POLICY TERMS AND CONDITIONS

YourHEALTH BENEFITS

www.april-international.com

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1. *OUR* CONTRACT WITH THE *POLICYHOLDER*

1.1 These terms and conditions need to be read together with the policy cover page, the *namelist*, the *benefits schedule*, and any endorsement(s). All of these documents, together with the statements made in *your* application and in the *policyholder's* application and any documents or statements submitted in connection with, or referred to in *your* application and in the *policyholder's* application; make up the entire policy.

1.2 No change to the policy will be effective unless contained in a written endorsement signed by *us*.

1.3 This policy uses defined terms which appear in italics. Defined terms have the same meaning wherever they appear. The meaning given to a defined term can be found in the definitions section at the end of these terms and conditions.

2. CO-INSURANCE AND *DEDUCTIBLES*

2.1 All *expenses* will be paid in excess of any *deductible* that applies and after *we* have applied any *co-insurance percentage*. If three or more members of *your* family suffer *injury* in the same *accident* while covered under this policy, *we* will pay *expenses* in excess of only one *deductible*, which shall be the largest of the *deductibles* which would have otherwise applied.

3. WHERE ARE *YOU* COVERED?

3.1 This plan covers services rendered within the area of cover stated in the *benefits schedule*.

3.2 Services rendered outside the area of cover will, subject to the limit for Out of Area Cover shown on the *benefits schedule*, be covered only if they are directly caused by *sudden illness or injury* occurring during the first 30 *travel days* of any trip outside the area of cover. This section does not apply to any trip:

3.2.1 commenced or continued against the orders or advice of any *physician* or other medical practitioner; or

3.2.2 undertaken in whole or in part for the purpose of obtaining medical care.

3.3 In the event *you* are hospitalised outside the area of cover on the 30th travel day for a covered *sudden illness* or *injury*, provided notice of such hospitalisation has been given to *us* prior to that date, and subject otherwise to the terms and conditions of this policy governing termination of benefits, coverage under section 3.2 shall be extended until such time that *you* no longer require hospitalisation for the *disability.*

4. WHO IS COVERED?

4.1 Persons whose names appear on the *namelist.*

4.2 The *policyholder* warrants that during the policy year it shall maintain cover for all *eligible employees* and *dependants.*

5. *PERIOD OF COVER* AND RENEWAL

5.1 The minimum initial *period of insurance* is 12 months, except that for persons added mid-term, the *period of insurance* shall be until the end of the current *policy year.*

5.2 Once the initial *period of insurance* has ended, cover will be renewed at a rate and terms determined by *us.*

6. CANCELLATION

6.1 If this policy is cancelled mid-term no refund will be made.

6.2 Subject to section 4.2, *eligible employees* and *dependants* may be deleted mid-term as per *our* usual underwriting practice.

7. PREMIUM PAYMENT AND GRACE PERIOD

7.1 *We* must receive *your* premiums on or before the Due Date stated on the Debit Note.

7.2 For the first premium payment of each *policy* year:

7.2.1 if the premium is received after the Due Date but before 11:59pm Hong Kong time on the 30th day following the Due Date, the policy will automatically be reinstated. If the premium is not received within that Grace Period the policy will lapse.

7.2.2 if the payment is received after the 30th day following the Due Date (or, for the first payment, at any time after the Due Date) will be treated as an application for reinstatement of coverage and additional proof of insurability may be required.

7.3 For mid-term premium payments:

7.3.1 *we* must receive payment within 30 days after the Due Date stated on the Debit Note. The *policyholder* may offset any balance due from *us* in making such payment.

7.3.2 in the event that mid-term premium payments remain unpaid after 30 or more days, *we* may provide notice of such suspension of claim payments or other services provided to *you*. Such suspension will be effective not less than 10 working days after notice is given.

7.3.3 if the premium remains unpaid for a further 30 days after the effective date of such notice, the policy will lapse. This is in addition to and not in lieu of any of *our* other rights or remedies under this Contract or at law.

8. WAITING PERIODS

8.1 Cover for the following benefits and disabilities will commence after an *insured person* has been covered for the following time periods after the first day of the *period of insurance* in respect of an *insured person,* unless waived by endorsement:
8.1.1 Maternity Benefits: 366 days prior to the date of service;
8.1.2 Newborn Additions: 366 days prior to the date of birth;
8.1.3 *Major dental treatment*: 300 days prior to the date of service;
8.1.4 *HIV/AIDS*: three years prior to *your* first positive HIV test result, or the date *you* received any treatment for *HIV/AIDS* (or following possible exposure to the virus), whichever is later;
8.1.5 *Assisted conception* and Infertility: 300 days prior to the date of service; and
8.1.6 Alcohol and Drug Rehabilitation: 366 days prior to date of service.
8.2 If *you* have changed the cover for an *insured person* after the start of the first *period of insurance*, the benefits for any *disability* or service subject to a waiting period will be those shown on the *benefits schedule* for that *disability* or service on the first day of the waiting period, or those shown on the current *benefits schedule*, whichever is less.

