Policy Terms and Conditions

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SECTION A: CORPORATE POLICYHOLDER SPECIFIC TERMS

1. OUR CONTRACT WITH THE POLICYHOLDER

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

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

1.3. The policyholder shall inform all insured persons of all the terms relevant to them.

2. WHO IS COVERED?

2.1. Persons whose names appear on the namelist.

2.2. The policyholder warrants that it shall maintain cover for all eligible employees and dependants throughout the policy year. The staff categories and eligibility terms are specified in the application form and/or the policy endorsement.

2.3. The maximum permitted age at the date of joining this policy is 65 years old.

2.4. Coverage for dependents begins on the same date as the insured employee or upon meeting the eligibility requirements for coverage, whichever is later.

2.5. We reserve the right to refuse enrolment or request additional information before coverage takes effect.

3. PERIOD OF COVER AND RENEWAL

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

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

3.3. Addition of Eligible Employees during the period of insurance: The policyholder must notify us to add an eligible employee to the policy within thirty (30) days from the employee's eligibility start date (i.e., the employment commencement date). If we are not notified within this window, the effective date of coverage will be no earlier than the date of written notification received by us, subject to policy terms and conditions and acceptance by us.

3.4. Addition of Eligible Dependents during the period of insurance: The policyholder must notify us to add eligible dependents either at the same time as the employee or within twenty-eight (28) days from the dependent's eligibility start date (i.e., the date of marriage for a spouse or the date of birth for a child). Coverage for these dependents will commence from the date of marriage or the date of birth. If we are not notified within this window, the effective date of coverage will be no earlier than the date of written notification received by us, subject to policy terms and conditions and acceptance by us.

3.5. The policyholder must notify us within thirty (30) days of any changes that need to be made to the list of covered members, such as the removal of an employee who has left the company, change of staff category, changes to an employee's dependents, etc.

4. CANCELLATION

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

4.2. Subject to section A - article 2.2, eligible employees and dependants may be deleted mid-term as per our usual underwriting practice.

5. PREMIUM PAYMENT AND GRACE PERIOD

5.1. We must receive the premium on or before the Due Date stated on the policy and/or the Debit Note. All payments must adhere to the terms of the policy and be in accordance with Hong Kong law.

5.2. For the first premium payment of each policy year:

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

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

5.3 For mid-term premium payments:

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

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

5.3.3 If the premium remains unpaid for a further 30 days after the effective date of such notice, the policy will lapse. This is in addition to and not in lieu of our other rights or remedies under this policy.

5.4. If any of the premium payments are unpaid, we reserve the right to recover any claims already paid as per section A - Paragraph 9.

6. OWNERSHIP

6.1. Unless an endorsement states otherwise, we shall treat the policyholder as the absolute owner of this policy and we are not bound to recognise any other claim to, or interest in, this policy.

7. IN THE EVENT OF FRAUD OR NONDISCLOSURE

7.1. We may cancel the policy from its inception and retain the premium, if the policyholder provided false information to us, or failed to disclose information to us, in connection with the application, or any application for addition of an insured person, upgrade, or reinstatement, and the misrepresentation or nondisclosure was fraudulent.

7.2 If this policy is cancelled due to the event of fraud or nondisclosure after claims have been paid, or after we have provided a guarantee of payment to a provider of services, we reserve the right to cancel any amounts paid or guaranteed or claim the payment back from the policyholder according to section A – article 9.1. The outcomes described above are in addition to, and not in the place of, other rights we may have including those based on the contract, statute, or common law. We will not be bound to pay any claim (in whole or part) where the policyholder or the insured person misrepresented facts in connection with that claim or related claims. Nondisclosure by an individual scheme member will not affect any other member's entitlement to receive benefits from the scheme, however, misrepresentations by the employer or other group scheme policyholder could affect coverage for the individual members.

8. MATERIAL CHANGES

8.1. The policyholder must disclose all material facts, including changes in employment status or duties, or changes in the country of residence of any insured person. Any change in the country of residence must be submitted to us for review and approval. We may, at our discretion, decline to continue coverage and terminate the policy if we consider the change to be material. In such cases, no refund of the premium will be given.

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

9. RIGHT OF RECOVERY

9.1. If we pay, guarantee, or authorise payment of expenses, or if an insured person obtains treatment through our direct billing network, and we later determine that the insured person was not entitled to that payment for any reason, we reserve the right to claim the payment back from the insured person and ultimately from the policyholder.

9.2. If the policyholder has not paid the premiums as per section A - Paragraph 5, we may deduct amounts from any claims or any sum then due or which at anytime thereafter may become due under this policy, until the said outstanding have been fully satisfied. Exercise by us of our rights here shall be without prejudice to any other rights or remedies available to us under this policy, or otherwise howsoever, at law or in equity.

10. GOVERNING LAW AND JURISDICTION

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

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

11. SANCTIONS AND COMPLIANCE WITH LAWS

11.1 We reserve the right not to accept applications for cover or to cease providing cover if, in our opinion, doing so would expose us to the risk of breaching any applicable laws or regulations, including international economic sanctions, laws, or regulations.

11.2 For the avoidance of doubt, we shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit under this policy to the extent that the provision of such cover, payment of such claim, or provision of such benefit would expose us to any sanction, prohibition, or restriction under United Nations resolutions or the trade or economic sanctions, laws, or regulations of the European Union ("EU"), United Kingdom ("UK"), United States of America ("USA"), France ("FR"), or any jurisdiction applicable to us.

