背書通知你該等變更的生效，或向你發出接獲指示的確認通知書。

2.6 更改資料

「受保人」及「保單持有人」必須就其任何個人資料，包括但不限於名稱、職業、居住國家及地址的任何更改立即通知「本公司」。

2.7 更改計劃級別 / 「自選保障」

減少或增加保障級別指任何更改「計劃級別」或「自選保障」。

2.7.1 「保單持有人」可於每個「周年日」前最少三十(30)天向「本公司」提交書面申請並就新受保級別支付有關的「保費」，當「本公司」批准後，將受保級別或自選保障更改為「保障賠償表」上所列的另一項計劃級別或自選保障。上述新的計劃級別便成為「本保單」的「計劃級別」或「自選保障」。

2.7.2 根據本第二部份條款2.7.1將「計劃級別」及 / 或「自選保障」升級後，任何增加的保障僅適用於：

(a) 在保障增加的簽發日或生效日（以較遲者為準）後遭遇的「身體損傷」；或

(b) 在保障增加的簽發日或生效日（以較遲者為準）後首次被診斷或顯露病狀或病徵或須接受醫療護理及/或須服用藥物的「疾病」；惟須受「本保單」的特定保障的條款所限。

2.8 續保

2.8.1 在遵守本第二部份條款2.15的前題下，「基本保單」的首次有效期限為十二(12)個「日曆月」，其後只須每次續保時繳付「保費」，及若「本公司」仍繼續簽發新的信諾糖路同行醫療保保單，則保單將會保證每次自動續保連續十二(12)個「日曆月」。

2.8.2 在遵守本第二部份條款2.15的前題下，「本保單」下的「自選保障」（如適用）的首次有效期限為十二(12)個「日曆月」，其後只須每次續保時繳付「保費」，及若「本公司」仍繼續就「基本保單」及不同的「自選保障」而簽發新的信諾糖路同行醫療保保單，則有關的「自選保障」將會保證每次自動續保連續十二(12)個「日曆月」。

2.8.3 「本公司」保留在每次續保時修訂「本保單」的條款及/或「保費」及/或「保障賠償表」之權利。

2.8.4 如「基本保單」及/或有關的信諾糖路同行醫療保的「自選保障」不被續期，我們則會在下一個「周年日」最少三十(30)日前，依據我們記錄上你的最新地址向你發出書面通知，通知你「基本保單」及/或有關的信諾糖路同行醫療保的「自選保障」不被續期。

2.9 錯誤陳述

2.9.1 倘「受保人」的「年齡」及/或「風險類別」被錯誤陳述及「受保人」仍有資格得到「本保單」的投保資格，則我們將根據正確的「年齡」及/或「風險類別」調整「本保單」應付的「保費」。多付的「保費」（不附利息）將退回給「保單持有人」；少付的「保費」需應我們要求時立即支付（視個別情況而定）。

2.9.2 倘「受保人」的「年齡」及/或「風險類別」被錯誤陳述及「受保人」原本不能符合「本保單」的投保資格，「本保單」，於「受保人」不符合「本保單」的投保資格期間，向該「受保人」提供的保障便無效。而「本公司」在「受保人」不符合投保資格期間的責任，只限於在書面要求下才會退回就該期間所支付的保費且不附利息，但倘「受保人」及/或「保單持有人」有詐騙行為，則不會退回任何「保費」。「本公司」保留權利追討任何根據「本保單」已支付的有關索償。

2.9.3 「本保單」是基於你及「受保人」在「陳述書」及其他有關聲明中所提供給「本公司」的資料的完整性及準確性而簽發的。如「保單持有人」或「受保人」在「陳述書」及/或其他有關聲明中有任何詐騙、錯誤陳述、失實陳述或聲明、嚴重過失或隱瞞，或如「保單持有人」或「受保人」就「本保單」應付的任何索償事宜有任何詐騙、錯誤陳述、失實陳述或聲明或隱瞞，則就一切目的而言，「本保單」應按「本公司」的全權及絕對酌情權被視為自「生效日」起無效。因此，「本公司」毋須支付「本保單」的任何保障。「本公司」有絕對自主權保留權利不退回任何已繳的「保費」。若已就「受保人」支付保單賠償款項包括但不限於索償金額，當「本公司」要求時，你須退回該款項予「本公司」。就此條款而言，「嚴重疏忽」將被視為在沒有理由的情況下未能遵守於訂立合同前須向「本公司」表明所有會影響「本公司」的風險評估的要求，而該些要求為完成「本保單」合同訂立的決定因素。

2.10 代位權

「本公司」有權以「受保人」名義，向直接或間接造成「受保人」「身體損傷」或「疾病」而按「本保單」須予賠償的第三方追討責任，費用由「本公司」自行承擔。在該等訴訟中，「受保人」同意給予「本公司」所需同意及協助。

2.11 通知及索償證明

2.11.1 索償通知

在產生索償的事件發生後三十(30)天內，必須向「本公司」提交書面索償通知。該通知應包括足以證明「受保人」的身份及索償性質的資料。

2.11.2 索償證明

(a) 填妥「本公司」規定的索償表格並經由有關「醫生」及/或「專科醫生」簽署後，須連同所有「醫療必須」費用的收據正本及「受保人」「年齡」的證明文件一併遞交。倘「保單持有人」選擇就同一醫療費用在另一家保險公司簽發的保單提出索償，亦應把已經向該保險公司提交的索償表格副本遞交予「本公司」。

(b) 「受保人」須向「本公司」或「本公司」指定的醫療服務提供者提供「本公司」或「本公司」指定的醫療服務提供者不時要求有關根據「本保單」的任何索償的證書、資料及證據，而所有索償要求應按「本公司」規定的格式作出，費用並由「受保人」承擔。

(c) 就評估索償而言，「受保人」須向「本公司」或「本公司」指定的醫療服務提供者提供全部醫療記錄及報告，並在要求下簽署所有授權表格，以授權「本公司」或「本公司」指定的醫療服務提供者取得「受保人」的全部及完整醫療記錄。

(d) 為了評估所提交的索賠證明有效性的目的，「本公司」有權要求「首席醫學顧問」及/或由「本公司」選擇的「醫生」及/或「專科醫生」隨時隨地對「受保人」進行檢查。

(e) 索償證明必須在「受保人」出院或引致索償的事件(以較遲者為準)後九十(90)天內提交。如索償證明沒有在規定的限期內提交，則必須證明已盡早在合理的時間內提交，否則「本公司」有權不支付任何索償款額。