9. NEWBORN ADDITIONS

9.1 A *newborn infant* born to a parent who has been covered under the policy for the period stated in section 8.1.2 may be added to the policy from birth without medical underwriting as long as the *newborn infant* was not born following *assisted conception*.
9.1.1 *You* must provide *us* with a Newborn Additions Form within 28 days of birth of the *newborn infant* so that *we* can add the child to the policy. The premium for the *newborn infant* must be paid according to Section 7.
9.1.2 *Your* child's cover will match the cover provided to the parent of the child on the first day of the twelve month period preceding the child's birth, excluding any optional cover chosen for Maternity Benefits or Dental and/or Optical Benefits. Cover for *neonatal disabilities* will be limited to the *neonatal disabilities* limit shown on the *benefits schedule*.
9.2 A child not meeting the criteria under 9.1 must be added by Medical Questionnaire, including any child:
9.2.1 whose mother has not been covered under the policy for 366 consecutive days;
9.2.2 for whom a Newborn Additions Form was not received by *us* within 28 days following birth;
9.2.3 who was adopted or was carried by a surrogate; or
9.2.4 who was born following *assisted conception*, unless the *assisted conception* treatment was covered by this policy.
9.3 *Our* underwriting process will apply to an addition under Section 9.2, and *we* may decline to provide cover or may offer cover at terms *we* require. The cover must be equal to the cover provided to the mother excluding any optional Maternity Benefits or Dental and/or Optical Benefits.

10. OWNERSHIP

10.1 *Expenses* will be paid to *you* or *your* legal representatives, whose receipt will discharge *our* liability for those *expenses*. *We* may, in *our* absolute discretion, pay *expenses* to a provider of services, unless *you* or *your* legal representative have instructed *us* in writing not to and *we* have not agreed to pay *expenses* to the provider prior to receiving such instruction.
10.2 Unless an endorsement states otherwise, *we* shall treat the *policyholder* as the absolute owner of this policy and *we* are not bound to recognise any other claim to, or interest in, this policy.

11. IN THE EVENT OF FRAUD OR *NONDISCLOSURE*

11.1 *We* may cancel *your* cover or the policy from inception and retain the premium if:
11.1.1 *you* and/or the *policyholder* provided false information to *us*, or failed to disclose information to *us*, in connection with *your* application or any application for addition of an *insured person*, upgrade, or reinstatement, and the misrepresentation or nondisclosure was fraudulent; or
11.1.2 any claim is in any respect fraudulent or if fraudulent means or devices are used by *you* or an *insured person* or anyone acting on *your* or an *insured person*'s behalf to obtain benefits under this policy.
11.2 If this policy is cancelled after claims have been paid, or after *we* have provided a guarantee of payment to a provider of services, any amounts paid or guaranteed will upon cancellation become immediately repayable by *you* to *us*. The outcomes described above are in addition to, and not in the place of, other rights we may have including those based on the contract, statute, or common law. The company will not be bound to pay any claim (in whole or part) where *you* misrepresented facts in connection with that claim or related claims. Nondisclosure by an individual scheme member will not affect any other member's entitlement to receive benefits from the scheme, however, misrepresentations by the employer or other group scheme policyholder could affect coverage for the individual members.
11.3 If non disclosure is found after claims have been paid, or after we have provided a guarantee of payment to a provider of services, any non-covered amounts paid or guaranteed will become immediately repayable by *you* to *us.*

12. MATERIAL FACTS AND CHANGES

12.1 The *policyholder* warrants that he/she has disclosed all known material facts including those concerning the general health, planned *surgery* or ongoing treatment of any persons to be insured under this plan.
12.2 The *policyholder* warrants that all employees to be insured under this policy are actively at work at the time of application.
12.3 The *policyholder* must report all changes including change of employment status or significant duties, country of residence; citizenship, of any member.

12.4 Failure to comply with 12.1 or 12.2 or notify *us* of any change listed in 12.3 may result in coverage being terminated and declination of claims.

12.5 The *policyholder* must inform *us* of any change in corporate address. We reserve the right to send notices to the address *we* have on file.

13. PROOF OF CLAIM AND COOPERATION

13.1 All claims for reimbursement of expenses must include the following (the "required claim documents"):

13.1.1 bills and supporting documents showing the breakdown of *expenses* and the diagnosis of the condition treated;

13.1.2 evidence of payment by *you*, and

13.1.3 a claim form with all relevant sections completed.

13.2 All required claim documents must be received by *us* within 90 days from the date service was rendered. Where it is not reasonably possible to present the required claim documents to *us* within this period, they must be received by *us* within 365 days from the date *you* incurred the expense.

13.3 Claims can be submitted to *us*:

13.3.1 by mail to *our* address, attaching original documents;

13.3.2 by email to claims.hk@april.com including copies of supporting documents; or

13.3.3 by fax to (852) 2526 0769 including copies of supporting documents.

13.4 If *you* submit claims by email or fax, *you* must retain a copy of the original documents for a minimum period of 2 years from when *you* submit the claim and must send the original documents to *us* upon request or when required by *our* claim instructions.

13.5 *You* must fully cooperate with *us* and *our* appointed agents in connection with any claim. *Your* cooperation may include, but is not limited to, providing original documents upon request, or providing any consent *we* reasonably need to obtain information relevant to *your* claim from any source, including a *physician* or other medical provider, *hospital*, or an insurance company.

13.6 If *we* ask for cooperation, documents, information, or consent to obtain documents or information, it shall be a condition precedent to liability that *you* provide the requested cooperation, document, information, or consent in a timely manner.

