保柏危疾全禦保計劃
Bupa Safe Critical Illness Insurance Scheme

合約
Contract

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(2026 年 1 月 1 日版本)

據本合約所訂之條款保柏謹簽發本合約予投保人並同意根據保障金額表支付有關保障予投保人；在保費成功收訖及已提交申請表予保柏之情況下，保柏將同意發出本合約並根據合約條款提供保障給會員。

一般條款

在詮釋本合約時：
(a) 稱為同類規則的規則不適用，因此，以「其他」一詞引述的一般詞語，不應由於前文有顯示特定行為、事項或事物類別的詞語而被賦予限制性的涵義；
(b) 一般詞語不應由於隨後有擬由該一般詞語包含的特定例子而被賦予限制性涵義；
(c) 本合約內的標題僅供參考之用，不應影響本合約任何條款的解釋及應用；及
(d) 所提述的「本合約」或「合約」應指可不時修訂的本合約。所提述的項、節及表指本合約的項、節及表。

1. 定義

本合約內凡有關詞語之單數字詞將包含眾數意義而相反亦然；另含陽性的字詞將包含陰性及中性；同時，除非內文另有註明，下列詞語將以下列定義闡釋：

意外	指外在、突發、強烈及不可預料而可見的事件，此事件是導致身體受傷的唯一原因並且與其他事件無關。
積極癌症治療	指針對癌症的手術、放射性治療（包括質子治療）、化療、標靶治療、骨髓移植、免疫治療、數碼導航刀、伽瑪刀或以上的治療組合，而該癌症治療屬醫療必需。荷爾蒙治療或紓緩治療均不包括在內。
額外癌症保障	指會員在符合**「危疾保障述要」**載列之病症被確診為患有癌症，符合其所定條件應支付的危疾保障。
麻醉科醫生	指在香港醫務委員會以麻醉科專科登記或具其他同等資歷的註冊西醫。
申請表	指投保人就本合約簽發或合約保障更改而提交予保柏之申請表格及其他證明文件。
保障	指保柏根據本合約應支付之保障。
賠償金額	指根據投保人所投保的計劃級別，在會員證書或保障金額表上列明的危疾保障可獲賠償的分項賠償金額。
保柏全禦卡	指保柏根據本合約發給合資格會員的醫療卡，而這張卡的使用受限於**「特別條款 - 信用額安排」**和「會員指引」所訂的條款。
保柏	指保柏（亞洲）有限公司。
保柏集團	指保柏及所有由保柏直接或間接控制、受控制於保柏或與保柏受共同控制的實體，包括屬於保柏及所有此等實體的聯營、聯繫公司及有關者。
保柏全禦網特選專科醫生	指在保柏全禦網特選醫院及專科醫生目錄內名為專科醫生的專科醫生。
保柏全禦網特選服務供應商	指由保柏委任，並與保柏訂立信用額安排的註冊西醫、醫院、癌症中心、日症中心及其他服務供應商，向會員提供醫療服務。指定服務供應商名單可於保柏全禦網目錄查閱。
保柏全禦網特選醫院及專科醫生目錄	指列載保柏全禦網特選服務供應商資料的電子版目錄。保柏會不時更新及修訂此名單，請於保柏的手機應用程式或網站查閱。
癌症	指**「危疾定義」**中所定義為「癌症」的疾病。
癌症治療賠償保障	指會員確診受保癌症後可獲**「危疾保障述要」C 節**第一至六部分提及的任何或所有保障。癌症治療賠償保障的總額不應超過保障金額表中訂明的最高賠償額及終生賠償額。
中藥	指按照香港法例第 549 章《中醫藥條例》於香港中醫藥管理委員會中藥組或按照提供中藥治療之任何其他地方之同等法定機構合法註冊之中藥材。
先天性病症	指自出生已存在之醫學異常，不論會員知道與否。這包括（但不排除在醫學上被視為先天性疾病之其他病症）斜視、腦積水、睪丸未降、美克爾氏憩室、扁平足、心間隔缺損及腹股溝斜疝（小腸氣）。
合約	指適用於保柏危疾全禦保計劃的規定包括本合約的條款、細則及除外條款、會員證書、保障金額表、申請表、經保柏授權代表簽署的背書及修訂協議及任何就可保資格而提供的醫療證明、書面陳述、投保確認書，及其他附加於本合約的資料頁。
合約週年日	指續保生效日期。首次續保日期為會員證書列明或隨之而簽發的背書（如有）上所規定之日期，在隨後之公曆年中與危疾保障開始日同日。
合約年度	指會員證書列明或隨之而簽發的背書（如有）上所規定之期間，即危疾保障開始日起開始至合約週年日結束。
控制	指一家公司已發行股本多於百分之二十五（25%）的實益擁有權或法律權利以指示或促使該公司的管理作出指示（而「受控制」亦據此解釋）。
受保癌症	指**「危疾保障述要」C節**中受保的疾病，涵蓋任何經組織學或血液系統的細胞檢查（包括但不限於外週血塗片及骨髓檢驗）確診為惡性之癌，並須有惡性細胞已不受控制地生長並侵略其他細胞組織的特徵。 就此合約而言，「受保癌症」是包括： (a) 所有級別的惡性癌，包括早期癌；及 (b) 受保原位癌， 但明確地不包括以下任何一項： I. 任何在組織病理學中分類為癌前病變腫瘤； II. 子宮頸界定的異常病變定為第一階段(CIN I)及第二階段(CIN II)；及 III. 人體免疫力缺乏病毒(HIV)感染同時存在的所有癌症。 為免存疑，本定義並不等同**「危疾定義」**中相關環節所界定的癌症、早期癌症和原位癌，且涵蓋的疾病範圍更闊。
受保原位癌	指**「危疾保障述要」C 節**中受保的疾病，這涵蓋經病史證實並局限在侵入性前之病變，即癌細胞並無穿透基底膜，亦未侵入（即指滲入及／或活躍地破壞）環繞組織或氣孔。
信用額	指「保柏全禦卡」提供的最高信用額，該金額可由保柏不時決定。
危疾	指保障金額表定義的應支付危疾保障之確診疾病或病症。疾病或病症症狀必須在**「一般條款」第 6 項(b)** 規定的九十(90)天等候期後首次出現病徵並被確診，但因意外引致的任何疾病或病症除外。所診斷之疾病或病症必須有病理學報告及／或其他適當檢驗結果及檢查支持，所有治療及手術（如適用）亦須由註冊西醫確認為醫療必需。
危疾保障	指**「危疾保障述要」A 節及 B 節**下所載之任何或所有保障，包括嚴重危疾保障、早期危疾保障及額外癌症保障。應支付危疾保障分項及合計金額不得超過會員證書所分別列明的賠償金額。

危疾保障開始日	指會員證書列明或隨之而簽發的背書（如有）上所規定之本合約保障開始日日期。
日症	指**「危疾保障述要」C 節**保障下，以診斷、檢驗或治療受保癌症為目的，由註冊西醫於診所或醫院日症病房可有效地進行之手術或非手術癌症治療而留院過夜乃非醫療必需。
危疾定義	指合約所附定義清單，其中載列每種危疾的資格及定義。
營養師	指保柏承認為營養師之人士，或於獲取食物及營養管理（營養學）學位後於香港接受完整訓練或引致醫療費用的任何其他地方擁有法律資格或許可下執業，並擁有最少等同香港營養師協會下的註冊營養師資格及法定認可人士（會員本身、其親屬、家人或業務伙伴則除外，除非經保柏批准）。
遠端轉移癌症	指在遠離腫瘤原發部位的器官形成新腫瘤，且腫瘤源自相同的惡性細胞。癌症擴散至淋巴結並不符合遠端轉移的條件。遠端轉移癌症必須由專科醫生證明，並有醫療檢查及報告證實為遠端轉移癌症。僅憑臨床診斷並不符合規定，必須有客觀醫療證明（包括但不限於應用放射學報告、組織學報告及化驗報告）。
早期危疾	指**「危疾保障述要」A 節**中「早期危疾保障」下所列之任何一(1)種受保障危疾。
早期危疾保障	指會員確診患有任何一(1)種受保早期危疾或接受任何一(1)種早期危疾的受保手術時，根據危疾保障應支付之保障。
緊急情況	指急病情況而沒有事先安排的住院，而有關初起病徵、診斷或治療均相距不超過 48 小時。
不保項目	指保柏可按會員的投保前已存在病症或其他影響其可保性的因素，就特定的疾病或病症而加設的不保項目。該等狀況載列於會員證書或背書。
實驗性治療現金津貼	指**「危疾保障述要」C 節**第五部分提及的任何或所有保障。
延伸支援保障	指**「危疾保障述要」C 節**第三部分提及的任何或所有保障。
香港	指中華人民共和國香港特別行政區。
醫院	指按其所在地法律妥為成立及註冊為醫院的機構，為不適及受傷的住院病人提供醫療服務，並 – (a) 具備診斷及進行大型手術的設施，或屬於《醫院管理局條例》（香港法例第 113 章）所界定的公營醫院或是根據《私營醫療機構條例》（香港法例第 633 章）領有牌照的醫院； (b) 由持牌或註冊護士提供二十四(24)小時護理服務； (c) 由一(1)位或以上註冊醫生駐診；及 (d) 非主要作為診所、戒酒或戒毒中心、自然療養院、水療中心、護理或療養院、寧養或紓緩護理中心、復康中心、護老院或同類機構。
住院及手術保障	指**「危疾保障述要」C 節**第二部分提及的任何或所有保障。.
住院	指由註冊西醫轉介以病人身份接受以西方醫療及外科手術服務的醫療必需之住院。根據合約所訂，會員必須在整個入院時段都住在醫院內，而同時醫院有向會員收取住房及膳食費。
深切治療部	指醫院內專為住院病人提供深切醫療及護理服務而設的部門。
保費徵費	指根據《保險業條例》（第 41 章）及《保險業(徵費)規例》（第 41I 章）所規定，及《保險業(徵費)令》（第 41J 章）內所訂明及計算的訂明徵費。
終生賠償額	指保柏向投保人支付之終生最高賠償限額，其餘額將成為下一個合約年度的終生賠償額。如終生賠償額已經耗盡，受終生賠償額所限之保障將不會再作出賠償。合約年度內可支付之終生賠償額的餘額將在會員證書中顯示。
嚴重危疾	指**「危疾保障述要」A 節及 B 節**中嚴重危疾保障下所列之任何一(1)種受保障危疾。
嚴重危疾保障	指會員確診患有任何一(1)種受保危疾或接受任何一(1)種危疾的受保手術時，根據危疾保障應支付的賠償。
最高賠償額	指根據本合約條款及細則，對於保障金額表中**「危疾保障述要」C 節**訂明之有關保障，經由保柏支付或賠償的最高限額。
醫療器具	指會員因患上受保癌症直接導致行動或日常活動受到妨礙而僅供該會員使用的輔助工具、器具或設備，以協助其行動和日常活動。醫療器具並不包括會員家居的改裝，包括永久或半永久固定的器具。
醫療必需	指醫療上必需的治療、醫療服務或藥物： (a) 以正常及慣常費用就病症之診斷提供相應之治療； (b) 符合良好及謹慎的醫療標準； (c) 就有關診斷或治療而所需的； (d) 非純為會員、註冊西醫、註冊中醫、物理治療師、麻醉科醫生或任何其他醫療服務供應商提供方便； (e) 以最合適之程度向會員提供安全及有效的治療；及 (f) 住院非純為診斷掃描目的、影像學檢驗或物理治療。 為免存疑，在考慮治療、醫療服務或藥物是否醫療必需時，主診註冊西醫的建議並不是唯一的考慮因素。 就本合約而言，在不損害上述的一般性的原則下，符合醫療所需條件的住院情況包括但不限於以下例子 - (i) 會員因急症需要在醫院接受緊急治療； (ii) 手術在醫學上需要在全身麻醉下進行； (iii) 醫院具備手術或治療程序所需的設備，有關手術或治療程序並不能以日症病人的方式進行； (iv) 會員同時發生的傷病屬明顯嚴重；及/或 (v) 考慮到會員的個人情況及會員安全後，所需的醫療服務應在醫院內進行。 就「良好及謹慎的醫療標準」之詮釋，保柏將會考慮以下事項： I. 醫療標準為必須經過適當審查的獨立醫學期刊中臨床證明所界定； II. 相關專業機構的建議；及 III. 符合良好醫療守則標準。
會員	指名字顯示在會員證書為會員的人士。會員必須是投保人、投保人配偶／同居伴侶或投保人子女（包括任何非婚生或合法監護的子女、領養子女及繼子女）。同居伴侶指民事結合的伴侶或與投保人共同生活，並保持持續、忠誠以及唯一的關係的人士（不論同性或異性），而期間投保人或該人士並沒有和任何其他人士成婚或結合。
會員證書	指由保柏發給本合約所保障投保人的證書。該證書上將顯示投保人姓名、會員姓名、危疾保障開始日、賠償金額、計劃級別、合約編號及其他不時修訂的資料。
非手術癌症治療	指治療受保癌症的化療、放射性治療、標靶治療、免疫治療及荷爾蒙治療。

正常及慣常	就醫療服務的收費而言，對情況類似的人士（例如同性別及相近年齡），就類似傷病提供類似治療、服務或物料時，不超過當地相關醫療服務供應者收取的一般收費範圍的水平。正常及慣常的收費水平由保柏合理及絕對真誠地決定，在任何情況下，此收費不得高於實際收費。 保柏必須參照以下資料（如適用）以釐定正常及慣常收費 - (a) 由保險或醫學業界進行的治療或服務費用統計及調查； (b) 公司內部或業界的賠償統計； (c) 香港政府憲報；及/或 (d) 提供治療、服務或物料當地的其他相關參考資料。
職業治療師	指保柏承認為職業治療師之人士，或於香港或引致醫療費用的任何其他地方接受完整訓練及擁有法律資格或註冊採用智能、體能或社交活動就因疾病或傷患造成的殘疾予以評估與醫治，使病者在日常生活盡可能可以自立，並擁有最少等同香港法例第 359B 章《職業治療師(註冊及紀律處分程序)規例》下的職業治療師資格（會員本身、其親屬、家人或業務伙伴則除外，除非經保柏批准）。
手術室	指任何指定並配備進行外科手術或程序的設施，及至少符合香港衞生署署長發出的《日間醫療中心實務守則》或《醫院實務守則》或根據香港法例第 633 章《私營醫療機構條例》規定的任何其他適用的實務守則或規例的要求。
門診護理及監測保障	指**「危疾保障述要」C 節**第四部分提及的任何或所有保障。
門診診斷及檢測保障	指**「危疾保障述要」C 節**第一部分提及的任何或所有保障。
物理治療師	指於香港或引致醫療費用的任何其他地方擁有最少等同香港法例第 359 章《輔助醫療業條例》下的註冊物理治療師資格，並從事以運動、人手治療及以機械能、熱能或電能就身體殘疾予以評估及醫治的具法定資格人士（會員本身、其親屬、家人及業務伙伴則除外，除非經保柏批准）。
已存在病症	指會員於危疾保障開始日、最後復效日或於此合約升級或增加保障後之開始日（以較遲日期為準）前已存在、開始或出現症狀的任何不適、疾病、受傷、生理、心理或醫療狀況或機能退化，包括先天性病症。
預防性檢查保障	指**「危疾保障述要」C 節**第六部分提及的任何或所有保障。
私家房	指會員在住院期間入住只供私人使用的病房，該病房附有睡房及浴室，但不設廚房、飯廳或客廳。
心理學家	指保柏承認為心理學家之人士，或於獲取心理學學位後於香港接受完整訓練或引致醫療費用的任何其他地方擁有法律資格或許可前提下從事就情緒及行為失調予以評估及提供服務，並擁有最少等同香港心理學會下的註冊心理學家資格及取得學位資格的法定認可人士（會員本身、其親屬、家人或業務伙伴則除外，除非經保柏批准）。
合資格護士	指於香港或治療當地擁有最少等同香港法例第 164 章《護士註冊條例》獲法定為註冊或登記護士資格並從事護理病人服務的人士（會員、其親屬、家人及業務伙伴除外，除非經保柏批准）。
註冊中醫	指於香港或引致醫療費用的任何其他地方擁有最少等同香港法例第 549 章《中醫藥條例》下的註冊中醫資格並從事中藥治療的法定認可中醫或任何人士（會員本身、其親屬、家人及業務伙伴則除外，除非經保柏批准）。
註冊牙醫	指於香港或引致醫療費用的任何其他地方擁有法律資格或許可從事牙科治療，並擁有最少等同香港法例第 156 章《牙醫註冊條例》下的註冊牙醫資格的任何人士（會員本身、其親屬、家人或業務伙伴則除外，除非經保柏批准）。
註冊西醫	指於香港或引致醫療費用的任何其他地方擁有最少等同香港法例第 161 章《醫生註冊條例》下的註冊西醫資格並提供西方醫療及外科手術服務的法定認可普通科醫生、專科醫生或任何人士（投保人、會員、其親屬、家人或業務伙伴則除外，除非經保柏批准）。
癌症復發	指在治療結束後，由相同惡性細胞來源引起的癌症復發，並有醫療證據證明在一段時間內無法發現癌症。癌症復發必須由專科醫生證明，並有醫學檢查及報告證實癌症復發。僅憑臨床診斷並不符合規定，必須有客觀醫療證明（包括但不限於應用放射學報告、組織學報告及化驗報告）。
保障金額表	指合約內顯示可不時修訂的保障項目細節及危疾保障應支付之賠償金額的保障金額表。
半私家房	指於香港的醫院列為半私家房的房間或於香港以外地方不多於三名人士共用的醫院病房。
差額	指使用「保柏全禦卡」所支付但在**「危疾保障述要」C 節**下不受保障的醫療費用。
專科醫生	指保柏承認為專科之註冊西醫或在香港醫務委員會以專科登記之註冊西醫或具其他同等資歷之人士並從事專科治療。
言語治療師	指保柏承認為言語治療師之人士，或於獲取以治療言語缺陷及失調之學位後於香港接受完整訓練或引致醫療費用的任何其他地方擁有法律資格或許可的前提下治療言語缺陷，並擁有最少等同香港言語治療師協會下的註冊言語治療師資格的認可人士（會員本身、其親屬、家人或業務伙伴則除外，除非經保柏批准）。
投保人	指在會員證書上名為投保人的合約持有人。
保費	指會員證書上所示之費用，即投保人因保柏同意為會員提供有關保障而應支付或已付予保柏之保費。
附加保費	指保柏因承受會員的額外健康風險，於本合約向投保人收取之標準保費以外的額外保費。附加保費按本合約標準保費的百分比釐定（即附加保費率）。適用於危疾保障和癌症治療賠償保障（如選擇）的比率可有差異。
西藥	指經香港衞生署藥劑部或任何其他地方提供西方醫療及外科手術治療服務之等同法定機構合法註冊的藥物。

2. 合約

(a) 本合約將構成投保人與保柏之間的完整同意書。

(b) 投保人所有聲明將被訂為陳述而非擔保。

(c) 除非本合約另有註明，任何關於本合約之更改，包括但不限於條款及細則之增加、修改、改正及刪除，除非得到保柏書面批准並經保柏之授權代表簽署同意，否則不會有效。

(d) 任何代理或經紀將不會獲授權代表保柏從事下列各項：

i. 刪除或更改本合約上任何條款及細則，或以書面或口頭的形式引入其他條款及細則於本合約內；

ii. 根據本合約提供陳述或同意任何先決條件，或簽定任何附屬合約；

iii. 接納投保人的任何要約或反要約；及

iv. 批核或拒絕任何在本合約下的索償。

(e) 除因**「一般條款」中第 7 項、8 項、12 項及 22-25 項**所指情況外，本合約不能在合約週年日前一日終結前由保柏或投保人單方面終止。

(f) 在預先向投保人發出書面通知的情況下，保柏可不時更改本合約的保費率、條款及細則，惟此等更改須在續保時適用於相同產品的所有同一年齡的會員。此等更改將於合約週年日生效。如因會員年齡遞增而增加保費（如適用），保柏毋須事先向投保人發出書面通知。

3. 投保資格

(a) 於本合約首次登記當日，會員並非**「一般條款」中第 8 項**所定義的美國、日本或波多黎各自由邦的永久居民；

(b) 作為本合約生效前的條件，於危疾保障開始日投保人必須為十八 (18) 歲或以上；及會員必須年屆十五 (15) 日及 六十(60) 歲（首尾計算在內）。本合約會員必須持有有效香港身份證，並於申請前十二 (12) 個月內在香港居住超過一百八十三 (183) 天。十八 (18) 歲以下之會員必須持有有效香港出生證明或香港身份證。

(c) 受限於**「一般條款」中第 7 項**，如於合約週年日會員已年滿一百 (100) 歲，則本合約於合約年度終結時不會續保。

(d) 除非經保柏同意及批准，每位會員僅可受保於一份合約。
(e) 保柏保留權利拒絕任何申請。

4. 繳交保費

(a) 本合約所須繳付的保費包括 (i) 根據保柏現行採用的保費表並參考會員現時年齡的標準保費；及 (ii) 附加保費（如適用）。
(b) 保柏必須在收取本合約所須繳付的保費並全數兌現後，合約方開始或繼續生效（及合約下的保障並方應計算或支付）。
(c) 本合約有效期一(1)年，但根據本合約有關條款終止除外。保費將分別於危疾保障開始日、其後的繳費日（如適用）及合約週年日（續保時）到期繳交。所有已繳保費均不可退還。
(d) 根據《保險業條例》(第 41 章)規定，保單持有人須就保險合約向香港保險業監管局繳付訂明徵費。除非保柏以書面形式另外通知，否則投保人必須按照《保險業(徵費)令》規定的徵費率，在繳交保費時一併向保柏支付須繳的保費徵費。投保人如未有支付相關的保費徵費，保柏會根據保險業監管局的要求向該局報告，並提供所有相關資料，包括投保人的姓名、聯絡資料、徵費金額，以及本合約的其他資料。
(e) 於提交申請表時及申請更改保障時，保柏將根據核保評估釐定適用的標準保費（即吸煙者或非吸煙者）及附加保費。但若健康狀況或吸煙情況有任何變化，投保人或會員可於續保時向保柏申請重新評估，並可按保柏當時適用的慣常做法調整保費。

5. 保障範圍及賠償

(a) 若純因紀錄的文書錯誤，將不會令會員應有效之保障失效，或應已終止之保障可繼續生效。
(b) 如會員於獲支付合資格保障前不幸身故，合資格保障將支付予其遺產承繼人。
(c) 保柏根據本合約承擔的保障，將支付予投保人或其指定之第三者，或以投保人與保柏就任何特定情況另行協定之其他方式支付，並受本合約之相關條款及細則所約束。下列情形將視作保柏已向投保人支付保障：
   i. 保柏按本合約之相關條款及細則以自動轉帳方式向投保人進行支付。如入賬的賬戶非投保人或認可的投保人親屬名下，則需投保人簽署授權書。保柏有絕對權利拒絕該安排; 或
   ii. 保柏向保柏全禦網特選服務供應商支付（如適用）會員的醫療開支，作爲**「危疾保障述要」C 節**下的賠償。

   如賠償以支票支付，當保柏將支票送遞予投保人，便視作已支付保障。保障一經支付，則保柏可完全免除所有在本合約內有關之責任。
(d) **「危疾保障述要」C 節**僅限於符合以下條件之與受保癌症相關的治療、醫療服務或藥物：
   i. 由註冊西醫、註冊中醫（如適用）、物理治療師、麻醉科醫生或其他專業服務供應商（未經保柏認可的醫生、醫院或醫療保健機構除外）為會員提供或個別控制；
   ii. 有關治療程序、檢驗或服務符合保柏不時發出之最合適護理指引並於保柏認可的設施內進行；及
   iii. 必須按合理程序減輕有關開支。
(e) 對於在**「危疾保障述要」C 節**下應支付的賠償，如會員所引致的部分或全數醫療費用可經由其他途徑獲補償、償還、保險賠償或支付，則**「一般條款」中第 11 項 (b)vii** 將適用，本合約將不應被視為該醫療費用的首要保障提供者。

6. 已存在病症及等候期

(a) 除非會員已向保柏申報任何病症或疾病並獲接納，否則保柏不會就已存在病症支付任何保障。
(b) 於危疾保障開始日、合約最後復效日或於此合約升級或增加保障後之開始日（如適用）（以較後者為準）後九十(90)日的等候期內，就會員出現病徵、接受治療、藥物治療或檢查、或確診的任何危疾或受保癌症（如適用），保柏將不會支付任何保障。在合約簽發之前可能需要較長時間進行核保的情況下，上述九十（90）日等候期會被替代為由背書中註明的簽發日起計。等候期不適用於因意外引致的危疾或受保癌症（如適用）。
(c) 適用於嚴重危疾保障、早期危疾保障及額外癌症保障的任何其他等候期，均列於**「危疾保障述要」**內。**「危疾保障述要」C 節第 28 項**的預防性檢查保障則按其下所訂明的等候期所限。

7. 終止保障及合約

(a) 在不限制**「一般條款」中第 11 項**應用的原則下，如投保人或會員未有履行至高誠信的責任，保柏將有權終止會員的保障或本合約，又或更改本合約的條款及細則。
(b) 保柏將給予投保人兩 (2) 個月繳交保費的寬限期，由每期保費到期日起計。本合約於寬限期內仍然生效，惟在收到保費前，保柏於該期間內不會支付任何賠償。如保柏在寬限期屆滿後之任何一個保費到期日或之前未有收到全數保費，保柏有權向投保人發出書面通知終止本合約，保柏不須為該合約年度負上責任。
(c) 如會員只選擇**「危疾保障述要」A 節及 B 節**（如適用），本合約將在下列最早日期自動終止：
   i. 根據**「一般條款」中第 8 項或第 22-25 項**，終止會員的保障的日期；
   ii. 當投保人於合約週年日前最少十(10)天以書面通知保柏終止本合約。該終止將於合約週年日生效；
   iii. 合約週年日前一日，除非本合約按合約條款續保；
   iv. 嚴重危疾保障、早期危疾保障及額外癌症保障已全數支付予投保人當日（不論會員年齡）；
   v. 會員年滿八十五 (85) 歲或以上，嚴重危疾保障及早期危疾保障已全數支付予投保人當日；
   vi. 當嚴重危疾保障及早期危疾保障已於會員年滿八十五 (85) 歲前已全數支付予投保人，則為會員年滿八十五 (85) 歲緊接其後的合約週年日；
   vii. 保柏決定終止本產品，向投保人發出終止通知當日；或
   viii. 會員去世當日。
(d) 如會員選擇**「危疾保障述要」A 節、B 節**（如適用）**及 C 節**，本合約將在下列最早日期自動終止：
   i. 根據**「一般條款」中第 8 項或第 22-25 項**，終止會員的保障的日期；
   ii. 當投保人於合約週年日前最少十(10)天以書面通知保柏終止本合約。該終止將於合約週年日生效；
   iii. 合約週年日前一日，除非本合約按合約條款續保；
   iv. 如到了**「一般條款」第 7 項 (c) iv 至 vi** 中的任何日期，危疾保障將會終止，而本合約的**「危疾保障述要」C 節**將繼續有效直至會員年滿一百(100)歲或緊接會員根據**「特別條款 - 會籍轉移權」**行使轉移會籍權後的合約週年日爲止，以較早者爲準；
   v. 保柏決定終止本產品，向投保人發出終止通知當日；或
   vi. 會員去世當日。
(e) **「危疾保障述要」B 節**將於嚴重危疾保障支付予投保人後立即自動終止，而按**「危疾保障述要」B 節**就該保單年度已支付的任何保費將不會退還。
(f) 如因以上**「一般條款」第 7 項**所述任何原因終止保障，保柏保留權利於支付任何保障前扣除該合約年度的任何到期但仍未繳付的保費。

8. 居民身份

如會員的所在國家、會員的居住地或國籍所屬國家的法律(包括但不限於美國和日本)，或任何其他對保柏或本合約適用的法律禁止保柏向當地國民、居民或公民提供醫療保障，保柏可終止相關會員的保障。該終止將立即生效或由合約週年日（如相關會員的保障獲准繼續有效至該日期）起生效。如投保人知悉任何會員於合約年度改變居住地或國籍，投保人須立即以書面通知保柏。任何會員如成為美國、日本或波多黎各自由邦的永久居民，相關會員的保障將不會續保，而此事不限制上列條款。「永久居民」指居於某國家並且身為該國公民或根據適用法律獲許在該國永久性居留及工作的人士。

9. 索償程序

(a) 索償通知
   i. 會員須以保柏提供的賠償申請表提出在本合約下的索償。而所有所需文件正本須由會員或其代表於危疾確診後九十（90）日內或按**「危疾保障述要」A 節及 B 節**所訂明的期限內遞交，否則保柏有絕對酌情權可在不提供任何理由下拒絕是項賠償。
   ii. 就**「危疾保障述要」C 節**的可支付保障提出任何索償而沒有使用保柏全禦卡，會員必須使用保柏提供的賠償申請表提出索償。所有有關該索償的所需文件正本須由會員或其代表於求診、診所手術、日症、出院或接受與索償有關的服務後九十（90）日內遞交，否則保柏有權可在不提供任何理由下拒絕是項賠償。
(b) 適用於**「危疾保障述要」A 節及 B 節**（如適用）應付賠償的索償證明
   i. 危疾的證明須符合以下要求：
      o 由保柏接受的適當註冊西醫發出的證書；
      o 經醫學診斷後的確認結果包括但不限於臨床的、應用放射學、組織學的及化驗的證明；及
      o 如危疾須進行手術治療，該手術必定須證明為醫療必需。
   ii. 保柏可在合理情況下要求索償人遞交與索償有關保柏要求的資料、證書、證明、醫療報告及其他有關數據或資料，並由索償人支付全部有關費用。
   iii. 如保柏以書面通知要求更多關於**「一般條款」中第 9 項(b)i 及 ii** 之資料，除非保柏在通知書發出日後六 (6) 星期內收到所需資料，否則保柏將不對任何索償負責（獲得保柏同意及批准除外）。
   iv. 任何其他特別適用於額外癌症保障索償證明的要求，見**「危疾保障述要」A 節及 B 節第 3 項及第 4 項(b)**。

(c) 適用於**「危疾保障述要」C 節**下應付賠償的索償證明

i. 受保癌症的證明須符合以下要求：

- 由保柏接受的適當註冊西醫發出的證書；及
- 經醫學診斷後的確認結果包括但不限於臨床的、應用放射學、組織學的及化驗的證明。

ii. 保柏可在合理情況下要求索償人遞交與索償有關保柏要求的資料、證書、證明、醫療報告及其他有關數據或資料，並由索償人支付全部有關費用。

iii. 如保柏以書面通知要求更多關於**「一般條款」中第 9 項(c)i 及 ii** 之資料，除非保柏在通知書發出日後六 (6) 星期內收到所需資料，否則保柏將不對任何索償負責（獲得保柏同意及批准除外）。

(d) 檢驗

如發生索償，保柏有權付費要求由其委派的註冊西醫替會員進行檢查。倘若會員去世，保柏可在法律不禁止的情況下進行驗屍，在可行情況下，埋葬或火化前應給予保柏充份通知，當中列明死因研訊（如有）時間及地點。

