YOUR BOWTIE CANCER MEDICAL PLAN
Cancer Fighter – 2M

Reading this because you want to make a claim? Contact us anytime at cs@bowtie.com.hk.

If you need help with anything else, get in touch by calling us at 3008-8123 or through our live chat on our website www.bowtie.com.hk.

Proudly Made in Hong Kong

Welcome to Bowtie.

We're glad to have you trust us.

This is your policy agreement. For this insurance to work, there needs to be a legal agreement between you and Bowtie. This protects you, as well as other policy holders and us.

At Bowtie, we believe insurance should be transparent and friendly. We want to make sure you know what you're getting, so we've tried to make this as easy-to-understand as possible. Here's an outline of the rest of this agreement:

Chapter 1 **What your Plan is** Sets out what your insurance benefits are, and how to claim them.	(a) Part 1: Summary — key facts and figures about your Plan
	(b) What are your benefits (i) Part 2: What is covered — what benefits you have, and when they can be used (ii) Part 3: What is not covered — situations where benefits are not provided
	(c) Part 4: How to claim — what you need to know if you are to make a claim
Chapter 2 **What makes this a valid and legal agreement between you and Bowtie** Sets out your responsibilities and rights under this Plan, other parts to a legal agreement, and what certain words mean.	(a) What are your responsibilities and rights (i) Part 5: What you need to do to keep this agreement valid (ii) Part 6: What changes you can make to this Plan
	(b) Part 7: What else makes this a valid legal agreement — the other legal terms and conditions completing this agreement
	(c) Part 8: What terms mean — explains the meaning of certain words used in this agreement

It is very important that you check the following document(s) on our electronic platform which, taken together with this document, form your Plan:

1. **Policy Schedule** - This customizes this agreement to you. It contains the information you provided us with, which we used to determine your policy.

Other documents important to your agreement are:

1. **Our terms of service** - This sets out your contract with us in using our electronic platform and other services.
2. **Our privacy policy** - This sets out how we use and protect your data.

Bowtie would strongly encourage you to read the relevant documents carefully at the start of your coverage. You can conveniently access these anytime from our electronic platform. Please make sure you are familiar with the scope of coverage to ensure you have the cover that you wanted. If you have any questions about these documents, please do not hesitate to get in touch with us at hello@bowtie.com.hk, or any of the other customer service channels we offer.

Bowtie strives to be environmentally friendly and endeavours to be paperless, so we use electronic communications as much as possible. It is essential that you keep us up-to-date with your contact information, including your email address and mobile phone number, so we can reach and update you when it's important to do so.

What your Plan contains

Chapter 1: What your Plan is **6**

Part 1: Summary **7**

1.1 Your cover in brief 7

1.2 Benefit Summary 9

Part 2: What is covered **14**

2.1 When are you covered 14

2.2 What are your Cancer Diagnosis and monitoring benefits 16

2.3 What are your Inpatient and Day Case Procedure benefits 17

2.4 What are your treatment and medication benefits 19

2.5 What are your supplementary benefits 20

2.6 What is your compassionate death benefit 21

Part 3: What is not covered **22**

3.1 What is excluded 22

Part 4: How to claim **24**

4.1 Notice of claim 24

4.2 Filing proof of claim 24

4.3 Medical examination 24

4.4 Other insurance 24

Chapter 2: What makes this a valid and legal agreement between you and Bowtie **26**

