AVIVA GLOBAL LIFECARE

Here is Your new insurance Policy. Please examine it together with the Policy Schedule to make sure that You have the protection You need.

It is important that the Policy, the Policy Schedule and any endorsements are read together to avoid misunderstanding.

How Your Insurance Operates

This Policy is a contract between Us, the Company, and You, the Insured named in the Policy Schedule based on the Application Form, declaration and any information given to the Company by or on behalf of the Insured Persons.

In consideration of You paying to Us the required premium, We agree to indemnify You in the manner and to the extent described in the Policy and in the Policy Schedule in respect of medical or other covered expenses incurred during the Policy Year, or any subsequent period for which You pay and We accept the required premium.

Our Promise of Service

We wish to provide You with a high standard of service and to meet any claims covered by this Policy honestly, fairly and promptly. Should You have any reason to believe that We have not done so, please contact Your servicing adviser who will be ready to help You with Your concerns.

Cooling-Off Period

You may cancel this Policy by giving Us written notice of cancellation provided that such notice of cancellation must be received by the Company at its Registered Office on or before the later of:-

(a) twenty-one (21) days after the date on which You signed the Application Form;

(b) fourteen (14) days after the Policy Issue Date;

(c) if this Policy replaces an existing life insurance policy, fourteen (14) days after the date the Customer Protection Declaration (CPD) form has been copied to the Company of that existing life insurance policy; or

(d) five (5) days from the date on which You received this Policy or a notice informing You about the availability of this Policy and the expiry date of the Cooling-Off period.

Upon cancellation We shall, unless a claim under this Policy has been made, refund the premium(s) received. We will not pay interest on refunded premium(s).

Contents

Definitions

When used in this Policy, the following terms will have the meanings shown below:

Company, We, Our, Us
means Aviva Life Insurance Company Limited.

You, Your, Insured
means the owner of the Policy who is named the Insured in the Policy Schedule.

Accident
means bodily Injury caused solely by violent, accidental, external and visible means and not by sickness, disease or gradual physical or mental process.

Annual Deductible
means the accumulative total amount of medical expenses incurred by an Insured Person during any one Policy Year in excess of which We will indemnify or compensate the Insured Person for medical expenses covered by the Policy.

Application Form
means the forms You signed to apply for this Policy from Us, including any written statement, representation or document given to the Company which contains information We relied on in issuing this Policy.

Approved Hospital
means a Hospital approved by the Company to provide treatment for which a benefit may be payable under the Policy.

Area of Cover
means the countries in which the Insured Person will be covered. Subject to the terms of this Policy, Zone 1 under this Policy offers worldwide coverage including the United States of America while all other Zones under this Policy offer worldwide coverage excluding the United States of America.

Dependant
means the Insured's:
(a) legal spouse below sixty-five (65) years of age who is not divorced or legally separated from the Insured at his or her Effective Date; or
(b) co-habitant below sixty-five (65) years of age at his or her Effective Date; and /or
(c) unmarried and unemployed child from a day old and above at his or her Effective Date,

who fulfils any of the requirements set out in Clauses 1(a)-(c) Eligibility, General Conditions, and whom We have agreed in writing to be eligible to participate in this insurance coverage as dependants under this Policy.

Due Date
means the date on which any payment of premium falls due depending on the frequency of premium payment.

Effective Date
means the date expressly stated by Us as the date on which the Insured Person's coverage under this Policy shall commence after We have received the relevant information from You on the Insured Person and accepted the Insured Person's application.

Emergency Medical Complaint
means a medical condition resulting from an Accident, or any sudden beginning or worsening of a severe Illness that:
(a) presents an immediate and serious threat to the Insured Person's health; and
(b) requires immediate medical attention by a Physician.

Home Country
means the country declared on the Application Form under the heading "Nationality". This is the country to which the Insured Person will return to if You wish to make a claim for repatriation. The Home Country of Dependants will be deemed to be the same Home Country as declared for the Insured in the Application Form.

Home Country Cover
means insurance cover provided by the Policy in the Insured Person's Home Country.

Hospital
means an institution which is legally licensed as a medical or surgical hospital in the country in which it is located. It must be under the constant supervision of a Physician. This does not include any entity which is primarily a place for alcoholics or drug addicts, a nursing, rest or convalescent home or a home for the aged or any other similar establishment.

Illness
means a physical condition marked by pathological deviation from the normal healthy state.

Injury
means bodily injury caused solely and directly by an Accident.

Inpatient
means a person admitted to a Hospital for treatment and for which the Hospital makes a daily room and board charge. It also includes admission of any duration for the purpose of surgery and any preparation and procedure in connection with the surgery without incurring any room and board charge.

Insured Person
means the Insured or Dependant, as applicable, whose relevant information You have provided Us and whom We have agreed in writing to be insured under the Policy.

Medically Necessary
means those services and supplies provided by a Physician to identify or treat an Injury or Illness which has been diagnosed or is reasonably suspected to be, and are:
(a) consistent with the diagnosis and treatment of the Insured Person's condition;
(b) according to standards of good medical practice;
(c) required for reasons other than for the convenience of the Insured Person or Physician; and
(d) the most appropriate supply or level of service which can be safely provided to the Insured Person.

Per Disability
means all complications and conditions arising from the same Illness or bodily Injury caused by an Accident. Any recurrence or relapse of such complications or conditions which occurs more than thirty (30) days following the respective Insured Person's last discharge from Hospital will be considered as a new disability.

Physician
means a person who is legally qualified in medical practice following attendance at a recognised medical school, to provide medical treatment and licensed by the competent medical authorities of the country in which treatment is provided but who should not be the Insured Person or the relative, sibling, spouse, child, parent of the Insured Person.