14. PROCESS TO OBTAIN *PRE-AUTHORISATION*

14.1 The following services on the *benefits schedule* require *pre-authorisation*:

- *hospital* benefits
- *surgery* performed while a day-patient in a clinic or in a *physician's* office
- *rehabilitation treatment*

14.2 Co-payment for *pre-authorisation*:

- 0% co-payment for services pre-authorised by *us*
- 20% co-payment for services not pre-authorised by *us*

The co-payment for services that are not pre-authorised will not apply where *you* can show the service was *medically necessary* due to an *emergency* and *you* contacted *us* within 24 hours after admission or as soon as reasonably possible.

14.3 To obtain *pre-authorisation*, *you* must submit *your* request at least 5 working days in advance before admission or treatment.

14.4 Upon receiving *your* request *we* will review the *medical necessity* and appropriateness of the requested service and within five working days will notify *you* of *our* decision to:

- Grant pre-approval
- Deny pre-approval
- Request further information

14.5 Pre-approval may be partly given and partly denied. If within the five days *pre-authorisation* is not given or denied, or additional information requested, then such service will not be subject to the co-payment applicable to services for which *pre-authorisation* was not maintained.

14.6 If *we* request further information *you* are required to provide any additional information *we* may require. Sections 13.5 and 13.6 of this policy apply.

14.7 *Pre-authorisation* is not a guarantee of benefits or eligibility and all services are subject to benefit limitations and other policy terms. *Pre-authorisation* may be revised or withdrawn if *we* determine later that the service is not covered or is not *medically necessary.* If *pre-authorisation* is given for a particular service, that *pre-authorisation* applies only to that service and further *pre-authorisation* must be obtained for other services even if related to the same *disability.*

14.8 If an extension of the length of stay is necessary, *you* must contact *us* before the pre-approved length of stay finishes. If *you* fail to do so any services rendered after the end of the planned admission period will be subject to the co-payment for services for which *pre-authorisation* was not obtained.

14.9 If *pre-authorisation* is denied *you* may appeal the decision, and *we* will make a further determination or request additional information within five days of receiving *your* appeal. Only one appeal is permitted per service.

15. RIGHT TO EXAMINE AN *INSURED PERSON*

15.1 *We* are entitled to require an *insured person* to undergo a medical examination at *our* expense by a *physician* of *our* choosing. If an *insured person* dies, *we* are entitled to require a post-mortem examination at *our* expense unless forbidden by law.

16. CLAIMS AGAINST THIRD PARTIES OR OTHER INSURANCE

16.1 If another medical or *accident* insurance covers *you* for *expenses* relating to a *disability* also covered by this policy, *we* will only be liable for the excess of the amount recoverable from such other source or insurance.

16.2 If another person or entity may have liability for *your expenses*, including but not limited to a third party who is responsible for an *injury*, *you* must take all steps necessary to secure reimbursement from that other person or entity.

16.3 *You* must not negotiate, settle, compromise, release or otherwise discharge any claim *you* may have against any third party who may have liability relating to *your expenses* without *our* prior written agreement. Failure to obtain *our* prior written agreement will result in *us* having no liability under this policy for *expenses* which might have been recoverable from that third party.

16.4 In the event of any payment under this policy, *we* shall be subrogated to *your* or any *insured person*'s rights of recovery against any other person or entity. *We* may take proceedings in *your* name, but at *our* expense, to recover any amount *we* pay under this policy. Neither *you* nor any *insured person* shall do anything likely to prejudice such recovery, and instead shall take all reasonable steps to assist *us* in obtaining such recovery.

17. RIGHT OF RECOVERY

17.1 If *we* pay, guarantee, or authorise payment of, *expenses*, or if *you* obtain treatment through *our* direct billing network, and *we* later determine that *you* were not entitled to that payment for any reason, *we* reserve the right to claim the payment back from *you*.

18. GOVERNING LAW AND JURISDICTION

18.1 This policy is governed by, and is to be interpreted according to, the laws of the Hong Kong Special Administrative Region and subject to the exclusive jurisdiction of the Hong Kong courts.

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

19. SANCTIONS AND COMPLIANCE WITH LAWS

19.1 This insurance does not apply to the extent that trade or economic sanctions or other similar laws or regulations prohibit the coverage provided by this insurance.

20. ARBITRATION AND TIME LIMITS

20.1 Any dispute, controversy, difference, or claim arising out of or relating to this policy, or the breach, termination or invalidity thereof, shall be settled in Hong Kong by arbitration in accordance with the Hong Kong International Arbitration Center Administered Arbitration Rules 2013 (the "HKIAC Rules").

20.2 The number of arbitrators shall be one. If the parties cannot agree on an arbitrator within 30 days after the notice of arbitration is received by the other party, and unless the parties agree to extend this period, the arbitrator shall be chosen according to the HKIAC Rules. The arbitrator may be of the same nationality as one of the parties.

20.3 A party wishing to commence arbitration shall issue a written notice of arbitration to the other party setting out the nature of the dispute. The notice of arbitration must be received by the other party within the following time limits:

20.3.1 for dispute, controversy, or claim relating to, or said to relate to, *our* refusal or failure to pay a claim: 365 days after the date *we* refused to pay the claim (or the date the claim was submitted, if no refusal was made); and

20.3.2 for any other dispute, controversy, or claim: 365 days after the last day of the *period of insurance* in which the first event causing the dispute, controversy, or claim occurred.