Part 5: What you need to do to keep this agreement valid **27**

5.1 What information we rely on from you 27

5.2 What if there is a misstatement of Age and/or sex 27

5.3 What if there is a misstatement of smoking habit 28

5.4 Premium payment, default and grace period 28

5.5 Change in Place of Residence 28

Part 6: What changes you can make to this Plan **30**

6.1 Who is the owner of the Plan 30

6.2 How to change ownership of the Plan 30

6.3 Whom we make payment of benefits to 31

6.4 How to change the Beneficiary 31

6.5 What are your cancellation rights within the cooling-off period 31

6.6 What are your cancellation rights after the cooling-off period 32

6.7 What is your guaranteed Renewal right 32

Part 7: What else makes this a valid legal agreement **33**
7.1 Enforceable agreement 33
7.2 Compliance with conditions 33
7.3 Interpretation 33
7.4 Modifications 33
7.5 Currency 34
7.6 Termination 34
7.7 Incontestability 34
7.8 Notices to us 34
7.9 Notices from us 34
7.10 Waiver 34
7.11 No third party rights 35
7.12 Subrogation 35
7.13 Legal action 35
7.14 Governing law and arbitration 35
7.15 Compliance with law 36
Part 8: What terms mean **37**

Chapter 1: What your Plan is

Part 1: Summary

This part summarizes the nature and key features of your Plan. Your coverage is subject to the other Plan Terms and Conditions set out in the rest of this document.

1.1 Your cover in brief

1.1.1 Who is covered

This Plan covers the Insured Person named in the **Policy Schedule**. It is important that you keep the information you have with us up-to-date, especially if you and/or the Insured Person have/has important life events such as relocating outside of Hong Kong.

As long as you pay your premiums and abide by these Plan Terms and Conditions, you will receive the insurance outlined in this agreement. The policy is effective from the Policy Effective Date until the moment you cancel it (see Sections 6.5 and 6.6) or it is terminated (see Section 7.6).

1.1.2 What is covered

We cover you for medical expenses if the Insured Person is Diagnosed with Cancer(s). This includes:

- Diagnostic tests for investigation and confirmation of a Covered Cancer, including procedures such as laboratory tests, CT scans and excisional biopsy - see Section 2.2.1(a);
- Treatment costs, including surgery and medication costs, the costs for Inpatient hospital stays, as well as advanced treatments such as targeted therapy and immunotherapy - see Sections 2.3 and 2.4; and
- Follow-up costs for the monitoring, evaluation and recovery of your condition, including medical tests for up to five (5) years after the completion of Active Treatment, physiotherapy, and reconstructive surgery - Section Sections 2.2.1(b), 2.4 and 2.5.

The purpose of this policy is to help cover medical expenses if the Insured Person is definitively diagnosed with Cancer, so diagnostic tests which do not lead to a confirmed diagnosis are not covered. Cancers diagnosed before the Policy Effective Date or occurring within ninety (90) days after the Policy Effective Date are also not covered.

These are explained in more detail in Part 2. It is also important that you understand the conditions under which you may not be covered, and this is explained in Part 3.

Your policy covers you worldwide.