Policy Commencement Date
means the date from which this Policy becomes effective.

Policy Year
means a period of twelve (12) consecutive months starting from the Policy Commencement Date and each consecutive 12-month period thereafter for which this Policy is renewed.

Pre-Existing Conditions
means any Injury, Illness, condition or symptom:
(a) for which treatment, or medication, or advice, or diagnosis has been sought or received or was foreseeable by You or the Insured Person prior to the Insured Person's Effective Date or the date of Upgrade or the date of the last Reinstatement, whichever is later, for the Insured Person concerned, or

(b) which originated or was known to exist by You or the Insured Person prior to the Insured Person's Effective Date or the date of Upgrade or the date of the last Reinstatement, whichever is later, whether or not treatment, or medication, or advice, or diagnosis was sought or received.

Reasonable and Customary Charges
means charges for medical care which We or Our medical advisers consider to be reasonable and customary if they are within general level of charges being made by other care providers of similar standing in the locality where the charges are incurred when giving like or comparable treatment, services or supplies to individuals of the same gender and of comparable age for a similar disease or Injury.

Renewal Date
means the anniversary date of the Policy Commencement Date or such other dates as may be agreed in writing between You and the Company.

Schedule
means the Schedule to this Policy headed "Policy Schedule" which sets out key terms like the name of the Insured, the Insured Persons, the benefits and the Policy limits.

Serious Medical Condition
means for the purpose of interpreting Emergency Medical Evacuation cover, a condition which in the opinion of the Company or its authorised representatives constitutes a serious or life threatening medical emergency requiring immediate evacuation to obtain urgent remedial treatment in order to avoid death or serious impairment to an Insured Person's immediate or long-term health prospects. Unless agreed otherwise by the Company it does not mean any circumstances in which the Insured Person is capable of travelling without a medical escort. The seriousness of the medical condition will be judged within the context of the Insured Person's geographical location and the local availability of appropriate medical care or facilities.

Specialist
means a qualified and licensed Physician, possessing the necessary additional qualifications and expertise to practice as a recognised specialist of diagnostic techniques, treatment and prevention, in a particular field of medicine like psychiatry, neurology, pediatrics, endocrinology, obstetrics, gynaecology and dermatology.

Upgrade
means a change in plan under the Policy whereby the Insured Person's plan is changed to a new plan offering higher benefits, under the same Policy.

Usual Country of Residence
means the country in which the Insured Person usually lives as stated in the Application Form or any other country which We are asked to substitute as the Insured Person's new Usual Country of Residence so long as
(a) We are informed in writing of any such permanent change* in the country where the Insured Person usually lives; and
(b) We confirm Our agreement to continue insuring the Insured Person under this Policy on such terms as We think are appropriate subject to the laws of the new Usual Country of Residence.

* The Insured Person is deemed to make a permanent change in his or her Usual Country of Residence if that Insured Person lives or intends to live in the other country for more than three (3) consecutive months.

Waiting Period(s)
means the period of time applicable to specific benefits under the Policy as set out under the relevant benefit provisions, starting from:

(a) the Insured Person's Effective Date under this Policy; or
(b) the date of the last notice of Reinstatement; or
(c) the date of Upgrade.

whichever is later, during which this Policy will not provide for that respective benefit regardless of treatment made necessary by any cause.

General Conditions

It is an important part of Our contract that You observe the following General Conditions:

1. **Eligibility**
   The following persons age eighteen (18) and above, and below age sixty-five (65) as at his or her Effective Date may apply as an Insured under this Policy:

   (a) all Hong Kong Residents;
   (b) Hong Kong Permanent Residents; or
   (c) foreign nationals living outside his or her Home Country.

   This Policy offers coverage under the applicable plan for all Insured Persons under this Policy subject to You having provided Us with relevant information on the respective applicants and Our express acceptance of each applicant as an Insured Person.

2. Geographical Scope
This Policy covers the Insured Person in the Area of Cover as stated in the Policy Schedule on a twenty-four (24) hour basis.

The Insured Person shall, wherever possible, seek treatment in the specified Area of Cover except for any treatment for an Emergency Medical Complaint as stated under Covered Benefits, Clause (1)(xi).

3. Commencement of Coverage
An Insured Person will be covered under the Policy on his or her Effective Date. If an Insured Person is in hospital confinement on the date which insurance coverage is to be effective, coverage will not become effective until the respective Insured Person is discharged.

4. Co-ordination of Benefits
The Policy will only provide compensation on a proportionate basis if the Insured Person has any other insurance in force or is entitled to indemnity from any other source in respect of the same Accident, Illness, death or expense claimed under the Policy. We have full rights where permitted by law to take proceedings in Your or the Insured Person's name, but at Our expense, to recover for Our benefit, the amount of any payment We have made under the Policy.

5. Co-operation
We will have no liability under this Policy unless You and/or the Insured Person or his/her representatives do all of the following:
(a) co-operate fully with Us and Our medical advisers;
(b) fully and faithfully disclose all material facts and matters which the Insured Person knows or ought to know; and
(c) upon Our request sign any document to empower the Company to obtain relevant information, at the Insured Person's expense, from any doctor or Hospital or other sources.

6. Material Changes
We must be informed immediately in writing of any material change in information or circumstances whether relating to occupation, business, sporting activity or Usual Country of Residence (including if this is the Insured Person's Home Country) affecting You or any Insured Person. Provided the laws of the new Usual Country of Residence (including if this is the Insured Person's Home Country) allow, We will continue cover for the Insured Person on terms and conditions, including premium rates, which We consider appropriate because of the material change in circumstances.

