

**For discussion on
19 March 2018**

LC Paper No. CB(2)1022/17-18(03)

Legislative Council Panel on Health Services

The Legislative Proposal for Introducing Tax Deduction under the Voluntary Health Insurance Scheme

PURPOSE

This paper seeks Members' comments on the legislative proposal for introducing tax deduction for taxpayers who purchase certified individual indemnity hospital insurance products¹ (IHIPs) under the Voluntary Health Insurance Scheme (VHIS), and briefs Members on the implementation of VHIS.

LEGISLATIVE PROPOSAL FOR TAX DEDUCTION

2. As announced in the 2018-19 Budget, the Government will introduce an Amendment Bill to the Inland Revenue Ordinance (Cap. 112) (the Bill) to allow tax deduction for premiums paid, as an added incentive for the public to purchase certified VHIS-compliant plans (Certified Plans) under the VHIS. Premiums paid by a person for himself/herself and his/her dependants will be allowed for tax deduction. The annual ceiling for tax deduction of premiums paid is **\$8,000 per insured person**. There is **no cap on the number of dependants** that are eligible for tax deduction.

Parameters of Tax Deduction

3. The Bill will set out that premiums paid in a year of assessment by a taxpayer, as a policy holder, for himself/herself and his/her dependants

¹ In this paper, individual hospital indemnity insurance refers to an individual hospital indemnity insurance where the insured will be reimbursed or indemnified by the insurer for his/her actual expenses incurred for medical treatments (in a hospital or an ambulatory setting). Other "health-related" insurance products, e.g. non-indemnity critical illness insurance, hospital income/cash plans, dental insurance coverage, outpatient insurance plans, are not covered by VHIS.

will be allowed for deduction. Only premiums paid in respect of a Certified Plan will be tax-deductible.

4. To recognise the special relation between husband and wife, a person is allowed to claim deduction of premiums paid by his/her spouse.

5. The Bill will set out the definitions of dependants, which will cover the taxpayer's spouse and children², and the taxpayer's or his/her spouse's grandparents, parents, brothers or sisters³.

6. For each taxpayer, deduction of premiums paid for a year of assessment will be subject to a cap of \$8,000 per insured person. There is no cap on the number of dependants and the number of policies per insured person.

7. Two illustrative examples of tax deduction are set out as follows –

Example 1: A taxpayer purchased a Certified Plan for himself

	Annual Premium Paid (Depending on age/product)	Tax-deductible Amount (Capped at \$8,000 per insured person)	Amount of Tax Saved (Assuming Tax Rate is 15%)
Scenario 1	\$3,000	\$3,000	\$450
Scenario 2	\$4,000	\$4,000	\$600
Scenario 3	\$4,800	\$4,800	\$720
Scenario 4	\$8,000	\$8,000	\$1,200
Scenario 5	\$12,000	\$8,000	\$1,200

² A child should be – (a) under the age of 18 years; (b) of or over the age of 18 years but under the age of 25 years and is receiving full time education at a university, college, school or other similar educational establishment; or (c) of or over the age of 18 years and is, by reason of physical or mental disability, incapacitated for work.

³ A brother or sister should be – (a) under the age of 18 years; (b) of or over the age of 18 years but under the age of 25 years and is receiving full time education at a university, college, school or other similar educational establishment; or (c) of or over the age of 18 years and is, by reason of physical or mental disability, incapacitated for work.

Example 2: A taxpayer purchased Certified Plans for himself and his dependants

Insured Person	Annual Premium Paid (Depending on age/product)	Tax-deductible Amount (Capped at \$8,000 per insured person)	Amount of Tax Saved (Assuming Tax Rate is 15%)
Taxpayer	\$5,000	\$5,000	
Spouse	\$4,100	\$4,100	
Grandmother	\$16,000	\$8,000	
Father	\$12,000	\$8,000	
Mother	\$11,000	\$8,000	
Son	\$2,500	\$2,500	
Total	\$50,600	\$35,600	

VHIS

8. The VHIS seeks to improve the quality of IHIPs and offers consumers a more comprehensive quality choice of IHIP. By improving the accessibility, quality and transparency of IHIPs, consumers will have more confidence and certainty in making use of their insurance coverage to patronage private healthcare services, thereby alleviating the long-term financing pressure on the public healthcare system. We hope to encourage people to purchase IHIPs at a younger age to benefit from continuous protection for lifetime.

9. Under the VHIS, there will be two types of Certified Plans, namely the Standard Plan and Flexi Plans, both of which are eligible for tax deduction -

- (a) The **Standard Plan** provides a basic level of protection (e.g. benefit limits for room and board at ward class) and meets all the requirements prescribed by the Food and Health Bureau (FHB).
- (b) A **Flexi Plan** must meet all basic requirements for a Standard Plan and on top, provide enhanced benefits, e.g. higher limits of

indemnity or wider benefit coverage with less restriction for enhanced protection.

Insurers that join the VHIS must make available the Standard Plan for consumers to apply⁴, while insurers are encouraged to offer Flexi Plans. Insurers can still issue and sell non-compliant IHIPs in the market to satisfy the needs of some consumers, but these insurance plans will not be eligible for tax deduction.

Standard Plan Policy Template

10. The Standard Plan Policy Template is a template of insurance contracts between insurers and consumers. It sets out the product design of the Standard Plan by providing a set of standard terms and conditions, a benefit schedule and a schedule of surgical operations. All insurers offering the Standard Plan will need to adopt the same policy template. As such, consumers will be able to better understand the policy terms upfront; standardisation facilitates comparison of plans offered by different insurers and minimises disputes.

Salient Features

11. Compared with many existing IHIPs, Certified Plans under VHIS are **more attractive** to the policy holders and the insured in a number of ways -

- (a) **Guaranteed renewal** – in order to protect consumers from discontinuity or a reduction of insurance coverage, or a sharp premium hike due to illness, insurers will be required to offer guaranteed renewal until 100 years old of the insured. Insurers can decide on the premium to be charged at the beginning of the policy; thereafter, the insurer may adjust the overall premium of the product regularly. But the premium adjustment for an insured person **cannot** be based on changes in the health condition of that individual insured;

⁴ For the avoidance of doubt, insurers are not required to guarantee its acceptance to all applications under VHIS. They can underwrite and consider accepting or rejecting an application.

- (b) **No “lifetime benefit limit”** – currently some insurers impose “lifetime benefit limit” on IHIPs. The insurance cover terminates when the cumulative claims amount of a policy holder reaches the lifetime limit. This could render the requirement of guaranteed renewal ineffective because the continuation of insurance cover would be conditional upon previous claims. As a standard feature of VHIS, insurers are **not** allowed to impose a “lifetime benefit limit”;
- (c) **Cooling off period** – while common for life insurance products, this is less common for IHIPs. We have reached a consensus with the insurance industry that, under VHIS, insurers are required to offer a minimum cooling off period of 21 days for consumers. During the cooling off period, consumers can cancel their policy with full refund of paid premium. This feature can enhance consumer protection; and
- (d) **Coverage extended to include** –
 - (i) **Unknown pre-existing conditions** – Under common market practice, any claims relating to pre-existing conditions, even unknown to the policy holders, are usually rejected. Under VHIS, however, medical expenses arising from pre-existing conditions that the insured is not aware of or would not have reasonably been aware of⁵ would be claimable subject to a three-year waiting period, counting as from the date of contract. There is no coverage for the first policy year. The coverage is 25% and 50% in the second and third policy years respectively. From the fourth policy year onwards, the coverage will be 100%;
 - (ii) **Congenital treatment** – this feature is uncommon in the existing market. Expenses in respect of investigation and treatment of congenital conditions which have manifested or been diagnosed after the age of eight are claimable, subject to

⁵ A pre-existing condition that should have been reasonably aware of is when – (a) the condition has been diagnosed, or (b) has manifested clear and distinct signs or symptoms, or (c) medical advice or treatment has been recommended or received. The burden of proof rests with the insurer.

the waiting period if the onset is within the three-year waiting period as mentioned in para. 11(d)(i) above.

- (iii) **Ambulatory procedures, including endoscopy** – currently, some IHIP products only provide reimbursement for procedures performed under an in-patient setting and require overnight hospital stay. Hence, even if a procedure can be performed under an ambulatory setting, the patient would stay overnight at the hospital for the expenses to be claimable. Under VHIS, ambulatory procedures, including endoscopy, will be covered. It will help avoid unnecessary overnight hospital stay and reduce medical expenses;
- (iv) **Prescribed diagnostic imaging tests** – to ensure consumers have basic and value-for-money protection, prescribed diagnostic imaging tests⁶ would be covered. These tests are not commonly covered by existing market products due to concerns of possible abuse by consumers. As an improvement over existing products, VHIS will provide cover for these tests even in ambulatory settings subject to a **30% co-payment** to be paid by the insured;
- (v) **Prescribed non-surgical cancer treatments** – more new IHIPs cover non-surgical cancer treatments, including radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy for treatment of cancer even in ambulatory settings. These therapies are of increasing importance as an integral part of cancer treatment. Such treatments will be covered under VHIS; and
- (vi) **Psychiatric treatment** – this feature is rare in existing market products. Expenses incurred as a result of confinement in a local psychiatric hospital or psychiatric ward of a local hospital are claimable.

⁶ They are: computed tomography (“CT Scan”), magnetic resonance imaging (“MRI”), positron emission tomography (“PET” scan), PET-CT combined and PET-MRI combined.

12. The abovementioned salient features will be set out in the terms and conditions under the Standard Plan Policy Template (Parts 1 to 8 of Annex A refer).

Benefit Schedule of the Standard Plan

13. To provide a reasonable coverage for general ward in average-priced hospitals, the benefit limits of the Standard Plan are set at prescribed levels. We appreciate that the Standard Plan should be **generally affordable and competitive** vis-à-vis non-VHIS plans. If the benefit limits are set too high, the premium of the Standard Plan will inevitably be raised. It would also be more difficult for existing policy holders to migrate to Certified Plans. We are also mindful that consumers who can afford more may choose to purchase Flexi Plans. Hence, in setting the benefit limits of the Standard Plan, there is a need to strike a balance between higher claim limits and an affordable premium.

14. The benefit schedule is set out on page 32 of the Standard Plan Policy Template (Annex A refers). The benefit schedule is **broadly in line** with existing average market products. The FHB will regularly review and adjust the benefit schedule and the schedule of surgical operations to cater for medical inflation and other market and technological developments.

Code of Practice

15. FHB will also devise and issue a Code of Practice for Insurance Companies under the Ambit of VHIS (Code of Practice) focusing on the service aspect of insurers in providing Certified Plans (Annex B refers). An important part of the Code of Practice concerns how insurers should encourage and facilitate the migration of existing policy holders of IHIPs to switch to Certified Plans. Other parts include requiring insurers to provide clear and accurate information about VHIS and Certified Plans in the sales and marketing process, adopt fair, objective and consistent practice in underwriting and applying case-based exclusions, enhance budget certainty and premium transparency, and support the administration of the Standard Plan Policy Template (e.g. reminding insurers to inform consumers of the cooling-off arrangements).

16. Insofar as migration arrangement is concerned, the aim is to facilitate a smooth transition from existing IHIP plans to Certified Plans for the two million plus policy holders if they choose to. In the Code of Practice, the migration arrangements are set out along the two principles below –

- (a) VHIS-participating insurers should offer an **option** to **all** of their existing **policy holders** to consider switching to Certified Plans provided by the same insurer; and
- (b) insurers should in principle provide such an option on a **portfolio**⁷ **basis**. This means that existing policy holders that belong to the same portfolio (i.e. **basically** the same terms and conditions and same benefit schedule) should be offered the same alternative Certified Plan portfolio. This can avoid insurers from “cherry-picking” policy holders within the same portfolio, i.e. offering differential treatment to customers under the same existing plan (say, offering tougher migration terms to existing policy holders with new health problems).

Choice of Healthcare Providers

17. VHIS requires that there must be no restriction of healthcare providers for the Standard Plan and the basic protection in Flexi Plans that measures up to the Standard Plan coverage. In other words, the policyholders of VHIS-compliant Plans should have **free choice** of healthcare providers as far as basic protection is concerned. The insurance companies are obliged to make this known to the customers in the selling process and upon enquiry.

Handling of Complaints

18. Currently, complaints concerning IHIPs can be filed to the concerned insurance companies directly, relevant self-regulatory organisations for insurance intermediaries or to the Insurance Authority (IA). In case of disputes, consumers can also make use of alternative

⁷ Portfolio means all policies of the same terms and conditions and benefit schedule. For example, an insurer offers an IHIP product with three levels of coverage, namely “general ward”, “semi-private ward” and “private ward”, then there are three separate portfolios.

dispute resolution means, including but not limited to mediation and adjudication through the Insurance Complaints Bureau⁸, and other means of mediation and arbitration as mutually agreed between consumers and the insurance companies, before a dispute is referred to a court.

19. After the setting up of the VHIS Office, complaints related to VHIS-specific requirements, including product compliance and availability, features of Certified Plans, etc. will be handled by the VHIS Office. Complaints that may amount to suspected “misconduct” of insurers as defined under section 41P of the Insurance Ordinance (Cap. 41) may be referred to IA.

BACKGROUND

20. Facing the challenges brought by the ageing population and increasing healthcare needs, the Government conducted two stages of public consultation on healthcare reform in 2008 and 2010 respectively to look for ways to maintain the long-term sustainability of our healthcare system. As the public expressed reservations about mandatory measures for healthcare financing, the Government proposed to implement a voluntary scheme, previously known as the Health Protection Scheme, to enhance the accessibility to and quality of hospital insurance.

21. From December 2014 to April 2015, the Government conducted a Public Consultation on the VHIS. As revealed by the consultation outcomes in 2017, there was broad support for the concept and policy objectives of the VHIS in general. Many considered it a positive step towards redressing the balance of the public-private healthcare sectors. There were, however, divergent views over the proposed establishment of the High Risk Pool (HRP). Some respondents questioned the concept of using public money to help high-risk individuals to purchase private hospital insurance, and the financial sustainability of the proposed HRP in general. Given the public’s diverse views on HRP, we consider that a more prudent approach is to separate the consideration of HRP from the other proposed requirements which have received broad

⁸ The Insurance Claims Complaints Panel under the Insurance Complaints Bureau handles claims-related complaints. The panel is led by an independent chairman and consists of four members - two from the insurance industry, one from the Consumer Council and one from the Hong Kong Institute of Certified Public Accountants.

support in the public consultation exercise. In order not to delay the implementation of the VHIS, a phased approach is adopted by launching VHIS first and re-examining the HRP proposal at a later stage, taking into account, among others, the experience of actual implementation of VHIS.

22. In preparing the Standard Plan Policy Template and the Code of Practice with the assistance of an independent consultant, FHB has set up a Consultative Group on VHIS⁹ to engage the stakeholders to solicit their views and suggestions. FHB also maintains close contact with the IA and seek their advice as appropriate.

LEGISLATIVE TIMETABLE

23. We are finalising details of the Bill to provide for the new tax deduction. We aim to introduce the Bill to the Legislative Council in the second quarter of this year.

ADVICE SOUGHT

24. Members are invited to comment on the legislative proposal above and note the implementation details of VHIS.

**Food and Health Bureau
Inland Revenue Department
March 2018**

⁹ The Consultative Group consists of members from the insurance companies, insurance brokers and agents, healthcare institutions, the Consumer Council and other civil societies and academics, while representatives of the IA join as observers.

DRAFT

**Voluntary Health Insurance Scheme
Standard Plan Policy Template¹**

Contents

Terms and Conditions

Part 1

Insuring Clause
The Policy

Part 2

General Conditions

Part 3

Premium Provisions

Part 4

Renewal Provisions

Part 5

Claim Provisions

Part 6

Benefit Provisions

Part 7

Exclusion

Part 8

Definitions

Benefit Schedule (including benefit coverage, benefit amount and **Schedule of Surgical Operations**)

Policy Schedule (no fixed template)

Endorsement (if applicable, no fixed template)

Rider (if applicable, no fixed template)

¹ As the language structures of English and Chinese are different, the words, phrases and sentence structure used and adopted in one language version of the Standard Plan Policy Template may not be exactly the same as those in the other language version. Instead of a direct literal translation, a pragmatic approach on the choice of words, phrases and sentence structure is adopted, with a view to expressing the meaning, purpose and intention of the content of this policy template effectively and accurately.

DRAFT

TERMS AND CONDITIONS

**PART 1
INSURING CLAUSE**

During the period of time the Policy is in force, if the Insured suffers from a Disability, the Company shall pay the Eligible Expenses in accordance with the terms of this Policy.

All benefits payable to the Policy Holder shall be on a reimbursement basis of the actual amounts of Eligible Expenses incurred and are subject to the maximum limits and cost-sharing arrangement as stated in the Benefit Schedule and the terms of this Policy.

Notwithstanding the above, no Lifetime Benefit Limit shall be applicable to this Policy.