1.1.3 How much is covered

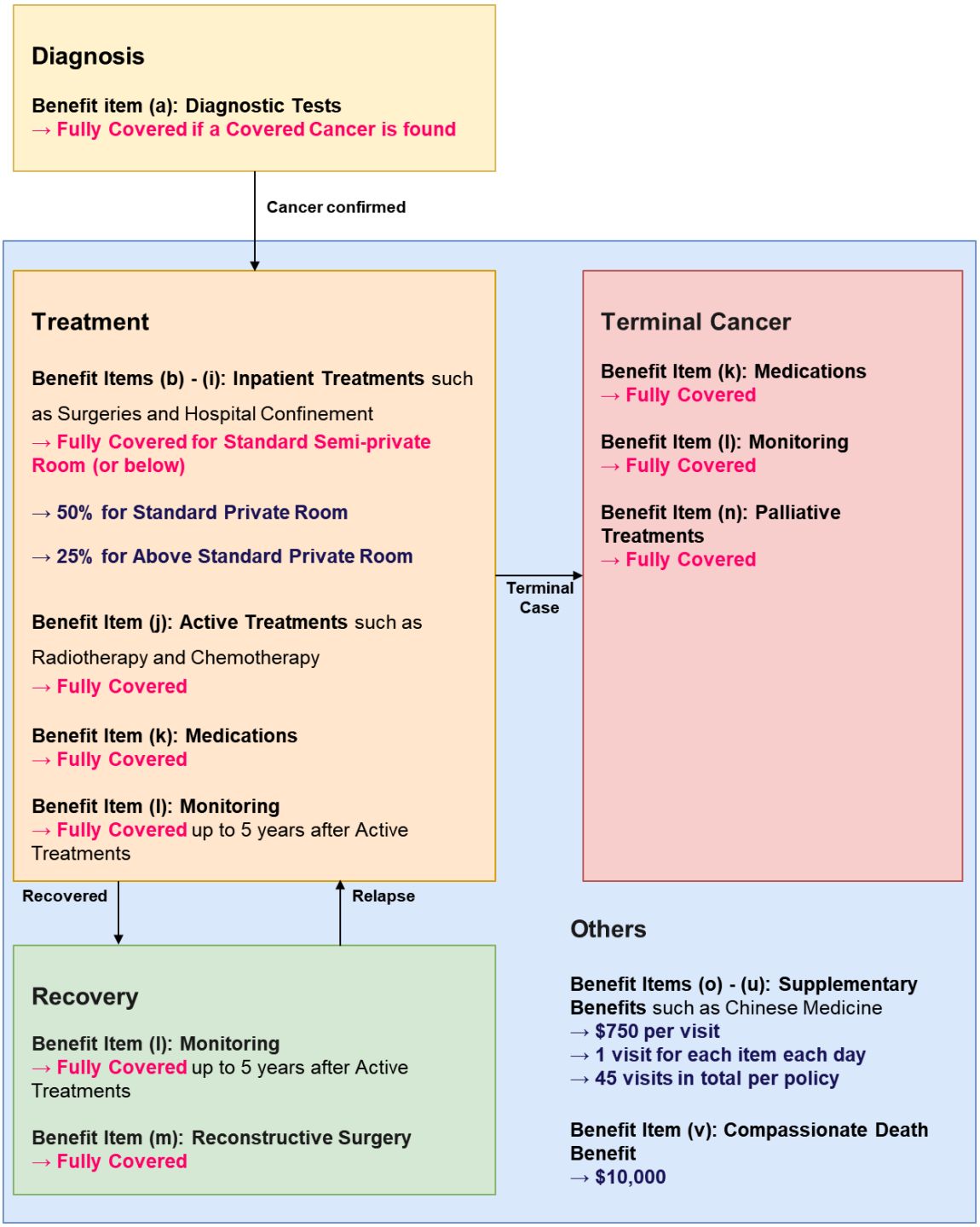
We will reimburse the actual medical expenses up to certain dollar amounts. These amounts, often known as benefit limits, are generally applied on either a “per policy” or “per visit” basis. There may also be a limit to the total number of visits under the Plan. There are also total benefit limits respectively for every three-year period starting from the date of first Diagnosis of the first Covered Cancer and for the entire effective period of the Plan.

The actual dollar amounts and limits are specified in your Benefit Summary (see Section 1.2).

1.2 Benefit Summary

Coverage	**Medical Services incurred from Covered Cancer(s)** — payable for the actual expenses for necessary Medical Services which are incurred from Covered Cancer(s).
Area Cover	**Worldwide**
Claim Method	**Reimbursement** — 1. We will reimburse the actual medical expenses arising from Covered Cancer(s) according to the benefit items and limits listed in the table below. 2. Same Eligible Expenses item will only be reimbursable under one benefit item. 3. If the Insured Person is entitled to a refund of all or part of such expenses from other source(s), we will only be liable for an amount in excess of the amount recovered from such other source(s).
Waiting period	**90 days** — Any Cancer occurring during the first 90 days after Policy Effective Date is not covered.
Benefit Limit	Limit 1: **Conditional item benefit limits** for benefit items (a) - (i) and **item benefit limits** for benefit items (o) - (u), and (v) — Learn more about what each benefit item refers to in the next section. Limit 2: **$1,000,000** for the first 3 years from the date of Diagnosis of the first Covered Cancer Limit 3: **$1,000,000** for every 3-year period after the 3-year period noted under Limit 2 above Limit 4: **$2,000,000** per policy **Bowties fully covers all benefits items, as long as the reimbursement does not exceed the above limits.** — Learn more about how Bowtie covers them in the next section.