12. ARBITRATION AND TIME LIMITS

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

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

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

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

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

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

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

SECTION B : TERMS AND CONDITIONS FOR INSURED PERSONS UNDER A CORPORATE SCHEME

1. OUR CONTRACT WITH THE POLICYHOLDER

1.1. The following terms and conditions are part of a corporate policy issued to your employer (hereinafter referred to as the 'policyholder'). The policy includes a cover page, a namelist, the benefits schedule, and any endorsement(s). It also includes an application form and individuals' application in case of a full medical underwriting policy. It is the duty of the policyholder to inform you of all the terms that are relevant to you.

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

2. WHO IS COVERED

2.1. This policy covers the eligible employees of the policyholder and their dependents (if dependents are eligible as agreed separately between us and the policyholder). The last entry age for employees and spouses is 65 years old. You will remain covered as long as you remain employed by the policyholder or are an eligible dependent of an employee.

3. CO-INSURANCE AND DEDUCTIBLES

3.1. All expenses will be paid in excess of any deductible that applies and after we have applied any co-insurance percentage, also known as co-payment percentage.

4. WHERE ARE YOU COVERED?

4.1. This policy covers services rendered within the area of cover stated in the benefits schedule.

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

4.2.1. commenced or continued against the orders or advice of any physician; or

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

5. WAITING PERIODS

5.1. Unless waived by a "Medical History Disregarded" endorsement, cover for the following benefits and disabilities will commence after an insured person has been continuously covered under the policy and any renewal thereof for the following time periods in respect of an insured person:

5.1.1. Maternity Benefits: 366 days prior to the date of service;

5.1.2. Major dental treatment: 300 days prior to the date of service; and

5.1.3. HIV/AIDS: coverage will apply only if signs or symptoms are present for the first time after three years continuous coverage under the plan and any renewal thereof.

5.2. If you have changed the cover for an insured person after the start of the first period of insurance, the benefits for any disability or service subject to a waiting period will be those shown on the benefits schedule for that disability or service on the first day of the waiting period, or those shown on the current benefits schedule, whichever is less.

6. NEWBORN ADDITIONS

6.1. A newborn infant born to a the mother who has been covered under the policy for more than 366 days may be added to the policy from birth without medical underwriting provided that the newborn infant was not born following major assisted conception.

6.1.1. You must notify us by submitting the Newborn Additions Form within 28 days of birth of the newborn infant so that we can add the child to the policy. The premium for the newborn infant must be paid by the policyholder.

6.1.2. Your child's cover will match the cover provided to the mother of the child. Cover for neonatal disabilities will be limited to the neonatal disabilities limit shown on the benefits schedule.

6.2. A child not meeting the criteria under section B – article 6.1 must be added by Medical Questionnaire, including any child:

6.2.1. whose mother has not been covered under the policy for 366 consecutive days;

6.2.2. for whom a Newborn Additions Form was not received by us within 28 days following birth;

6.2.3. who was adopted or was carried by a surrogate; or

6.2.4. who was born through major assisted conception.

6.3. Our underwriting process will apply to an addition under section B - article 6.2, and we may decline to provide cover or may offer cover at terms we require. The cover must be equal to the cover provided to the mother (or the father if the mother is not covered under this policy).. The start date of coverage for the child will be the date on which the underwriting results are finalised.

7. OWNERSHIP

7.1. Expenses will be paid to you or your legal representatives, whose receipt will discharge our liability for those expenses. We may, in our absolute discretion, pay expenses to a provider of services, unless you or your legal representative have instructed us in writing not to and we have not agreed to pay expenses to the provider prior to receiving such instruction.

8. IN THE EVENT OF FRAUD OR NONDISCLOSURE

8.1. We may cancel your and your dependents' coverage under the policyholder's policy from inception if:

8.1.1. you or an insured person or anyone acting on your or an insured person's behalf provided false information to us, or failed to disclose information to us, in connection with your application or any application for addition of an insured person, upgrade, or reinstatement, and the misrepresentation or nondisclosure was fraudulent; or

8.1.2. any claim is in any respect fraudulent or if fraudulent means or devices are used by you or an insured person or anyone acting on your or an insured person's behalf to obtain benefits under this policy.

8.2. We reserve the right to re-underwrite your application if any claim is related to pre-existing conditions which were not stated in the application form.

8.3. If you and your dependents' coverage is cancelled due to the event of fraud or nondisclosure after claims have been paid, or after we have provided a guarantee of payment to a provider of services, we reserve the right to cancel any amounts paid or guaranteed or claim the payment back from you according to section B –Paragraph 14. The outcomes described above are in addition to, and not in the place of, other rights we may have including those based on the contract, statute, or common law. We will not be bound to pay any claim (in whole or part) where you misrepresented facts in connection with that claim or related claims. Nondisclosure by an individual scheme member will not affect any other member's entitlement to receive benefits from the scheme, however, misrepresentations by the employer or other group scheme policyholder could affect coverage for the individual members.

8.4. If nondisclosure is found after claims have been paid, or after we have provided a guarantee of payment to a provider of services, any non-covered amounts paid or guaranteed will become immediately repayable by you to us.

9. MATERIAL CHANGES

9.1. As a condition precedent to liability, you must inform us as soon as reasonably practicable of any change in your name, occupation, the country(ies) of which you hold a passport or citizenship, or your country of residence. Such a change may result in an adjustment of the applicable premium and, in certain cases, the termination of coverage without refund. If such notice is not given we will have no liability under this policy for expenses occurring after the date of such change.

9.2. You must inform us as soon as reasonably practicable of any change to your residential address or correspondence address. Until such notice is given we may continue to send correspondence to the last address given to us by you, and shall not bear any consequences if such correspondence is not received by you.

