HSBC

AXA 安盛

Preferred Care

The Policy

Please read this Policy carefully

Your right to change your mind

If you are not completely satisfied, or our plan's coverage overlaps with your other existing protection plans coverage or exceed your needs, then please return the policy to us within 30 days. We will cancel this plan and refund any premium you have paid. Otherwise, we will assume you have accepted this plan subject to its terms and conditions.

Your right to cancel the policy is based on the following conditions:

- Your request to cancel must be signed by you and received directly by any HSBC branch or by AXA General Insurance Hong Kong Limited within 30 days after the date of the delivery of your policy.
- No refund can be made if a claim has already been paid.

Should you have any queries or need further explanation, you may contact Customer Care Hotline on (852) 2867 8678 (please note that tele-conversations may be recorded to ensure service quality) or write to us.

AXA General Insurance Hong Kong Limited

P.O. Box No. 90918 Tsim Sha Tsui Post Office, Kowloon, Hong Kong
5/F, AXA Southside, 38 Wong Chuk Hang Road, Wong Chuk Hang, Hong Kong
Customer Care Hotline: (852) 2867 8678

Personal Information Collection Statement

AXA General Insurance Hong Kong Limited (referred to hereinafter as the "**Company**") recognises its responsibilities in relation to the collection, holding, processing, use and/or transfer of personal data under the Personal Data (Privacy) Ordinance (Cap. 486) ("**PDPO**"). Personal data will be collected only for lawful and relevant purposes and all practicable steps will be taken to ensure that personal data held by the Company is accurate. The Company will take all practicable steps to ensure security of the personal data and to avoid unauthorised or accidental access, erasure or other use.

Please note that if you do not provide us with your personal data, we may not be able to provide the information, products or services you need or process your request.

Purpose: From time to time it is necessary for the Company to collect your personal data (including credit information and claims history) which may be used, stored, processed, transferred, disclosed or shared by us for purposes ("**Purposes**"), including:

1. offering, providing and marketing to you the products/services of the Company, other companies of the AXA Group ("**our affiliates**") or our business partners (see "**Use and provision of personal data in direct marketing**" below), and administering, maintaining, managing and operating such products/services;
2. processing and evaluating any applications or requests made by you for products/services offered by the Company and our affiliates;
3. providing subsequent services to you, including but not limited to administering the policies issued;
4. any purposes in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates, including investigation of claims;
5. detecting and preventing fraud (whether or not relating to the products/services provided by the Company and/or our affiliates);
6. evaluating your financial needs;
7. designing products/services for customers;
8. conducting market research for statistical or other purposes;
9. matching any data held which relates to you from time to time for any of the purposes listed herein;
10. making disclosure as required by any applicable law, rules, regulations, codes of practice or guidelines or to assist in law enforcement purposes, investigations by police or other government or regulatory authorities in Hong Kong or elsewhere;
11. conducting identity and/or credit checks and/or debt collection;
12. complying with the laws of any applicable jurisdiction;
13. carrying out other services in connection with the operation of the Company's business; and
14. other purposes directly relating to any of the above.

Transfer of personal data: Personal data will be kept confidential but, subject to the provisions of any applicable law, may be provided to:

1. any of our affiliates, any person associated with the Company, any reinsurance company, claims investigation company, your broker, industry association or federation, fund management company or financial institution in Hong Kong or elsewhere and in this regard you consent to the transfer of your data outside of Hong Kong;
2. *The Hongkong and Shanghai Banking Corporation Limited ("**HSBC**") for any of the Purposes and for the following additional bank related purposes: ensuring ongoing credit worthiness of customers, creating and maintaining credit and risk related models, providing the personal data to credit reference agencies for the purposes of conducting credit checks and other directly related purposes, determining the amount of indebtedness owed to or by customers and collection of amounts outstanding from customers and those providing security for customers' obligations;
3. any person (including private investigators) in connection with any claims made by or against or otherwise involving you in respect of any products/services provided by the Company and/or our affiliates;
4. any agent, contractor or third party who provides administrative, technology or other services (including direct marketing services) to the Company and/or our affiliates in Hong Kong or elsewhere and who has a duty of confidentiality to the same;
5. credit reference agencies or, in the event of default, debt collection agencies;
6. any actual or proposed assignee, transferee, participant or sub-participant of our rights or business;
7. any government department or other appropriate governmental or regulatory authority in Hong Kong or elsewhere; and
8. the following persons who may collect and use the data only as reasonably necessary to carry out any of the purposes described in paragraphs nos. 2, 3, 4 and 5 of the Purposes specified above: insurance adjusters, agents and brokers, employers, health care professionals, hospitals, accountants, financial advisors, solicitors, organisations that consolidate claims and underwriting information for the insurance industry, fraud prevention organisations, other insurance companies (whether directly or through fraud prevention organisation or other persons named in this paragraph), the police and databases or registers (and their operators) used by the insurance industry to analyse and check data provided against existing data.