The following chart provides an overview on which benefit item would be of value to you at each Cancer phase:



Benefit Items & Their Limits (if any)	Phase
Bowtie Fully Covers: **(a) Diagnostic Tests (if a Covered Cancer is found)** — including but not limited to Laboratory tests, Imaging (X-Ray / Ultrasound / CT / MRI / PET Scans), fine needle aspiration (cytology or histopathology), and excisional biopsy (histopathology).	**Diagnostic**
Bowtie Offers Conditional Full Coverage on: **(b) Room and board** **(c) Attending doctor's visit fees** **(d) Specialist's fees** **(e) Intensive care** **(f) Confinement miscellaneous charges** **(g) Surgeon's fees** **(h) Anaesthetist's fees** **(i) Operating theatre charges** with the following conditions: • **Semi-private Room (or below): Full Coverage** • **Standard Private Room: 50% of Eligible Expenses** • **Above Standard Private Room: 25% of Eligible Expenses** — For example, if the Insured Person is confined in a room of Above Standard Private Room level, and the Eligible Expenses incurred during Confinement is HK$10,000, the actual benefit payable after applying this adjustment will be: HK$10,000 x 25% = HK$2,500 .	**Treatment**
Bowtie Fully Covers: **(j) Active Treatments** — including but not limited to Radiotherapy, Chemotherapy, Targeted Therapy, Hormonal Therapy & Immunotherapy.	**Treatment**

Bowtie Fully Covers: **(k) Medications** — including but not limited to Anti-nausea drugs, Anti-rejection drugs and Anti-vertigo drugs.	**Treatment** **Terminal Cancer**
Bowtie Fully Covers: **(l) Monitoring** — The charges to monitor the response to treatment, or progress of recovery and follow-up evaluations including: • consultation fees • laboratory tests • imaging procedures • screening tests.	**Treatment** **Terminal Cancer** **Recovery**
Bowtie Fully Covers: **(m) Reconstructive Surgery** — Reconstructive surgery of the head and/or breast due to a Covered Cancer.	**Recovery**
Bowtie Fully Covers: **(n) Palliative Treatments** — Outpatient consultation and treatment with the aim of relieving pain or reducing signs and symptoms of a Covered Cancer.	**Terminal Cancer**

Bowtie Covers: **(o) Chinese Medicine Practitioner Consultation, Acupuncture Treatment and Chinese Medicine** **(p) Dietician Consultation** **(q) Physiotherapy** **(r) Occupational Therapy** **(s) Speech Therapy** **(t) Psychological Counselling and Medication** **(u) Home Nursing** — Maximum 1 Qualified Nurse during any given time slot. subject to the following limits: • **45 visits in total** • **$750 per visit** • **1 visit for each of the above items per day** and offers **$10,000** for**:** **(v) Compassionate Death Benefit**	**Others**

Part 2: What is covered

This part sets out your benefits. The next part, Part 3, tells you when you are not covered.

