PACIFIC CROSS

PrimaryCare International Medical Plan

Terms and Conditions

INTRODUCTION

This Policy is issued in consideration of the payment of the premiums stated herein and in reliance on the statements set out in the Application. The Application—including all questions and the answers provided—constitutes the basis of this insurance contract and is incorporated into this Policy. By incorporating those questions and answers, the truth and accuracy of the responses are conditions precedent to the validity of this Policy.

Acceptance of any Application is subject to the Company's discretion. The Company may withhold acceptance of applications for cover if, in its opinion, acceptance would expose the Company to the risk of breaching any applicable sanctions, laws or regulations, or any jurisdiction applicable to the Company.

The Company will pay benefits, where applicable, in accordance with and subject to the terms and conditions of this Policy.

14-Day Free Look: The Policyholder may cancel this Policy by returning it to the Company within fourteen (14) days of receipt. A full refund of premiums paid will be issued, provided that no benefits have been paid under the Policy.

TERMS & CONDITIONS

1. DEFINITIONS

In this Policy, the following terms carry the meanings set out below unless the context requires otherwise:

"Accident" means an event (a) occurring entirely beyond the Insured Person's control and caused by violent, external and visible means; and (b) happening while the Insured Person is covered under this Policy.

"Act of Terrorism" means an act—whether or not involving violence or force—and/or the threat or preparation thereof, by any person or group(s), acting alone or on behalf of or in connection with any organisation(s) or government(s), for political, religious, ideological, ethnic or similar purposes, including the intent to influence any government and/or instil fear in the public or any section of the public.

"Ambulatory Surgery" means a surgical procedure where patient is admitted and discharged on the same day in a hospital day case unit, ambulatory facility, or a specialist clinic.

"Anaesthetist" means a Physician who specialises in anaesthesiology and is duly registered to practice that specialty under the laws and regulations of the place of practice.

"APAC" means the Asia-Pacific countries. For the purposes of this Policy, APAC is limited to Asia and Oceania, which include:

- East Asia: China, Hong Kong (China), Macau, Japan, South Korea, Chinese Taipei (Taiwan), Mongolia
- South and Southeast Asia: Brunei Darussalam, Indonesia, Malaysia, Philippines, Singapore, Thailand, Vietnam, Nepal, Sri Lanka, Cambodia, and Laos
- Oceania / Pacific: Australia, New Zealand, and Papua New Guinea

"Application" means the application form signed by the Policyholder and, if different, by each Insured Person, by which coverage was applied for under this Policy and which forms part of this Policy.

"Attending Physician / Physician" means a person qualified by degree and licensed or registered to practice medicine under the laws and regulations of the country of practice. The Attending Physician managing an

Insured Person's Illness must not be the Insured Person, an Immediate Family Member, or a travelling companion.

"Benefits Schedule" means the benefits schedule attached to this Policy.

"Bonesetter" means a person who specialises in bone-setting and is licensed or registered to practice bone-setting under the laws and regulations of the place of practice.

"Cancer/Malignant Tumour" means a disease marked by the presence of a malignant tumour, characterised by the uncontrolled growth and spread of abnormal cells and the invasion of surrounding tissue confirmed by histopathological evidence of malignancy. Excludes benign tumours and early detected conditions such as dysplasia.

"Carrier" means a transportation company whose principal business is the carriage by air, sea or land of passengers and/or cargo for hire or reward, and which is duly licensed or certified in all relevant jurisdictions.

"Child" means a minor under the laws of the Country of Residence, or a full-time student not more than 23 years old. Includes stepchildren or legally adopted children. The Child must be accompanied by a parent/guardian who is also insured under the same Policy, and the Child's coverage level must not exceed that of the parent/guardian.

"Chinese Medicine Practitioner" means a person licensed or registered to practice Chinese medicine under the laws and regulations of the place of practice.

"Claims Recovery" means any amount previously paid by the Company under a claim, or any amount billed by a healthcare provider, that is subsequently determined to be ineligible, outside the scope of coverage, or otherwise not payable under this Policy. Claims Recovery includes, but is not limited to:

(a) Amounts paid in excess of the entitlement under this Policy;

(b) Deductibles, co-payments, Co-insurance, excluded services, amounts exceeding benefit limits, or treatment incurred during waiting periods; and

(c) Any sums paid without entitlement.

Such amounts shall be recoverable by the Company from the Policyholder and constitute Indebtedness under this Policy.

"Close Business Partner" means a business associate who shares in the Insured Person's business.

"Co-insurance" means the percentage share of Eligible Expenses payable by the Insured Person.

"Company" means Pacific Cross Insurance Company Limited.

"Complications of Pregnancy" means inpatient treatment of an eligible medical condition arising during the antenatal period of pregnancy or during childbirth. Coverage under this benefit is limited to the treatment of the following eligible medical conditions only:

- Cephalopelvic disproportion
- Ectopic pregnancy
- Hydatidiform mole
- Retained placenta
- Placenta praevia

- Eclampsia
- Diabetes (where diabetes is not excluded under the policy due to prior medical history)
- Post-partum haemorrhage
- Miscarriage requiring immediate surgical treatment

This benefit does not cover voluntary or emergency caesarean section procedures, or failure to progress in labour, unless such procedures are required as a result of one of the Eligible Medical Conditions listed above.

Coverage for any Complications of Pregnancy is provided only if the pregnancy itself is covered under the Optional Maternity Benefit (if purchased), and is subject to the waiting periods set out in that benefit.

"Congenital Condition" means a physical or mental abnormality existing at birth.

"Cosmetic Surgery" means reconstructive or other surgery that is not medically necessary or is performed primarily to improve appearance, including procedures performed for psychological reasons, adaptation or personal satisfaction, even if related to a covered Disability.

"Country of Residence" means the country where the Insured Person (spouse or a Child, as applicable) resides for not less than six (6) months in a Policy Year as declared in the Application, unless otherwise endorsed by the Company.

"Custodial Care" means (a) Care provided mainly for personal needs, comfort or convenience, whether or not rendered by persons with specialised medical training; or (b) care provided mainly to maintain rather than improve a medical condition, to prevent deterioration of a physical or mental function, or to provide a protected environment.

"Deductible" means the amount stated in the Benefits Schedule to be deducted from benefits payable for Eligible Expenses in each Policy Year.

"Dentist" means a person qualified by degree and licensed or registered to practice dentistry under the laws and regulations of the place of practice.

"Disability" means an Illness or Injury, including symptoms, sequelae or complications thereof; for Injury, includes all injuries arising from the same event or a series of contiguous events.

"Eligible Expenses" means Medically necessary expenses for treatments and services required to treat a Disability.