For our policy on using your personal data for marketing purposes, please see the section below "**Use and provision of personal data in direct marketing**".

Transfer of your personal data will only be made for one or more of the Purposes specified above.

Use and provision of personal data in direct marketing: The Company intends to:

1. use your name, contact details, products and services portfolio information, transaction pattern and behaviour, financial background and demographic data held by the Company from time to time for direct marketing;
2. conduct direct marketing (including but not limited to providing reward, loyalty or privileges programmes) in relation to the following classes of products and services that the Company, our affiliates, our co-branding partners and our business partners may offer:
   a) insurance, banking, provident fund or scheme, financial services, securities and related products and services;
   b) products and services on health, wellness and medical, food and beverage, sporting activities and membership, entertainment, spa and similar relaxation activities, travel and transportation, household, apparel, education, social networking, media and high-end consumer products;
3. the above products and services may be provided by the Company and/or:
   a) any of our affiliates;
   b) third party financial institutions;
   c) the business partners or co-branding partners of the Company and/or affiliates providing the products and services set out in 2. above;
   d) third party reward, loyalty or privileges programme providers supporting the Company or any of the above listed entities
4. in addition to marketing the above products and services, the Company also intends to provide the data described in 1. above to all or any of the persons described in 3. above for use by them in marketing those products and services, and the Company requires your written consent (which includes an indication of no objection) for that purpose;

Before using your personal data for the purposes and providing to the transferees set out above, the Company must obtain your written consent, and only after having obtained such written consent, may use and provide your personal data for any promotional or marketing purpose.

You may in future withdraw your consent to the use and provision of your personal data for direct marketing.

If you wish to withdraw your consent, please inform us in writing to the address in the section on "**Access and correction of personal data**". The Company shall, without charge to you, ensure that you are not included in future direct marketing activities.

Access and correction of personal data: Under the PDPO, you have the right to ascertain whether the Company holds your personal data, to obtain a copy of the data, and to correct any data that is inaccurate. You may also request the Company to inform you of the type of personal data held by it.

Requests for access and correction or for information regarding policies and practices and kinds of data held by the Company should be addressed in writing to:

Data Privacy Officer
AXA General Insurance Hong Kong Limited
5/F, AXA Southside, 38 Wong Chuk Hang Road, Wong Chuk Hang, Hong Kong

A reasonable fee may be charged to offset the Company's administrative and actual costs incurred in complying with your data access requests.

* This is applicable only if you are applying for a product and/or service of, or making a request to, the Company through HSBC as the Company's distribution agent. Your personal data will not be provided to HSBC for any of the Purposes and the additional purposes and for direct marketing by HSBC set out in the paragraphs above if you do not apply for the product and/or service of, or make a request to, the Company through HSBC as the Company's distribution agent.

Contents

Part 1 Benefits....2

Part 2 Pre-treatment Review and Approval....4

Part 3 Definitions....5

Part 4 Exclusions....8

Part 5 Eligibility and Effective Date....8

Part 6 Premium....9

Part 7 Termination....9

Part 8 Claims....10

Part 9 General Policy Provisions....10

Schedule of Benefits....14

This Policy, the Schedule and any Memoranda thereon shall be considered one document and any word or expression to which a specific meaning has been attached in any of them shall bear such meaning throughout.

Whereas:

1. The Policyholder has applied for insurance, and
2. AXA General Insurance Hong Kong Limited (hereinafter defined as 'the Company') has agreed to provide such insurance.

The Company agrees only on the basis of the Terms and Conditions contained in this Policy to provide insurance cover to the Insured Persons for those risks insured against to the extent and in the manner stated in the Policy Schedule.

PART 1 Benefits

The Policy covers costs of the following covered treatments in Participating Hospitals. The Policy covers not only the direct medical costs but also travel and accommodation expenses.

This insurance is subject to the maximum applicable annual limit, and sub-limits, as stated in the Schedule of Benefits.

A. Covered Treatments

The Policy will cover the following treatments:

1. **Cardiac or Heart Surgery** that involves surgical intervention specifically to:
   - 1.1 Correct narrowed or blocked coronary arteries by means of bypass grafts; or
   - 1.2 Correct valvular abnormalities.

A coronary angiogram will be required for pre-approval.

2. **Interventional Cardiology Procedures** that involves correcting a substantial narrowing of two or more coronary arteries by means of dilating (coronary angioplasty). A coronary angiogram will be required for pre-approval.
3. **Major Vascular Surgery** that involves open surgical repair of one or more major arteries, limited to repair of the aorta, carotid, iliac, femoral and cerebral arteries.
4. **Cancer Treatment** that covers all forms of cancer except:
   - 4.1 Pre-malignant lesions and in-situ tumors;
   - 4.2 Benign tumors, polyps or other lesions;
   - 4.3 Any skin cancer (except invasive skin cancer such as malignant melanoma and mycosis fungoides); and
   - 4.4 Any malignancy in the presence of any Human Immuno-deficiency Virus (HIV).
5. **Selected Neurosurgical Procedures** covers only the surgical intracranial procedures performed to remove a malignant or non-malignant tumor or to repair an intracranial blood vessel. Procedures performed for conditions related to trauma or injury are excluded.
6. **Major Organ Transplants** covers treatment of the recipient Insured Person when undergoing a transplant of the heart, lung, heart and lung, liver, kidney, pancreas or bone marrow with specific coverage as defined in Organ Transplant Benefits.