7. Renewal
Each Insured Person's coverage is automatically renewed for the next Policy Year by payment of the renewal premium before the Renewal Date provided the existing plan(s) You have selected for this Policy is still available. On the Renewal Date, We may vary the benefits, cover and /or premium or even cancel all policies in a particular age group or of a plan type by giving thirty (30) days advance notice in writing to You, but We will not cancel any individual policy.

8. Cancellation

You may cancel the Policy by giving Us at least thirty (30) days' prior notice in writing of Your intention to cancel the Policy.

Where premium is charged on an annual basis and the Insured cancels the Policy during any Policy Year, the coverage under this Policy for all Insured Persons will cease upon Our receipt of the cancellation notice. You will be entitled to a pro-rated refund of the annual premium paid to Us for the unexpired period of coverage. If a claim has arisen in respect of that Policy Year, no refund will be made.

Where premium is charged on other regular basis and the Insured cancels the Policy, the coverage under this Policy for all Insured Persons will cease on the Due Date after Our receipt of the cancellation notice. The Company is entitled to the balance of the premium payable for the entire Policy Year if a claim arises in respect of that Policy Year. The Company will deduct the balance of the premium from any claim amount due.

9. Termination of Insurance

An Insured Person's cover under this Policy will terminate automatically on the date any one of the following events first occurs:

(a) upon request of cancellation of an Insured Person's coverage under this Policy by You;
(b) upon the death of the Insured Person;
(c) non-payment of premium after the grace period; or
(d) the Insured Person, who is a citizen or permanent resident (or equivalent) of the USA, returns to the USA for three (3) consecutive months or more.

10. Continuity of Benefits after Termination of Policy

If the Policy is terminated as provided in Clause 9, covered benefits in respect of any valid claim will continue to be payable for up to a maximum period of thirty (30) days after the Policy terminates but only if all of the following are satisfied:

(a) the claim was reported and accepted by Us before the Policy was terminated;
(b) the Insured Person's Usual Country of Residence at the time of the Accident or Illness giving rise to the claim, was within the Area of Cover stated in the Schedule; and
(c) the claim only relates to covered treatment obtained within the Area of Cover stated in the Schedule.

11. Misstatement of Age

If the age of any Insured Person has been misstated and the premium paid as a result is insufficient, any claim payable under this Policy shall be pro-rated based on the ratio of the actual premium paid to the correct premium which should have been charged for the entire period of Insurance. Any excess premium that may have been paid as a result of any misstatement of age shall be refunded without interest. If at the correct age an Insured Person would not have been eligible for cover under this Policy, no benefit shall be payable, and Our liability shall be limited to the refund of the total premium paid without interest.

12. Subrogation

If You receive reimbursement of any medical costs from a third-party in relation to the transmission of the Human Immunodeficiency Virus (HIV) to the Insured Person through blood transfusion, You shall reimburse any benefit paid by Us under this Policy in relation to the transmission of HIV to the respective Insured Person through blood transfusion up to the total amount of benefits paid by Us or the total amount of reimbursement received from the third party, whichever is lower.

13. Age

For the purpose of determining premiums payable, an Insured Person's age shall be based on his or her age as at last birthday.

14. Fraud

If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Insured Person or anyone acting on his or her behalf to obtain benefits under this Policy, the Policy will be cancelled immediately and all benefits and premiums paid under the Policy shall be forfeited.

15. Trust and/or Assignment

We will not recognise or be affected by any notice of trust, charge or assignment relating to this Policy and the receipt of monies payable under this Policy by the Insured or the Insured's legal personal representative(s) or providers of covered medical, transportation or other services, as applicable, shall in all cases be deemed full and final discharge of Our liability.

16. Applicable Law

The terms and conditions of this Policy will be governed by and construed, determined and enforced in accordance with the laws of Hong Kong.

17. Legal Personal Representative(s)

The terms, exceptions and conditions of this Policy also apply to the legal personal representative(s) of the Insured.

18. Currency

Payment of all claims and benefits will be made in the currency in which this Policy is effected based on the prevailing exchange rate used by Us on the date the claim(s) is processed.

19. Grace Period

A grace period of thirty (30) days from the premium Due Date is allowed for payment of the required premium. If the premium due is not paid on or before the last day of the grace period, the cover under the Policy will be terminated on the Due Date and may only be reinstated with Our consent.

20. Reinstatement

If the Policy terminates due to non-payment of premium, You may apply to reinstate this Policy within thirty (30) days of the date of notice of termination by providing Us with satisfactory evidence of insurability for each Insured Person at Your expense, provided the Insured Person for whom reinstatement is requested is not older than age sixty-five (65) on the date of reinstatement. All outstanding premiums must be received by Us before the Policy can be reinstated.

Treatment provided to the Insured Person after the date of termination and within thirty (30) days of the date of notice of reinstatement will not be covered unless the treatment is for Injuries caused by an Accident occurring after the date of notice of reinstatement.

21. Payment of Benefits

Any benefits payable under this Policy shall be paid to the Insured or the Insured's legal personal representative(s) or providers of covered medical, transportation or other services, as applicable, whose receipt of any benefit payable under this Policy shall in all cases be deemed full and final discharge of Our liability.

22. Change of Plan

You may change the plan of an Insured Person, subject to Our approval in writing, by giving Us a written notice at least thirty (30) days prior to the Renewal Date of this Policy. This is subject to satisfactory evidence of insurability for each Insured Person at Your expense for any Upgrade and, where applicable, satisfaction of the terms of the Reinstatement provision, before the change can be effected on the Renewal Date or Reinstatement date, as applicable.