(f) 若在中國大陸確診及「住院」，必須要在三級甲等或以上的「醫院」或「本公司」不時指定的「醫院」內確診及「住院」，否則「本公司」不會支付任何保障。

(g) 「本公司」履行「本保單」的任何付款責任的先決條件為「受保人」、索償人及「保單持有人」全面遵守「本保單」的條款及條件。除非「保單持有人」已完成並提交已獲得「本公司」接受/批准的入院前審批表，不然「本公司」或「本公司」指定的醫療服務提供者將不會發出任何付款保證或就信用額度承擔任何責任。

(h) 除非「首席醫學顧問」獲准檢查「受保人」(費用由「本公司」支付)，否則「本公司」毋須支付「本保單」的任何保障。若「首席醫學顧問」及另一名「醫生」所提出的醫學意見有任何衝突，以「首席醫學顧問」的意見為準。

2.11.3 扣除索償

「本公司」有權從「本保單」應付的任何保障中扣除任何「欠款」結欠。

2.12 保障的協調

如任何「醫療必須」費用已根據其他人士或「本公司」的另一保險計劃作出賠償，則「本公司」只負責上述償付金額與「本保單」原本應付的保障總額之間的差額。

2.13 支付索償

我們將把保障金額支付給你，或如你在該款項支付之時已不在世，則支付給你的遺產；款項將以港元支付，不計利息。

儘管前文所述，「本保單」的所有索償款項須向「本公司」提供令我們接納的有效證明以確認「保單持有人」及/或「受保人」及/或遺產執行人或遺產管理人(視情況而定)的身份。由你或遺產執行人或遺產管理人(視情況而定)簽署的收據方為有效及將被視為完全及最終的證據，證明有權收款的人士已收妥該等賠償，但所有「本公司」於「本保單」的任何責任亦被解除。

2.14 利息

除非「本保單」另外訂明，否則「本公司」在「本保單」應付的所有款項均不附帶任何利息。

2.15 終止

2.15.1 由「保單持有人」取消

「保單持有人」可向「本公司」發出不少於三十(30)天的書面通知以取消「本保單」。該取消而導致「本保單」的終止將於該書面通知指明的日期或「本公司」認可的日期（以較後者為準）生效。「本公司」不會退回已繳「保費」及「本公司」保留權利收取終止後直至該「保單年度」完結時的「保費」。

2.15.2 由「本公司」取消

(a) 倘「保單持有人」或「受保人」在索償或任何其他事件對審核「本保單」或其他由「本公司」簽發並由「保單持有人」或「受保人」持有的其他任何保單構成影響的情況下，如「保單持有人」或「受保人」觸犯詐騙、嚴重虛報資料或隱瞞或違反誠信或提出任何虛假或誇大之索償時，則「本公司」有權在任何時間即時取消「本保單」。在上述情況下，「本公司」有絕對自主權保留權利不退回任何已繳的「保費」。若已就「受保人」支付保單賠償款項包括但不限於索償金額，當要求時你須退回該保單賠償款項給我們。

(b) 若根據本第二部分條款 2.18 所述的「差額」未能於「本公司」或根據本第二部分條款 2.18 所述的「本公司」指定的醫療服務提供者發出差額通知書後的十四(14)日內償還，則「本公司」有權可即時取消「本保單」(若該「差額」於上述期限後尚未償還，縱使未即時取消「本保單」，「本公司」仍然享有權利可隨時取消「本保單」)。

2.15.3 自動終止

「本保單」將於下列情況發生時（以較早發生者為準）即時終止：

(a) 「受保人」死亡；
(b) 「保單持有人」或「本公司」分別根據本第二部份條款 2.15.1 或 2.15.2 取消「本保單」；
(c) 如「本保單」因第二部份條款 2.8.4 下任何原因不被續期；或
(d) 「寬限期」屆滿後仍未支付全部或分期「保費」。

2.16 筆誤

「本公司」造成的任何筆誤，將不會令原已生效的保單失效，或令任何已失效的保單繼續生效，而在解釋「本保單」時，應視該等筆誤沒有發生。

2.17 限制

在依據「本保單」要求下向「本公司」提交索償證明後起計首六十(60)日內，或在依據「本保單」須向「本公司」提交索償的書面證明之日起兩(2)年後，絕不可向「本公司」採取任何法律行動以追討任何索償。

2.18 信諾糖路同行醫療卡

(a) 所有在「本保單」簽發時，均可獲「本公司」簽發一張信諾糖路同行醫療卡。

(b) 已投保「本保單」的「受保人」可使用信諾糖路同行醫療卡連同「本公司」或「本公司」指定的醫療服務提供者發出的付款保證信，於私家醫院「住院」時支付醫療費用，唯該醫院接受由「本公司」或「本公司」指定的醫療服務提供者發出的付款保證信。

(c) 所有透過信諾糖路同行醫療卡支付的賬項除非已經由「本公司」或「本公司」指定的醫療服務提供者通知「保單持有人」已獲賠償該合資格的費用，否則該賬項仍屬「保單持有人」所須承擔的責任。

(d) 如「受保人」所涉及的費用為不受保障項目、超過付款保證信的信用額或並未獲得「本公司」或「本公司」指定的醫療服務提供者批核，則「保單持有人」/「受保人」將負責及同意於出院前自行繳付該費用。

(e) 如「受保人」經由信諾糖路同行醫療卡所支付的賬項已超過其最高賠償額或不屬於「本保單」的合資格費用（此等情況包括「受保人」在使用信諾糖路同行醫療卡時「本保單」或保障經已終止），則「保單持有人」同意於收到「本公司」或「本公司」指定的醫療服務提供者發出差額通知書的十四(14)天內發還有關「差額」。「本公司」保留權利向「保單持有人」收取超過十四(14)天仍未償還之「差額」的利息。

(f) 使用信諾糖路同行醫療卡將構成接納簽發此卡所列之條款。倘此卡被竊或遺失，「保單持有人」須負責一切所涉及之賬項，直至向「本公司」書面通知有關被竊或遺失為止。

(g) 信諾糖路同行醫療卡乃屬「本公司」所有。持有此卡之「受保人」應將此卡存放於安全的地方。此卡只供獲發卡之「受保人」使用，不得轉讓。信諾糖路同行醫療卡將在下列最早出現的情況即時失效，「保單持有人」須負責於開始失效起七(7)天內將任何實體信諾糖路同行醫療卡歸還「本公司」：
(i) 「本保單」按當中之條款終止；或
(ii) 在「本公司」的要求下。

(h) 「保單持有人」將負責歸還所有結欠「差額」予「本公司」或「本公司」指定的醫療服務提供者，並確保會適當地使用信諾糖路同行醫療卡。

(i) 「本公司」將不會就「受保人」/「保單持有人」在使用信諾糖路同行醫療卡時，無論是直接或間接所引致的

損失、毀壞、支出、起訴、行動或訴訟而向「受保人」/「保單持有人」負責。

(j) 「本公司」保留權利從任何可退還予「保單持有人」的「保費」或賠償中扣除款項以支付「保單持有人」於「本公司」或「本公司」指定的醫療服務提供者的任何「差額」結欠。