B. Covered Benefits

1. Medical Treatment

The Policy covers Medical Treatments, both Inpatient Treatment and Outpatient Treatment, which are provided during the course of an Episode of Treatment.

2. Travel and Accommodation

The following costs are covered for the Insured Person or the Insured Person and one companion at the limits per Episode of Treatment stated in the Schedule of Benefits:

- 2.1 a round trip by scheduled airline service to the USA;
- 2.2 costs of accommodation in the USA.

The sub-limit for travel and accommodation applies to the Insured Person or the Insured Person and one companion taken together.

3. PGH Services

From the time of the request for treatment for one of the covered illnesses, the Insured Person receives care management in the form of advice, help in obtaining the appropriate care in the USA and the assistance of a personal care manager throughout the treatment there. The support is provided by the staff of PGH, the National Medical Adviser and a PGH personal care manager in the USA. The cost for these services are included in the premium charged.

4. Maximum Duration of Medical Treatments

The maximum duration (in days) of an Episode of Treatment is stated in the Schedule of Benefits. With prior approval, the maximum duration of an Episode of Treatment may be increased, as stated in the Schedule of Benefits, in the event of continued or prolonged cancer treatment requiring inpatient acute care or intensive outpatient medical monitoring but this does not cover adjuvant therapy (which is ongoing treatment following cancer treatment), rehabilitation or palliative treatment.

5. Ambulance Benefits

Medically Necessary ambulance transportation in the USA will be covered during an Episode of Treatment. Ambulance transportation is covered when rendered by a licensed private professional ambulance service, or an ambulance service that charges the public, providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

6. Transportation Benefit in the Event of Death

In the event that an Insured Person dies in the USA during an Episode of Treatment, the costs of transporting the deceased's body to his or her home country/region are covered as shown in the Schedule of Benefits.

C. Organ Transplant Benefits

The Pre-Transplant Evaluation, Procuring a donor organ and Transplant Procedure as described below form part of the Episode of Treatment.

1. Pre-Transplant Evaluation

Subject to the sub-limits for Pre-Transplant Evaluation stated in the Schedule of Benefits, the Policy covers:

1.1 Preliminary examination and Medical Treatment in a Participating Hospital in the USA in order to evaluate the Insured Person as a candidate for an organ transplant and/or the taking of bone marrow or stem cells from the Insured Person as required for a preliminary examination for a bone marrow transplant.

1.2 Travel and accommodation costs for the Insured Person or the Insured Person and one companion. The sub-limit for travel and accommodation applies to the Insured Person or the Insured Person and one companion taken together.

2. Procuring a Donor Organ

Subject to the sub-limits for Organ Procurement stated in the Schedule of Benefits, the Policy covers:

2.1 medical expenses associated with removal of the donor organ and the medical treatment of the live donor if the donor organ is received by a recipient Insured Person; and

2.2 costs of storing the donor organ in accordance with approved medical practice; and transportation to and storage of the donor organ at the transplant site.

Subject to sub-limits, travel expenses of a live donor are covered if it has been established that the organ to be donated will be compatible.

3. Transplant Procedure

Medical Treatments and Travel and Accommodation expenses as described under Covered Benefits above, in relation to an approved transplant are covered by this Policy.

The costs associated with the care and treatment of a live donor are covered under the Policy only for recipient Insured Persons and are part of the maximum applicable annual limit of the recipient Insured Person as stated in the Schedule of Benefits.

If an organ transplant does not proceed as scheduled due to the medical condition or death of the Insured Person intended to undergo the transplant, covered costs are paid on the basis of the pre-approved transplant prior to the Insured Person's death, or the date on which the Participating Practitioner decides not to perform the organ transplant.

4. Availability of Donor Organs

The availability of donor organs cannot be guaranteed under the Policy. Organ transplants can only be performed when an organ is available in accordance with the rules and regulations which apply in the State in which the USA-based Participating Hospital is located.

5. Organ Transplant Exclusions

The following exclusions apply to organ transplant procedures:

5.1 costs incurred by an Insured Person only as a live donor;

5.2 organ procurement, organ transplant or another medical service outside the USA;

5.3 costs incurred by an Insured Person who is in the USA waiting for a donor organ to become available;

5.4 costs incurred by an Insured Person while a transplant is delayed;

5.5 costs of acquisition or other considerations for an organ purchased on a commercial basis;

5.6 animal to human organ transplants;

5.7 artificial or mechanical devices designed to replace organs either permanently or temporarily or costs incurred in order to maintain an individual on an artificial device while awaiting an organ transplant;

5.8 any form of renal dialysis, except dialysis during a pre-approved treatment;

5.9 cardiac rehabilitation services which are not part of the organ transplant treatment.