To effect a change of plan for an Insured Person classified as a Dependant child ("**Dependant Child**"), all Dependant Children must apply, at the same time, for a change of plan to the same plan.

In the event of an Upgrade, any claim arising from a Pre-Existing condition after the Upgrade and/or any claim arising during the applicable Waiting Period after the Upgrade, will be assessed under the terms and conditions of the plan prior to the Upgrade and if such a claim is admissible, any benefit payout would be limited to the benefits under the plan prior to the Upgrade**.**

23. Exclusion of Rights under the Contracts (Rights of Third Parties) Act

A person who is not a party to this Policy shall have no right under the Contracts (Right of Third Parties) Act (and any subsequent amendments or replacement of this Act) to enforce any of its terms.

SECTION I - EXTENT OF COVER

The Policy will pay up to the Annual Limits and sub-limits stated in the Schedule for medical or other covered expenses as defined and required as a direct result of the Insured Person suffering an Accident, Illness, death or any other covered event.

We will pay any benefits due under this Policy either to the Insured or Insured's legal personal representative(s) or the providers of covered medical, transportation or other services, as applicable, whose receipt of that benefit will discharge Us from the liability We have under the Policy. Only the usual Reasonable and Customary Charges in the geographical area where covered treatment or services are provided will be paid.

Satisfactory Proof of Claim must be submitted in all cases and We may appoint independent administrators to settle claims on Our behalf.

SECTION II - LIMITS OF LIABILITY

The Company's liability is limited in amount to the sub-limits which the Schedule says applies to each item or type of cover provided.

The Annual Limit per Insured Person stated in the Schedule is the maximum amount recoverable under the Policy as a whole in respect of any one Insured Person during any one Policy Year.

If benefits are properly claimable after the date of termination or non-renewal of the Policy, the amounts payable shall be calculated as if the expenses had been incurred wholly during the preceding Policy Year.

SECTION III – DEDUCTIBLE

A Deductible is the amount of a claim which has to be borne by the Insured Person before any benefit is payable under this Policy.

An Annual Aggregate Deductible is the accumulative total amount of medical expenses incurred by an Insured Person during any one Policy Year in excess of which the Policy will indemnify or compensate the Insured Person for medical expenses covered by the Policy. The Annual Aggregate Deductible is calculated on a Policy Year basis. The Annual Aggregate Deductible applicable for each Policy Year is aggregated from the start of that Policy Year and shall apply to all medical claims in that Policy Year. Should the Policy be renewed, the Annual Aggregate Deductible for that Policy Year shall apply.

In order to claim for any expense in excess of the Deductible, the Insured Person must be able to substantiate that incurred expense said to fall within the Deductible would have been covered by the Policy if the Deductible were not applied.

SECTION IV - COVERED BENEFITS

The following benefits are available under this Policy. Benefits will only apply if the plan the Insured Person is covered under, as reflected on the Schedule, offers such benefits. Please refer to the Schedule to determine the cover actually provided to the Insured Person concerned.

1. HOSPITAL & RELATED SERVICES

(i) **Hospital Treatment & Services**

All Medically Necessary treatment and services provided by or on the order of a Physician to the Insured Person when admitted as a registered Inpatient to a Hospital.

Cover includes Hospital accommodation up to the cost of a standard private class single-bed air conditioned room categorised as a standard private in that Hospital, meal charges, general nursing services, diagnostic, laboratory or other Medically Necessary facilities and services, physician's / surgeon's / anaesthetist's or physiotherapist's fees, operating theatre charges, intensive care unit charges, specialist consultations or visits and all drugs, dressings or medications prescribed by the treating Physician for in-hospital use. We do not pay for the costs of non-Medically Necessary goods or services including such items as telephone, television and newspapers.

For the avoidance of doubt, if the Insured Person is admitted to any luxury suite or special room that may be available at that Hospital, cover under this Policy shall be up to the cost of a standard private class single-bed air conditioned room categorised as a standard private in that Hospital.

(ii) **Cancer Treatment**
Charges for treatment of an Insured Person for cancer irrespective of whether such treatment is received as a registered Inpatient or as an outpatient at a registered cancer treatment centre.

(iii) **Kidney Dialysis Treatment**
Charges for treatment of an Insured Person for kidney dialysis irrespective of whether such treatment is received as a registered Inpatient or as an outpatient at a legally registered dialysis centre.

(iv) **Physiotherapy Treatment**
Charges for physiotherapy treatment of an Insured Person which is received as a registered Inpatient at a Hospital.

(v) **Inpatient Psychiatric Treatment**
Charges for psychiatric treatment received as an Inpatient in a psychiatric unit of a Hospital, subject to a continuous Waiting Period of ten (10) months. All treatment must be administered under the direct control of a registered psychiatrist.

(vi) **Day Surgery**
The cover provided by the Hospital Treatment & Services benefit extends to include Day Surgery. Day Surgery means all Medically Necessary surgical procedures and related treatment provided by or on the order of a Physician to the Insured Person at a Hospital or clinic.

We do not pay for non-surgical procedures and related treatment.

(vi) **Casualty Ward Accident & Emergency Services**
Services provided to the Insured Person as an outpatient in a Hospital Casualty Ward immediately following an Emergency Medical Complaint or Accident**.**

(vii) **Pre-Hospital Specialist and Diagnostic Services**
Charges by Specialist and Laboratory, X-ray or other Medically Necessary diagnostic procedures ordered by a Physician and which within sixty (60) days of being carried out, result in the Insured Person being admitted as a registered Inpatient to a Hospital for the treatment of the specific medical condition diagnosed, provided that such medical condition is covered by the Policy.