"Eligible Person" means (a) a person who is not a Child; or (b) a Child whose parent/guardian is or will become an Insured Person.

"Emergency" means a bona fide situation involving a sudden change in health requiring urgent medical or surgical intervention to avoid imminent danger to life or health.

"Grace Period" means thirty (30) days commencing from the date a premium payment is due, provided that such period applies only to the first premium or first instalment of each Policy Year, unless otherwise expressly stated in this Policy.

"Herb" means a plant whose leaves are used medicinally for the treatment of an Illness or Injury covered under this Policy and prescribed by a Herbalist or Chinese Medicine Practitioner.

"Herbalist" means a person who grows or sells Herbs and is licensed, registered or authorised under local laws to do so.

"Hereditary condition" means a disease or disorder caused by genetic abnormalities inherited from one or both parents, whether manifested at birth or developing later in life.

"Home Nursing" means nursing care (not personal assistance) provided by a licensed nurse at home immediately after hospital confinement, certified by the Attending Physician as medically necessary.

"Hospice Care" means a program that gives medical, emotional, social, and spiritual support to people with a terminal illness. It must be prescribed by a doctor and provided by a licensed hospital or care facility.

"Hospital" means an institution legally licensed as a medical or surgical hospital whose main functions are not those of a spa, hydro-clinic, sanatorium, nursing home, home for the aged, rehabilitation centre, or a place for alcoholics or drug addicts, and which is under constant supervision of a resident Physician.

"Hospital Room Accommodation" means the room entitlement for any eligible confinement hospital room and board accommodation. Please refer to the accommodation below:

- **Private Room** – usually refer to single occupancy room use by the Insured Person, where the base class of rooms having a single bed per room with bath/shower, excluding any higher-tier or higher-class room (e.g. deluxe, suite, executive, VIP/VVIP)
- **Semi-private room** – usually refer to double occupancy room use by the Insured Person, where the base class of rooms having two (2) beds per room with a shared bath/shower, excluding any higher-tier or higher-class room (e.g. Semi-Private single room)
- **Ward** – A class of room with three (3) or more beds per room

If the Insured Person is admitted to a higher category of room accommodation than their plan entitlement, whether voluntary or involuntary, a co-insurance adjustment of fifty percent (50%) applies to the benefits payable under the Benefits Schedule, including but not limited to Room & Board.

"Hospitalisation Treatment" means a treatment that is: (a) provided as Inpatient, Day Surgery/Day-Patient, Ambulatory Surgery, hospital-based infusion endoscopy under monitored anaesthesia care, or any other treatment delivered in a hospital or clinic setting, and (b) in the Company's reasonable medical opinion, requires hospital facilities (e.g., procedural suite, anaesthesia/sedation, post-procedure monitoring, or comparable resources), regardless of whether the patient occupies a bed or not.

"Illness" means a sickness or disease marked by a pathological deviation from the normal healthy state: (a) beginning or occurring after the Policy Effective Date; and (b) requiring treatment by a Physician, Specialist or Surgeon; and (c) covered by this Policy.

"Immediate Family Members" means an Insured Person's legal spouse, children (natural or adopted), siblings, siblings-in-law, parents, parents-in-law, grandparents, grandchildren, legal guardians, stepparents or stepchildren.

"Indebtedness" means any sum owed to the Company under this Policy, including but not limited to unpaid premiums and Claims Recovery amounts. Indebtedness may be deducted from any refund, benefit, or sum otherwise payable under this Policy.

"Injury" means a bodily injury (excluding all psychiatric conditions) arising wholly and exclusively from an Accident and which, independently of all other causes, directly results in a loss covered by this Policy.

"Inpatient" means an Insured Person admitted to Hospital for treatment of a Disability who occupies a hospital bed and stay there for at least one (1) night or longer.

"Insured Person" means any person named as an Insured Person in the Policy Schedule.

"Kidney Dialysis" means haemodialysis or peritoneal dialysis upon written referral by Attending Physician and performed at a hospital or at a legally registered dialysis centre when an Insured is diagnosed with irreversible end-stage Kidney Failure.

"Medically Necessary" means medical care or treatment for a covered Injury or Illness that is: (a) consistent with the diagnosis and customary medical treatment; (b) in accordance with good and prudent medical practice; (c) not for the convenience of the Policyholder, the Insured Person, caregivers or family; and (d) necessary to safely perform surgery/treatment/services that cannot be safely delivered without confinement, where confinement is claimed.

"Medicines and Drugs" means medicines or drugs (other than experimental or unproven) prescribed by a Physician and specifically required to treat a Disability.

"Miscellaneous Charges" means expenses for laboratory tests, diagnostic imaging, Professional Fees, medicines and drugs, blood and plasma, wheelchair rentals, outpatient surgery, surgical appliances and devices, and intra-operative standard prosthetic devices.

"Non-surgical Oncology Treatment" means treatment must be received as an inpatient or outpatient at a hospital, or at an oncology day case centre within a Hospital, or at a cancer treatment centre licensed by the relevant health authority or accredited by an internationally recognised oncology body. Outpatient consultation by oncologist or attending Specialist, prescribed laboratory tests and diagnostic imaging tests during non-surgical oncology treatment period.

"Normal, Usual and Customary Charges" means a reasonable charge that is (a) usual and customary when compared with charges for similar services/supplies in the Insured Person's locality; and (b) made to persons with similar medical conditions in that locality.

"North America" means Canada, the United States of America, Mexico and the Caribbean Islands.

"Oncology Treatment" means non-surgical treatment of Radiotherapy, Chemotherapy, targeted therapy, immunotherapy, hormonal therapy (by way of infusion, injections or oral medications) and fees for bone marrow transplant and peripheral stem cell transplants when treatment cancer with or without high dose chemotherapy received as inpatient, day case or outpatient treatments.

"Optional Benefit" means a benefit included at the Policyholder's option with the Company's agreement, evidenced by a rider attached to this Policy and described as an affirmed benefit, for which additional premium is payable.

"Period of Insurance" means the period stated in the Policy Schedule as the period of insurance, or any renewal period during which the Policy is in effect.

"Persistent Vegetative State" means (a) a severe decrease of consciousness in which the Insured Person is in a state of partial arousal rather than true awareness, with superficial signs such as eye opening, swallowing and spontaneous breathing possibly persisting; and (b) the state has continued for at least four (4) weeks with no sign of improvement despite reasonable attempts to alleviate the condition.

"Policy" means this policy document, including the Application, Policy Schedule, Benefits Schedule, Surgical Schedule, any Optional Benefits with riders, and any endorsements or amendments approved by an executive officer of the Company.

"Policy Effective Date" means 12:00 midnight (local time in the Country of Residence) on the first day of the Period of Insurance.