PART 2 Pre-treatment Review and Approval

1. Pre-treatment review and approval

Payment of Medical Treatment costs and PGH Services under this Policy is granted only if prior approval has been obtained from PGH for the treatment in question. Pre-treatment approval is granted through the pre-treatment review process, which determines that:

1.1 The Insured Person is suffering from an illness or condition for which a treatment covered under this Policy is indicated, and

1.2 The treatment required is Medically Necessary.

2. Pre-approval process

Prior approval is required in order to receive treatment covered under this Policy. The process is as follows:

2.1 The Insured Person applies to the Company for treatment;

2.2 The Company informs PGH;

2.3 The pre-treatment review and approval process is based on the information obtained from the Insured Person's Local Medical Practitioner and medical records. PGH ensures that via the National Medical Adviser (NMA), that the information from/about the Insured Person, translated and summarised if necessary, is made available for evaluation by a Participating Practitioner;

2.4 PGH selects a Participating Practitioner specialising in the illness or complaint to (re)evaluate the medical records;

2.5 The Participating Practitioner selected by PGH in Clause 2.4 above verifies the exact nature of the illness and identifies and recommends what treatment, in his/her opinion, will produce the best results. He/she also determines whether the treatment is Medically Necessary;

2.6 If the treatment for condition is covered under this Policy and if the treatment is Medically Necessary, PGH grants approval and the treatment may start.

The PGH personal care manager then arranges all medical contacts and organises travel and accommodation.

Responsibility to request approval in advance

It is the Insured Person's responsibility to initiate the pre-treatment review procedure, as described above, in order to obtain a treatment covered by the Policy.

PART 3 Definitions

Company

AXA General Insurance Hong Kong Limited

Asia

Australia, Bangladesh, Brunei, Burma, Cambodia, Hong Kong Special Administrative Region (SAR), India, Indonesia, Japan, Korea, Laos, Macau SAR, Malaysia, mainland China, New Zealand, Pakistan, Philippines, Singapore, Sri Lanka, Taiwan, Thailand and Vietnam.

Episode of Treatment

A time period, which begins on the Insured Person's arrival in the USA for covered Medical Treatment under this Policy and ends when the Insured Person has been medically approved for the return home.

If a complication related to a covered treatment or requirement of additional covered treatment occurs within 30 days after the end of an Episode of Treatment, such additional treatment will be regarded as part of the original Episode of Treatment. This means that the number of days of the additional treatment is counted towards the calculation of the maximum number of days covered for the Medical Treatment, travel expenses and accommodation of the original Episode of Treatment and the related expenses and fees will be paid according to the Schedule of Benefits.

Experimental/Investigative

Means a treatment, service, procedure, drug or use of a drug, facility or use of a facility, equipment or use of equipment, or supply (each hereinafter called "treatment") deemed by the Company and/or PGH, on the basis of the following considerations, to be Experimental or Investigative in nature:

1. If the approval of a government authority is required before the treatment and it has not yet been given at the time when the treatment is to be provided, or
2. If, according to generally accepted medical standards within the Participating Hospitals, the treatment has not been recognised as safe and as possibly effective for the condition in question, irrespective of the question whether the treatment is legally permitted for use during testing or other studies on human beings, or
3. If, in the case of a medicine, therapy or device, the treatment has not been approved for use by the American Federal Drug Administration.

Child/Children

Where the Policyholder is an individual, all legally dependent unmarried children including step children and legally adopted children of the Policyholder, who are 12 months of age or over but under 27 years on the effective date of Insurance of this Policy or where the Policyholder is a body corporate, all legally dependent unmarried children including step children and legally adopted children (who are 12 months of age or over but under 27 years on the effective date of Insurance of this Policy) of each of the Policyholder's employees (who are covered under the Policy). The term "Child/Children" includes, for the purpose of this Policy, child/children living abroad for the purpose of study.

Eligible Family Members

Where the Policyholder is an individual, the legally married spouse of the Policyholder under 75 years of age on the effective date of Insurance of the Policy and all the Children of the Policyholder or, where the Policyholder is a body corporate, the legally married spouse of each of the Policyholder's employees (who are covered under the Policy) under 75 years of age on the effective date of Insurance of the Policy and all the Children of such employees.

Inpatient Treatment (Hospital Admission)

Inpatient Treatment comprises the following, but may not be limited to:

(a) necessary pre-admission tests

(b) room, board and nursing in a participating hospital

(c) medical treatment

(d) necessary physiotherapy

(e) medicines, aids and dressings

If available, the Insured Person will be offered a single room. If no single room is available, a double room will be offered until a single room becomes available.

Insured Person

Eligible person named in the Policy Schedule.