(viii) **Post-Hospital Follow-up Treatment**
The Medically Necessary follow-up treatment ordered by a Physician to be rendered for up to three (3) months from the Insured Person's discharge from Hospital and in total for any one claim or disability. Cover is restricted to follow-up treatment of the specific medical condition for which the Insured Person received in-hospital treatment covered by the Policy.

(ix) **Hospital Accommodation for accompanying parent of Insured child**
Accommodation charges incurred by one parent sharing the Hospital room of a Dependant Child under eighteen (18) years of age, where the latter is treated for Illness or Injury at a Hospital, as an Inpatient for a period.

(x) **Local Ambulance Services**
The Medically Necessary transportation of the Insured Person by road ambulance to a local Hospital. Cover extends to include local transportation of the Insured Person between airports and/or home and/or Hospitals by taxi or other suitable modes of transport for the purpose of receiving Inpatient Hospital treatment covered by the Policy.

For the purpose of this clause, "local" means within the country in which the Insured Person is in when he requires the service.

(xi) **Emergency Treatment in the United States of America (USA)**
Charges for an Emergency Medical Complaint occurring during short period business or holiday travel not exceeding three (3) consecutive months per trip in the USA will be covered for Insured Persons, including those who are citizens of the USA, whose Area of Cover under this Policy excludes the USA. This benefit is available to those whose Area of Cover under this Policy includes the USA whereby the three (3) month requirement set out above will not apply. We will

not cover any costs for treatment provided in a Hospital unless the hospitalization begins within twenty-four (24) hours after the Emergency Medical Complaint arose.

(xii) **Accident Dental Treatment**
Dental treatment required to restore or replace sound natural teeth lost or damaged in an Accident and for which treatment was received within fourteen (14) days following the Accident.

(xiii) **Home Nursing following Hospitalization**
Following discharge from Hospital, cost of a full-time or part-time services of a State registered or Government-licensed nurse in the Insured Person's home so long as all of the following apply:

- it is prescribed by a Physician for the continued treatment of the specific medical condition for which the Insured Person was hospitalised, and
- is essential for medical as distinct from domestic reasons.

Cover is limited to a maximum period of twenty-six (26) weeks in any one Policy Year and in total for any one claim or event.

(xiv) **Daily Hospital Cash**
If an Insured Person is admitted to Hospital as a non-paying Inpatient, where the treatment received is free of charge and covered within the terms of the Insured Person's plan under this Policy, We will pay a daily hospital cash benefit up to the sub-limits stated in the Schedule and for a maximum of thirty (30) days Per Disability per Policy Year.

2. ORGAN TRANSPLANTATION

The cost of operations for the transplantation of the kidneys, heart, liver, lung or bone marrow where the Insured Person is the recipient.

We do not pay for the costs of acquiring the organ or expenses incurred by the donor. No other type of benefit insured by the Policy provides cover in connection with Organ Transplantation.

3. EMERGENCY MEDICAL EVACUATION AND REPATRIATION

This benefit applies while the Insured Person is travelling:

a) outside the Home Country or Usual Country of Residence on holiday or business not exceeding three (3) months per trip; or
b) within the Home Country or Usual Country of Residence

but excluding war zones and countries where the prevailing conditions render evacuation impracticable.

The Company and its medical advisers reserve the absolute right to decide if the Insured Person's medical condition is sufficiently serious to warrant Emergency Medical Evacuation and/or Repatriation. The Company or its medical advisers shall also decide the place to which the Insured Person shall be evacuated and the means by which the evacuation should be carried out, having regard to all the assessed facts and circumstances of which the Company is aware at the relevant time.

(A) Emergency Medical Evacuation and Assistance
The cover under this Benefit Clause 3A is defined as:

(i) Emergency Medical Evacuation
We will only pay for evacuation or repatriation arrangements if it is prior approved and authorised by Our 24-hour Emergency Assistance Centre.

We will pay in full the reasonable transportation costs for the Insured Person to be evacuated for Inpatient treatment if the treatment needed is covered under the Policy and is recommended by the Insured Person's Physician for medical reasons and is not available locally. This must be approved in advance by the 24-hour Emergency Assistance Centre. You must provide Us with any information or proof that We may reasonably ask You to support Your request.

We will only pay for the evacuation of the Insured Person requiring the treatment to the nearest place where the treatment is available. This could be another part of the country which the Insured Person is in if this is appropriate. Please note that the nearest country may not be the Insured Person's Home Country.

(ii) Compassionate Travel

We will pay the expense, up to the cost of one economy class return airfare and all ancillary charges including accommodation, for one (1) person to join an Insured Person who becomes seriously ill while travelling alone outside the Home Country or Usual Country of Residence and so long as:

- The Insured Person has been or will be hospitalised in a Hospital for a period that is more than seven (7) days and with Our prior approval; and
- We or Our medical advisers consider it necessary on medical grounds and/or to avoid the need for medical evacuation.

(iii) Return of Minor Children

The expense, up to the cost of economy class one way airfares and usual ancillary charges, to return children who are left unattended to the Home Country or Usual Country of Residence as a result of the accompanying adult Insured Person's Accident, Illness, death, hospitalization or medical evacuation covered by the Policy.

(iv) Dispatch of Medicines

The expense incurred by or on the order of the Company or its medical advisers to replace essential medical commodities for an Insured Person travelling outside the Home Country or Usual Country of Residence in circumstances where such commodities have been lost or stolen and no suitable replacements or substitutes are available locally.

(B) Repatriation

The cover under this Benefit Clause 3B is defined as:

(i) Repatriation or Travel Expenses

We will pay the expense necessarily and unavoidably incurred in returning the Insured Person to the nearer of the Home Country or Usual Country of Residence following Emergency Medical Evacuation provided that such additional costs are Medically Necessary and approved in advance by Us or Our medical advisers. We will also pay reasonable transportation costs for one other person to travel or remain with the Insured Person during evacuation when this is considered necessary for medical reasons. We only pay for one repatriation per Illness or Injury.