"Policy Schedule" means the policy schedule attached to this Policy.

"Policy Year" means a calendar year commencing on the Policy Effective Date or any anniversary of that date.

"Policyholder" means the person named as Policyholder in the Policy Schedule, to whom this Policy is issued in respect of the Insured Persons, and who is at least eighteen (18) years old at the time the Application is signed.

"Post-hospitalisation" means treatment ordered by the Attending Physician of the hospitalisation, including follow-up consultations, relevant medicines, diagnostic tests and physiotherapy. Cover is limited to the specific condition for which inpatient treatment was covered. It excludes routine outpatient consultations and long-term medication for chronic conditions.

"Pre-existing Condition" means any Disability (a) existing before the Policy Effective Date that presented signs or symptoms of which the Insured Person was aware or should reasonably have been aware; or (b) for which treatment, medication, advice or diagnosis was sought or received during the two (2) years before Policy commencement; or (c) known by the Insured Person to exist prior to Policy commencement whether or not treatment, medication, advice or diagnosis was sought or received.

"Professional Fees" means fees payable to licensed medical professionals such as Chinese Medicine Practitioners, occupational therapists, physiotherapists, acupuncturists, dieticians, Attending Physicians (except Surgeons), pathologists and radiologists.

"Psychiatric Treatment" means treatment by a person licensed by the competent medical authority of the country in which treatment is provided or completed studies in the relevant field, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

"Public Conveyance" means public common carriers such as multi-engined aircraft, buses, trains, ships, hovercrafts, ferries and taxis licensed to carry fare-paying passengers, and coaches arranged by travel agencies (not private or contractor carriers).

"Rehabilitation" means a combination of therapies (e.g., physical, occupational, speech therapy) aimed at restoring function after an acute event requiring inpatient treatment, subject to written certification by the Attending Physician. Rehabilitation must start during hospitalisation or within fourteen (14) days immediately after discharge.

"Renewal Date" means the date specified in the Policy Schedule as the renewal date.

"Room & Board" means reimbursement of Normal, Usual and Customary Charges for actual hospital accommodation and meals during confinement. If confined in a room class above the eligible level on any day—voluntarily or involuntarily—all inpatient benefits, including Room & Board, are adjusted. Please refer to the definition of "Hospital Room Accommodation".

"Specialist" means a Physician specialising in a particular field of medicine.

"Surgeon" means a person who is licensed or registered to practice surgery under the laws and regulations of the place of practice.

"Surgeon's Fee" means the fee payable to a Surgeon(s) for surgery to treat a Disability, including pre-surgical assessment, hospital visits and normal post-surgical care, subject to Normal, Usual and Customary Charges.

"Terminal Illness" means a condition which, in the opinion of the Attending Physician is incurable, irreversible, and expected to result in death within twelve (12) months, despite appropriate medical treatment.

"US$ / US Dollars" means the lawful currency of the United States of America.

"Waiting Period" means a period commencing on the Policy Effective Date (or such other start date as specified in the relevant benefit provision) during which no benefits are payable for a specified condition, treatment, or type of expense, even if otherwise covered under this Policy. The duration of the Waiting Period for each applicable benefit is set out in the relevant benefit provision or in the Benefits Schedule.

"Walk-in Emergency Treatment" means emergency room treatment that does not result in hospital confinement or is unrelated to an accident.

2. TERM

2.1. Each Period of Insurance begins at 12:00 midnight on the first day and ends at 11:59 p.m. on the last day (local time in the Insured Person's Country of Residence).

2.2. Except where the Company has agreed in writing to accept periodic premium payments, there is no cover until all premiums payable under this Policy are paid. Once paid, cover commences on the first day of the Period of Insurance, subject to the terms, conditions and exclusions of this Policy and excluding: (a) any Disability for which signs or symptoms existed prior to the date premiums were paid, of which the Insured Person was or should reasonably have been aware; and (b) any Illness that begins or manifests during the Waiting Period.

2.3. Where periodic premium payment is permitted, cover shall automatically lapse if any periodic premium remains overdue or unpaid for thirty (30) days after its due date. For instalment payments, the Grace Period shall apply only to the first instalment of each Policy Year. Any subsequent instalment must be paid on or before its due date, failing which cover shall immediately lapse without further Grace Period. The Company may offset any Indebtedness under this Policy, including unpaid periodic premiums and Claims Recovery amounts, against any benefits payable or sums otherwise due to the Policyholder or Insured Person.

3. MINIMUM ENROLMENT AGE

No person may be insured under this Policy at first enrolment if less than fifteen (15) days old, except for newborn addition where the parent (Father or Mother) of the newborn had been insured for twelve (12) months or more.

4. CANCELLATION

4.1. Any policy cancellation requires written confirmation to the Company. No premium refund will be available during the first twelve (12) months of the Policy, except during the **Free Look Period**.

4.2. The Policyholder may cancel this Policy at any time by written notice sent by email or registered post to the Company's third-party administrative office. The effective date of cancellation is subject to the Company's acknowledgement and confirmation.

4.3. Without prejudice to any claim incurred or beginning prior to cancellation, and without prejudice to the Company's rights to avoid this Policy, the Company may cancel this Policy at any time by written notice to the Policyholder's last known address in any of the following circumstances: (a) misstatement of age; (b) misstatement or misrepresentation (by omission or commission) of physical or mental condition; (c) withholding or failure to disclose material facts regarding physical or mental condition; (d) failure to advise or disclose occupation/vocation or changes thereof; (e) failure to advise change of address, including change of Country of Residence.

4.4. If this Policy is cancelled by either the Policyholder or the Company, the Company shall refund the pro-rated premium for the remaining non-insured number of days, provided no claim has been paid or is payable during the current Policy Year. Refund is subject to return of any valid Coverage Card(s)

and/or outpatient card(s). Any Indebtedness under this Policy shall be deducted from the premium to be refunded.

4.5. Pro-rated premium calculation: Annual Premium divided by the actual number of days in the Policy Year, multiplied by the number of non-insured days.

5. PREMIUMS

5.1. Premiums and Indebtedness—including premiums for the addition of Insured Persons—are payable by the Policyholder on the first day of each Period of Insurance. For the purposes of this Policy, "Premium" means the amount payable by the Policyholder to the Company for insurance coverage under this Policy, calculated in accordance with the Company's rate tables and underwriting rules.

5.2. Premium is based on each Insured Person's age on the first day of the Period of Insurance, the Company's table of rates in force on the due date, and the Premium basis by residence and area of cover set out in Clause 6.3, together with any other relevant factors.