10. 貨幣

保費、保費徵費及保障將以港幣支付。

11. 不受保障項目

(a) 除非本合約另有特別規定，如 (I) **「危疾保障述要」A 節及 B 節**下的危疾；及 (II) **「危疾保障述要」C 節**下的受保癌症，與下列的任何情況直接或間接相關或由該等情況而引致的，保柏將不須支付任何賠償：

i. 任何不保項目（如適用）及任何已存在病症（除非該等病症已在申請表中披露並獲保柏接納）。

ii. 根據**「一般條款」第 6 項(b)**所述的等候期內出現任何病徵或症狀、接受治療、藥物或檢查或診斷的疾病或病症。

iii. 感染愛滋病及愛滋病相關綜合症，或感染人類免疫力缺乏病毒（受保於**「危疾保障述要」B 節**之因輸血感染人類免疫力缺乏病毒、因侵害而感染之人類免疫力缺乏病毒、因器官移植而感染人類免疫力缺乏病毒、醫療引致感染人類免疫力缺乏病毒及因職業引致之人類免疫力缺乏病毒除外）。

iv. 自殺、試圖自殺、蓄意自傷身體，無論會員神智清醒與否。

v. 醉酒或並非由註冊西醫處方的藥物。

vi. 任何先天性病症。

vii. 戰爭、入侵、外敵行動、開戰（不論是否已宣戰）、內戰、暴動、革命、叛亂或軍事或非法奪權或恐怖活動。

viii. 參與或試圖違反法律或拒捕或參與任何犯罪活動。

ix. 乘搭任何飛機，但乘坐商用飛機的繳費旅客除外。

x. 吸入氣體，職業所附帶危害除外。

xi. 參與（或練習）拳擊、洞穴探險、攀爬、賽馬、小型高速滑艇、武術、攀山、在滑雪道以外滑雪、探洞、賽艇、潛水、帆船競賽、空中運動或任何比賽、測試或牽涉計時的機動車駕駛。

(b) 除了以上**「一般條款」中第 11 項(a)**所訂的不受保障項目外，除非本合約另有特別規定，如**「危疾保障述要」C 節**下的受保癌症，與下列的任何情況直接或間接相關或由該等情況而引致的，保柏將不須支付任何賠償：

i. 於會員申請保單復效、新增或增加**「危疾保障述要」C 節**下的保障獲保柏批准後，由保柏提出的任何額外不保項目（如適用）及其復效日或升級或增加保障後的開始日之前已經存在的任何已存在病症（除非該等病症已在相關申請中披露並獲保柏接納）。

ii. 任何在組織病理學上被分類為癌前病變腫瘤。

iii. 子宮頸界定的異常病變定為第一階段（CIN I）及第二階段（CIN II）。

iv. 一般檢查、健康檢查或基於預防或在沒有受保癌症病徵或病史下進行作受保癌症的檢查（**「危疾保障述要」C 節第 28 項**下可作賠償的預防性檢查保障除外）。

v. 進行任何治療方法而根據特定的定義在會員的體內沒有清晰確診受保癌症。

vi. 受限於**「一般條款」第 5 項(e)，**任何在法例下或其他保險計劃內或從其他途徑可獲賠償之疾病，除非此等費用未能在該等補償、保險計劃或途徑獲得賠償。

vii. 在水療中心、天然治療中心或類似機構所提供之住宿、護理或服務的費用。

viii. 任何所有類型的心理病或精神病症，包括但不限於精神病、神經機能病、抑鬱、焦慮、神經性厭食、精神分裂、行為失常、譫妄症、失眠、神經衰弱等直接或間接引致的治療（根據**「危疾保障述要」C 節第 19 項**應支付的臨床心理輔導保障或根據**「危疾保障述要」C 節第 13 項**與受保癌症有關的任何精神病狀況和應支付的精神科治療保障則除外）。

ix. 手術性或非手術性整容或整形治療、聽覺測驗、常規驗血、預防注射或接種疫苗、毛髮礦物質含量分析、健康補品或體重控制，及因視力不正常而引致之治療，包括但不限於常規視力測驗或所需之眼鏡或鏡片費用（根據**「危疾保障述要」C 節第 15 項**應支付的人工裝置保障則除外）。

x. 與懷孕有關的治療，包括診斷性產科檢查、生育、墮胎或小產；與男女任何一方的節育、絕育或變性；由於不育而直接或間接進行的治療，包括體外受孕或任何非自然受孕或人工受孕；與性機能失常有關之治療，包括但不限於陽萎、不舉及早泄（不論任何原因導致）。

xi. 另類治療，包括但不限於中藥治療、針灸、穴位按摩、推拿、催眠治療、羅爾夫按摩療法、按摩治療、香薰治療（根據**「危疾保障述要」C 節第 18 項和第 25 項**應支付的中醫師及輔助療法保障則除外）。

xii. 非醫療性服務，包括但不限於客人膳食、收音機、電話、影印、稅項（就醫療服務所徵收的增值稅或商品及服務稅除外）、醫療報告等費用。

xiii. 任何牙科治療或口腔手術收費（根據**「危疾保障述要」C 節第 2 至 17 項**應支付由口腔頜面外科專科的註冊牙醫所進行的醫療必需手術則除外）。

xiv. 因不符合「良好及謹慎的醫療標準」的實驗性或未經證實醫療成效的醫療技術或治療程序而招致的費用。就「良好及謹慎的醫療標準」之詮釋，保柏將會考慮以(I) 醫療標準為必須經過適當審查的獨立醫學期刊中臨床證明所界定；(II)相關專業機構的建議；及(III)符合良好醫療守則標準（根據**「危疾保障述要」C 節第 27 項**應支付的實驗性治療現金津貼保障則除外）。

xv. 在未經保柏認可的醫生、醫院或醫療保健機構產生的任何費用，包括但不限於以下治療的費用：

I. 由醫生、醫院或醫療保健機構提供的治療，或任何人或機構在香港或進行治療的地方的有關當局不認可其具有治療方面的專業知識的任何人或其他機構進行或提供醫療、疾病或受傷的治療；

II. 由會員本人、其親屬、家人或商業夥伴或與會員同住的任何人所提供的治療，若治療在一所機構進行，則上述人士是該機構的股東及／或持有該機構的控制權，除非已告知保柏並獲其批准； 或

III. 由保柏未有或不再因應其保險計劃而認可的醫生、醫院或醫療保健機構所提供的治療。

未經認可的醫生及供應商的列表可參閱本公司的手機應用程式或網站。 此列表可能會不時更新，恕不另行通知。

12. 重要披露

(a) 如會員於申請時不慎誤報其年齡或出生日期或其他相關資料（包括於合約簽發日或危疾保障開始日（以較後者為準）前更新及更改該等所需資料），而該誤報將影響有關保障的範圍或所需繳付保費的釐定依據或本合約的條款及細則，保柏有全權按會員之真實年齡及事實重新決定能否於本合約條款下繼續提供保障，及調整保障範圍。

(b) 保柏於履行本合約下之賠償責任而支付保障前，投保人或會員須遵照及符合本合約條款及細則並提供真確的陳述或聲明予保柏，而所有保柏在合理情況下索取資料作核實用途所引致的費用將由投保人或會員自行支付。

(c) 倘下列任何一項事情發生，保柏有全權決定本合約無效並要求投保人或會員即時繳還就該事項曾支付予投保人或會員的保障及保留權利追討因本合約無效所需的費用：

i. 如投保人或會員在申請表或表中任何陳述或聲明中不正確地提供或漏報任何可影響保柏評估本合約風險的、關於投保人或會員的事實（包括但不限於會員的吸煙習慣）（包括於合約簽發日或危疾保障開始日（以較後者為準）前更新及更改該等所需資料）；

ii. 如於獲得本合約時作錯誤陳述、誤導或隱瞞；或

iii. 提出任何虛假或誇大之索償。

13. 續保及更改保障

(a) 根據本合約**「一般條款」**，本合約將生效期為一 (1) 年，並保證由保柏每年自動續保（除非根據**「一般條款」第 7 項、8 項或 22-25 項**終止），但須按保柏根據**「一般條款」第 2 項(f)** 釐定之保費率及條款於指定銀行賬戶／信用卡（如適用）自動成功收訖保費。

(b) 如保柏在合約週年日前不少於十(10)日從投保人收到不續約的書面通知，則本合約將不會按**「一般條款」第 13 項(a)** 續約。

(c) 投保人只可於本合約續保時更改保費繳付方法，投保人須於合約週年日前不少於一個月以書面通知保柏，此等更改將適用於續保合約。

(d) 投保人可不時申請更改保障，但必須於合約週年日前最少一(1)個月向保柏發出書面通知。投保人可申請新增或增加保障，惟須符合 (i) 會員於本合約下已連續獲得兩(2)年保障；(ii) 會員於過去兩(2)年內未新增或增加任何保障；及 (iii) 會員之前未在本合約下提出任何索償。

(e) 保柏根據其現行的核保慣常做法評估更改保障申請，並保留權利拒絕該等申請或向投保人發出通知設立按其認為合適的更改條件。

14. 合約復效

如合約因欠交保費而失效，投保人可於首次保費逾期未付的保費到期日起計三(3)個月內申請合約復效。申請合約復效時投保人須向保柏遞交：

(a) 使用保柏提供的復效表格提出復效申請；
(b) 保柏滿意的投保健康證明，有關費用由投保人支付；
(c) 繳付所有過期保費；
(d) 任何有關投保人及／或會員身體狀況的額外資料，有關費用由投保人支付；及
(e) 如本合約的復效申請已獲保柏批准，保柏可訂定條款及細則作為復效的條件。上述**「一般條款」第 6 項(b)** 規定的等候期應自最後復效之日起重新計算。

15. 合約持有及轉讓權

除非另行議訂，保柏視投保人為本合約之絕對持有人，而在沒有保柏的書面同意下，本合約不能視作全部或部分之轉讓或轉承。

16. 仲裁或法律訴訟

在以下情況不能向保柏提出任何仲裁或法律訴訟：

(a) 在根據本合約的要求下提交有關索償證據予保柏後不足六十(60)日；或
(b) 在根據本合約的要求下須提交保柏有關索償證據日起計一(1)年後仍未提交該證據。

17. 有效時間及地域限制

(a) 有關本合約所提及之任何時間或日期將以香港時間上午 12 時 01 分開始計算。
(b) 本合約提供全球性的保障。

18. 管限法律及司法管轄權

本合約將受香港法律的管限及闡釋。根據**「一般條款」中第 19 項**，各方均同意接受香港法院的專屬管轄權所管轄。

19. 仲裁

任何在本合約下之糾紛及分歧將被轉介至香港國際仲裁中心並由該中心根據本地仲裁條例加以仲裁和辦理。

20. 取消合約權益及退還保費

如在本合約下未向投保人支付賠償或有應付賠償，投保人有權以書面通知保柏取消本合約，並全數取回已付保費及保費徵費。惟有關通知必須由投保人簽署，並於危疾保障開始日或本合約的簽發日期起計二十一(21)天內（以較後者為準）交回保柏。取消合約權益並不適用於續保之合約。

21. 不設第三者權利

任何不是本合約某一方的人士或實體，不能根據香港法例第 623 章《合約(第三者權利)條例》強制執行本合約的任何條款。

22. 賄賂及貪污

22.1 投保人聲明及保證，就保柏或投保人根據本合約訂立或履行任何義務而言，投保人或任何代表投保人或會員行事的人士概不會：
(a) 提供、承諾、給予、授權、索取或接受任何不正當的財務或其他任何形式的好處，投保人或彼等在訂立本合約後亦不會採取任何該等行動；
(b) 從事任何在反賄賂及反貪污事宜的適用法律下或會構成罪行的活動、行動或行為；及
(c) 作出或不作出任何行動或系列行動，致使或導致保柏違反任何反賄賂及反貪污事宜的適用法律。

22.2 倘任何人士就保柏或投保人訂立或履行本合約任何義務作出任何請求或要求任何不當財務或其他任何形式的好處或其他行為，且有關請求或要求一旦被滿足即違反任何反賄賂及反貪污事宜的適用法律，投保人需及時向保柏報告。

23. 制裁

23.1 倘保柏提供有關保障、支付有關索賠或提供有關保障將：
(a) 違反聯合國決議或保柏或保柏集團的任何實體、僱員或人員受約束的任何司法管轄區（可能包括但不限於歐盟、香港、澳大利亞、英國及／或美國的司法管轄區）的貿易或經濟制裁、法律或法規；
(b) 使保柏或保柏集團的任何實體、僱員或人員面臨被任何有關當局或主管機構制裁的風險；及／或
(c) 使保柏或保柏集團的任何實體、僱員或人員面臨參與（直接或間接）被任何相有關當局或主管機構認為屬禁止的行為的風險；

保柏將被視為不提供保障，且保柏無須根據本合約支付任何索賠或提供任何保障。

23.2 倘**「一般條款」第 23.1(a)項**中提及的有關決議、制裁、法律或法規適用於或變得適用於本合約，為確保保柏及保柏集團的任何實體、僱員或人員持續合規，保柏保留其採取其全權酌情認為屬必要的所有及任何有關行動的權利，包括但不限於終止保障。投保人知悉倘出現制裁相關問題可能會限制或延遲保柏在本合約項下的義務，保柏亦可能無法支付有關索賠。

23.3 倘投保人或任何會員有任何身分、法律狀況及資料上的改變時，在投保人有合理知悉時，應及時通知保柏。

24. 欺詐

24.1 倘投保人或會員有以下行為，保柏有權拒絕支付全部或部分索償，並收回保柏已就索償支付的任何款項：
(a) 根據本合約提出欺詐、誇大或虛假陳述索償；
(b) 已發送虛假或偽造文件或其他虛假證據，或作出虛假陳述，以支持根據本合約提出的索償；及／或
(c) 未能向保柏提供投保人或會員（視情況而定）知悉的會令保柏拒絕本合約項下索償的資料。

24.2 倘保柏偵測到會員進行或涉及會員的上述**「一般條款」第 24.1 項**所列的一類型的欺詐活動（包括欺詐索償或欺詐遺漏提供相關資料），保柏保留自相關欺詐活動發生之日起暫停或終止於本合約下享有的保障（全部或該會員之部份），且投保人將會接獲相關通知。保柏將無需進一步支付全部或部分索償或退還與該會員或該等會員有關的任何保費。

24.3 投保人應採取一切合理措施防止有關本合約的欺詐，如投保人有理由懷疑任何與本合約有關連的欺詐已發生、正在發生或可能發生，應立即通知保柏。

25. 協助逃稅

25.1 投保人聲明及保證，就保柏或投保人根據本合約訂立或履行任何義務而言，投保人或任何會員概無且亦不會從事在適用法律下任何構成逃稅或協助逃稅罪行的活動、行動或行為。

25.2 倘任何人士就保柏或投保人訂立或履行本合約任何義務作出任何提出進行任何行動的請求或要求，且有關請求或要求一旦被滿足即違反任何逃稅或協助逃稅的適用法律，投保人需及時向保柏報告。

危疾保障述要

A 節 - 危疾基本保障

B 節 - 嚴重危疾延伸保障（自選保障）

若會員被確診或接受於保障範圍內的任何一 (1) 種危疾或受保手術，保柏將支付以下危疾保障，而每項危疾在**「危疾定義」**部分有關標題下有其特定意義，且必須由註冊西醫證明。

在本合約條款及細則以及等候期規定下，會員終生最多可獲得一(1)次嚴重危疾保障、一(1)次早期危疾保障及一(1)次額外癌症保障（並受每項保障的保障期所約束）。危疾保障下的應支付金額不得超過保障金額表所列的個別賠償金額。就該合約年度危疾保障下各保障項目仍可用之賠償金額，會員須參閱會員證書。

1. 嚴重危疾保障

如會員首次被確診為患有以下一(1)種病症，將可獲支付嚴重危疾保障，金額相當於會員證書上所列明的賠償金額：

受保病症	保障於緊接以下年齡後的合約週年日結束
1. 癌症	100
2. 急性心肌梗塞	100
3. 中風	100

如會員證書內列明已投保 **B 節 -「嚴重危疾延伸保障」**，除上述病症外，會員於首次被確診或接受以下任何一(1)種病症或受保手術，亦會獲支付嚴重危疾保障：

受保病症	保障於緊接以下年齡後的合約週年日結束
與心臟有關的疾病／病症／手術	
4. 心肌病	100
5. 冠狀動脈手術	100
6. 夾層主動脈瘤	100
7. 心瓣手術	100
8. 其他嚴重冠狀動脈疾病	100
9. 原發性肺動脈高血壓	100
10. 主動脈手術	100
11. 嚴重傳染性心內膜炎	100
與主要器官及功能有關的疾病／病症／手術	
12. 雙目失明	100
13. 慢性腎上腺功能不全（愛狄信病）	100
14. 慢性自體免疫性肝炎	100
15. 慢性阻塞性肺病	100
16. 昏迷	100
17. 末期肝病	100
18. 末期肺病	100
19. 腎衰竭	100
20. 不能獨立生活	65
21. 失聰（損失聽覺）	100
22. 肢體缺失	100
23. 失去一肢及一眼	100
24. 損失說話能力	100
25. 主要器官移植	100
26. 囊腫性腎髓病	100
27. 嗜鉻細胞瘤	100
28. 嚴重支氣管擴張	100
29. 嚴重肺氣腫	100
30. 嚴重特發性肺纖維化	100
31. 完全永久傷殘	65
與神經系統退化有關的疾病／病症／手術	
32. 亞爾茲默氏病 ／不可還原之器質性腦退化疾病	100
33. 皮質基底核退化症	100
34. 嚴重克雅二氏症	100
35. 柏金遜症	100
與神經系統相關的疾病／病症／手術	
36. 肌萎縮性脊髓側索硬化	100
37. 植物人	100
38. 細菌性腦膜炎	100
39. 良性腦腫瘤	100
40. 腦部外科手術	100
41. 須作開顱手術之腦動脈瘤或腦動靜脈畸型	100
42. 腦炎	100
43. 偏癱	100
44. 嚴重頭部創傷	100
45. 多發性硬化症	100
46. 肌肉營養不良症	100
47. 癱瘓	100
48. 脊髓灰質炎	100
49. 原發性側索硬化	100
50. 進行性延髓麻痹	100
51. 進行性肌肉萎縮症	100
52. 進行性核上神經麻痺症	100

受保病症	保障於緊接以下年齡後的合約週年日結束
53. 脊髓肌肉萎縮症	100
54. 系統性硬化症	100
55. 結核性腦膜炎	100
與消化系統有關的疾病／病症／手術	
56. 急性壞死性胰臟炎	100
57. 急性出血壞死性胰臟炎	100
58. 再發性慢性胰臟炎	100
59. 暴發性肝炎	100
60. 嚴重克羅恩氏病	100
61. 嚴重潰瘍性結腸炎	100
與肌肉骨骼系統有關的疾病／病症／手術	
62. 糖尿病併發症引致的足截除	100
63. 嚴重燒傷	100
64. 壞死性筋膜炎	100
65. 意外引致的臉部嚴重燒傷	100
66. 嚴重重症肌無力症	100
與血液有關的疾病／病症／手術	
67. 再生障礙性貧血	100
68. 因輸血感染人類免疫力缺乏病毒	100
69. 因侵害而感染之人類免疫力缺乏病毒	100
70. 因器官移植而感染人類免疫力缺乏病毒	100
71. 醫療引致感染人類免疫力缺乏病毒	100
72. 因職業引致之人類免疫力缺乏病毒	100
與免疫科及風濕病學有關的疾病／病症／手術	
73. 系統性紅斑狼瘡連狼瘡性腎炎	100
74. 嚴重牛皮癬關節炎	100
75. 嚴重類風濕關節炎	100
76. 系統性硬皮病	100
其他嚴重疾病／病症／手術	
77. 伊波拉出血熱	100
78. 象皮病	100
79. 永久氣管造口術	100
80. 末期疾病	100

在任何情況下，本合約下的嚴重危疾保障不得支付一(1)次以上。為免存疑，即使會員同時患有多於一(1)種嚴重危疾，亦只可就嚴重危疾保障索償一 (1) 次。

當嚴重危疾保障一經支付，**B 節 -「嚴重危疾延伸保障」**將即時終止，而 **B 節 -「嚴重危疾延伸保障」**於合約年度餘下之保障期的保費亦將不會安排任何退款。保柏將於支付嚴重危疾保障前，可扣除該合約年度仍未支付的 **B 節 -「嚴重危疾延伸保障」**的每月保費。

2. 早期危疾保障

早期危疾保障將於會員就以下任何一(1) 種病症首次確診或接受受保手術時支付，金額相當於會員證書上所示的賠償金額：

受保病症	保障於緊接以下年齡後的合約週年日結束
1. 原位癌	100
2. 須作手術之頸動脈疾病	100
3. 因冠狀動脈疾病進行血管成形術及其他創傷性治療	100
4. 早期惡性腫瘤	100
5. 大腦動脈瘤的血管介入治療	100

在任何情況下，本合約的早期危疾保障均不會支付多於一(1)次。為免存疑，即使會員同時患有多於一(1)種早期危疾，但在此早期危疾保障下只可提出一(1)次索償。

如會員同時受保於「保柏智安保危疾保障計劃」，其「特別危疾保障」及於本合約的早期危疾保障下，終生可獲賠償總額為港幣 400,000 元。

3. 額外癌症保障

若嚴重危疾保障已獲賠償並且一(1)年之等候期屆滿後，如會員被確診為患有以下受保病症，將可獲支付額外癌症保障，金額相當於會員證書上所示的賠償金額：

受保病症	保障於緊接以下年齡後的合約週年日結束
1. 癌症	85

在任何情況下，本合約的額外癌症保障均不會支付多於一(1)次。為免存疑，即使會員同時患有多於一(1)種癌症，但在此額外癌症保障下只可提出一(1)次索償，而且必須符合以下**本 A 節及 B 節第 4 項(b)** 所載條件／等候期
如要獲額外癌症保障賠償，會員須提供以下資料：
(a) 根據**「一般條款」第 9 項(b) i**，前一次嚴重危疾首次被確診或進行手術之日起一(1)年後證明癌症存在的醫療報告；及
(b) 本 **A 節及 B 節第 4 項(b)** 所述積極癌症治療證明。

4. 保障項目賠償之間的等候期

(a) 嚴重危疾保障與早期危疾保障之間的等候期

首次被確診為患有嚴重危疾及早期危疾的日期須相隔最少四十五(45)天，方可獲得嚴重危疾保障及早期危疾保障全數賠償。

若會員首先被確診為患有早期危疾，其後四十五(45)天內患上嚴重危疾，則嚴重危疾保障將取代任何已付或應支付的早期危疾保障。為免存疑，自首次確診嚴重危疾之日起計四十五(45)天等候期屆滿後，如另新確診或接受另一種早期危疾的受保病症或手術，早期危疾保障可恢復重新作出支付。

(b) 嚴重危疾保障與額外癌症保障之間的等候期

在符合下列適用的等候期及規定下，方可獲得額外癌症保障：

如已支付的嚴重危疾保障為	額外癌症保障將於以下情況下支付賠償	等候期及規定
除癌症以外的嚴重危疾	癌症	首次嚴重危疾的確診或接受受保手術日期與隨後之癌症的確診日期必須相隔最少一(1)年。
癌症	新患癌症 (必須為不同的惡性細胞源引起)	首次癌症的確診日期與新患癌症的確診日期必須相隔最少一(1)年。
癌症	癌症復發	首次癌症的確診日期與癌症復發/ 遠端轉移癌症的確診日期必須相隔最少一(1)年。會員必須提交積極癌症治療證明。
癌症	遠端轉移癌症	
癌症	相同癌症	此保障須於會員正在接受持續週期性的積極癌症治療，由積極癌症治療開始首日起計一(1)年後予以支付。 此外，會員必須提供醫療報告證明在積極癌症治療最近的週期完成後，癌症仍然存在，該週期完成日期必須在積極癌症治療開始首日起計不少於一(1)年之後。積極癌症治療證明及醫療報告必須於積極癌症治療最近的週期完成日起計九十（90）日內提交，方可獲支付賠償。
任何嚴重危疾	於嚴重危疾確診或接受受保手術的當日起計的首年內被確診的任何癌症	

積極癌症治療證明必須提交以下文件：

(a) 收據正本及／或分項賬單正本，列明治療類別及治療程序；及
(b) 保柏為評估索償而合理要求的相關資料、證明書、報告、證據、轉介信及其他數據或文件，費用由投保人或會員承擔。

C 節 - 癌症治療賠償保障（自選保障）

受限於本合約的條款及細則，如會員在適用的等候期後獲註冊西醫確認已確診受保癌症，保柏應支付以下第一至五部分所述的保障。第一至四部分只可賠償與受保癌症相關（包括治療而引致的併發症）的確診測試及治療所引致的正常及慣常醫療開支或服務費用，惟受限於保障金額表所示的適用最高賠償額、最高賠償日數、每日最多求診次數、賠償百分比和終生賠償額。於本 **C 節**下應支付的保障不得超過為會員進行的治療或服務所引致的實際開支。

第一部分 - 門診診斷及檢測保障
本第一部分應支付的保障將涵蓋經門診接受醫療必需的診斷檢測及檢查後確認確診受保癌症。任何根據本部分賠償的合資格醫療費用金額不得超過向會員提供醫療服務的實際開支，並以保障金額表所訂的最高賠償額為限。

1. 門診診斷及檢測

此保障將賠償會員於醫院的門診部或診所在註冊西醫的監督下進行醫療必需的診斷檢測費用（包括但不限於化驗、X 光、電腦斷層素描、磁力共振、正電子斷層素描），以檢測及確認確診受保癌症直接相關。

如所需要進行的檢測涉及手術程序（包括但不限於針取細胞或組織，或活組織檢查）不論該檢查是在門診或住院環境下進行，該診斷檢測費用將會根據本 **C 節第 2 至 17 項**下的相關保障按日症或住院形式支付。

如診斷檢測在住院期間進行但該次住院並非醫療必需，合資格費用將被視為門診費用並根據此保障支付，不會於本 **C 節第 2 至 17 項**下獲得賠償。

為免存疑，任何用以檢測受保癌症預期後果的診斷檢測均不在此保障的範圍內，並應僅根據本 **C 節第 12 或 26 項**單獨支付（如適用）。

第二部分 - 住院及手術保障
(a) 本第二部分應支付的保障僅涵蓋會員在下列期間為受保癌症的治療、確診及支援護理所引致醫療必需的醫療費用：
i. 住院；
ii. 日症或非手術癌症治療；
iii. 入院前及出院後之門診護理；或
iv. 康復治療及緩和治療。

醫療必需的居家睡眠窒息症測試連同其測試前、後的諮詢所引致的相關費用（如合資格）將僅按照住院及手術保障項下的住院雜費以及入院前及出院後/日症前後之門診護理支付。
保柏只會賠償正常及慣常的合資格醫療費用。
為免存疑，如會員住院但該次住院並非醫療必需，則不可視為上述 i 項下的合資格醫療費用。然而，投保人仍有權根據上述 ii 項索償該次住院期間的醫療服務所引致的相關合資格醫療費用。

(b) 合資格的診所手術或日症，將於本第二部分之相關保障內作賠償。
(c) 本第二部分應支付的合資格醫療費用金額不得超過向會員提供醫療服務的實際開支，惟受限於保障金額表所訂的最高賠償額。
(d) 儘管在**「一般條款」第 11 項(b)xiii** 所述的不受保障項目，由口腔頜面外科專科註冊牙醫所進行與受保癌症相關的醫療必需手術（如合資格）可獲本第二部分的相關賠償。
(e) 儘管在**「一般條款」第 11 項(b)x** 所述的不受保障項目，本第二部分也涵蓋因受保癌症而必須進行的乳房、頭部或頸部重建手術所需的醫療費用，而有關重建手術必須在乳房切除術或其他腫瘤切除手術同時或其後十二(12)個月內進行。
(f) 本第二部分不會就入住總統套房 /貴賓房 / 豪華房的住院費用而作出賠。如會員入院後所住的病房級別高於本合約指定病房級別，就相關的住院日數，可獲得的賠償將按以下的調整值計算：，

指定病房級別	實際入住級別	調整值
大房	半私家房	50%
大房	私家房	25%

如會員由於以下原因住院時入住較高級別的病房，本第二部分應支付的保障則不受上述調整值所限，（i）在緊急情況接受治療的情況下醫院之指定或較之為低的病房級別床位短缺；或（ii）需要住院隔離導致需要入住特定級別的病房。

2. 住房及膳食費

此保障將支付會員於住院期間由院方徵收及發佈的住宿及膳食費用，而有關費用賠償將等於會員住院期間實際被院方收取的住房及膳食費。

此保障並不包括特別看護費及由除住院會員以外的其他人士使用的住房及膳食費。

3. 住院雜費

除於保障內刪除或特別註明於保障金額表內，此保障將支付下列住院服務費用，而有關費用賠償將等於實際被院方收取有關下列服務的費用：
(a) 往來醫院的陸上救護運送服務；

(b) 施行麻醉及氧氣；
(c) 輸血；
(d) 敷料及石膏；
(e) 在醫院內使用的藥物及有助治療的物品；
(f) 在住院後出院時或完成日症當日處方，以供其後四(4)星期內使用的藥物；
(g) 訂明診斷影像檢測（僅限電腦斷層掃描（"CT"掃描）、磁力共振掃描（"MRI"掃描）、正電子放射斷層掃描（"PET"掃描）、PET-CT組合及PET-MRI 組合）及必須於住院期間進行的診斷；
(h) 診斷影像服務，包括但不限於超聲波及X光以及其分析，但不包括所有已按第3 (g) 項涵蓋的訂明診斷影像檢測，並必須於住院期間或在接受有關手術當日進行；
(i) 靜脈注射；
(j) 實驗室化驗；
(k) 放射性同位素；
(l) 在手術室內使用的物品；及
(m) 植入物包括但不限於支架及起搏器。

此保障將伸延至醫療必需的器材租用費以及按照註冊西醫的建議在會員家中或診斷中心進行居家睡眠窒息症測試後的檢驗報告費用。
藥物及有助治療的物品包括所有西藥、IV 輸液、敷料、繃帶、藥棉及其他於住院期間內使用及消耗之醫療及護理物品；於手術用之儀器例如麻醉機、胃鏡、腸鏡、碎石機、X 刀、數碼導航刀及伽碼刀則不在此列。

4. 深切治療
此保障將支付會員經主診註冊西醫建議下入住醫院的深切治療部，而有關費用賠償以不超過保障金額表所的適用最高賠償額為限。

5. 外科醫生費及巡房費
此保障將支付註冊西醫為會員進行其合資格提供及符合診斷之手術而收取的手術費，包括會員住院期間之巡房費用，而有關費用賠償將等於實際就一位或以上之註冊西醫所徵收的有關手術費及巡房費用。

6. 麻醉科醫生費
此保障將支付會員在進行手術中除註冊西醫外另須麻醉科醫生提供麻醉服務的費用，但在本合約下對同一手術之「外科醫生費及巡房費保障」必須同時可獲賠償；而有關費用賠償將等於實際專業麻醉科醫生為有關手術施行麻醉所徵收的費用。

7. 手術室費用
此保障將支付會員因須進行任何手術而屬醫療必需使用手術室的費用，但在本合約下對同一手術之「外科醫生費及巡房費保障」必須同時可獲賠償；而有關費用賠償將等於實際就租用手術室，及在內使用的儀器所徵收的費用。