(ii) Repatriation or Local Burial of Mortal Remains

We will pay the expense of preparation and air transportation of the mortal remains of an Insured Person from the place of death to the Home Country or Usual Country of Residence, or the preparation and local burial of the mortal remains of an Insured Person who dies outside the Home Country or Usual Country of Residence. Within the stipulated Policy limit for this benefit, cover includes the cost of a single, economy class airfare for one (1) person accompanying the body back to the Home Country or Usual Country of Residence.

For the purpose of this clause "local" means within the country where the Insured Person died.

(C) Emergency Medical Advice and Assistance

In emergencies, You may call Our 24 hour Emergency Assistance Centre hotline at any time for medical advice, and evaluation from the attending co-ordinator doctor in order to locate suitable medical services anywhere in the world or to provide referral to Physicians or Hospitals for personal assessment and/or treatment as medically appropriate.

You understand and agree for Yourself and for each Insured Person that such telephone conversations cannot establish a diagnosis and must be considered as advice only.

The Emergency Assistance Centre will, as far as it is reasonably possible, facilitate necessary Hospital admissions by confirming the extent of insurance cover, monitoring claims procedures and issuing appropriate guarantees in accordance with the Payment Guarantee condition of this Policy.

(D) International Travel Assistance Services

While the Insured Person is travelling**,** the 24-hour Emergency Assistance Centre can provide the following administrative assistance and services:

i) visa, immunisation, vaccination, special medication and weather information services prior to departure;
ii) retrieval and redirection of lost luggage;
iii) replacement and delivery of essential lost travel documents such as passport, travel tickets and credit cards; and/or
iv) emergency message transmission and interpreting service.

You understand and agree that any third-party fees or charges reasonably and properly incurred by the Company in the delivery of these services must be borne entirely by the Insured Person or Yourself.

4. OUTPATIENT BENEFITS

Medically Necessary treatment provided to an Insured Person who is not a registered Inpatient at a Hospital and defined as:

(i) General Practitioner Services

Charges for outpatient services provided by a Physician in his or her capacity as a general practitioner including the cost of prescribed drugs.

(ii) Specialist Services

Charges for outpatient services provided by or on the order of a Physician who is licensed and practices as a Specialist or consultant in respect of the services rendered including the cost of prescribed drugs.

(iii) Outpatient Psychiatric Treatment

Charges for outpatient psychiatric treatment administered under the direct control of a registered psychiatrist up to the sub-limits stated in the Schedule. This benefit is subject to a continuous Waiting Period of ten (10) months.

(iv) Outpatient Laboratory, X-ray and Diagnostic Services

Laboratory, testing, radiographic and medicine procedures including physiotherapy, speech therapy, oculomotor therapy, CT, PET and MRI scans used to diagnose or treat medical conditions. Such services must be provided by or ordered by a Physician.

(v) Prescribed Drugs

Drugs and medications which are Medically Necessary and legally restricted to the order of a Physician and prescribed for use by the Insured Person as an outpatient.

(vi) Prescribed Outpatient Therapies

Charges for treatment by a legally qualified physiotherapist, speech therapist or oculomotor therapist and provided You have been referred for such treatment by a Physician.

(vii) Prescribed Medical Aids

Medical aids which are ordered by a Physician and Medically Necessary such as artificial limbs, hearing aids, rental or purchase of wheel chair.

(viii) Alternative Medicine

We pay for treatment by a qualified chiropractor, homeopath, osteopath, acupuncturist or Chinese medicine physician.

For the purpose of this clause, “qualified” means the person is fully trained, legally qualified, registered and licensed to practice in the country in which the treatment is provided but who should not be the Insured Person or the relative, sibling, spouse, child, parent of the Insured Person.

5. HEALTH SCREEN BENEFIT

If the plan the Insured Person is covered under, as stated in the Schedule, offers the Health Screen Benefit, We will reimburse the cost of a health screen up to the stated sub-limits in the Schedule provided the cost of the health screen is incurred after the completion of two (2) continuous years of coverage under this Policy. For the avoidance of doubt, this benefit may be claimed once every two (2) complete years of coverage under the Policy.

6. MATERNITY BENEFIT

If the Insured Person above the age of eighteen (18) at the point of delivery, is covered under a plan that offers the Maternity Benefit, as stated on the Schedule, We will pay for medical expenses up to the sub-

limit stated in the Schedule that the Insured Person incurs provided the expenses are incurred after the applicable continuous Waiting Period.

Medical expenses include ante-natal care such as ultrasound scans, hospital charges, obstetricians' and midwives' fees for childbirth, post-natal care required by the mother immediately following childbirth, secondary conditions brought about by pregnancy such as backache, high blood pressure, vaginal bleeding, nausea, and vomiting.

Standard nursery expenses for newborn children up to seven (7) days of age are covered under this benefit.

No other type of benefit insured by the Policy (except for Emergency Medical Evacuation services) provides any cover for expenses incurred in connection with maternity or childbirth.

This benefit is subject to a continuous Waiting Period of ten (10) months unless the claim is made by an Insured Person who is a Dependant Child or who is the only Insured Person under this Policy or who is not the first Insured Person to claim this benefit under this Policy, whereby a continuous Waiting Period of fifteen (15) months shall apply.

7. DEATH BENEFIT

Upon receipt of due proof, in the form prescribed by the Company, of death of an Insured Person, an amount determined in accordance with the Benefit Schedule shall be payable. Amount shall be reduced by half at the policy anniversary following the 65th birthday of the Insured Person.