9.3. If your country of residence changes to the USA, we reserve the right to cancel your coverage.

9.4. Any change in your country of residence must be submitted to us for review and approval. We may, at our discretion, decline to continue coverage and terminate the coverage if we consider the change to be material.

9.5. If your country of residence is changed from Hong Kong to another country, and you have selected double occupancy room in coverage, your room level will be automatically changed to single occupancy room without any additional underwriting upon policy renewal.

10. PROOF OF CLAIM AND COOPERATION

10.1. As a condition precedent to liability, all claims for reimbursement of expenses must include the following (the "required claim documents"):

10.1.1. bills and supporting documents showing the breakdown of expenses and the diagnosis of the condition treated;

10.1.2. evidence of payment made by you, and

10.2. All required claim documents must be received by us within 365 days from the date the service was rendered or 45 days from the date coverage under this policy is terminated. Where it is not reasonably possible to present the required claim documents to us within this period, they must be received by us within 365 days from the date you incurred the expense.

10.3. Claims can be submitted to us:

10.3.1. via the April Easy Claim smartphone app;

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

10.3.3. by mail to our address, attaching original documents.

10.4. If you submit claims by email or via the April Easy Claim smartphone app, you must retain a copy of the original documents for a minimum period of 1 year from when you submit the claim and must send the original documents to us upon request or when required by our claim instructions.

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

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

11. PROCESS TO OBTAIN PRE-AUTHORISATION

11.1. As indicated in the benefits schedule, some services require pre-authorisation, such as but not limited to:
- hospital benefits
- cancer treatment
- surgery performed while a day-patient in a clinic or in a physician's office
- stem cell treatment
- rehabilitation treatment

11.2. Co-payment for pre-authorisation outside the USA:
- 20% co-payment for services not pre-authorised by us

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

11.3. Co-payment for planned hospitalisation or surgeries in the USA:
- 40% co-payment for services rendered outside our preferred USA network
  The co-payment for services that are rendered outside our preferred USA network will not apply where you can show the services were medically necessary due to an emergency and you or hospital contacted us within 24 hours after admission or as soon as reasonably possible.

11.4. To obtain pre-authorisation, you must submit your request, via the April Easy Claim smartphone app or via provider.asia@april.com, at least 5 working days in advance before admission or treatment.

11.5. Upon receiving your request we will review the medical necessity and appropriateness of the requested service and within five working days will notify you of our decision to:
- grant pre-approval
- deny pre-approval / Request further information

11.6. Pre-approval may be partly given and partly denied. If within the 5 days pre-authorisation is not given or denied, or additional information is requested, then such service will not be subject to the co-payment applicable to services for which pre-authorisation was not maintained.

11.7. If we request further information you are required to provide any additional information we may require. Section B - articles 10.5 and 10.6 of this policy apply.

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

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

11.10. If pre-authorisation is denied you may appeal the decision, and we will make a further determination or request additional information within 5 days of receiving your appeal. Only one appeal is permitted per service.

11.11. Particular provisions applicable to certain medical conditions:

11.11.1. In the case of treatments related to sleep disorders (for children and adults), our medical team retain sole discretion to determine whether a proposed treatment or surgical procedure is related to a sleep disorder, including but not limited to sleep apnea and chronic snoring, in both pediatric and adult cases. This determination may be made even in the absence of a formal sleep study. The absence of diagnostic testing shall not preclude the classification of a treatment as sleep disorder-related if clinical indicators and medical judgment support such a conclusion.

11.11.2. In cases of surgical procedures involving septoplasty and/or rhinoplasty, these procedures must be subject to a mandatory Second Medical Opinion (SMO) review conducted by Teladoc. Coverage will only be granted if the procedure is deemed medically necessary by both our medical team and Teladoc's SMO panel. Standardized clinical questions will be incorporated into the SMO report to ensure consistency and transparency in decision-making.

12. RIGHT TO EXAMINE AN INSURED PERSON

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

13. CLAIMS AGAINST THIRD PARTIES OR OTHER INSURANCE

13.1. If another medical or accident insurance covers you for expenses relating to a disability also covered by this policy, you should claim from such source or insurance first and we will only be liable for the excess of the amount recoverable from such other source or insurance. Amounts paid by another source or insurance are applicable to your policy deductible should you have any, and provided that a proof of payment is submitted to us.

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

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

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

14. RIGHT OF RECOVERY

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

15. GOVERNING LAW AND JURISDICTION

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

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

15.3. By subscribing to this policy, you give consent to Asia Insurance Company Limited and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to you or other individuals that you have furnished via any means in the past, present & in the future, for one or more of the purposes described in Asia Insurance Personal Information Collection Statement available at https://www.asiainsurance.hk/_files/ugd/a318ab_5ac446def49945ccaee813015eefac71.pdf.

15.4. You warrant that all personal data you have provided are accurate and complete, and you shall inform Asia Insurance of any changes to the personal data to my knowledge as soon as practicable.

16. SANCTIONS AND COMPLIANCE WITH LAWS

16.1. We reserve the right not to accept applications for cover or to cease providing cover if, in our opinion, doing so would expose us to the risk of breaching any applicable laws or regulations, including international economic sanctions, laws, or regulations.

16.2. For the avoidance of doubt, we shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit under this policy to the extent that the provision of such cover, payment of such claim, or provision of such benefit would expose us to any sanction, prohibition, or restriction under United Nations resolutions or the trade or economic sanctions, laws, or regulations of the European Union ("EU"), United Kingdom ("UK"), United States of America ("USA"), France ("FR"), or any jurisdiction applicable to us.