8. 住院醫生巡房費
此保障將支付會員因非手術性治療而住院所需之註冊西醫巡房費，而有關費用賠償將等於實際就註冊西醫所收取的有關診症費用。以電話形式會診，即註冊西醫並無與會員實際會見及檢查，將不作賠償。

9. 住院專科醫生費
此保障將支付會員在住院期間由專科醫生提供專科服務而收取的費用。病理學家、放射學家及物理治療師在住院期間所提供之服務亦將於此保障下支付。除非此等服務由病理學家、放射學家及物理治療師所提供，否則必須經主診註冊西醫以書面轉介。
此保障將不會支付：
(a) 於任何外科手術進行當日或之前或此手術後於療養期間內所獲得之治療，除非有關治療：
  i. 乃由施行該外科手術之外科醫生以外的專科醫生所提供，及
  ii. 與需要上述外科手術之病症完全不相關之病症有關；或
(b) 以電話形式會診，即專科醫生或物理治療師並無與會員實際會見及檢查。

10. 住院加床費
如本 **C 節第 2 或 4 項**獲得賠償，此保障將支付會員住院期間由院方徵收及發佈的一(1)張住院加床費用，而有關費用賠償將等於會員住院期間實際被院方收取的住院加床費。
此保障並不包括住院會員以外人士的膳食費。

11. 非手術癌症治療
此保障將支付會員在住院期間或醫院日症房或診所經主診註冊西醫建議下之非手術癌症治療、使用數碼導航刀及伽碼刀以治療癌症之費用及其他與該治療/手術相關之雜費包括但不限於住院期間或治療當日診斷影像檢測、實驗室化驗及藥物之費用。於此保障下支付之有關費用賠償將等於院方或診所實際收取的有關治療費用。

為免存疑，如有關此項的合資格費用亦同時屬本 **C 節第 3 項**的保障之內，該費用只可於此項內單獨獲得賠償而不會根據本 **C 節第 3 項**作出賠償。

12. 入院前及出院後/日症前後之門診護理
在本 **C 節第 2、3、5 或 11 項**獲賠償的情形下，此保障可支付下列費用：
(a) 住院、診所手術或日症（視情況而定）前在保障金額表內指定的期限內有關該住院、診所手術或日症（視情況而定）診斷的門診（註冊西醫的診症費、處方西藥、物理治療和診斷影像及化驗所引致之費用）或居家睡眠窒息症測試；及
(b) 所有在出院、診所手術或日症（視情況而定）後在保障金額表內指定的期限內由主診註冊西醫建議的跟進療程門診護理（註冊西醫的診症費、處方西藥、物理治療和診斷影像及化驗所引致之費用）或居家睡眠窒息症測試，而此等診症、處方西藥、物理治療或診斷測試必須與住院、診所手術或日症的病症或居家睡眠窒息症測試有直接關係並為該同一病症而引致的結果（包括任何及所有併發症）。

此保障所賠償的費用將等於實際被收取該等入院前或跟進護理的費用。為免存疑，任何在保障金額表內指定的期限中所引致的合資格醫療費用應僅根據此保障單獨支付，而不會根據本 **C 節第 20 或 26 項**作出賠償。

13. 精神科治療
此保障應支付會員在住院期間接受與受保癌症（包括但不限於因癌症治療而起的副作用）有關的精神科治療費用，而有關費用賠償將等於會員住院期間實際被院方收取的費用。

此保障將取代本 **C 節第 2 至 11 項及 14 至 17 項**的保障項目作出賠償。為免存疑，若會員並非純粹為接受精神科治療住院，則本保障只會賠償與精神科治療相關醫療服務的合資格費用。在有關合資格費用同時涉及精神科治療與非精神科治療但未能明確分攤費用的情況下，如精神科治療為最初導致住院的原因，有關合資格費用會全數由此保障賠償；如精神科治療並非最初導致住院的原因，則有關合資格費用會全數由本 **C 節第 2 至 11 項及 14 至 17 項**的保障項目賠償。

14. 康復治療
此保障須取得保柏批准支付會員在住院後於復康中心接受院舍式康復治療所需的費用，而所接受的康復治療必須與需要住院的病況（包括其任何及所有併發症）直接相關。

該復康中心必須根據其所在地的法律獲認可、設立及註冊為復康中心，以為病人、傷者或需要康復治療服務的人士提供住院康復治療服務。

15. 人工裝置

此保障將支付下列正常及慣常的費用：

(a) 賠償於住院、日症或出院後，按醫療必需以完全或部份替換任何永久性失去功能或功能異常的身體部分或人工裝置，因而放置在受保人體內或表面的人工裝置費用；及/或

(b) 非手術植入的義肢，包括但不限於受保癌症手術或與治療有關的狀況所直接導致所需的發聲裝置、假髮或可移除的人工乳房。

此保障不會支付替換任何人工裝置或非手術植入義肢的費用。

人工裝置指人工耳朵、眼球及/或放置在會員身體表面或裏面的肢體。

16. 善終服務及緩和治療

此保障將支付會員於善終服務或緩和治療中心接受院舍式緩和治療所收取的費用。該機構須為根據其所在地的法律獲認可、組成及登記為善終服務或緩和治療中心，以提供院舍式緩和治療和服務。會員必須經主診註冊西醫確診受保癌症為末期，而該註冊西醫在預測病情發展時表明並無治愈性治療可達致康復， 以及會員的預期剩餘壽命很可能為十二(12)個月或以內。此保障將賠償會員所招致的下列費用：

(a) 住房及膳食；

(b) 合資格護士提供的護理服務；

(c) 註冊西醫處方及留宿期間服用的西藥；及

(d) 身心靈支援照料。

17. 私家看護費

此保障將支付會員經主診註冊西醫書面轉介下由合資格護士於醫院或出院後在家中提供的專業護理服務費用。此保障支付的金額應等於實際的服務費用。所接受的護理服務必須由主診註冊西醫以書面形式建議，並且必須與需要住院的病況（包括其任何及所有併發症）直接相關。

第三部分 - 延伸支援保障

除根據本 **C 節第 25 項**支付的保障以及根據本 **C 節第 19 項**支付臨床心理輔導保障予照顧者外，本第三部分應支付的保障涵蓋會員在門診接受受保癌症治療或支援護理所引致的醫療必需費用。根據本第三部分支付的合資格費用之金額必須屬正常及慣常，且不得超過為會員提供服務或醫療器具的實際開支，惟受限於保障金額表所示的終生賠償額、最高賠償額、賠償百分比和每日最多探訪次數。

會員可參閱會員證書就延伸支援保障於此合約年度適用之終生賠償額。

18. 中醫師

此保障將支付會員於註冊中醫門診診所由註冊中醫診治的診症費，及於診治當日由該中醫處方並由合法來源於診治當日取得之醫療必需中藥費用。此保障亦會支付由註冊中醫於門診進行的針灸治療。

19. 臨床心理輔導

此保障將支付會員及/或會員的照顧者就受保癌症有關的精神、心理、神智或行為狀況於門診向臨床心理學家尋求輔導或諮詢所產生的合理費用。

20. 物理治療

此保障將支付會員於門診由物理治療師進行物理治療的診療費用，但須有註冊西醫的書面轉介信。

為免存疑，於本 **C 節第 12 項**出院後/日症的物理治療服務所收取的任何費用將不會經此保障支付，只會按保障金額表所示的指定期限根據本 **C 節第 12 項**支付。

21. 職業治療

此保障將支付會員在獲得主診註冊西醫書面轉介的情況下，於門診接受由職業治療師進行職業治療的只限診療費用。

22. 言語治療

此保障將支付會員在獲得主診註冊西醫書面轉介的情況下，於言語治療師的診所接受由言語治療師進行的只限診療費用。

23. 營養諮詢

此保障將支付會員在獲得主診註冊西醫書面轉介的情況下，於營養師的辦公室接受由營養師進行諮詢的只限診症費用。

24. 醫療器具

此保障將支付會員在獲得主診註冊西醫、職業治療師或物理治療師書面轉介的情況下，從合法途徑購買或租用醫療器具的成本，而醫療器具的使用是醫療必需的且與受保癌症或其併發症導致的狀況有關。

25. 輔助療法

此保障將支付由脊醫提供的脊骨療法、及由專業服務提供者提供香薰治療、順勢療法、藝術療法、瑜伽班、推拿、氣功班、太極班及其他康復療法予會員的費用。

只有經當地國家/地區向政府註冊的公司或組織發出的正式收據方可接受。保柏保留權利向服務提供者索取專業資格證明。由會員、投保人（如有）和他們各自的業務夥伴和親屬提供的療法或課堂概不受保障。

第四部分 - 門診護理及監測保障

本第四部分支付的保障涵蓋監測受保癌症的治療反應、預期後果或紓緩其副作用而接受醫療必需的門診診症、診斷化驗及西藥的費用。本第四部分賠償的合資格醫療費用必須屬正常及慣常，而且不得超過向會員提供醫療服務的實際費用，惟受限於保障金額表所示的最高賠償額和指定期限的規定。

另外，如門診診症的目的為緩和治療，此保障亦會支付相關費用並不會應用保障金額內所表示的指定期限。

26. 門診護理及監測

此保障將支付下列門診所需的醫療必需費用：

(a) 診症費及診斷化驗，包括實驗室化驗、x 光、電腦斷層素描、磁力共振、正電子斷層素描，以監測已確診的受保癌症治療反應（如適用）和預期後果；及/或

(b) 在完成癌症治療後經主診註冊西醫建議或為進行緩和治療而處方用以舒緩病徵或症狀或減輕痛楚的止噁心、反排斥、止暈眩和鎮痛的西藥。

為免存疑，於本 **C 節第 12 項**可獲賠償的任何費用並不會由此保障支付，只會按保障金額表所示的指定期限根據本 **C 節第 12 項**單獨支付。

對於任何被診斷為復發的受保癌症及用以確定陽性癌症結果的醫療費用，與診斷化驗有關的費用和診症費僅於此保障下單獨支付，而不會根據本 **C 節第 1 項**獲得賠償。

如會員出現病徵或症狀或主診註冊西醫根據診斷檢測結果在醫學上顯示建議，屬醫療必需情況需要進行如結腸鏡檢查或針取檢查之手術程序，以進一步了解癌症復發或擴散的可能性，該相關醫療費用將根據本 **C 節第 2 至 17 項**按日症或住院形式支付 。

與之前確診的受保癌症沒有直接關係，於門診進行的任何例行健康檢查均不在此保障範圍內。

第五部分 - 實驗性治療現金津貼

如會員就受保癌症接受實驗性治療，本第五部分將提供一筆過現金津貼保障。此保障在終生只會賠償一次，並受限於保障金額表所示的保障金額。會員可參閱會員證書就實驗性治療現金津貼於此合約年度適用之終生賠償額。

27. 實驗性治療現金津貼

如會員按照腫瘤科專科醫生的建議接受實驗性治療且該會員必須完成一個療程或用藥一個週期，此保障將會支付有關現金津貼。實驗性治療指使用未經美國食品及藥物管理局（U.S. Food and Drug Administration）和香港衞生署藥劑部批准的治療程序、醫療技術或藥物，以按照腫瘤科專科醫生的建議治療受保癌症或控制受保癌症的增長。

為免存疑，實驗性治療的開支不在此保障範圍內，而在根據本 **C 節**其他條款支付任何保障前 **「一般條款」第 11 項(b)xiv** 中的不受保障項目仍然適用。

第六部分 - 預防性檢查保障

28. 預防性檢查保障（適用於年滿十八(18)歲或以上的會員）

(a) 此保障僅適用於在任何合約週年日年滿十八(18)歲或以上的會員並持續受保於本 **C 節**保障超過一(1)年。於會員符合此保障的資格後，此保障將會每兩(2)個合約年度提供一(1)次。

(b) 保柏將會向投保人發出換領信，用以在相關的合約週年日後九十(90)日內接受免費預防性檢查。

(c) 會員可於換領信內所定的時間內在保柏指定的香港健康檢查中心出示換領信後接受一(1)次預防性檢查。

(d) 預防性檢查的範圍由保柏合理酌情決定，但會員最少可享有以下項檢查項目：

i. 子宮頸抹片檢查（女會員）；
ii. 前列腺特異抗原（男會員）；或
iii. 大便常規化驗包括寄生蟲及蟲卵和隱血

以及由註冊西醫進行的身體檢查。

D 節 - 健康支援服務

使用健康支援服務（如適用）須隨時受限於保柏所規定之「健康支援服務條款及細則」，該條款及細則構成本合約的一部分，保柏並會不時修訂該條款及細則。最新版本之條款及細則請參閱保柏網頁 https://www.bupa.com.hk/health-coaching-services 內之「健康支援服務條款及細則」。「健康支援服務條款及細則」內第 2 節所訂明的服務已列明於保障金額表。

特別條款 - 信用額安排

已投保本合約 **「危疾保障述要」C 節**的會員均可獲得下列的信用額安排並可獲發「保柏全禦卡」。

1. 保柏全禦卡

(a) 保柏會向已投保本合約 **「危疾保障述要」C 節**並且相關的保障在會員證書中列明的合資格會員發出「保柏全禦卡」。根據以下 **「特別條款 - 信用額安排」第 2 項**所述的初步保障審核程序和「會員指引」，會員可在香港使用「保柏全禦卡」支付 **「危疾保障述要」C 節第 2 至 11 項及第 17 項**下可獲賠償並由保柏全禦網特選服務供應商收取的合資格醫療費用。

(b) 「保柏全禦卡」可在下列情況用於支付 **「危疾保障述要」C 節第 2 至 11 項及第 17 項**下的合資格醫療費用:

i. 因受保癌症及其併發症而住院；
ii. 手術移除或切除惡性腫瘤；或
iii. 腫瘤科專科醫生處方的非手術癌症治療。

會員必須遵從以下 **「特別條款 - 信用額安排」第 2 項**所述的初步保障審核程序和「會員指引」。為免存疑，信用額安排將不適用於支付保柏全禦網特選服務供應商處方的西藥費用，針對受保癌症而進行的非手術癌症治療之西藥費用則除外。

(c) 使用「保柏全禦卡」的信用額服務時，須受限於以下 **「特別條款 - 信用額安排」第 2 項**所述的初步保障審核程序（由保柏按其現行的運作而定），並受限於本合約的條款及細則以及 **「危疾保障述要」C 節第 2 至 11 項及第 17 項**在相關的合約年度可用的保障額。

(d) 若保柏已支付任何差額，投保人須按保柏的合理要求立即向保柏全數償還差額。若於收到保柏差額通知書後十四(14)日內仍未償還相關差額，保柏將按投保人或會員給予保柏之指定信用卡直接收取費用的授權，並在收到差額通知書後的第二十一(21)日或之後於該指定信用卡扣除款項以償還差額。

(e) 保柏保留權利從任何可退還予投保人的保費或賠償中扣除款項以支付會員產生的任何差額結欠。

(f) 「保柏全禦卡」乃屬保柏所有。持有此卡之會員應將此卡存放於安全的地方。此卡只供獲發卡之會員使用，不得轉讓。倘此卡被竊或遺失，會員須負責一切所涉及之賬項，直至向保柏書面通知有關被竊或遺失為止。

(g) 「保柏全禦卡」將在下列最早出現的情況即時失效。投保人須負責於開始失效起七(7)天內將此卡歸還給保柏：

i. 本合約終止；或
ii. 保柏合理地要求歸還「保柏全禦卡」並向投保人和/或會員以書面通知有關原因。

2. 初步保障審核程序

(a) 若因急症情況而未能於接受相關醫療服務前取得初步保障審核，或保柏於支援時間（可於會員指引內查閱）外未能處理初步保障審核的 要求，投保人、會員、會員的授權代表及／或保柏全禦網專科醫生須於會員接受檢測、治療或手術後緊接的下個工作日向保柏補辦的初步保障審核程序。保柏將負責確保保柏全禦網專科醫生在填寫初步保障審核表格時，了解所需提供的資料。

(b) 如初步保障審核確認／付款保證信中的項目，就所覆蓋的範圍、性質或估算金額有任何更改，投保人、會員、會員的授權代表及／或保柏全禦網專科醫生須於檢測、治療或手術前最少兩(2)個工作日向保柏作出通知以事先獲得書面接納有關更改。

(c) 保柏所發出的初步保障審核確認／付款保證信，不應被視為保柏同意支付初步保障審核確認／付款保證信上所列的全數或部分金額。投保人可獲的任何賠償，將根據本合約的條款及細則及保柏的最終理賠審核而定。

(d) 如會員所產生的費用為不受保障項目或不合資格項目、超過信用額或付款保證信的信用額或並未獲得保柏批核，則投保人須於收到保柏的差額通知書後十四(14)日內向保柏全數償還該差額。

特別條款 - 會籍轉移權

本節所述的會籍轉移權僅為已投保 **「危疾保障述要」C 節**的會員而設。

(a) 已投保 **「危疾保障述要」C 節**的會員有權行使本節訂明的會籍轉移權，將 **「危疾保障述要」C 節**獨立轉移至「保柏自願醫保計劃」或「保柏靈活配自願醫保計劃 - 基本」（新合約）。如符合下列所有情況，會員可於無需再另行提供可保證明的情況下，保證將會籍轉移至新合約：

i. 會員已連續受保於 **「危疾保障述要」C 節**不少於五(5)年；及
ii. 會員在新合約生效日的年齡必須為五十九(59)歲或以下。

(b) 以下條款適用於會籍轉移權之行使：

i. 必須於合約週年日前一(1)個月提出行使轉移會籍權；
ii. 在成功轉移新合約後，本合約的 **「危疾保障述要」C 節**將於新合約生效日起終止；
iii. 於會籍轉移後，保障將根據新合約之保單條款及細則及任何由保柏以現行程序施加的條件作出賠償；
iv. 於新合約保障開始日或合約生效日前最少一(1)個月內，會員須向保柏遞交行使會籍轉移權的申請文件，以及由新合約投保人支付的首期保費，並以保柏收妥為準；及
v. 新合約的保費將根據新合約的合約生效日時保柏所訂定的實際保費率而釐定。

(c) 在轉移後，任何受保於 **「危疾保障述要」C 節**之相關病症或身體損傷於新合約生效日前已存在或出現病徵和症狀有關醫療費用將按照新合約的最高賠償額支付。如有個別的不保事項適用於 **「危疾保障述要」C 節**並在本合約簽發時記錄於會員證書或背書，該等不保事項將會連同新合約的一般不保事項列為新合約之不保事項。為免存疑，在 **「危疾保障述要」C 節**生效或升級或增加保障（如適用）前已出現的任何已存在病症將不會受保於新合約。

危疾定義

嚴重危疾

就本**「危疾定義」**部分而言，
日常活動指:
(a) 洗澡 - 沐浴或淋浴（包括自行出入浴缸或沖淋房）或以任何其他方式清洗身體的能力。
(b) 更衣 - 穿衣、脫衣、扣緊或解開任何衣服以及包括任何矯正架、義肢或其它外科器具（如適用）的能力。
(c) 進食 - 在食物已經準備好的情況下，自己進食的能力。
(d) 如廁 - 自行使用廁所和控制大小便，能夠保持滿意的個人生能力。
(e) 移動 - 自床上移動至座椅或輪椅，或自座椅或輪椅移動至床上的能力。
(f) 行動 - 室內從房間到房間之間平地行動能力。

1	癌症	癌症指惡性腫瘤。其特徵為惡性細胞漸進地不受控制地生長，侵入及破壞正常及周邊組織。癌症必須由組織病理學報告證實腫瘤呈陽性。癌症包括白血病、淋巴瘤或惡性肉瘤。 以下不在保障範圍內： (a) 原位癌（包括子宮頸上皮內贅瘤 CIN-1、CIN-2 及 CIN-3）或組織學上被界定為癌前病變的情況； (b) 所有皮膚癌，除非惡性黑色素瘤； (c) 如 TNM 組織學分期在 T1(a) 或 T1(b)或其他分級方法中同等或更低分級的前列腺癌； (d) RAI 級別 III 以下的慢性淋巴性白血病； (e) 如 TNM 組織學分期在 T1N0M0 或更低分級的甲狀線惡性腫瘤。
2	急性心肌梗塞	因心臟血液供應不足，引致部份心臟肌肉（心肌）壞死，並須符合下列所有準則： (a) 典型的胸痛病史； (b) 在相關心臟事故期間心電圖（ECG）顯示新近具急性心肌梗塞特徵的變化；及 (c) 心肌酵素（CK-MB）提高至一般公認的實驗室水平的正常水平以上或 心肌旋轉蛋白 T（Troponin T）> 0.5 ng/ml 或心肌旋轉蛋白 I（Troponin I）> 0.5ng/ml。 心絞痛並不包括在內。
3	中風	指腦血管事故包括腦組織梗塞、腦出血、蛛網膜下腔出血，腦栓塞及腦血栓。診斷必須由以下各項支持： (a) 由註冊神經科專科醫生書面證明永久性神經損害由事故發生後持續至少四(4)週； 及 (b) 磁力共振或電腦掃描的報告或其他可靠的影像技術證明此為新發生的中風事故。 以下的情況不在保障範圍內： (a) 短暫性腦缺血發作； (b) 引起眼或視神經障礙的血管疾病；及 (c) 前庭系統的缺血性異常。
4	心肌病	多種病因導致心室功能受損，引致永久及不可逆轉的損害，其程度至少為美國紐約心臟病學會心臟功能分級的第 4 級。必須由心臟專科醫生診斷，並且有相應的檢查報告支持，報告中應包括心臟超聲波檢查。 由於酒精或濫用藥物引起的心肌病不在保障範圍內。 美國紐約心臟病學會心功能分級 4 級指病人已經接受藥物治療及調節飲食後仍然在日常活動中出現症狀，而且在身體檢查及實驗室檢驗證實心室功能異常。
5	冠狀動脈手術	確實接受開胸手術進行冠狀動脈搭橋手術以矯正或治療冠狀動脈疾病。 微創手術、血管成形術及所有其他經動脈穿刺進行的手術、導管技術、鎖孔手術或激光手術程序，均不受此保障。
6	夾層主動脈瘤	指主動脈的內膜破裂導致血液流入主動脈壁中層形成夾層動脈瘤。在本定義中，主動脈指胸主動脈與腹主動脈而非其旁支。有關診斷必須由專科醫生及檢驗結果證實，檢驗包括電腦掃描(CT)、磁力共振掃描(MRI)及磁力共振血管造影(MRA) 或心導管檢查的證明，並有必要進行緊急修補手術。
7	心瓣手術	確實接受開胸手術以置換心瓣或治療心瓣異常。心導管或超聲心動圖必須證實心瓣異常，而手術須由一名心臟科專科醫生認為是必須之手術服務。微創手術包括但不限於氣囊瓣膜切開術均不受此保障。
8	其他嚴重冠狀動脈疾病	不論會員曾否接受任何冠狀動脈外科手術，經冠狀動脈造影檢查證實最少三(3)條主要冠狀動脈管腔縮窄達 60%。 此段之主要冠狀動脈指左主幹、左前降支、回旋支及右冠狀動脈（不包括分支血管）。
9	原發性肺動脈高血壓	經由包括心導管插入術在內之檢查明確診斷為原發性肺動脈高血壓及伴有右心室嚴重擴大，導致永久性身體受損最少達到紐約心臟協會界定的第 3 級心臟受損程度。 定義不包括繼發性肺動脈高血壓，其起因包括但不限於慢性肺部疾病、肺栓塞、瓣膜疾病及左心室疾病。 美國紐約心臟病學會心功能分級 3 級指病人的體力活動受到嚴重限制及於其在靜止休息時沒有症狀，但進行低於正常體力消耗活動會導致疲勞、心悸或呼吸困難。
10	主動脈手術	須要通過開腹或開胸手術切除並移植替換患病主動脈的一個部分以治療主動脈疾病。本定義中，主動脈是指胸主動脈或腹主動脈而非其分支。有關手術必須由專科醫生認為是醫學上必需的情況下進行。保障範圍不包括治療主動脈周圍分支的血管病之手術，即使手術過程中主動脈的一部分被移除。
11	嚴重傳染性心內膜炎	是指由感染性微生物引致的心臟內膜炎症，並須符合下列所有準則： (a) 血液培植結果呈陽性反應，證明感染性微生物的存在； (b) 出現由傳染性心內膜炎導致的最少中度之心臟瓣膜功能不全（即返流部份達 20%或以上）或中度之心臟瓣膜狹窄（即心臟瓣面積為正常值的 30%或以下）; 及 (c) 傳染性心內膜炎的診斷及瓣膜受損的嚴重程度必須由心臟病專科醫生確定。
12	雙目失明	臨床證明因為疾病或意外導致雙目視力不可逆轉的下降。雙目矯正後視力必須低於 6/60 或 20/200（如根據 Snellen 測試類別標準）或雙目視野均小於或等於 20°。如一般的醫療建議認為儀器或植入手術可以 恢復完全或部分視力，則不在保障範圍內。
13	慢性腎上腺功能不全（愛狄信病）	因自體免疫機制失調，令腎上腺逐漸受破壞，須要終身接受糖皮質激素及鹽皮質激素替代療法。有關失調必須經內分泌專科醫生透過以下測試證實： (a) 促腎上腺皮質激素（ACTH）刺激測試； (b) 胰島素誘發低血糖測試； (c) 血漿促腎上腺皮質激素（ACTH）水平測量；及 (d) 血漿腎素活動（PRA）水平測量。 保障範圍只包括由自體免疫機制引起的原發性腎上腺功能不全。所有其他原因引起的腎上腺功能不全並不包括在內。

14	慢性自體免疫性肝炎	一種成因不明之慢性肝壞死性的肝炎，血液中有自身抗體和高血清球蛋白血運行。必須完全符合以下所有準則： (a) 高丙種球蛋白質症。 (b) 至少存在以下其中一種自身抗體： i. 抗細胞核抗體 ii. 抗平滑肌抗體 iii. 抗肌動蛋白抗體 iv. 抗 LKM-1 抗體 (c) 肝臟活組織檢查結果確診為自體免疫性肝炎。 自體免疫性肝炎必須經由肝病專科的醫生確診。
15	慢性阻塞性肺病	慢性阻塞性肺病，需要永久性的大劑量吸氧治療，及「第一秒最大呼氣量」測試（FEV1）結果持續少於 1 公升。確診必須由呼吸系統科的專科醫生確認。
16	昏迷	會員在最少九十六(96)小時持續地完全失去知覺的狀態下，對任何外來刺激不能作出任何反應，亦無法對自己的身體內在需求作出回應，而需要倚靠維生系統維持生命，最後導致永久性神經系統受損。有關診斷必須由神經專科醫生證實。 因酒精或濫用藥物而引致的昏迷並不受此保障。
17	末期肝病	末期肝臟衰竭而必須有以下病徵證明： (a) 永久性黃疸； (b) 腹水腫; 及 (c) 腦病。 有關診斷必須由肝病專科醫生或腸胃科專科醫生證實。保障範圍不包括任何由酗酒或濫用藥物直接地或間接地，完全地或部分地導致的肝病。
18	末期肺病	末期肺疾病，包括需要大量與永久性氧療法的間質性肺疾病且「第一秒最大呼氣量」測試（FEV1）結果持續地少於 1 公升。有關診斷必須由呼吸系統科的專科醫生證實。
19	腎衰竭	末期腎衰竭，雙腎出現慢性不可逆轉的功能喪失，導致會員已開始定期接受腎臟透析或已實施腎臟移植。
20	不能獨立生活	會員在沒有他人長期輔助的情況下，永久地喪失進行三(3)項或以上的日常活動能力。 本嚴重疾病承保範圍至受保人年屆六十五(65) 歲時終止，本嚴重危疾病況不包括任何因精神科引起的情況。
21	失聰（損失聽覺）	雙耳完全及不可復原失去聽覺（即在所有頻率中損失聽力最少 80 分貝）。必須由專科醫生臨床確診，並經聽力測驗確定。
22	肢體缺失	指由於疾病或意外導致兩(2)個或以上的肢體自腕關節或踝關節以上完全斷離。 倘若斷肢是因糖尿病併發症所引起，根據此合約只會予糖尿病併發症引致的腳部截除一項作出保險賠償。
23	失去一肢及一眼	指會員因外傷或疾病出現以下兩(2)項情況： (a) 單眼不可逆轉地失去視力，並須符合下列任何一項條件： i. 根據斯內倫(Snellen) 視力表或同等測試， 一隻眼睛的最佳矯正視力是相等或低於 2/60；或 ii. 一隻眼睛的最佳矯正視野闊度是相等或低於 5 度。 診斷須由眼科專科醫生確認；及 (b) 一肢於手腕或腳踝或以上完全且不可逆轉地截斷。
24	損失說話能力	在不涉及任何其他因素下，直接因聲帶器質性的損傷而導致完全及不可治癒地失去說話能力持續十二(12)個月。 有關臨床診斷必須由專科醫生作出。保障範圍不包括所有與心理相關的因素。
25	主要器官移植	會員須為器官移植的接受者，並實際進行人與人之間的造血幹細胞骨髓移植手術，且於手術前曾進行骨髓完全消融；或人與人之間的心、肺、肝、胰或腎移植手術之器官移植接受者。移植手術從醫學角度而言是必須之手術服務，以治療相關器官不可逆轉的末期衰竭。 定義不包括其他幹細胞移植、胰島細胞移植及部份器官移植。
26	囊腫性腎髓病	是一種遺傳疾病，其特徵為因為腎髓質內的囊腫導致會員漸進地失去腎功能。 診斷必須由影像檢查證明多個髓質囊腫的存在，伴有皮質萎縮。
27	嗜鉻細胞瘤	一種發生於腎上腺或腎上腺外嗜鉻組織的神經內分泌腫瘤，導致身體分泌過量的兒茶酚胺。 診斷須符合以下所有條件： (a) 已對腫瘤實施手術清除；及 (b) 嗜鉻細胞瘤的診斷必須由內分泌科專科醫生確認。
28	嚴重支氣管擴張	嚴重支氣管擴張，需要永久性的大劑量吸氧治療，及「第一秒最大呼氣量」測試（FEV1）結果持續少於 1 公升。確診必須由呼吸系統科的專科醫生確認。
29	嚴重肺氣腫	嚴重肺氣腫，需要永久性的大劑量吸氧治療，及「第一秒最大呼氣量」測試（FEV1）結果持續少於 1 公升。確診必須由呼吸系統科的專科醫生確認。
30	嚴重特發性肺纖維化	特發性肺纖維化（IPF）是一種慢性導致肺部疤痕的肺病，其特徵是肺功能逐漸和不可逆轉地下降，必須符合以下條件： (a) 肺活量（FVC）< 50% (b) 一氧化碳肺擴散容量 DLCO < 30% 必須由肺病學專科醫生確診。
31	完全永久傷殘	完全永久傷殘的保障年期至六十五(65)歲。 完全永久傷殘是指會員因疾病或身體傷害而完全喪失從事任何職業或工作以獲取收入的能力。這種狀態必須已經持續連續一百八十(180)日或以上，以便保柏確定會員永久喪失工作能力。
32	亞爾茲默氏病 ／不可還原之器質性腦退化疾病	經會員的臨床狀態及標準問卷或測驗證明會員的思考能力退化或喪失，或行為舉止之失常是由亞爾茲默氏病或其他不可還原之器質性腦退化疾病引致，並導致會員之思維能力及社交活動能力嚴重退減，進而影響會員須接受持續性之護理。亞爾茲默氏病或其他不可還原之器質性腦退化疾病的診斷必須由腦神經專科醫生臨床確定。 以下所列並不包括在內： (a) 非器質性腦疾病如神經機能疾病及精神病；及 (b) 任何藥物或酒精引起的器質性腦疾病。
33	皮質基底核退化症	皮質基底核退化症直接引至會員永久不能完成最少三(3)項日常生活活動作為證明，有關診斷必須由神經科專科醫生證明。
34	嚴重克雅二氏症	克雅二氏症是一種少見的致命性的腦組織海綿狀病變，症狀包括小腦功能障礙、嚴重進行性癡呆、不可控制的肌肉痙攣、手震及手足徐動症。診斷必須由神經科專科醫生確認並提供腦電圖、腦脊液檢查結果以及電腦掃描和磁力共振影像掃描資料。瘋牛症引至的變異型克雅二氏症也受本保障。 其他一般原因所導致之痴呆須經由脊椎穿刺檢查排除。保障範圍不包括因為人類生長激素治療所導致的疾病。