5.3. On renewal or resumption, the Company may revise premiums based on the then-applicable rate table.

6. GUARANTEED RENEWAL INVITATION OF POLICY

6.1. Subject to Clause 4.3, the Company guarantees renewal at the end of each Period of Insurance upon payment of premium on the Renewal Date. Renewal Premiums may be revised at each Renewal Date based on: (a) the product's overall claims experience and pool performance; (b) inflationary and healthcare cost trends; (c) changes in the Company's underwriting criteria; and (d) other actuarial and commercial factors at the Company's sole discretion.

6.2. The Company will issue a renewal invitation prior to the Policy expiry date, in accordance with its standard administrative practice. Any changes to the Policy including plan, Optional Benefits, Country of Residence (address), payment method, or instalment arrangements must be notified to the Company at least ten (10) days prior to the Renewal Date. Failure to disclose any change(s) may result in denial of claims and/or cancellation of the Policy under Clause 4.3.

6.3. Premium basis by residence and area of cover:

(a) Premiums are determined by the Insured Person's Country of Residence and the selected Treatment Area. Cover is not available to residents in USA, Canada, or any sanctioned country.

(b) For the purposes of this Policy, the following areas of cover are referred to as Treatment Areas:

i. Treatment Area 1 - Worldwide excluding treatment in USA:

- Residents Group 1: Hong Kong and Singapore
- Residents Group 2: Asia Pacific countries (excluding Hong Kong and Singapore), as defined as "APAC" under this Policy
- Residents Group 3: High-cost European countries: Luxembourg, Switzerland, Norway, Germany, Denmark, Iceland, Sweden, Ireland
- Residents Group 4: Rest of World (excluding North America and sanctioned countries). The High-Cost Country Option, as set out in Clause 39, is only available to Insured Persons covered under Treatment Area 1 and belongs to Residents Group 1 or Residents Group 2.

ii. Treatment Area 2: Worldwide including treatment in USA:

- Available to Residents Group 1–4
- An additional adjustment is applied to medical premiums (Zone 1 Premium). The High-Cost Country Option is not available under Treatment Area 2.

6.4. Renewal of this Policy is subject to the Company's discretion. The Company may withhold renewal if, in its opinion, renewal would expose the Company to the risk of breaching any applicable sanctions, laws or regulations, or any jurisdiction applicable to the Company.

7. SUSPENSION AND RESUMPTION OF COVER

7.1. Subject to Clause 4, cover continues during the Grace Period for premiums due for the relevant Policy Year where a Grace Period applies. If such premium is not received before the end of the Grace Period, cover shall lapse in accordance with Clause 2.3, and any premium received thereafter shall be deemed an application to resume cover. For subsequent instalments where no Grace Period applies under Clause 2.3, cover lapses immediately if payment is not received on the due date. Any premium received thereafter is deemed an application to resume cover.

7.2. Any receipt issued for such premium is conditional upon approval of resumption. It is not confirmation of reinstatement. No cover is provided until approval is granted and written confirmation is issued under Clause 7.4.

7.3. The Company may require additional information or documents to consider resumption. If not provided, cover remains suspended and premiums paid for the relevant Policy Year may be refunded.

7.4. Reinstatement is at the Company's sole discretion and is effective only upon written confirmation.

7.5. Upon reinstatement after suspension: (a) For Illness: a thirty (30) day waiting period applies only if the Insured Person was receiving treatment for that Illness prior to suspension; (b) For Injury: no waiting period applies, and cover resumes from the reinstatement date.

8. COVERAGE CARD

A Coverage Card will be issued to each Insured Person at enrolment. Subject to Clause 4, a card confirms cover while premiums are paid. Cards are non-transferable and valid only when signed by the Cardholder. The Policyholder must collect and return cards from terminated members. The Policyholder and/or Cardholder is liable for any ineligible expenses incurred by unreturned cards, payable to the Company immediately upon notice. A fee applies for replacement of lost cards.

9. ABSOLUTE OWNERSHIP

Unless expressly endorsed otherwise, the Company may treat the Policyholder as the absolute owner of this Policy and need not recognise any other claim to or interest in it. Receipt by the Policyholder (or personal representative) fully discharges the Company's liability. No third party who is not a party to this Policy has any right to enforce its terms.

10. NO CLAIM DISCOUNT and FAMILY DISCOUNT

We will offer No Claim Discount to Policyholder (along with their spouse and dependents) if none of the Insured Persons had any claims incurred/reimbursed during the policy period. Our discount offering as follows:

(a) No Claims incurred / reimbursed, during

(b) Twelve (12) months (1 policy period): 10% upon renewal, continuously

(c) Twenty-four (24) months (2 policy period): 15% upon renewal

(d) Capped max. no claim discount at 15%

Should there be a claim incurred during the policy period, the no claim discount will be back to zero percent (0%) upon renewal.

The No Claim Discount applies only to the premium in respect of the basic benefits. Claims against any Optional Benefits (Dental Care, Optical Care and Maternity Benefit) and Medical Check-up and Vaccination will not affect the No Claim Discount.

For Family Discount please refer to the following table:

Single	No discount
Couple	5%
Family of 3	10%
Family of 4 and above	15%

Couple: Policyholder + 1 (spouse or dependent child)

Family of 3: Policyholder + 2 (1 x spouse and 1 x dependent child) or (2 x dependent child)

Family of 4: Policyholder + 3 (1 x spouse and 2 dependent child) or (3 x dependent child)

11. NOTIFICATION OF CHANGES

11.1. The Policyholder must immediately notify the Company in writing of any change in circumstances of the Policyholder or any Insured Person, including change of address, residence, occupation or vocation, habits or pursuits.

11.2. Each Insured Person must immediately notify the Policyholder in writing of all information, and any changes thereto, required for the Policyholder's notification to the Company.

11.3. The Company is not liable for losses arising from such changes unless: (a) written notice is given; (b) any required additional premium is paid and received; and (c) the change is endorsed on the Policy.

11.4. Failure to notify changes may affect cover under this Policy.

12. PAYMENT OF BENEFITS

12.1. If an Insured Person suffers or incurs a Disability during the Period of Insurance, the Company will pay benefits in accordance with the Benefits Schedule.

12.2. Where a Deductible or Co-insurance applies, the Company pays Eligible Expenses only to the extent they exceed the Deductible and after deducting Co-insurance.

12.3. Benefits are paid to the Insured Person or the personal representative unless otherwise requested in writing by the Policyholder. The Company may pay providers directly unless the Insured Person requests otherwise in writing. All payments are in US Dollars.

12.4. Classification and Reclassification of Treatment:

(a) The Company determines a claim's classification as outpatient, day-patient, or inpatient based on the treatment's resource requirements and clinical appropriateness, referencing internationally accepted medical guidelines and practices. This determination applies regardless of the billing label or service classification provided by the treating facility.