Local Medical Practitioner

A doctor who is responsible for the ongoing medical care of the Insured Person in his/her home country/region.

Medically Necessary (or Medical Necessity)

Those treatments and services which are provided by a Participating Hospital or Participating Practitioner based in the USA in order to treat a covered illness or condition, which has been diagnosed, or of which there is a reasonable suspicion, and which:

(a) are in accordance with the diagnosis of the Insured Person's complaint, and

(b) are in accordance with the standards of good medical practice within the Participating Hospitals, and

(c) are necessary for reasons other than the convenience of the Insured Person or his or her Local Medical Practitioner(s).

In relation to hospital admission, Medically Necessary also means that, on the basis of the medical symptoms or condition of the Insured Person, the treatments or supplies cannot safely be provided to the Insured Person without hospital admission.

Medical Treatment

Medically Necessary services or supplies which an Insured Person receives and are provided by a Participating Practitioner, Participating Hospital, facility or recognised supplier based in the USA in relation to a covered treatment after prior approval has been granted.

National Medical Advisor

A doctor in Asia, who is appointed by PGH, or a PGH staff doctor. This practitioner is responsible, among other things, for supporting PGH in the exchange and sending and, where necessary, translation or supplementation, of information between the Insured Person's Local Medical Practitioner and the selected Participating Practitioners in the USA.

Outpatient Treatment

Outpatient Treatment comprises

(a) Medical Treatments for which Inpatient Treatment is not required

(b) Medicines, aids and medical supplies for such Medical Treatment

(c) Radiotherapy

(d) Physiotherapy

(e) Nursing Care visits on an outpatient basis

Participating Hospital

A quality institution based and licensed in the USA which provides inpatient and outpatient Medical Treatments and has been accepted by PGH as a Participating Hospital. A list of the Participating Hospitals is available from the Company.

Participating Practitioner

A U.S. licensed, practicing medical doctor who is affiliated with a Participating Hospital. These Participating Practitioners are Board certified in their defined medical specialties.

Physiotherapy

Physiotherapy is treatment using physical aids (hydrotherapy, heat or similar aids, physical aids based on biochemical and neurophysiological techniques) in order to restore maximum function and/or to prevent or limit full or partial disability following illness or surgery. These treatments must be prescribed by a Participating Practitioner.

Policy

It shall mean all the terms and conditions contained herein, including the Policy Schedule, endorsements and attachments thereto and is the contract between the Company and the Policyholder.

Policyholder

The one in whose name the Policy is issued and who is named in the Policy Schedule.

Policy Schedule

The Policy Schedule which is attached to and forms part of this Policy.

Pre-Existing Conditions

Any medical conditions for which the Insured Person received medical treatment or advice within forty eight months prior to the effective date of Insurance or conditions of which the Insured Person knew or should have been aware before the effective date of Insurance. It does not include any such conditions which the Insured Person had notified the Company in writing and had been accepted by the Company. Notwithstanding the foregoing and subject to the approval by the Company in writing, after twenty four months of continuous coverage the Insured Person will be eligible for applying for insurance cover of any excluded condition, provided that the Insured Person has not consulted any physician for advice, treatment or any medical examination and has remained free from taking any form of medication including drugs, medicines, special diet or injections for the condition in question for such continuous forty-eight month period prior to receiving treatment for such condition.

Preferred Global Health, Ltd. (PGH)

This is the organisation which advises, assists and supports Insured Persons undergoing a covered Medical Treatment in the USA. PGH is responsible for travel and accommodation arrangements, communications and coordination with the National Medical Advisers and for all contacts with Participating Practitioners and Hospitals in the USA. It is a company incorporated under the laws of Bermuda whose registered office is situated at Clarendon House, 2 Church Street, P.O. Box 1022, Hamilton, HX DX, Bermuda.

Pre-Transplant Evaluation

The medical examination, tests and evaluations in the USA which are necessary in order to determine whether an Insured Person can be accepted as a candidate for transplant and as a recipient of an organ for transplant.

Transplant Event

The medical procedure by which a donor organ or tissue is implanted into the Insured Person as the recipient.

Transplant Event Benefit Period

The period of time which starts 3 days before the organ transplant procedure, or 30 days before the bone marrow transplant, and ends 365 consecutive days after the organ transplant or reinfusion is performed.