35	柏金遜症	因失去含色素腦神經細胞而引致的中樞神經系統緩慢地漸進式退化性疾病。由經腦神經專科醫生作出無可置疑之診斷為柏金遜症, 並符合以下條件: (a) 無法以醫藥療法控制; (b) 有逐漸轉壞的症狀; 及 (c) 會員有永久失能，在沒有協助的情況下無法完成此合約內界定之日常生活活動六(6)項的其中最少三(3)項活動。 合約只保障不明起因的柏金遜症，因藥物或中毒導致的柏金遜症除外。
36	肌萎縮性脊髓側索硬化	出現明確的持續性脊神經束和腦部運動中樞的神經功能損害症狀，肢體出現強直性肌無力和肌肉萎縮。須由神經科專科醫生做出明確書面診斷，並有相應的的神經肌肉檢查（如肌電圖）證實。
37	植物人	指腦皮質廣泛壞死，惟腦幹仍保持完整。有關診斷必須獲神經科專科醫生書面證明，且此狀態須已持續最少三十(30)日。
38	細菌性腦膜炎	因細菌性腦膜炎引起腦膜或脊髓膜發炎，導致神經系統功能嚴重及永久受損，診斷必須經由神經科專科醫生證實。
39	良性腦腫瘤	腦部或顱腦膜內的良性腫瘤，並產生顯示顱內壓增高的徵狀，例如：視神經乳頭水腫、精神症狀、癲癇及感覺障礙。 良性腦腫瘤的存在必須由影像研究如電腦掃描(CT scan)或磁力共振(MRI)造影確定。 保障範圍不包括水囊腫、肉芽瘤、腦動脈或靜脈畸形、血腫、膿腫、聽覺神經瘤及下垂體或脊椎腫瘤。
40	腦部外科手術	在全身麻醉下進行經頭顱的顱骨切開術作腦部手術 。腦部外科手術包括顱骨鑽孔術，惟以下情況概不受保 ： (a) 不需手術切開或切除組織的治療如伽瑪射線、腦血管神經放射介入治療如栓塞形成、血栓溶解及立體定位活檢； (b) 經蝶竇手術 ；及 (c) 因意外而需要進行的腦部外科手術。 有關手術必須獲相關醫學範疇的專科醫生認為屬醫療需要 。
41	須作開顱手術之腦動脈瘤或腦動靜脈畸型	實際已接受頭部開顱手術，以清除腦動脈瘤或腦動靜脈畸型，診斷必須由專科醫生經由電腦掃描、磁力共振掃描或磁力共振血管造影證明。頭部開顱手術以外之治療並不在保障範圍內。
42	腦炎	因嚴重的腦實質炎症導致嚴重的永久性神經機能缺損，並證明已持續最少三十(30)天。腦炎的診斷必須獲腦神經專科醫生證實。
43	偏癱	因疾病或受傷（自致之受傷除外）導致癱瘓以致半邊身體完全及永久失去功能。 確診必須由相關醫學範疇專科醫生確認。
44	嚴重頭部創傷	頭部因意外受傷導致功能嚴重及永久受損，並由創傷或受傷之日起計持續最少九十(90)日。該永久性嚴重功能受損之診斷必須經由神經科專科醫生證實。
45	多發性硬化症	大腦神經組織因脫髓鞘病變所引致的疾病。必須經一名神經科專科醫生診斷為多發性硬化症，並有詳細病臨床歷證實病況曾出現多於一次的惡化及緩解。磁力共振掃描、電腦斷層掃描或其他可靠的顯影技術檢查所得的結果，須明確地確認此診斷。必須有證據顯示神經系統持續至少六(6) 個月出現涉及協調、運動感官功能缺損。 定義不包括因紅斑狼瘡及人類免疫力缺乏症病毒所引致的神經受損。
46	肌肉營養不良症	肌肉營養不良症是一組遺傳性肌肉變性病變，特徵為不累及神經系統的肌肉無力和肌肉萎縮。在此合約中，病情必須導致會員出現神經功能損害，永久性不可逆轉的喪失在室內房間之間平地行走能力。 須由神經科專科醫生以書面作出診斷及經適當的神經肌肉檢查例如肌電圖檢查確定。
47	癱瘓	最少二肢因癱瘓而不可逆轉地完全喪失功能。
48	脊髓灰質炎	受脊髓灰質炎病毒的感染而引致癱瘓性之疾病。因脊髓灰質炎引致的癱瘓必須由腦神經專科醫生確定，而不涉及癱瘓的個案則不包括在內。
49	原發性側索硬化	大腦皮質運動神經元進行性變性病症，引致以上運動神經元（受損）為基礎的廣泛性無力。臨床特徵為肢體進行性強直性無力，伴有發音障礙和吞嚥困難，顯示皮質脊髓束和皮質延髓束受損。須由神經科專科醫生做出明確診斷，並有相應的神經肌肉檢查（如肌電圖）證實。
50	進行性延髓麻痺	經神經科專科醫生診斷之肌肉（包括延髓肌肉）逐步虛損及萎縮。診斷必須由一名神經科專科醫生證實，並經適當的神經肌肉測試如肌電圖檢查等核實。
51	進行性肌肉萎縮症	經神經科專科醫生診斷之肌肉虛損及逐漸惡化之痙攣。診斷須經適當的神經肌肉測試如肌電圖檢查等核實。
52	進行性核上神經痲痺症	進行性核上神經痲痺症在不涉及任何其他因素下引致永久性神經機能缺損，並直接導致會員永久不能完成日常生活活動的其中最少三(3)項活動。有關進行性核上神經痲痺症的診斷必須由腦神經專科醫生確認。
53	脊髓肌肉萎縮症	脊髓前角細胞和腦幹運動核的變性病症。以肢體（尤其下肢）近端肌肉無力和萎縮為特徵，進而延展至肢體遠端肌肉。須由神經科專科醫生以書面做出明確診斷，並有相應的神經肌肉檢查（如肌電圖）證實。
54	系統性硬化症	一種慢性及全身性的自身免疫疾病，特徵有組織纖維化、小血管病變和自身抗體形成。 診斷須符合以下所有條件： (a) 有證據顯示下列至少一個器官受到損害： i. 食道； ii. 肺； iii. 心臟；或 iv. 腎臟； 及 (b) 系統性硬化的診斷及器官損害須由風濕病學專科醫生或免疫病學專科醫生確認。
55	結核性腦膜炎	因結核桿菌而引起的腦膜炎，導致永久性的神經損害，有關診斷必須由神經科專科醫生證實。
56	急性壞死性胰臟炎	急性壞死性胰臟炎必須由認可的註冊外科醫生書面確診，並有病理證據支持。會員必須已接受了外科手術以進行壞死組織清除、壞死病灶切除或胰臟切除。因酒精導致的急性壞死性胰臟炎不在保障範圍內。
57	急性出血壞死性胰臟炎	急性胰腺實質發炎及壞死、胰腺脂肪酶病灶性壞死及因血管壞死而出血，並須符合下列所有準則： (a) 所需治療是以手術清除壞死組織或進行胰切除術；及 (b) 診斷必須以組織病理學的特徵為準，並由胃腸病專科醫生確定。 因酒精或濫用藥物引致的胰腺炎並不受此保障。
58	再發性慢性胰臟炎	根據醫療紀錄，胰臟炎發生超過三(3)次，導致胰臟功能紊亂，引致吸收不良，須要接受酵素替代療法。 再發性慢性胰臟炎必須由腸胃病專科醫生診斷，並且由內窺鏡逆行性膽胰造影術（ERCP）證明。 由酒精引起的再發性慢性胰臟炎不在保障範圍。

59	暴發性肝炎	因為肝炎病毒感染造成部分或大部分的肝壞死導致急驟性肝臟衰竭。暴發性肝炎的診斷必須符合下列所有條件： (a) 肝臟急速萎縮； (b) 全部肝葉壞死，只存留萎陷的肝臟網狀支架；及 (c) 肝功能測試顯示肝功能急速退化。 必須提供以下證明： (a) 肝功能顯示大面積的肝實質病變；及 (b) 肝性腦病的客觀症狀。
60	嚴重克羅恩氏病	克羅恩氏病是一種發生於腸道的慢性炎症性疾病，以肉芽腫為特徵。 診斷須符合以下所有條件： (a) 疾病必須已經造成以下腸道併發症中的至少一(1)項： i. 瘻管形成（肛瘻除外）； ii. 腸梗阻；或 iii. 腸穿孔（並非由於介入性操作所致）； 及 (b) 診斷必須有組織病理學病徵支持並且由消化科專科醫生確認。
61	嚴重潰瘍性結腸炎	嚴重潰瘍性結腸炎是指急性暴發性潰瘍性結腸炎，伴隨危及生命的電解質平衡紊亂。 診斷須符合以下所有條件： (a) 全部結腸被累及並導致嚴重的血性腹瀉； (b) 必須進行全結腸切除和迴腸造口術；及 (c) 診斷必須有組織病理學病徵支持並且由消化科專科醫生確認。
62	糖尿病併發症引致的足截除	因糖尿病引起的神經及血管病變而經糖尿病或內分泌專科醫生或血管外科醫生建議，由足踝或以上位置截除雙腳是維持生命的唯一方法。保障範圍不包括切除一隻或多隻腳趾或因任何其他原因引起的截除術。
63	嚴重燒傷	會員最少有 20%的身體表面受到三級燒傷。
64	壞死性筋膜炎	指符合以下所有條件的壞死性筋膜炎： (a) 符合一般壞死性筋膜炎的臨床標準； (b) 所識別的細菌是引致壞死性筋膜炎的原因；及 (c) 廣泛性肌肉及其他軟組織損壞並導致受感染部位完全及永久性功能喪失。 有關診斷必須由專科醫生證實。
65	意外引致的臉部嚴重燒傷	指最少有 70% 的臉部表面直接由意外導致而受到三級燒傷(皮膚全層燒傷)。
66	嚴重重症肌無力症	一種引致神經肌肉傳遞障礙之後天免疫性疾病，並導致波動性之肌無力及容易疲勞，且須符合下列所有條件： (a) 永久出現肌無力，並根據下列按美國重症肌無力基金會（Myasthenia Gravis Foundation of America）的臨床分類界定為第 III、IV 或 V*級；及 (b) 重症肌無力的診斷及分類必須由神經科專科醫生證實。 * 美國重症肌無力基金會的臨床分類： 第 I 級：任何眼肌無力, 可能出現上眼瞼下垂, 沒有其他肌肉無力的證據 第 II 級：任何程度的眼肌無力，其他肌肉出現輕度無力 第 III 級：任何程度之眼部肌肉無力，及其他部位之中度肌肉無力 第 IV 級：任何程度之眼部肌肉無力，及其他部位之嚴重肌肉無力 第 V 級：須要插管以維持氣管暢通
67	再生障礙性貧血	永久不可復原之骨髓衰竭而導致貧血、嗜中性白血球減少及血小板減少，並須接受下列最少兩(2)項的治療： (a) 輸入血液製品； (b) 刺激骨髓藥物； (c) 免疫系統抑制性藥物；或 (d) 骨髓移植。 再生障礙性貧血的診斷必須以骨髓穿刺細胞檢查及血液科專科醫生確定。
68	因輸血感染人類免疫力缺乏病毒	會員感染人類免疫力缺乏病毒 (HIV)，並符合下列所有條件： (a) 感染由於輸血引起，且導致感染的輸血日期在危疾保障開始日、合約簽發日或合約最後復效日（以較後者為準）之後； (b) 提供輸血的單位承認責任或者法院終審庭裁定此醫療責任，而且不准上訴；及 (c) 受感染的會員並非血友病患者。 由其他途徑傳播之人體免疫力缺乏病毒(HIV)，包括性行為或靜脈注射毒品，則明確不受此保障。 如果醫學上出現能夠治癒愛滋病或 HIV 病毒影響的任何方法，或出現能夠預防愛滋病的方法，本保障將不再適用。 會員必須讓保柏取得會員所有血液樣本，並保留對此血液樣本進行獨立檢測的權利。
69	因侵害而感染之人類免疫力缺乏病毒	指人類免疫力缺乏病毒(HIV)感染並該感染直接源自以下因素： (a) 因人身侵害而被迫接觸受 HIV 感染的針頭或銳器，或被已感染 HIV 人士性侵害； (b) 侵害事件在危疾保障開始日、合約簽發日或合約最後復效日（以較後者為準）於香港特別行政區或澳門特別行政區發生，並在事件發生後十四(14)天內向香港特別行政區或澳門特別行政區警方報案；及 (c) 須在事件發生後十四(14)天內進行測試，顯示 HIV 或 HIV 抗體為陰性。以及在事件發生後六(6)個月內重新進行測試，並顯示感染人類免疫力缺乏症病毒。 由其他途徑傳播之人體免疫力缺乏病毒(HIV)，包括性行為或靜脈注射毒品, 則明確不受此保障。 如果醫學上出現能夠治癒愛滋病或 HIV 病毒影響的任何方法，或出現能夠預防愛滋病的方法，本保障將不再適用。 會員必須讓保柏取得會員所有血液樣本，並保留對此血液樣本進行獨立檢測的權利。
70	因器官移植而感染人類免疫力缺乏病毒	指會員於香港特別行政區內進行器官移植，而因由該器官移植而感染人類免疫力缺乏病毒 (HIV)。 會員感染人類免疫力缺乏病毒 (HIV)，並須符合下列所有條件： (a) 感染是由於接受器官移植引起，並且該器官移植必須在危疾保障開始日之後進行； (b) 該器官移植必須於香港特別行政區內進行及提供器官移植的醫療單位承認責任或者法院終審庭裁定此醫療責任，而且不准上訴；及 (c) 受感染的會員並非血友病患者。 由其他途徑傳播之人體免疫力缺乏病毒(HIV)，包括性行為或靜脈注射毒品, 則明確不受此保障。 如果醫學上出現能夠治癒愛滋病或 HIV 病毒影響的任何方法，或出現能夠預防愛滋病的方法，本保障將不再適用。 會員必須讓保柏取得會員所有血液樣本，並保留對此血液樣本進行獨立檢測的權利。
71	醫療引致感染人類免疫力缺乏病毒	會員感染人類免疫力缺乏病毒 (HIV)，並符合下列所有條件： (a) 感染是由於接受手術或醫療/牙科程序引起，且導致感染的手術或醫療/牙科程序日期在危疾保障開始日之後； (b) 提供手術或醫療/牙科程序的單位承認責任或法院終審庭裁定此醫療責任，而且不准上訴；及 (c) 受感染的會員並非血友病患者。 此項醫療事件須已向相關當局報告並按制訂程序進行調查。 如果醫學上出現能夠治癒愛滋病或 HIV 病毒影響的任何方法，或出現能夠預防愛滋病的方法，本保障將不再適用。 由其他途徑傳播之人體免疫力缺乏病毒(HIV)，包括性行為或靜脈注射毒品, 則明確不受此保障。 會員必須讓保柏取得會員所有血液樣本，並保留對此血液樣本進行獨立檢測的權利。

72	因職業引致之人類免疫力缺乏病毒	會員於執行其慣常職業之職務期間因意外感染人類免疫力缺乏症病毒，並於意外發生後六(6)個月內出現血清轉呈陽性。 任何可能會引致索償之意外必須於發生後十四(14)天內向保柏報告，並須同時提交於意外發生後立即接受之人類免疫力缺乏症病毒抗體測試之陰性結果報告以作支持。 由其他途徑傳播之人體免疫力缺乏病毒(HIV)，包括性行為或靜脈注射毒品, 則明確不受此保障。 如果醫學上出現能夠治癒愛滋病或 HIV 病毒影響的任何方法，或出現能夠預防愛滋病的方法，本保障將不再適用。 會員必須讓保柏取得會員所有血液樣本，並保留對此血液樣本進行獨立檢測的權利。
73	系統性紅斑狼瘡連狼瘡性腎炎	多系統自身免疫性疾病，特徵是產生自身抗體以對抗多種自身抗原。 就危疾之定義而言，系統性紅斑狼瘡僅限指涉及腎臟（經腎臟活檢確定為國際腎臟協會／腎臟病理協會[Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS)]的狼瘡性腎炎分類(2003)中的 III 級、IV 級、V 級或 VI 級）的系統性紅斑狼瘡。其他類型如盤狀紅斑狼瘡，以及只涉及血液和關節的系統性紅斑狼瘡，則明確不受此保障。 國際腎臟協會／腎臟病理協會[Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS)]的狼瘡性腎炎分類(2003)： 第 I 級 － 微小系膜狼瘡性腎炎 第 II 級 － 系膜增生性狼瘡性腎炎 第 III 級 － 病灶性狼瘡性腎炎 第 IV 級 － 彌漫性節段性（IV-S 級）狼瘡性腎炎或全球性（IV-G 級）狼瘡性腎炎
74	嚴重牛皮癬關節炎	經明確診斷為系統性免疫疾病的牛皮癬關節炎， 需符合下列所有條件： (a) 根據牛皮癬關節炎 (CASPAR) 的分類標準條件，需符合炎性關節病下列診斷條件之特徵至少 3 分； i. 現在罹患牛皮癬（2 分） ii. 有牛皮癬病史，現在並無罹患牛皮癬（1 分） iii. 牛皮癬家族史，現在並無罹患牛皮癬，也無牛皮癬病史（1 分） iv. 指炎（1 分） v. 關節旁新骨形成（1 分） vi. 類風濕因子檢查陰性（1 分） vii. 指甲營養不良（1 分） (b) 廣泛的關節破壞和下列關節有三(3)個或以上產生畸形: 手、腕、肘、膝、髖、踝、頸椎或腳； (c) 有關病變必須在不涉及任何其他因素下直接導致永久不能完成基本日常生活活動的其中最少三(3)項；及 (d) 上述條件已經存在至少六(6)個月。
75	嚴重類風濕關節炎	嚴重類風濕關節炎必須符合以下所有條件： (a) 美國風濕病學院（American College of Rheumatology）的診斷標準； (b) 永久不能完成最少二(2) 項日常生活活動； (c) 關節廣泛受損，並經臨床證實出現最少三(3) 個下列關節位置嚴重變形：手部、手腕、肘部、膝部、髖部、踝部、頸椎或腳部；及 (d) 該狀況持續最少一百八十(180)日。
76	系統性硬皮病	該症狀須達至系統性侵犯程度且影響心臟、肺部或腎臟的其中兩個器官。有關診斷須由風濕科專科醫生證實並以活檢結果及血清學證據確定。 (a) 肺受影響之證明為一氧化碳肺擴散容量(DLCO)是少於預測值的 70%，或「第一秒最大呼氣量」（FEV1）、肺活量(FVC)或肺總量(TLC)是少於預測值的 75%； (b) 腎受影響之證明為腎小球濾過率(GFR)是每分鐘少於 60 毫升（60ml/min）；及／或 (c) 心臟受影響之證明為充血性心力衰竭、心律失常以致需服用藥物、或心包炎（中度至大量心包積液）。 保障範圍不包括以下情況： (a) 局部硬化病(線性硬化病或硬斑病) (b) 嗜酸性粒細胞筋膜炎 (c) 明確的 CREST 症候群
77	伊波拉出血熱	指因伊波拉病毒感染造成的發熱以及內出血或外出血。 診斷須符合以下所有條件： (a) 經實驗室檢驗證實伊波拉病毒的確存在； (b) 已發生粘膜或胃腸道出血；及 (c) 伊波拉出血熱的診斷必須由傳染病科專科醫生確認。
78	象皮病	末期淋巴絲蟲病，其特徵為身體受感染部位 (腿部 、生殖器官或乳房) 因淋巴管受絲蟲堵塞而顯著增大及明顯變形。有關診斷必須由專科醫生證實患有永久性淋巴堵塞，同時經化驗證實循環性絲蟲病原或微絲蚴血液塗片確認（班氏吳策絲蟲或馬來絲蟲）。保障範圍不包括其他淋巴水腫或急性淋巴管炎。
79	永久氣管造口術	是指實際進行氣管造口術，以治療肺疾病或氣管疾病，或因嚴重創傷或燒傷後而需要氣管造口成為通氣支撐。會員必須為指定深切治療部的病人而需要相關醫學範疇專科醫生照料，須要保持該氣管造口及其功用能維持連續 十二(12)個月，方合符此保障條件。
80	末期疾病	末期疾病的確診為沒有已知的治療方法或已經發展到無法治療的疾病，必須經專科醫生確診，並由保柏指定醫生證實, 會員確診後預期壽命不超過三百六十五(365)日。在感染人類免疫力缺乏病毒的情況下之末期疾病不在保障範圍內。 而此保障須於末期疾病確診後會員生存不少於十四(14)日始會支付。

早期危疾保障

1	原位癌	原位癌是指經病史證實並局限在侵入性前之病變，即癌細胞並無穿透基膜，亦未侵入（即指滲入及／或活躍地破壞）下列任何一項的受保之器官群組的環繞組織或氣孔，並以所列的任何類別作準： (a) 乳房，而腫瘤級別被界定為 TNM 階段 TIS； (b) 子宮，而腫瘤級別被界定為 TNM 階段 TIS；或子宮頸界定為第三階段的子宮頸表層細胞癌變(CIN III)或原位癌(CIS)； (c) 卵巢及/或輸卵管，而腫瘤級別按 TNM 分期法必須被界定為 TIS 或屬 FIGO* 的 0 階段； (d) 陰道或外陰，而腫瘤級別按 TNM 分期法必須被界定為 TIS 或屬 FIGO* 的 0 階段； (e) 大腸及直腸； (f) 陰莖； (g) 睾丸； (h) 肺； (i) 肝； (j) 胃及食道； (k) 泌尿道，就膀胱的原位癌而言，包括被界定為 Ta 階段的乳頭狀癌；或 (l) 鼻咽。 就此合約而言，原位癌疾病必須以活組織檢查術確定。 *FIGO 是指國際婦女產科合會(Federation Internationale de Gynecologie et d'Obstetrique)的分期法。

2	須作手術之頸動脈疾病	於頸動脈進行血管成形術或內膜切除術是指一(1)條或以上的頸動脈經血管造影術證明有 50%或以上狹窄的治療。同時必須符合以下(a)及(b)的標準： (a) 兩者其中之一： i. 確實進行動脈內膜切除術以減輕症狀；或 ii. 確實進行血管介入治療, 例如血管成形術及/或進行植入支架或動脈粥樣瘤清除手術，以減輕症狀；及 (b) 診斷及治療的醫療之必要性必須由相關專科醫生確定。
3	因冠狀動脈疾病進行血管成形術及其他創傷性治療	因冠狀動脈疾病進行血管成形術及其他創傷性治療為實際進行之血管成形術及支架植入、氣囊血管成形術、動脈粥樣硬化斑塊切除術或激光手術，以治療一(1)條或以上之主要冠狀動脈縮窄（狹窄程度最少達 50%）。治療必須由相關專科醫生確認為醫療必需。 醫療證明須包括以下各項在內： (a) 心臟科主診醫生的完整報告； (b) 心電圖證實出現顯著及相關變化（如 ST 段下降）；及 (c) 血管造影檢查結果確定一(1)條或以上的主要冠狀動脈病變之狹窄位置及程度。 主要冠狀動脈指左主幹、左前降支、回旋支及右冠狀動脈。
4	早期惡性腫瘤	出現以下任何一種惡性腫瘤： (a) RAI 分期為 I 期或 II 期的慢性淋巴球白血病； (b) 非黑色素瘤的皮膚癌； (c) 經組織化驗證實屬於 T N M 分期系統中的 T1(a)或 T1(b)期的前列腺癌；或 (d) 組織化驗證實屬於 T N M 分期系統中的 T1N0M0 期的甲狀腺癌。 以上並未列出的其它癌前病變除外。
5	大腦動脈瘤的血管介入治療	大腦動脈瘤的血管介入治療是指確實進行血管介入治療，如經血管內栓塞治療(endovascular embolisation)、經血管內盤繞治療（endovascular coiling）、血管成形術及 / 或植入支架或置入流量分流器，以預防大腦動脈瘤破裂或減輕因大腦動脈瘤破裂而導致出血。有關程序必須視爲醫療所需及由相關專科醫生進行。

中、英文之意思如有差別，概以英文為準。

(1 January 2026 Edition)

Bupa issues this Contract to the Subscriber and agrees, subject to all the terms and conditions appearing in the Contract, to pay to the Subscriber the Benefits in accordance with the Schedule of Benefits. In consideration of the payment of Subscriptions and on the basis of the Application submitted to Bupa, Bupa hereby agrees to issue this Contract to cover the Member and provide the Benefits in accordance with the terms and conditions set out herein.

General Conditions

In construing this Contract:

(a) the rule known as the ejusdem generis rule shall not apply and accordingly general words introduced by the word "other" shall not be given a restrictive meaning by reason of the fact that they are preceded by words indicating a particular class of acts, matters or things;

(b) general words shall not be given a restrictive meaning by reason of the fact that they are followed by particular examples intended to be embraced by the general words;

(c) the headings in this Contract are for the purposes of reference only and shall not affect the interpretation or application of any of the terms hereof; and

(d) references to "this Contract" or "the Contract" shall mean this Contract as amended from time to time. References to Clauses, Section and Schedules are to clauses, section and schedules of this Contract.

1. Definitions

In this Contract where consistent with the contents, the singular shall include the plural and vice versa; words importing the masculine gender shall include the feminine and neuter gender; and each of the following words and expressions used in this Contract shall have the following meanings, except where the context otherwise requires.

"Accident"	means an external, sudden, violent and unexpected event of visible nature which shall, independently of any other cause, be the sole cause of bodily injury.
"Active Cancer Treatment"	means Cancer directed surgery, radiotherapy (including proton therapy), chemotherapy, targeted therapy, bone marrow transplant, immunotherapy, cyber knife, gamma knife or a combination of these treatments which is Medically Necessary for the curative treatment of Cancer. Hormonal therapy or palliative care are specifically excluded.
"Additional Cancer Benefit"	means the benefit payable under Critical Illness Benefits if the Member is diagnosed to have suffered from Cancer after satisfying the conditions set out under the **Description of Critical Illness Benefits**.
"Anaesthetist"	means a Registered Medical Practitioner who is registered under Anaesthesiology of the Specialist Register of the Medical Council of Hong Kong or the equivalent.
"Application"	means the application form and other supporting documents submitted by the Subscriber to Bupa for the issuance of this Contract or change of Benefit under the Contract.
"Benefit"	means any benefit payable by Bupa under this Contract.
"Benefit Amount"	means the itemised benefit amount payable under Critical Illness Benefit indicated as such in the Membership Certificate or stated in the Schedule of Benefits according to the plan level subscribed by the Subscriber.
"BSN Card"	means the medical card issued by Bupa to an eligible Member under this Contract, and the use of the card is subject to the conditions set out in **Special Conditions – Credit Facilities** and the membership guide.
"Bupa"	means Bupa (Asia) Limited.
"Bupa Group"	means Bupa and all entities that directly or indirectly Control, are Controlled by or are under common Control with Bupa, together with its and their respective joint ventures, affiliates and related parties.
"Bupa SafeNet Appointed Specialist"	means a Specialist referred to as a Specialist in the Bupa SafeNet Network Directory.
"Bupa SafeNet Appointed Service Providers"	means the Registered Medical Practitioners, Hospitals, cancer centres, day-case centres and other medical service providers as having been appointed by Bupa and who have entered into credit facility arrangements with Bupa to provide medical services to the Member on Bupa's undertaking to pay for the services so provided. The list of service providers can be found in the Bupa SafeNet Network Directory.
"Bupa SafeNet Network Directory"	shall mean the list printed in digital formal which contains the particulars of Bupa SafeNet Appointed Service Providers appointed by Bupa. The list may be updated and amended by Bupa from time to time and the latest list is available at the Bupa's mobile app or website.
"Cancer"	means the illness as defined under "Cancer" in **Definition of Critical Illnesses**.
"Cancer Treatment Reimbursement Benefit"	means any or all of the Benefits as outlined in Parts I to VI under **Section C of the Description of Critical Illness Benefits** if the Member is diagnosed to be suffered from a Covered Cancer. The aggregate amount of Cancer Treatment Reimbursement Benefit payable shall not exceed the Maximum Limit and Lifetime Limit as stated in the Schedule of Benefits.
"Chinese Medicines"	means the Chinese medicines legally registered in the Chinese Medicines Board under Chinese Medicine Council in Hong Kong pursuant to the Chinese Medicine Ordinance (Chapter 549, Laws of Hong Kong) or the equivalent legal authority of any other place rendering Chinese medicines treatment.
"Congenital Diseases"	means medical abnormalities existing at the time of birth, regardless of whether they are known or unknown to the Member. They shall include (but not to the exclusion of others which may medically be regarded as congenital conditions), strabismus (squint), hydrocephalus, undescended testicle, Meckel's diverticulum, flat foot, heart septal defect and indirect inguinal hernias.
"Contract"	means the terms, conditions and exceptions contained in or endorsed in this contract applicable to Bupa Safe Critical Illness Insurance Scheme, the Membership Certificate, the Schedule of Benefits, the Application, and any endorsement(s) and amendment(s) thereto signed by the authorised representative of Bupa, any medical evidence, written statements and answers as evidence of insurability, the acceptance letter and any other schedule attached to this contract.
"Contract Anniversary Date"	means the effective date of renewal. The first renewal date shall be the same date in the subsequent calendar year as the Critical Illness Benefit Coverage Commencement Date, stated as such in the Membership Certificate or as stipulated in subsequent endorsements, if any.
"Contract Year"	means the period commencing from the Critical Illness Benefit Coverage Commencement Date and expiring on the Contract Anniversary Date stated as such in the Membership Certificate or as stipulated in subsequent endorsement, if any.