(b) If a treatment, by its nature, is commonly and appropriately delivered with Hospitalisation Treatment resources, the Company may treat it as Hospitalisation Treatment, and the High-Cost Country Option cost-sharing provision will apply, even if it is billed as outpatient. For treatments subject to the High-Cost Country Option, reimbursement will first apply the Co-insurance provision, followed by the applicable annual deductible.

13. CLAIMS RECOVERY

13.1. The Policyholder and each Insured Person shall be jointly and severally liable for any Claims Recovery amounts. These must be paid directly to the healthcare provider or repaid to the Company, as applicable. Failure to pay does not relieve this obligation and may result in collection action by the relevant provider.

13.2. The Company may recover any amounts paid, guaranteed, or authorised that are later determined to be ineligible or where entitlement is denied, including treatment obtained through the Company's direct billing network. Recovery must be initiated within twelve (12) months of discovery. Any amounts not recovered within this period shall be deemed settled.

13.3. If Claims Recovery obligations remain outstanding, the Company may withhold or defer issuance of any Guarantee of Payment ("GOP") for future treatment until such obligations are settled. In emergency situations, only a GOP for stabilisation of the acute episode may be issued.

13.4. The Company may offset any outstanding Claims Recovery amounts against any claim payment or other sum due, or which may thereafter become due, under this Policy until such obligations are fully satisfied.

13.5. The Company may decline renewal of this Policy if Claims Recovery amounts remain unpaid for more than twelve (12) months, following two written notices, or if there is a consistent pattern of repeated non-payment across successive policy periods.

13.6. The Company's rights under this clause are without prejudice to any other rights or remedies available under this Policy or at law. Failure to enforce these rights in any instance shall not constitute a waiver of the Company's right to enforce them in future claims.

14. SUCCESSOR INSURED

14.1. If the Policyholder is an individual and dies, the Policyholder's spouse (if an Insured Person) or the Policyholder's personal representative becomes the Policyholder.

14.2. If the Policyholder is a body corporate and is wound up (other than a reconstruction), this Policy terminates and premiums are refunded per Clause 4.4.

15. CLAIMS

15.1. In the event of a loss or claim under this Policy, the Policyholder or relevant Insured Person must submit a claim and give the Company written notice as soon as reasonably practicable and in any event no later than ninety (90) days after the covered loss occurs or ends. The notice must state the Insured Person's name, the Policy number, and a description of the loss, and be sent to the Company's administrative address together with proof of loss, including written proof of the occurrence, type and amount of loss.

15.2. Claim form (or other proof of loss) is incomplete unless all medical and hospital bills, certificates, information, and any other evidence reasonably required by the Company have been submitted and

accepted. Only actual costs incurred constitute Eligible Expenses for reimbursement. Any variation or waiver is at the Company's sole discretion.

15.3. Failure to submit a completed claim form or proof of loss within the required time will not affect a claim if it was not reasonably possible to do so, provided that the completed claim form or proof of loss is submitted within three hundred sixty-five (365) days after the covered loss occurred or ended.

16. FRAUDULENT / UNFOUNDED CLAIMS

16.1. No benefits are payable if an Insured Person has concealed or misrepresented any material fact or circumstance relating to this Policy.

16.2. If any claim is in any respect fraudulent or unfounded, all benefits paid or payable in relation to that claim are forfeited and, if paid, recoverable by the Company.

16.3. The Company reserves the right to assess claims based on the underlying resources required and treatment complexity rather than billing format or provider codes. Any deliberate misclassification by the policyholder or provider may result in denied claims or additional co-insurance.

17. AMENDMENTS TO THIS POLICY

No amendment, including to any attachment or endorsement, is valid unless signed or initialled by an officer or authorised representative of the Company.

18. ADDITIONS

The Policyholder may apply in writing to extend this Policy to cover an Eligible Person. The Eligible Person becomes an Insured Person when the Company accepts the request under its current underwriting rules and receives the required additional premium.

For the avoidance of doubt, the premiums for addition of Insured Persons during the Period of Insurance are not entitled to refund.

19. CLAIMING AGAINST THIRD PARTY OR OTHER INSURANCE

19.1. If another medical or accident insurance policy also covers the Insured Person's expenses for a Disability covered under this policy, the Insured Person shall first claim from that other insurer and the Company shall pay only the excess. Any amounts paid by another source shall be applied toward the Deductible, provided that proof of payment is submitted.

19.2. If any other person or entity may be responsible for the Insured Person's expenses (including any liable third party), the Insured Person shall take all necessary steps to recover compensation from such person or entity.

19.3. The Insured Person must not settle, compromise, release, or otherwise discharge any claim against a third party without the prior written consent of the Company. Failure to obtain such consent shall result in no liability under this Policy to the extent of any expenses that could have been recovered from that third party.

19.4. If the Company pays any amount under this policy, it shall be subrogated to the rights of recovery of the Policyholder and any Insured Person against any other person or entity. The Company may, at its own expense, take proceedings in the name of the Policyholder or the Insured Person. The Policyholder and the Insured Person shall not prejudice such rights and shall provide all reasonable assistance to the Company in the exercise of such rights.

20. SUBROGATION

The Policyholder and the Insured Person agree that the Company may, at its expense, take legal action in their name to recover compensation from a third party for any indemnity provided or benefit paid/payable under this Policy, and any recovery belongs to the Company. The Insured Person assigns to the Company the right to bring such action in the Insured Person's name.

21. EMERGENCY ASSISTANCE SERVICES

21.1. The Company has arrangements with designated assistance companies to provide immediate assistance. Where applicable, the Insured Person or representative may contact the assistance company using the details on the Coverage Card (providing name, Policy Number, Member Number, nature of problem, location and contact). After validation, services will be provided subject to Policy terms. No reimbursement claims will be accepted for these services.

Access to emergency medical services while travelling is provided, provided that (a) the Insured Person travels outside the Country of Residence for no more than ninety (90) consecutive days; and (b) travel is not for the purpose of obtaining or seeking medical or surgical treatment.

21.2. Emergency Evacuation: The Company will pay travel and transportation costs reasonably incurred for necessary medical evacuation when: (a) adequate treatment is unavailable at the location; (b) the Insured Person cannot travel as an unaccompanied, seated passenger; and (c) evacuation is to the nearest suitable facility by the most economical means without endangering life or health. All arrangements must be made through designated assistance companies and monitored on the Company's behalf.

21.3. Hospital Expenses Guarantee: The Company will arrange, via the designated assistance company, to guarantee or pay required medical expenses for a covered Disability where hospital bills are expected to exceed US$2,500.