(k) 「本公司」或「本公司」指定的醫療服務提供者保留權利從「保單持有人」所授權的信用卡保留信用額及扣取款項以支付「差額」結欠。

2.19 付款保證信

(a) 「本公司」或「本公司」指定的醫療服務提供者保留絕對權利根據「受保人」/「保單持有人」所提供的資料而接受或拒絕付款保證信之申請。

(b) 如「受保人」/「保單持有人」未能於遞交付款保證信申請時提供正確、足夠及完整的資料以作信用卡付款授權,「本公司」或「本公司」指定的醫療服務提供者有絕對的酌情權拒絕付款保證信之申請。

(c) 「本公司」或「本公司」指定的醫療服務提供者根據本條文所批出之付款保證信將不被視為「本公司」已同意承擔根據「本保單」支付及/或賠償「保單持有人」的責任;亦不被視為「本公司」已同意對任何違反本合約條款及細則的情況不予追究。

2.20 不得爭議

除非有欺騙性的誤述或欺騙性的知情不報情況,否則「本保單」於「受保人」在世及「本保單」生效期間,自(i)「基本保單」的「簽發日」、(ii)「基本保單」的「生效日」或(iii)任何「基本保單」復效的批准日(以較後發生者為準)起計兩(2)年後,即屬不可爭議。若「本公司」爭議「本保單」,我們有酌情決定權,沒收任何及所有根據「本保單」收取的款項。

但此不得爭議條款並不適用於「本保單」內「自選保障」的合約。

2.21 保單擁有權

在「本保單」生效期間,「保單持有人」可以行使「本保單」下的所有權利、特權及選項。在「受保人」在身期間,你可更改「本保單」的擁有權。該更改須獲我們記錄在案,並經我們批准及發出有關背書才生效。

2.22 第三者權利

《合約(第三者權利)條例》(下稱「《條例》」)不適用於「本保單」。除「本公司」及「保單持有人」外,任何非「本保單」一方之人士(包括但不限於「受保人」或任何受益人)無權於《條例》下執行「本保單」內的任何條款。

2.23 英文與中文版本

「本保單」之英文版本方為法定版本,中文版本祇供作參考之用。若英文版本與中文版本互相抵觸或有分歧,概以「本保單」之英文版本為準。

第三部份 - 「保費」規定

3.1 「本保單」的「保費」款項包括以下各項：

(a) 「基本保費」

在「基本保單」下，你須按「保單承保表」內所列的供款期數定期在「保費到期日」支付「基本保費」。

(b) 「自選保障」

你可在「本保單」申請附加保障，而該等附加保障的「自選保障保費」將列於「保單承保表」內，並於「保費到期日」繳付。

3.2 繳款形式

「本保單」是一份一年的保單。在「本保單」須繳交的任何「保費」可以每年或每月形式支付。你可透過書面方式要求更改「本保單」有效期間內繳款形式，惟須經「本公司」批准。

3.3 支付「保費」

3.3.1 「保費」是根據「受保人」在「生效日」及續保「本保單」時已屆的「年齡」及「風險類別」而計算。

3.3.2 如你未能就「本保單」支付首期保費，則就任何目的而言，「本保單」應被視為自「生效日」起無效。因此，「本公司」毋須支付「本保單」的任何保障賠償。除首期保費付款外，「保費」或其任何部份於任何「保費到期日」後一(1)個「日曆月」為「寬限期」。在「寬限期」內「本保單」之保障仍然生效。如「保費」或其任何部份在「寬限期」結束時仍未支付，則「本保單」應在「保費到期日」終止。

3.3.3 就修訂「保費」而言，「本公司」保留在每個「周年日」或「續期」時修訂「保費」的權利，同時亦可自行決定只考慮「本公司」認為相關的原因。

3.3.4 如(i)因「保單持有人」或「受保人」的詐騙、重大錯誤陳述或隱瞞、或違反誠信、或「保單持有人」在要求賠償時作出或「受保人」於索償或任何事情上會影響或與「本保單」或其他由「保單持有人」或「受保人」持有由「本公司」簽發的保單的核保結果有關的情形下欺詐或誇大索償，而「本公司」取消「本保單」或(ii)「保單持有人」取消「本保單」，任何「保費」概不獲退回。

3.3.5 倘「保單持有人」在「保單年度」中取消「本保單」，「本公司」保留權利收取直至該「保單年度」完結時的「保費」。

3.4 復效

3.4.1 若「本保單」因欠繳「保費」而失效，經「本公司」批准後，「本保單」可自欠繳「保費」首次到期之日起計三(3)個「日曆月」內被復效；惟須符合下列各項：

(a) 提交「本公司」指定的表格，以書面申請復效；

(b) 提供可令「本公司」接納的「受保人」的可保證明；及

(c) 收訖所有欠繳「欠款」(如有)。

3.4.2 為免存疑，「本保單」復效日期前已經診斷或已顯露其病徵或已需要醫療指引及 / 或治療及 / 或配處藥方的「身體損傷」或「疾病」，「本公司」將毋須就此支付任何保障。

3.4.3 在遵守有關復效而附加或隨附於「本保單」的任何規定的前提下，「保單持有人」擁有於緊接終止日期前在「本保單」既有的相同權利。然而，「本公司」毋須對在復效之前自「本保單」終止日期起至批准復效日期止期間發生的事件的任何索償承擔責任。

第四部份 - 保障規定

4.1 保障範圍

在「本保單」生效期間及在遵守「本保單」的條款的前提下，「本公司」須根據以下最早的日子：(i)入院日及(ii)在「醫生」診所施行手術的日子已選取的「計劃級別」而支付「基本保單」。只有在「保單承保表」上訂明享有「門診保障」，方可獲得有關保障。「本公司」有權要求「受保人」在引致有關費用前獲得「本公司」的預先批准。

4.2 「計劃級別」

4.2.1 「基本保單」保障是環球，但「自選保障」只會就在「香港」境內進行的醫療諮詢 / 測試 / 治療 / 配處藥方提供保障。

4.2.2 除非另有明述，「本保單」的所有保障都須受限於「計劃級別」及「最高賠償額」包括但不限於「本保單」的「保障賠償表」內所列的每日賠償額及每年賠償額。

4.2.3 在「基本保單」項下，「本公司」將賠償由受保事項產生的實際「合理及慣常」費用。而有關費用賠償將根據如下公式計算，即在任何一個「保單年度」下以不超過有關保障所適用之「最高賠償額」為限:

{合資格醫療費用 **減(-)(**同一受保事項而引致的醫療費用已根據另一保險計劃獲其他人士或我們作出賠償)}

請注意:

(a) 此保障並不支付就入住總統套房/貴賓房/豪華房的「住院」費用。

4.3 「住院及手術保障」

4.3.1 住院及膳食費用

「本公司」將賠償「受保人」於接受「醫療必須」西方醫療或服務的「住院」期間由「醫院」徵收及發佈的實際「合理及慣常」住宿及膳食費用。有關賠償日數及費用賠償將以不超過「保障賠償表」內的住院及膳食費用所適用之「最高賠償額」為限。

4.3.2 深切治療部費用

「本公司」將賠償「受保人」入住「醫院」「深切治療部」的實際「合理及慣常」費用。「受保人」須經主診「醫生」建議下入住「深切治療部」接受「醫療必須」西方醫療。有關賠償日數及費用賠償將以不超過「保障賠償表」內的深切治療部費用所適用之「最高賠償額」為限。

4.3.3 主診醫生巡房費

「本公司」將賠償「受保人」於接受「醫療必須」西方醫療或服務的「住院」期間由「醫生」徵收的實際「合理及慣常」巡房費。有關巡房須在「醫院」內進行及與「受保人」實際會見及檢查。有關賠償日數及費用賠償將以不超過「保障賠償表」內的主診醫生巡房費所適用之「最高賠償額」為限。

4.3.4 手術保障

「本公司」將賠償因「受保人」「身體損傷」或「疾病」而由「醫生」提供的「醫療必須」「外科手術程序」所徵收的實際「合理及慣常」外科醫生費用、「麻醉師」費用、手術室費用及諮詢費（諮詢費只限於在「醫生」診所施行「外科手術程序」）；有關「外科手術程序」會在「醫院」進行或在「醫生」診所進行。有關費用賠償將以不超過「保障賠償表」內的手術保障所適用之「最高賠償額」為限（將按「簡明手術表」所列的"手術類別"分類），惟：

(a) 若在「住院」期間施行「外科手術程序」，「本公司」會賠償此保障由一名或多過一名「醫生」就該手術而收取的實際外科醫生費；及

(b) 若在「醫生」診所施行「外科手術程序」，「本公司」亦會償付向「受保人」提供手術及輔助服務（儀器、手術室時間、麻醉師費等）當日所需的「醫生」諮詢費（如有）。

4.3.5 專科診治費

「本公司」將賠償「受保人」於接受「醫療必須」西方醫療或服務由非主診「醫生」或非在「住院」時的外科醫生之「專科醫生」徵收的實際「合理及慣常」費用。有關服務須在「醫院」內進行及與「受保人」實際會見及檢查。有關服務須有主診「醫生」的書面轉介信。有關費用賠償將以不超過「保障賠償表」內的專科診治費所適用之「最高賠償額」為限。

4.3.6 家屬陪伴床位費

「本公司」將賠償「受保人」在「住院」期間「受保人」之直系家屬佔用的一(1)個床位而「醫院」徵收的實際「合理及慣常」住宿及膳食費用；惟相同「住院」須獲得「本保單」的住院及膳食保障。有關賠償日數及費用賠償將以不超過「保障賠償表」內的家屬陪伴床位費所適用之「最高賠償額」為限。

4.3.7 私家看護費

「本公司」將賠償「受保人」在「住院」期間由「護士」所提供的「醫療必須」特別護理服務而徵收的實際「合理及慣常」費用，而有關服務須有主診「醫生」的書面轉介信。

有關賠償日數及費用賠償將以不超過列明在「保障賠償表」內的私家看護費保障所適用之「最高賠償額」為限。

4.3.8 其他醫療費用

「本公司」將賠償「受保人」在「住院」期間經「醫生」建議下接受「醫療必須」西方醫療或服務而「醫院」徵收的實際「合理及慣常」費用；惟相同「住院」須獲得「本保單」的住院及膳食保障。有關費用賠償將以不超過「保障賠償表」內的其他醫療費用所適用之「最高賠償額」為限。

此保障包括以下服務：

(a) 往來「醫院」的陸上救護運送服務；

(b) 底片及診斷影像服務包括 X 光、磁力共振掃描、電腦斷層掃描、PET 掃描及正電子放射斷層掃描。「受保人」須經主診「醫生」建議接受「醫療必須」西方醫療，「本公司」才賠償「受保人」在「醫院」進行或在「醫生」診所或影像中心進行的底片及診斷影像服務。「受保人」於最近「住院」之入院日前三十(30)天內或在最近「住院」之出院日後三十(30)天內引致的底片及診斷影像服務費用，及此等費用必須與「受保人」在該「住院」的病症有直接關係，這樣提出的索償才能獲得賠償；

(c) 實驗室及病理化驗；

(d) 在「住院」時使用的藥物、靜脈注射液及消耗物品；

(e) 敷料、夾板及石膏；

(f) 輸血（購買血液及血漿費不包括在內）；

(g) 物理治療及緊急費用；

(h) 一般「護士」護理服務，但不包括在私家看護保障下可支付的護理費用；

(i) 植入物包括但不限於支架及起搏器；

(j) 在手術中「醫生」使用的手術設備，但不包括所有外在的義肢、特別支架、工具或設備；及

(k) 「醫療必須」西方醫療服務、醫療棄置物及耗材，但不包括「住院及手術保障」下已覆蓋的其他保障項目。

4.3.9 癌症治療及透析

「本公司」將賠償因「受保人」「疾病」而徵收的實際「合理及慣常」費用：

(a) 治療癌症包括放射治療、化療、標靶治療、使用伽碼刀及數碼導航刀；或

(b) 治療因慢性和不可復原之腎功能衰竭包括腹膜透析血及液透析。

「受保人」須經「醫生」建議下在「醫院」內或「醫生」診所內接受「醫療必須」西方醫療或服務。有關費用賠償將以不超過「保障賠償表」內的癌症治療及透析所適用之「最高賠償額」為限。

4.3.10 器官移植

「本公司」將賠償「受保人」因須進行心臟、腎臟、肝臟或骨髓移植的「醫療必須」手術而徵收的實際「合理及慣常」費用，而「受保人」須是該器官接受者。此保障包括因進行器官移植而引致的費用包括「受保人」在「醫院」內的住院及膳食費用、深切治療部費用、主診醫生巡房費、專科診治費、家屬陪伴床位費、其他醫療費用及手術保障。所有其他的費用包括獲得及運送器官的費用惟不受保障。