20.4 The arbitrator shall have the power to dispense with a hearing and make a decision on written submissions.

20.5 Judgment on the award rendered by the arbitrator may be entered by any court of competent jurisdiction.

21. EXCLUSIONS

This policy does not cover:

21.1 Treatment, care or a test which is not *medically necessary*.

21.2 Services which have not been prescribed by *your* attending *physician* other than a second opinion before *surgery* unless otherwise stated on the *benefits schedule*.

21.3 Treatment which is covered by insurance or a source of indemnity other than this policy.

21.4 Services by a *dentist*, other than services claimed under Dental Benefits where specifically provided on the *benefits schedule*.

21.5 Emergency *Dental Treatment* related directly or indirectly to biting, chewing or teeth grinding.

21.6 *Reconstructive surgery* except when required as a direct result of a *disability* covered under this policy.

21.7 *External prosthesis* except when required as a direct result of a *disability* first occurring during a *period of insurance*.

21.8 Treatment, care or tests directly or indirectly related to:

21.8.1 *assisted conception*, contraception, sterilisation, fertility or infertility, prior history of miscarriages, hypogonadism or testosterone deficiency, other than services claimed under the *assisted conception* and infertility treatment benefit where specifically provided for on the *benefits schedule*;

21.8.2 sexual dysfunction, or abortion other than for therapeutic reasons;

21.8.3 pregnancy or childbirth, or complications of pregnancy following *assisted conception*, other than services claimed under the Maternity and Childbirth benefits where specifically provided for on the *benefits schedule*;

21.8.4 elective caesarian section prior to the 38th week of term;

21.8.5 *sexually transmitted disease*;

21.8.6 *congenital conditions* and *hereditary conditions,* other than as provided by the *congenital conditions* and *hereditary conditions* benefit shown on the *benefits schedule* as covered by this policy;

21.8.7 *cosmetic treatment* or gender reassignment *surgery* or therapy;
21.8.8 refractive defects of the eye other than services claimed under Optical Benefits where specifically provided for on the *benefits schedule*;
21.8.9 *terminal illness* other than as provided by the *hospice* or *palliative treatment* benefit as shown on *your benefits schedule*;
21.8.10 weight loss or weight management;
21.8.11 self-inflicted *injury*, suicide or attempted suicide;
21.8.12 abuse of alcohol, illegal drugs, or medicines not prescribed to the *insured person* by a *physician* or taken in excess of prescribed quantities, other than services claimed under the alcohol and drug rehabilitation benefit where specifically provided for on the *benefits schedule*;
21.8.13 sleep disorders or *behavioural* or *developmental disorders* other than services claimed under the outpatient *behavioural* or *developmental disorders* benefit where specifically provided for on the *benefits schedule*;
21.8.14 *injury* related to participation in professional sports, or deliberate exposure to exceptional danger except in an effort to save human life.
21.9 Purchase or rental of prostheses, corrective devices, or durable medical equipment other than *surgical implants*, *external prosthesis* or *medical appliances* shown on the *benefits schedule* as covered by this policy.
21.10 The cost of purchasing an organ for transplantation.
21.11 The following services, whether or not recommended or prescribed by a physician:
21.11.1 Experimental or unproven treatment;
21.11.2 Non-western or non-allopathic treatment except to the extent specifically stated in the *Complementary Medicine* and Traditional Chinese Medicine section of the *benefits schedule*;
21.11.3 Stem cell treatment;
21.11.4 Any service rendered while an *insured person* is an inmate of a prison, jail or any correctional facility including halfway houses or similar facilities, or while a patient of any mental institution;
21.11.5 House calls, delivery of medicine or other items, or any service rendered at a person's home, office, hotel room, or similar place;
21.11.6 Services or treatment while a bed patient at any facility that is not a *hospital*, including an institution such as an *intermediate care facility or nursing home*;
21.11.7 Vitamins, nutritional supplements, chelation therapy, bioresonance therapy or diagnosis, or colonic hydrotherapy;
21.11.8 *custodial or maintenance care* or rest cures;
21.11.9 *Hospital* inpatient treatment for convalescence, rehabilitation, supervision or which in the opinion of *our* medical advisor, could be properly treated as an outpatient;
21.11.10 Outpatient treatment of *mental and nervous conditions* other than services claimed under the Outpatient Psychiatric benefit where specifically provided on the *benefits schedule*;
21.11.11 *Dental treatment* for purely cosmetic or decorative purposes (applicable only when Dental benefits are covered under the policy);
21.11.12 Orthodontic treatment that is commenced after the age of 16 (applicable only when Dental benefits are covered under the policy);
21.11.13 Eyeglass frames (applicable only when Optical benefits are covered under the policy);
21.11.14 Services by a psychologist or counsellor other than services claimed under the outpatient *behavioural* or *developmental disorders* benefit where specifically provided for on the *benefits schedule*.
21.12 *Disability* suffered while serving as a member of a police force or military unit of any country or international authority, or due to participation in *war*, civil *war*, invasion, insurrection, revolution, use of military power, usurpation of government or military power, or any known or suspected terrorist act or any illegal act.
21.13 *Disability* as a result of exposure to ionising radiation or radioactive contamination of any kind.
21.14 Travel *expenses* incurred to obtain medical treatment other than in the course of an emergency medical evacuation *we* have approved in advance, or which has been approved by the *emergency assistance provider*.
21.15 Treatment outside *your* area of cover as stated on *your benefits schedule* except to the extent Out of Area Cover is provided for in *your benefits schedule*.
21.16 All expenses:
21.16.1 which are not *reasonable and customary*;
21.16.2 for medical certificates or administrative fees such as a charge for providing a claim form or medical records;
21.16.3 incurred outside the *period of insurance* or in any period for which the appropriate premium has not been paid;
21.16.4 incurred during the *period of insurance* for drugs and/or medical services consumed or provided once the *period of insurance* has ended; or
21.16.5 for services performed or items sold by *you*, *your* parents, *your* children, or any entity in which *you*, *your* parents, or *your* children either are an employee or director or have a greater than 1% ownership interest.