17. ARBITRATION AND TIME LIMITS

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

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

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

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

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

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

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

17.6 You may contact the Hong Kong International Arbitration Centre at:

38th Floor Two Exchange Square
8 Connaught Place
Central
Hong Kong
Telephone: (852) 2525-2381
Fax: (852) 2524-2171
Email: adr@hkiac.org

SECTION C: EXCLUSIONS

18. This policy does not cover the following treatments, medical conditions, services or procedures. Any adverse consequences or complications thereof, are not covered, unless otherwise indicated in the benefits schedule:

18.1. Pre-existing conditions and any related, associated or consequential disabilities which were not disclosed to us before the period of insurance and which we have not agreed in writing to cover under this policy. This exclusion applies only to fully underwritten policies

18.2. Any pre-existing or related medical condition which occurred or was treated within a 24-month period prior to your effective date or has one of the following characteristics will be excluded from cover:

- was foreseeable
- clearly showed itself
- you have had signs or symptoms or you were aware of the condition
- you have received treatment for or sought medical advice on the condition or a related condition (including medical check-ups)
- to the best of your knowledge you were aware you had
- requires monitoring according to generally accepted medical advice or opinion

Any pre-existing medical condition or related medical condition may be covered after you have had 24 months of continuous cover under the policy and within that time you have not experienced signs or symptoms; asked for advice (including medical checkups); or needed or received treatment, medication, monitoring, or a special diet.

If within a 24-month period following your effective date, in relation to a pre-existing condition you have experienced signs or symptoms; asked for advice (including medical checkups); or needed or received treatment, medication, monitoring or a special diet; then you will have to wait until you have completed a continuous 24-month period when none of these apply to you. Such pre-existing medical conditions or related medical conditions may then be covered.

This exclusion applies only to moratorium policies.

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

18.4. Treatment outside your area of cover as stated on your benefits schedule, except to the extent Out of Area Cover is provided for in your benefits schedule.

18.5. Travel expenses incurred to obtain medical treatment other than in the course of an emergency medical evacuation we have approved in advance, or which has been approved by the emergency assistance provider.

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

18.7. Hospital inpatient treatment for convalescence, rehabilitation, supervision, or which in the opinion of our medical advisor, could be properly treated as an outpatient;

18.8. Medicine, treatment or investigations that are not related to the diagnosis, or that are unrelated to signs and symptoms indicated in the medical certificate.

18.9. Services which have not been prescribed by your attending physician unless otherwise stated on the benefits schedule.

18.10. Routine physical examinations or medical check-ups, unless specifically covered under the benefits schedule.

18.11. Investigations, treatments or preventive measures intended to relieve symptoms possibly related to ageing, premenopause or menopause.

18.12. Hormone replacement therapy, unless specifically covered under the benefits schedule.

18.13. Dental services, except where specifically covered under the Dental Benefits section of the benefits schedule

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

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

18.16. Treatment involving transplant or harvesting of stem cells, unless specifically covered under the Stem Cell Treatment benefit in the benefits schedule.

18.17. The cost of purchasing an organ for transplantation.

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

18.19. Purchase or rental of any devices including but not limited to prostheses, corrective devices, or durable medical equipment other than surgical implants, external prosthesis or medical appliances shown on the benefits schedule as covered by this policy.

18.20. Treatment, care or tests directly or indirectly related to:

18.20.1. major assisted conception, contraception, sterilisation, fertility or infertility, prior history of miscarriages, hypogonadism or testosterone deficiency, sexual dysfunction, or abortion other than for therapeutic reasons;

18.20.2. complications of pregnancy following major assisted conception, other than services claimed under Maternity Benefits or Routine Outpatient Maternity where specifically provided on the benefits schedule;

18.20.3. pregnancy or childbirth other than services claimed under Complications of Pregnancy, Routine Outpatient Maternity or Maternity Benefits where specifically provided on the benefits schedule. For the purposes of this exclusion, the post-partum period is deemed complete 45 days after delivery of the baby.

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

18.20.5. sexually transmitted disease;

18.20.6. gender reassignment therapy and surgery;

18.20.7. congenital and hereditary conditions other than services claimed under the Congenital and Hereditary Conditions benefit where specifically provided on the benefits schedule;

18.20.8. terminal illness, other than as provided by the hospice or palliative treatment benefit as shown on your benefits schedule;

18.20.9. artificial life maintenance including mechanical ventilation where such treatment will not or is not expected to result in your recovery or to restore you to your previous state of health;

18.20.10. any treatment for weight loss or weight problems, other than the consultations and medicines provided by a dietician claimed under the Complementary Medicine Benefit (among others, claim related to bariatric procedures, diet pills or supplements, health club memberships, diet programs and residential eating disorder programs will not be covered);

18.20.11. cosmetic treatment, surgery or any direct or indirect complications or consequences related to cosmetic procedures;

18.20.12. obstructive sleep apnea, sleeping disorders and snoring

18.20.13. contact lenses, spectacle lenses, spectacle frames, sunglasses, eyesight tests for long or short sightedness and treatment related to refractive error other than services claimed under Optical Benefits where specifically provided for on the benefits schedule;

18.20.14. LASIK surgery;

18.20.15. lenses other than monofocal lens following a cataract surgery;

18.20.16. preventive treatment except to the extent specifically stated in the benefits schedule;

18.20.17. dandruff and complications related to hair loss;

18.20.18. experimental investigations and treatment;