21.4. Medical Repatriation: If medically necessary, the Company will arrange, via the designated assistance company, and pay for the Insured Person's return to the Country of Residence by appropriate transport following Emergency Medical Evacuation and subsequent hospitalisation outside the Country of Residence.

21.5. Transportation of Mortal Remains: The Company will arrange, via the designated assistance company, for transportation of mortal remains to the airport of the Country of Residence or Country of Origin (citizenship). Conditions (a) & (b) under Clause 21.1 do not apply to this service.

21.6. Compassionate Visit: The Company will arrange one round-trip economy class air ticket for a relative or friend to join an Insured Person who is travelling alone and is hospitalised outside the Country of Residence for more than seven (7) days.

21.7. Return of Minor Children: The Company will arrange a one-way economy class ticket for unattended minor children below eighteen (18) to return to the Country of Residence if left unattended as a result of the accompanying Insured Person's hospitalisation or emergency evacuation. Escort will be provided when necessary.

21.8. Accommodation: The Company will arrange hotel accommodation of US$150 per day up to five (5) days while travelling in relation to an incident requiring Emergency Medical Evacuation, Medical Repatriation or hospitalisation before the Insured Person is fit to fly.

21.9. Delivery of Essential Medicine: The designated assistance company will arrange delivery of essential medicines, drugs and medical supplies necessary for care/treatment but unavailable locally, subject to local laws and regulations. The Insured Person is responsible for medicine and delivery costs.

21.10. Referral Services: Upon request, referral services (provider referral, inoculation/visa information, embassy, legal assistance, interpreter, replacement of lost travel documents, luggage or air ticket) may be provided via the assistance company. The Company is not liable for: (a) fees for such services; (b) advice; or (c) medical diagnosis/treatment. Although referrals may be made, quality cannot be guaranteed; final selection rests with the Insured Person. Care and diligence will be exercised in selecting providers.

21.11. Prior approval for 21.2 to 21.8 is required and all arrangements must be coordinated by the designated assistance company.

21.12. The Company and its service provider(s) are not responsible for failure or delays caused by strikes, war, terrorist activities or other social unrest, adverse weather, geological events, or other conditions beyond control, including flight conditions or legal/regulatory prohibitions. Assistance will be attempted but no obligation is assumed beyond policy terms and conditions.

22. NEWBORN CHILD COVER

22.1. The Policyholder may apply for cover for the newborn Child of an Insured Person who has been insured for not less than twelve (12) consecutive months. Provided the Policyholder submits the birth certificate and application form (excluding Medical Questionnaires) within thirty (30) days from the Child's date of birth and the application is approved by the Company, coverage for the Child shall take effect from the Child's date of birth, regardless of the date on which the Company approves the application. The Child's cover and level of benefits shall match the Insured Person's. If both parents are Insured Persons at different benefit levels, the Child's level shall be the lower level.

22.2. Cover continues on renewal provided a personal health record/Application for the Child is submitted as required and the additional premium is paid and received.

22.3. Coverage is only available to a newborn Child of an Insured Person who is covered under this Policy at the time of the Child's birth.

22.4. Newborn Acute Condition Cover, as set out in the Benefit Schedule, applies to Inpatient Treatments received by the newborn Child and shall not extend to outpatient treatments. This coverage shall apply for a period of thirty (30) days commencing from the Child's date of birth, subject to the successful application for newborn Child cover in accordance with Clause 22.1.

23. OCCUPATIONAL RISK CLASSIFICATIONS

Class I: Very light hazards—professional and mercantile occupations not superintending or engaging in manual labour (e.g., professional, administrative, managerial, clerical).

Class II: Light hazards—superintending but not engaging in manual labour; wholesale/retail trade; frequent business travel.

Class III: Non-hazardous manual labour—occupations involving light manual work.

Class IV: Occupations involving manual work other than light manual work, or use of machinery.

24. EXPERIMENTAL TREATMENT

Any experimental, unproven, or new medical technology or procedure that has not been approved by the Company in accordance with generally accepted medical practice and standards prevailing in the locality where the treatment is rendered.

25. ORGAN TRANSPLANT

The cost of acquiring an organ and any expenses related to reimplantation are not covered, except for donor costs as expressly provided in the Benefit Schedule. This is a lump-sum maximum per organ including complications/sequelae; no other policy benefits (e.g., regular care, diagnostic tests, long-term medication) are payable in respect of Organ Transplant.

26. ACCIDENTAL DAMAGE TO TEETH

The Company covers emergency dental expenses necessary to restore or replace sound natural teeth lost or damaged in an Accident and the immediate relief of pain following an Accident, provided treatment is within seven (7) days of the Accident in a registered dental clinic or Hospital. No benefits for restorative treatments such as permanent crowns, dental implants, etc., or damage/loss of teeth caused by eating, drinking, tooth-brushing or oral hygiene procedures.

27. OTHER INSURANCE

The Policyholder must immediately inform the Company if an Insured Person is or becomes insured under any other medical or other insurance policy and provide a copy (including benefits schedule) indicating current period, Insured Person(s) and coverage. Failure to notify at Application or during the Period of Insurance may affect claim payments under this Policy.

28. TAKE-OVER POLICIES

The Company may maintain the underwriting terms or special acceptance conditions applied by the Insured Person's previous insurer, including any exclusions for Pre-Existing Conditions. Any premium loading for a Pre-Existing medical condition shall be subject to the Company's guidelines.

The Company reserves the right to request supporting documentation from the previous insurer to verify coverage, terms, and the original Policy Effective Date.

The original Policy Effective Date, recognised by the previous insurer may be carried over to this Policy for the purpose of waiting periods, provided that no enhanced benefits are granted as part of the transfer.

Any transfer from a group policy arranged by an employer to this individual policy requires the prior written agreement of the Company.

29. TERMINATION OF BENEFITS

29.1. Cover ends for all Insured Persons and any Child when this Policy terminates.

29.2. Cover for a Child ends on the Renewal Date following marriage or attainment of age nineteen (19) (twenty-three (23) if a full-time student). Thereafter, no cover is provided unless the Policyholder applies for that person to become an Insured Person and the required premium is paid and received by the Renewal Date.

30. TREATMENT AREA

Cover applies only to Disability and treatment within the area specified in the Benefits Schedule as the area of cover for which the appropriate premium has been paid.

31. EMERGENCY BENEFIT FOR OUTSIDE YOUR AREA OF COVER

Coverage for inpatient treatment outside the Treatment Area, or in restricted coverage area as specified below, is extended during travel to such areas from the date and time of arrival to the date and time of departure from the international departure point of that area, for up to thirty (30) accumulated days in any one Policy Year. Coverage applies for Injury or the acute onset of an Illness/medical condition arising there, provided the Insured Person was asymptomatic and not suffering from the respective Illness/condition/Injury at any time before travel.