THE POLICY

The Policy Holder and the Company agree that -

1. This Policy shall consist of these Terms and Conditions, the Application, declarations, Policy Schedule, Benefit Schedule and any Riders, Endorsements, supplements, schedules or attachments attached to these Terms and Conditions, all of which shall be read together as one contract formed between the Policy Holder and the Company.
2. No alteration to these Terms and Conditions shall be valid unless it is made in accordance with these Terms and Conditions.
3. All statements made by or for the Insured in the Application shall be treated as representations and not warranties.
4. All information provided and all statements made by or for the Insured as required under this Policy and the Application shall be provided to the best of his knowledge and in his utmost good faith.
5. This Policy comes into force on the Policy Effective Date as specified in the Policy Schedule on the condition that the Policy Holder has paid the first premium in full.
6. In the event of any inconsistency between -
 - (a) the terms of these Terms and Conditions and the Benefit Schedule; and
 - (b) any other terms of this Policy,in each case whether they are contained in a Rider, Endorsement or any other supplement, schedule or attachment to this Policy -
 - (i) the terms which are more favourable to the Policy Holder or Insured shall prevail to the extent of such inconsistency; and

DRAFT

- (ii) the terms which impose additional restrictions or limitations to the Policy Holder or Insured shall become ineffective.

Both (i) and (ii) shall not apply to the exception in Section 9 of this Part 1 and any other exceptions as may be approved by the Government.

For the avoidance of doubt, no rights, powers, benefits or entitlements of the Policy Holder or Insured under these Terms and Conditions shall be adversely affected in any respect by any other term of this Policy, save for the exception in Section 9 of this Part 1 and any other exceptions as may be approved by the Government.

7. At Policy inception and at each Policy Renewal, in the event of any inconsistency between -
- (a) these Terms and Conditions, the terms of any Riders, Endorsements, supplements, schedules or attachments to these Terms and Conditions, and the Benefit Schedule; and
 - (b) the Standard Plan Terms and Benefits,

in each case whether they are contained in a Rider, Endorsement or any other supplement, schedule or attachment to this Policy -

- (i) the terms which are more favourable to the Policy Holder or Insured shall prevail to the extent of such inconsistency; and
- (ii) the terms which impose additional restrictions or limitations to the Policy Holder or Insured shall become ineffective.

Both (i) and (ii) shall not apply to the exception in Section 9 of this Part 1 and any other exceptions as may be approved by the Government.

If the Standard Plan Terms and Benefits prevail, such terms shall be deemed to be incorporated into these Terms and Conditions.

8. At Policy inception and at each Policy Renewal, to the extent any additional benefits which are not covered or are exceeding the coverage under Standard Plan Terms and Benefits, if the terms applicable to such additional benefits are not the same as the terms applicable to the Standard Plan Terms and Benefits, it shall not amount to an inconsistency contemplated under Sections 6 and 7 of this Part 1.
9. At the time this Policy is first issued, the Company may, by way of Rider, Endorsement, supplement, schedule or attachment to these Terms and Conditions, apply Case-based Exclusion due to a Pre-existing Condition or other factor that affects the insurability of the Insured notified to the Company in the Application.
10. The Company acknowledges that, as part of the underwriting process, it is the obligation of the Company to ask the Policy Holder and Insured in the Application all requisite questions for the Company to make the underwriting decision. Each of the Policy Holder and Insured shall have the obligation to respond to the questions, and to disclose such material facts as requested in the questions. The Company agrees that if any such questions are not included in the Application, the Company shall be deemed to have waived the disclosure obligation of the Policy Holder and Insured in respect of the information that was not requested.

DRAFT

11. All questions included in the Application must be sufficiently specific and unambiguous, and consistent with the rules and regulations of the Voluntary Health Insurance Scheme ("VHIS"), so as to allow the Policy Holder and Insured (as the case may be) to understand the information being requested and to provide clear and unequivocal responses. In case of dispute, the burden of proving that the questions are sufficiently specific and unambiguous shall rest with the Company.

12. If the Policy Holder or Insured fails to make the relevant disclosures under Section 10 or 11 of this Part 1, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right as provided in Sections 13 and 14 of Part 2.

DRAFT

PART 2 GENERAL CONDITIONS

1. Interpretation

- (a) Throughout this Policy, where the context so requires, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.
- (b) Headings are for convenience only and shall not affect the interpretation of this Policy.
- (c) A time of day is a reference to the time in Hong Kong.
- (d) Unless otherwise defined, capitalised terms used in this Policy shall have the meanings ascribed to them under Part 8.

This Policy has been prepared in both English and Chinese. Both English and Chinese versions are official versions and neither one shall prevail over the other. Any inconsistencies shall be interpreted in favour of the Policy Holder and Insured.

2. Cancellation within cooling-off period

The Policy Holder may exercise the right of cancellation with full refund of paid premium during the cooling-off period. The cancellation right is subject to the following conditions -

- (a) The request to cancel must be signed by the Policy Holder and received by the Company within [insert a period of not less than 21 days]_____ days after -
 - (i) the delivery of the Policy; or
 - (ii) the issue of a notice to the Policy Holder or his representative stating that the Policy is available and when the cooling-off period would expire;

whichever is the earlier; and

- (b) no refund can be made if a benefit payment has been made, is to be made or impending.

The above right shall not apply at Renewal.

To exercise this right, the Policy Holder must -

- (c) return the original Policy; and
- (d) attach a letter, signed by the Policy Holder, requesting cancellation or in other forms acceptable by the Company.

The Policy shall then be cancelled and the premium paid shall be fully refunded. In such event, this Policy shall be deemed to have been void from the Policy Effective Date and the Company shall not be liable to pay any benefit.

3. Cancellation

DRAFT

After the cooling-off period, the Policy Holder can request for cancellation of the Policy by giving [insert a period of not more than 30 days]_____ days prior written notice to the Company, provided that there has been no benefit payment under this Policy during the relevant Policy Year.

The cancellation right under this Section shall also apply after this Policy has been Renewed upon expiry of its first (or subsequent) Policy Year.

4. Benefit entitlement

If Eligible Expenses are incurred for Medical Services provided to the Insured, the Benefit Schedule and the Terms and Conditions of this Policy prevailing at the time such Eligible Expenses are incurred shall be applicable to the Eligible Expenses under the relevant section. For the avoidance of doubt, if the Policy is terminated but Eligible Expenses incurred within a period of thirty (30) days after termination are covered pursuant to Section 15 of this Part 2, the Benefit Schedule and the Terms and Conditions applicable shall be those prevailing as at the day immediately preceding the date of termination of this Policy.

5. Assignment

The rights, benefits, obligations and duties of the Policy Holder under these Terms and Conditions shall not be assignable and the Policy Holder warrants that any amounts payable under these Terms and Conditions shall not be subject to any trust, lien or charge.

6. Clerical error

Clerical errors in keeping the records shall neither invalidate coverage which is validly in force nor justify continuation of coverage which has been validly terminated.

7. Currency

Any claim for Eligible Expenses made by the Insured in any foreign currency shall be converted to [HKD]² at the opening indicative counter exchange selling rate published by The Hong Kong Association of Banks in respect of that foreign currency at the time of the settlement of the claim by the Company. If no such rate exists, the Company shall convert the foreign currency at the rate certified as appropriate by the Company's bankers which shall be deemed to be final and binding.

8. Interest

Save as otherwise specified in this Policy, no benefit and expenses payable under this Policy shall carry interest.

9. Company's obligation

The Company shall at all times perform its obligations in this Policy in good faith and comply with the rules and regulations of VHIS, the relevant guidelines issued by the Insurance Authority, and all applicable laws and regulations.

10. Governing law

This Policy is issued in Hong Kong and shall be governed by and construed in accordance with the laws of Hong Kong. The Company and Policy Holder agree to be subject to the exclusive jurisdiction of the Hong Kong courts.

² Or other currency denomination as specified in the Benefit Schedule of this Policy

DRAFT

11. Dispute resolution

If any dispute, controversy or disagreement arises out of this Policy, including matters relating to the validity, invalidity, breach or termination of this Policy, the Company and Policy Holder shall use their endeavours to resolve it amicably, failing which, it may (but is not obliged to) be referred to any form of alternative dispute resolution, including but not limited to mediation or arbitration, as may be agreed between the Company and the Policy Holder, before it is referred to a Hong Kong court.

Each party shall bear its own costs of using services under alternative dispute resolution.

12. Liability

The Company shall not accept any liability under this Policy unless the terms of this Policy relating to anything to be done or not to be done are duly observed and complied with by the Policy Holder and Insured, and the information and representations made in the Application and declaration are correct. Notwithstanding the above, the Company shall not disclaim liability unless any non-observance or non-compliance with the terms of this Policy, or the inaccuracy of the information and representations made in the Application and declaration, shall materially and adversely affect the interests of the Company.

13. Misstatement of personal information

Without prejudice to the Company's right to declare this Policy void in the case of misrepresentation on health related information or fraud as provided in Section 14 of this Part 2, if the non-health related information of the Insured that may impact the risk assessment by the Company (including but not limited to Age, sex or smoking habit) is misstated in the Application or in any subsequent document submitted to the Company for the purpose of the Application, the Company may adjust the premium, for the past, current or future Policy Years, on the basis of the correct information. Where additional premium is required, no benefits shall be payable unless the additional premium has been paid. If the additional required premium is not paid within a grace period of [insert a period of not less than 30 days] ____ days after the due date as notified by the Company to the Policy Holder, the Company shall have the right to terminate this Policy with effect from such due date, in which case Section 15 of this Part 2 shall apply. Where there has been an overpayment of premium by the Policy Holder, the Company shall refund the overpaid premium.

Where the Company, based on the correct information of the Insured and the Company's underwriting guidelines, considered that the application of the Insured should have been rejected, the Company shall have the right to declare this Policy void as from the Policy Effective Date and notify the Policy Holder that no cover shall be provided for the Insured. In such circumstances, if a benefit has been paid in respect of the Insured, the Company shall have -

(a) the right to demand refund of the benefits previously paid; and

(b) the obligation to refund the premium received,

in each case [**Option A** - for the current Policy Year and the previous Policy Years in which the Policy was in force] OR [**Option B** - for the current Policy Year only], subject to a reasonable administration charge payable to the Company. This refund arrangement shall be the same as that in Section 14 of this Part 2.

14. Misrepresentation or fraud

The Company has the right to declare this Policy void as from the Policy Effective Date and refuse to provide coverage under this Policy in case of any of the following events -

DRAFT

- (a) any material fact relating to the health related information of the Insured which may impact the risk assessment by the Company is incorrectly stated in, or omitted from, the Application or any statement or declaration made for or by the Insured in the Application. The circumstances that a fact shall be considered "material" include, without limitation, the situation where the disclosure of such fact at the time of Application submission would have affected the underwriting decision of the Company, such that the Company would have imposed Premium Loading, included Case-based Exclusion, or rejected the application. For the avoidance of doubt, this paragraph (a) shall not apply to non-health related information of the Insured, which shall be governed by Section 13 of this Part 2; or
- (b) any Application or claim submitted is fraudulent or where a fraudulent representation is made.

The burden of proving (a) and (b) shall rest with the Company. The Company shall have the duty to make all necessary inquiries on all facts which are material to the Company for underwriting purpose as provided in Section 10 of Part 1.

In the event of (a), the Company shall have -

- (i) the right to demand refund of the benefits previously paid; and
- (ii) the obligation to refund the premium received,

in each case [**Option A** - for the current Policy Year and the previous Policy Years in which the Policy was in force] OR [**Option B** - for the current Policy Year only], subject to a reasonable administration charge payable to the Company.

In the event of (b), the Company shall have -

- (iii) the right to demand refund of the benefits previously paid; and
- (iv) the right not to refund the premium received.

15. Termination of Policy

This Policy shall be automatically terminated on the earliest of the followings -

- (a) when the Policy is terminated due to non-payment of premiums after the grace period as specified in Section 13 of this Part 2 or Section 3 of Part 3; or
- (b) upon the death of the Insured; or
- (c) the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write or continue to write this Policy.

If the Policy is terminated pursuant to this Section 15, the termination shall be effective at 00:00 hours of the effective date of termination.

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

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

DRAFT

Where the Policy is terminated pursuant to (b) or (c), the Company shall refund the relevant premium paid for the current Policy Year on a pro rata basis.

This Policy shall also be terminated if the Policy Holder decides to cancel this Policy or not to Renew this Policy in accordance with Section 3 of this Part 2 or Section 1 of Part 4, as the case may be, by giving the requisite written notice to the Company. If the Policy is terminated under Section 3 of this Part 2, the effective date of termination shall be the date as stated in the cancellation notice given by the Policy Holder. However, such date shall not be within or earlier than the notice period as required by Section 3 of this Part 2 for the cancellation. If the Policy is not Renewed under Section 1 of Part 4, the effective date of termination shall be the day immediately after the expiry of the Policy Year during which the Policy remains valid.

If the Policy is terminated under (a) or (c) of this Section 15, in the case where the Insured is being Confined or is undergoing Non-surgical Cancer Treatment for a Disability suffered before such termination, then, with respect to the Confinement or treatment in relation to the same Disability, Eligible Expenses incurred shall continue to be covered under this Policy until (i) the Insured is discharged or the treatment is completed or (ii) thirty (30) days after the termination of the Policy, whichever is the earlier. The Benefit Schedule and the Terms and Conditions applicable shall be those prevailing as at the date of termination of this Policy. The Company shall have the right to deduct any outstanding premium from any benefit payment.

For the avoidance of doubt, where the Policy includes other additional benefits beyond those under the Standard Plan Terms and Benefits, removal/downgrading of any such other additional benefits by the Company shall not adversely affect -

- (d) the benefits corresponding to the Standard Plan Terms and Benefits which shall continue to be in full force and effect; and
- (e) the continuity of this Policy, and shall not adversely affect the Company's compliance with the licensing requirement in order to continue to write this Policy.

16. Notices to Company

All notices which the Company requires the Policy Holder to give shall be in writing, or in other forms acceptable by the Company, addressed to the Company.

17. Notices from Company

Any notice to be given under this Policy shall be sent by post to the latest address of the Policy Holder as notified to the Company, or sent by email to the latest email address of the Policy Holder as notified to the Company. Any notice so served shall be deemed to have been duly received by the Policy Holder as follows -

- (a) if sent by post, two (2) working days after posting; or
- (b) if sent by email, on the date and time transmitted.

18. Other insurance

If the Policy Holder has taken out other insurance policies besides this Policy, the Policy Holder shall have the right to claim under any such other insurance policies or this Policy, provided that in the event that the Policy Holder or Insured has already recovered all or part of the expenses from any such other

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insurance policies, the Company shall only be liable for such amount of Eligible Expense, if any, which is not compensated by any such other insurance policies.

19. Ownership and discharge under the Policy

The Company shall treat the Policy Holder as the absolute owner of the Policy and shall not recognise any equitable or other interest of any other party in the Policy. The payment of any benefits hereunder to the Policy Holder shall be deemed to be full and effective discharge of the Company's obligations in respect of such payment under the Policy.

20. Change of Policy Holder

Subject to the approval of the Company at its discretion, the Policy Holder may transfer the ownership of the Policy by completing the prescribed form and sending it to the Company. The change of ownership shall not be effective until the Company has approved the change and notified in writing to the Policy Holder and transferee. From the effective date of the change of ownership, the transferee shall be treated as the Policy Holder and the absolute owner of the Policy as described in Section 19 of this Part 2, and be responsible for the payment of the premiums as well as any outstanding premiums.

The Company shall not reject any application by the Policy Holder for the transfer of ownership to -

- (a) the Insured if he has reached the Age of eighteen (18) years; or
- (b) the parent or guardian of the Insured if he is under the Age of eighteen (18) years.

The Policy Holder may nominate a person to be the successive policy holder of the Policy in the event of the death of the Policy Holder. If the Policy Holder dies, but has not named a successive Policy Holder for the Policy or the named successive Policy Holder refuses the transfer, the ownership of the Policy shall be transferred to -

- (c) the Insured if he has reached the Age of eighteen (18) years; or
- (d) the administrator or executor of the Policy Holder's estate if the Insured is under the Age of eighteen (18) years.

The transfer of ownership of the Policy in accordance with the above paragraph shall be conditional upon the Company having received satisfactory evidence of the Policy Holder's death.

21. Rights of third parties

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.

22. Subrogation

After the Company has paid a benefit under this Policy, the Company shall have the right to proceed at its own expense in the name of the Policy Holder and/or Insured against any third party who may be responsible for events giving rise to such benefit claim under this Policy. Any amount recovered from any such third party shall belong to the Company to the extent of the amount of benefits which has been paid by the Company in respect of the relevant benefit claim under this Policy. The Policy Holder and/or Insured must provide full details in his possession or within his knowledge on the fault of the third party and fully cooperate with the Company in the recovery action. For the avoidance of doubt, the above subrogation right shall only apply if the third party is not the Policy Holder or Insured.