18.20.19. use of robotic surgery where it is not medically necessary and a conventional alternative is available. In such cases, reimbursement will be limited to the reasonable and customary cost of the equivalent conventional treatment;

18.20.20. the usage of non-medically necessary ultrasound scans, other than 2D ultrasounds (applicable when Maternity benefits are purchased in the benefits schedule);

18.20.21. non-western or non-allopathic treatment except to the extent specifically stated in the Complementary Medicine and Traditional Chinese Medicine section of the benefits schedule;

18.20.22. personality disorders, attention deficit disorders, autism, ADHD, stress, eating disorders, behavioural or developmental disorders other than where specifically provided on the benefits schedule under the Outpatient Behavioural and Developmental Disorders benefit (if any);

18.20.23. outpatient treatment of mental and nervous conditions other than services claimed under the Outpatient Mental and Nervous Conditions benefit where specifically provided on the benefits schedule;

18.20.24. services by a psychologist or counsellor other than where specifically provided on the benefits schedule under the Mental and Nervous Conditions Benefit.

18.20.25. suicide or self-inflicted injury or illness, or any related attempt whether self-inflicted or agreed with other persons, even though you are fully conscious or have a mental disorder, including those accidentally caused by any chemical or toxin substances intake or medication overdose

18.20.26. any loss or injury arising from your actions while under the influence of alcohol, addictive or psychoactive drugs, or narcotic drugs to the extent of being unable to properly control your mind;

The term "under the influence of alcohol" in the event of a blood test refers to a blood/alcohol level of 150 mg/dL or 0.15% and over;

18.20.27. any loss or injury arising from your own act: while under the influence of drugs or narcotics and incapable of staying conscious;

18.20.28. any loss or injury arising from your own act: while under the influence of liquor and incapable of staying conscious, in the absence of any measurement or blood alcohol content testing;

18.20.29. abuse of alcohol, illegal drugs, or medicines not prescribed to the insured person by a physician or taken in excess of prescribed quantities;

18.20.30. drug addiction, smoking, alcoholism, or use of any psychoactive substances;

18.20.31. smoking cessation, including but not limited to consultations, treatments, products, therapies, medications, and any other services or interventions aimed at quitting smoking;

18.20.32. injury related to participation in professional sports on a full time or part time basis; disability as a result of participation in mountaineering or trekking above 3,000 metres; caving or potholing; downhill off-piste skiing and snowboarding; riding on a snowmobile; motor sports on land; boating in vessels designed to travel at 30 knots or more; diving in excess of 12 metres below the surface of the water; rock climbing involving ropes or pitons; hunting; ice hockey; parachute jumping; wrestling; polo; water skiing or wake-boarding; boating activities beyond 5 kilometres from a coastline; aviation activities other than as a fee-paying passenger on a regular scheduled airline or licensed chartered aircraft; or deliberate exposure to exceptional danger except in an effort to save human life;

18.20.33. any loss or injury arising whilst boarding, leaving or travelling as a passenger in an aircraft which does not have a license for carriage of passengers and does not operate as a commercial airline;

18.20.34. any loss or injuries arising whilst driving under the influence of alcohol or driving without a legal or valid driving license in accordance with local regulations;

18.20.35. any loss or injuries arising whilst driving a motorcycle without wearing a helmet or without a legal or valid motorcycle driver's license in accordance with local regulations.

18.21. The following services, whether or not recommended or prescribed by a physician:

18.21.1 harvesting of stem cells for future, unplanned or unknown treatments;

18.21.2 any service rendered while an insured person is an inmate of a prison, jail or any correctional facility including halfway houses or similar facilities, or while a patient of any mental institution;

18.21.3 services or treatment while a bed patient at any facility that is not a hospital, including an institution such as an intermediate care facility or nursing home;

18.21.4 custodial or maintenance care or rest cures;

18.21.5 house calls, delivery of medicine or other items, or any service rendered at a person's home, office, hotel room, or similar place other than services claimed under Maternity Benefits where specifically provided for on the benefits schedule; Telehealth services are not part of this exclusion and will be covered provided that they are reasonable and customary and medically necessary;

18.21.6 Sleep medication, chelation therapy, bioresonance therapy or diagnosis, colonic hydrotherapy, as well as non-medicated pharmaceutical products, including but not limited to: pharmaceutical expenses, cosmetics, hygiene products, sunscreens and/or moisturisers, make-up, comfort care products, vitamins and minerals (except when medically prescribed in the case of a proven deficiency), probiotics, food supplements, dietetic products, baby foods, and mineral water.

18.21.7 any inoculations and vaccinations other than services claimed under the vaccination benefit where specifically stated on the benefits schedule as covered by the policy;

18.21.8 dental treatment utilising precious stones and orthodontic treatment that is commenced from the age of 16 (applicable only when Dental benefits are covered under the policy);

18.21.9 dental examination and treatment for cosmetic or decorative purposes unless specifically stated in the benefits schedule (applicable only when Dental benefits are covered under the policy)

18.21.10 Disability suffered while serving as a member of a police force or military unit of any country or international authority, or due to participation in war (whether declared or undeclared), civil war, invasion, insurrection, revolution, use of military power, usurpation of government or military power, or any known or suspected terrorist act, utilization of nuclear weapons, chemical or biological weapons of mass destruction.

18.21.11 Participation in any illegal or criminal act or contravening clear and absolute government advisories to avoidance of disability.