"Control"	means the beneficial ownership of more than twenty-five percent (25%) of the issued share capital of a company or the legal power to direct or cause the direction of the general management of the company (and "Controlled" shall be construed accordingly).
"Covered Cancer"	means the covered illness under **Section C of the Description of Critical Illness Benefits** which covers any cancer positively diagnosed with histological confirmation or preparations from the haemic system (including but not limited to, peripheral blood smears and bone marrow examination), and characterized by the uncontrolled growth of malignant cells and invasion of tissue. For the purpose of this Contract, the term Covered Cancer will include: (a) all stages of malignant cancer, including early stage cancer ;and (b) Covered Carcinoma-in-situ, but will specifically exclude the following: I. any tumour which is histologically classified as pre-malignant; II. abnormal lesions of cervix uteri classified as cervical intra-epithelial neoplasia grade I (CIN I) and grade II (CIN II); and III. any cancer where HIV infection is also present. For the avoidance of doubt, this definition above does not equivalent to Cancer, Early Stage Cancer and Carcinoma In Situ as defined under the relevant sections of **Definitions of Critical Illnesses** and a boarder range of illnesses are covered.
"Covered Carcinoma In Situ"	means the covered illness under **Section C of the Description of Critical Illness Benefits** which covers a histologically proven, localised pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma without any organ group specified.
"Credit Limit"	means the maximum credit amount of the BSN Card that is determined by Bupa from time to time.
"Critical Illness"	means a diagnosed illness or condition as defined under the Schedule of Benefits in which Critical Illness Benefits shall be payable. The illness or condition must have symptoms first occurred and diagnosed after the ninety (90) days' waiting period applicable under **Clause 6(b) of the General Conditions**, except for any illness or condition caused by an Accident. The diagnosed illness or condition must be supported by histological report and/or other appropriate test results and investigations and all medical treatments and surgeries (if applicable) must also be confirmed as Medically Necessary by the Registered Medical Practitioner.
"Critical Illness Benefits"	means any or all of the Benefits as outlined in **Section A and Section B of the Description of Critical Illness Benefits**, which shall be inclusive of Major Critical Illness Benefit, Early Stage Critical Illness Benefit and Additional Cancer Benefit. The itemised and aggregate amount of Critical Illness Benefits payable shall not exceed the respective Benefit Amount as stated in the Membership Certificate.
"Critical Illness Benefit Coverage Commencement Date"	means the coverage commencement date of this Contract as stated in the Membership Certificate or as stipulated in subsequent endorsement, if any.
"Day Case"	means a surgical procedure or Non-surgical Cancer Treatment covered under **Section C of the Description of Critical Illness Benefits** for the purposes of confirming, investigating or treating a Covered Cancer which may effectively be undertaken at a clinic or day-case unit of a Hospital by a Registered Medical Practitioner where an overnight stay in Hospital is not Medically Necessary.
"Definition of Critical Illnesses"	means the list of definitions attached to the Contract which sets out the eligibility and definition of each Critical Illness.
"Dietitian"	means a person (other than the Member himself, his relatives, family or business partners unless approved by Bupa) approved as such by Bupa or a person who is fully trained in Hong Kong or legally qualified and permitted in any other place where expenses are incurred to practice dietetics following completion of a degree in food and management of diets (dietetics) and has qualifications at least equivalent to those of an accredited dietitian registered with the Hong Kong Dietitians Association.
"Distant Metastasis of Cancer"	means the formation of new tumour(s) in organ(s) away from the primary site of tumour with the same malignant cell origin. Spread of Cancer to the lymph nodes does not qualify as distant metastasis. Distant Metastasis of Cancer must be certified by a Specialist with medical investigations and reports confirming Metastasis of Cancer. Clinical diagnosis alone does not meet the requirement and objective medical evidence (including but not limited to radiological, histological and laboratory reports) is required.
"Early Stage Critical Illness"	means any one (1) of the Critical Illnesses covered under Early Stage Critical Illness Benefit under **Section A of the Description of Critical Illness Benefits**.
"Early Stage Critical Illness Benefit"	means the benefit payable under Critical Illness Benefits if the Member is diagnosed to be suffering from or undergoes a covered surgery of any one (1) of the Early Stage Critical Illnesses.
"Emergency"	means unplanned Hospital Confinement and condition that is acute in nature and wherein the initial sign or symptom, and the consultation or treatment for this condition cannot be and are not separated by more than forty-eight (48) hours.
"Excluded Conditions"	means the exclusion of a particular illness or condition from the coverage of this Contract that may be applied by Bupa based on a Pre-existing Illnesses or factors affecting the insurability of the Member. These conditions are set out in the Membership Certificate or endorsement.
"Experimental Treatment Cash Allowance"	means any or all the Benefits as outlined in Part V under **Section C of the Description of Critical Illness Benefits**.
"Extended Care Benefits"	means any or all the Benefits as outlined in Part III under **Section C of the Description of Critical Illness Benefits**.
"Hong Kong"	means the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	means an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing medical service for sick and injured persons as inpatients, and which - (a) has facilities for diagnosis and major operations, or is a public hospital as defined in the Hospital Authority Ordinance (Cap. 113 of the Laws of Hong Kong) or a hospital for which a licence is issued under the Private Healthcare Facilities Ordinance (Cap. 633 of the Laws of Hong Kong); (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.

"Hospital and Surgical Benefit"	means any or all the Benefits as outlined in Part II under **Section C of the Description of Critical Illness Benefits**.
"Hospital Confinement"	means confinement in a Hospital for western medicine and surgical services as a result of a Medically Necessary condition and recommended by a Registered Medical Practitioner. For the purpose of this Contract, the Member must stay in the Hospital for the entire period of confinement and room and board charges must be incurred.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for inpatients.
"Levy"	means the prescribed levy as stipulated in the Insurance Ordinance (Cap. 41) and the Insurance (Levy) Regulation (Cap. 41I) and as prescribed and calculated in the Insurance (Levy) Order (Cap. 41J).
"Lifetime Limit"	mean the maximum amount of Benefits paid by Bupa to the Subscriber in a lifetime basis and the remaining balance will become the lifetime limit of the next Contract Year. After the lifetime limit is exhausted, those Benefits which are subject to lifetime limit shall no longer be payable. The remaining balance of lifetime limit for the Contract Year will be shown on the Membership Certificate.
"Major Critical Illness"	means any one (1) of the Critical Illnesses covered under Major Critical Illness Benefit under **Sections A and B of the Description of Critical Illness Benefits**.
"Major Critical Illness Benefit"	means the benefit payable under Critical Illness Benefits if the Member is diagnosed to be suffering from or undergoes a covered surgery of any one (1) of the Major Critical Illnesses.
"Maximum Limit"	means the maximum amount that will be paid or reimbursed by Bupa under **Section C of the Description of Critical Illness Benefits** subject to the terms and conditions of this Contract with regard to the relevant Benefit as specified in the Schedule of Benefits.
"Medical Appliances"	means any aid, device or appliance provided for the sole use of the Member to assist the Member with mobility or other activities of daily living that have become impaired as a direct result of the Covered Cancer. Medical Appliance shall not include adaptation of the Member's home including the fixing of devices in a permanent or semi-permanent manner.
"Medically Necessary"	means the necessity to have a treatment, medical service or medication which is: (a) consistent with the diagnosis and customary medical treatment for the condition at a Normal and Customary charge; (b) in accordance with standards of good and prudent medical practice; (c) necessary for such a diagnosis or treatment; (d) not furnished primarily for the convenience of the Member, Registered Medical Practitioner, registered Chinese medicine practitioner, physiotherapist, anaesthetist or any other medical service providers; (e) furnished at the most appropriate level which can be safely and effectively provided to the Member; and (f) with respect to Hospital Confinement, not furnished primarily for diagnostic scanning purpose, imaging examination or physical therapy. For the avoidance of doubt, the recommendation of the attending Registered Medical Practitioner is not the sole factor to be considered when determining whether a treatment, medical service or medication is Medically Necessary. For the purpose of this Contract, without prejudice to the generality of the foregoing, circumstances where a Hospital Confinement is considered Medically Necessary include, but are not limited to - (i) the Member is having an Emergency that requires urgent treatment which should be performed at a Hospital; (ii) surgical procedures which are medically required to be performed under general anaesthesia; (iii) equipment for surgical procedure is available in Hospital and procedure cannot be done on a Day Case basis; (iv) there is significantly severe co-morbidity of the Member; and/or (v) taking into account the individual circumstances of the Member and for the safety of the Member, the medical service should only be conducted in Hospital. For the purposes of interpreting "standards of good and prudent medical practice", Bupa shall consider the followings: I. standards that are based on clinically proven evidence in appropriately reviewed, independent medical journals; II. relevant specialty body recommendations; and III. in accordance with standards of generally accepted medical practice.
"Member"	means the person named as the Member in the Membership Certificate. The member must be either the Subscriber, the Subscriber's spouse/domestic partner or the Subscriber's child (including any child born out of wedlock or under legal custody, adoptive child and stepchild). Domestic partner shall mean civil partner, or the person (of same or different sex), with whom the Subscriber lives with in a continuous, committed, exclusive relationship during which period neither the Subscriber nor that person was or is married to or partnered with any other person.
"Membership Certificate"	means the certificate issued by Bupa to the Subscriber covered under this Contract. The certificate shall list out the name of the Subscriber, the name of the Member, the Critical Illness Benefit Coverage Commencement Date, the Benefit Amount, the plan level, the contract number and other particulars as amended from time to time.
"Non-surgical Cancer Treatment"	means treatment for Covered Cancer including chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy.
"Normal and Customary"	in relation to fees, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar age, for a similar disability, as reasonably determined by Bupa in utmost good faith. The Normal and Customary charges shall not in any event exceed the actual charges incurred. In determining whether a charge is Normal and Customary, Bupa shall make reference to the followings (if applicable), (a) treatment or service fee statistics and surveys in the insurance or medical industry; (b) internal or industry claim statistics; (c) gazette published by the Hong Kong government; and/or (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.

"Occupational Therapist"	means a person (other than the Member himself, his relatives, family or business partners unless approved by Bupa) approved as such by Bupa or a person who is fully trained and legally registered to assess and treat disabilities caused by diseases or injuries using mental, physical or social activities to enable the disabled to achieve the maximum possible independence in daily life in Hong Kong or any other place where expenses are incurred and has qualifications at least equivalent to those of an occupational therapist registered pursuant to the Occupational Therapists (Registration and Disciplinary Procedure) Regulations (Chapter 359B, Laws of Hong Kong).
"Operating Theatre"	means any facility designated for and equipped to perform surgical operations or procedure, and have satisfied at least equivalent to the requirements stipulated in the Code of Practice for Day Procedure Centres or the Code of Practice for Hospitals issued by the Director of Health in Hong Kong, or any other applicable code of practice or regulation pursuant to the Private Healthcare Facilities Ordinance (Chapter 633, Laws of Hong Kong).
"Out-patient Care and Monitoring Benefit"	means any or all the Benefits as outlined in Part IV under **Section C of the Description of Critical Illness Benefits**.
"Out-patient Diagnosis and Testing Benefit"	means any or all the Benefits as outlined in Part I under **Section C of the Description of Critical Illness Benefits**.
"Physiotherapist"	means a person (other than the Member himself, his relatives, family or business partners unless approved by Bupa) who is legally authorised in Hong Kong or any other place where medical expenses are incurred to render assessment and treatment service on physical disabilities by means of remedial exercises, manual therapy and mechanical, thermal or electrical energy and has qualifications at least equivalent to those of a physiotherapist registered pursuant to the Supplementary Medical Professions Ordinance (Chapter 359, Laws of Hong Kong).
"Pre-existing Illnesses"	means, in respect of the Member, any sickness, disease, injury, physical, mental or medical condition or physiological degradation, including Congenital Diseases, that has existed, commenced or presented sign(s) and symptoms, prior to the Critical Illness Benefit Coverage Commencement Date, date of last reinstatement or the commencement date of this Contract after addition or upgrade of Benefits, whichever is the later.
"Preventive Check-up Benefit"	means any or all the Benefits as outlined in Part VI under **Section C of the Description of Critical Illness Benefits**.
"Private Room"	means a room for the Member's private use during his Hospital Confinement with its own private facilities. This includes a bedroom and bath or shower room, but not including kitchen, dining or sitting rooms.
"Psychologist"	means a person (other than the Member himself, his relatives, family or business partners unless approved by Bupa) approved as such by Bupa or a person who is fully trained in Hong Kong or legally qualified and permitted in any other place where medical expenses are incurred to render services for emotional and behavioural disorder following completion of a degree in psychology and has qualifications at least equivalent to those of a psychologist registered with the Hong Kong Psychological Society.
"Qualified Nurse"	means a nurse (other than the Member himself, his relatives, family or business partners unless approved by Bupa) who is legally qualified in Hong Kong or any other place where medical expenses are incurred to render nursing services and has qualifications at least equivalent to those of a nurse registered or enrolled pursuant to the Nurses Registration Ordinance (Chapter 164, Laws of Hong Kong) and "nursing" shall be construed accordingly.
"Registered Chinese Medicine Practitioner"	means a Chinese medicine practitioner or any person (other than the Member himself, his relatives, family or business partners unless approved by Bupa) who is legally authorised in Hong Kong or any other place where medical expenses are incurred to render Chinese Medicines treatment and has qualifications at least equivalent to those of a Chinese medicine practitioner registered pursuant to the Chinese Medicine Ordinance (Chapter 549, Laws of Hong Kong).
"Registered Dentist"	means any person (other than the Member himself, his relatives, family or business partners unless approved by Bupa) who is legally authorised in Hong Kong or any other place where medical expenses are incurred to render dental services and has qualifications at least equivalent to those of a dentist registered pursuant to the Dentist Registration Ordinance (Chapter 156, Laws of Hong Kong).
"Registered Medical Practitioner"	means a General Practitioner, Specialist or any person (other than the Subscriber or the Member, or any of their respective relatives, family or business partners unless approved by Bupa) who is legally authorised in Hong Kong or any other place where medical expenses are incurred to render western medicine and surgical services and has qualifications at least equivalent to those of a medical practitioner registered pursuant to the Medical Registration Ordinance (Chapter 161, Law of Hong Kong).
"Recurrence of Cancer"	means the recurrence of Cancer arising from the same malignant cell origin after treatment has been completed and for a period of time in which Cancer could not be detected as supported by medical evidence. The recurrence of Cancer must be certified by a Specialist with medical investigations and reports confirming Recurrence of Cancer. Clinical diagnosis alone does not meet the requirement and objective medical evidence (including but not limited to radiological, histological and laboratory reports) is required.
"Schedule of Benefits"	means the schedule set out herein as amended from time to time in which details of each Benefit item and Benefit Amount payable under Critical Illness Benefits.
"Semi-Private Room"	shall mean a room categorised as a semi-private or second class room by a Hospital in Hong Kong, or a room in Hospital outside of Hong Kong shared by no more than three (3) people but excluding any Standard Private Room or above.
"Shortfall"	means expenses incurred by a person who has used the BSN Card for payment of such expenses, which is not covered by **Section C of the Description of Critical Illness Benefits**.
"Specialist"	means a Registered Medical Practitioner approved as such by Bupa or a Registered Medical Practitioner who is registered under the Specialist Register of the Medical Council of Hong Kong or equivalent and qualified to practise specialist care according to the qualified specialty.
"Speech Therapist"	mean a person (other than the Member himself, his relatives, family or business partners unless approved by Bupa) approved as such by Bupa or a person who is fully trained in Hong Kong or legally qualified and permitted in any other place where expenses are incurred to render speech therapy services following completion of a degree in treating speech defects and disorders and has qualifications at least equivalent to those of a speech and language therapist registered with the Hong Kong Association of Speech Therapists.
"Subscriber"	means the owner of the Contract whose name appears as the Subscriber in the Membership Certificate.
"Subscription"	means the sum stated as such in the Membership Certificate, being payable or paid by the Subscriber to Bupa in consideration of Bupa agreeing to provide the Benefit to the Member.

"Subscription Loading"	means the additional Subscription on top of the standard subscription charged by Bupa to the Subscriber on this Contract according to the additional health risk assessed for the Member. Subscription Loading is set as a percentage of standard Subscription of this Contract (i.e. rate of Subscription Loading). The rates apply to Critical Illness Benefit and Cancer Treatment Reimbursement Benefit (if opted) may be different.
"Western Medication"	means medication legally registered with the Pharmaceutical Service of Department of Health in Hong Kong or the equivalent legal authority of any other place where expenses are incurred to render western medicine and surgical services.

2. The Contract

(a) This Contract constitutes the entire agreement between the Subscriber and Bupa.

(b) All statements made by the Subscriber shall be deemed representations and not warranties.

(c) Save as otherwise provided in this Contract, any change to this Contract proposed by the Subscriber including but not limited to addition, alteration, amendment and deletion of any terms and conditions of the Contract shall not be valid unless approved by Bupa in writing and signed by the authorised representative of Bupa.

(d) No agent or broker is authorised to do any of the following things on behalf of Bupa:

i. remove or vary any of the terms and conditions of the Contract or introduce any other terms and conditions, written or oral, into this Contract;

ii. make any representation, agree any condition precedent or enter into any collateral contract with respect to this Contract;

iii. accept any offer or counter-offer made by the Subscriber; and

iv. approve or reject any claim under this Contract.

(e) Except as provided for in **Clauses 7, 8, 12 and 22-25 of the General Conditions**, the Contract cannot be terminated unilaterally by Bupa or the Subscriber before it expires on the day before the Contract Anniversary Date.

(f) Bupa may amend the rate of Subscription, terms and conditions of the Contract from time to time subject to prior written notice to the Subscriber, provided that such amendments apply to all members of the same age under the same product and upon renewal. Any such changes shall be effective on the Contract Anniversary Date. Prior written notice by Bupa to the Subscriber is not required for Subscription adjustments (if any) according to the age of a Member.

3. Eligibility

(a) On the date of first-time registration under this Contract, the Member is not a permanent resident of the United States of America, Japan or the Commonwealth of Puerto Rico as defined under **Clause 8 of the General Conditions**;

(b) As a condition precedent to this Contract taking effect, the Subscriber must be aged eighteen (18) years or above on the Critical Illness Benefit Coverage Commencement Date and the Member must be between the age of fifteen (15) days and sixty (60) years (both inclusive) on the Critical Illness Benefit Coverage Commencement Date. The Member under this Contract shall hold a valid Hong Kong Identity Card and have been residing in Hong Kong for more than one hundred and eighty-three (183) days in the past twelve (12) months at application. Member under the age of eighteen (18) should hold a valid Hong Kong Birth Certificate or a Hong Kong Identity Card.

(c) Subject to **Clause 7 of the General Conditions**, this Contract shall not be renewable on the expiry of the Contract Year if on the Contract Anniversary Date, the Member has attained the age of one hundred (100) years.

(d) Each Member only entitles to be covered under one Contract unless agreed and approved by Bupa.

(e) Bupa reserves the right to decline any Application.

4. Payment of Subscription

(a) The Subscription payable under this Contract shall include (i) the standard Subscription according to the prevailing table of Subscriptions adopted by Bupa with reference to the current age of the Member; and (ii) the Subscription Loading, if applicable.

(b) The Contract shall not commence or continue to be in force (and no Benefit shall accrue or be payable hereunder) until the Subscription payable under the Contract is received in full in cleared funds by Bupa.

(c) This Contract shall last for one (1) year except when being terminated under the relevant provisions of this Contract. Subscription shall be due on the Critical Illness Benefit Coverage Commencement Date, subsequent payment dates according to the billing cycles (as applicable) and the Contract Anniversary Date (upon renewal), as the case may be. Subscription paid is non-refundable.

(d) The Insurance Ordinance (Cap. 41) stipulates that a prescribed levy is payable to the Hong Kong Insurance Authority for the insurance contract by its policy holder. Unless otherwise informed by Bupa in writing, the Subscriber is required to pay such amount of Levy and at such rates as specified by the Insurance (Levy) Order through Bupa together with the Subscription. Any non-payment of Levy by the Subscriber will result in Bupa making a report to the Insurance Authority for such non-payment as well as providing all relevant information including the Subscriber's name, contact information, levy amount and other information of this Contract as required by the Insurance Authority.

(e) Bupa shall determine the applicable standard Subscription (i.e. smoker or non-smoker) and Subscription Loading based on the underwriting assessment at Application and when applying for change of benefits. However, if there is any change of health condition or smoking status, the Subscriber or Member may apply to Bupa for reassessment upon renewal and the Subscription may be adjusted according to the prevailing rules of Bupa.

5. Entitlement to and Payment of Benefits

(a) Clerical error in keeping the records shall not invalidate the Benefits of the Member which are otherwise validly in force nor continue such Benefits which are otherwise validly terminated.

(b) If the Member unfortunately passes away before the eligible Benefit is paid, the eligible Benefit shall be payable to the estate.

(c) All liabilities in respect of Benefits admitted by Bupa hereunder shall be paid to the Subscriber, or to any third party as directed by the Subscriber or in such other manner as may otherwise be agreed between the Subscriber and Bupa in any particular case, subject to the relevant terms and conditions of this Contract. Payment of Benefits shall be deemed to have been made by Bupa to the Subscriber where Bupa pays:

i. the Subscriber through autopay to the Subscriber, subject to the relevant terms and conditions of this Contract. If the account to be credited is not in the name of the Subscriber or approved relatives of the Subscriber, an authorisation letter from the Subscriber is required. Bupa has the absolute right to reject the arrangement; or

ii. if applicable, the appropriate Bupa SafeNet Appointed Service Providers for the settlement of the medical expenses incurred by the Member for the Benefits payable under **Section C of the Description of Critical Illness Benefits**.

If any payment of Benefits is to be made by cheque, payment of Benefits shall be deemed to have been made by Bupa to the Subscriber when Bupa delivers or sends the cheque to the Subscriber for the eligible Benefits. Payment of Benefits by Bupa shall be a full discharge of the liability of Bupa in respect of which the payment is made under the Contract.

(d) **Section C of the Description of Critical Illness Benefits** shall only be in respect of a medical treatment, service or medication which is related to a Covered Cancer and being:

i. given or personally controlled by a Registered Medical Practitioner, Registered Chinese Medicine Practitioner (if applicable), Physiotherapist, Anaesthetist or other professional service providers (except medical practitioner, hospital or healthcare facility unrecognised by Bupa) for the services received by the Member ;

ii. undertaken at facilities approved by Bupa for the treatment procedures, tests or services concerned and consistent with Bupa's guidelines for the best practice care and attention as issued from time to time; and

iii. given where all reasonable steps have been taken to minimise expenditure.

(e) For the Benefits payable under **Section C of the Description of Critical Illness Benefits**, if a part or whole of the medical expense incurred by the Member is covered by compensation, reimbursement, insurance or indemnity under any other sources, **Clause 11(b)vii of the General Conditions** shall apply and this Contract shall not be regarded as the primary provider of benefits for such medical expenses.

6. Pre-existing Conditions and Waiting Period

(a) Bupa will not pay any Benefit for any Pre-existing Illnesses, unless the conditions or illnesses have been declared to and accepted by Bupa.

(b) Bupa will not pay any Benefit if the Member has any signs or symptoms, receive treatment, medication or investigation for or is diagnosed with, any Critical Illnesses and Covered Cancer (if applicable) within the ninety (90) days immediately following the Critical Illness Benefit Coverage Commencement Date, date of last reinstatement or the commencement date of this Contract after addition or upgrade of Benefits (if applicable), whichever is the later. For circumstances which may require a prolonged underwriting time before the issuance of the Contract, the above ninety (90) days waiting period may be superseded and counted from the issue date as set out in an endorsement. No waiting period is applied if the Critical Illness and Covered Cancer (if applicable) is caused by an Accident.

(c) Any other waiting periods applicable for Benefit payout under Major Critical Illness Benefit, Early Stage Critical Illness Benefit and Additional Cancer Benefit are shown under the **Description of Critical Illness Benefits**. Preventive check-up benefit under **Clause 28 of Section C of the Description of Critical Illness Benefits** is subject to the waiting period as stated thereunder.

7. Termination of Benefits and Contract

(a) Without limiting the application of **Clause 11 of the General Conditions**, if the Subscriber or the Member fails to act in utmost good faith, Bupa shall have the right to terminate the Member's coverage or the Contract, or revise the terms and conditions of the Contract.

(b) Bupa shall allow a grace period of two (2) months after the Subscription due date for payment of Subscription. This Contract shall continue to be in effect during the grace period, but no benefits shall be payable unless the payment of Subscription is paid. If full payment of any Subscription is not received by Bupa on or before any Subscription due date at the expiration of the grace period, Bupa shall have the right to terminate this Contract by way of a written termination notice to the Subscriber and Bupa shall bear no liabilities in that particular Contract Year.

(c) If the Member only opts for **Section A and Section B** (if applicable) **of the Description of Critical Illness Benefits**, this Contract shall automatically terminate on the earliest of the following dates:

i. the date of termination of cover of the Member pursuant **to Clause 8 or 22-25 of the General Conditions**;
ii. when the Subscriber requests termination of this Contract by giving at least ten (10) days written notice to Bupa before the Contract Anniversary Date. Such termination shall be effected on the Contract Anniversary Date;
iii. the day before the Contract Anniversary Date unless this Contract is renewed pursuant to this Contract;
iv. the date of payment when Major Critical Illness Benefit, Early Stage Critical Illness Benefit and Additional Cancer Benefit have all been paid to the Subscriber (irrespective of the age of the Member);
v. the date of payment when Major Critical Illness Benefit and Early Stage Critical Illness Benefit have all been paid to the Subscriber when the Member reaches age of eighty-five (85) or above;
vi. the Contract Anniversary Date immediately following the Member reaches age of eighty-five (85) and Major Critical Illness Benefit and Early Stage Critical Illness Benefit have all been paid to the Subscriber before age of eighty-five (85);
vii. the date of termination notice issued by Bupa to the Subscriber if Bupa decides to terminate this product; or
viii. the date of death of the Member.

(d) If the Member opts for **Section A, Section B** (if applicable) **and Section C of the Description of Critical Illness Benefits**, this Contract shall automatically terminate on the earliest of the following dates:

i. the date of termination of cover of the Member pursuant to **Clause 8 or 22-25 of the General Conditions**;
ii. when the Subscriber requests termination of this Contract by giving at least ten (10) days written notice to Bupa before the Contract Anniversary Date. Such termination shall be effected on the Contract Anniversary Date;
iii. the day before the Contract Anniversary Date unless this Contract is renewed pursuant to this Contract;
iv. if any date under **Clauses 7(c) iv - vi of the General Conditions** above has been reached, Critical Illness Benefit shall be terminated and **Section C of the Description of Critical Illness Benefits** under the Contract shall remain in force until the Contract Anniversary Date immediately after the Member reaches the age of 100 or the date when the Member exercises the membership transfer option pursuant to **Special Conditions - Membership Transfer Option**, whichever is the earlier;
v. the date of termination notice issued by Bupa to the Subscriber if Bupa decides to terminate this product; or
vi. the date of death of the Member.

(e) **Section B of the Description of Critical Illness Benefits** shall automatically terminate immediately after Major Critical Illness Benefit is paid to the Subscriber and any Subscriptions paid under **Section B of the Description of Critical Illness Benefits** for that particular Contract Year shall not be refunded.

(f) Bupa reserves the right to deduct any outstanding Subscriptions owed for that particular Contract Year before any Benefit is paid in the event of termination due to any reasons as stated under **Clause 7 of the General Conditions** above.

8. Residency

Bupa may terminate the cover of the relevant Member(s) with immediate effect or (where permitted to continue the cover of the relevant Member(s) until such date) with effect from the Contract Anniversary Date, if the law of the country in which the Member is located, or the Member's place of residence or nationality, including but not limited to the United States of America and Japan, or any other law which applies to Bupa or this Contract, prohibits the provision of healthcare cover by Bupa to local nationals, residents or citizens. The Subscriber is required to immediately notify Bupa in writing if it comes to the Subscriber's notice that any of the Members change place of residency or nationality during the Contract Year. Without limitation to the foregoing, a Member's cover shall not be renewed if such Member becomes a permanent resident of the United States of America, Japan or the Commonwealth of Puerto Rico. 'Permanent resident' shall mean a person residing in a country who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in that country.

9. Claims Procedure

(a) Notification of Claim

i. Any claim incurred by the Member under the Contract must be made in such claim form as prescribed by Bupa. All necessary original documents must be furnished by or on behalf of the Member within ninety (90) days after the diagnosis of the Critical Illness or within the specified period described in the **Section A and Section B of the Description of Critical Illness Benefits**, otherwise Bupa may reject such claim at its absolute discretion without assigning any reasons.
ii. Any claim for Benefit items payable under **Section C of the Description of Critical Illness Benefits** without using BSN Card, the Member must submit a claim using the claim form prescribed by Bupa. All necessary original documents must be furnished by or on behalf of the Member within ninety (90) days after clinical visit, clinical operation, Day Case, discharge from Hospital or receiving the service to which the claim relates, otherwise Bupa may reject such claim at its absolute discretion without assigning any reasons.

(b) Proof of Claim applicable to Benefits payable under **Section A and Section B** (if applicable**) of the Description of Critical Illness Benefits**

i. Proof of occurrence of the Critical Illness must be supported by:
   - a certificate from an appropriate Registered Medical Practitioner accepted by Bupa;
   - confirmatory results from medical investigations including but not limited to clinical, radiological, histological and laboratory evidence; and
   - if the Critical Illness requires a surgical procedure to be performed, the procedure must be certified Medically Necessary.
ii. All information, certificates, evidence, medical reports and other data or materials as reasonably required by Bupa shall be furnished at the expenses of the claimant.
iii. Bupa shall not accept liability for any claim unless the required information referred to in **Clauses 9(b) i and ii of the General Conditions** is received by Bupa within six (6) weeks from the issue date of any written request(s) from Bupa requesting such further information, unless otherwise agreed and approved by Bupa.
iv. Any other requirement specifically applicable for proof of claim for Additional Cancer Benefit is shown under **Clauses 3 and 4(b) of Section A and Section B of the Description of Critical Illness Benefits**.

(c) Proof of Claim applicable to Benefits payable under **Section C of the Description of Critical Illness Benefits**

i. Proof of Covered Cancer must be supported by:
   - a certificate from an appropriate Registered Medical Practitioner accepted by Bupa; and
   - confirmatory results from medical investigations including but not limited to clinical, radiological, histological and laboratory evidence.
ii. All information, certificates, evidence, medical reports and other data or materials as reasonably required by Bupa shall be furnished at the expenses of the claimant.

iii. Bupa shall not accept liability for any claim unless the required information referred to in **Clauses 9(c) i and ii of the General Conditions** is received by Bupa within six (6) weeks from the issue date of any written request(s) from Bupa requesting such further information, unless otherwise agreed and approved by Bupa.

(d) Examinations

Where a claim occurs, Bupa shall have the right to require the Member to be examined by a Registered Medical Practitioner appointed by Bupa at the Bupa's cost. In the event of the death of the Member, Bupa shall be entitled to have a post mortem examination where it is not forbidden by law and sufficient notice shall, when practicable, be given to Bupa before interment or cremation, stating the time and place of any inquest.

10. Currency

Subscriptions, Levy and Benefits shall be payable in Hong Kong dollars.