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23. Suits against third parties

Nothing in this Policy shall oblige the Company to join, respond to or defend (or indemnify in respect of the costs for) any suit or alternative dispute resolution process for damages for any cause or reason which may be instituted by the Policy Holder or Insured against any Registered Medical Practitioner, Hospital or healthcare services provider, including without limitation to any suit or alternative dispute resolution process for negligence, malpractice or professional misconduct or any other causes in relation to or arising out of the medical investigation or treatment of the Disability of the Insured under the terms of this Policy.

24. Waiver

No waiver by any party of any breach by any other party of any provisions of this Policy shall be deemed to be a waiver of any subsequent breach of that or any other provision of this Policy, and any forbearance or delay by any party in exercising any of its rights under this Policy shall not be construed as a waiver of such rights. Any waiver shall not take effect unless it is expressly agreed, and the rights and obligations of the Company and Policy Holder under this Policy shall remain in full force and effect except and only to the extent that they are waived.

25. Compliance with Law

If this Policy is or becomes illegal under the law applicable to the Policy Holder or Insured, the Company shall have the right to declare this Policy void from the date it becomes illegal and the Company shall refund the relevant premium received for such period this Policy is void on a pro rata basis.

26. Personal data privacy

The Company shall comply with the Personal Data (Privacy) Ordinance (Cap. 486 of the Laws of Hong Kong) and the related codes, guidelines and circulars.

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**PART 3
PREMIUM PROVISIONS**

1. Premium payable

The premium payable for this Policy with respect to the coverages in these Terms and Conditions only includes -

- (a) the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company; and
- (b) the Premium Loading, if applicable.

2. Payment of premiums

The amount of premium payable is specified in the Policy Schedule and/or any Riders or Endorsements attached to this Policy. The premium, whether paid annually or by instalment as agreed by the Company, shall be paid in advance when due before any benefits under this Policy shall be paid. Premium once paid shall not be refundable, unless otherwise specified in the Policy.

Premium due dates, Renewal dates and Policy Years are determined with reference to the Policy Effective Date as shown on the Policy Schedule. The first premium is due on the Policy Effective Date.

3. Grace period

The Company shall allow a grace period of [insert a period of not less than 30 days]_____ days after the premium due date for payment of each premium. The Policy shall continue to be in effect during the grace period but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, the Policy shall be terminated immediately on the date on which the unpaid premium is first due.

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PART 4 RENEWAL PROVISIONS

1. Renewal

This Policy shall be effective from the Policy Effective Date in consideration of the payment of premium and is Renewable on an annual basis in accordance with the terms of this Part 4. Renewal is guaranteed up to the Age of one hundred (100) years.

- (a) Unless the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write this Policy, or has ceased to maintain its registration with the Government as a VHIS provider, or the Policy Holder decides not to Renew this Policy by giving the Company not less than [insert a period of not more than 30 days] _____ days prior notice in writing in accordance with Section 3 of Part 2, Renewal shall be arranged automatically with the Renewed Policy updated or amended in accordance with the terms of the latest version of the Standard Plan Terms and Benefits prevailing at the time of Renewal, save for the exception in Section 9 of Part 1 and any other exceptions as may be approved by the Government.
- (b) At the time of Renewal, if the Company shall cease or has ceased to maintain its registration with the Government as a VHIS provider while maintaining the requisite authorisation under the Insurance Ordinance to write this Policy, Renewal shall be arranged automatically with terms no less favourable than the Standard Plan Terms and Benefits in force at the time when the Company ceased to maintain its registration as a VHIS provider, save for the exception in Section 9 of Part 1 and any other exceptions as may be approved by the Government.
- (c) After the Company has ceased to maintain its registration with the Government, if the Company subsequently re-registers with the Government as a VHIS provider, then at the Renewal date coinciding with or immediately following such re-registration, this Policy shall be Renewed and revised to align the Terms and Conditions and the Benefit Schedule of this Policy with the Standard Plan Terms and Benefits prevailing at the time of the Renewal, save for the exception in Section 9 of Part 1 and any other exceptions as may be approved by the Government.

Renewal of this Policy shall not be subject to re-underwriting, save for the limited circumstances stated in Section 5 of this Part 4.

2. Revision

Notwithstanding the foregoing, at the time of Renewal under (a) to (c) in Section 1 of this Part 4, the Company may offer additional terms and benefits that render this Policy more favourable than the applicable Standard Plan Terms and Benefits under (a) to (c) in Section 1 of this Part 4 (as the case may be); or if there are already any terms and benefits that render this Policy more favourable than the applicable Standard Plan Terms and Benefits under (a) to (c) in Section 1 of this Part 4 (as the case may be), the Company may maintain or revise any such terms and benefits. However, the Company must ensure that -

- (a) the above shall be made on an overall Portfolio basis;
- (b) nothing involved in the above shall render this Policy in any respect to be less favourable than the applicable Standard Plan Terms and Benefits under (a) to (c) in Section 1 of this Part 4, save for the exception in Section 9 of Part 1 and any other exceptions as may be approved by the Government;

DRAFT

- (c) this Policy shall not be subject to re-underwriting, save for the limited circumstances stated in Section 5 of this Part 4; and
- (d) this Policy shall be Renewed in accordance with the applicable Standard Plan Terms and Benefits under (a) to (c) in Section 1 of this Part 4 if the Policy Holder so requests.

3. Premium

Irrespective of whether the Company revises these Terms and Conditions or the Benefit Schedule under this Policy upon Renewal, the Company shall have the right to adjust the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company on an overall Portfolio basis. For the avoidance of doubt, if the Premium Loading is set as a percentage of the Standard Premium (i.e. rate of Premium Loading), the amount of Premium Loading payable shall be automatically adjusted according to the change in Standard Premium.

This Policy shall automatically be terminated on the Renewal date or last premium due date, whichever is the earlier, unless the Policy Holder pays the premium before the expiry of the grace period as specified in Section 3 of Part 3.

During each Policy Year and upon Renewal, the Company shall not impose any additional rate of Premium Loading (or any additional amount of Premium Loading if the Premium Loading is set in dollar terms rather than as a percentage of the Standard Premium) or Case-based Exclusion on the Insured by reason of any change in the Insured's health conditions.

4. Notification of Renewal

Irrespective of whether the Company revises these Terms and Conditions or the Benefit Schedule under this Policy upon Renewal, the Company shall in accordance with the terms of this Section 4 give the Policy Holder a written notice of not less than [insert a period of not less than 30 days]_____ days prior to Renewal.

The written notice shall specify the premium for Renewal and the effective date of Renewal. If the Company revises these Terms and Conditions or the Benefit Schedule under this Policy is revised in accordance with these Terms and Conditions upon Renewal, the Company shall make available the revised Terms and Conditions and the Benefit Schedule to the Policy Holder together with the written notice. The revised Terms and Conditions or the Benefit Schedule (as the case may be) and premium for Renewal shall take effect on the Renewal date.

5. No Re-underwriting except in limited circumstances

The Company shall not have the right to re-underwrite this Policy irrespective of any change in health conditions of the Insured since the Policy Effective Date.

The Company shall not have the right to re-underwrite this Policy irrespective of any change in the coverage under this Policy that applies on an overall Portfolio basis (as permitted under these Terms and Conditions). This restriction applies to any change including but not limited to where there is any upgrade or downgrade of any benefits, or any addition or removal of any benefits, whether they are in Riders or Endorsements or otherwise.

The Company shall have the right to re-underwrite this Policy only under the following circumstances -

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- (a) Where the Policy Holder requests the Company to re-underwrite this Policy at the time of Renewal for reduction in Premium Loading or removal of Case-based Exclusion according to the Company's underwriting practices;
- (b) At any time when the Policy Holder requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits (in which cases the re-underwriting shall be limited to such upgrade or additional benefits).
 - (i) However, at any time when the Policy Holder requests to unsubscribe the additional benefits (if any) in this Policy, or switch to another insurance plan which provides downgrade or reduction of benefits, the Company shall not have the right to re-underwrite this Policy but shall have the discretion to accept or reject the request according to its prevailing practices in handling similar requests;
 - (ii) The Company shall not have the right to terminate or not to Renew this Policy if any of the aforesaid requests is rejected by the Company or the re-underwriting result is not accepted by the Policy Holder;

- (c) **[Optional]** Where there is change in the Place of Residence of the Insured

At Policy Renewal, the Company shall have the right to re-underwrite this Policy due to a change in the Place of Residence of the Insured provided that -

- (i) The Company has taken into account the Place of Residence of the Insured in underwriting this Policy before its inception;
- (ii) The Company has specifically informed the Policy Holder of the consideration at the time of submission of application of this Policy and that any change to the Place of Residence could lead to re-underwriting upon Policy Renewal;
- (iii) The Company has maintained underwriting practices which show unambiguously how changes in the Place of Residence will affect the underwriting result, and the underwriting practices are readily accessible by the Policy Holder;
- (iv) The Company shall carry out the re-underwriting solely in respect of the said changes (i.e. the change in the Place of Residence of the Insured); and
- (v) The re-underwriting result may be more advantageous or adverse to the Policy Holder and Insured.

For the purpose of this paragraph (c), the Company shall have the obligation to request the Policy Holder to inform the Company of any change of Place of Residence of the Insured, which means that as at the Renewal date if his Place of Residence differs from that as at the last Renewal date (or the Policy Effective Date in the event of first Policy Renewal). After receiving the request, the Policy Holder shall have the obligation to inform the Company of such a change.

- (d) **[Optional]** Where there is change in the occupation of the Insured

At Policy Renewal, the Company shall have the right to re-underwrite this Policy due to a change in the occupation of the Insured provided that -

- (i) The Company has taken into account the occupation of the Insured in underwriting this Policy before its inception;

DRAFT

- (ii) The Company has specifically informed the Policy Holder of the consideration at the time of submission of application of this Policy and that any change to the occupation could lead to re-underwriting upon Policy Renewal;
- (iii) The Company has maintained underwriting practices which show unambiguously how changes in the occupation will affect the underwriting result, and the underwriting practices are readily accessible by the Policy Holder;
- (iv) The Company shall carry out the re-underwriting solely in respect of the said change (i.e. the change in the occupation of the Insured); and
- (v) The re-underwriting result may be more advantageous or adverse to the Policy Holder and Insured.

For the purpose of this paragraph (d), the Company shall have the obligation to request the Policy Holder to inform the Company of any change of occupation of the Insured, which means that as at the Renewal date if his occupation differs from that as at the last Renewal date (or the Policy Effective Date in the event of first Policy Renewal). After receiving the request, the Policy Holder shall have the obligation to inform the Company of such a change.

The Company and Policy Holder acknowledge that -

- (e) if under the terms of this Part 4, the Company has the right, or is required, to re-underwrite this Policy based on certain factors at Renewal, the Company shall, in accordance with the terms of this Part 4 and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and
- (f) as a result of re-underwriting, this Policy may be terminated, new Premium Loading may be applied, existing Premium Loading may be adjusted upwards or downwards, new Case-based Exclusions may be applied, and existing Case-based Exclusions may be revised or removed.

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**PART 5
CLAIM PROVISIONS**

1. Submission of claims

All claims incurred shall be submitted to the Company within [insert a period of not less than 90 days]_____ days after the date on which the Insured is discharged from the Hospital, or (where there is no Confinement) the date on which the relevant treatment, procedure, test or service is performed and completed. For this purpose, a claim shall be deemed not valid or complete and benefit shall not be payable unless -

- (a) all original receipts and/or original itemised bills together with the diagnosis, type of treatment, procedure, test or service provided shall have been submitted to the Company; and
- (b) all relevant information, certificates, reports, evidence, referral letter and other data or materials as reasonably required by the Company shall have been furnished to the Company for processing of such claim.

Policy Holders shall notify the Company if claims cannot be submitted within the above timeframe, otherwise the Company shall have the right to reject claims submitted after the above timeframe.

All certificates, information and evidence that are reasonably required by the Company and which can be reasonably provided by the Policy Holder shall be furnished at the expenses of the Policy Holder. The Company shall bear all expenses incurred in obtaining further certificates, information and evidence for the purposes of verification of the claim after the Policy Holder has submitted all required information pursuant to (a) and (b) above.

2. Claimable amount estimate

Before the Insured receives a Medical Service, the Policy Holder may request the Company to provide an estimate on the amount that may be claimed under this Policy. The Policy Holder shall provide the Company with the estimated fees to be incurred as furnished by the Hospital and/or attending Registered Medical Practitioner as required by the laws and regulations regulating the private healthcare facilities in Hong Kong at the time of request. Upon receiving the request, the Company shall inform the Policy Holder of the claimable amount estimate under this Policy based on the estimation furnished by the Hospital and/or attending Registered Medical Practitioner. The Company's estimate is for reference only, and the actual amount claimable by the Policy Holder shall be subject to the final expenses as evidenced in items (a) and (b) of Section 1 of this Part 5.

3. Legal action

No legal action shall be brought by the Policy Holder to recover any claim amount payable under this Policy within the first [insert a period of not more than 60 days]_____ days from which all proof of claims as required by the Policy has been received by the Company.

4. Medical examination

When a claim occurs, the Company shall have the right to require the Insured to be examined by a Registered Medical Practitioner appointed by the Company at the Company's cost.

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**PART 6
BENEFIT PROVISIONS**

1. Territorial scope of cover

All benefits described in this Policy are applicable worldwide except where otherwise stated.

2. Benefits covered

If during the period while this Policy is in force, the Insured, as a result of a Disability,

- (a) is Confined in a Hospital; or
- (b) undergoes any Day Case Procedure, Advanced Diagnostic Imaging Test or Non-surgical Cancer Treatment,

the Company shall reimburse the Policy Holder Eligible Expenses which are Reasonable and Customary in accordance with Sections 3 to 13 of this Part 6 and, for those expenses related to psychiatric condition, the Company's liability shall be further subject to Section 14 of this Part 6.

The amount of Eligible Expenses payable under this Policy shall not exceed the actual costs for Medical Services provided to the Insured, subject to the maximum limits for each benefit and (for each Policy Year) the Annual Benefit Limit for all benefits covered in the Benefit Schedule.

For the avoidance of doubt, only Eligible Expenses incurred for Medical Services provided to the Insured shall be reimbursed under this Policy. Expenses incurred for hospital confinement, procedures, tests, treatments or services undergone by or provided to persons other than the Insured shall not be covered, unless otherwise specified.

3. Room and board

Eligible Expenses on room and board incurred by the Insured for the cost of accommodation and meals charged by the Hospital shall be payable when, upon recommendation of a Registered Medical Practitioner, the Insured is Confined in a Hospital or undergoes any Day Case Procedure or Non-surgical Cancer Treatment and incurs charges in relation to such accommodation and meals.

4. Miscellaneous charges

Eligible Expenses on miscellaneous charges incurred shall be payable when the Insured is Confined in a Hospital or on the day he undergoes any Day Case Procedure for receiving Medical Services. These charges shall cover the following -

- (a) Road ambulance service to and/or from the Hospital;
- (b) Anaesthetic and oxygen administration;
- (c) Administration charges for blood transfusion;
- (d) Dressing and plaster casts;
- (e) Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;

DRAFT

- (f) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
- (g) Additional surgical appliances, equipment and devices other than those inclusively paid under Section 10 of this Part 6, and implants, disposables and consumables used during surgical procedure or operation;
- (h) Medical disposables, consumables, equipment and devices;
- (i) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Advanced Diagnostic Imaging Tests which shall be covered under Section 11 of this Part 6;
- (j) Intravenous (“IV”) infusions including IV fluids;
- (k) Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
- (l) Rental of walking aids and wheelchair for Inpatients; and
- (m) Physiotherapy, occupational therapy and speech therapy during Confinement.

5. Attending doctor's visit fee

If on any day of Confinement it is Medically Necessary for the Insured to be treated by a Registered Medical Practitioner, the Company shall reimburse an amount equal to the Eligible Expenses on the charges charged by the attending Registered Medical Practitioner for such visit or consultation.

6. Specialist's fee

If on any day of Confinement it is Medically Necessary for the Insured to be treated by a Specialist (not being the attending Registered Medical Practitioner under Section 5 of this Part 6) as recommended in writing by the attending Registered Medical Practitioner, the Company shall reimburse an amount equal to the Eligible Expenses on the charges charged by the Specialist for such visit or consultation. The recommendation by the attending Registered Medical Practitioner may be in the form of a written referral or a testifying statement on the claim form.

7. Intensive care

If on any day of Confinement, the Insured is admitted to an Intensive Care Unit as recommended by the attending Registered Medical Practitioner, Eligible Expenses on the actual Hospital charges incurred on Medically Necessary intensive care services shall be payable. For the avoidance of doubt, if on any day of Confinement intensive care services are payable, the Eligible Expenses so incurred shall not be payable under Section 3 of this Part 6.