18.21.12 While you are committing a felony or while you are being arrested, under arrest or escaping the arrest,

18.21.13 While engaging in a brawl / fight or taking part in initiating and / or inciting a brawl / fight;

18.21.14 Disability as a result of exposure:
- to ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
- the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof;
- any weapon of war employing atomic or nuclear fission and/or fusion or other like reaction or radioactive force or matter.
- any weapon of war employing chemical or biological force or matter

18.22 All expenses:

18.22.1 which are not reasonable and customary;

18.22.2 incurred in jurisdictions subject to sanctions, prohibitions, or restrictions under United Nations resolutions or the trade or economic sanctions of the European Union, the United Kingdom, or the United States of America

18.22.3 for medical certificates or administrative fees such as a charge for providing a claim form or medical records;

18.22.4 incurred outside the period of insurance or in any period for which the appropriate premium has not been paid;

18.22.5 incurred during the period of insurance for drugs and/or medical services to be consumed or provided once the period of insurance has ended; or

18.22.6 for services performed or items sold by you, your parents, your children, or any entity in which you, your parents, or your children either are an employee or director or have a greater than 1% ownership interest.

SECTION D: DEFINITIONS

A. **ACCIDENT OR ACCIDENTAL:** A sudden, unexpected and specific event, external to the body, beyond one's control, and directly leading to physical injury, which occurs at an identifiable time and place.

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

B. **BEHAVIOURAL OR DEVELOPMENTAL DISORDER:** A disability classified in categories F53 and F59 to F98 of the International Classification of Diseases 10th Revision (2025 version).

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

C. **CHRONIC CONDITION:** A disease, illness or injury that has one or more of the following characteristics:
a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests; or
b. it needs ongoing or long-term control or relief of symptoms; or
c. you need to be rehabilitated or specially trained to cope with it; or
d. it continues indefinitely; or
e. it has no known cure; or
f. it comes back or is likely to come back.

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

C. **COMPLICATIONS OF CHILDBIRTH:** Any complications that arise during the delivery stage including emergency C-section. The coverage of the complication of childbirth is applicable to the mother and child.

C. **COMPLICATIONS OF PREGNANCY:** Only the complications that arise during the antenatal stage of pregnancy are covered. Any claims related to wholly or partially or arising directly or indirectly during the delivery stage, including complications arising from the delivery stage, shall not be covered. The coverage of the complication of pregnancy is applicable to the mother only.

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

C. **CONFINEMENT:** A medically necessary overnight stay as a registered bed patient in a hospital.

C. **CONGENITAL CONDITION:** Any condition classified as a congenital anomaly in the International Classification of Diseases 10th Revision (2025 version).

C. **CONTINUOUS PERSONAL MEDICAL EXCLUSIONS:** Means that we apply the special underwriting terms of a preceding policy. Any pre-existing condition which would have been covered by the preceding policy shall continue to be covered under this Policy, but not to exceed the limits which would have been obtainable under the provisions of the Preceding Policy or the provisions of this Policy, whichever is lower.

C. **COSMETIC TREATMENT:** Surgery, chemical treatment, or other procedures performed to reshape or modify structures of the body or physical appearance, including treatment of any medical condition which arises in any way from cosmetic procedures.

C. **COUNTRY OF RESIDENCE:** The geographical country in which the policyholder or insured person, as the case may be, spends the greatest amount of time during the period of insurance.

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

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

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

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

D. **DEPENDANT:** Your spouse under the law of your country of residence or your de facto partner. Each of your unmarried children, stepchildren or adopted children who are under twenty-three (23) years of age for all or part of the period of insurance.

D. **DIAGNOSTIC SCANS AND TESTS:** Medically necessary tests and procedures, including surgery on the skin and subcutaneous tissue to treat an illness, prescribed by an attending physician, other than surgery following a confirmed diagnosis of cancer. This benefit also includes - unless otherwise stated on the benefits schedule: laboratory tests and pathology, CT scan, PET Scan, MRI, ultrasound, ECG, endoscopic exams such as laryngoscopy, nasopharyngoscopy and otoscopy (not including invasive endoscopic examinations), and x-ray.

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

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

E. **ELIGIBLE EMPLOYEE:** A full time employee of the policyholder who has a staff grade as listed in the policy endorsement or as agreed separately between us and the Policyholder.

E. **EMERGENCY:** A sudden change in your health as a result of an accident or acute exacerbation of a disability which requires immediate medical or surgical intervention within 24 hours to avoid permanent damage to your life or health.

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

E. **EXPERIMENTAL TREATMENT:** Treatment and drugs are deemed experimental if they have not been approved by the European Medicines Agency (EMA), and the Food and Drug Administration (FDA) despite the treatment is approved by the local governance. Approved treatment and drugs should be used within the terms of a valid license, it means that off-label drug will be considered as experimental.
Surgery, procedures are deemed experimental if they have not been recommended by international clinical guidelines and used within their indication. Clinical consensus is not considered as an international clinical guideline.
Should these agencies or guidelines have conflicting views or provide no guidance, APRIL medical team will make a decision based on published medical articles which are using a rigorous scientific method (including randomised controlled trial) to prove the safety and efficacy of the treatment and drug. This definition also includes medical equipment, technique or approach used for purposes other than those defined under their license or which is undergoing study, research or testing

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

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

H. **HEREDITARY CONDITIONS:** An illness caused by a genetic abnormality passed down from the parents' genes. Cancers that are present in combination with other symptoms of the hereditary condition are included in this definition.

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

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

H. **HOSPICE OR PALLIATIVE TREATMENT:** A program of medical, psychological, social, and spiritual care provided to persons who have been diagnosed as suffering from a terminal illness. Treatment must be prescribed by a physician and provided by a hospital or institution licensed by the competent medical authorities of the country in which care is provided and which, in providing care, is practicing within the scope of its license.