11. General Exclusions

(a) Unless this Contract expressly provides to the contrary, Bupa shall not be liable to pay any Benefit due to (I) a Critical Illness under **Section A and Section B of the Description of Critical Illness Benefits**; and (II) a Covered Cancer under **Section C of the Description of Critical Illness Benefits** in respect of any illnesses or conditions directly or indirectly in connection to or arising from:

i. Any Excluded Conditions (if applicable) and any Pre-existing Illnesses (unless such conditions have been disclosed in the Application and accepted by Bupa).

ii. Any illnesses or conditions with signs or symptoms, treatment received, medication or investigation for or is diagnosed within the waiting period as specified in **Clause 6(b) of the General Conditions**.

iii. Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex or Human Immune Deficiency Virus infections (except for HIV due to Blood Transfusion, HIV due to Assault, HIV due to Organ Transplant, Medically Acquired HIV and Occupationally Acquired HIV payable under **Section B of the Description of Critical Illness Benefits**).

iv. Suicide, attempted suicide or intentionally self-inflicted injury, whether the Member is sane or insane.

v. Intoxication by alcohol or drugs not prescribed by a Registered Medical Practitioner.

vi. Any Congenital Diseases.

vii. War, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military or usurped power or terrorist acts.

viii. Violation or attempted violation of the law or resistance to arrest or participation in any criminal act.

ix. Travel in any aircraft, except as a fare paying passenger in a commercial aircraft.

x. Inhaling gas except from hazard incidental to occupation.

xi. Engaging in (or practising) boxing, caving, climbing, horse-racing, jet skiing, martial arts, mountaineering, off-piste skiing, pot-holing, power-boat racing, under water diving, yacht racing, aerial sport or any race, trial or timed motor sport.

(b) In additional to the general exclusions set out in **Clause 11(a) of the General Conditions** above, Bupa shall not be liable to pay any Benefit incurred due to a Covered Cancer under **Section C of the Description of Critical Illness Benefits** that directly or indirectly in connection with and/ or for, in relation to any of the following:

i. when the application for reinstatement, or addition or upgrade of Benefits under **Section C of the Description of Critical Illness Benefits** is accepted by Bupa, any additional Excluded Conditions which may be imposed by Bupa (if applicable) and any Pre-existing Illnesses that existed before the reinstatement date or commencement date of addition or upgrade of Benefits (unless such conditions have been disclosed in the relevant application and accepted by Bupa).

ii. any tumour which is histologically classified as pre-malignant.

iii. abnormal lesions of cervix uteri classified as cervical intra-epithelial neoplasia grade I (CIN I) and grade II (CIN II).

iv. general check-ups, screening or check-up looking for the presence of a Covered Cancer on a preventive basis or where there are no symptoms or history of a Covered Cancer (except for preventive check-up benefit payable under **Clause 28 of Section C of the Description of Critical Illness Benefits**).

v. Any treatment modality undergone without a definite diagnosis of the presence of a Covered Cancer in the Member's body as per the definition specified.

vi. Subject to **Clause 5(e) of the General Conditions**, any illness for which compensation is payable under any laws or regulations or any other insurance policy or any other sources except to the extent that such charges are not reimbursed by any such compensation, insurance policy or sources.

vii. Any charges for accommodation, nursing and services received in health hydros, nature cure clinics or similar establishments.

viii. Psychological or psychiatric condition(s) of any and all kinds, including but not limited to psychoses, neuroses, depression, anxiety, anorexia nervosa, schizophrenia, behavioural disorders, delirium, insomnia, neurasthenia (except for psychological counselling benefit payable under **Clause 19 of Section C of the Description of Critical Illness Benefits** or any psychiatric condition which is in connection with the Covered Cancer and psychiatric treatment benefit payable under **Clause 13 of Section C of the Description of Critical Illness Benefits**).

ix. Any charges in respect of surgical or non-surgical cosmetic treatment, or hearing tests, routine blood tests, vaccinations or inoculations, Hair Mineral Analysis (HMA), health supplements or body weight control, eye refraction including but not limited to routine eye tests or any costs of fitting of spectacles or lens (except for prosthetic device benefit payable under **Clause 15 of Section C of the Description of Critical Illness Benefits**).

x. Treatment relating to pregnancy, including diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control, sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; sexual dysfunction including but not limited to impotence, erectile dysfunction, premature ejaculation, regardless of cause.

xi. Alternative treatment including but not limited to Chinese medicines treatment, acupuncture, acupressure, Tui Na, hypnotism, rolfing, massage therapy, aromatherapy (except for Chinese herbalist and complementary therapy benefits payable under **Clauses 18 and 25 of Section C of the Description of Critical Illness Benefits**).

xii. Non-medical services, including but not limited to guest meals, radio, telephone, photocopy, taxes (except the Value-Added Tax or Goods and Services Tax for medical services), medical report charges and the like.

xiii. Charges for any dental treatment or oral surgery (except for Medically Necessary surgery performed by a Registered Dentist specialised in Oral and Maxillofacial Surgery payable under **Clauses 2-17 of Section C of the Description of Critical Illness Benefits**) .

xiv. Expenses incurred for experimental or unproven medical technology or procedure not in accordance with the standards of good and prudent medical practice. For the purposes of interpreting "standards of good and prudent medical practice", Bupa shall consider (I) standards that are based on clinically proven evidence in appropriately reviewed, independent medical journals; (II) relevant specialty body recommendations; and (III) in accordance with standards of generally accepted medical practice (except for experimental treatment cash allowance benefit payable under **Clause 27 of Section C of the Description of Critical Illness Benefits**).

xv. Any charges incurred at a medical practitioner, hospital or healthcare facility unrecognised by Bupa, including but not limited to charges for the following treatment:

I. Treatment provided by a medical practitioner, hospital or healthcare facility, or otherwise any person or establishment which is not recognised by the relevant authorities in Hong Kong or any other place where the treatment takes place as having specialist knowledge, or expertise in, the treatment of the disease, illness or injury being treated;

II. Treatment provided by the Member himself, his relatives, family or business partners or anyone with the same residence as the Member or in case the treatment is provided in an establishment, that one of the above mentioned persons is a shareholder and/or having a power control such establishment unless it has been made known to and approved by Bupa; or

III. Treatment provided by a medical practitioner, hospital or healthcare facility whom Bupa do not or no longer recognise for the purpose of Bupa's insurance plans.

A list of unrecognised medical practitioners and providers can be found at Bupa's mobile app or website. The list is subject to update from time to time without prior notice.

12. Material Disclosure

(a) If the age or date of birth or other relevant facts relating to a Member shall be found to have been inadvertently misstated at Application, including any updates of and changes to such requisite information before the issue date of the Contract or Critical Illness Benefit Coverage Commencement Date (whichever is later), and if such misstatement affects the scope of cover, the basis of determination of the amount of Subscription payable or the terms and conditions of the Contract, the true age and facts shall be used in determining, whether Benefits are available under the terms of the Contract, and the scope of cover under this Contract may be adjusted accordingly by Bupa at its sole discretion.

(b) The truth of any statement or declaration made by the Subscriber or the Member and the due observance and fulfillment of the terms and conditions of the Contract insofar as they relate to anything to be done or complied with by the Subscriber or the Member shall be a condition precedent to the liability of Bupa to pay any Benefits under the Contract. The costs of obtaining any information reasonably required by Bupa for verification shall be borne by the Subscriber or the Member.

(c) If any of the events listed below takes place, the Contract shall be void at the sole and absolute discretion of Bupa and any Benefits obtained by the Subscriber or the Member as a result of such events shall become immediately repayable to Bupa and Bupa reserves the rights to recover from the Subscriber any cost related to the void Contract:

i. if any fact relating to the Subscriber or the Member which may impact the risk (including without limitation the smoking status of the Member) assessment by Bupa is incorrectly stated in, or omitted from the Application, including any updates of and changes to such requisite information before the issue date of the Contract or Critical Illness Benefit Coverage Commencement Date (whichever is later), or any statement or declaration made for or by the Subscriber or the Member in the Application;

ii. if the Contract thereof is obtained through any misstatement, misrepresentation or suppression; or

iii. if any claim made under this Contract is fraudulent or exaggerated.

13. Renewal and Change of Benefit

(a) Subject to the provisions of the **General Conditions** of the Contract, the Contract will be effective for a period of one (1) year and shall be guaranteed to be renewed automatically by Bupa (unless terminated pursuant to **Clauses 7, 8 or 22-25 of the General Conditions**) on a yearly basis subject to successful collection of the Subscription automatically from the designated bank account/ credit card (where applicable) at such rate and on such terms as Bupa may determine in accordance with **Clause 2(f) of the General Conditions**.

(b) This Contract will not be renewed pursuant to **Clause 13(a) of the General Conditions** if a written notice not to renew is received by Bupa from the Subscriber not less than ten (10) days before the Contract Anniversary Date.

(c) The Subscriber may only change the method of payment on renewal of this Contract. The Subscriber may change the payment method of Subscription by giving written notice to Bupa not less than one (1) month before the Contract Anniversary Date. Any such changes shall apply to the renewed Contract.

(d) The Subscriber may from time to time apply for variation of Benefits by giving written notice to Bupa at least one (1) month before the Contract Anniversary Date. The Subscriber may apply to add or upgrade the Benefits provided that (i) the Member has been continuously covered under this Contract for two (2) consecutive years; (ii) no addition or upgrade of Benefits has taken effect for the Member within previous two (2) years; and (iii) no claim has been submitted under this Contract previously.

(e) Bupa shall assess the application for variation of Benefits according to its prevailing underwriting practices and reserve the right to decline such an application or apply conditions for variation as it sees fit by giving notice to the Subscriber.

14. Reinstatement

If this Contract has lapsed due to non-payment of any Subscription, the Subscriber may apply to reinstate this Contract within three (3) months from the due date of the earliest outstanding but unpaid Subscription. To apply for reinstatement of this Contract, the Subscriber is required to submit to Bupa:

(a) an application for reinstatement made in such form as prescribed by Bupa;

(b) evidence of insurability satisfactory to Bupa provided at the Subscriber's expenses;

(c) payment of all overdue Subscriptions;

(d) any such additional information on the medical conditions of the Subscriber and / or the Member as Bupa may require at the Subscriber's expenses; and

(e) If the application for reinstatement of this Contract has been approved by Bupa, Bupa may impose terms and conditions as conditions for reinstatement. The waiting period stipulated under **Clause 6(b) of the General Conditions** above shall be counted afresh from the date of last reinstatement.

15. Ownership and Assignment of the Contract

Unless otherwise provided, Bupa shall be entitled to treat the Subscriber as the absolute owner of the Contract. This Contract cannot be assigned or transferred, whether in whole or in part, to any person without the written consent of Bupa.

16. Arbitration or Legal Proceedings

No arbitration or legal proceedings shall be brought against Bupa either:

(a) before the expiration of sixty (60) days after proof of claim has been submitted to Bupa in accordance with the requirements of the Contract; or

(b) after the expiration of one (1) year from the date on which proof of claim is required to be and has not been submitted to Bupa in accordance with the requirements of this Contract.

17. Time Effective and Territorial Limit

(a) 12:01AM Hong Kong time shall be deemed to be the effective time with respect to any times or dates referred to in the Contract.

(b) The cover under this Contract is provided on a worldwide basis.

18. Governing Law and Jurisdiction

The Contract shall be governed by and construed in accordance with the laws of Hong Kong. Subject to **Clause 19 of the General Conditions**, the parties submit to the exclusive jurisdiction of the Courts in Hong Kong.

19. Arbitration

Any disputes or differences arising out of or in connection with the Contract shall be referred to and determined by arbitration at the Hong Kong International Arbitration Centre and in accordance with its Domestic Arbitration Rules.

20. Cancellation Rights and Refund of Subscription

The Subscriber has the rights to cancel this Contract and obtain a refund of the Subscription and Levy paid, by giving Bupa written notice, provided that no Benefit has been paid or is payable under this Contract. Such notice must be signed by the Subscriber and received by Bupa within twenty-one (21) days from the Critical Illness Benefit Coverage Commencement Date or issue date of this Contract, whichever is later. Cancellation rights are not applicable to renewed Contract.

21. No Third Parties Rights

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

22. Bribery and Corruption

22.1 The Subscriber represents and warrants that neither the Subscriber nor any person acting on the behalf of the Subscriber or any Member, in connection with the entry into or performance of any obligation by either Bupa or the Subscriber under this Contract:

(a) has offered, promised, given, authorised, solicited or accepted any undue financial or other advantage of any kind, nor will the Subscriber or they take any such action after entry into this Contract;

(b) will engage in any activity, practice or conduct that would constitute an offence under any applicable laws relating to anti-bribery and anti-corruption matters; and

(c) will do, or omit to do, any act or series of acts that will cause or lead Bupa to be in breach of any applicable laws relating to anti-bribery and anti-corruption matters.

22.2 The Subscriber will promptly report to Bupa any request or demand by any person, in connection with the entry into or performance of any obligation by either Bupa or the Subscriber under this Contract, for any undue financial or other advantage of any kind or other act or acts that would, if such request or demand were met, be in breach of any applicable laws relating to anti-bribery and anti-corruption matters.

23. Sanctions

23.1 Bupa shall be deemed not to provide cover and Bupa shall not be liable to pay any claim or provide any benefit under this Contract to the extent that the provision of such cover, payment of such claim or provision of such benefit would:

(a) be in contravention of a United Nations resolution or the trade or economic sanctions, laws or regulations of any jurisdiction to which Bupa or any entity, employee or officer of the Bupa Group is subject (which may include without limitation those of the European Union, Hong Kong, Australia, the United Kingdom, and/or the United States of America).

(b) expose Bupa or any entity, employee or officer of the Bupa Group to the risk of being sanctioned by any relevant authority or competent body; and/or

(c) expose Bupa or any entity, employee or officer of the Bupa Group to the risk of being involved in conduct (either directly or indirectly) which any relevant authority or competent body would consider to be prohibited.

23.2 Where such resolution, sanctions, laws or regulations referred to in **Clause 23.1(a) of the General Conditions** are or become applicable to this Contract, Bupa reserves all of its rights to take all and any such actions as may be deemed necessary in its absolute discretion, to ensure that Bupa and any entity, employee or officer of the Bupa Group continues to be compliant, including but not limited to terminating coverage. The Subscriber acknowledges that this may restrict or delay Bupa's obligations under this Contract and Bupa may not be able to pay such claim in the event of a sanctions related concern.

23.3 The Subscriber shall upon its reasonable knowledge, inform Bupa promptly if there is any change to the identity, status and particulars of the Subscriber or any Member.

24. Fraud

24.1 Bupa reserves the right to refuse to pay the whole or any part of a claim, and to recover any payments Bupa has already made in respect of a claim, where the Subscriber or a Member:

(a) has made a fraudulent or exaggerated or falsely stated claim under this Contract;

(b) has sent fake or forged documents or other false evidence, or made a false statement, in support of a claim under this Contract; and/or

(c) has failed to provide Bupa with information that the Subscriber or the Member (as the case may be) knows would otherwise enable Bupa to refuse a claim under this Contract.

24.2 In the event that Bupa detects fraudulent activity of a type described in **Clause 24.1 of the General Conditions** (including a fraudulent claim or fraudulent omission to provide relevant information) made by or concerning the Subscriber or a Member, Bupa reserves the right to suspend or terminate cover under this Contract (as a whole or for that Member) from the date of occurrence of the relevant fraudulent activity and the Subscriber shall be notified accordingly. Bupa will not be required make any further payment of the whole or part of any claim or to refund any Subscriptions relating to the whole Contract or to that Member or those Members.

24.3 The Subscriber shall take all reasonable steps to prevent fraud in connection with this Contract and notify Bupa immediately if the Subscriber has reason to suspect that any fraud in connection with this Contract has occurred, is occurring or is likely to occur.

25. Facilitation of Tax Evasion

25.1 The Subscriber represents and warrants that neither the Subscriber nor any of the Members, in connection with the entry into or performance of any obligation by either Bupa or the Subscriber under this Contract engaged or will engage in any activity, practice or conduct which would constitute any tax evasion offence or tax evasion facilitation offence under any applicable laws.

25.2 The Subscriber will promptly report to Bupa, in connection with the entry into or performance of any obligation by either Bupa or the Subscriber under this Contract, any request or demand by any person for any act or acts that would, if such request or demand were met, be in breach of any applicable laws against tax evasion or tax evasion facilitation.

Description of Critical Illness Benefits

Section A – Critical Illness Basic Benefits
Section B – Extended Major Critical Illness Benefit (Optional Benefit)

Bupa will pay the Critical Illness Benefit below if the Member is diagnosed to be suffering from or undergoes a covered surgery of any one (1) of the Critical Illnesses, whereby each Critical Illness shall have its meaning given under the relevant headings as stated in the **Definition of Critical Illnesses** and must be certified by a Registered Medical Practitioner.

Subject to the terms and conditions and waiting period as stated hereunder, a maximum of one (1) Major Critical Illness Benefit, one (1) Early Stage Critical Illness Benefit and one (1) Additional Cancer Benefit shall be payable throughout the lifetime of the Member (subject to the coverage period of each Benefit). The amount payable under Critical Illness Benefit shall not exceed the respective Benefit Amounts as stated in the Schedule of Benefits. The Member shall refer to the Membership Certificate for the available Benefit Amount applicable under the current Contract Year for each of the benefit items payable under Critical Illness Benefit.

1. Major Critical Illness Benefit

Major Critical Illness Benefit, which is equivalent to the Benefit Amount as shown in the Membership Certificate, shall be payable if the Member is first diagnosed to be suffering from one (1) of the conditions below:

Covered conditions	Coverage ends at the Contract Anniversary Date immediately following the Age of
1. Cancer	100
2. Heart Attack	100
3. Stroke	100

If the Member has opted for **Section B - Extended Major Critical Illness Benefit** as specified in the Membership Certificate, in addition to the conditions above, Major Critical Illness Benefit shall also be payable if the Member is first diagnosed to be suffering from or undergoes a covered surgery in any one (1) of the conditions below:

Covered conditions	Coverage ends at the Contract Anniversary Date immediately following the Age of
Illnesses/ conditions/ surgeries related to the Heart	
4. Cardiomyopathy	100
5. Coronary Artery Disease Surgery	100
6. Dissecting Aortic Aneurysm	100
7. Heart Valve Surgery	100
8. Other Serious Coronary Artery Disease	100
9. Primary Pulmonary Arterial Hypertension	100
10. Surgery to Aorta	100
11. Severe Infective Endocarditis	100
Illnesses/ conditions/surgeries related to major organs and functions	
12. Blindness	100
13. Chronic Adrenal Insufficiency (Addison's Disease)	100
14. Chronic Auto-immune Hepatitis	100
15. Chronic Obstructive Lung Disease	100
16. Coma	100
17. End Stage Liver Disease	100
18. End Stage Lung Disease	100
19. Kidney Failure	100
20. Loss of Capacity for Independent Living	65
21. Loss of Hearing	100
22. Loss of Limbs	100
23. Loss of One Limb and One Eye	100
24. Loss of Speech	100
25. Major Organ Transplantation	100
26. Medullary Cystic Disease	100
27. Pheochromocytoma	100
28. Severe Bronchiectasis	100
29. Severe Emphysema	100
30. Severe Idiopathic Pulmonary Fibrosis	100
31. Total and Permanent Disability	65
Illnesses/ conditions/ surgeries related to Neurological Degeneration	
32. Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders	100
33. Corticobasal degeneration	100
34. Creutzfeld-Jacob Disease	100
35. Parkinson's Disease	100
Illnesses/ conditions/ surgeries related to the Nervous System	
36. Amyotrophic Lateral Sclerosis	100
37. Apallic Syndrome	100
38. Bacterial Meningitis	100
39. Benign Brain Tumour	100
40. Brain Surgery	100
41. Cerebral Aneurysm or Arteriovenous Malformation Requiring Craniotomy	100
42. Encephalitis	100
43. Hemiplegia	100
44. Major Head Trauma	100
45. Multiple Sclerosis	100
46. Muscular Dystrophy	100
47. Paralysis	100
48. Poliomyelitis	100
49. Primary Lateral Sclerosis	100
50. Progressive Bulbar Palsy	100
51. Progressive Muscular Atrophy	100

Covered conditions	Coverage ends at the Contract Anniversary Date immediately following the Age of
52. Progressive Supranuclear Palsy	100
53. Spinal Muscular Atrophy	100
54. Systemic sclerosis	100
55. Tuberculous Meningitis	100
Illnesses/ conditions/ surgeries related to the Digestive System	
56. Acute Necrotic Pancreatitis	100
57. Acute Necrohaemorrhagic Pancreatitis	100
58. Chronic Relapsing Pancreatitis	100
59. Fulminant Hepatitis	100
60. Severe Crohn's Disease	100
61. Severe Ulcerative Colitis	100
Illnesses/ conditions/surgeries related to the Musculoskeletal System	
62. Amputation of Feet due to Complication from Diabetes	100
63. Major Burns	100
64. Necrotising Fasciitis	100
65. Severe Facial Burns due to Accident	100
66. Severe Myasthenia Gravis	100
Illnesses/ conditions/ surgeries related to blood	
67. Aplastic Anaemia	100
68. HIV due to Blood Transfusion	100
69. HIV due to Assault	100
70. HIV due to Organ Transplant	100
71. Medically Acquired HIV	100
72. Occupationally Acquired HIV	100
Illnesses/ conditions/ surgeries related to Immunology and Rheumatology	
73. Systemic Lupus Erythematosus	100
74. Severe Psoriasis with Arthritis	100
75. Severe Rheumatoid Arthritis	100
76. Systemic Scleroderma	100
Other major illnesses/ conditions/ surgeries	
77. Ebola Haemorrhagic Fever	100
78. Elephantiasis	100
79. Permanent Tracheostomy	100
80. Terminal Illness	100

Under no circumstances shall this Major Critical Illness Benefit be paid more than once under this Contract. For the avoidance of doubt, notwithstanding the Member suffers from more than one (1) Major Critical Illness at the same time, only one (1) claim can be made under this Major Critical Illness Benefit.

Once a Major Critical Illness Benefit has been paid, **Section B - Extended Major Critical Illness Benefit** shall be terminated immediately but no subscriptions refund in respect of **Section B - Extended Major Critical Illness Benefit** shall be arranged for the unused period of the Contract Year. Bupa shall deduct any outstanding monthly subscription(s) owed for that particular Contract Year in respect of **Section B - Extended Major Critical Illness Benefit** before Major Critical Illness Benefit is paid.

2. Early Stage Critical Illness Benefit

Early Stage Critical Illness Benefit, which is equivalent to the Benefit Amount as shown in the Membership Certificate of the Member, shall be payable if the Member is first diagnosed to be suffering from or undergoes a covered surgery in any one (1) of the conditions below:

Covered conditions	Coverage ends at the Contract Anniversary Date immediately following the Age of
1. Carcinoma in Situ	100
2. Carotid artery disease requiring surgery	100
3. Coronary artery disease requiring angioplasty and other invasive treatments	100
4. Early Stage Cancer	100
5. Endovascular treatment for cerebral aneurysm	100

Under no circumstances shall this Early Stage Critical Illness Benefit be paid more than once under this Contract. For the avoidance of doubt, notwithstanding the Member suffers from more than one (1) Early Stage Critical Illness at the same time, only one (1) claim can be made under this Early Stage Critical Illness Benefit.

If the Member is also insured under Bupa Critical Essential Care, benefits payable under its Special Critical Illness and Early Stage Critical Illness Benefit under this Contract shall be subject to an aggregate benefit limit of HKD400,000 throughout the lifetime of the Member.

3. Additional Cancer Benefit

On the condition that Major Critical Illness Benefit has been paid and after the expiration of one (1) year waiting period, Additional Cancer Benefit, which is equivalent to the Benefit Amount that is shown in the Membership Certificate of the Member, shall be payable if the Member is diagnosed to be suffering from the covered condition below:

Covered condition	Coverage ends at the Contract Anniversary Date immediately following the Age of
1. Cancer	85

Under no circumstances shall this Additional Cancer Benefit be paid more than once under this Contract. For the avoidance of doubt, notwithstanding the Member suffers from more than one (1) Cancer at the same time, only one (1) claim can be made under this Additional Cancer Benefit and the conditions/waiting period set out in **Clause 4(b)** of these **Section A and B** below must be satisfied.

For Additional Cancer Benefit to be payable, the Member is required to provide:

(a) medical report as specified in **Clause 9(b)i of the General Conditions** dated after one (1) year from the date in which the preceding Major Critical Illness was first diagnosed or surgery performed to provide evidence for the existence of Cancer; and

(b) proof of Active Cancer Treatment as specified in **Clause 4(b)** of these **Section A and B**.

4. Waiting periods between payment of Benefit items

(a) Waiting period between Major Critical Illness Benefit and Early Stage Critical Illness Benefit

The date of first diagnosis of Major Critical Illness and Early Stage Critical Illness shall be separated by at least forty-five (45) days so that both Major Critical Illness Benefit and Early Stage Critical Illness Benefit shall be payable in full.

In the event the Member is first diagnosed with an Early Stage Critical Illness and then subsequently suffered from a Major Critical Illness within forty-five (45) days, Major Critical Illness Benefit shall be payable in place of any paid or payable Early Stage Critical Illness Benefit. For the avoidance of doubt, Early Stage Critical Illness Benefit can be revived and payable again for another newly diagnosed or undergoes another Early Stage Critical Illness after the expiration of forty-five (45) days waiting period counting from the first diagnosed date of Major Critical Illness.

(b) Waiting period between Major Critical Illness Benefit and Additional Cancer Benefit

Additional Cancer Benefit shall only be payable, provided that the applicable waiting period and requirements set out below are satisfied:

Major Critical Illness Benefit already paid for	Additional Cancer Benefit will be payable for	Waiting Period and Requirements
Major Critical Illness except Cancer	Cancer	The date of diagnosis or covered surgery performed for the first Major Critical Illness and subsequent Cancer must be at least one (1) year apart.
Cancer	new Cancer (must be of a different malignant cell origin)	The date of diagnosis of the first Cancer and new Cancer must be at least one (1) year apart.
Cancer	Recurrence of Cancer	The date of diagnosis of the first Cancer and Recurrence of Cancer/ Distant Metastasis of Cancer must be at least one (1) year apart, and proof of Active Cancer Treatment must be provided.
Cancer	Distant Metastasis of Cancer	
Cancer	same Cancer	Benefits will be payable one (1) year after the start date of Active Cancer Treatment if the Member is receiving ongoing cycles of Active Cancer Treatment. Further, the Member must provide medical report(s) to show that the Cancer still exists after the completion of the latest Active Cancer Treatment cycle, which is not less than one (1) year after the Active Cancer Treatment start date. Benefits shall only be payable when proof of Active Cancer Treatment and medical report are submitted within ninety (90) days from the completion date of the latest Active Cancer Treatment cycle.
Any Major Critical Illness	any Cancer diagnosed within the first year from the date of diagnosis or covered surgery performed for a Major Critical Illness	

Proof of Active Cancer Treatment must be supported by the following documents:

(a) The original receipts and/or original itemised bills listing out the type of treatment and treatment procedure performed; and
(b) All relevant information, certificates, reports, evidence, referral letter and other data or materials as reasonably required by Bupa for claims assessment, at the expenses of the Subscriber or Member.

Section C - Cancer Treatment Reimbursement Benefit (Optional Benefit)

Subject to the terms and conditions of this Contract, the Benefits described under Parts I to V below shall be payable if the Member is confirmed to have diagnosed with a Covered Cancer by a Registered Medical Practitioner after the applicable waiting period. Parts I to IV shall only reimburse Normal and Customary medical expenses or service charges arising from diagnostic tests and treatments in connection with a Covered Cancer including the complications arising from cancer treatment, subject to the applicable Maximum Limit, maximum number of days, maximum number of visits per day, reimbursement percentage and Lifetime Limit as shown in the Schedule of Benefits. Benefits payable under this **Section C** shall not exceed the actual costs for medical treatment or services provided to the Member.

Part I – Out-patient Diagnosis and Testing Benefit

Benefits payable under this Part I shall cover Medically Necessary diagnostic tests and investigations received at an out-patient setting to confirm the diagnosis of a Covered Cancer. The amount of eligible medical expenses payable under this section shall not exceed the actual costs for medical services provided to the Member, subject to the Maximum Limit as stated in the Schedule of Benefits.

1. Out-patient Diagnosis and Testing

This Benefit shall be payable when the Member undergoes for Medically Necessary diagnostic tests including but not limited to laboratory tests, X-rays, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) where such tests are directly related to investigate and confirm the positive diagnosis of a Covered Cancer in the outpatient department of Hospital or a clinic under the supervision of a Registered Medical Practitioner.

Any charges for diagnostic tests which require a surgical procedure including but not limited to fine needle aspiration for cytology or histopathology, or excisional biopsy for histopathology will be payable as a Day Case or Hospital Confinement under the relevant Benefit within the **Clauses 2-17** of this **Section C**, regardless these tests are performed at an out-patient or inpatient setting.

If the diagnostic tests are performed during Hospital Confinement but the Hospital Confinement is considered not Medically Necessary, such expenses shall not be payable under **Clauses 2-17** of this **Section C** but the eligible expenses shall be regarded as incurred at an out-patient setting and payable under this Benefit.

For the avoidance of doubt, any diagnostic tests to monitor the prognosis of Covered Cancer will not be covered under this Benefit and shall be exclusively payable under **Clauses 12 or 26** of this **Section C**, whenever applicable.

Part II – Hospital and Surgical Benefit

(a) Benefits payable under this Part II shall only cover Medically Necessary medical expenses incurred by the Member for treatment, diagnosis and supportive care of a Covered Cancer during
   i. Hospital Confinement;
   ii. Day Case or Non-surgical Cancer Treatment;
   iii. pre-admission and post-hospitalisation out-patient care; or
   iv. the course of rehabilitation and palliative care.

   Relevant expenses incurred for Medically Necessary home sleep apnea test, together with its pre-test and post-test consultation, if eligible, shall be exclusively paid under Miscellaneous Hospital Services and Pre-admission & Post-hospitalisation/ Day Case Out-patient Care under the Hospital and Surgical Benefit.

Bupa shall only reimburse the eligible medical expenses which are Normal and Customary.
For the avoidance of doubt, where a Member is in Hospital Confinement but the Hospital Confinement is considered not Medically Necessary, the expenses incurred as a result of such Hospital Confinement shall not regarded as eligible medical expenses for the purposes of i. above. However, the Subscriber shall still have the right to claim for the relevant eligible medical expenses incurred during such Hospital Confinement on medical services under ii. above.

(b) Clinical operation or Day Case, if eligible, shall be paid under the relevant Benefit within this Part II.
(c) The amount of eligible medical expenses payable under this Part II shall not exceed the actual costs for medical services provided to the Member, subject to the Maximum Limit as stated in the Schedule of Benefits.
(d) Nothwithstanding the general exclusions as stated under **Clause 11(b)xiii of the General Conditions**, Medically Necessary surgery performed by a Registered Dentist specialised in Oral and Maxillofacial Surgery for a condition related to Covered Cancer, if eligible, shall be paid under the relevant Benefit within this Part II.
(e) Nothwithstanding the general exclusions as stated under **Clause 11(b)x of the General Conditions**, this Part II shall also cover medical expenses incurred for the reconstructive surgeries of the breast, head or neck as a result of Covered Cancer provided that such reconstructive surgeries occur at the same time or within twelve (12) months from the date of the mastectomy or other cancer removal surgeries.
(f) This Part II shall not be payable for Hospital Confinement in class of suite/V.I.P./deluxe room of a Hospital. If the Member is confined in a Hospital with room class higher than the restricted room class under this Contract, in relation to such days of Hospital Confinement, the following adjustment factors shall be applied to the Benefits payable:

Restricted room class	Actual confined room class	Adjustment factor
Ward	Semi-Private Room	50%
Ward	Private Room	25%

The Benefits payable under this Part II shall not be subject to the above adjustment factors if the Member stays in a room class higher than the restricted room class during Hospital Confinement as a result of (i) unavailability of a specified or lower room level due to room shortage at the Hospital for Emergency treatment; or (ii) Hospital Confinement in isolation that requires a specific room level.