8. Surgeon's fee

Eligible Expenses on Surgeon's fee shall be payable if a Medically Necessary surgical procedure or operation (including endoscopy) is performed on the Insured by the attending Surgeon during Confinement or in a setting for providing Medical Services to a Day Patient.

The Surgeon's fee shall be paid according to the relevant surgical category and the categorisation of such procedure or operation under the Schedule of Surgical Operations as categorised and reviewed from time to time by the Government. If a procedure or operation performed is not included in the Schedule of Surgical Operations, the Company may reasonably determine its surgical category

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according to the gazette published by the Government or any other relevant publication or information including but not limited to the schedule of fees recognised by the government, relevant authorities and medical association in the locality where the procedure or operation is performed.

If any alternative procedures including radiosurgery and radiotherapy are used for treating non-cancerous condition in place of any cutting operation listed in the Schedule of Surgical Operations, the Company shall, subject to all other provisions for this Section 8, pay a benefit which is Reasonable and Customary for such alternative procedures up to an amount equal to the amount of maximum benefit payable for the replaced cutting operation, as provided for in the Benefit Schedule according to the Schedule of Surgical Operations. The use of non-surgical procedures for any cancer treatment shall be covered under Section 12 of this Part 6.

9. Anaesthetist's fee

If Surgeon's fee is payable under Section 8 of this Part 6, the Company shall reimburse the Eligible Expenses on charges for Medically Necessary services rendered by the Anaesthetist in relation to the surgical procedure or operation of the Insured.

10. Operating theatre charges

If Surgeon's fee is payable under Section 8 of this Part 6, the Company shall reimburse the Eligible Expenses incurred for the Medically Necessary use of an operating theatre (including but not limited to a treatment room and recovery room) during the surgical procedure or operation of the Insured. Additional surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be covered under Section 4 of this Part 6.

11. Advanced Diagnostic Imaging Tests

Eligible Expenses on charges incurred for Medically Necessary Advanced Diagnostic Imaging Test during Confinement or in a setting for providing Medical Services to a Day Patient recommended in writing by the attending Registered Medical Practitioner for the investigation or treatment of a Disability shall be covered, subject to the Coinsurance arrangement as specified in Section 16 of this Part 6 and the Benefit Schedule. The recommendation by the attending Registered Medical Practitioner may be in the form of a written referral or a testifying statement on the claim form. For the avoidance of doubt, if the Confinement is solely for the purpose of Advanced Diagnostic Imaging Test, expenses other than those for Advanced Diagnostic Imaging Test which may otherwise fall within other Sections of this Part 6 would not be reimbursed.

12. Non-surgical Cancer Treatments

Eligible Expenses on charges incurred for Medically Necessary Non-surgical Cancer Treatment during Confinement or in a setting for providing Medical Services to a Day Patient, outpatient consultation by a Specialist in treatment planning, and monitoring of prognosis and development during the course of Non-surgical Cancer Treatment shall be covered. Eligible Expenses incurred as a result of Confinement that fall within other Sections of this Part 6 shall be payable under the respective sections.

13. Pre- and post-Confinement/Day Case Procedure outpatient care

The Company shall reimburse the Eligible Expenses for -

- (a) the Insured's outpatient visit or Emergency consultation resulting in a Confinement or Day Case Procedure (including consultation, western medication prescribed or diagnostic test); and

DRAFT

- (b) the Insured's follow-up outpatient visit (including consultation, western medication prescribed, dressings, physiotherapy, occupational therapy, speech therapy or diagnostic test) to, or recommended by, the attending Registered Medical Practitioner, within the period stated in the Benefit Schedule after (i) discharge from Hospital or (ii) Day Case Procedure, provided that such consultation, western medication, physiotherapy, occupational therapy, speech therapy or diagnostic test is directly related to and a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

The benefits payable under (b) of this Section 13 are applicable for Eligible Expenses incurred after the discharge from Hospital or the date of Day Case Procedure.

For the purpose of (a) and (b) above, Advanced Diagnostic Imaging Tests and Non-surgical Cancer Treatments shall not be covered.

14. Psychiatric treatment

Eligible Expenses on the charges incurred under Sections 3 to 11 of this Part 6 as a result of Confinement in a psychiatric Hospital or psychiatric ward of a Hospital recommended by a Specialist shall be covered for Confinement in Hong Kong only, and the total Eligible Expenses paid in each Policy Year shall be subject to the annual benefit limit for psychiatric treatment as stated in the Benefit Schedule.

15. Pre-existing Conditions

Eligible Expenses arising from Pre-existing Conditions that are notified to the Company upon Application, subject to the Case-based Exclusions (if any), shall be payable in accordance with these Terms and Conditions and Benefit Schedule of this Policy. The Company may only impose Case-based Exclusions to this Policy at the time this Policy is first issued by reason of a Pre-existing Condition notified to the Company in the Application. After the issuance of this Policy, the Company shall not impose any additional Case-based Exclusion, save for the limited circumstances stated in Section 5 of Part 4.

Eligible Expenses arising from Pre-existing Conditions that the Insured was not aware and would not reasonably have been aware of shall be payable in accordance with the terms of this Part 6, subject to the following waiting period and reimbursement arrangement -

First Policy Year	no coverage
Second Policy Year	25% reimbursement
Third Policy Year	50% reimbursement
Fourth Policy Year onwards	full coverage

For the avoidance of doubt, the Company shall not have the right to re-underwrite or terminate this Policy where the Insured was not aware and would not reasonably have been aware of the Pre-existing Condition.

If the Policy Holder or Insured is requested but fails to disclose to the Company upon submission of Application that the Insured is suffering from a Pre-existing Condition, and such Pre-existing Condition has been treated or diagnosed or has manifested signs or symptoms of which the Policy Holder or Insured is aware or should have reasonably been aware of, the Company has the right to declare the

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Policy void, demand repayment of any benefits paid and/or refuse to provide coverage under this Policy. In such event, the Company shall refund the premium in accordance with Section 14 of Part 2. The burden of proving the above shall rest with the Company.

16. Cost-sharing requirement

The Policy Holder is required to pay Coinsurance for certain benefit items specified in the Benefit Schedule. For the avoidance of doubt, Coinsurance does not include any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits under this Policy.

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**PART 7
EXCLUSION**

The Company shall not cover the following -

1. Treatment, procedure, medication, test or service which are not Medically Necessary.
2. Expenses incurred for the whole or part of the Confinement solely for the purpose of diagnostic procedures or allied health services, including but not limited to physiotherapy, occupational therapy and speech therapy, unless such procedure or service is recommended by a Registered Medical Practitioner for Medically Necessary investigation or treatment of a Disability which cannot be effectively performed in a setting for providing Medical Services to a Day Patient.
3. Expenses directly or indirectly arising from Human Immunodeficiency Virus (“HIV”) and its related Disability, which is contracted or occurs before the Policy Effective Date. Irrespective of whether it is known or unknown to the Insured at the time of application for this Policy, such Disability shall be generally excluded from any coverage of this Policy if it exists before the Policy Effective Date. If evidence of proof as to the time at which the such Disability is first contracted or occurs is not available, manifestation of such Disability within the first five (5) years after the Policy Effective Date shall be presumed to be contracted or occur before the Policy Effective Date, while manifestation after such five (5) years shall be presumed to be contracted or occur after the Policy Effective Date.

However, the exclusion under this entire Section 3 shall not apply where HIV and its related Disability is caused by sexual assault, medical assistance, blood transfusions or blood donation, or infection at birth, and in such cases the other terms of these Terms and Conditions shall apply.

4. Medical Services provided to the Insured as a result of Disability directly or indirectly arising from or consequential upon the dependence / overdose / influence of drugs, alcohol, narcotics or similar drugs or agents, self-inflicted injuries or attempted suicide, illegal activity, or venereal and sexually transmitted disease or its sequelae.
5. Any charges in respect of services for -
 - (a) beautification or cosmetic purposes, unless necessitated by Injury caused by an Accident and the Insured receives the Medical Services within ninety (90) days of the Accident; or
 - (b) correcting visual acuity or refractive errors that can be corrected by fitting of spectacles or contact lens, including eye refractive therapy, LASIK and any related tests, procedures and services.
6. Expenses incurred for prophylactic treatment or preventive care, including general check-ups, routine tests, screening procedures for asymptomatic conditions, screening or surveillance procedures based on the health history of the Insured and/or his family members, Hair Mineral Analysis (HMA), immunisation or health supplements. For the avoidance of doubt, this Section 6 does not apply to -
 - (a) treatment, monitoring, investigation or procedures with the purpose of avoiding complications arising from any other Medical Services provided;
 - (b) removal of pre-malignant conditions arising from a Disability; and
 - (c) treatment for prevention of recurrence or complication of a previous Disability,all of which shall not be excluded under this Policy.

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7. Dental treatment and oral and maxillofacial procedures performed by a dentist except for Emergency Treatment and surgery during Confinement arising from an Accident received by the Insured. Follow-up dental treatment or oral surgery after discharge from Hospital shall not be covered.
8. Medical Services and counselling service relating to maternity conditions and its complications, including diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction or pre-mature ejaculation, regardless of cause.
9. Purchase of durable medical equipment or appliances including but not limited to wheelchairs, beds and furniture, airway pressure machines and masks, portable oxygen and oxygen therapy devices, dialysis machines, exercise equipment, spectacles, hearing aids, special braces, walking aids, over-the-counter drugs, air purifiers or conditioners and heat appliances for home use. For the avoidance of doubt, this exclusion shall not apply to rental of medical equipment or appliances during Confinement or on the day of the Day Case Procedure.
10. Traditional Chinese Medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na, and other forms of alternative treatment including but not limited to hypnotism, qigong, massage therapy, aromatherapy, naturopathy, hydrotherapy, chiropractic, homeotherapy and other similar treatments.
11. Experimental or unproven medical technology or procedure in accordance with the common standard, or not approved by the recognised authority, in the locality where the treatment, procedure, test or service is received.
12. Any charges in respect of Medical Services provided as a result of Congenital Conditions which have manifested or been diagnosed before the Insured attained the Age of eight (8) years.
13. Eligible Expenses which have been reimbursed under any law, or medical program or insurance policy provided by any government, company or other third party.
14. Treatment for Disability directly or indirectly arising from war (declared or undeclared), civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power.

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**PART 8
DEFINITIONS**

In this Policy, words and expressions used shall have the following meanings -

"Accident"	shall mean a sudden and unforeseen event occurring entirely beyond the control of the Insured and caused by violent, external and visible means.
"Advanced Diagnostic Imaging Test"	shall mean computed tomography ("CT" scan), magnetic resonance imaging ("MRI"), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.
"Age"	shall mean the attained age of the Insured.
"Annual Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder in a Policy Year irrespective of whether any limits of any benefits stated in the Benefit Schedule have been reached. The Annual Benefit Limit is counted afresh in a new Policy Year.
"Application"	shall mean the application submitted to the Company in respect of this Policy, including the application form, questionnaires, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such application.
"Benefit Provisions"	shall mean the terms under Part 6 of these Terms and Conditions.
"Benefit Schedule"	shall mean a schedule of benefits attached to this Policy which sets out the benefit terms and maximum benefits covered.
"Case-based Exclusion"	shall mean the exclusion of a particular Sickness or Disease from the Benefit Provisions that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured.
"Company"	shall mean [name of insurer].
"Confinement" or "Confined"	shall mean an admission of the Insured to a Hospital that is recommended by a Registered Medical Practitioner for treatment and as an Inpatient for a period of no less than six (6) consecutive hours as a result of a Medically Necessary condition, provided that no minimum period is required for Confinement in connection with any Emergency Treatment in a Hospital as a result of an Emergency for the performance of a surgical procedure or other Medically Necessary treatment in a Hospital. Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured must stay in the Hospital continuously for the entire period of Confinement.

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"Congenital Condition"	shall mean (i) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (ii) any neo-natal abnormalities developed within six (6) months of birth.
"Coinsurance"	shall mean a fixed percentage or portion of Eligible Expenses the Policy Holder must contribute.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured receiving Medically Necessary services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured is not in Confinement.
"Disability"	shall mean a Sickness or Disease or Injury, including any and all complications arising therefrom.
"Eligible Expenses"	shall mean Medically Necessary expenses incurred with respect to a Disability.
"Emergency"	shall mean an event or situation that treatment is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured's health.
"Emergency Treatment"	shall mean consultation or treatment required in an Emergency. The Emergency event or situation, and the required consultation or treatment cannot be and are not separated by an unreasonable period of time.
"Endorsement"	shall mean any document attached to this Policy which amends the existing terms (including but not limited to the Benefit Provisions) of this Policy.
"Government"	shall mean the Hong Kong Special Administrative Region Government.
"HKD"	shall mean Hong Kong dollars [or any currency denomination as specified in the Benefit Schedule of this Policy e.g. US dollars].
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for the care and treatment of sick and injured persons as Inpatients, and which - (a) has facilities for diagnosis and major operations;

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- (b) provides twenty-four (24) hours nursing services by licensed or registered nurses;
 - (c) has one or more Registered Medical Practitioners; and
 - (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
- "Injury" shall mean any bodily damage (with or without a visible wound) solely caused by an Accident independent of any other causes.
- "Inpatient" shall mean an Insured who is Confined.
- "Insurance Authority" shall mean the Insurance Authority of Hong Kong established pursuant to section 4AAA of the Insurance Ordinance.
- "Insurance Ordinance" shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).
- "Insured" shall mean any person who is insured under this Policy, and named as the "Insured" in the Policy Schedule or the subsequent Endorsement to this Policy.
- "Intensive Care Unit" shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
- "Lifetime Benefit Limit" shall mean the maximum amount of benefits paid by the Company to the Policy Holder cumulatively since the inception of the Policy, irrespective whether any limits of any benefits stated in the Benefit Schedule have been reached or whether the Annual Benefit Limit in a Policy Year has been reached.
- "Medical Services" shall mean Medically Necessary services provided to the Insured, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.
- "Medically Necessary" shall mean the need to have Confinement, treatments, procedures, tests, examinations or other related services for the purpose of investigating or treating the relevant Disability in accordance with the generally accepted standards of medical practice and such treatment or service must -
- (a) require the expertise of, or be referred by, a Registered Medical Practitioner;
 - (b) be consistent with the diagnosis and necessary for the treatment of the Disability;
 - (c) be rendered in accordance with standards of good and prudent medical practice, and, in the prudent professional judgment of the attending Registered Medical Practitioner, not be rendered

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primarily for the convenience or the comfort of the Insured, his family, caretaker or the attending Registered Medical Practitioner;

- (d) be rendered in the setting most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice for the Confinement, treatments, procedures, tests, examinations or other related services; and
- (e) be furnished at the most appropriate level which, in the prudent professional judgment of the attending Registered Medical Practitioner, can be safely and effectively provided to the Insured.

For the purpose of this Policy, without prejudice to the generality of the foregoing, circumstances where a Confinement is considered Medically Necessary include, but not limited to -

- (i) the Insured is having an Emergency that requires urgent treatment in Hospital; and/or
- (ii) surgery is performed under general anaesthesia; and/or
- (iii) equipment for surgery / procedure is available in Hospital and procedure cannot be done on a Day Patient basis; and/or
- (iv) there is significantly severe co-morbidity of the Insured; and/or
- (v) taking into account the individual circumstances of the Insured, the attending Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured, the treatment or service should be conducted in Hospital; and/or
- (vi) in the prudent professional judgment of the attending Registered Medical Practitioner, the length of Confinement of the Insured is appropriate for the treatment or service concerned; and/or
- (vii) in the case of diagnostic procedures or allied health services prescribed by a Registered Medical Practitioner, such Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured, such procedures or services should be conducted in Hospital.

For the purpose of exercising his prudent professional judgment in (v) to (vii) above, the attending Registered Medical Practitioner shall have regard to whether the Confinement -

- (aa) is in accordance with standards of good and prudent medical practice in the locality for the treatment or service rendered, and, in the prudent professional judgment of the attending

DRAFT

Registered Medical Practitioner, not rendered primarily for the convenience or the comfort of the Insured, his family, caretaker or the attending Registered Medical Practitioner; and

(bb) is in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice in the locality for the treatment or service rendered.