2.1 When are you covered

2.1.1 We will pay the Eligible Expenses set out in Sections 2.2 to 2.5, where the conditions set out in (a), (b) and (c) below are met:

(a) The Insured Person:

(i) suffers from a **Covered Cancer** or any complications arising from it;

AND

(ii) the Covered Cancer **occurs more than 90 days after the Policy Effective Date**, where a Cancer is regarded as having occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested;

AND

(iii) the Covered Cancer or its complications require(s) **any of the treatments set out below**:

(1) any of the following (as set out in Section 2.2):

a) Diagnostic Tests;

b) Monitoring during Active Treatment and within five (5) years from the date of completion of Active Treatment;

(2) Inpatient Medical Services or Day Case Procedure (as set out in Section 2.3);

(3) any of the following (as set out in Section 2.4):

a) Active Treatments;

b) Palliative Treatments;

c) Medications;

d) Reconstructive surgery;

(4) any of the following (as set out in Section 2.5) as recommended by a Registered Medical Practitioner in writing:

a) Chinese Medicine Practitioner consultation;

b) Dietician consultation;

c) Physiotherapy;

d) Occupational therapy;

e) Speech therapy;

f) Psychological counselling;

g) Home nursing.

AND

(b) The Eligible Expenses are:

(i) incurred while the Plan is **effective and in force**;

AND

(ii) for Medical Services:

(1) provided only **to the Insured Person and no one else**; and

(2) set out in Sections 2.2 to 2.5 below;

AND

(iii) **Reasonable and Customary**.

AND

(c) The amount of Eligible Expenses payable does not exceed any of the following:

(i) the **actual costs** for the Medical Services;

(ii) the **limits as stated in the Benefit Summary** set out in Section 1.2 above.

2.1.2 Ward class adjustment

All benefits described in these Plan Terms and Conditions are not subject to any restriction in the choice of ward class in Hospital.

However, if the Insured Person is Confined in a room of a higher level than Standard Semi-Private Room, the amount of any benefit payable under Section 2.3 during Confinement shall be reduced to a percentage of the benefit that would otherwise have been paid. This percentage is set out in the following table:

Level of room in which the Insured Person is Confined	Percentage of benefit payable under Section 2.3 during Confinement
Standard Ward Room	100%
Standard Semi-Private Room	100%
Standard Private Room	50%
Above Standard Private Room	25%

2.2 What are your Cancer Diagnosis and monitoring benefits

2.2.1 Eligible Expenses payable for Diagnosis and monitoring pursuant to Section 2.1 above are as follows:

(a) Diagnostic Tests

The charges for Diagnostic Tests in a Hospital or clinic under the supervision of a Registered Medical Practitioner.

For the avoidance of doubt, any charges incurred in respect of routine health screenings which are not for the specific purpose of identifying the existence, nature or extent of a Covered Cancer are not covered, regardless of the results of such screenings.

(b) Monitoring

The charges to monitor the response to treatment, or progress of recovery and follow-up evaluations including:

(i) Consultation fees;
(ii) Laboratory tests;
(iii) Imaging procedures; and
(iv) Screening Tests.

This benefit covers the monitoring and evaluation received during Active Treatment and within five (5) years from the date of completion of Active Treatment. For the avoidance of doubt, any routine health screenings which are not for the specific purpose of monitoring a Covered Cancer shall not be covered.

2.3 What are your Inpatient and Day Case Procedure benefits

2.3.1 Eligible Expenses for Inpatient Medical Services and Day Case Procedure pursuant to Section 2.1 above are as follows:

(a) Room and board

The cost of accommodation and meal charged by the Hospital other than intensive care service charges in (d) below.

(b) Attending doctor's visit fees

The charges of the attending Registered Medical Practitioner for a consultation with the Insured Person.

(c) Specialist's fees

The charges of the Specialist for a consultation with the Insured Person. Such consultation must be recommended in writing by the attending Registered Medical Practitioner.

(d) Intensive care

The charges for intensive care services during the Insured Person's admission to an Intensive Care Unit.