有關費用賠償將以不超過「保障賠償表」內的器官移植保障所適用之「最高賠償額」為限及在任何情況下此保障不會與「住院及手術保障」下的任何其他保障同時支付。

若就住院及膳食費用及 / 或深切治療部費用不可獲賠償（除在「醫生」診所進行治療），「本公司」並不會就主診醫生巡房費、手術保障、專科診治費、家屬陪伴床位費、私家看護費及其他醫療費用的保障作出賠償。

4.4 「延伸保障」

4.4.1 入院前及出院後之門診護理

「本公司」將賠償實際「合理及慣常」門診診症費、處方「西藥」及診斷測試費用；惟相同「住院」須獲得「本保單」的「住院及手術保障」，或在「醫生」診所內進行相同手術而須獲得「本保單」的手術保障：

(a) 該「住院」或在「醫生」診所內進行相同手術前三十(30)天內的入院診斷門診護理。此等門診護理必須經「醫生」建議下接受「醫療必須」西方醫療或服務及符合「住院」或在「醫生」診所內進行相同手術的診斷或病症；及

(b) 所有在出院或在「醫生」診所內進行相同手術後一百八十(180)天內的跟進療程門診護理，而此等門診服務必須與「住院」或在「醫生」診所內進行相同手術的診斷或病症有直接關係。

有關費用賠償將以不超過「保障賠償表」內的入院前及出院後之門診護理所適用之「最高賠償額」為限。

4.4.2 康復治療保障

「本公司」將賠償因「受保人」出院後九十(90)日內入住康復中心的接受「醫療必須」康復治療所徵收的實際「合理及慣常」費用；惟「受保人」須經主診「醫生」建議下接受「醫療必須」西方醫療或服務及該住院須已獲得本保單支付「住院及手術保障」。

有關費用賠償將以不超過「保障賠償表」內的康復治療所適用之「最高賠償額」為限及在任何情況下此保障不會與「住院及手術保障」下的任何其他保障同時支付。

4.4.3 善終服務保障

「本公司」將因「受保人」在「善終服務的等候期」後經「醫生」認為患上末期疾病非常可能導致該「受保人」自確診之日起計十二(12)個「日曆月」內死亡而賠償「受保人」在註冊善終服務中心的住院及接受「醫療必須」照顧及護理服務所徵收的實際「合理及慣常」費用；惟「受保人」須經主診「醫生」建議下接受「醫療必須」西方醫療或服務。每「受保人」只會支付此保障一次及該末期疾病的病徵及症狀須在「善終服務的等候期」後出現才受保障。

有關費用賠償將以不超過「保障賠償表」內的善終服務保障所適用之「最高賠償額」為限及在任何情況下此保障不會與「住院及手術保障」下的任何其他保障同時支付。

4.5 「門診保障」(如適用)

有關賠償日數及費用賠償將以不超過列明在「保障賠償表」內的「門診保障」所適用的「最高賠償額」為限。

4.5.1 普通科醫生門診診症

「受保人」於「網絡醫生」之診所接受由「普通科醫生」為治療而提供的門診服務及連同三（3）天「基本藥物」；但須受「保障賠償表」內的普通科醫生門診診症所適用之賠償次數所限。

4.5.2 專科醫生門診診症

「受保人」於「網絡醫生」之診所接受由「專科醫生」為治療而提供的門診服務及連同五（5）天「基本藥物」；但須受「保障賠償表」內的專科醫生門診診症所適用之賠償次數所限。

4.5.3 中醫診症（如適用）

「受保人」於「網絡醫生」之診所接受由「中醫」為治療而提供的門診服務及連同兩（2）包「中藥」（不包括跌打及針灸治療）；但須受「保障賠償表」內的中醫診症所適用之賠償次數所限。

4.5.4 針灸（如適用）

「受保人」於「網絡醫生」之診所接受由「中醫」為治療而提供的針灸治療；但須受「保障賠償表」內的針灸所適用之「最高賠償額」。

4.5.5 營養輔導（如適用）

「本公司」將賠償「受保人」接受「醫療必須」治療而「營養師」徵收的實際「合理及慣常」診金。有關賠償次數及費用賠償將以不超過「保障賠償表」內的營養輔導所適用之「最高賠償額」；惟須有「醫生」的書面轉介信，並由簽發日期起計六（6）個「日曆月」內有效。

4.5.6 醫生處方西藥

「本公司」將賠償「受保人」接受「醫療必須」「西藥」醫療而徵收的實際「合理及慣常」費用。當索償時，須提交「醫生」處方，，而「西藥」必須由合法來源取得，包括註冊藥店或藥房。有關費用賠償將以不超過「保障賠償表」內的醫生處方西藥所適用之「最高賠償額」為限。

4.5.7 診斷影像及化驗

「本公司」將賠償「受保人」接受於門診進行為確診而引致之影像或化驗所的實際「合理及慣常」費用。獲得「醫生」書面轉介的情況下接受檢查，該檢查須「醫療必須」及符合「受保人」的徵狀或診斷。有關費用賠償將以不超過「保障賠償表」內的診斷影像及化驗所適用之「最高賠償額」為限。

4.6 健康獎賞

4.6.1 若已全額支付「保單年度」內的「保費」，「保單持有人」會在下一個「周年日」享有「保障賠償表」內的健康獎賞所列之現金獎賞；惟須於「保單年度」完結時都符合下述情況：

(a) 「受保人」在「本公司」發出書面通知指明的限期前提供「受保人」的近期可保證明；及

(b) 「受保人」「年齡」達十八(18)歲或以上者，須完全符合下列有關表格內之五(5)項核保標準以切合「本公司」的健康獎賞準則；及

(c) 「受保人」「年齡」達十八(18)歲以下者，須完全符合下列有關表格內之四(4)項核保標準以切合「本公司」的健康獎賞準則。

「受保人」「年齡」達十八(18)歲或以上者，並被「醫生」確診患有一型糖尿病：

身體檢查類型	身體檢查項目	讀數	符合標準與否
血糖讀數	糖化血紅蛋白	7% 以下	符合
		7% 或以上	不符合
血壓	收縮壓	90以下	不符合
		90 – 140	符合
		140以上	不符合
	舒張壓	60以下	不符合
		60 – 80	符合
		80以上	不符合
身高體重	體格指數	17以下	不符合
		17 – 25	符合
		25以上	不符合
膽固醇	低密度脂蛋白膽固醇	<116 mg/dl or <3 mmol/l	符合
		≥116 mg/dl or ≥3 mmol/l	不符合
隨機尿液樣本中發現蛋白 / 白蛋白	尿液中蛋白濃度	<0.02g/l or <2mg/dl	符合
		≥0.02g/l or ≥2mg/dl	不符合