"Non-surgical Cancer Treatment"	shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.
"Place(s) of Residence"	shall mean the jurisdiction(s) in which a person legally has the right of abode. A change in the Place(s) of Residence refers to the situation where a person has been granted the right of abode of additional jurisdiction(s), or has ceased to have the right of abode of existing jurisdiction(s). The above definition of "Place(s) of Residence" is used solely for the purpose of this Policy. For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, shall not be treated as a Place of Residence.
"Policy"	shall mean this "XXXXXXXXXXXXXXXXXXXX" policy underwritten and issued by the Company, which is the entire contract between the Policy Holder and the Company including but not limited to these Terms and Conditions, Application, declarations, Policy Schedule, Benefit Schedule and any Riders, Endorsements, supplements, schedules or attachments attached to this Policy, if applicable.
"Policy Effective Date"	shall mean the commencement date of this Policy which is specified as "Policy Effective Date" in the Policy Schedule.
"Policy Schedule"	shall mean a schedule attached to this Policy, which sets out the Policy details, the Policy Effective Date, the name and the relevant particulars of the Policy Holder and Insured, his eligible benefits and premium details under this Policy.
"Policy Year"	shall mean the period of time the Policy is in force, which is specified as one (1) year from (a) the Policy Effective Date in the Policy Schedule and/or (b) the Renewal date in any subsequent Endorsement to this Policy.
"Policy Holder"	shall mean the person who owns this Policy and is named as the "Policy Holder" in the Policy Schedule or subsequent Endorsement to this Policy.
"Portfolio"	shall mean all policies of the same Terms and Conditions and Benefit Schedule.
"Pre-existing Condition"	shall mean, in respect of the Insured, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation,

DRAFT

including Congenital Condition, that has existed prior to the Policy Effective Date. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, when -

- (a) it has been diagnosed; or
- (b) it has manifested clear and distinct signs or symptoms; or
- (c) medical advice or treatment has been sought, recommended or received.

"Premium Loading"

shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured.

"Reasonable and Customary"

shall mean, in relation to a charge for Medically Necessary treatment or service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals of the same sex and similar Age, for a similar Disability, as reasonably determined by the Company in good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred.

In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable) -

- (a) treatment or service fee statistics and surveys in the insurance or medical industry;
- (b) internal or industry claim statistics;
- (c) gazette published by the Government; and/or
- (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.

"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"

shall mean a medical practitioner of western medicine,

- (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in good faith); and
- (b) legally authorised for rendering relevant medical or surgical service in Hong Kong or the relevant jurisdiction outside Hong Kong where the treatment is provided to the Insured,

but in no circumstance shall include the following persons - the Insured, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or Insured (unless approved in advance by the Company in writing). If the practitioner is not duly qualified and registered under

DRAFT

the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in good faith), the Company shall exercise reasonable judgment to determine whether such practitioner shall nonetheless be considered qualified and registered.

"Renewal", "Renew", "Renewed" or "Renewable"	shall mean the Policy is renewed in accordance with these Terms and Conditions without any discontinuance.
"Rider"	shall mean any document attached to this Policy which contains additional top-up benefits to the Benefit Provisions of this Policy.
"Schedule of Surgical Operations"	shall mean the list of surgical operations attached to this Policy which sets out the surgical category of different surgeries/procedures according to their relative degree of complexity, which is from time to time published and subject to regular review by the Government.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occurs to the Insured and whether or not any diagnosis is confirmed.
"Standard Plan"	shall mean the insurance plan with terms and benefits equivalent to the minimum compliant product requirements of VHIS, which are from time to time published and subject to regular review by the Government.
"Standard Plan Terms and Benefits"	shall mean the Terms and Conditions and the Benefit Schedule of the Standard Plan, which are from time to time published and subject to regular review by the Government.
"Standard Premium"	shall mean the basic premium charged by the Company to the Policy Holder on an overall Portfolio basis, which may be adjusted in accordance with the Age, gender and/or lifestyle factors of the Insured.
"Terms and Conditions"	shall mean the terms and conditions in Part 1 to Part 8 of this Policy.
"VHIS"	shall mean the Voluntary Health Insurance Scheme implemented by the Government.

DRAFT

BENEFIT SCHEDULE

Benefit Items⁽¹⁾	Benefit Limit (in [HKD])⁽⁵⁾
Room and board	\$750 per day Maximum 180 days per Policy Year
Miscellaneous charges	\$14,000 per Policy Year
Attending doctor's visit fee	\$750 per day Maximum 180 days per Policy Year
Specialist's fee ⁽²⁾	\$4,300 per Policy Year
Intensive care	\$3,500 per day Maximum 25 days per Policy Year
Surgeon's fee	Per surgery, subject to surgical category for the surgery/procedure in the Schedule of Surgical Operations - <ul style="list-style-type: none"> • Complex \$50,000 • Major \$25,000 • Intermediate \$12,500 • Minor \$5,000
Anaesthetist's fee	35% of surgeon's fee payable
Operating theatre charges	35% of surgeon's fee payable
Advanced Diagnostic Imaging Tests ^{(2) (3)}	\$20,000 per Policy Year Subject to 30% Coinsurance
Non-surgical Cancer Treatments ⁽⁴⁾	\$80,000 per Policy Year
Pre- and post-Confinement/Day Case Procedure outpatient care	\$580 per visit, up to \$3,000 per Policy Year <ul style="list-style-type: none"> • 1 prior outpatient visit or Emergency consultation per Confinement/Day Case Procedure • 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)
Psychiatric treatment	\$30,000 per Policy Year
Annual Benefit Limit	\$420,000
Lifetime Benefit Limit	Nil

Notes -

- (1) Eligible Expenses incurred in respect of the same item shall not be recoverable under more than one benefit item in the table above.
- (2) Written referral or testifying statement on the claim form by the attending doctor or Registered Medical Practitioner is required.
- (3) Tests covered here only include computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET" scan), PET-CT combined and PET-MRI combined.

DRAFT

- (4) Treatments covered here only include radiotherapy, chemotherapy, targeted therapy, immunotherapy and hormonal therapy.
- (5) [This note serves illustration purpose only and shall not form part of the Benefit Schedule. If the Benefit Limit is denominated in currency other than HKD, the amount of Benefit Limit denominated in such currency in the Benefit Schedule shall be based on a reference exchange rate set out by the Government.]

DRAFT

SCHEDULE OF SURGICAL OPERATIONS

Procedure / Surgery		Category
ABDOMINAL AND DIGESTIVE SYSTEM		
Oesophageal / stomach / duodenum	Excision of oesophageal lesion / destruction of lesion or tissue of oesophagus, cervical approach	Major
	Highly selective vagotomy	Major
	Laparoscopic fundoplication	Major
	Laparoscopic repair of hiatal hernia	Major
	Oesophagogastroduodenoscopy (OGD) +/- biopsy and/or polypectomy	Minor
	OGD with removal of foreign body	Minor
	OGD with ligation / banding of oesophageal/ gastric varices	Intermediate
	Oesophagectomy	Complex
	Total oesophagectomy and interposition of intestine	Complex
	Percutaneous gastrostomy	Minor
	Permanent gastrostomy / gastroenterostomy	Major
	Partial gastrectomy +/- jejunal transposition	Major
	Partial gastrectomy with anastomosis to duodenum / jejunum	Major
	Partial gastrectomy with anastomosis to oesophagus	Complex
	Proximal gastrectomy / radical gastrectomy / total gastrectomy +/- intestinal interposition	Complex
	Suture of laceration of duodenum / patch repair, duodenal ulcer	Major
	Vagotomy and /or pyloroplasty	Major
	Jejunum, ileum and large intestine	Appendicectomy, open or laparoscopic
Anal fissurectomy		Minor
Anal fistulotomy / fistulectomy		Intermediate
Incision & drainage of perianal abscess		Minor
Delorme operation for repair of prolapsed rectum		Major
Colonoscopy +/- biopsy		Minor
Colonoscopy with polypectomy		Minor
Sigmoidoscopy		Minor
Haemorrhoidectomy, internal or external		Intermediate
Injection / banding of haemorrhoid		Minor
Ileostomy or colostomy		Major
Anterior resection of rectum, open or laparoscopic		Complex
Abdominoperineal resection, open or laparoscopic		Complex

DRAFT

Procedure / Surgery		Category
	Colectomy, open or laparoscopic	Complex
	Low anterior resection of rectum , open or laparoscopic	Complex
	Reduction of volvulus or intussusception	Intermediate
	Resection of small intestine and anastomosis	Major
Biliary tract	Cholecystectomy, open or laparoscopic	Major
	Endoscopic retrograde cholangio-pancreatography (ERCP)	Intermediate
	ERCP with papilla operation, stone extraction or other associated operation	Intermediate
Liver	Fine needle aspiration (FNA) biopsy of liver	Minor
	Liver transplantation	Complex
	Marsupialization of lesion / cyst of liver or drainage of liver abscess, open approach	Major
	Removal of liver lesion, open or laparoscopic	Major
	Sub-segmentectomy of liver, open or laparoscopic	Major
	Segmentectomy of liver, open or laparoscopic	Complex
	Wedge resection of liver, open or laparoscopic	Major
Pancreas	Closed biopsy of pancreatic duct	Intermediate
	Excision / destruction of lesion of pancreas or pancreatic duct	Major
	Pancreaticoduodenectomy (Whipple's Operation)	Complex
Abdominal wall	Exploratory laparotomy	Major
	Laparoscopy / peritoneoscopy	Intermediate
	Unilateral repair of inguinal hernia, open or laparoscopic	Intermediate
	Bilateral repair of inguinal hernia, open or laparoscopic	Major
	Unilateral herniotomy / herniorrhaphy, open or laparoscopic	Intermediate
	Bilateral herniotomy / herniorrhaphy, open or laparoscopic	Major
BRAIN AND NERVOUS SYSTEM		
Brain	Brain biopsy	Major
	Burr hole(s)	Intermediate
	Craniectomy	Complex
	Cranial nerve decompression	Complex
	Irrigation of cerebroventricular shunt	Minor
	Maintenance removal of cerebroventricular shunt, including revision	Intermediate
	Creation of ventriculoperitoneal shunt or subcutaneous cerebrospinal fluid reservoir	Major
	Clipping of intracranial aneurysm	Complex
	Wrapping of intracranial aneurysm	Complex

DRAFT

Procedure / Surgery		Category
	Excision of arteriovenous malformation, intracranial	Complex
	Excision of acoustic neuroma	Complex
	Excision of brain tumour or brain abscess	Complex
	Excision of cranial nerve tumour	Complex
	Radiofrequency thermocoagulation of trigeminal ganglion	Intermediate
	Closed trigeminal rhizotomy using radiofrequency	Major
	Decompression of trigeminal nerve root/ open trigeminal rhizotomy	Complex
	Excision of brain, including lobectomy	Complex
	Hemispherectomy	Complex
Spine	Lumbar puncture or cisternal puncture	Minor
	Decompression of spinal cord or spinal nerve root	Major
	Cervical sympathectomy	Intermediate
	Thoracoscopic or lumbar sympathectomy	Major
	Excision of intraspinal tumour, extradural or intradural	Complex
CARDIOVASCULAR SYSTEM		
Heart	Cardiac catheterization	Intermediate
	Coronary artery bypass graft (CABG)	Complex
	Cardiac transplantation	Complex
	Insertion of cardiac pacemaker	Intermediate
	Pericardiocentesis	Minor
	Pericardiotomy	Major
	Percutaneous transluminal coronary angioplasty (PTCA) and related procedures, including use of laser, stenting, motor-blade, balloon angioplasty, radiofrequency ablation technique, etc.	Major
	Pulmonary valvotomy, Balloon / Transluminal laser / Transluminal radiofrequency	Major
	Percutaneous valvuloplasty	Major
	Balloon aortic / mitral valvotomy	Major
	Closed heart valvotomy	Complex
	Open heart valvuloplasty	Complex
Valve replacement	Complex	
Vessels	Intra-abdominal venous shunt/ spleno-renal shunt / portal-caval shunt	Complex
	Resection of abdominal vessels with replacement / anastomosis	Complex
ENDOCRINE SYSTEM		
Adrenal Gland	Unilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Major

DRAFT

Procedure / Surgery		Category
	Bilateral adrenalectomy, laparoscopic or retroperitoneoscopic	Complex
Pineal gland	Total excision of pineal gland	Complex
Pituitary Gland	Operation of pituitary tumour	Complex
Thyroid Gland	Fine needle aspiration (FNA) of thyroid gland +/- imaging guidance	Minor
	Hemithyroidectomy / partial thyroidectomy / subtotal thyroidectomy / parathyroidectomy	Major
	Total thyroidectomy / complete parathyroidectomy / robotic-assisted total thyroidectomy	Major
	Excision of thyroglossal cyst	Intermediate
EAR/ NOSE / THROAT / RESPIRATORY SYSTEM		
Ear	Canaloplasty for aural atresia / stenosis	Major
	Excision of preauricular cyst / sinus	Minor
	Haematoma auris, drainage / buttoning / excision	Minor
	Meatoplasty	Intermediate
	Removal of foreign body	Minor
	Excision of middle ear tumour via tympanotomy	Major
	Myringotomy +/- insertion of tube	Minor
	Myringoplasty / tympanoplasty	Major
	Ossiculoplasty	Major
	Labyrinthectomy, total / partial excision	Major
	Mastoidectomy	Major
	Operation on cochlea and / or cochlear implant	Complex
	Operation on endolymphatic sac / decompression of endolymphatic sac	Major
	Repair of round window or oval window fistula	Intermediate
Tympanosympathectomy	Major	
Vestibular neurectomy	Intermediate	
Nose, mouth and pharynx	Antral puncture and lavage	Minor
	Cauterization of nasal mucosa / control of epistaxis	Minor
	Closed reduction for fracture nasal bone	Minor
	Closure of oro-antral fistula	Intermediate
	Dacryocystorhinostomy	Intermediate
	Excision of lesion of nose	Minor
	Nasopharyngoscopy / rhinoscopy +/- including rhinoscopic biopsy +/- removal of foreign body	Minor
	Polypectomy of nose	Minor

DRAFT

Procedure / Surgery	Category	
Caldwell-Luc operation / Maxillary sinusectomy with Caldwell-Luc approach	Intermediate	
Endoscopic sinus surgery on ethmoid / maxillary / frontal / sphenoid sinuses	Intermediate	
Extended endoscopic frontal sinus surgery with trans-septal frontal sinusotomy	Major	
Frontal sinusotomy or ethmoidectomy	Intermediate	
Frontal sinusectomy	Major	
Functional endoscopic sinus surgery (FESS)	Major	
Functional endoscopic sinus surgery (FESS) bilateral	Comple	
Maxillary / sphenopalatine / ethmoid artery ligation	Intermediate	
Other intranasal operation, including use of laser (excluding simple rhinoscopy, biopsy and cauterisation of vessel)	Intermediate	
Rhinoplasty	Intermediate	
Resection of nasopharyngeal tumour	Intermediate	
Sinoscopy +/- biopsy	Minor	
Septoplasty +/- submucous resection of septum	Intermediate	
Submucous resection of nasal septum	Intermediate	
Turbinectomy / submucous turbinectomy	Intermediate	
Adenoidectomy	Minor	
Tonsillectomy +/- adenoidectomy	Intermediate	
Excision of pharyngeal pouch / diverticulum	Intermediate	
Pharyngoplasty	Intermediate	
Sleep related breathing disorder – hyoid suspension, maxilla / mandible / tongue advancement, laser suspension / resection, radiofrequency ablation assisted uvulopalatopharyngoplasty, uvulopalatopharyngoplasty	Intermediate	
Marsupialization / excision of ranula	Intermediate	
Parotid gland removal, superficial	Intermediate	
Parotid gland removal / parotidectomy	Major	
Removal of submandibular salivary gland	Intermediate	
Submandibular duct relocation	Intermediate	
Submandibular gland excision	Intermediate	
Respiratory system	Arytenoid subluxation – laryngoscopic reduction	Minor
	Bronchoscopy +/- biopsy	Minor
	Bronchoscopy with foreign body removal	Minor
	Laryngoscopy +/- biopsy	Minor

DRAFT

Procedure / Surgery		Category
	Laryngeal / tracheal stenosis – endolaryngeal / open operation with stenting / reconstruction	Major
	Laryngeal diversion	Intermediate
	Laryngectomy +/- radical neck resection	Complex
	Microlaryngoscopy +/- Biopsy +/- excision of nodule / polyp / Reinke's edema	Minor
	Partial / total resection of laryngeal tumour	Intermediate
	Removal of vallecular cyst	Intermediate
	Repair of laryngeal fracture	Major
	Injection for vocal cord paralysis	Minor
	Tracheoesophageal puncture for voice rehabilitation	Minor
	Thyroplasty for vocal cord paralysis	Intermediate
	Vocal cord operation, including use of laser (excluding carcinoma)	Minor
	Tracheostomy, temporary / permanent / revision	Minor
	Lobectomy of lung / pneumonectomy	Complex
	Pleurectomy	Major
	Segmental resection of lung	Major
	Thoracocentesis / insertion of chest tube for pneumothorax	Minor
	Thoracoscopy +/- biopsy	Intermediate
	Thoracoplasty	Major
	Thymectomy	Major
EYE		
Eye	Excision / curettage / cryotherapy of lesion of eyelid	Minor
	Blepharorrhaphy / tarsorrhaphy	Minor
	Repair of entropion or ectropion +/- wedge resection	Minor
	Reconstruction of eyelid, partial-thickness	Intermediate
	Excision / destruction of lesion of conjunctiva	Minor
	Excision of pterygium	Minor
	Corneal grafting, severe wound repair and keratoplasty, including corneal transplant	Major
	Laser removal / destruction of corneal lesion	Intermediate
	Removal of corneal foreign body	Minor
	Repair of cornea	Intermediate
	Suture / repair of corneal laceration or wound with conjunctival flap	Intermediate
	Aspiration of lens	Intermediate
	Capsulotomy of lens, including use of laser	Intermediate