8. DENTAL BENEFIT (OPTIONAL COVER)

If the plan the Insured Person is covered under, as stated in the Schedule, offers the Dental Benefit, We will pay for dental expenses up to the sub-limit stated in the Schedule, per person per Policy Year, for routine and restorative dental treatment as follows:

(a) Routine dental treatments including scaling, polishing, x-rays, compound fillings, tooth extractions, gum treatments, surgery for wisdom tooth extractions; and

(b) Restorative dental treatments and prosthesis including surgery for removal of impacted tooth, removal of roots, crowning, root canal treatment, bridging new or repair of upper or lower dentures, implants provided the Insured Person has been covered under this benefit for six (6) consecutive months before incurring the claimable dental expense.

Claims Conditions

We will act in good faith in all Our dealings with You. You, in turn, must ensure that the following are observed:

1. Notification of Circumstances that may give rise to a Claim

If there are circumstances which will or may give rise to a claim on this Policy, You must ensure that the following are adhered:

- The 24-hour Emergency Medical Assistance Centre We have appointed must be informed immediately, if the Insured Person may require emergency medical evacuation or repatriation of mortal remains.

- Before an Insured Person begins treatment as a Hospital Inpatient (except in cases of Accident or acute medical emergency), the Insured Person must notify the 24-hour Emergency Medical Assistance Centre immediately in writing of the intention to seek such treatment, with full details of the proposed treatment and the names and addresses of the Physician and Hospital concerned.

- In cases of Accident or acute medical emergency, written notification together with reasonably available supporting medical information must be submitted to Us within 48 hours of the event.

2. Payment Guarantees & Direct Settlements

When We are given adequate advance notice of a claim as provided in Claims Condition 1 above, We or the 24-hour Emergency Medical Assistance Centre will give You a confirmation of the extent of insurance benefits, monitor claims procedures, issue (wherever reasonably possible) appropriate Payment Guarantees and/or arrange direct settlement of the bills rendered by Hospitals, Physicians or other service providers.

We will not provide Payment Guarantees or direct settlements if neither We nor the 24-hour Emergency Medical Assistance Centre is contacted reasonably in advance with all relevant details as stated in Claim Condition 1 above.

Covered Outpatient Services are not subject to Payment Guarantees or direct settlement and must be paid by the Insured Person and reimbursed subsequently under the Policy.

If We make any payment under the Payment Guarantee or direct settlement which payment should have been made by You, You shall reimburse the amount(s) paid by Us within thirty (30) days of being notified.

3. Making a Claim

If You intend to make a claim, You must in addition:

- complete Our Claim Form and submit it to Us as soon as possible after an Insured Person seeks covered treatment.

In respect of Our Claim Form:

- the Insured Person or the Insured Person's legal personal representative(s) must complete all the questions in Section A and sign it;
- the treating Physician must complete all questions in Section B, affix his rubber stamp on the Claim Form and sign it;
- give Us all supporting medical information (including originals of all relevant documents and bills) within three (3) months after the treatment begins or as soon as possible after such information is reasonably available, whichever is earlier. We will not accept photocopies of the relevant documents; and
- use a new Claim Form for each separate claim or course of treatment.

Failure to observe these Claim conditions, without any reasonable explanation, may invalidate a claim.

4. Approved Hospitals

The Company has made direct billing arrangements with many leading Hospitals and Physicians. Use of other Hospitals and Physicians will not invalidate a covered claim provided the Notification of Claim conditions of the Policy have been met and furthermore, that the Company's liability shall not exceed the level of charges that would have been made at such Approved Hospitals for providing similar treatment or services. The Company reserves the right to make appropriate reductions to the benefits payable in respect of treatment obtained from a Physician or Hospital which is not an Approved Hospital if the charges incurred are not considered to be Reasonable and Customary.

5. Proof of Claim

Original documentation and receipts together with a fully completed Claim Form signed by the treating Physician must be submitted to the Company within the time limits defined above and before Payment Guarantees for Inpatient treatment can be made. Photocopies are not acceptable. If on the balance of medical fact or probability it is appropriate for the Company to decline a claim by virtue of the Pre-Existing Conditions exclusion, the Insured Person shall have the right and obligation to produce such medical evidence as the Company may reasonably require to enable it to reconsider a claim under the Policy.

6. Examinations

The Company shall have the right and opportunity through its medical representatives to examine the Insured Person whenever and as often as it may reasonably require within the duration of any claim. In addition, the Company shall have the right to require a post mortem examination, where this is not forbidden by law.

7. Legal Proceedings

No action in law or equity shall be brought to recover under the Policy until after the expiration of sixty (60) days from the date Proof of Claim has been furnished in accordance with the Policy conditions. The parties have agreed that the Law of the country in which the Policy has been issued by the Company shall govern and control in the event of any conflict or dispute between the parties with regard to the Policy, and that the parties submit themselves to that exclusive venue and jurisdiction for the resolution of any such conflict or dispute.

8. Arbitration

Any difference of medical opinion in connection with the results of any Accident, Illness, death or expense will be settled between two medical experts appointed respectively in writing by the two parties to the dispute. Any difference of opinion between the two medical experts shall be referred to an umpire, who shall have been appointed in writing by the two medical experts at the outset.

General Exclusions

The following treatment items, conditions, activities and their related or consequential expenses are excluded from the Policy and the Company will not be liable for them.

If We say that because of this Exclusion any loss, damage, cost or expense is not covered by this Policy the burden is on You to prove otherwise.