H. **HOSPITAL:** An institution licensed by the competent medical authorities of the country in which it is located to provide care and treatment of sick and injured persons as bed patients and which:

a. has full diagnostic, therapeutic and surgical procedures; and

b. provides 24 hour a day nursing services by registered graduate nurses; and is supervised by a staff of physicians; and

c. Is not primarily a clinic, an intermediate care facility or nursing home, a mental institution, a home for the aged, or a place for alcoholics or drug addicts.

H. **HOSPITAL ROOM AND BOARD:** Room and board and general nursing care, subject to the following accommodation levels as stated on the benefits schedule.
SINGLE OCCUPANCY ROOM – The base class of rooms having one (1) patient bed per room with an en-suite bath or shower room. Single occupancy room does not include higher-tier accommodations and luxury rooms such as suites, VIP rooms, or deluxe rooms.
DOUBLE OCCUPANCY ROOM – A class of room having two (2) patient beds per room and shared bath or shower room, whether both beds are occupied or not.
WARD – A class of room having three (3) or more patient beds per room, whether all beds are occupied or not.

Room Category Coverage and Penalties: If a member is admitted to a higher category room than entitled to, a 50% co-payment penalty will be applied.

- In Hong Kong and Singapore, this penalty will be applied to the entire hospital bill.
- In other countries, the 50% penalty will be applied to all items impacted by the room type selected. This approach accounts for regional variations in healthcare practices and costs.

H. **HYPNOSIS:** also referred to as guided hypnosis, is a form of psychotherapy that uses relaxation, extreme concentration, and intense attention to achieve a heightened state of consciousness or mindfulness.

H. **HYPNOTHERAPIST:** Qualified Hypnotherapists and Psychologists can administer hypnosis to individuals.

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

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

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

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

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

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

I. **INVASIVE ENDOSCOPIC EXAMINATION:** The following endoscopies: arthroscopy, colonoscopy, cystoscopy, enteroscopy, laparoscopy, mediastinoscopy, sigmoidoscopy, thoracoscopy/pleuroscopy, upper gastrointestinal endoscopy, ureteroscopy.

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

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

M. **MAJOR DENTAL TREATMENT:** Surgical removal of impacted, buried, or unerupted teeth/roots or odontomes; treatment of disorders of the temporomandibular joint (TMJ); orthodontics treatment commenced below the age of 16; dental implants; root canal therapy or apicoectomy; dentures (new/repair of old); gold, amalgam, composite or porcelain crowns and bridges; treatment by a dentist of illnesses of the oral mucosa and directly related laboratory tests or pathology services; antibiotics or medicines for pain management for which a prescription is required for purchase and which have been prescribed by a dentist; periodontics, deep oral prophylaxis or root planing.

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

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

M. **MEDICALLY NECESSARY:** Possessing an identifiable relationship to either a covered disability or symptom(s) of a disability which if existing would be covered under the policy. It refers to necessary and appropriate medical treatment, services or supplies, i.e. :

a. a therapeutic service required to treat or prevent damage to life or health where you have an illness or injury;

b. a diagnostic service to determine whether therapeutic services are necessary, where you have active symptoms, the cause of which are unknown, but which are suggestive of an illness or injury, or

c. A treatment or service required for reasons other than the comfort or convenience of you or physicians.

The term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. It also includes the appropriateness of the type of service (outpatient/daypatient/inpatient) based on the medical standard. When specifically applied to inpatient request, we reserve the right to decline an inpatient stay for a procedure or treatment that is commonly prescribed as outpatient/daypatient.

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

M. **MENTAL AND NERVOUS CONDITION:**. Any condition classified in categories F01 – F09, F20 – F48, F54 and F99 of the International Classification of Diseases 10th Revision (2025 version)

M. **MINOR ASSISTED CONCEPTION:** The use of oral or injected medication to induce or regularise the menstrual cycle in order to increase the chance of conception.

M. **MINOR DENTAL TREATMENT:** Dental check-up, x-ray, gold or amalgam or composite or porcelain, inlays/onlays/fillings; routine tooth cleaning, scaling, and prophylaxis (including when done by an oral hygienist); simple extractions; mouth guard; and application of sealants.

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

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

- ► was foreseeable
- ► clearly showed itself
- ► you have had signs or symptoms or you were aware of the condition
- ► you have received treatment for or sought medical advice on the condition or a related condition (including medical checkups)
- ► to the best of your knowledge you were aware you had
- ► requires monitoring according to generally accepted medical advice or opinion

These conditions may be covered after you have had continuous cover with us for 24 months during which you have not had any symptoms, sought advice, needed or received any medication, treatment for the pre-existing condition or any related condition. If the pre-existing condition recurs, then once you have completed a 24-month period where none of these apply, the medical condition may then be covered.
Certain pre-existing conditions may never be covered under a moratorium policy. These include disabilities and chronic and incurable conditions; for example diabetes, chronic hypertension (raised blood pressure), hyperlipidaemia (raised cholesterol levels), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders. If you have suffered from any of these conditions, or any other condition for which it is generally accepted medical advice that it be monitored, then that condition may never be covered. Any condition related to an excluded condition will also be excluded from cover. Maximum entry age is 45 under Moratorium policies.

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

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

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

N. **NETWORK PROVIDERS (formerly SPECIFIED INPATIENT PROVIDERS):** Medical providers within our network where full coverage is available, depending on your selected plan (Standard or Premium).
► **PREMIUM NETWORK:** Provides full coverage at all medical providers.
► **STANDARD NETWORK:** Provides full coverage at all medical providers, except for selected providers in Asia, where a 40% co-insurance applies. For the list of these providers, please refer to your Benefits Schedule.