DRAFT

Procedure / Surgery	Category
Extracapsular / intracapsular extraction of lens	Intermediate
Intraocular lens / explant removal	Intermediate
Chorioretinal lesion operations	Intermediate
Phacoemulsification and implant of intraocular lens	Intermediate
Pneumatic retinopexy	Intermediate
Retinal Photocoagulation	Intermediate
Repair of retinal detachment / tear	Intermediate
Repair of retinal tear / detachment with buckle	Major
Scleral buckling / encircling of retinal detachment	Major
Cyclodialysis	Intermediate
Trabeculectomy, including use of laser	Intermediate
Surgical treatment for glaucoma including insertion of implant	Intermediate
Diagnostic aspiration of vitreous	Minor
Injection of vitreous substitute	Intermediate
Mechanical vitrectomy / removal of vitreous	Major
Biopsy of iris	Minor
Excision of lesion of iris / anterior segment of eye / ciliary body	Intermediate
Excision of prolapsed iris	Intermediate
Iridotomy	Intermediate
Iridectomy	Intermediate
Iridoplasty +/- coreoplasty by laser	Intermediate
Iridencleisis and iridotaxis	Intermediate
Scleral fistulization +/- iridectomy	Intermediate
Thermocauterization of sclera +/- iridectomy	Intermediate
Diminution of ciliary body	Intermediate
Biopsy of extraocular muscle or tendon	Minor
Operation on one extraocular muscle	Intermediate
Eyeball, perforating wound of, with incarceration or prolapse of uveal tissue repair	Major
Enucleation of eye	Intermediate
Evisceration of eyeball / ocular contents	Intermediate
Repair of eyeball or orbit	Intermediate
Conjunctivocystorhinostomy	Intermediate
Conjunctivorhinostomy with insertion of tube / stent	Intermediate
Dacryocystorhinostomy	Intermediate

DRAFT

Procedure / Surgery		Category
	Excision of lacrimal sac and passage	Minor
	Excision of lacrimal gland / dacryoadenectomy	Intermediate
	Probing +/- syringing of lacrimal canaliculi / nasolacrimal duct	Minor
	Repair of canaliculus	Intermediate
	Coreoplasty	Intermediate
FEMALE GENITAL SYSTEM		
Cervix	Amputation of cervix	Intermediate
	Colposcopy +/- biopsy	Minor
	Conization of cervix	Minor
	Destruction of lesion of cervix by excision/ cryosurgery / cauterization / laser	Minor
	Endocervical curettage	Minor
	Loop electrosurgical excision procedure (LEEP)	Minor
	Marsupialization of cervical cyst	Minor
	Repair of cervix	Minor
	Repair of fistula of cervix	Intermediate
	Suture of laceration of cervix / uterus / vagina	Intermediate
Fallopian tubes and ovaries [^]	Dilatation / insufflation of fallopian tube	Minor
	Excision / destruction of lesion of fallopian tube, open or laparoscopic	Major
	Repair of fallopian tube	Major
	Salpingostomy / salpingotomy	Intermediate
	Total or partial salpingectomy	Intermediate
	Tuboplasty	Intermediate
	Aspiration of ovarian cyst	Minor
	Ovarian cystectomy, open or laparoscopic	Major
	Wedge resection of ovary, open or laparoscopic	Major
	Oophorectomy	Intermediate
	Oophorectomy, laparoscopic	Major
	Salpingo-oophorectomy, open or laparoscopic	Major
	Drainage of tubo-ovarian abscess, open or laparoscopic	Intermediate
	<i>[^] The category applies to both unilateral and bilateral procedures unless otherwise specified.</i>	
Uterus	Dilatation and curettage of Uterine (D&C)	Minor
	Hysteroscopy +/- biopsy	Minor
	Hysteroscopy with excision or destruction of uterus and supporting structures	Intermediate

DRAFT

Procedure / Surgery	Category
Hysterotomy	Major
Laparoscopic assisted vaginal hysterectomy (LAVH)	Major
Vaginal hysterectomy +/- repair of cystocele and/or rectocele	Major
Total / subtotal abdominal hysterectomy +/- bilateral salpingo-oophorectomy, open or laparoscopic	Major
Radical abdominal hysterectomy	Complex
Myomectomy, open or laparoscopic	Major
Uterine myomectomy, vaginal or hysteroscopic	Intermediate
Laparoscopic drainage of female pelvic abscess	Intermediate
Colposuspension	Major
Pelvic floor repair	Major
Pelvic exenteration	Complex
Uterine suspension	Intermediate
Vagina	
Destruction of lesion of vagina by excision / cryosurgery / cauterization / laser	Minor
Insertion / removal of vaginal supportive pessaries	Minor
Marsupialization of Bartholin's cyst	Minor
Vaginal stripping of vaginal cuff	Minor
Vaginotomy	Intermediate
Partial vaginectomy	Intermediate
Vaginectomy, complete	Major
Radical vaginectomy	Complex
Anterior colporrhaphy +/- Kelly plication	Intermediate
Posterior colporrhaphy	Intermediate
Obliteration of vaginal vault	Intermediate
Sacrospinous ligament suspension or fixation of the vagina	Intermediate
Sacral colpopexy	Intermediate
Vaginal repair of enterocele	Intermediate
Closure of urethro-vaginal fistula	Intermediate
Repair of rectovaginal fistula, vaginal approach	Intermediate
Repair of rectovaginal fistula, abdominal approach	Major
Culdocentesis	Minor
Culdotomy	Minor
Excision of transverse vaginal septum	Minor
McCall's culdeplasty / culdoplasty	Intermediate

DRAFT

Procedure / Surgery		Category
	Vaginal reconstruction	Major
Vulva and introitus	Destruction of lesion of vulva by excision / cryosurgery / cauterization / laser	Minor
	Wide local excision of vulva with cold knife or LEEP	Minor
	Excision of vestibular adenitis	Minor
	Excision biopsy of vulva	Minor
	Incision and drainage of vulva and perineum	Minor
	Lysis of vulvar adhesions	Minor
	Repair of fistula of vulva or perineum	Minor
	Suture of lacerations / repair of vulva and/or perineum	Minor
	Vulvectomy	Intermediate
	Radical vulvectomy	Major
HEMIC AND LYMPHATIC SYSTEM		
Lymph Nodes	Drainage of lesion / abscess of lymph node	Minor
	Biopsy / excision of superficial lymph nodes / simple excision of lymphatic structure	Minor
	Incisional biopsy of cervical lymph node / fine needle aspiration (FNA) biopsy of lymph nodes	Minor
	Excision of deep lymph node / lymphangioma / cystic hygroma	Intermediate
	Bilateral inguinal lymphadenectomy	Intermediate
	Cervical lymphadenectomy	Intermediate
	Inguinal and pelvic lymphadenectomy	Major
	Radical groin dissection	Major
	Radical pelvic lymphadenectomy	Major
	Selective / radical / functional neck dissection	Major
	Wide excision of axillary lymph node	Major
Spleen	Splenectomy, open or laparoscopic	Major
MALE GENITAL SYSTEM		
Prostate	External drainage of prostatic abscess	Minor
	Photoselective vaporization of prostate	Major
	Plasma vaporization of prostate	Major
	Prostate biopsy	Minor
	Transurethral microwave therapy	Intermediate
	Transurethral prostatectomy or TURP	Major
	Prostatectomy, open or laparoscopic	Major
	Radical prostatectomy, open or laparoscopic	Complex

DRAFT

Procedure / Surgery		Category
Penis	Circumcision	Minor
	Release of chordee	Major
	Repair of buried / avulsion of penis	Intermediate
Testicles [^]	Epididymectomy	Intermediate
	Exploration of testis	Intermediate
	Exploration for undescended testis, laparoscopic	Major
	Orchidopexy	Intermediate
	Orchidectomy or orchidopexy, laparoscopic	Major
	Reduction of torsion of testis and fixation	Intermediate
	Testicular biopsy	Minor
	High ligation of hydrocoele	Intermediate
	Tapping of hydrocoele	Minor
	Excision of varicocele and hydrocoele of spermatic cord	Intermediate
	Varicocelectomy (microsurgical)	Major
	<i>[^] The category applies to both unilateral and bilateral procedures unless otherwise specified.</i>	
Spermatic cord	Vasectomy	Minor
MUSCULOSKELETAL SYSTEM		
Bone	Amputation of finger(s) / toe(s) of one limb	Intermediate
	Amputation of one arm / hand / leg / foot	Intermediate
	Bunionectomy	Intermediate
	Bunionectomy with soft tissue correction and osteotomy of the first metatarsal	Major
	Excision of radial head	Intermediate
	Mandibulectomy for benign disease	Intermediate
	Patellectomy	Major
	Partial ostectomy of facial bone	Intermediate
	Sequestrectomy of facial bone	Intermediate
	Wedge osteotomy of bone of wrist / hand / leg	Major
	Wedge osteotomy of bone of upper arm / lower arm / thigh	Major
	Wedge osteotomy of scapula / clavicle / sternum	Major
Joint	Arthroscopic drainage and debridement	Intermediate
	Arthroscopic removal of loose body from joints	Intermediate
	Arthroscopic examination of joint +/- biopsy	Intermediate
	Arthroscopic assisted ligament reconstruction	Major
	Arthroscopic Bankart repair	Major

DRAFT

Procedure / Surgery	Category
Arthroscopic repair for superior labral tear from anterior to posterior of shoulder	Major
Arthroscopic rotator cuff repair	Major
Acromioplasty	Major
Arthrodesis of shoulder	Major
Arthrodesis of Elbow / Triple arthrodesis	Major
Arthrodesis of knee / hip	Complex
Arthroplasty of hand / finger / foot / Toe joint with implant	Major
Fusion of wrist	Major
Synovectomy of wrist	Intermediate
Interphalangeal joint fusion of toes	Intermediate
Interphalangeal fusion of finger	Major
Excisional arthroplasty shoulder / hemiarthroplasty of shoulder	Major
Excisional arthroplasty of hip / knee / Wrist / Elbow	Major
Excisional arthroplasty of hip / knee with local antibiotic delivery	Complex
Temporomandibular arthroplasty +/- autograft	Major
Joint aspiration / injection	Minor
Manipulation of joint under anesthesia	Minor
Metal femoral head insertion	Major
Anterior cruciate ligament reconstruction	Major
Meniscectomy, open or arthroscopic	Major
Posterior cruciate ligament reconstruction	Major
Repair of the collateral ligaments	Major
Repair of the cruciate ligaments	Major
Suture of capsule or ligament of ankle and foot	Major
Total shoulder replacement	Complex
Total knee replacement	Complex
Total hip replacement	Complex
Partial hip replacement	Major
Muscle/ Tendon	
Achilles tendon repair	Intermediate
Achillotenotomy	Intermediate
Change in muscle or tendon length (except hand) / excision of lesion of muscle	Intermediate
Change in muscle or tendon length of hand	Major
Excision of lesion of muscle	Intermediate

DRAFT

Procedure / Surgery	Category	
	Lengthening of tendon, including tenotomy	Intermediate
	Open biopsy of muscle	Minor
	Release of De Quervain's disease	Minor
	Release of trigger finger	Minor
	Release of tennis elbow	Minor
	Transfer / transplantation / reattachment of muscle	Major
	Tendon repair / Suture of tendon not involving hand	Intermediate
	Tendon repair / Suture of tendon of hand	Major
	Tenosynovectomy / synovectomy	Intermediate
	Transposition of tendon of wrist / hand	Major
	Secondary repair of tendon, including graft, transfer and / or prosthesis	Major
Fracture/ dislocation	Closed reduction of dislocation of temporomandibular / interphalangeal / acromioclavicular joint	Minor
	Closed reduction of dislocation of shoulder / elbow / wrist / ankle	Intermediate
	Closed reduction for Colles' fracture with percutaneous k-wire fixation	Major
	Closed reduction for fracture of arm / leg / patella / pelvis with internal fixation	Major
	Close reduction for mandibular fracture with internal fixation	Intermediate
	Closed reduction for fracture of clavicle / scapula / phalanges / patella without internal fixation	Minor
	Closed reduction for fracture of upper arm / lower arm / wrist / hand / leg / foot bone without internal fixation	Intermediate
	Closed reduction for fracture of clavicle / hand / ankle /foot with internal fixation	Intermediate
	Closed reduction for fracture of femur +/- internal fixation	Major
	Closed / open reduction of fracture of acetabulum with internal fixation	Complex
	Open reduction for mandibular fracture with internal fixation	Major
	Open reduction for clavicle / hand / foot (except carpal / talus / calcaneus) +/- internal fixation	Intermediate
	Open reduction for arm / leg / patella / scapula +/- internal fixation	Major
	Open reduction for femur / calcaneus / talus/ +/- internal fixation	Major
	Operative treatment of compound fracture with external fixator and extensive wound debridement	Intermediate
	Removal of screw, pin and plate, and other metal for old fracture except fracture femur	Minor
Spine	Artificial cervical disc replacement	Complex

DRAFT

Procedure / Surgery		Category
	Anterior spinal fusion, cervical / cervicothoracic/ C4/5 and C5/6 and locking plate	Major
	Anterior spinal fusion (excluding cervical / cervicothoracic/ C4/5 and C5/6 and locking plate)	Complex
	Anterior spinal fusion with instrumentation	Complex
	Laminoplasty for cervical spine	Major
	Laminectomy / diskectomy	Major
	Laminectomy with diskectomy	Complex
	Posterior spinal fusion, thoracic / cervico-thoracic / thoracolumbar / T5 to L1/ atlas-axis	Major
	Posterior spinal fusion, (excluding thoracic / cervico-thoracic / thoracolumbar / T5 to L1 / atlas-axis)	Complex
	Posterior spinal fusion with instrumentation	Complex
	Spinal biopsy	Minor
	Spinal fusion +/- foraminotomy +/- laminectomy +/- diskectomy	Complex
	Spine osteotomy	Complex
	Vertebroplasty / kyphoplasty	Inter
Others	Excision of ganglion / bursa	Minor
	Closed/ Percutaneous needle fasciotomy for Dupuytren disease	Minor
	Radical (or total) fasciectomy for Dupuytren disease	Major
	Release of carpal / tarsal tunnel, open or endoscopic	Intermediate
	Release of peripheral nerve	Intermediate
	Transposition of ulnar nerve	Intermediate
	Sliding / reduction genioplasty	Inter
SKIN AND BREAST		
Skin	Curettage / cryotherapy / cauterization / laser treatment of lesion of skin	Minor
	Drainage of subungual haematoma or abscess	Minor
	Excision of lipoma	Minor
	Excision of skin for graft	Minor
	Incision and /or drainage of skin abscess	Minor
	Incision and /or removal of foreign body from skin and subcutaneous tissue	Minor
	Local excision or destruction of lesion or tissue of skin and subcutaneous tissue	Minor
	Suture of wound on skin	Minor
	Surgical toilet and suturing	Minor

DRAFT

Procedure / Surgery		Category
	Wedge resection of toenail	Minor
Breast	Breast tumour/ lump excision +/- biopsy	Intermediate
	Fine needle aspiration (FNA) of breast cyst	Minor
	Incisional breast biopsy	Minor
	Modified radical mastectomy	Major
	Partial or simple mastectomy	Intermediate
	Partial or radical mastectomy with axillary lymphadenectomy	Major
	Total or radical mastectomy	Major
	Duct papilloma excision	Intermediate
	Gynaecomastia excision	Intermediate
URINARY SYSTEM		
Kidney	Extracorporeal shock wave lithotripsy for urinary stone (ESWL)	Intermediate
	Nephrolithotomy / pyelolithotomy	Major
	Nephroscopy	Major
	Percutaneous insertion of nephrostomy tube	Minor
	Renal biopsy	Minor
	Nephrectomy, open or laparoscopic or retroperitoneoscopic	Major
	Nephrectomy, partial/ lower pole	Complex
	Kidney transplant	Complex
Bladder, ureter and urethra	Cystoscopy +/- biopsy	Minor
	Cystoscopy with catheterization of ureter/ transurethral bladder clearance	Minor
	Cystoscopy with electro-cauterisation/ laser lithotripsy	Intermediate
	Excision of urethra caruncle	Minor
	Insertion of urethral/ureter stent	Intermediate
	Diverticulectomy of urinary bladder, open or laparoscopic	Major
	Transurethral resection of bladder tumour	Major
	Partial cystectomy, open or laparoscopic	Major
	Radical/ total cystectomy, open or laparoscopic	Complex
	Ureterolithotomy, open or laparoscopic or retroperitoneoscopic	Major
	Closure of urethro-rectal fistula	Major
	Repair of urethral fistula	Major
	Repair of vesicovaginal fistula	Major
	Repair of vesicocolic fistula	Major
Repair of rupture of urethra	Major	

DRAFT

Procedure / Surgery		Category
	Repair of urinary stress incontinence	Major
	Formation of ileal conduit, including ureteric implantation	Complex
	Ileal or colonic replacement of ureter	Major
	Unilateral reimplantation of ureter into bowel or bladder	Major
	Bilateral reimplantation of ureter into bowel or bladder	Major
DENTAL		
	Any kind of dental surgery due to injury caused by an accident	Minor

DRAFT

POLICY SCHEDULE

No fixed template or format of the Policy Schedule is required under VHIS. However, the Policy Schedule must include the following information -

- (a) Names of the Policy Holder and Insured;
- (b) Policy Effective Date;
- (c) Insurance coverages under the Policy (i.e. the VHIS plan and any other top-up benefits);
- (d) Premium information including the applicable Standard Premium schedule (e.g. smoker / non-smoker), Premium Loading (if any); and
- (e) Amount of premium payable and period covered.