Restricted coverage areas include:

(a) United States of America (for Insured Persons with Treatment Area 1 - Worldwide excluding treatment in USA)

(b) Hong Kong and Singapore (for Insured Persons with High-Cost Country Option; cost-sharing provisions apply under Clause 39)

For Insured Person with High-Cost Country Option coverage in Hong Kong or Singapore, the cost-sharing provisions set out in Clause 39 apply. In such cases, thirty percent (30%) Co-insurance and the applicable Deductible will apply to emergency inpatient treatment under this benefit.

32. CHANGE OF BENEFITS

The Policyholder may apply at renewal to change the class/level of cover for an Insured Person. If a Disability occurs or begins before completion of underwriting and Company confirmation of the change, the benefits payable will not exceed the maximums under the prior class/level of cover (or the new class if lower).

33. ABANDONED CLAIMS

If the Company disclaims liability and the Policyholder/Insured Person does not refer the claim to dispute resolution within one hundred eighty (180) days from the date of disclaimer, the claim is deemed abandoned and no longer recoverable. Likewise, if the Policyholder/Insured Person fails to communicate in writing regarding a notified claim within one hundred eighty (180) days of the last written communication by either party, the claim is deemed abandoned and unrecoverable.

34. DISPUTE RESOLUTION

34.1. All disputes arising out of or in connection with this Policy shall first be referred by the Policyholder or Insured Person to the Company in writing. The parties shall attempt in good faith to resolve the dispute within thirty (30) days from receipt of such written notice.

34.2. If the dispute is not resolved within such thirty (30)-day period, the dispute shall be referred to and finally resolved by arbitration. Unless otherwise required by applicable law, arbitration shall be the exclusive mode of resolving such dispute. The parties may agree in writing on the applicable arbitration rules, arbitral institution, seat, and venue of arbitration.

34.3. If the parties are unable to agree on the applicable arbitration rules, arbitral institution, seat, or venue within thirty (30) days from the referral to arbitration, such matters shall be determined in accordance with applicable arbitration laws and rules. If the parties are unable to agree on the applicable

arbitration rules, arbitral institution, seat, or venue within thirty (30) days from referral to arbitration, the dispute shall be referred to and finally resolved by arbitration administered by the Hong Kong International Arbitration Centre under the HKIAC Administered Arbitration Rules in force when the Notice of Arbitration is submitted. In such case, the seat and venue of arbitration shall be Hong Kong.

34.4. If the parties are unable to agree on the applicable arbitration rules, arbitral institution, seat, or venue within thirty (30) days from referral to arbitration, the dispute shall be referred to and finally resolved by arbitration administered by the Hong Kong International Arbitration Centre under the HKIAC Administered Arbitration Rules in force when the Notice of Arbitration is submitted. In such case, the seat and venue of arbitration shall be Hong Kong.

34.5. The arbitral tribunal shall consist of one (1) arbitrator, unless otherwise agreed by the parties or required under the applicable arbitration rules. The language of the arbitration shall be English, unless otherwise agreed by the parties or required by applicable law.

34.6. The parties shall bear their own costs incurred in connection with the good faith negotiations. The costs of arbitration, including the fees and expenses of the arbitral tribunal and administering institution, and the parties' legal costs and expenses, shall be allocated by the arbitral tribunal in the final award, subject to the applicable arbitration rules and any mandatory requirements of applicable law.

35. CONDITIONS PRECEDENT TO ANY LIABILITY

Any liability of the Company is conditional upon: (a) provision of all required statements and declarations, truthfully and accurately given by the Policyholder and relevant Insured Person (or parent/guardian for a Child) in the Application or any other Company form—these are conditions precedent; (b) the complete truth and accuracy of all statements and declarations made in respect of any claim—also conditions precedent; and (c) observance and fulfilment of Policy terms, conditions and provisions (including endorsements) by the Policyholder or any Insured Person—also conditions precedent.

36. GOVERNING LAW

This Policy is governed by the laws of Hong Kong as to construction, validity and performance.

37. DATA PROTECTION

Any personal data, including health and medical information, of the Policyholder and Insured Persons collected by the Company may be processed for purposes relating to the Policy, including underwriting, policy administration, claims handling, direct billing, fraud prevention, reinsurance, and as required by applicable law or regulations. The Company shall use, disclose, transfer, store, and otherwise process such personal data in accordance with applicable data protection laws and the Company's Privacy Policy, as may be updated from time to time.

38. EXCLUSIONS

This Policy does not cover, and provides no benefits for, any of the following (including consequences, complications and sequelae) unless otherwise stated:

(a) Pre-existing Conditions, except those declared to and accepted by the Company;

(b) Treatment where payment is not required; treatment performed or prescribed by an Immediate Family Member; or treatment payable by other insurance or indemnity;

(c) Maternity and its complications unless covered under an optional maternity benefit; foetal surgery; birth control; treatment of impotence/infertility (including artificial insemination, IVF, embryo transfer); sterilisation reversal; elective abortion; methods of birth control or infertility treatment; sex transformation and related conditions;

(d) Congenital and hereditary conditions other than services claimed under the Congenital and Hereditary Conditions benefit where specifically provided on the benefits schedule;

(e) Custodial Care, home care, routine examinations/check-ups, or treatments/services deemed unnecessary by the Company. This includes check-ups, vaccinations (except side effects from COVID vaccinations), counselling (marriage, family, dietary, adjustment, psychological adaptation), hearing tests, refractive defects, corrective eye surgery for refractive error, corrective devices (spectacles, contact lenses, hearing aids, orthodontic appliances, braces, corrective shoes) or dental treatment unless covered under optional optical care/dental care benefits;

(f) Cosmetic or reconstructive surgery, treatment or procedures and any complications, except:

i. Reconstructive surgery due to Injury caused by an Accident during the Period of Insurance and undertaken within twelve (12) months of the Accident; or

ii. Breast reconstruction coincident with or within twelve (12) months of surgery for breast cancer, provided the Policy remains in force (if benefit/class/level changed, the lower amount applies);

(g) Disability arising directly or indirectly from excessive alcohol consumption or misuse of drugs/solvents, or any addiction;

(h) Experimental or unproven treatment, procedures, or drugs not recognised by the Company; Experimental Treatment: Any experimental, unproven, or new medical technology or procedure that has not been approved by:

i. The US Food & Drug Administration (FDA); or

ii. The European Medicines Agency (EMA); or

iii. The relevant national health authority of the country where treatment is rendered (e.g., Health Ministry, Pharmaceutical Authority), in accordance with that authority's standards for clinical efficacy and safety. The Company retains discretion to cover emerging treatments approved by internationally recognised oncology or medical societies (e.g., ASCO, ESC) if deemed medically necessary by the Attending Physician;