2. Room and Board

This Benefit shall be payable for the charges as levied and published by a Hospital for the cost of accommodation and meals for the Member during the Member's Hospital Confinement. The amount payable under this Benefit shall be equal to the actual amount charged by the Hospital in respect of room and board during the Member's Hospital Confinement.

This Benefit shall not be payable for special nursing services for the Member, nor for accommodation and meal for persons other than the Member who is subject to Hospital Confinement.

3. Miscellaneous Hospital Services

This Benefit shall be payable for the following Hospital services, except where deleted or omitted from coverage or specified to the contrary in the Schedule of Benefits. The amount payable under this Benefit shall be equal to the actual amount charged by the Hospital for the following services rendered:

(a) road ambulance service to and / or from the Hospital;
(b) anaesthesia and oxygen and their administration;
(c) blood transfusions;
(d) dressing and plaster casts;
(e) drugs, medicine, and curative materials consumed on premises;
(f) medicine and drug prescribed upon discharge from Hospital Confinement or on the day of completion of Day Case for use up to the ensuing four (4) weeks;
(g) prescribed diagnostic imaging tests (limited to computed tomography ("CT" scan), magnetic resonance imaging ("MRI" scan), positron emission tomography ("PET") scan), PET-CT combined and PET-MRI combined) which must be performed during Hospital Confinement;
(h) diagnostic imaging services, including but not limited to ultrasound and X-ray and their interpretation, except all types of prescribed diagnostic imaging tests which already covered by Clause 3(g), which must be performed on the day of the relevant surgery or during Hospital Confinement;
(i) intravenous infusions;
(j) laboratory examinations;
(k) radioactive isotope;
(l) consumables used in the Operating Theatre; and
(m) implants including but not limited to stent and pacemaker.

This Benefit shall be further extended to cover Medically Necessary rental charges of device used and the examination report fee for conducting home sleep apnea test at the Member's home or diagnostic centre as recommended by the Registered Medical Practitioner.

Medicine and curative material shall include all Western Medications, IV fluid, dressings, gauze, swabs, and other medical disposables and consumables used during Hospital Confinement for medical and nursing care. Instruments and other hardware used in an operation such as anaesthesia machine, gastroscope, colonoscope, lithotripter, x-knife, cyberknife and gamma knife do not belong to this category.

4. Intensive Care

This Benefit shall be payable for the charges incurred as a result of the Member being accommodated in an Intensive Care Unit in a Hospital recommended by the Registered Medical Practitioner in charge. The amount payable under this Benefit shall in no event exceed the applicable Maximum Limit as stated in the Schedule of Benefits.

5. Surgeon and Attendance Fees

This Benefit shall be payable for the fees charged by Registered Medical Practitioner(s) in performing surgery that he is qualified to render and consistent with the diagnosis including charges for ward round fees during Member's Hospital Confinement. The amount payable under this Benefit shall be equal to the actual surgeon and attendance charges for such surgical operation performed by one or more Registered Medical Practitioners.

6. Anaesthetist's Fees

This Benefit shall only be payable if an Anaesthetist is used in addition to the Registered Medical Practitioner in any surgical procedure requiring the services of an Anaesthetist, and the surgeon and attendance fees benefit is payable for the same operation under this Contract. The amount payable under this Benefit shall be equal to the actual charges for services provided by a professional Anaesthetist for the cost and administration of anaesthetics for the surgical operation or procedure.

7. Operating Theatre Fees

This Benefit shall be payable for the use of the Operating Theatre which is Medcially Necessary for the carrying out of any surgical procedure in a Hospital, provided that the surgeon and attendance fees benefit is also payable for the same operation under this Contract. The amount payable under this Benefit shall be equal to the actual charges for the use of the operating room and equipment used in the Operating Theatre of a Hospital to perform the surgical operation or procedure.

8. In-patient Physician's Fees

This Benefit shall be payable for attendance fee of Registered Medical Practitioner for non-surgical Hospital Confinement of the Member. The amount payable under this Benefit shall be equal to the actual consultation fee of Registered Medical Practitioner. This Benefit shall not be payable for telephone consultation where the Registered Medical Practitioner does not actually see and examine the Member.

9. In-patient Specialist's Fees

This Benefit shall be payable for fees charged by a Specialist in respect of Specialist services provided to the Member during the Member's Hospital

Confinement. Services provided by pathologist, radiologist and Physiotherapist during Hospital Confinement shall be payable under this Benefit. A written referral letter must be provided by the attending Registered Medical Practitioner for Specialist service except for services performed by pathologist, radiologist or Physiotherapist.The amount payable under this Benefit shall be equal to the actual charges for such services.

This Benefit shall not be payable for:
(a) treatment received before or on the day of any surgical procedure or during convalescent therefrom, unless such treatment:
    i. is given by a Specialist other than the surgeon who performed the surgical procedure, and
    ii. is in connection with a condition entirely unrelated to the condition which requires the surgical procedure mentioned herein; or
(b) telephone consultation where the Specialist or Physiotherapist does not actually see and examine the Member.

10. Companion Bed

If **Clauses 2 or 4** of this **Section C** is payable, this Benefit shall be payable for the charges as levied and published by a Hospital for the cost of one (1) companion bed during the Member's Hospital Confinement. The amount payable under this Benefit shall be equal to the actual charges made by the Hospital in respect of companion bed during the Member's Hospital Confinement.

This Benefit shall not be payable for meals for persons other than the Member subject to Hospital Confinement.

11. Non-surgical Cancer Treatment

This Benefit shall be payable for charges of Non-surgical Cancer Treatment, cyberknife and gamma knife for cancer treatment and other miscellaneous charges in connection with such treatment/ procedure including but not limited to diagnostic imaging tests, laboratory examination, drugs and medicine received during the same Hospital Confinement or on the same day of treatment performed on the Member during Hospital Confinement or in day-case unit of a Hospital or clinic under the recommendation of the attending Registered Medical Practitioner. The amount payable under this Benefit shall be equal to the actual charges levied by the Hospital or clinic for such treatment.

For the avoidance of doubt, if the eligible medical expenses under this Benefit are also covered under **Clause 3** of this **Section C**, these expenses shall be exclusively paid under this Benefit and no benefit shall be payable under **Clause 3** of this **Section C**.

12. Pre-admission & Post-hospitalisation/ Day Case Out-patient Care

Provided that the Benefits are payable under **Clauses 2, 3, 5 or 11** of this **Section C** above, this Benefit shall be payable for:
(a) all out-patient visits resulting in a Hospital Confinement, clinical operation or Day Case as the case maybe (for the expenses of consultation fee for Registered Medical Practitioners, Western Medication prescribed, physiotherapy and diagnostic imaging and laboratory tests) or home sleep apnea test within the period specified in the Schedule of Benefits before such Hospital Confinement, clinical operation or Day Case; and
(b) all follow-up visits on an out-patient basis (for the expenses of consultation fee for Registered Medical Practitioners, Western Medication prescribed, physiotherapy and diagnostic imaging and laboratory tests) referred by the attending Registered Medical Practitioner within the period specified in the Schedule of Benefits after discharge from Hospital, clinical operation or Day Case as the case may be or home sleep apnea test, provided that such consultation, Western Medication, physiotherapy or diagnostic test is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Hospital Confinement, clinical operation or Day Case or home sleep apnea test.

The amount payable under this Benefit shall be equal to the actual charges for such pre-admission or follow-up care. For the avoidance of doubt, any eligible medical expenses so incurred and payable under this Benefit during the time specified in the Schedule of Benefits should be exclusively payable under this Benefit and no benefit shall be payable under **Clauses 20 or 26** of this **Section C**.

13. Psychiatric Treatment

This Benefit shall be payable for the expenses charged on psychiatric treatments during the Member's Hospital Confinement in connection with the Covered Cancer including but not limited to the associated side effect due to the cancer treatment.

This Benefit shall be payable in lieu of other Benefits under **Clauses 2-11 and 14-17** of this S**ection C**. For the avoidance of doubt, where a Hospital Confinement is not solely for the purpose of psychiatric treatments, this Benefit shall only be payable for the eligible medical expenses charged on the medical services related to psychiatric treatments. Where the expenses involve both psychiatric and non-psychiatric treatments and apportionment of the expenses is not available, the eligible medical expenses in entirety shall be payable under this Psychiatric Treatment Benefit if the Hospital Confinement is initially for the purpose of psychiatric treatments. If the Hospital Confinement initially is not for the purpose of psychiatric treatments, the expenses in entirety shall be payable under **Clauses 2-11 and 14-17** of this **Section C**.

14. Rehabilitation

This Benefit shall be payable subject to approval by Bupa for the charges incurred as a result of a Member's in-patient rehabilitation at a rehabilitation centre following a Hospital Confinement, provided further that the rehabilitation treatment is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Hospital Confinement.

Such rehabilitation centre shall be recognised, constituted and registered as a rehabilitation centre under the laws of the territory in which it is situated to provide in-patient rehabilitation services for the sick, the injured or those who require such services.

15. Prosthetic Device

This Benefit shall be payable for the Normal and Customary cost of
(a) Prosthetic Device placed inside or on the surface of the Member's body which is Medically Necessary for the purpose of replacing wholly, or in part, any permanently inoperative or malfunctioning body part or Prosthetic Device during Hospital Confinement, Day Case or after discharge from a Hospital; and/or
(b) non-surgically implanted prosthesis including but not limited to voice boxes, hairpieces, and removable breast prostheses that are prescribed as a direct result of surgery or associated condition from treatment for Covered Cancer.

This Benefit shall not be payable for the cost of replacement of any Prosthetic Device or non-surgically implanted prosthesis.

"Prosthetic Device" shall mean artificial ears, eyeballs, and/or body limb placed inside or on the surface of the Member's body.

16. Hospice and Palliative Care

This Benefit shall be payable for the expenses charged on the Member in receiving institutional palliative care in a hospice or palliative care center. Such institution shall be recognised, constituted and registered as a hospice or palliative care centre under the laws of the territory in which it is situated to provide institutional palliative care. Member must be diagnosed to have a Covered Cancer at terminal stage by the attending Registered Medical Practitioner and the Registered Medical Practitioner has indicated a prognosis that no curative treatment which will lead to a recovery and the life expectancy of the Member is highly likely to be twelve (12) months or less. This Benefit shall cover the following charges incurred by the Member:
(a) accommodation and meals;
(b) nursing care provided by Qualified Nurse(s);
(c) western medication prescribed by a Registered Medical Practitioner and consumed during the stay; and
(d) physical and psychological support care.

17. Private Nursing

This Benefit shall be payable subject to a written referral letter provided by a Registered Medical Practitioner when a Member incurs expenses for services rendered by a Qualified Nurse in respect of specialised nursing care received in a Hospital or at home after discharge from Hospital. The amount payable under this Benefit shall be equal to the actual charges for such services. Such nursing care received must be recommended in writing by the attending Registered Medical Practitioner and is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Hospital Confinement.

Part III – Extended Care Benefits
Except for Benefits payable under **Clause 25** of this **Section C** and psychological counselling payable to the care giver(s) under **Clause 19** of this **Section C**, Benefit payable under this Part III shall cover Medically Necessary expenses incurred by the Member in an out-patient setting for receiving supportive care or treatment of a Covered Cancer. The amount of eligible expenses, which is Normal and Customary, payable under this Part III shall not exceed the actual costs for services or Medical Appliances provided to the Member, subject to the Lifetime Limit, Maximum Limit, reimbursement percentage and maximum number of visits per day as stated in the Schedule of Benefits.

The Member shall refer to the Membership Certificate for the available Lifetime Limit applicable for current Contract Year under Extended Care Benefits.

18. Chinese Herbalist
This Benefit shall be payable when the Member is treated by a Registered Chinese Medicine Practitioner on an out-patient basis at the Registered Chinese Medicine Practitioner's clinic and incurs consultation fee and charges for Medically Necessary Chinese Medicines prescribed by such practitioner at the time of consultation and obtained at a legitimate source on the same day of consultation. This Benefit shall also be payable for acupuncture performed by a Registered Chinese Medicine Practitioner on an out-patient basis.

19. Psychological Counselling
This Benefit shall be payable for the reasonable cost incurred for counselling or consultation by the Member and/ or the care giver(s) of the Member with a Clinical Psychologist on an out-patient basis on account of psychiatric, psychological, mental, or behavioural conditions in relation to the Covered Cancer.

20. Physiotherapist
This Benefit shall be payable when the Member is treated by a Physiotherapist on an out-patient basis, and incurs medical expenses for physiotherapy only, provided that the visit to the Physiotherapist is made with a written referral letter from a Registered Medical Practitioner.

For the avoidance of doubt, any charges for post-hospitalisation/Day Case physiotherapy services that are payable under **Clause 12** of this **Section C** for shall not be payable under this Benefit and shall be exclusively payable under **Clause 12** of this **Section C** during the time specified under the Schedule of Benefits.

21. Occupational Therapy
This Benefit shall be payable when the Member is treated by an Occupational Therapist on an out-patient basis and incurs medical expenses for occupational therapy treatment only, provided that the visit to the Occupational Therapist is made with a written referral letter from the attending Registered Medical Practitioner.

22. Speech Therapy
This Benefit shall be payable when the Member is treated by a Speech Therapist on an out-patient basis at the Speech Therapist's clinic and incurs expenses for speech therapy treatment only, provided that the visit to the Speech Therapist is made with a written referral letter from the attending Registered Medical Practitioner.

23. Dietetic Consultation
This Benefit shall be payable when the Member is treated by a Dietitian on an out-patient basis at the Dietitian's office and incurs consultation fee for dietetic consultation only, provided that the visit to the Dietitian is made with a written referral letter from the attending Registered Medical Practitioner.

24. Medical Appliances
This Benefit shall be payable for the costs incurred by the Member for purchasing or renting Medical Appliances from a legitimate source and the use of the Medical Appliance must be Medically Necessary and related to a condition caused by Covered Cancer or its complications, subject to a written recommendation by the attending Registered Medical Practitioner, Occupational Therapist or Physiotherapist.

25. Complementary Therapy
This Benefit shall be payable for the costs incurred for chiropractic therapy rendered by a chiropractor, aromatherapy, homeopathic therapy, art therapy, yoga class, Tui Na, qigong class, tai chi class and other rehabilitation therapy rendered by a professional service provider to the Member.

Only official receipts that are issued from a registered company or organisation registered with the government in the local countries are accepted. Bupa reserves the right to seek for proof of professional qualification from the service provider. Any therapies or classes rendered by the Member, the Subscriber (if any) and their respective business partners and relatives shall not be covered.

Part IV – Out-patient Care and Monitoring Benefit
Benefits payable under this Part IV shall cover the out-patient visits, diagnostic tests and Western Medications which are Medically Necessary received at an out-patient setting to monitor the response of the treatment, the prognosis or sooth the side effect of the Covered Cancer. The amount of eligible medical expenses payable under this Part IV must be Normal and Customary and shall not exceed the actual costs for medical services provided to the Member, subject to the Maximum Limit and the specified period as stated in the Schedule of Benefits.

Further, this Benefit shall also be payable for out-patient visit which is aiming for palliative treatment only and the specified period as stated in the Schedule of Benefits shall not apply.

26. Out-patient Care and Monitoring
This Benefit shall be payable for the Medically Necessary costs incurred on an out-patient basis for:
(a) the consultation fees and diagnostic tests such as laboratory tests, X-rays, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) to monitor the response to the treatment (if applicable) and the prognosis of the diagnosed Covered Cancer; and/ or
(b) any Western Medications prescribed for anti-nausea drugs, anti-rejection drugs, anti-vertigo drugs and anti-anodyne for soothing the signs or symptoms or relieving the pain as recommended by the attending Registered Medical Practitioner subsequent to the completion of cancer treatments or aiming for palliative treatment.

For the avoidance of doubt, any charges that are payable under **Clause 12** of this **Section C** above shall not be payable under this Benefit and shall be exclusively payable under **Clause 12** of this **Section C** during the time specified under the Schedule of Benefits.

For any Covered Cancer that is diagnosed to be recurrent in nature and medical expenses are incurred to confirm positive cancer findings, the costs of related diagnostic tests and consultation fees incurred at out-patient setting shall be exclusively payable under this Benefit and such expenses shall not be payable under **Clause 1** of this **Section C**.

If the Member presents with signs or symptoms or investigation results of the diagnostic tests medically indicated that surgical procedure such as colonoscopy or fine needle aspiration would be Medically Necessary for further investigation on the possibility of recurrence or metastasis as recommended by the attending Registered Medical Practitioner, medical expenses incurred for such procedure will be payable as a Day Case or Hospital Confinement under **Clauses 2-17** of this **Section C**.

Any routine health screening carried out at out-patient setting which is not directly related to a previously diagnosed Covered Cancer shall not be covered under this Benefit.

Part V – Experimental Treatment Cash Allowance
Benefit payable under this Part V shall provide a lump sum cash allowance if the Member has undergone an Experimental Treatment on Covered Cancer. This Benefit shall only be payable once per lifetime, subject to the Benefit Amount as stated on the Schedule of Benefits. The Member shall refer to the Membership Certificate for the available Lifetime Limit applicable for current Contract Year under Experimental Treatment Cash Allowance.

27. Experimental Treatment Cash Allowance

The Benefit shall be payable if the Member has undergone an Experimental Treatment as recommended by a Specialist in Oncology and the Member must have taken one course or one cycle of the medication or drugs. Experimental Treatment means the use of procedures, methods or drugs, which have not yet approved by the U.S. Food and Drug Administration (FDA) and Pharmaceutical Service of Department of Health in Hong Kong, for the purpose of curing Covered Cancer or controlling the growth of Covered Cancer as recommended by a Specialist in Oncology.

For the avoidance of doubt, the costs incurred for Experimental Treatment shall not be covered under this Benefit and the general exclusions under **Clause 11(b)xiv of the General Conditions** shall still apply before payment of any Benefits under other clauses of this **Section C**.

Part VI – Preventive Check-up Benefit

28. Preventive Check-up Benefit (Applicable for Member aged eighteen (18) or above)

(a) This Benefit is only applicable for Member who has attained age eighteen (18) or above on any Contract Anniversary Date and continuously covered under this **Section C** for more than one (1) year. Once the Member is eligible for this Benefit, the Benefit will be provided every two (2) Contract Years.
(b) Bupa shall send a redemption letter to the Subscriber for free preventive check-up service within ninety (90) days after the relevant Contract Anniversary Date.
(c) Upon presentation of the redemption letter, the Member can receive one (1) preventive check-up service at Bupa's designated health screening centre in Hong Kong within the timeframe as specified in the redemption letter.
(d) The scope of the preventive check-up service provided shall be determined by Bupa at its reasonable discretion, but at least the Member can entitle one of the following screening test:
    i. Pap smear (female Member);
    ii. Prostate-Specific Antigen (male Member); or
    iii. Stools Routine with Ova & Parasites and occult blood

with physical examination by a Registered Medical Practitioner.

Section D - Health Coaching Services

The usage of the health coaching services (if applicable) should at all times be subject to the "Terms and conditions for Health Coaching Services" prescribed by Bupa. Such terms and conditions shall form part of this Contract and Bupa may amend such terms and conditions from time to time. For an updated version of such terms and conditions, please refer to the "Terms and conditions for Health Coaching Services" on Bupa's website at https://www.bupa.com.hk/health-coaching-services. The availability of the service(s) set out under Section 2 of the "Terms and conditions for Health Coaching Services" is listed out in the Schedule of Benefits.

Special Conditions – Credit Facilities
Credit facilities described below are provided to each Member who has been enrolled under **Section C of the Description of Critical Illness Benefits** under this Contract and issued with a BSN Card.

1. BSN Card

(a) Bupa shall issue a BSN Card to eligible Member who has successfully enrolled with **Section C of the Description of Critical Illness Benefits** with the Benefits shown on the Membership Certificate. Subject to the pre-authorisation procedures as stated in in **Clause 2 of Special Conditions – Credit Facilities** below and the membership guide, the Member can use the BSN Card to settle eligible medical expenses payable under **Clauses 2-11 and 17 of Section C of theDescription of Critical Illness Benefits** and incurred at Bupa SafeNet Appointed Service Providers in Hong Kong.
(b) BSN Card can be used to settle eligible medical expenses under **Clauses 2-11 and 17 of Section C of the Description of Critical** Illness Benefits for the following conditions:
    i. Hospital Confinement arising from the Covered Cancer and its complications;
    ii. Surgical removal or excision of malignant tumour; or
    iii. Non-surgical cancer treatment prescribed by a Specialist in Oncology.

Member must follow to the pre-authorisation procedures as stated in in **Clause 2 of Special Conditions – Credit Facilities** below and the membership guide. For the avoidance of doubt, credit facilities are not applicable to any costs of Western Medication prescribed by a Bupa SafeNet Appointed Service Providers except for the costs of Western Medication incurred during non-surgical cancer treatment of a Covered Cancer.
(c) The uses of BSN Card are subject to the required pre-authorisation procedures stated in **Clause 2 of Special Conditions – Credit Facilities** below, which is determined by Bupa according to its prevailing practice and subject to the terms and conditions of this Contract and Benefit Amount available under **Clauses 2-11 and 17 of Section C of the Description of Critical Illness Benefits** for the Contract Year.
(d) In case any Shortfall is paid by Bupa, the Subscriber shall repay the Shortfall in full to the Bupa immediately upon the Bupa's reasonable demand. If the Shortfall has not been settled within fourteen (14) days of receipt of a Shortfall invoice, Bupa shall, in accordance with the authorisation provided by the Subscriber or Member for Bupa to debit money from a designated credit card, collect the Shortfall directly from the designated credit card on or after twenty-one (21) days of receipt of the Shortfall invoice from Bupa.
(e) Bupa has the right to offset any Subscription refundable or claim payable to the Subscriber against any amount of Shortfall or arising from the Member.
(f) BSN Card shall remain the property of Bupa and the Member to whom it is issued shall keep it safe at all times. It may only be used by the Member to whom it is issued, and it shall not be transferable. In the event of theft or loss of the BSN Card, the Subscriber is responsible for any transactions involving its use until such theft or loss is reported to Bupa in writing.
(g) BSN Card shall immediately cease to be valid upon the earliest of the following events and the Subscriber is required return it to Bupa within seven (7) days after it becomes invalid -
    i. this Contract is terminated; or
    ii. Bupa reasonably demands the return of the BSN Card with the reasons notified to the Subscriber and/or the Member in writing.

2. Pre-authorisation procedures

(a) If it is infeasible to obtain the pre-authorisation before the Member receives the relevant medical service due to Emergency conditions or Bupa is unable to process the pre-authorisation request outside of Bupa's support hours (which can be found in the membership guide), the Subscriber, the Member, the Member's authorised representative and/ or the Bupa SafeNet Appointed Specialist shall submit the pre-authorisation request on the next working day immediately after the day on which the Member receives the test, treatment or procedure. Bupa shall be responsible for ensuring that the Bupa SafeNet Appointed Specialist is aware of the required information to be included when completing the pre-authorisation request form.
(b) If there is any variation in the extent, nature or estimated cost of the items covered by the pre-authorisation confirmation/ guarantee of payment letter, the Subscriber, the Member, the Member's authorised representative and/or the Bupa SafeNet Appointed Specialist should inform Bupa at least two (2) working day before the test, treatment or procedure and obtain prior written acceptance of such change.
(c) The issuance of a pre-authorisation confirmation/ guarantee of payment letter from Bupa shall not be deemed as an agreement on the Bupa's part to pay the total amount or part of the costs set out in the pre-authorisation confirmation/ guarantee of payment letter. The Subscriber's entitlement to any reimbursement shall be subject to the terms and conditions of the Contract and the final claims assessment of Bupa.
(d) If a Member incurs any expenses that are excluded or ineligible under this Contract, in excess of the credit limit as stated in the pre-authorisation confirmation/ guarantee of payment letter or not approved by Bupa, the Subscriber shall settle such charges with the provider directly or if such expense has been settled by Bupa, the Subscriber shall reimburse Bupa in full for the Shortfall within fourteen (14) days of receipt of a Shortfall invoice from Bupa.

Special Conditions - Membership Transfer Option

Membership transfer option described in this section will only provide to Member who has been enrolled under **Section C of the Description of Critical Illness Benefits**.

(a) Members successfully enrolled with **Section C of the Description of Critical Illness Benefits** shall have the right to exercise the membership transfer option as stated in this section to convert **Section C of the Description of Critical Illness Benefits** to a standalone Bupa MyBasic VHIS Plan or Bupa MyFlexi VHIS Plan – Standard ("New Contract"). Bupa shall guarantee transfer to the New Contract without asking for further evidence of insurability from the Member if all of the conditions below are fulfilled:
   i. the Member has been continuously covered under **Section C of the Description of Critical Illness Benefits** for a minimum of five (5) years; and
   ii. the Member must be aged fifty-nine (59) years or below on the effective date of the New Contract.

(b) The following terms shall apply to the exercise of the membership transfer option:
   i. request of membership transfer option must be made one (1) month prior to the Contract Anniversary Date;
   ii. upon successful transfer to the New Contract, **Section C of the Description of Critical Illness Benefits** under this Contract shall be terminated from the effective date of the New Contract;
   iii. all benefits payable after transfer shall follow the terms and conditions under the New Contract and Bupa may other conditions under the New Contract accordingly to the prevailing practice at the time of transfer;
   iv. the Member shall submit the application for exercising the Membership Transfer Option using such form as prescribed by Bupa and payment of the first subscription made by the subscriber of the New Contract must be received by Bupa at least one (1) month before the contract effective date of the New Contract; and
   v. the subscription for the New Contract shall be determined in accordance with Bupa's subscription rate in effect as at the contract effective date of the New Contract.

(c) After the transfer, medical expenses in relation to any illness or injury that commenced or presented signs and symptoms payable under **Section C of the Description of Critical Illness Benefits** and before the contract effective date of the New Contract shall be payable up to the maximum benefit limit under the New Contract. If this Contract was issued with any exclusions under **Section C of the Descrption of Critical Illness Benefits** as set out in the Membership Certifcate or endorsement), the same exclusions shall also be imposed on the New Contract together with its general exclusions. For the avoidance of doubt, any pre-existing conditions that exists before the **Section C of the Description of Critical Illness Benefits** taking effect or addition or upgrade of Benefits (if applicable) will not be covered under the New Contract.

Definition of Critical Illnesses

Major Critical Illnesses

For the purposes of this section of **Definition of Critical Illnesses**,

"Activities of Daily Living" means:
(a) Washing – the ability to wash in a bath or shower (including getting into and out of the bath or shower) or to wash satisfactorily by other means.
(b) Dressing – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.
(c) Feeding – the ability to feed oneself once food has been prepared and made available.
(d) Toileting – the ability to use the lavatory or otherwise manage bowel and bladder function so as to maintain a satisfactory level of personal hygiene.
(e) Transferring – the ability to move from a bed to an upright chair or wheelchair and vice versa.
(f) Mobility - The ability to move indoors from room to room on level surfaces.

1	Cancer	Cancer means the presence of a malignant tumour that is characterised by progressive, uncontrolled growth of malignant cells and invasion and destruction of normal and surrounding tissue. Cancer must be positively diagnosed with histopathological confirmation. This also includes leukaemia, lymphoma or sarcoma. The following are excluded: (a) Tumours showing the malignant changes of carcinoma-in-situ, cervical dysplasia, CIN-1, CIN-2, CIN-3 or which are histologically described as pre-malignant; (b) All skin cancers other than malignant Melanomas; (c) Prostate cancers which are histologically described as TNM Classification T1(a) or T1(b) or are of another equivalent or lesser classification; (d) Chronic Lymphocytic Leukaemia less than RAI Stage III; (e) Thyroid cancers which are histologically described as TNM classification T1N0M0 or a lesser classification.
2	Heart Attack	The death of a portion of the heart muscle (myocardium) as a result of inadequate blood supply, where all of the following criteria are met: (a) a history of typical chest pain; (b) new characteristic ECG changes indicating acute myocardial infarction at the time of the relevant cardiac incident; and (c) the elevation of the cardiac biomarkers, inclusive of CK-MB above the generally accepted normal laboratory levels, or Troponin T > 0.5ng/ml or Troponin I > 0.5ng/ml. Angina is specifically excluded.
3	Stroke	Any cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis. Diagnosis must be supported by all of the following conditions: (a) Evidence of permanent neurological damage confirmed by a consultant neurologist at least four (4) weeks after the event; and (b) Findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke. The following conditions are excluded: (a) Transient Ischaemic Attacks; (b) Vascular disease affecting the eye or optic nerve; and (c) Ischaemic disorders of the vestibular system.
4	Cardiomyopathy	Impaired ventricular function of variable aetiology, resulting in permanent and irreversible physical impairments to the degree of at least Functional Class 4 of the New York Heart Association Functional Classification of cardiac impairment. The diagnosis must be confirmed by a Specialist who is a cardiologist and supported by the appropriate test results including echocardiography. Cardiomyopathy caused by alcohol or drug abuse is specifically excluded. Class 4 of the New York Heart Association Classification of cardiac impairment means that the patient is symptomatic during ordinary daily activities despite the use of medication and dietary adjustment, and there is evidence of abnormal ventricular function on physical examination and laboratory studies.
5	Coronary Artery Disease Surgery	The actual undergoing of open chest surgery to correct or treat coronary artery disease (CAD) by way of coronary artery by-pass grafting. Minimally invasive surgery, angioplasty and all other intra-arterial, catheter-based techniques, keyhole or laser procedures, are excluded.
6	Dissecting Aortic Aneurysm	A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separates its layers. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. The diagnosis must be made by a Specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Emergency surgical repair is required.
7	Heart Valve Surgery	The actual undergoing of open chest surgery to replace or repair heart valve abnormalities. Evidence of the heart valve abnormality from cardiac catheterisation or echocardiogram must be provided and the procedure must be considered surgically necessary by a Specialist who is a cardiologist. Minimally invasive surgery including balloon valvotomy is excluded.
8	Other Serious Coronary Artery Disease	The narrowing of the lumen of at least three major coronary arteries by a minimum of 60% as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. Major coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery (but not including their branches).
9	Primary Pulmonary Arterial Hypertension	Primary pulmonary hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterisation, resulting in permanent physical impairment to the degree of at least Class 3 of the New York Heart Association Classification of cardiac impairment. Secondary causes of pulmonary hypertension, including, but not limited to, chronic lung disease, pulmonary emboli, valve disease and left sided heart disease are excluded. Class 3 of the New York Heart Association Classification of cardiac impairment means that the patient has marked limitation of physical activity and is comfortable at rest but performing less than ordinary activity will cause fatigue, palpitation or dyspnea.
10	Surgery to Aorta	Undergoing of a laparotomic or thoracotomic surgery to treat a disease of aorta by excision and replacement of a portion of diseased aorta with a graft. For this definition, aorta means the thoracic and abdominal aorta but not its branches. The surgery must be considered medically necessary by a Specialist. Surgery to treat peripheral vascular disease of the aortic branches is excluded even if a portion of aorta is removed during the operative procedure.