Should there be any change to the information of (a) – (e) above in the Policy Schedule, the Company is required to issue a new Policy Schedule to the Policy Holder.

For item (c), where applicable, the Company is required to include information related to top-up benefits whether they are in Riders or Endorsements or other supplements.

For item (e), the Company is allowed to show the information on Renewal premiums in other documents (e.g. Renewal notice) instead of this Schedule. In this case, the Company is not required to issue a new Policy Schedule if the information on the Renewal premiums is set out in such other documents. However, there must be clear indications of the cross reference between this Schedule and the documents concerned.

**Code of Practice
for Insurance Companies under the Ambit
of Voluntary Health Insurance Scheme**

DRAFT

Food and Health Bureau

DRAFT

Contents

1. Introduction	1
2. Product availability for application	5
3. Migration arrangement	7
4. Sales and marketing	9
5. Application, underwriting and issuance of policies	11
6. After-sales services	13
Annex A Details of disclosure of cooling-off rights and cooling-off period	15
Annex B Glossary	17

DRAFT

1. Introduction

Status of this Code of Practice

- 1.1 This Code of Practice (“Code”) is issued by the Food and Health Bureau (“FHB”) of the Hong Kong Special Administrative Region Government in relation to the implementation of the Voluntary Health Insurance Scheme (“the Scheme” or “VHIS”) that primarily covers individual Indemnity Hospital Insurance Plans (“IHIP”).
- 1.2 This Code is non-statutory in nature. It applies to the insurance companies which are allowed to offer insurance plans to individual consumers under the ambit of VHIS (“Company” or “Companies”) according to the scheme registration system implemented by FHB.
- 1.3 The requirements set out in this Code should not supplant or conflict with any existing Laws, rules, codes or guidelines applicable to licensing of the Companies to offer IHIP. The Companies bound by or complying with this Code should concurrently comply with the existing Laws, rules, codes and guidelines applicable to licensing of the Companies to offer IHIP.

Objectives

- 1.4 This Code is intended to –
 - (a) set out the required conduct and practices to supplement the VHIS Standard Plan Policy Template (including Terms and Conditions, and Benefit Schedule);
 - (b) enhance transparency and accessibility of the VHIS market segment so as to assist consumers to make proper comparison between VHIS-compliant Plans certified by FHB (“Certified Plans”) and exercise informed choice;
 - (c) ensure fair treatment to customers;
 - (d) facilitate compliance with the minimum requirements of VHIS; and
 - (e) facilitate claim for tax deductions for the premium paid by policy holders for Certified Plans.

Principles

- 1.5 The above objectives are to be achieved having regard to –
 - (a) the policy objectives of VHIS – to enhance the accessibility, continuity, quality and transparency of individual IHIP for better consumer protection, with a view to encouraging more people to make use of private inpatient services and day case procedures, thereby alleviating pressure on the public healthcare system and enhancing the long-term sustainability of Hong Kong’s healthcare system as a whole;
 - (b) the need to observe the principles of fair trade and fair competition; and
 - (c) the need to strike a reasonable balance among consumer protection, consumer choice, commercial viability, and market flexibility.

Application

- 1.6 This Code applies to all Certified Plans.
- 1.7 Where a Company is no longer registered as a VHIS provider but continues to renew the existing policies of Certified Plans, the business conduct and practices related to these policies should

DRAFT

continue to be subject to this Code as a prerequisite for these plans to continue to be certified by FHB as VHIS-compliant.

Scope

- 1.8 The conduct and practices required by this Code relate to the following business aspects –
- (a) Product availability for application;
 - (b) Migration arrangement;
 - (c) Sales and marketing;
 - (d) Application, underwriting and issuance of policies; and
 - (e) After-sales services.

Reference

- 1.9 This Code is to be read in conjunction with the Standard Plan Policy Template of VHIS (including Terms and Conditions, and Benefit Schedule), both of which would be binding on Companies offering Certified Plans.
- 1.10 Companies applying to join the VHIS will first have to observe the registration rules for insurance companies joining VHIS (including the detailed arrangements on product compliance), promulgated separately by FHB.
- 1.11 FHB may be publishing other information on the VHIS to clarify or elaborate on certain parts of the Code (say, in the form of Frequently Asked Questions). Such information will not form part of the Code.

Relevant regulations and guidelines

- 1.12 Where appropriate, this Code should be read in conjunction with other relevant Laws, rules, codes and guidelines issued by the relevant regulatory authorities and industry bodies, including but not necessarily limited to –
- (a) Laws of Hong Kong, e.g.
 - (i) Insurance Ordinance (Cap. 41);
 - (ii) Personal Data (Privacy) Ordinance (Cap. 486); and
 - (iii) Competition Ordinance (Cap. 619)
 - (b) Guidelines issued by the Insurance Authority (“IA”), e.g.
 - (i) Guideline on the Use of Internet for Insurance Activities (GL 8);
 - (ii) Guideline on the Corporate Governance of Authorised Insurers (GL 10);
 - (iii) Guideline on Underwriting Long Term Insurance Business (other than Class C Business) (GL 16); and
 - (iv) Guideline on Minimum Requirements for Insurance Brokers
 - (c) Codes and Guidelines issued by The Hong Kong Federation of Insurers (“HKFI”), e.g.
 - (i) The Code of Conduct for Insurers;
 - (ii) The Code of Practice for the Administration of Insurance Agents;

DRAFT

- (iii) Cooling-off Period; and
- (iv) Direct Marketing, e.g. circular on “Recent convictions under the direct marketing regime” issued on 12 October 2015
- (d) Codes and Guidelines issued by Office of the Privacy Commissioner for Personal Data, e.g.
 - (i) New Guidance on Direct Marketing.

1.13 The Companies bound by this Code should continue to comply with the applicable Laws, rules, codes and guidelines.

Consequence of non-compliance

1.14 Non-compliance of this Code may result in action taken by FHB according to the registration rules for insurance companies joining VHIS, such as suspension or deregistration from the Scheme and reprimand.

Review

1.15 This Code is subject to review and revision from time to time, in consultation with relevant stakeholders, to maintain consistency with insurance market developments and other existing Laws, rules, codes and guidelines. This edition is effective from [date of VHIS implementation].

Interpretation in both official languages

1.16 FHB should have the power to determine the meaning of this Code in both English and Chinese versions and to resolve inconsistencies, if any, between the two versions of this Code. Any determination made by FHB should be conclusive.

Role and responsibility of FHB

1.17 The VHIS Office of FHB [to be established] is responsible for administering the VHIS and handling enquiries and complaints related to compliance of the VHIS, enforcing VHIS-specific provisions under the Code and making referrals to other regulatory agents including IA as necessary.

1.18 FHB reserves the final right of interpretation of this Code and the right to grant partial exemption from compliance with this Code.

1.19 For greater transparency and accountability, FHB reserves the right to disclose in public and report to the Legislative Council updates as necessary on the implementation status of the VHIS and this Code.

Role of IA

1.20 In accordance with the Insurance Ordinance (Cap. 41), IA is responsible for regulating and supervising the insurance industry for the promotion of the general stability of the insurance industry and for the protection of existing and potential policy holders. One of its major functions is to promote and encourage the adoption of proper standards of conduct and prudent business practices by authorised insurers.

1.21 Complaints that may amount to suspected “misconduct” of insurers as defined under section 41P of the Insurance Ordinance (Cap. 41) may be referred to IA.

DRAFT

- 1.22 IA may also provide guidance to the insurance industry on businesses relating to individual IHIP (whether they are Certified Plans or otherwise).

Enquiries

- 1.23 This Code can be viewed or downloaded from the website of VHIS. Enquiries about this Code can be addressed to the VHIS Office of FHB. Its current address, email address and telephone number are as follows –

[Address, Email Address and Telephone Number of the VHIS Office of FHB to be inserted]

2. Product availability for application

Principles

- 2.1 The Standard Plan should be widely available for application.
- 2.2 Availability of Flexi Plans should hinge on market initiatives. Proper flexibility is allowed to promote product development, competition and choices.

Requirements

Availability of Certified Plans for new applications

- 2.3 As long as a Company is registered as a VHIS provider, it is required to make available at least the Standard Plan duly certified by FHB for application. In respect of the Standard Plan policies issued, the Company would be bound to continue to comply with this Code and the policy terms and conditions of the Standard Plan **even if** it ceases to be registered as a VHIS provider.
- 2.4 A Company may opt to offer Flexi Plan(s). But once it has offered a Flexi Plan, then in respect of the Flexi Plan policies issued, the Company would be bound to continue to comply with this Code and the policy terms and conditions of the Flexi Plan **even if** the Company ceases to be registered as a VHIS provider or decides to cease to offer that Flexi Plan to new policy holders.

New applications

- 2.5 The Companies offering Certified Plans are required to consider applications in relation to persons to be insured who are –
 - (a) Hong Kong residents¹; and
 - (b) aged between 15 days and 80 years².
- 2.6 All applications are subject to underwriting. The Companies are allowed to impose Premium Loading and/or Case-based Exclusion(s) when accepting an application, reject an application, or postpone handling of an application due to missing information.

Plans for renewal

- 2.7 For the existing policy holders who have signed up for IHIP before the implementation of the VHIS, the Company concerned should offer them a Standard Plan or Flexi Plan option. (See Migration section)
- 2.8 For policy holders who have signed up to the existing Standard Plan policies, the Company concerned should offer the Standard Plan for renewal, but is allowed to offer Flexi Plans as an additional option(s) for renewal.
- 2.9 For policy holders who have signed up to Flexi Plan policies, the Company concerned should offer the Standard Plan as the fall-back renewal option if a policy holder refuses to accept the Flexi Plan offered for renewal.

¹ Including holders of Hong Kong Identity Card, and children who are Hong Kong residents and under the age of 11.

² This requirement may be exempted for the Certified Plans of which the product design is targeted at particular age groups, such as people in younger ages.

DRAFT

Top-up coverage

- 2.10 The Companies are allowed to offer top-up coverage for the Standard Plan. The Companies should provide an option for the applicants not to purchase the top-up coverage irrespective of whether such coverage is offered for free or not.
- 2.11 The requirement in paragraph 2.10 does not apply where the Company is legally required to provide top-up coverage of such nature in issuing an IHIP policy for individuals.
- 2.12 The requirement in paragraph 2.10 does not apply to Flexi Plans.

3. Migration arrangement

Principles

- 3.1 Policy holders who have signed up for IHIP before the implementation of the VHIS (“existing IHIP policy holders” in short) will be entitled to a **one-off** migration facilitation by the relevant Company concerned. The Company commits to offering each such existing IHIP policy holder a **VHIS-compliant option as soon as possible** after the Company has registered as a VHIS provider. This commitment will be open for **ten years** after the implementation of VHIS (i.e. after registration of VHIS is officially commenced).
- 3.2 The migration arrangement(s) should be transparent and fair to the existing IHIP policy holders.
- 3.3 The Companies are under no obligation to offer migration facilitation to policy holders other than the existing IHIP policy holders, estimated to be around 2.3 million in numbers in 2016³.

Requirements

- 3.4 The Companies should provide the following migration arrangements to their existing IHIP policy holders –

(a) Same plan with VHIS features incorporated, without re-underwriting

- (i) under this arrangement, existing IHIP policy holder will be offered the same plan with the incorporation of VHIS features for renewal. **No re-underwriting** is allowed⁴. In other words, while the Standard Premium of the plan may be adjusted by the Company, such other premium adjustment cannot be based on the health condition of the individual insured;
- (ii) the Company is required to offer **all** existing IHIP policy holders **belonging to the same Portfolio**⁵ the same Certified Plan for renewal. This migration principle of offering same Certified Plan for a group on a Portfolio basis is designed to avoid unfair practices upon renewal;
- (iii) if the plan offered is a Flexi Plan, the Company is required to allow the policy holders, who decline the offer, to renew their policies into the Standard Plan policies; and
- (iv) the waiting period for coverage of unknown pre-existing conditions under the policy terms and conditions of the plan is counted from the inception date of the existing IHIP policy;

and / or

(b) Different plan with VHIS features incorporated, subject to re-underwriting

- (i) under this arrangement, existing IHIP policy holder will be offered a different plan incorporating VHIS features. If policy holders opt to switch to the new Certified Plan, the existing IHIP policies will not be renewed. **Re-underwriting is allowed**;

³ The corresponding number of insured persons is about 2 million in 2016, with the difference from 2.3 million being due to the fact that some people hold more than one policy.

⁴ Except in cases where the existing policy provisions do not provide renewal guarantee.

⁵ See Glossary for definition of Portfolio.

DRAFT

- (ii) the Company is required to offer **all** existing IHIP policy holders **belonging to the same Portfolio** the same new Certified Plan. This migration principle of offering same Certified Plan for a group on a Portfolio basis is designed to avoid unfair practices upon the switching to the new Certified Plan;
 - (iii) the Company is required to allow policy holders to **opt** to stay insured with the existing IHIP policies according to the existing policy provisions;
 - (iv) if the Company rejects an application after re-underwriting or the policy holder concerned refuses to accept the application result and underwriting decision, the Company is required to allow the policy holder to stay insured with the existing policies according to the existing policy provisions;
 - (v) the waiting period for coverage of unknown pre-existing conditions under the policy terms and conditions of the plan is counted from the inception date of the new policy, or an earlier date offered by the Company; and
 - (vi) in any case, the Companies are required to offer at least the Standard Plan for all existing IHIP policy holders.
- 3.5 There is no restriction on the number of designated Certified Plans to be offered to the same Portfolio.
- 3.6 The cooling-off period in this Code applies to the arrangement in 3.4(b).
- 3.7 The Companies should make known to their existing individual IHIP policy holders of the availability of migration arrangement(s) and the associated underwriting arrangement through at least one accessible means, such as company website, email notification and letter of notification.
- 3.8 The Companies should provide convenient channel(s) and trained staff to handle enquiries from the existing IHIP policy holders about the migration arrangement(s) available to them.

4. Sales and marketing

Principle

- 4.1 Clear, accurate and non-misleading information about VHIS and Certified Plans should be provided and easily accessible so that consumers can make informed choices.

Requirements

Accuracy of information

- 4.2 The Companies should ensure that all sales and marketing materials, including company website, social media, advertisement, leaflets and other printed and online materials, provide information about VHIS and the Certified Plans in a clear, accurate and non-misleading manner, and in bilingual and plain language. In case complete information cannot be readily available due to space constraints, the Companies should make available access to complete information (e.g. printing of website address for complete information on advertisement or leaflets).

Access to information

- 4.3 In the course of marketing Certified Plans, the Companies and their sales representatives should exercise due diligence in explaining the key product and premium information of Certified Plans to the customers.
- 4.4 The Companies should provide easy access to essential information, such that customers can enquire about the Companies' registration status, product and premium information of Certified Plans on offer, underwriting factors and material facts and information of customers for underwriting purpose, eligibility for tax deduction, complaint handling procedures, etc. Examples include company website, communication with sales representatives and service representatives, and telephone hotline to handle enquiry.

Company participation in the Scheme

- 4.5 Upon registration with VHIS, the Companies should make their registration status known to customers at least through the company website.
- 4.6 Upon deregistration with VHIS, the Companies should immediately make this change known to customers at least through the company website.

Product information

- 4.7 The Companies should make known to customers an up-to-date list of Certified Plans that they offer at least through the company website.
- 4.8 For each Certified Plan, the Companies should disclose the following product information –
- (a) whether the plan is a Standard Plan or Flexi Plan;
 - (b) certification number issued by FHB;
 - (c) enhanced and exempted features vis-à-vis the Standard Plan in the case of a Flexi Plan;
 - (d) policy terms and conditions, including general exclusions, waiting period for unknown Pre-existing Conditions; and
 - (e) benefit schedule, including meaning of benefit items and limitation rules.