(e) Confinement miscellaneous charges

Miscellaneous charges for:

(i) Road ambulance service to and/or from the Hospital;
(ii) Anaesthetic and/or oxygen administration;
(iii) Administration charges for blood transfusion;
(iv) Medicine, drug, Intravenous ("IV") infusions, and dressing and plaster casts prescribed and consumed during Confinement or any Day Case Procedure;
(v) Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
(vi) Surgical appliances, equipment and devices, that are not operating theatre charges as defined in (h) below;
(vii) Disposables, consumables, equipment and devices of a medical nature, that are not operating theatre charges as defined in (h) below;
(viii) Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, that are not Diagnostic Tests charges as defined in Section 2.2;
(ix) Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
(x) Rental of walking aids and wheelchairs; and
(xi) Physiotherapy, occupational therapy and speech therapy during Confinement.

(f) Surgeon's fees

The charges of the attending Surgeon's fee for a surgical procedure.

(g) Anaesthetist's fees

Where a Surgeon's fee is payable under (f) above, the charges of the Anaesthetist in relation to the surgical procedure.

(h) Operating theatre charges

Where a Surgeon's fee is payable under (f) above, charges for the use of an operating theatre, a treatment room and/or recovery room during the surgical procedure.

Any charges for surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be payable only under (e) above.

2.4 What are your treatment and medication benefits

2.4.1 Eligible Expenses for treatments and medications payable pursuant to Section 2.1 above are as follows:

(a) Active Treatments

The charges for Outpatient consultations with a Registered Medical Practitioner and for Active Treatments, including but not limited to radiotherapy, chemotherapy, targeted therapy, hormonal therapy, immunotherapy, proton therapy and day surgery.

For the avoidance of doubt, Eligible Expenses incurred for radiotherapy include the consultation fee for the planning session and consumables specified for the purpose of radiotherapy.

(b) Palliative Treatments

The charges for Outpatient Palliative Treatments by a Registered Medical Practitioner.

(c) Medications

The charges for medications prescribed during Active Treatments or Palliative Treatments, including but not limited to anti-nausea drugs, anti-rejection drugs, anti-vertigo drugs and anodyne. Long-term medication for Active Treatments or Palliative Treatments is also covered.

(d) Reconstructive Surgery

The charges for plastic or reconstructive surgeries on the head or on the breast (including costs of any implants) to restore function or appearance following previous surgery(ies) on the head or breast done for treatment of a Covered Cancer, where such plastic or reconstructive surgeries are Medically Necessary and recommended in writing by the Insured Person's attending Registered Medical Practitioner. Surgery solely for isolated dental restorations is excluded.

2.5 What are your supplementary benefits

2.5.1 Eligible Expenses for supplementary Medical Services payable pursuant to Section 2.1 above are as follows:

(a) Chinese Medicine Practitioner Consultation, Acupuncture Treatment and Chinese Medicine

The charges for Outpatient consultations with a Registered Chinese Medicine Practitioner, including acupuncture treatment and Chinese medicines prescribed by the Registered Chinese Medicine Practitioner.

(b) Dietician Consultation

The charges for Outpatient consultations with a Registered Dietician.

(c) Physiotherapy

The charges for Outpatient consultations with a Registered Physiotherapist.

(d) Occupational Therapy

The charges for Outpatient consultations with a Registered Occupational Therapist.

(e) Speech Therapy

The charges for Outpatient consultations with a Registered Speech Therapist.

(f) Home Nursing

The charges for nursing service provided to the Insured Person by a maximum of one (1) Qualified Nurse in the Insured Person's home after discharge from Confinement or surgery covered in Section 2.3, where such nursing service is directly related to and as a result of the noted Confinement and/or surgery.

(g) Psychological Counselling and Medication

The charges for Outpatient consultations with a Registered Clinical Psychologist or Registered Psychiatrist for psychological counselling and prescribed medications.

2.5.2 Eligible Expenses referred to in Section 2.5.1 above are subject to the limits set out in the Benefit Schedule set out in Section 1.2 above.

2.5.3 Eligible Expenses referred to in Section 2.5.1 excludes Eligible Expenses referred to in Section 2.3, such that all expenses incurred during Confinement and Day Case Procedures shall not be reimbursed under this section.