「受保人」「年齡」達十八(18)歲以下者，並被「醫生」確診患有一型糖尿病：

身體檢查類型	身體檢查項目	讀數	符合標準與否
血糖讀數	糖化血紅蛋白	7.5% 以下	符合
		7.5% 或以上	不符合
血壓	收縮壓	參考以下表格#一	
	舒張壓		
身高體重	體格指數	參考以下表格#二	
膽固醇	低密度脂蛋白膽固醇	<110 mg/dl or <2.8 mmol/l	符合
		≥110 mg/dl or ≥2.8 mmol/l	不符合

「受保人」「年齡」達十八(18)歲或以上者，並未曾被「醫生」確診患有一型糖尿病：

身體檢查類型	身體檢查項目	讀數	符合標準與否
血糖讀數	糖化血紅蛋白	8% 以下	符合
		8% 或以上	不符合
血壓	收縮壓	90以下	不符合
		90 – 140	符合
		140以上	不符合
	舒張壓	60以下	不符合
		60 – 90	符合
		90以上	不符合
身高體重	體格指數	17以下	不符合
		17 – 30	符合
		30以上	不符合
膽固醇	低密度脂蛋白膽固醇	<129 mg/dl or <3.3 mmol/l	符合
		≥129 mg/dl or ≥3.3 mmol/l	不符合
隨機尿液樣本中發現蛋白 / 白蛋白	尿液中蛋白濃度	<0.66g/l or <66mg/dl	符合
		≥0.66g/l or ≥66mg/dl	不符合

「受保人」「年齡」達十八(18)歲以下者，並未曾被「醫生」確診患有一型糖尿病：

身體檢查類型	身體檢查項目	讀數	符合標準與否
血糖讀數	糖化血紅蛋白	8% 以下	符合
		8% 或以上	不符合
血壓	收縮壓	參考以下表格#一	
	舒張壓		
身高體重	體格指數	參考以下表格#二	
膽固醇	低密度脂蛋白膽固醇	<110 mg/dl or <2.8 mmol/l	符合
		≥110 mg/dl or ≥2.8 mmol/l	不符合

表格#一 - 血壓水平（符合標準範圍）：

到達年齡	男孩		女孩	
	收縮壓	舒張壓	收縮壓	舒張壓
1	83 – 100	36 – 53	85 – 101	39 – 55
2	87 – 104	41 – 58	87 – 103	44 – 60
3	89 – 107	45 – 62	88 – 104	48 – 64
4	91 – 109	49 – 66	90 – 106	51 – 67
5	93 – 110	52 – 69	91 – 107	53 – 69
6	94 – 111	54 – 71	93 – 109	55 – 70
7	95 – 113	56 – 73	95 – 111	56 – 72
8	97 – 114	58 – 74	96 – 113	57 – 73
9	98 – 115	59 – 76	98 – 114	58 – 74
10	100 – 117	60 – 76	100 – 116	59 – 75
11	102 – 119	60 – 77	102 – 119	60 – 77
12	104 – 121	61 – 77	104 – 121	61 – 77
13	106 – 124	61 – 78	106 – 124	61 – 78
14	109 – 126	61 – 79	109 – 126	63 – 79
15	112 – 129	63 – 80	112 – 129	63 – 80
16	114 – 131	64 – 81	114 - 131	64 – 81
17	116 – 134	66 – 83	116 – 134	66 - 83

表格#二 - 身高體重（符合標準範圍）：

到達年齡	身高（厘米）	體重（千克）
1	63 – 93	6.3 – 15.1
2	75.4 – 101.4	8.9 – 17.3
3	83 – 109	10 – 20.4
4	89 – 116.3	11.3 – 24
5	95 – 98.1	12.6 – 28
6	101.2 – 130.9	14.1 – 32.8
7	107.1 - 138	15.5 – 38.4
8	112.2 – 144.6	17.1 – 44.9
9	116.6 – 150.6	18.8 – 52
10	120.5 – 156.4	20.7 – 59.1
11	124.6 – 162.8	23.1 – 66.2
12	130.8 – 170.2	25.8 – 72.7
13	137.8 – 177.5	28.9 – 79.1
14	142.1 – 182.9	31.9 – 85.1
15	143.9 – 186.0	34.7 – 91.2
到達年齡	**體格指數（男孩）**	**體格指數（女孩）**
16	20.4 - 23.7	20.4 - 23.1
17	20.8 - 23.9	20.4 - 23.2

4.7 重複保單

4.7.1 任何「受保人」不可投購超過一份「信諾醫療保系列」保單。如「受保人」受到多於一份「信諾醫療保系列」保單的保障，則：

(a) 「本公司」將會視「受保人」受到該一份在「基本保單」下提供最高的保障金額的「信諾醫療保系列」保單保障；或

(b) 如每份「信諾醫療保系列」保單的「基本保單」所提供的保障金額相同，則「本公司」將會視「受保人」受到首先簽發的一份「信諾醫療保系列」保單保障。

4.7.2 除了在條款4.7.1所提及的一份「信諾醫療保系列」保單仍然有效外，該「受保人」的任何其他「信諾醫療保系列」保單之保險均被視為從有關保單的生效日起無效(「廢除保單」)及在「廢除保單」下不會提供任何保障。你須立即退回我們就「廢除保單」已支付的所有金額及「欠款」（如有）。當我們收回所有該等退回款項後，我們會退回就「廢除保單」已支付的保費或我們有權從「廢除保單」已支付的保費中扣除我們已支付的所有金額以抵銷我們應退回的款項。

第五部份 - 不保事項規定

5.1 不保事項

5.1.1 「本公司」毋須就直接或間接來自或源於或歸咎於下列原因支付「本保單」的任何索償或引致的費用：

(a) 「之前已存在病症」及根據「本保單」的特別不保事項；

(b) 「戰爭」、侵略、外敵入侵、戰鬥（不論已宣戰與否）、「內亂」、叛亂、革命、起義、軍事、奪權力量或「恐怖主義」；

(c) 「受保人」從事或參與：

(i) 海軍、陸軍或空軍服役或執勤，武裝部隊或任何國家的警隊服務；

(ii) 職業體育運動或危險活動，例如但不限於使用輔助呼吸設備的戴水肺潛水、攀石、攀山、跳傘、懸吊滑翔（不論使用電源與否）、滑翔飛行、笨豬跳、冬季運動或任何非使用雙足的速度競賽；

(iii) 洞穴潛水、打撈潛水或自由潛水、專業潛水、並沒有持有正確的潛水認證（如潛水教練專業協會）及下潛深度低於 40 米的潛水；

(iv) 專業、半專業或有競賽成分的冬季運動、越野滑雪或單板滑雪、滑雪橇或單板跳台滑雪、乘直升機到高山滑雪、在滑雪道外滑雪或單板滑雪、競速滑雪；

(v) 高空工作（20 呎以上）；

(vi) 操作重型機器；

(vii) 航空或空中活動，除非身為購票乘客或空中工作人員，乘搭一架有適當牌照、固定機翼及多引擎、用以接載旅客並由有執照的商業航空公司營運的飛機，或一架由商業公司擁有及營運、領有牌照以定期接載購票乘客的直升機，惟該直升機必須僅在商業航機場及 / 或有牌照商業直升機場之間航行，並在上述兩個情況下，該旅程的目的概與飛機內或飛機上進行的交易或技術運作無關；或