(i) Outpatient treatment of mental and nervous conditions, except for services claimed under the Psychiatric and Mental Disorders benefit, where specifically provided in the benefits schedule;

(j) Intentionally self-inflicted injury, suicide or attempted suicide, whether sane or insane;

(k) Screening and Treatment of venereal diseases and their sequelae;

(l) Obesity or weight loss treatment/management or bariatric surgery;

(m) Developmental abnormalities including learning difficulties, behavioural problems and issues of physical development;

(n) Treatment for Persistent Vegetative State or permanent neurological damage ceasing after ninety (90) days from commencement of treatment;

(o) HIV and/or HIV related illnesses including AIDS, ARC and any mutation, derivation or variation, manifesting within five (5) years from the Insured Person's effective date;

(p) Prostheses, orthotic devices, corrective devices, medical appliances such as CPAP, BP monitor, blood glucose monitor, and appliances not required for a surgical operation;

(q) Participation in any illegal activity or unlawful act;

(r) Expenses incurred for providing medical/hospital bills, certificates, documentation, information or other evidence required by the Company;

(s) Sleeping disorders including treatment for insomnia, sleep apnoea, narcolepsy, restless legs syndrome (RLS), parasomnias, and circadian rhythm disorder;

(t) Travel or accommodation costs, or costs arising from personal travel and accommodation;

(u) Injury sustained while participating in (including practice/conditioning for) any sport contest or competition including but not limited to auto/car racing, professional sport, contact sport, motorcycle racing, powerboat racing, dressage competition. Professional sport refers to participation in sport for which the Insured Person is paid, including but not limited to scholarships, monetary awards, steady periodic income, or multi-year/season contracts;

(v) Extreme and high risk sports or activities, such as skydiving, parasailing, hang gliding, flying (other than as a fare paying passenger on a duly licensed commercial aircraft), caving, rock or mountain climbing (with or without equipment), trekking to a height of over 4,000 meters, bungee jumping, non-recreational scuba diving, scuba diving below thirty (30) meters, polo, steeple chasing or other hazardous activity unless declared and accepted; deliberate exposure to exceptional danger (except to save human life);

(w) Disability or Treatment of any Condition which arises directly or indirectly from, is caused by, or is in any way connected with:

i. War (whether declared or not), acts of foreign hostility, civil war, rebellion, revolution, insurrection, military or usurped power, mutiny, riot, strike, martial law, state of siege, or any attempt to overthrow a government;

ii. Military service or participation in military operations;

iii. Nuclear, biological, or chemical contamination;

iv. Any act of terrorism, except where the Insured Person is injured as an innocent bystander and is not taking part in such act, in which case benefits shall be payable up to a maximum of US$100,000 per incident; or

v. The Insured Person's participation in, or attempted participation in, any illegal, unlawful, or criminal act.

(x) No cover is provided for any claim or benefit to the extent that provision of such cover, payment of such claim, or provision of such benefit would expose the Company to any sanction, prohibition, or restriction under applicable laws or regulations, or any jurisdiction applicable to the Company.

39. HIGH-COST COUNTRY OPTION

(a) This High-Cost Country Option is available exclusively to Insured Persons whose Country of Residence is within APAC, as determined by the Company.

(b) For Hospitalisation Treatment and non-surgical cancer treatment received in Hong Kong or Singapore, the Company will apply a cost-sharing provision under which seventy percent (70%) of Eligible Expenses are reimbursable by the Company, with the remaining thirty percent (30%) Co-insurance payable by the Insured Person, subject to the Policy Year maximum and any applicable Deductibles.

(c) These cost-sharing provisions apply notwithstanding the billing label or place of service code used by the provider. Coverage under this option extends to all qualifying Hospitalisation Treatments.

(d) For purposes of reimbursement, the Co-insurance provision is applied first, followed by the annual Deductible.

40. SEVERABILITY

If any provision of this Policy is held to be invalid, illegal, or unenforceable by any competent court, tribunal, regulator, or authority, such provision shall be deemed modified to the minimum extent necessary to make it valid, legal, and enforceable. If such modification is not possible, the relevant provision shall be deemed severed from this Policy. The validity, legality, and enforceability of the remaining provisions shall not be affected.

OPTIONAL BENEFITS

Optional benefits require additional premium as specified on the Application. They may only be purchased at Policy inception or upon each renewal and no midterm addition is available. An optional benefit applies only if the relevant rider is attached and premium received. No refund is made on termination of optional benefits. Because the nature of cover differs, certain conditions herein are modified for Optional Benefits.

OPTIONAL DENTAL CARE BENEFITS (when a Dental Care Rider is attached)

The Insured Person may select from the optional Dental Benefit under Pulse or Complete option, a waiting period of eight (8) months is applicable for each Insured Person. This benefit is only available for selection at policy inception or upon each renewal.

OPTIONAL MATERNITY BENEFIT (when a Maternity Rider is attached)

The Insured Person may select from the optional Maternity Benefit under Pulse or Complete option. A waiting period of twelve (12) months applies for each Insured Person. This benefit is only available for female Policyholder or spouse at policy inception or upon each renewal.

Eligible Expenses during pregnancy are payable subject to the following periods and conditions:

- For normal pregnancy and delivery, and for Complications of Pregnancy (as defined in Clause 1, but excluding miscarriage and therapeutic abortion): the Insured Person must have been continuously insured under this Policy for at least twelve (12) consecutive months, and conception must occur after such 12-month period. No benefits are payable for any pregnancy where conception occurred during the waiting period, regardless of when the first expense is incurred.
- All pregnancy related Expenses incurred due to a Disability during pregnancy are payable within maternity benefit limit.
- This benefit includes all pre-natal and post-natal care, hospital room and board, Professional Fees (except paediatrician), Miscellaneous Charges and up to seven (7) days of nursery care, and complications arising after childbirth. Nursery care includes infant formula, room-in costs and newborn screening as reasonable in the jurisdiction, subject to the Company's determination after consultation with medical advisors.
- Expenses due to miscarriage and therapeutic abortion (certified as medically necessary to avoid danger to the mother's life or physical health) are covered provided the Insured Person has been insured under this Policy for not less than ninety (90) consecutive days before the date of such event.

OPTIONAL OPTICAL CARE BENEFITS (when an Optical Care Rider is attached)

The Insured Person may select from the optional Optical Care Benefit under Pulse or Complete option. This benefit is only available for selection at policy inception or upon each renewal. Expenses for corrective eye surgery for refractive error and related complications are not covered.

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