2.6 What is your compassionate death benefit

2.6.1 While this Plan is in force, upon the death of the Insured Person, whether due to Covered Cancer or natural causes, this benefit shall be payable in the amount as stated on the Benefit Schedule set out in Section 1.2 above.

Part 3: What is not covered

3.1 What is excluded

3.1.1 Except for the compassionate death benefit under Section 2.6 above, no payment will be made under the Plan for expenses caused directly or indirectly, wholly or partly by any of the following:

(a) **Confinement solely for diagnostic procedures**: the whole (or part) of the Confinement solely for the purpose of diagnostic procedures or allied health services. The exception is where a Registered Medical Practitioner confirms in writing that such procedure or service is for Medically Necessary investigation and that it cannot be effectively performed in a setting for providing Medical Services to a Day Patient, rendering Confinement necessary;

(b) **Treatment without definitive diagnosis of Cancer:** any treatment modality undergone without a definitive diagnosis of the presence of Cancer in the Insured Person's body;

(c) **General check-ups:** general check-up (whether with or without any positive findings(s) of Cancer on the Insured Person), convalescence, custodial or rest care not related to a Covered Cancer; screening or check-ups looking for the presence of Covered Cancer on a preventative basis or where there are no symptoms or history of Covered Cancer, except where such screening or check-ups are covered under Section 2.2.1;

(d) **Vaccines:** vaccines for the prevention of Cancer;

(e) **Non-medical services:** non-medical services, including but not limited to guest meals, radio, telephone, photocopy, taxes, personal items, medical report charges and the like;

(f) **Unproven procedures:** any experimental, unproven or unconventional medical technology/ procedure/ therapy or novel drugs/ medicines/ stem cell therapy not yet approved by the government, relevant authorities and/ or recognized medical association of the country or region where the treatment is sought;

(g) **Tests for genetic predispositions:** genetic tests undertaken to test for a genetic predisposition to Cancer;

(h) **Pre-existing or congenital conditions:** including any congenital Cancer that gave rise to signs or symptoms, or was diagnosed, before the Insured Person attains seventeen (17) years of age;

(i) **Cosmetic purposes:** Medical Services for beautification or cosmetic purposes, except where such Medical Services are covered under Section 2.4.1(d);

(j) **Visual correction:** correcting visual acuity or refractive errors that can be corrected by the fitting of spectacles or contact lens. This includes, but is not limited to, eye refractive therapy, LASIK and any related tests, procedures and services;

(k) HIV and AIDS: any Cancer (and its complications) under the presence of human immunodeficiency virus (HIV) and/or any HIV-related illness including AIDS and/or any mutations, derivations or variations thereof;

(l) Already reimbursed: treatment of any Disability for which expenses have been reimbursed under any law, medical program, or insurance policy provided by any government, company or other third party;

(m) Drugs and illegal activities: Cancers (and its complications) arising from, or consequential upon:

(i) the dependence, overdose or influence of any of drugs, alcohol, narcotics or similar drugs or agents;
(ii) illegal activity;
(iii) violation or attempted violation of the law;
(iv) venereal and sexually transmitted disease or its sequelae (except for HIV and its related Disability);

(n) Medications and supplements that were not prescribed: narcotics or over-the-counter medication and nutrient supplement not prescribed by a Registered Medical Practitioner;

(o) Nuclear, biological, and chemical activities: Cancers (and its complications) arising from nuclear, biological and chemical related activities. This includes, but is not limited to, nuclear fission, nuclear fusion, ionizing radiation or contamination by radioactivity from any nuclear fuel, from nuclear waste resulted from combustion of nuclear fuels or nuclear weapons, or any act of nuclear, chemical or biological terrorism, including but not limited to the use of nuclear, biological or chemical weapons and agents; and

(p) Mental disorders: mental disorder, psychological or psychiatric conditions, behavioural problems or personality disorder except where such Medical Services are covered under Section 2.5.1(g).