11	Severe Infective Endocarditis	Inflammation of the inner lining of the heart caused by infectious organisms. All of the following criteria must be met: (a) Positive result of the blood culture proving presence of the infectious organism; (b) Presence of at least moderate valve incompetence (means regurgitant fraction of 20% or above) or moderate valve stenosis (means valve area of 30% or less of normal value) attributable to Infective Endocarditis; and (c) The diagnosis of Infective Endocarditis and the severity of valvular impairment must be confirmed by a Specialist who is a cardiologist.
12	Blindness	Clinically proven irreversible reduction of sight in both eyes as a result of sickness or Accident. The corrected visual acuity must be less than 6/60 or 20/200 using e.g. Snellen test types, or visual field restriction to 20° or less in both eyes. No Benefit will be payable if in general medical opinion a device, or implant could result in the partial or total restoration of sight.
13	Chronic Adrenal Insufficiency (Addison's Disease)	An autoimmune disorder causing a gradual destruction of the adrenal gland resulting in the need for life long glucocorticoid and mineral corticoid replacement therapy. The disorder must be confirmed by a Specialist in endocrinology through: (a) ACTH simulation tests; (b) Insulin-induced hypoglycaemia test; (c) Plasma ACTH level measurement; and (d) Plasma Renin Activity (PRA) level measurement. Only autoimmune cause of primary adrenal insufficiency is included. All other causes of adrenal insufficiency are excluded.
14	Chronic Auto-immune Hepatitis	A chronic necro-inflammatory liver disorder of unknown cause associated with circulating auto-antibodies and a high serum globulin level. The following criteria must all be satisfied: (a) Hypergammaglobulinaemia (b) The presence of at least one of the following auto-antibodies: i. anti-nuclear antibodies ii. anti-smooth muscle antibodies iii. anti-actin antibodies iv. anti-LKM 1 antibodies (c) Liver biopsy confirmation of the unequivocal diagnosis of auto-immune hepatitis The unequivocal diagnosis of auto-immune hepatitis must be confirmed by a Specialist who is a hepatologist.
15	Chronic Obstructive Lung Disease	Severe chronic obstructive lung disease requiring extensive and permanent oxygen therapy as well as FEV 1 test result of consistently less than 1 litre. The unequivocal diagnosis must be confirmed by a Specialist in respiratory medicine.
16	Coma	The state of unconsciousness with no reaction to external stimuli or internal needs persisting continuously with the use of life support systems for a period of at least 96 hours and resulting in permanent neurological deficit. The diagnosis must be made by a Specialist who is a neurologist. Coma resulting directly from alcohol or drug abuse and medically induced coma are excluded.
17	End Stage Liver Disease	End stage liver failure as evidenced by all of the following: (a) Permanent jaundice; (b) Ascites; and (c) Encephalopathy. The diagnosis must be made by a Specialist in gastroenterology or hepatology. Liver disease caused directly or indirectly, wholly or partly, by alcohol or drug abuse is excluded.
18	End Stage Lung Disease	End stage lung disease including interstitial lung disease requiring extensive and permanent oxygen therapy as well as Forced Expiratory Volume at one second (FEV1) test result of consistently less than 1 litre. The diagnosis must be made by a Specialist in respiratory medicine.
19	Kidney Failure	End stage renal failure presenting chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis has been initiated, or renal transplant has been carried out.
20	Loss of Capacity for Independent Living	The permanent inability of the Member to perform, without assistance, three (3) or more of the Activities of Daily Living. The coverage of this Major Critical Illness condition will cease at age sixty-five (65) of the Member. This Critical Illness condition does not cover any event caused by a psychiatric condition.
21	Loss of Hearing	Total and irreversible loss of hearing (involving the loss of at least eighty (80) decibels in all frequencies of hearing) in both ears. The diagnosis must be clinically made by a Specialist and confirmed with audiometry test.
22	Loss of Limbs	Complete severance of two or more limbs above the wrist or ankle through Accident or disease. If Severance of Limbs is due to complication from diabetes, the benefit under this Contract is only payable for Amputation of Feet due to Complication from Diabetes.
23	Loss of One Limb and One Eye	The Member, as a result of injury or disease, has sustained both of the following: (a) Irreversible loss of sight in one eye where any one of the following conditions is met: i. the best corrected visual acuity in one eye must be 2/60 or less using a Snellen Chart or equivalent test; or ii. the best corrected visual field in one eye must be 5 degrees or less. The loss of sight must be confirmed by a Specialist who is an ophthalmologist; and (b) Total and irreversible severance of one limb at or above the wrist or ankle.
24	Loss of Speech	Total and irrecoverable loss of the ability to speak effected independently of all other causes and directly by physical damage to the vocal cords which must be established for a continuous period of twelve (12) months. The diagnosis must be clinically made by a Specialist. All psychological related causes are excluded.
25	Major Organ Transplantation	The actual undergoing, as a recipient of, a human to human transplant of bone marrow using haematopoietic stem cells preceded by total bone marrow ablation, or human to human transplant of a heart, lung, liver, pancreas, or kidney. The transplant must have been surgically necessary to treat irreversible end stage failure of the relevant organ. Other stem cell transplants, islet cell transplants and transplants of part of an organ are excluded.
26	Medullary Cystic Disease	A hereditary kidney disorder characterised by gradual and progressive loss of kidney function because of cysts in the kidney medulla. Diagnosis must be supported by imaging evidence of multiple medullary cysts with cortical atrophy.
27	Pheochromocytoma	Neuroendocrine tumour of the adrenal or extra-adrenal chromaffin tissue resulting in excessive secretion of catecholamines. All of the following criteria must be met: (a) Surgical removal of the tumour must has been performed; and (b) The diagnosis of Pheochromocytoma must be confirmed by a Specialist who is an endocrinologist.

28	Severe Bronchiectasis	Severe bronchiectasis requiring extensive and permanent oxygen therapy as well as FEV 1 test result of consistently less than 1 litre. The unequivocal diagnosis must be confirmed by a Specialist in respiratory medicine.
29	Severe Emphysema	Severe emphysema requiring extensive and permanent oxygen therapy as well as FEV 1 test result of consistently less than 1 litre. The unequivocal diagnosis must be confirmed by a Specialist in respiratory medicine.
30	Severe Idiopathic Pulmonary Fibrosis	Idiopathic pulmonary fibrosis (IPF) is a type of chronic scarring lung disease characterised by a progressive and irreversible decline in lung function and the following conditions must be met: (a) Forced vital capacity (FVC) of <50% (b) DLCO of < 30% The diagnosis must be confirmed by a Specialist in pulmonology.
31	Total and Permanent Disability	Coverage for the Total and Permanent Disability is up to sixty-five (65) years old. Total and Permanent Disability is defined as a state of inability caused by disease or bodily injury as wholly prevents the Member from engaging in any occupation or from performing any work for remuneration or profit. Such state of inability must have continued without interruption for one hundred and eighty (180) days or for such longer period as Bupa may reasonably require proving that the inability is permanent in nature.
32	Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders	Deterioration or loss of intellectual capacity or abnormal behaviour as evidenced by the Member's clinical state and accepted standardised questionnaires or tests arising from Alzheimer's Disease or other irreversible organic degenerative brain disorder, which results in significant reduction in the Member's mental and social functioning such that continuous care and supervision of the Member is required. The diagnosis of Alzheimer's Disease or other irreversible organic degenerative brain disorder must be clinically confirmed by a Specialist who is a neurologist. The following are excluded: (a) non-organic brain disorders such as neurosis and psychiatric illnesses; and (b) drug or alcohol related organic brain disorder.
33	Corticobasal degeneration	Corticobasal degeneration occurring independently of all other causes and resulting in a permanent neurological deficit, which is directly responsible for a permanent inability to perform at least three (3) of the Activities of Daily Living. The diagnosis of Corticobasal Degeneration must be confirmed by a Specialist who is a neurologist.
34	Creutzfeld-Jacob Disease	Creutzfeld-Jacob Disease is a rare, usually fatal spongiform encephalopathy accompanied by signs and symptoms of cerebellar dysfunction, severe progressive dementia, uncontrolled muscle spasm, tremor and athetosis. Diagnosis must be made by a Specialist who is a neurologist and based on conclusive EEG and CSF findings as well as CT scan and MRI. Variant CJD caused by BSE (Mad Cow Disease) is also a covered condition. Other common causes of dementia should be ruled out by a spinal tap. Disease caused by human growth hormone treatment is excluded.
35	Parkinson's Disease	Slowly progressively degenerative disease of the central nervous systems as a result of loss of pigment containing neurones of the brain. There must be an unequivocal diagnosis by a Specialist who is a neurologist where the condition: (a) Cannot be controlled with medication; (b) Shows signs of progressive impairment; and (c) There is the permanent inability to perform without assistance any three (3) of the six (6) Activities of Daily Living. Only idiopathic Parkinson's Disease is covered. Drug induced, or toxic causes of Parkinsonism are excluded.
36	Amyotrophic Lateral Sclerosis	Unequivocal diagnosis confirming well defined neurological deficit with persistent signs of involvement of the spinal nerve columns and the motor centres in the brain and with spastic weakness and atrophy of the muscles of the extremities. The diagnosis must be made in writing by a registered neurologist and confirmed by appropriate neuromuscular testing such as Electromyogram (EMG).
37	Apallic Syndrome	Universal necrosis of the brain cortex with the brainstem remaining intact. Diagnosis must be confirmed in writing by a Specialist who is a neurologist and condition must be documented for at least thirty (30) days.
38	Bacterial Meningitis	Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in significant and permanent functional neurological impairment. The diagnosis must be confirmed by a Specialist who is a neurologist.
39	Benign Brain Tumour	A non-cancerous tumour in the brain or meninges within the cranium, giving rise to characteristic signs of increased intra-cranial pressure such as papilloedema, mental symptoms, seizures and sensory impairment. The presence of the underlying tumour must be confirmed by imaging studies such as CT scan or MRI. Conditions such as cysts, granulomas, malformations in the arteries or veins of the brain, haematomas, abscesses, acoustic neuroma, and tumours of the pituitary gland or spinal cord are not covered.
40	Brain Surgery	The actual undergoing of surgery to the brain via the skull or cranium under general anaesthesia during which a craniotomy is performed. Burr hole surgery is included. However, the followings are excluded: (a) minimally invasive treatment where no surgical incision is performed to expose the target, such as irradiation by gamma knife or endovascular neuroradiological interventions such as embolisation, thrombolysis and stereotactic biopsy; (b) transphenoidal surgery; and (c) brain surgery as a result of an Accident. The procedure must be considered to be Medically Necessary by a Specialist in the relevant field.
41	Cerebral Aneurysm or Arteriovenous Malformation Requiring Craniotomy	The actual undergoing of intracranial surgery through craniotomy to the head to obliterate cerebral aneurysm or arteriovenous malformation. The diagnosis must be made by a Specialist with computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiograph (MRA) or angiogram. Procedures not involving craniotomy are excluded.
42	Encephalitis	Severe inflammation of brain substance, resulting in permanent neurological deficit which is documented for a minimum of thirty (30) days. Diagnosis of Encephalitis must be confirmed by a Specialist in a neurology.
43	Hemiplegia	The total and permanent loss of the use of one (1) side of the body through paralysis caused by illness or injury, except when such injury is self-inflicted. The unequivocal diagnosis must be made by a Specialist in the relevant medical field.
44	Major Head Trauma	Accidental head injury causing significant and permanent neurological deficit which has lasted for a minimum period of 90 days from the date of the trauma or injury. The resultant significant permanent neurological deficit must be confirmed by a Specialist who is a neurologist.
45	Multiple Sclerosis	A disease due to demyelination of neurological brain tissue. A Specialist, who is a neurologist, must make a diagnosis of Multiple Sclerosis as evidenced by a well-documented clinical history of exacerbations and remissions and investigations such as Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques must unequivocally confirming the diagnosis. There must be evidence of neurological deficits of involvement of co-ordination and motor and sensory function occuring over a continuous period of at least six (6) months. Other causes of neurological damage such as Systemic Lupus Erythematosus (SLE) and HIV are excluded.

46	Muscular Dystrophy	Muscular Dystrophies are a group of genetic degenerative myopathies characterised by weakness and atrophy of muscle without involvement of the nervous system. In respect of this Contract, the Member has been diagnosed with Muscular Dystrophy causing neurological deficit resulting in the permanent and irreversible inability of the Member to move indoors from room to room on level surfaces. The diagnosis must be made by a Specialist who is a neurologist and confirmed by appropriate neuromuscular testing such as Electromyogram (EMG).
47	Paralysis	The total and irreversible loss of use of two or more limbs through paralysis.
48	Poliomyelitis	Infection with the poliovirus, leading to paralytic disease. Paralysis due to Poliomyelitis must be confirmed by a Specialist who is a neurologist, and cases not involving paralysis are excluded.
49	Primary Lateral Sclerosis	A progressive degenerative disorder of the motor neurons of the cerebral cortex resulting in widespread weakness on an upper motor neuron basis. Clinically it is characterised by progressive spastic weakness of the limbs, preceded or followed by spastic dysarthria and dysphagia, indicating combined involvement of the corticospinal and corticobulbar tracts. The diagnosis must be made by a Specialist who is a neurologist and confirmed by appropriate neuromuscular testing such as Electromyogram (EMG).
50	Progressive Bulbar Palsy	Degenerative wasting of the muscles including the bulbar muscles as diagnosed by a Specialist who is a neurologist. The diagnosis must be confirmed by a Specialist who is a neurologist and confirmed by appropriate neuromuscular testing such as Electromyogram (EMG).
51	Progressive Muscular Atrophy	Involving the wasting of muscles and increased spasticity as diagnosed by a Specialist who is a neurologist. The diagnosis must be confirmed by appropriate neuromuscular testing such as Electromyogram (EMG).
52	Progressive Supranuclear Palsy	Progressive Supranuclear Palsy occurring independently of all other causes and resulting in a permanent neurological deficit, which is directly responsible for a permanent inability to perform at least three (3) of the Activities of Daily Living. The Diagnosis of Progressive Supranuclear Palsy must be confirmed by a Specialist who is a neurologist.
53	Spinal Muscular Atrophy	Degenerative diseases of the anterior horn cells in the spinal cord and motor nuclei of the brainstem, characterised by profound proximal muscular weakness and wasting, primarily in the legs, followed by distal muscle involvement. The diagnosis must be made in writing by a Specialist who is a neurologist and confirmed by appropriate neuromuscular testing such as electromyogram (EMG).
54	Systemic sclerosis	A chronic systemic autoimmune disease characterised by tissue fibrosis, small blood vessel vasculopathy and the development of auto-antibodies. All of the following criteria must be met: (a) Evidence must be provided that at least one of the following organs is involved: i. oesophagus; ii. lung; iii. heart; or iv. kidney; and (b) The diagnosis of Systemic Sclerosis and the organ involvement must be confirmed by a Specialist who is a Rheumatologist and Immunologist.
55	Tuberculous Meningitis	Meningitis caused by tubercle bacilli, resulting in permanent neurological deficit. The diagnosis must be confirmed by a Specialist in neurology.
56	Acute Necrotic Pancreatitis	Diagnosis of Acute Necrotic Pancreatitis must be confirmed in writing by a registered surgeon with pathological evidence support. Surgery must be performed to clear the necrotic tissue, excise the lesion or for pancreatectomy. Acute Necrotic Pancreatitis induced by alcohol is excluded.
57	Acute Necrohaemorrhagic Pancreatitis	Acute inflammation and necrosis of pancreas parenchyma, focal enzymic necrosis of pancreatic fat and haemorrhage due to blood vessel necrosis, where all of the following criteria are met: (a) The necessary treatment is surgical clearance of necrotic tissue or pancreatectomy; and (b) The diagnosis is based on histopathological features and confirmed by a Specialist who is a gastroenterologist. Pancreatitis due to alcohol or drug abuse is excluded.
58	Chronic Relapsing Pancreatitis	More than three medically documented attacks of pancreatitis resulting in pancreatic dysfunction causing malabsorption needing enzyme replacement therapy. The diagnosis must be made by a Specialist who is a gastroenterologist and confirmed by Endoscopic Retrograde Cholangio Pancreatography (ERCP). Chronic Relapsing Pancreatitis caused by alcohol use is excluded.
59	Fulminant Hepatitis	A sub-massive to massive necrosis of the liver by a Hepatitis virus, leading precipitously to liver failure. The diagnosis in respect of this illness must be based on the meeting of all of the following criteria: (a) A rapidly decreasing liver size; (b) Necrosis involving entire lobules, leaving only a collapsed reticular framework; and (c) Rapid deterioration of liver function tests. Evidence of the following must be produced: (a) Liver function test to show massive parenchymal liver disease; and (b) Objective signs of portasystemic encephalopathy.
60	Severe Crohn's Disease	Chronic granulomatous inflammatory disease of the intestine. All of the following criteria must be met: (a) The disease must have resulted in at least one of the following intestinal complications: i. Fistula Formation (excluding Fistula-in-ano); ii. Obstruction of the bowel; or iii. Perforation of the bowel (not caused by an intervention); and (b) The diagnosis must be based histopathological features and confirmed by a Specialist who is a gastroenterologist.
61	Severe Ulcerative Colitis	Acute fulminant ulcerative colitis with life threatening electrolyte disturbances. All of the following criteria must be met: (a) The entire colon is affected with severe bloody diarrhoea; (b) The necessary treatment is total colectomy and ileostomy; and (c) The diagnosis must be based on histopathological features and confirmed by a Specialist who is a gastroenterologist.
62	Amputation of Feet due to Complication from Diabetes	Diabetic neuropathy and vasculitis resulting in the amputation of both feet at or above ankle as advised by a Specialist in diabetology or endocrinology or vascular surgeon as the only means to maintain life. Amputation of toe or toes, or any other causes for amputation are excluded.
63	Major Burns	Third degree burns covering at least 20 percent of the surface of the body of the Member.

64	Necrotising Fasciitis	The occurrence of necrotising fasciitis where all of the following conditions are met: (a) The usual clinical criteria of necrotising fasciitis are met; (b) The bacteria identified is a known cause of necrotising fasciitis; and (c) There is widespread destruction of muscle and other soft tissues that results in a total and permanent loss of function of the affected body part. The diagnosis must be made by a Specialist.
65	Severe Facial Burns due to Accident	Third degree (i.e. full thickness skin destruction) burns covering at least 70% of the surface of the face directly resulting from an Accident.
66	Severe Myasthenia Gravis	An acquired autoimmune disorder of neuromuscular transmission leading to fluctuating muscle weakness and fatiguability. All of the following criteria must be met: (a) Presence of muscle weakness categorised as Class III, IV or V* according to the Myasthenia Gravis Foundation of America Clinical Classification below; and (b) The diagnosis of Myasthenia Gravis and categorisation must be confirmed by a Specialist who is a neurologist. * Myasthenia Gravis Foundation of America Clinical Classification: Class I: Any eye muscle weakness, possible ptosis, no other evidence of muscle weakness elsewhere Class II: Eye muscle weakness of any severity, mild weakness of other muscles Class III: Eye muscle weakness of any severity, moderate weakness of other muscles Class IV: Eye muscle weakness of any severity, severe weakness of other muscles Class V: Intubation needed to maintain airway
67	Aplastic Anaemia	Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least two of the following: (a) Blood product transfusion; (b) Marrow stimulating agents; (c) Immunosuppressive agents; or (d) Bone marrow transplantation. The diagnosis must be confirmed by a bone marrow biopsy and a Specialist in haematology.
68	HIV due to Blood Transfusion	The Member being infected by Human Immunodeficiency Virus (HIV) provided that: (a) The infection is due to a blood transfusion received after Critical Illness Benefit Coverage Commencement Date, issue date of this Contract or date of last reinstatement of this Contract, whichever is later; (b) The institution which provided the transfusion admits liability or there is a final court verdict that cannot be appealed indicating such liability; and (c) The infected Member is not a haemophiliac. HIV infection transmitted by any other means including sexual activity or recreational intravenous drug use is specifically excluded. This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. Bupa must have open access to all blood samples of the Member and reserves the right to obtain independent testing of such blood samples.
69	HIV due to Assault	Infection by any Human Immunodeficiency Virus (HIV) provided the infection results directly from: (a) A physical assault involving involuntary contact with either a needle or sharp instrument infected with HIV, or sexual assault by a person infected with HIV; (b) The incident happens in Hong Kong or Macau after the Critical Illness Benefit Coverage Commencement Date, issue date of this Contract or date of reinstatement, whichever is the later and is reported to the Hong Kong or Macau Police within fourteen (14) days of the incident; and (c) A test, showing no HIV or HIV antibodies, is made within fourteen (14) days of the incident and a later test is made within six (6) months showing infection of HIV. HIV infection transmitted by any other means including sexual activity or recreational intravenous drug use is specifically excluded. This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. Bupa must have open access to all blood samples of the Member and reserves the right to obtain independent testing of such blood samples.
70	HIV due to organ transplant	The Member being infected by the Human Immunodeficiency Virus (HIV) arising from an organ transplant to the Member performed in Hong Kong. The Member being infected by Human Immunodeficiency Virus (HIV) provided that: (a) The infection is due to an organ transplant received after the Critical Illness Benefit Coverage Commencement Date; and (b) The organ transplant must be performed in Hong Kong and the medical institution which provided the transplant admits liability or there is a final court verdict that cannot be appealed indicating such liability; and (c) The infected Member is not a haemophiliac. HIV infection transmitted by any other means including sexual activity or recreational intravenous drug use is specifically excluded. This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. Bupa must have open access to all blood samples of the Member and reserves the right to obtain independent testing of such blood samples.
71	Medically Acquired HIV	The Member being infected by Human Immunodeficiency Virus (HIV) provided that: (a) The infection is due to an operation or a medical or dental procedure after the Critical Illness Benefit Coverage Commencement Date; and (b) The institution which provided the operation or the medical or dental procedure admits liability or there is a final court verdict that cannot be appealed indicating such liability; and (c) The infected Member is not a haemophiliac. The incident must have been reported to appropriate authorities and have been investigated in accordance with the established procedures. This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. Infection in any other manner, including infection as a result of sexual activity or recreational intravenous drug use is excluded. Bupa must have open access to all blood samples of the Member and reserves the right to obtain independent testing of such blood samples.

72	Occupationally Acquired HIV	Infection with the Human Immunodeficiency Virus (HIV) where the virus is acquired as the result of an accident occurring during the course of the Member's normal occupation and where sero-conversion to the HIV infection occurs within six (6) months of the accident. Any accident causing a potential claim must be reported to Bupa within fourteen (14) days of the accident and be supported by a negative HIV antibody test taken immediately after the accident. HIV infection transmitted by any other means including sexual activity or recreational intravenous drug use is specifically excluded. This Benefit will not apply in the event that any medical cure is found for AIDS or the effects of the HIV virus or a medical treatment is developed that results in the prevention of the occurrence of AIDS. Bupa must have open access to all blood samples of the Member and reserves the right to obtain independent testing of such blood samples.
73	Systemic Lupus Erythematosus	Multi-system, autoimmune disorder characterised by the development of auto-antibodies, directed against various self-antigens. For purposes of the definition of Critical Illness, SLE is restricted to only those forms of systemic lupus erythematosus, which involve the kidneys and are characterised as Class III, Class IV, Class V or Class VI lupus nephritis under the Abbreviated International Society of Nephrology/Renal Pathology Society (ISN/RPS) classification of lupus nephritis (2003) below based on renal biopsy. Other forms such as discoid lupus, and those forms with only haematological and joint involvement are specifically excluded. Abbreviated ISN/RPS classification of lupus nephritis (2003): Class I - Minimal mesangial lupus nephritis Class II - Mesangial proliferative lupus nephritis Class III - Focal lupus nephritis Class IV - Diffuse segmental (IV-S) or global (IV-G) lupus nephritis Class V - Membranous lupus nephritis Class VI - Advanced sclerosing lupus nephritis
74	Severe Psoriasis with arthritis	Unequivocal diagnosis of systemic immune disorder of Psoriasis arthritis where all of the following criteria are met: (a) Diagnostic criteria of The Classification Criteria for Psoriatic Arthritis (CASPAR) consist of established inflammatory articular disease with at least 3 points from the following features: i. Current psoriasis (assigned a score of 2) ii. A history of psoriasis (in the absence of current psoriasis; assigned a score of 1) iii. A family history of psoriasis (in the absence of current psoriasis and history of psoriasis; assigned a score of 1) iv. Dactylitis (assigned a score of 1) v. Juxta-articular new-bone formation (assigned a score of 1) vi. RF negativity (assigned a score of 1) vii. Nail dystrophy (assigned a score of 1) (b) Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; (c) The damage must result independently of all other causes and directly in the Member's permanent inability to perform at least three (3) of the Activities of Daily Living; and (d) The foregoing conditions have been present for at least six (6) months.
75	Severe Rheumatoid Arthritis	Severe Rheumatoid Arthritis where all of the following criteria are met: (a) The diagnostic criteria of the American College of Rheumatology; (b) Permanent inability to perform at least two (2) of the Activities of Daily Living; (c) Widespread joint destruction and major clinical deformity of three (3) or more of the following joint areas: hands, wrists, elbows, knees, hips, ankle, cervical spine or feet; and (d) The condition has been present for at least one hundred and eighty (180) days.
76	Systemic Scleroderma	The diagnosis must be unequivocally confirmed by biopsy and serological evidence and the condition must have reached systemic proportions to involve any two (2) of the following organs: heart, lungs or kidneys. The diagnosis must be confirmed by a Specialist in rheumatology. Two of the following criteria are met: (a) pulmonary involvement showing carbon monoxide diffusing capacity (DLCO) < 70% of the predicted value, or forced expiratory volume in 1 sec (FEV1), forced vital capacity (FVC) or total lung capacity (TLC) < 75% of the predicted value; (b) renal involvement showing glomerular filtration rate (GFR) < 60 ml/min; and/or (c) cardiac involvement showing evidence of either congestive heart failure, cardiac arrhythmia requiring medication, or pericarditis with moderate to large pericardial effusion. The following are excluded: (a) Localised scleroderma (linear scleroderma or morphea) (b) Eosinophilic fasciitis (c) CREST syndrome unequivocal
77	Ebola Haemorrhagic Fever	The infection with the Ebola virus causing fever and internal or external bleeding. All of the following criteria must be met: (a) Presence of the Ebola virus has been confirmed by laboratory testing; (b) Mucosal or gastrointestinal bleeding has occurred; and (c) The diagnosis of Ebola Haemorrhagic Fever must be confirmed by a Specialist specialised in infectious disease.
78	Elephantiasis	End stage Lymphatic Filariasis, characterised by significant enlargement and disfiguration of the infected body area (legs, genitals or breasts) due to blockage of the lymphatic system by filariae parasites. The diagnosis of permanent lymphatic obstruction must be made by a Specialist and supported by laboratory tests showing circulating filariae antigen or microfilariae in a blood smear (Wuchereria bancrofti or Brugia malayi). Other forms of lymphoedema or acute lymphangitis are specifically excluded.
79	Permanent Tracheostomy	The performance of tracheostomy for the treatment of lung disease or airway disease or as a ventilatory support measure following major trauma or burns. The Member must have been a patient in a designated intensive care unit under the care of a Specialist in the relevant medical field. The benefit is only payable if the tracheostomy is required to remain in place and functional for a period of twelve (12) consecutive months.
80	Terminal Illness	The conclusive diagnosis of an illness that has either no known cure or has progressed to the point where it cannot be cured; and is expected to result in the death of the Member within three hundred and sixty-five (365) days. This diagnosis must be supported by a Specialist and confirmed by Bupa's appointed doctor. Terminal Illness in the presence of HIV infection is excluded. The Benefit will be paid after the Member survives a period of not less than fourteen (14) days following diagnosis of Terminal Illness.

Early Stage Critical Illnesses

1	Carcinoma in Situ	Carcinoma in Situ shall mean a histologically proven, localised pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and/ or actively destroying) the surrounding tissues or stroma in any one (1) of the following covered organ groups, and subject to any classification stated: (a) Breast, where the tumour is classified as TIS according to the TNM Staging method; (b) Uterus, where the tumour is classified as TIS according to the TNM Staging method; or cervix uteri, classified as cervical intraepithelial neoplasia grade III (CIN III) or carcinoma in situ (CIS); (c) Ovary and/or fallopian tube, where the tumour is classified as TIS according to the TNM Staging method or FIGO* Stage 0; (d) Vagina or vulva, where the tumour is classified as TIS according to the TNM Staging method or FIGO* Stage 0; (e) Colon and rectum; (f) Penis; (g) Testis; (h) Lung; (i) Liver; (j) Stomach and oesophagus; (k) Urinary tract, for the purpose of in-situ cancers of the bladder, stage Ta of papillary carcinoma is included; or (l) Nasopharynx. For purposes of this Contract, Carcinoma in Situ must be confirmed by a biopsy. *FIGO refers to the staging method of the Federation Internationale de Gynecologie et d'Ostetrique.
2	Carotid artery disease requiring surgery	The undergoing of angioplasty or endarterectomy for carotid arteries for the treatment of stenosis of fifty percent (50%) or above, as proven by angiographic evidence, of one (1) or more carotid arteries. Both criteria (a) and (b) below must be met: (a) Either: i. Actual undergoing of endarterectomy to alleviate the symptoms; or ii. Actual undergoing of an endovascular intervention such as angioplasty and/or stenting or atherectomy to alleviate the symptoms; and (b) The diagnosis and medical necessity of the treatment must be confirmed by a Specialist in the relevant field.
3	Coronary artery disease requiring angioplasty and other invasive treatments	The actual undergoing of angioplasty with stenting, balloon angioplasty, atherectomy or laser treatment to correct a narrowing (minimum of 50% stenosis) of 1 or more major coronary arteries. The treatment must be confirmed by a Specialist in the relevant field as Medically Necessary. Medical evidence shall include all of the following: (a) Full report from attending cardiologist; (b) Evidence of significant and relevant ECG Changes (For example, ST segment depression); and (c) Angiographic evidence to confirm the location and degree of stenosis of one or more major coronary arteries. Major coronary arteries are defined as left main stem, left anterior descending, circumflex and right coronary artery.
4	Early Stage Cancer	The presence of one of the following malignant conditions: (a) Chronic lymphocytic leukaemia classified as RAI Stage I or II; (b) Non melanoma skin cancer; (c) Tumour of the prostate histologically classified as T1(a) or T1(b) accordingly to TNM classification; or (d) Tumour of the thyroid histologically classified as T1N0M0 according to the TNM classification Pre-malignant lesions and conditions, unless listed above, are excluded.
5	Endovascular treatment for cerebral aneurysm	Endovascular Treatment for Cerebral Aneurysm shall mean the actual undergoing of an endovascular intervention, such as endovascular embolisation, endovascular coiling, angioplasty and/or stenting or the insertion of a flow diverter, to prevent rupture of a cerebral aneurysm or to alleviate the bleeding due to rupture of a cerebral aneurysm. The procedure must be considered Medically Necessary and performed by a Specialist in the relevant field.

In the event of any discrepancy in respect of the meaning between the Chinese version and English version, the English version shall prevail.

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