1. Pre-Existing Conditions as defined unless otherwise declared on the application form and/or at any subsequent application for Upgrade or Reinstatement and expressly accepted by Us.
2. Routine medical examinations or check-ups, routine eye or ear examinations, vitamins and health supplements, vaccinations except as provided for under any benefit under this Policy, medical certificates, examinations for employment or travel, spectacles, contact lenses, cosmetic treatments and cosmetic surgery, all dental treatment or oral surgery related to teeth (except when such dental benefits are being covered under the policy), rest cures and services or treatment in any home, spa, hydro-clinic, sanatorium or long term care facility that is not a Hospital as defined.
3. Tests or treatment related to infertility, contraception, sterilisation, impotence, sexual dysfunction, birth defects, congenital Illnesses, hereditary conditions or any abortion performed due to psychological or social reasons and consequences thereof.
4. Pregnancy or childbirth, including standard nursery expenses for newborn children except as provided for under any benefit under this Policy and /or when such benefits are shown in the policy Schedule.
5. Any Emergency Medical Evacuation expense:
    a) related to pregnancy or childbirth except abnormal pregnancy or vital complication of pregnancy occurring within the first six (6) months of pregnancy which endangers the life of the Insured Person and/or any of her unborn children; and/or
    b) any evacuation expense related to pregnancy or childbirth or miscarriage after the first six (6) months of pregnancy.
6. Prosthesis, corrective devices and medical appliances which are not surgically required; treatment by a family member; and all treatment that is not scientifically recognised by western European or North American standards except as defined and covered under Alternative Medicine.
7. All costs relating to cornea, muscular, skeletal or human organ or tissue transplant from a donor to a recipient and all expenses directly or indirectly related to organ transplantation (except as provided for under the Organ Transplantation Benefit).
8. Treatment of self-inflicted Injury, suicide, abuse of alcohol, drug addiction or abuse, psychological, emotional or mental problems or conditions (unless specifically covered by any benefit under this Policy), sexually transmitted diseases, and any treatment or test in connection with Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) or any HIV or AIDS related conditions or diseases excluding HIV due to blood transfusion.
9. Treatment which an Insured Person, whose Area of Cover excludes the USA, has elected to receive in the USA except as provided for under any benefit under this Policy and/or as stated in the Schedule.
10. Experimental or pioneering medical and surgical techniques which the Insured Person chooses to receive even though treatment usually and customarily provided for the medical condition concerned is available within the Area of Cover of the Policy.
11. Additional fees billed by a referring Physician for treatment given after the date on which an Insured Person has been referred to another Physician or Specialist.
12. Injury or Illness while serving as a full-time member of a police or military unit and treatment resulting from participation in war, riot, civil commotion or any illegal act including resultant imprisonment.
13. Injury or Illness sustained while the Insured Person has resided outside the pre-defined Area of Cover for more than three (3) consecutive months during the Policy Year.
14. Outpatient services except as defined under the Outpatient Benefits.
15. Hospital Inpatient treatment if the Insured Person could have been properly treated for the condition as an outpatient.
16. Travel costs in respect of trips made specifically for the purpose of obtaining medical treatment unless in the course of an approved Emergency Medical Evacuation, and all Emergency Medical Evacuation costs which are not approved in advance by Us or Our appointed 24-hour Emergency Assistance Centre.
17. Hotel or non-Hospital accommodation costs except as provided for in the Policy.

18. Rock climbing, mountaineering, pot-holing, skydiving, parachuting, hang-gliding, para-sailing, ballooning, all diving unless the person concerned has been duly qualified and certified as a diver by an internationally recognised diving organisation or unless such person is at the time of the happening of the event giving rise to a claim actually receiving diving instruction from a duly qualified and certified diving instructor, racing of any kind other than on foot and all professional or inherently dangerous sports unless declared to and accepted by Us in writing prior to the event giving rise to a claim.

19. Costs or benefits payable under any legislation or corresponding insurance cover relating to occupational death, Injury, Illness or disease.

20. Costs arising under any legislation which increases the cost of medical treatment and services received by the Insured Person above charge levels which would be considered Reasonable and Customary in the absence of such legislation.

21. The cost of transporting an Insured Person by means of his or her employer's owned or leased watercraft or aircraft or the cost of medical treatment given by the following parties unless We agree in writing to meet such costs:

    a) the employer's personnel or at employer-provided medical facilities; or

    b) by a third party under a contract between that third party and the Insured Person's Employer.

22. Costs arising out of any litigation or dispute between the Insured Person and any medical person or establishment from whom treatment has been sought or given, or any other costs not directly and specifically related to the payment of the medical expenses covered by the Policy.

23. Any loss or damage, cost or expense of whatever nature directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at same time or in any other sequence to the loss:

    (a) ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;

    (b) the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component; and/ or

    (c) any weapon of war employing atomic or nuclear fission and/or fusion or other like reaction of radioactive force or matter.

24. Death, disability, loss, damage, destruction, any legal liabilities, cost or expense including consequential loss of every type which is, directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at same time or in any other sequence to the loss:

    (a) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war is declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; and/or

    (b) any act of terrorism including but not limited to:

        (i) the use or threat of force, violence;

        (ii) harm or damage to life or to property (or the threat of such harm or damage) including, but not limited to, nuclear radiation and/or contamination by chemical and/or biological agents,

        by any person(s) or group(s) of persons, committed for political, religious, ideological or similar purposes, express or otherwise, and/or to put the public or any section of the public in fear; or

        (iii) any action taken in controlling, preventing, suppressing or in any way relating to (a) or (b) above.

IMPORTANT
The Insured is requested to read this Policy. If any error or misdescription is found, the Policy should be returned to the issuing office for correction.