DRAFT

Premium information

- 4.9 For each Certified Plan, the Companies should provide the following premium information –
- (a) Standard Premium Schedule by age, gender and other factors (e.g. smoking habit) at least through the company website;
 - (b) definition of age for age-banded premium (last birthday, next birthday or nearest birthday); and
 - (c) where premium discount e.g. no-claim discount is available, how the discount operates in broad terms.

Disclosure obligation for underwriting

- 4.10 The Companies should inform customers of their obligation to disclose personal information and material facts for underwriting, and the possible consequences of material non-disclosure, misrepresentation and fraud.
- 4.11 Where Companies stipulate in the Standard Policy Terms and Conditions that the Companies may withhold part of premium refund for reasonable administration charges, the Companies should explain the relevant practices and calculation to the customer upfront.

Cooling-off arrangements

- 4.12 The Companies should inform customers that under the Standard Policy Terms and Conditions for the Certified Plans, the policy holder has the right of cancelling the policy with full refund of paid premium during the cooling-off period.
- 4.13 The cooling-off period lasts for 21 days (or longer if offered by the Companies) after the delivery of the policy or issuance of a notice to the policy holder or the policy holder's representative stating that the policy is available and when the cooling-off period would expire, whichever is the earlier.

Choice of healthcare providers

- 4.14 VHIS requires that there must be no restriction of healthcare providers for benefits covered in the Standard Plan and the basic protection in Flexi Plans that measures up to the Standard Plan coverage. In other words, the policy holders of Certified Plans should have free choice of healthcare providers as far as basic protection is concerned. The Companies should make the above known to the customers in the selling process and upon enquiry.
- 4.15 Where better benefits such as full cover are offered upon the use of selected healthcare providers, the Companies should inform the customers of their rights stated in paragraph 4.14 in the selling process and upon enquiry.

Eligibility for tax deduction

- 4.16 Subject to the rules on tax deduction to be promulgated by the Government, the Companies should inform the customers of eligibility of the Certified Plans for claiming tax deduction in the selling process and upon enquiry.

5. Application, underwriting and issuance of policies

Principles

- 5.1 The Companies should inform or make known to the applicants of their rights and obligations in the application and disclosure of personal information in accordance with the Standard Policy Terms and Conditions of VHIS, and the reasons for the underwriting decision and application result.
- 5.2 The underwriting process and practice that Companies adopt should be fair, objective, and consistently applied when assessing applicants with similar risk.

Requirements

Collection and use of information

- 5.3 In designing the application form and underwriting questions, the Companies should ensure that –
- (a) the type and amount of personal information obtained from applicants for the insured are relevant and sufficient for application processing and underwriting;
 - (b) the application form is clear and succinct such that it can be easily understood by an average applicant (e.g. use of plain/jargon-free language, legible fine prints);
 - (c) the questions are specific, relevant and easy to respond to such that all material facts essential to underwriting can be effectively collected (e.g. how questions should be answered are explained with illustrations);
 - (d) the inquired facts are within a well-defined period;
 - (e) the inquired medical history is well defined with respect to hospital admission, diagnoses, or signs and symptoms, etc.; and
 - (f) important information is prominently displayed and highlighted as appropriate to draw the attention of the applicants (e.g. disclosure of health conditions to the best knowledge of the applicant, and possible consequences of non-disclosure).

Disclosure of cooling-off rights on application form

- 5.4 The Companies should announce cooling-off rights on the application form by prominently displaying a statement (see Annex A) immediately above the space for the signature and where applicable clearly explained to the applicant holder by the insurance intermediary.
- 5.5 The size of the printing for the above statement should be in bold type no smaller than the main font type used on the application form and the print size used for other declarations on the form. Furthermore, the font size should not be smaller than eight.
- 5.6 The statement should be communicated in the same language(s) as are used for all other sections of the application form.

Due process in underwriting

- 5.7 Upon the receipt of personal information of the insured at the time of application that is material to underwriting, the Companies should assess the risks according to its underwriting practice which should be fair, objective and consistently applied to assess applicants with similar risk.

DRAFT

- 5.8 The Companies should make known to the applicants the health and non-health factors in general terms that may affect its underwriting decision. Where the underwriting involves risk assessment associated with occupation grouping and Place(s) of Residence, the Companies should make known to the applicants the classification involved and implications to the underwriting decision, including the rate of Premium Loading if applicable.
- 5.9 Where the underwriting decision involves imposition of Case-based Exclusion(s), the Companies should ensure that the scope of exclusion is clearly defined and specific to the underwritten information. The Companies should apply Case-based Exclusion on a particular health condition instead of the whole body part or signs and symptoms where possible.
- 5.10 The Companies are allowed not to disclose information about their underwriting practices that are proprietary and sensitive.

Notification and explanation of application results

- 5.11 The Companies should inform the applicants of the application results within a reasonable time upon the completion of underwriting. In the event that additional time is required for handling applications, the Companies should notify the applicants the delay of application results and, where necessary, the additional information required for processing the applications.
- 5.12 The Companies should explain to the applicants the application results based on the underwriting decisions and, upon applicants' request, provide written notice for such explanation. In the event that the reported health conditions lead to Premium Loading and/or Case-based Exclusion or rejection, the Companies should notify the applicants –
- (a) the rationale of applying Premium Loading and/or Case-based Exclusion, or rejection;
 - (b) details of the Premium Loading and/or Case-based Exclusion being applied (e.g. amount of loading attributable to different factors, health conditions resulting in such exclusion, extent of health condition/body part being excluded, possible complications that may be excluded from coverage, and whether exclusion is temporary or permanent); and
 - (c) risk class information and the applicable Premium Loading for smoking habit, occupation and Place(s) of Residence if such factors are considered at time of underwriting.
- 5.13 The Companies should provide further information and appropriate channel(s) for more detailed enquiry about and appeal against the application results or underwriting decisions upon request.

Issuance of policies and notification of cooling-off rights

- 5.14 The Companies should ensure the policies are delivered to the applicants within a reasonable period of time upon the acceptance with first premium paid by the applicants.
- 5.15 The Companies should ensure the cooling-off rights of policy holders of Certified Plans are highlighted when the policies are delivered. The cooling-off period gives purchasers of VHIS policies a chance to re-think within a reasonable period of time their decision to purchase a Certified Plan, and obtain a full refund of premium paid if no benefit payment has been made, is to be made or impending. The cooling-off period is applicable to all Certified Plans⁶.
- 5.16 Details of cooling-off period are at Annex A.

⁶ Except those offered for renewal, including renewals under the migration arrangement.

6. After-sales services

Principle

- 6.1 The Companies should provide effective after-sales services to assist their customers to understand their rights under the Certified Plans, and handle complaints unique to Certified Plans.

Budget certainty and claimable amount estimate

- 6.2 Upon receipt from policy holders the estimated charges provided for non-emergency operations/procedures to be performed⁷, the Companies should provide to the policy holders upfront claimable amount estimates for the whole course of operations/procedures with reference to the insurance coverage (subject to Case-based Exclusions).
- 6.3 The Companies should inform policy holders that claimable amount estimates remain estimates and do not constitute a liability. Claim decision should depend on the submission of all supporting documents as required for claim assessment in accordance with the policy terms and conditions and benefit entitlement in the policy year. The final claimable amounts and out-of-pocket expenses will be subject to the actual bill amounts and breakdowns as stated in the invoices/receipts issued by healthcare service providers.
- 6.4 If there is an option of higher benefits upon the use of selected healthcare providers, the Companies should inform the policy holders when providing the claimable amount estimates that the claimable amounts may be subject to change if the policy holders use other healthcare providers. For the avoidance of doubt, policy holders are always allowed to have a free choice of healthcare providers for benefits covered in Standard Plan and the basic protection in Flexi Plans that measure up to the Standard Plan coverage.

Facilitating claim for tax deduction

- 6.5 The Companies should provide proof of premium payment to assist policy holders to claim tax deduction for Certified Plans. The proof must show clearly the amount of premium eligible for tax deduction and the necessary remarks explaining the ineligible part of the premium paid⁸, which may be in the form of premium receipt or annual premium statement. In any case, the proof has to be issued to the policy holders before end-April for the premium paid during the 12 months ended March of the same year.

Handling of enquiries and complaints about VHIS

- 6.6 The Companies should have in place internal procedures and provide easily accessible channel(s) with trained staff to handle enquiries and complaints about VHIS and Certified Plans from customers.
- 6.7 The Companies should make known to customers the availability of the following channels for making enquiries and lodging complaints –
- (a) VHIS Office of FHB – for issues specific to VHIS including product availability, features

⁷ Under the Private Healthcare Facilities Bill being scrutinised by the Legislative Council, a private hospital must put in place a budget estimate system to provide estimates of the fees and charges for the treatments and procedures specified by the Director of Health.

⁸ In the case where part of the premium of the policy (which may include for example, life coverage, hospital cash) is not IHIP-related.

DRAFT

of Certified Plans and compliance of this Code; and

(b) IA – for issues concerning the general conduct of insurance companies and intermediaries.

6.8 The Companies should also make known to the customers the availability of alternative dispute resolution means, including but not limited to mediation and adjudication through the Insurance Complaints Bureau, and other means of mediation and arbitration as mutually agreed between policy holders and the Companies, before a dispute is referred to a Hong Kong court.

Details of disclosure of cooling-off rights and cooling-off period

1. The statement on the application form is as follows –

Cancellation Rights and Refund of Premium(s)

I understand that I have the right to cancel and obtain a refund of any premium(s) paid by giving written notice. Such notice must be signed by me and received directly by [Address of the Company's Hong Kong Main Office] within [21 days, or longer if offered by the Company] after the delivery of the policy or issuance of a notice to the policy holder or the policy holder's representative, whichever is the earlier.

2. Details of cooling-off period are as follows –

- (a) the cooling-off period is 21 days [or longer if offered by the Company] after the delivery of the policy or issuance of a notice to the policy holder or the policy holder's representative, whichever is the earlier;
- (b) the notice should inform the policy holder of the availability of the policy and the expiry date of the cooling-off period. The notice should remind the policy holder that he/she has the right to re-think his/her decision to purchase the Certified Plan and to obtain a refund of premium paid if the policy is cancelled within the cooling-off period. The notice should also remind the policy holder to contact the Customer Service Department of the Company directly [service hotline number should be provided] if he/she does not receive the policy contract within nine days from the issuance date of the notice;
- (c) the Companies should keep a copy of the notice or acknowledgement of receipt of policy delivery. In case of a reasonable complaint or dispute, the Companies will be required to produce evidence to show that the policy notice or policy has been delivered;
- (d) the Companies are advised to –
 - (i) specify in their intermediaries' training materials and internal guidelines that insurance intermediaries must –
 - inform prospective policy holders of their cooling-off rights and the expiry date of the cooling-off period when policy holders sign their policy application forms; and
 - make all reasonable endeavour to deliver policies to the policy holders within a period of time consistent with (b) above and (d)(ii) below after the policies are issued if they are vested with the obligation to deliver policies on behalf of the Companies;
 - (ii) devise internal control measures which will ensure and prove that –
 - policies are delivered no later than nine days after the policy issuance date; or
 - a notice to inform policy holders of the availability of the policies and the expiry date of the cooling-off period is issued no later than nine days from the policy issuance date; and
 - (iii) maintain records in respect of complaints or disputes for cases where policy holders seek refunds outside the period defined in (a) above but are refused by the Companies and to provide these records to the FHB upon request.

3. The following statement must be included in a letter from the Companies mailed direct to the policy holders, or a statement on the policy jacket or policy cover (either printed or by way of label) to remind the policy holders of their cooling-off rights at time of issuing policy –

DRAFT

Your Right to Change Your Mind

<p>If you are not fully satisfied with this policy, you have the right to change your mind.</p>

We trust that this policy will satisfy your financial needs. However, if you are not completely satisfied then you should –

- return the policy; and
- attach a letter, signed by you, requesting cancellation.

The policy will then be cancelled and the premium(s) paid will be refunded.

These cancellation rights have the following conditions –

- your request to cancel must be signed by you and received directly by our [Address of the Company's Hong Kong Main Office] within [21 days, or longer if offered by the Company] after the delivery of the policy or issuance of a notice to the policy holder or the policy holder's representative, whichever is the earlier; and
- no refund can be made if a claim payment has been made.

Should you have any further queries you may contact [a responsible staff of the Company] and we will be happy to explain your cancellation rights further.

4. The size of the printing for the above statement should not be smaller than ten.
5. The statement should be communicated in the same language(s) as are used for all other communication at the time of policy issuance.

Glossary
[prepared for the purpose of this Code]

Case-based Exclusion

The exclusion of a particular sickness or disease from the benefit provisions of the insurance contract that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the insured.

Flexi Plan

An insurance plan with enhancement(s) of indemnity hospital insurance nature to any or all of the protections or terms that the Standard Plan provides to the policy holder and/or insured and with certification by the Food and Health Bureau, save for allowable exemptions as stipulated in the detailed arrangements on product compliance to be promulgated separately by Food and Health Bureau.

Indemnity Hospital Insurance Plan

An insurance plan with classification of contract of insurance falling within Class 2 (sickness) of Part 3 of the First Schedule to the Insurance Ordinance (Cap. 41) (or simply Class 2) which provides for benefits in the nature of indemnity against risk of loss to the insured attributable to sickness or infirmity that requires hospitalisation. An individual policy of an Indemnity Hospital Insurance Plan may be issued to an individual as a standalone Class 2 policy or as an additional cover combined with, hence, forming part of a contract of long-term business (e.g. a medical insurance rider attached to and forming part of a life insurance policy).

Migration

The process for existing individual Indemnity Hospital Insurance Plan policy holders to transfer their plans to Certified Plans voluntarily.

Place(s) of Residence

The jurisdiction(s) in which a person legally has the right of abode. A change in the Place(s) of Residence of a person refers to the situation where a person has been granted the right of abode of additional jurisdiction(s), or has ceased to have the right of abode of existing jurisdiction(s). For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, should not be treated as a Place of Residence.

Portfolio

All policies under a Portfolio are of the same terms and conditions and benefit schedule. As an illustrative example, if an existing Indemnity Hospital Insurance Plan has three levels of coverage, namely “General ward”, “Semi-private” and “Private”, and each with an optional supplementary major medical (“SMM”) rider, there will be six Portfolios as shown below –

- (a) Portfolio one – “General ward”;
- (b) Portfolio two – “Semi-private”;
- (c) Portfolio three – “Private”;
- (d) Portfolio four – “General ward + SMM”;
- (e) Portfolio five – “Semi-private + SMM”; and
- (f) Portfolio six – “Private + SMM”.

DRAFT

Pre-existing Condition

Any sickness, disease, injury, physical, mental or medical condition or physiological degradation, including congenital condition, that has existed prior to the policy effective date in respect of the insured. An ordinary prudent person should be reasonably aware of a Pre-existing Condition, when –

- (a) it has been diagnosed; or
- (b) it has manifested clear and distinct signs or symptoms; or
- (c) medical advice or treatment has been sought, recommended or received.

Premium Loading

Additional premium on top of the Standard Premium charged by the Company to the policy holder according to the additional risk assessed for the insured.

The level of Premium Loading is correlated to the risk class determined through underwriting. One common form of Premium Loading is in a percentage of Standard Premium.

Standard Plan

The insurance plan with terms and benefits equivalent to the minimum compliant product requirements of VHIS, which are from time to time published and subject to regular review by the Government.

Standard Plan Policy Template

The policy template that includes the Standard Policy Terms and Conditions, and the benefit schedule of Standard Plan.

Standard Policy Terms and Conditions

The policy terms and conditions of Standard Plan.

Standard Premium

The basic premium charged by the Company to the policy holder on an overall Portfolio basis, which may be adjusted in accordance with the age, gender and/or lifestyle factors of the insured.

Standard Premiums also vary from one product to another and from one Company to another, depending on the cost factors and pricing strategy.

Underwriting / Re-underwriting

In the context of health insurance, the process by which a Company evaluates the risk of an applicant. The underwriting result helps the Company decide whether to accept the application, and whether to introduce Premium Loading and/or Case-based Exclusion in the insurance policy to manage risk.

Re-underwriting refers to the re-evaluation by a Company of the risk of an individual after he/she is insured with a policy.

Certified Plans

Individual Indemnity Hospital Insurance Plans certified under the Scheme as VHIS-compliant, including the Standard Plan and Flexi Plans.

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Waiting period for unknown Pre-existing Conditions

A period after issuance of a VHIS policy during which the policy holder is not eligible for, partially or fully, benefit coverage of Pre-existing Conditions that the policy holder is not aware and would not reasonably have been aware of. For the Standard Plan, the waiting period is set at three years, with reimbursement ratio at 0%, 25% and 50% for the first three years respectively. A shorter waiting period or higher reimbursement ratio is allowed for Flexi Plans.