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

N. **NURSERY CARE :** includes (i) accommodation for the child, (ii) customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures (these essential examinations are carried out immediately following birth) and, (iii) further preventive diagnostic procedures, such as routine swabs, blood typing , and hearing tests, if they occur before the child's s discharge and if they are performed within 7 days from the childbirth.

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

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

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

P **PARENTAL ACCOMMODATION:** A fee for an additional bed in the same room for a parent or legal guardian staying with a dependant child below age 23 covered under this policy who is admitted as an inpatient in a hospital for the treatment of a covered disability.

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

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

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

P. **POLICYHOLDER:** An individual or organization that enters into an insurance contract with the insurer and pays the insurance premium. The policyholder has an insurable interest in the insured person. The policyholder may also be the insured person or the beneficiary.

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

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

P. **PRECEDING POLICY:** Means a long-term international health insurance policy covering illness and bodily injury which terminates no earlier than the day prior to the effective date in respect of an insured person, and a copy of which has been provided to us upon application. It must be of an equivalent class of cover as that being applied for and meet the acceptability criteria defined by us at the time of application.

P. **PRE-EXISTING CONDITION:** Any disability:

a. which existed before the period of insurance and which presented signs or symptoms of which you were aware or should reasonably have been aware of; or
b. for which you have sought or received treatment, medication, advice or diagnosis in the 24 months before the period of insurance; or
c. which you knew to exist before the period of insurance and whether or not you sought or received treatment, medication, advice, or diagnosis for it.

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

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

P. **PREVENTIVE (PROPHYLACTIC) SURGERY:** refers to surgical procedures performed to remove tissues, organs, or glands that have a high probability of becoming cancerous in the future, aimed at reducing the risk of future health issues. This includes, but is not limited to, procedures such as mastectomy or prophylactic oophorectomy when a parent, grandparent, sibling, or child has been diagnosed with a disease that is part of a hereditary cancer syndrome (such as breast cancer or ovarian cancer) confirmed by a genetic test. The surgery should be prescribed by a qualified medical professional and approved as medically necessary by our Medical Team or a qualified physician approved by us.

P. **PREVENTIVE TREATMENT:** Treatments that prevent occurrence or recurrence of a disability, injury or illness, rather than treating a disability.

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

P. **PSYCHOLOGIST OR PSYCHOTHERAPIST** : A psychologist / psychotherapist other than yourself or someone related to you by blood, marriage or adoption, who is licensed by the competent medical authorities of the country in which treatment is provided or in which the psychologist / psychotherapist finished the study, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

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

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

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

R. **REHABILITATION CENTRE:** A facility specifically licensed to care for people who have suffered neurological, musculoskeletal, orthopaedic and other serious medical conditions and are not yet able to care for themselves at home. It must be:

- a unit within a hospital or a separate facility having accommodation for bed patients;
- organised to provide an intensive rehabilitation program to inpatients;
- under supervision of a physician; and
- staffed full-time by nurses working under the supervision of a registered nurse.

R. **REHABILITATION TREATMENT:** Treatment following a disability upon referral by an attending specialist to restore normal form/near to normal form or function to the body. In addition to room and board and general nursing fees, the following additional costs incurred while admitted to the rehabilitation centre will be covered under this benefit:

- occupational therapy fees
- special treatment room fees
- speech therapy fees

Rehabilitation centre services must be certified by a specialist as medically necessary. The factors to be considered in making such certification must include, but are not necessarily limited to:

- the type and severity of the illness or injury, and the insured person's overall state of health and prior treatment history;
- the amount of therapy expected to be performed every day;
- the risk of deterioration or non-recovery of function if therapy is not completed; and
- the extent to which the insured person will be able to perform activities of daily living during the rehabilitation period.

In all cases, we reserve the right to require re-authorisation of rehabilitation centre services at any time upon notice to the insured.

S. **SEXUALLY TRANSMITTED DISEASE:** Illness classified as an infection with a predominantly sexual mode of transmission in the International Classification of Diseases 10th Revision (2025 version).

S. **STEM CELL TREATMENT:** Treatment for a disability where an immediate advantage compared to other forms of treatment can be identified and verified by us. It does not include preventive treatment.

S. **SUDDEN ILLNESS OR INJURY:** Either

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

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

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

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

T. **TERMINAL ILLNESS:** An illness that is approaching its final stages, for which treatment can no longer be expected to cure and will lead to death (life expectancy being a matter of months). In all circumstances, treatments for Terminal illnesses must be pre-approved by us. We reserve the right to consider any treatment for a Terminal Illness as Palliative and to apply the corresponding limits of your benefits schedule.

T. **TERRORIST ACT:** An act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist act can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of a terrorist act can either be acting alone, or on behalf of, or in connection with any organisation(s) or government(s).

T. **THERAPEUTIC ABORTION:** The termination of a pregnancy that is deemed medically necessary if there is an underlying or life-threatening condition which will endanger the mother's physical health or if there is a fetal abnormality.

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

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

W. **WAITING PERIOD:** A period during which related insurance benefits shall not be covered, including benefits for claims filed after the waiting period but medical expenses or consequences of medical treatment have been incurring during the waiting period.

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

W. **WE, US, OUR:** Asia Insurance Company, Limited.

Y. **YOU, YOUR:** The policyholder and/or insured person and/or his or her dependants named on the namelist.

MH HK 2025/11

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