DEFINITIONS

A *ACCIDENT or ACCIDENTAL:* A sudden, unexpected and specific event, external to the body, which occurs at an identifiable time and place.

A *ACTIVE CANCER TREATMENT:* A course of treatment intended to affect the growth of the cancer by shrinking the cancer, stabilising it or slowing the spread of disease, and not given solely to relieve symptoms or to prevent a recurrence. It also includes the first consultation with the oncologist after the last treatment in the last planned course of *active cancer treatment*, and any associated *diagnostic scans and tests*.

A *ASSISTED CONCEPTION:* The use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra-uterine insemination (IUI), In vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) or the use of any form of treatment to induce or increase ovulation.

B *BEHAVIOURAL OR DEVELOPMENTAL DISORDER:* A *disability* classified in categories F50 to F98 of the International Classification of Diseases 10th Revision (2010 version).

B *BENEFITS SCHEDULE:* The schedule(s) showing each of the benefits available under this policy and the limit available for those benefits.

C *CO-INSURANCE PERCENTAGE:* The share of *expenses* for which *you* are liable, shown on the *benefits schedule*.

C *COMPLICATIONS OF PREGNANCY:* Acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy, puerperal infection, eclampsia, toxemia, or hydatidiform mole. It also includes a condition whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy, and which requires *confinement* or *surgery* prior to the full term of pregnancy to avoid the threat of permanent damage to the life or health of the mother.

C *COMPLEMENTARY MEDICINE:* Therapeutic services rendered by one of the types of practitioner listed in the *Complementary Medicine* and Traditional Chinese Medicine section of the *benefits schedule*, other than someone related to *you* by blood, marriage or adoption, who is qualified by education and training and, if required or permitted to be licensed or registered by the laws of the place where service took place, is licensed or registered in that place, and who in performing such services is acting within the scope and training of that discipline.

C *CONFINEMENT:* A continuous period of not less than 18 hours as a registered bed patient in a *hospital*.

C *CONGENITAL CONDITION:* Any condition classified as a congenital anomaly in the International Classification of Diseases 10th Revision (2010 version).

C *COSMETIC TREATMENT:* *Surgery*, chemical treatment, or other procedures performed to reshape or modify structures of the body or physical appearance.

C *CUSTODIAL OR MAINTENANCE CARE:* Care provided mainly:
a) For personal needs, comfort or convenience for which specialised medical training or skills are not necessary; or
b) To maintain, rather than improve, a physical or mental function, or to provide a protected environment, including *physician*-prescribed bed rest.

D *DEDUCTIBLE:* An amount shown on the *benefits schedule* corresponding to a benefit available under this policy. *We* are entitled to deduct this amount from any payment of *expenses*.

D *DENTAL TREATMENT:* Evaluation, diagnosis, prevention, and surgical or non-surgical treatment of diseases, disorders and conditions of the oral cavity, maxillofacial area and the adjacent and associated structures.

D *DENTIST:* A properly qualified practitioner other than someone related to *you* by blood, marriage or adoption, who is licensed by the competent authorities of the country in which treatment is provided to render *dental treatment*, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

D *DEPENDANT:* *Your* spouse under the law of *your usual country of residence* or *your* de facto partner. Each of *your* unmarried children, stepchildren or adopted children who are under nineteen (19) years of age for all or part of the *period of insurance* or, if a full-time student and primarily dependent on *you* for support and maintenance while a full-time student, under twenty-three (23) years of age for all or part of the *period of insurance*.

D *DIAGNOSTIC SCANS AND TESTS:* *Medically necessary* tests and procedures prescribed by an attending *physician* to investigate the cause and nature of symptoms of a *disability*. Limited to the following tests and scans unless otherwise stated on the *benefits schedule*: laboratory tests and pathology, CT scan, PET Scan, MRI, ultrasound, ECG, endoscopic exams, and x-ray.

D *DISABILITY:* An *illness* or *injury*, and any symptoms, sequelae, or complications thereof. In the case of *injury*, it means all *injuries* arising from the same event or series of contiguous events.

E *EFFECTIVE DATE:* The date specified on the *namelist* as the date on which the *period of insurance* in respect of any *insured person* commences under this policy.

E *EMERGENCY:* A sudden change in *your* health which requires urgent medical or surgical intervention to avoid permanent damage to *your* life or health.