PART 4 Exclusions

The Company shall not be liable for and shall not pay any claims in respect of:

1. Riot, civil commotion, war, invasion, act of foreign enemy, hostilities (whether war declared or not), civil war, rebellion, revolution, insurrection or military or usurped power or terrorism;
2. Ionising, radiations or contamination by radioactivity from any nuclear fuel, or from any nuclear waste from the combustion of nuclear fuel, nuclear fission, nuclear weapons or radioactive contamination, unless this is a consequence of a medical treatment;
3. Pre-Existing conditions and associated complications;
4. Treatments not approved through the pre-treatment review and approval process;
5. Treatments which are Experimental or Investigative in nature, unless specifically approved in advance;
6. Treatments which are not Medically Necessary for the Insured Person's illness or condition;
7. Drug addiction, alcoholism, or wilful misuse of drugs or alcohol, attempted suicide or intentional self-inflicted illness or injury while sane or insane or participating in an illegal activity;
8. Treatments and diagnostic testing or other medical services which were not prescribed or administered by a USA based Participating Hospital or Participating Practitioner;
9. Expenses directly or indirectly arising from Human Inmuno-deficiency Virus (HIV) related disability, including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutation, derivations or variations thereof which proceeds from an HIV infection;
10. Treatments which are normally provided free of charge;
11. Care provided by private nurses which were requested by the Insured Person;
12. Treatments provided solely as physiotherapy and/or occupational therapy, or rehabilitation of any kind; such treatments will be covered if within an Episode of Treatment;
13. Costs incurred as a result of failure to keep an appointment, unless the appointment was missed due to circumstances outside the Insured Person's control;
14. Expenses that are recoverable from a third party;
15. Surgery or treatment for cosmetic purpose;
16. All complications arising from pregnancy;
17. Illness or injury arising out of and in the course of employment or covered under workers' compensation or occupational accident benefits;
18. Non-performance, omission, default, or negligence of any of the service providers, including PGH, in the arrangement envisaged in this Policy.
19. Sanction Limitation and Exclusion Clause

    No insurer shall be deemed to provide cover and no insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

PART 5 Eligibility and Effective Date

Eligibility

Insured Persons must be over the age of 1 and under the age of 75 on effective date of Insurance of the Policy. An application accompanied by a health declaration should be submitted for each Insured Person. It is possible to insure children on condition that, besides the spouse, applications are submitted for all children over the ages of 1 and under the age of 27 years. The Company is not under a duty of acceptance.

Effective Date

This Policy shall become effective and commence on the date specified in the Policy Schedule and subject to approval by the Company.

If, before the effective date of coverage:

1. an Insured Person develops an illness on the basis of which the Company, had it known about it at the time of the application for the Insurance, would not have accepted the application or would have accepted subject to conditions, there is no coverage for that condition.
2. an Insured Person who is admitted to the hospital, the Insured Person must inform the Company of the reasons for admission and the date of discharge from hospital. The coverage does not become effective until the Insured Person has been discharged from hospital, with the provisions of paragraph 1 above remaining in full force.

PART 6 Premium

1. The consideration for this Policy is the payment of premium at the pre-agreed intervals, the first payment of which is due immediately upon the applicant's acceptance of the terms of this Policy notwithstanding that such date may be in advance of the effective date of Insurance.
2. The Company will only adjust the level of premium if there is an overall adjustment in premium for the whole Preferred Care programme.
3. If payment is not received by the Company on or before the due date, the Policy shall terminate on such date. The liability of the Company shall be restricted to expenditure incurred prior to that date (provided that where an overdue payment is received by the Company within 30 days after the due date, the Company may at its discretion determine that the entitlements to benefits thereunder shall continue in full force and effect.) The Company is not obliged to give the Policyholder notice of default.
4. Premium for each Insured Person is based upon the attained age on the effective date of Insurance.

PART 7 Termination

1. Whilst this Policy shall not be cancelled because of eligible claims made by the Policyholder or any Insured Person, the Company may at any time terminate this Policy if the Policyholder or any Insured Person has at any time:

   1.1 misled the Company by misstatement;

   1.2 knowingly claimed benefits for any purpose other than as are provided for under this Policy;

   1.3 agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the Company's detriment and/or;

   1.4 failed to act with utmost good faith.

   The Company will serve an immediate cancellation notice by sending registered letter to the Policyholder at his last known address and in such event will return to the Policyholder the premium paid less the pro rata portion thereof for the period the Policy has been in force.

   The Policy may be cancelled at any time by the Policyholder and provided no claim has arisen during the then current period of Insurance, the Policyholder shall be entitled to a return of premium at the Company's short period rates for the period the Policy has been in force.

2. The Policy shall terminate upon the death of the Policyholder. Any Eligible Family Members shall cease to be an Insured Person upon his or her death or upon his or her ceasing to be an Eligible Family Members. In the event of the death of a Policyholder, Family Members previously covered may apply to the Company within 60 days upon such termination or before the next renewal date, whichever is the earlier, to effect the Policy independently. Applications not submitted within such period must be accompanied by a health declaration, and subsequently go through the usual acceptance procedure.
3. Insurance in respect of the Policyholder and spouse shall terminate upon the renewal date next following his or her attainment of age 99 years.

4. Insurance in respect of an insured dependent Child, shall terminate upon the renewal date next following i) his or her marriage or ii) upon reaching the age of 27 years, or iii) otherwise ceasing to be a dependent of the Policyholder. A Child who has been previously covered may apply to the Company within 60 days upon such termination to effect the Policy independently. Applications not submitted within these 60 days must be accompanied by a health declaration, and subsequently go through the usual acceptance procedure.
5. Non-payment of any premium or subsequent premiums shall terminate insurance under this Policy as from that premium due date.