(viii) 製造、儲存、注滿、細分、處理及運送任何爆炸品(包括但不限於煙花或爆竹)或化學物品；

(d) 不論在神智清醒或錯亂的情況下，「受保人」自殺、企圖自殺或蓄意自我損傷；

(e) 「受保人」受酒精或藥物影響，除非就服用藥物而言，能證明該藥物乃根據「醫生」的正式處方服用，並且非作戒毒用途；

(f) 「受保人」駕駛任何交通工具導致「身體損傷」或「疾病」的「意外」發生，而當時其血液內的酒精含量超過所在國家或地區的法律所允許的限度；

(g) 「受保人」採取不符合所在國家或地區法律的行徑，因而導致「身體損傷」或「疾病」；

(h) 「受保人」懷孕、分娩、小產或墮胎，包括有關併發症，儘管該事件可能由「身體損傷」或「疾病」促成或引致；

(i) 染上人體免疫缺損病毒或其變體病症，包括後天免疫缺損綜合症（愛滋病）及愛滋病相關綜合症；

(j) 性傳染病或其治療；

(k) 不育或絕育或任何種類的生育；

(l) 先天缺陷、「先天性疾病」、「遺傳性疾病」或由此引起的傷殘；

(m) 整容及非必要施行的外科手術，但不限於以下：
(i) 整形美容（除皺術）；
(ii) 鼻子整形（隆鼻）；
(iii) 吸脂手術及其他程序，去除脂肪組織；
(iv) 植髮；及
(v) 手術來改變乳房外觀、隆大或縮少乳房（為治療乳癌的乳房改造除外）；

(n) 眼睛折射偏差及包括以下治療但不限於激光治療、屈光角膜切開術，屈光性角膜切-削術；惟因「身體損傷」導致的則除外。若因「疾病」或「身體損傷」(如白內障或視網膜脫落）而引致「醫療必須」改善或恢復視力的治療，「本公司」會就該治療作出賠償；

(o) 眼睛及耳朵例行檢查、眼鏡、隱形眼鏡、助聽器及人工晶體費用；

(p) 疫苗及防疫注射；

(q) 所有由牙醫師提供的牙科治療；惟因「身體損傷」須在「住院」期間由「醫生」提供的緊急牙科治療則除外。但不包括該「住院」之跟進治療；

(r) 心理、精神或神經疾病、人格障礙及性格障礙；

(s) 器官移植，惟在器官移植條款下獲得保障則除外；

(t) 由手足病醫生或足科醫生提供的足部護理；

(u) 「發育異常」包括但不限於：
(i) 學習困難，如誦讀困難；
(ii) 行為問題，如自閉症或注意力缺陷障礙；或
(iii) 身體發育問題，如身材矮小；

(v) 因過重而需要治療肥胖，包括但不限於減肥班，減肥輔助劑及藥物。「本公司」只會支付捆紮帶胃或胃繞道手術，如「受保人」：
(i) 身體質量指數（BMI）40 或以上，並已被診斷為病態肥胖；及
(ii) 在過去的二十四（24）個「日歷月」內已嘗試了其他的減肥方法(須提供書面證據)；

(w) 人工生命維持包括機械通氣，倘此種治療不會或預計不

會導致「受保人」康復或恢復「受保人」以前的健康狀況；

(x) 胎兒手術或治療；

(y) 由成癮情況及障礙促成的相關情況之治療，包括但不限於戒煙；

(z) 除非有醫療證明「受保人」患有睡眠呼吸暫停，否則不保睡眠失調包括失眠、打鼾、睡眠相關呼吸困難。「本公司」只會就以下情況支付由「住院」引致的費用：
(i) 每年一次睡眠研究；及
(ii) 需要「醫療必須」的手術；

(aa) 不是「醫療必須」；或

(bb) 「受保人」自願暴露於任何災難或危險中。

5.1.2 「本公司」毋須償付「受保人」因下列原因產生的任何費用及 / 或開支：

(a) 在任何療養院或類似機構接受康復住院或護理或服務；

(b) 器官捐贈：
(i) 機械或動物器官，除了在等待移植時暫時用來維持身體功能的機械設備；
(ii) 從任何途徑購買器官捐贈；或
(iii) 收集及儲藏的幹細胞，針對未來可能出現的疾病之預防性措施；

(c) 在「本保單」終止後或「保障期」屆滿後接受的醫療，儘管該等費用可能由於「保障期」發生的「身體損傷」或「疾病」而引致；

(d) 例行醫療檢查或健康檢查；

(e) 根據一般規定條款 2.11，任何在政府法例下或其他醫療保險計劃內可獲賠償之治療「身體損傷」或「疾病」費用，除非此等費用未能在該等法例或保險計劃內獲得賠償；

(f) 另類治療，包括但不限於中藥治療、針灸、穴位按摩、推拿、催眠治療、羅爾夫按摩療法、按摩治療、香薰治療（除非在「保障賠償表」下的中醫診症及針灸獲得保障）；

(g) 所有未經「本公司」批准之實驗性或最新治療；

(h) 非醫療性服務，包括但不限於客人膳食、收音機、電話、影印、稅項、醫療報告費用及類似費用；

(i) 治療或言語治療，本質上難以恢復，或該治療：
(i) 用於提高仍未完全發育的說話技巧；
(ii) 是視為保管或教育；或
(iii) 為了保持語音溝通。

(j) 變性手術或為了預備或恢復進行手術的治療（如心理輔導），包括由該治療引起的併發症；

(k) 治療性功能障礙性疾病（如陽痿）或任何原因造成的其他性生活問題；

(l) 因在「醫院」接受治療時或由醫療專業人士導致的任何損失、傷害、或可能出現的「疾病」及 / 或「身體損害」的結果，即使「本公司」已批准「受保人」接受可獲賠償的治療；及