E *EMERGENCY ASSISTANCE PROVIDER:* APRIL Assistance

E *EXPENSES:* Amounts *you* incur during the *period of insurance* for a *medically necessary* service and which fall within the categories of benefits shown on the *benefits schedule*.

E *EXTERNAL PROSTHESIS:* An artificial body part prescribed by an attending *physician* as part of treatment relating to a *disability* covered by this policy.

F *FULL MEDICAL UNDERWRITING:* means that *you* provide *us* with a detailed medical history on the Full Medical Underwriting Application Form to enable *us* to decide whether to accept or decline *your* application and whether *we* need to apply any specific exclusions or loadings to *your* policy.

H *HEREDITARY CONDITIONS:* An *illness* caused by a genetic abnormality passed down from the parents' genes. It does not include cancers where the *hereditary condition* is not causing other symptoms.

H *HIV/AIDS:* Infection with the Human Immunodeficiency Virus and any mutation thereof and/or Acquired Immune Deficiency Syndrome ("AIDS") and any symptoms relating thereto or *illnesses* arising therefrom. AIDS includes any cancer or infection in an HIV-infected person who, on or at any time before the date of service, had a CD4 T-cell count below 200 cells per microliter. *HIV/AIDS* costs may only be claimed under the *HIV/AIDS* section of the *benefits schedule*, and no other type of benefit under this policy provides coverage in connection with *HIV/AIDS*.

H *HOME COUNTRY:* The country of the passport or identity document of *insured persons* listed on the application or notified to *us* under the terms governing material changes. For any dependant who does not have a passport, it will be the *home country* of the parent who is an *employee* of the *policyholder*.

H *HOSPICE OR PALLIATIVE TREATMENT:* A program of medical, psychological, social, and spiritual care provided to persons who have been diagnosed as suffering from a *terminal illness*. Treatment must be prescribed by a *physician* and provided by a *hospital* or institution licensed by the competent medical authorities of the country in which care is provided and which, in providing care, is practicing within the scope of its license. *Hospice* or *palliative treatment* costs may only be claimed under the *hospice* or *palliative treatment* section of the *benefits schedule*, and no other type of benefit under this policy provides coverage in connection with *hospice* or *palliative treatment*.

H *HOSPITAL:* An institution licensed by the competent medical authorities of the country in which it is located to provide care and treatment of sick and injured persons as bed patients and which:
a) Has full diagnostic, therapeutic and surgical procedures; and
b) Provides 24 hour a day nursing services by registered graduate nurses; and is supervised by a staff of physicians; and
c) Is not primarily a clinic, an *intermediate care facility or nursing home*, a mental institution, a home for the aged, or a place for alcoholics or drug addicts.

H *HOSPITAL ROOM AND BOARD:* Room and board and general nursing care, subject to the following accommodation levels as stated on the *benefits schedule*.
STANDARD PRIVATE ROOM – The base class of rooms having one (1) patient bed per room with an en-suite bath or shower room. Standard private room does not include a suite.
SEMI-PRIVATE ROOM – A class of room having two (2) patient beds per room and shared bath or shower room, whether both beds are occupied or not.
WARD – A class of room having three (3) or more patient beds per room, whether all beds are occupied or not.

I *ILLNESS:* A physical condition, including symptoms, sequelae, or complications, marked by a pathological deviation from the normal healthy state during the *period of insurance*.

I *INJURY:* Identifiable physical damage to *your* body which is caused by an *accident* solely and independently of any other causes, is not intentionally self-inflicted, and does not result from *illness*.

I *INTENSIVE CARE UNIT:* A class of room dedicated to the constant, close monitoring of the vital body functions of critically ill patients, which provides a high ratio of nursing staff to patients, and which has full facilities for the resuscitation of patients. This definition also includes a coronary care unit which has facilities not less comprehensive than those described above.

I *INSURED PERSON:* The person/persons identified on the *namelist.*

I *INTERMEDIARY:* The authorised agent, broker or financial advisor who arranged this cover.

I *INTERMEDIATE CARE FACILITY OR NURSING HOME:* A place devoted to providing support services for individuals requiring medical, nursing, or *custodial or maintenance care* in a residential setting.

K *KIDNEY DIALYSIS:* Hemodialysis and peritoneal dialysis. *Kidney dialysis expenses* may only be claimed under the *kidney dialysis* section of the *benefits schedule*, and no other type of benefit under this policy provides coverage in connection with *kidney dialysis*.

M *MAJOR DENTAL TREATMENT:* Surgical removal of impacted, buried, or unerupted teeth/roots or odontomes; treatment of disorders of the temporomandibular joint (TMJ); orthodontics; dental implants; root canal therapy or apicoectomy; dentures (new/repair of old); gold, amalgam, composite or porcelain inlays, onlays, crowns and bridges; treatment by a *dentist* of *illnesses* of the oral mucosa and directly related laboratory tests or pathology services; antibiotics or medicines for pain management for which a prescription is required for purchase and which have been prescribed by a *dentist*; periodontics, deep oral prophylaxis or root planing.

M *MEDICAL APPLIANCES:* The following items and their accessories if prescribed by a *physician* for a *disability*: cranial helmets, nebulisers, oxygen pumps and masks, hearing aids, corrective splints, insulin pumps, infusion pumps, glucose monitors and lancets, orthotic/orthopaedic braces and supports, tracheo-esophageal voice prosthesis, arch support, and consumable diabetes or ostomy supplies.