Moving to Another Country/Region

If an Insured Person settles permanently outside of Asia the coverage ends for that Insured Person upon the next renewal date.

Change in Conditions

The Company is entitled to revise the conditions of this Policy with effect from a date to be determined by the Company in writing to the Policyholder. The Policyholder is entitled to cancel the Policy within 30 days of receiving notification of the change. As such, the insurance ends on the date on which the revision is to take effect.

PART 8 Claims

1. Payment of Benefits

PGH will pay or arrange to pay the Participating Practitioners, Participating Hospitals and other service providers in accordance with the terms of this Policy. PGH does not provide medical services/treatments, but, as a service provider, does pay on the Company's behalf for covered services/treatments received by the Insured Person.

2. Submission of Claim

If costs are inadvertently paid by the Insured Person, invoices should be submitted to PGH within 90 days of the date on which the costs were incurred. If a claim is not submitted to PGH within 90 days as aforesaid, entitlement to benefits continues to exist if the Insured Person demonstrates to PGH's satisfaction that invoices will be provided as soon as is reasonably practicable, and in any event no later than six months from the date on which the relevant costs are incurred.

3. Payment of Non-covered Items/Treatments/Services

Payment must be made by the Insured Person, directly to providers, vendors or other agents for goods, services and treatments rendered which are not covered by the Policy.

4. Insured Person/Hospital/Practitioner Relationship

The choice of a U.S. based Participating Practitioner or Hospital is at the sole discretion of PGH.

5. Benefits are Non-assignable

Benefits or payments cannot be assigned to third parties, except for the customary assignment of benefits to a USA-based Participating Practitioner or Hospital which has carried out the treatment for which benefits are paid.

6. Suits Against Third Parties

Nothing in this Policy shall render the Company and/or PGH liable in respect of, or liable to prosecute, respond to or defend, any suit for damages which may arise in connection with any negligence, omissions, default or malpractice of any selected medical and service providers, National Medical Advisors, Participating or non-participating practitioners or hospitals based in the USA to provide any treatment or conduct any medical examination of any Insured Persons.

PART 9 General Policy Provisions

Additions

Any person becoming eligible after the effective date of this Policy may be added as a named Insured Person by the Policyholder, subject to proof of eligibility and insurability satisfactory to the Company and payment of the required additional premium. Insurance coverage for the new Insured Person shall commence on the date such proposal has been approved by the Company.

Alterations

No alterations in the terms of this Policy nor any document forming part thereof will be valid unless the same are signed by an authorised representative of the Company.

Assignment and Sub-contract

The Company shall be entitled to assign any of its rights under this Policy without the consent of the Policyholder. In addition, the Company shall be entitled to sub-contract any part of its duties under this Policy to third parties without the consent of the Policyholder provided that the Company will remain liable under this Policy.

Authorisation to Release Information

For the proper evaluation and processing of a claim, it is necessary for the Company, PGH and the National Medical Adviser, to have access to all information which they deem necessary. As a rule, such information will be held by the Local Medical Practitioners or hospitals treating the Insured Person.

The Insured Person will therefore grant authorisation for the provision of medical information to the National Medical Adviser and to the Participating Practitioners and Hospitals in the USA. Failure to grant such authorisation results PGH to repudiate the claim.

Clerical Errors

An Insured Person is not entitled to benefits that constitute an overpayment, or benefits that are paid as a result of a mistake made by the Company and/or PGH. The Insured Person will reimburse the Company and/or PGH for any such payments directly received.

Consideration

This Policy is issued in consideration of the statements contained in the application form and the Policy Schedule and the Policyholder's agreement to pay premium when due.

Currency

Claims payable under this Policy shall be in the US Dollar currency, unless otherwise stated.

Duties of the Policyholder/Insured Person

The due observance and fulfilment of the Terms and Conditions of this Policy in so far as they relate to anything to be done or complied with by the Policyholder or the Insured Person shall be conditions precedent to any liability of the Company and/or PGH to make such payment under this Policy.

Entire Contract: Changes

This Policy, including the Policy Schedule, Applications, all amendments and endorsements thereto, if any, will constitute the entire contract between the parties. No change in this Policy shall be valid unless approved by the Company and evidenced by endorsement or amendment.

Governing Law

This Policy shall be governed by and interpreted in accordance with the Hong Kong SAR law, except as otherwise stated herein.

Interest

No benefit payable under this Policy shall carry interest.

Jurisdiction

The Company will in all competent judicial proceedings at the instance of parties suing in respect of matters arising out of this insurance acknowledge the jurisdiction of the Courts in the Hong Kong SAR only.

Legal Proceedings

No action shall be brought to recover on this Policy prior to the expiration of sixty days after notice of claim has been filed to the Company. Furthermore, no such action should be brought at all unless commenced within three hundred and sixty five days from the notice of claim being filed.