(m) 由與「受保人」在相同地址居住的任何人或「受保人」的家庭成員提供的治療。

簡明手術表

「外科手術程序」	手術類別	「外科手術程序」	手術類別
腹部		**胸心**	
闌尾切除	中	胸廓成形術、經胸廓進入胃部、橫膈膜、食道、交感神經切除術或喉切除術	大
膽囊切除或該器官的手術	大		中
胃腸吻合術	大	心臟導管插入術	
胃部、結腸或直腸切除	大	心血管造影術	中
胃食管吻合術	複雜	安裝心臟起搏器	中
胰腺切除術	複雜	冠狀動脈成形術	大
胃全部切除術	複雜	切除肺部或部份肺部	大
		支氣管內窺檢查、食道內窺檢查	小
膽管道		製造人工氣胸，每個首次充氣(以後不超過十二次)	小
肝管十二指腸吻合術	複雜		
肝部份切除術或切除	複雜	任何心臟或大血管手術，包括冠狀動脈分流術	複雜
截肢		門腔靜脈吻合術	複雜
股、腿部	大		
上臂、前臂、整隻手掌或腳掌	中	**脫位、復位術**	
每隻手趾或腳趾	小	臀部、一節或多節脊椎骨、足踝關節、手肘或膝部關節(膝蓋骨除外)	小
乳房		肩膊	小
良性腫瘤或囊腫切除	小	下顎、鎖骨、手腕或膝蓋骨	小
全乳房切除	中	任何涉及開刀手術的移位	中
根治性乳房切除	大		
		切除或切開復位及固定	
		髖關節	大
		肩膊、膝部關節、關節半月板、手腕或足踝關節	中
		切除骨骼的有病部份，包括刮除術(不包括牙槽窩骨)	中
		矯正臗關節移位	複雜
		矯正膝部移位	複雜

簡明手術表 (接上頁)

「外科手術程序」	手術類別	「外科手術程序」	手術類別
耳、鼻、喉		**骨折**	
開窗術，單耳或雙耳	大	治療股、一節或多節脊椎骨、盆骨	
簡單乳突小房鑿開，單邊或雙邊	中	- 單純性骨折	中
徹底乳突小房鑿開，單邊或雙邊	大	- 複合骨折或需進行開刀手術的骨折	大
扁桃體切除術、增殖腺切除術或二者	小	治療腿部、膝蓋、上臂、足踝 (波特氏骨折)	
竇穿刺	小		
切割鼻竇手術，鼻內或鼻外	中	- 單純性、複合骨折或需進行開刀手術的骨折	中
切除鼻息肉	小		
鼻膈膜黏膜下層切除	中	治療下顎(不包括牙槽窩骨)、鎖骨、肩胛骨、前臂、手腕 (科勒斯骨折)、頭蓋骨	
氣管切開術	中		
鼻甲骨燒灼	小		
咽切除術	複雜	- 單純性或複合骨折	小
咽喉切除術	複雜	- 需進行開刀手術的骨折	中
喉切除術	大	治療手、腳、手趾或腳趾、鼻、肋骨	
喉切除術，需根治性解剖	複雜	- 單純性、複合或需進行開刀手術的骨折	小
眼			小
雷射或激光凝固視網膜脫離	中	為舊骨折拆除釘或鏍絲	
治療視網膜脫離手術	大		
斜視矯正	大		
切除白內障	大		
其他眼球切入手術(切入角膜或鞏膜)或眼部肌肉的切割手術	中		
切除眼球	中		
切割或刮除麥粒腫或臉板腺囊腫	小		

簡明手術表 (接上頁)

「外科手術程序」	手術類別	「外科手術程序」	手術類別
生殖泌尿道		**甲狀腺腫**	
切除或切入腎臟	大	切除甲狀腺、全部或部份	大
腎臟固定	大	切除甲狀腺腺瘤或良性腫瘤	中
清除輸尿管或膀胱的腫瘤或結石			
- 使用切除手術	大	**疝**	
- 使用內窺鏡	小	一粒疝	中
- 使用體外衝擊波碎石術	中	一粒以上	大
膀胱鏡檢查	小		
全膀胱切除術	複雜	**關節**	
前列腺切除術		切入術，穿刺放液法除外	小
- 正中山脊鑿孔術	小		
- 透過膀胱鏡進行部份切除	中	**韌帶及腱**	
- 以任何方法完全切除	大	切割或移植，一條或多條	中
包皮環切	小	腱縫合，一條	小
精索靜脈曲張、陰囊水囊腫、睪丸切除術或附睪切除術		腱縫合，多條	中
- 一個或一對	中	**穿刺術**	
子宮切除術或全子宮切除術	大	穿刺放液法	小
子宮切開術	大		
切除卵巢囊腫	中		
卵巢切除術、輸卵管切除術或輸卵管造口術	大	**直腸**	
子宮頸截除	中	痔瘡硬化治療	小
擴張術及刮除術(非產後)、子宮頸燒灼或錐形切除術、息肉切除術、或上述任何組合	小	痔切除術，外部、內部或二者	中
		切割撕裂手術	小
		形成血栓痔切割手術	小
陰道整形、膀胱突出或直腸突出的手術	中	肛門‧管切除手術，一條或多條	中

簡明手術表 (接上頁)

「外科手術程序」	手術類別
皮膚及皮下組織	
燒傷及燙傷，使用麻醉治療	中
游離移植	小
皮膚移植	中
傷口縫合或切除及縫合	小
切除藏毛竇囊或囊腫	中
頭蓋骨	
環鋸	小
頸動脈動脈瘤	複雜
頸動脈內膜切除術	複雜
顱骨切開術，以治療腦膿腫、切除腦腫瘤(大腦神經膠質瘤)、腦膜瘤、後窩顱骨切開術，以治療動脈瘤、聽覺神經瘤、三叉神經脊神經根切除術	複雜
為破裂的頭蓋骨，包括有創及凹陷骨裂，施行手術	複雜 大
施行鑽孔，以治療腦膿腫、清除血腫、腫瘤活組織檢查	大 大
三叉神經根手術	大
顱骨成形術	大
脊柱及脊髓	
脊髓腫瘤手術	大
切除一節或多節脊骨手術	中
切除部份或全部尾骨、橫突或棘突	小
推拿或牽引腰部脊柱	複雜
脊髓前側柱切斷術	

「外科手術程序」	手術類別
頸部脊骨神經根減壓術，以治療椎間盤機能障礙	複雜
脊柱狹窄	複雜
脊髓減壓術	複雜
探查移除機能障礙的脊髓	複雜
脊膜瘤	複雜
腫瘤	
良性或表面腫瘤及囊腫、疣、雞眼或膿瘡，需「住院」或毋需「住院」	小 中
面部、唇或皮膚的惡性腫瘤	
靜脈曲張	
注射治療，完整程序，單腳或雙腳	小
切入手術，完整程序	
- 單腳	小
- 雙腳	中

備註：

倘所施行的手術並無列於「簡明手術表」，而「本保單」細則亦無明確表示豁免，則「本公司」須決定該項手術的分類。嚴重程度相似的任何手術將作為「本公司」最後決定的基準。「本公司」保留權利不時更改手術類別。