M *MEDICAL CHECKUP:* Consultations and tests that are undertaken without any clinical signs or symptoms being present.

M *MEDICALLY NECESSARY:* Possessing an identifiable relationship to either a covered *disability* or symptom(s) of a *disability* which if existing would be covered under the policy.
a) A therapeutic service required to prevent permanent damage to life or health where *you* have an *illness* or *injury*; or
b) A diagnostic service to determine whether therapeutic services are necessary, where *you* have active symptoms, the cause of which are unknown, but which are suggestive of an *illness* or *injury*.

M *MEDICINES AND DRUGS: Medicines and drugs* for which a *physician*'s prescription is required for purchase, and which have been dispensed by a *physician*'s office or by a licensed pharmacist after having been prescribed by a *physician*.

M *MENTAL AND NERVOUS CONDITION:* Any condition classified as a mental and *behavioural* disorder in the International Classification of Diseases 10th Revision (2010 version).

M *MINOR DENTAL TREATMENT:* Dental *checkup*; amalgam, composite or porcelain inlays, onlays, or fillings; routine tooth cleaning, scaling, and prophylaxis (including when done by an oral hygienist); simple extractions; and application of sealants.

M *MOBILITY AIDS:* Crutches, canes, walkers, manual wheelchairs and non-motorised knee scooters.

M *MORATORIUM:* Under *moratorium* policies, any pre-existing or related medical condition which occurred or was treated within a 24 month period prior to *your effective date* or has one of the following characteristics will be excluded from cover:

- Was foreseeable
- Clearly showed itself
- *You* have had signs or symptoms or *you* were aware of the condition
- *You* have received treatment for or sought medical advice on the condition or a related condition (including *medical checkups*)
- To the best of *your* knowledge *you* were aware *you* had
- Requires monitoring according to generally accepted medical advice or opinion

These conditions may be covered after *you* have had continuous cover with *us* for 24 months during which *you* have not had any symptoms, sought advice, needed or received any medication, treatment for the pre-existing condition or any related condition. If the pre-existing condition recurs, then once *you* have completed a 24 month period where none of these apply, the medical condition may then be covered.

Certain pre-existing conditions may never be covered under a *moratorium* policy. These include *disabilities* and chronic and incurable conditions; for example diabetes, chronic hypertension (raised blood pressure), hyperlipidaemia (raised cholesterol levels), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders. If *you* have suffered from any of these conditions, or any other condition for which it is generally accepted medical advice that it be monitored, then that condition may never be covered. Any condition related to an excluded condition will also be excluded from cover.

N *NAMELIST:* A section of the policy identifying the *insured persons* covered under this policy.

N *NEONATAL DISABILITY:* A *disability* which existed during the *neonatal period*, and any *disabilities* directly or indirectly arising therefrom or relating thereto. It includes *pre-term birth* and any *congenital conditions* which are diagnosed or present symptoms of which medical professionals or parents are aware or reasonably should be aware of during the *neonatal period*.

N *NEONATAL PERIOD:* The period between birth and either the 28th day of life or the 15th day after discharge from *hospital* (dates inclusive), whichever is later.

N *NEWBORN INFANT:* A child under 28 days of age.

O *ORAL HYGIENIST:* A properly qualified employee of a *dentist* who is licensed, if required, by the competent medical authorities of the country in which treatment is provided to render services such as cleaning and anaesthesia, and who is rendering such treatment at the direction of, and under the direct supervision of a *dentist*.

O *ORGAN TRANSPLANTATION:* Transplantation of a cornea, kidney, heart, liver, lung or bone marrow from one human to another.

P *PANEL NETWORK:* Medical providers in *our* network who are indicated as *panel network* providers in the current Outpatient Direct Billing network list.

P *PARENTAL ACCOMMODATION:* A fee for an additional bed in the same room for a parent or legal guardian staying with a dependant child covered under this policy who is admitted as an inpatient in a *hospital* for the treatment of a covered *disability*.

P *PERIOD OF INSURANCE:* The period starting at 00:00 a.m. Hong Kong time on the first day shown on the policy cover page and ending at 11:59pm Hong Kong time on the last day shown on the policy cover page. If an *insured person* has been added to the policy mid-year, it means the period shown on the *namelist* in respect of that *insured person*. If this policy is renewed, the effective date shown on the renewal endorsement will be first day of the new *period of insurance*.

P *PHYSICIAN:* A doctor of western medicine other than someone related to *you* by blood, marriage or adoption, who is licensed by the competent medical authorities of the country in which treatment is provided, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

P *PHYSIOTHERAPY:* Treatment of a *disability* by physical methods such as manipulation and mobilisation, Transcutaneous Electrical Neural Stimulation, heat treatment, and exercise rather than by drugs or *surgery*. Treatment must be performed by a physiotherapist, other than someone related to *you* by blood, marriage or adoption, acting within the scope and training of the *physiotherapy* discipline and who, if required or permitted to be licensed or registered by the laws of the place where service took place, is licensed or registered in that place.

P *POLICYHOLDER:* The company or organisation named in the policy cover page as the *policyholder*.

P *POST-HOSPITALISATION BENEFITS: Physician* consultation fees, *diagnostic scans and tests*, *medicines and drugs*, *physiotherapy*, rental of *mobility aids* ordered/prescribed by a *physician* following *confinement* and used as a direct consequence of the *disability* which led to *confinement*.