Misstatement of Age

If the age of any Insured Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age. In the event the age of the Insured Person has been misstated, and if according to the correct age of the Insured Person, the coverage provided by this Policy would not have become effective, or would have ceased prior to the acceptance of any premium then the liability of the Company during the period the Insured Person is not eligible for cover shall be limited to the refund of premium that would be applicable.

Misstatement or Fraud

Any false statement made by the Policyholder or the Insured Person in the Application Form or concerning any claim shall entitle the Company and/or PGH to repudiate liability under the Policy.

Policy Renewal

This Policy may be renewed for further consecutive twelve months period by the payment of premium before the effective date of the renewal at the Company's premium rate in force at the time of renewal. The Company shall not be under any obligation to renew this Policy or any part thereof and shall not be obliged to give any reason for its decision.

Premium Rate

The rates of premiums and any rates of premium discounts or surcharge of this Policy shall be prescribed from time to time by the Company which shall also have the right to prescribe the method of payment of premiums.

Short Period Rates

The Company's Short Period Rates are:

Period in force not exceeding	**The Company Retains**
1 month	20% of annual premium
2 months	30% of annual premium
3 months	40% of annual premium
4 months	50% of annual premium
5 months	60% of annual premium
6 months	70% of annual premium
8 months	80% of annual premium
Exceeding 8 months	Full annual premium

Subrogation

The Company has the right to proceed at its own expense in the name of the Policyholder against third parties who may be responsible for an occurrence giving rise to a claim under this Policy.

Claim Payment

Payment of any claim, or a portion of any claim under any part or parts of this Policy is made without prejudice and any payment shall not be an admission of liability under any part or parts of this Policy.

Duplicate Application

An Insured Person shall not be covered under more than one Preferred Care or Private Care Policy issued by the Company. If the Company discovers that an Insured Person is covered under both the Preferred Care Policy and the Private Care Policy, the Company will deem such Insured Person to be insured only under the policy which provides the greatest amount of Benefit. If the Company discovers that the Insured Person is covered under more than one Preferred Care Policy or more than one Private Care Policy, the Company will deem such Insured Person to be insured under the policy which was issued at the earliest date (in chronological order). In either case, the Company will remove the Insured Person's name from all other Preferred or Private Care Policies under which he/she was previously covered. The Company will refund any duplicated insurance premium payment which may have been made by or on behalf of that person.

Terms and Conditions

Benefits payable under this Policy are subject to the Definitions and all other pertinent Terms, Provisions and Conditions.

Arbitration

All differences arising out of this Policy shall be referred to the decision of an arbitrator to be appointed by the Policyholder and the Company or, if they cannot agree upon a single arbitrator, to the decision of two arbitrators, one to be appointed in writing by each party, and in case of disagreement between the arbitrators, to the decision of an umpire who shall have been appointed in writing by the arbitrators before entering on the reference and an award shall be a condition precedent to any liability of the Company or right of action against the Company. Arbitration shall be conducted in accordance with the provisions of the Arbitration Ordinance (CAP 341, Laws of Hong Kong).

Contracts (Rights of Third Parties) Ordinance

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.

Levy collected by the Insurance Authority has been imposed on this policy at the applicable rate. For further information, please visit www.axa.com.hk/ia-levy or contact AXA at (852) 2867 8678.

Important Notes:
The above policy is underwritten by **AXA General Insurance Hong Kong Limited** ("AXA"), which is authorised and regulated by the Insurance Authority of the Hong Kong SAR. AXA will be responsible for providing your insurance coverage and handling claims under your policy. The Hongkong and Shanghai Banking Corporation Limited ("HSBC") is registered in accordance with the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong) as an insurance agent of AXA for distribution of general insurance products in the Hong Kong SAR. General insurance plans are products of AXA but not HSBC.

Schedule of Benefits

Maximum applicable annual limit per Insured Person For all covered Medical Treatments, travel and accommodation expenses, taken together, during the period of Insurance	**US Dollar** $2,000,000
Sub-Limits	
1. Travel and accommodation expenses (for the Insured Person or the Insured Person and one companion)	
(A) Travel and accommodation expenses per Episode of Treatment (Subject to maximum accommodation $300 USD per day)	$20,000
2. Organ Transplant (per transplant)	
Pre-transplant Evaluation	
(A) Medical costs	$25,000
(B) Travel and accommodation expenses for the Insured Person or the Insured Person and one companion (Subject to maximum accommodation $300 USD per day)	$7,000
Procurement costs	
(C) Medical costs	$50,000
(D) Travel expenses of the living donor	$3,000
3. Transportation benefit in the event of death	$5,000
4. Maximum duration of an Episode of Treatment	**IN DAYS**
(A) For treatment related to organ transplant	365
(B) For cancer treatment (except that an extra 245 days will be added to the maximum duration for continued or prolonged cancer treatment)	120
(C) For all other Episodes of Treatment	90
Remarks: Deductible per Episode of Treatment = $0 USD	