P *PRE-AUTHORISATION:* Means the determination by *us* that a service is *medically necessary* and appropriate, including consideration of the need for the proposed level of care and the availability of alternatives.

P *PRE-EXISTING CONDITION:* Any *disability*:
a) Which existed before the *period of insurance* and which presented signs or symptoms of which *you* were aware or should reasonably have been aware of; or
b) For which *you* have sought or received treatment, medication, advice or diagnosis in the two (2) years before the *period of insurance*; or
c) Which *you* knew to exist before the *period of insurance* and whether or not *you* sought or received treatment, medication, advice, or diagnosis for it.

P *PRE-HOSPITALISATION BENEFITS:* *Physician* consultation fees, *diagnostic scans and tests*, *medicines and drugs* used as a direct consequence of the *disability* which led to *confinement*.

P *PRE-TERM BIRTH:* Birth of a living child before 37 weeks of pregnancy are completed.

P *PROFESSIONAL FEES:* Surgeon's fees, anaesthetist fees, dietician fees, general nursing fees, physiotherapist fees, speech therapist fees and attending *physician* fees.

R *REASONABLE AND CUSTOMARY:* An amount comparable to that charged by others of similar professional standing in the same locality, for the same class of *hospital* room, for a person of similar sex and age, for a similar *disability*, without regard to ability to pay or the availability or adequacy of insurance. Where an *insured person* stays in a *hospital* room above the *hospital* room and board level shown on the *benefits schedule*, *reasonable and customary* charges will be limited to comparable charges for the highest class of room for which the *insured person* is covered.

R *RECONSTRUCTIVE SURGERY:* *Surgery* performed to improve the function or appearance of abnormal structures of the body caused by a *disability*.

R *REFERRAL:* A dated, written letter or note from an attending *physician* prior to commencement of treatment identifying *you*, the *disability* to be treated and the reasons for treatment.

R *REHABILITATION CENTRE:* A facility specifically licensed to care for people who have suffered neurological, musculoskeletal, orthopaedic and other serious medical conditions and are not yet able to care for themselves at home. It must be:
- A unit within a *hospital* or a separate facility having accommodation for bed patients;
- organised to provide an intensive rehabilitation program to inpatients;
- under supervision of a *physician*; and
- staffed full-time by nurses working under the supervision of a registered nurse.

R *REHABILITATION TREATMENT:* Treatment following a *disability* upon referral by an attending specialist to restore normal form/near to normal form or function to the body. In addition to room and board and general nursing fees, the following additional costs incurred while admitted to the *rehabilitation centre* will be covered under this benefit:
- occupational therapy fees
- special treatment room fees
- speech therapy fees
Rehabilitation centre services must be certified by a specialist as *medically necessary*. The factors to be considered in making such certification must include, but are not necessarily limited to,
- The type and severity of the *illness* or *injury*, and the *insured person*'s overall state of health and prior treatment history;
- The amount of therapy expected to be performed every day;
- The risk of deterioration or non-recovery of function if therapy is not completed; and
- The extent to which the *insured person* will be able to perform activities of daily living during the rehabilitation period. *We* reserve the right to require re-authorisation of *rehabilitation centre* services at any time upon notice to the insured.

S *SEXUALLY TRANSMITTED DISEASE:* *Illness* classified as an infection with a predominantly sexual mode of transmission in the International Classification of Diseases 10th Revision (2010 version).

S *SUDDEN ILLNESS OR INJURY:* Either
- a *disability* occurring wholly and exclusively during the first 30 *travel days* of any trip outside *your* area of cover; or
- a *disability* existing prior a trip outside *your* area of cover which had not required any advice (other than routine follow-up), treatment or any new/changed medication in the 30 days prior to the time *you* commenced *your* journey.

In the case of an *injury*, the *accident* must occur during the trip in which treatment is obtained. *Sudden illness* or *injury* does not include any *disability* of which symptoms existed prior to the start of the trip and which would have caused a reasonable person to seek medical care, and it does not include pregnancy or *complications of pregnancy*..

S *SURGERY:* Cutting or destruction of tissue performed by a *physician* involving the use of surgical instruments, ultrasound, heat, cold, or radiation. It also includes reduction of broken bones or manipulation of a joint under anaesthesia, when performed by a *physician*.

S *SURGICAL IMPLANTS:* A device or devices which are surgically implanted to form a permanent or long term part of the body but does not include *external prosthesis*.

T *TERMINAL ILLNESS:* An *illness* that is approaching its final stages, will lead to death and for which treatment can no longer be expected to cure.

T *TRAVEL DAYS:* Successive 24-hour periods between the time *you* first arrive at an international border of a country outside *your country of residence*, and the time *you* next arrive at an international border of a country within *your* area of cover.

U *UNITED STATES OF AMERICA (USA):* The United States of America (including its territories and possessions).

U *USUAL COUNTRY OF RESIDENCE:* The country in which the *policyholder* spends the greatest amount of time during the *period of insurance*.

W *WAR:* *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.

W *WE, US, OUR:* Liberty International Insurance Limited (Hong Kong).

Y *YOU, YOUR:* *Eligible employees* and *dependants* named on the *namelist*.

Underwritten by:

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