3.1.2 If we would be exposed to any Sanctions by providing any benefit to you, then we will not provide cover and we are not liable to pay any claim or provide any benefit under this Plan.

3.1.3 If the Insured Person dies by suicide, whether sane or insane, within one (1) year of the Policy Issuance Date, our liability will be limited to premiums paid.

3.1.4 If we allege that, by reason of this Part 3, any loss, damage, cost or expense is not covered by this Plan, then the burden of proving the contrary shall be upon you.

Part 4: How to claim

This part sets out what is required of you for making a claim under your Plan.

4.1 Notice of claim

4.1.1 All cases of death must be notified immediately to us.

4.1.2 Other claims must be submitted to us within ninety (90) days after the covered event happens.

4.1.3 The claim will not be invalidated solely by reason of failure to give notice as required by Sections 4.1.1and 4.1.2 above if it is shown that:
(a) it was not reasonably possible to give the required notice; and
(b) notice of claim was given as soon as reasonably possible.

4.2 Filing proof of claim

4.2.1 Your proof of claim must be accompanied by supporting documents, forms and information that we require, at your expense, within ninety (90) days after the covered event, unless we specify otherwise.

4.2.2 We may require any additional proof in support of the claim, including but not limited to originals of any documents and receipts showing itemized expenses.

4.2.3 To be fair to other policy holders, if you submit a claim which is in any respect fraudulent, unfounded, incorrect, incomplete or misleading, or if you withhold any information or conspire with a third party to obtain a benefit from this Plan, we may:

(a) declare this Plan void from the Policy Effective Date. If this happens, our liability under this Plan will be limited to returning the premiums paid without interest and we reserve the right to recover any benefit previously paid; or

(b) preserve this Plan and we reserve the right to recover any benefit previously paid in relation to any claim which is not eligible.

4.3 Medical examination

4.3.1 We may require any additional proof and request medical examination of the Insured Person at your cost. In case of death, we may require, if appropriate and legally allowable, an autopsy at your cost.

4.4 Other insurance

4.4.1 If you and/or the Insured Person is insured by one or more insurance policies other than this Plan, you may claim under any such other insurance policies or this Plan. If, however, you or the Insured Person have already recovered all or part of the expenses from any such

other insurance policies, we will only be liable for such amount of a claim and/or benefits, if any, which is not paid under any such other insurance policies.

Chapter 2: What makes this a valid and legal agreement between you and Bowtie

Part 5: What you need to do to keep this agreement valid

This part sets out the responsibilities you have as the owner of this Plan, including what you must do if there are changes in the Insured Person's Place of Residence, and what happens if you do not do what is required.

5.1 What information we rely on from you

5.1.1 We rely on the information you provided in the Application in deciding whether or not to accept the Application. We also rely on that information to decide whether or not to apply Case-based Exclusion(s) and/or Premium Loading to this Plan. We will treat all statements made in the Application to be representations and not warranties.

5.1.2 If the Application omits facts or contains materially incorrect or incomplete facts, we reserve the right to declare this Plan void from the Policy Effective Date. If this happens, our liability under this Plan will be limited to returning the premiums paid without interest. We reserve the right to recover any benefit previously paid.

5.1.3 If your premiums are based on incorrect or incomplete information and we later have to change the premiums based on the correct and complete information, we will collect (or refund) the difference, and this may include imposing Case-based Exclusion(s) and/or Premium Loading on this Plan. Such changes shall apply from the Policy Effective Date retrospectively.

5.2 What if there is a misstatement of Age and/or sex

5.2.1 If the Insured Person’s Age and/or sex is misstated in the Application, the amount payable by us under this Plan will be adjusted on the basis of the correct Age and sex. The amount payable will be adjusted at the time we make any payment under this Plan:

(a) Where a higher premium would have applied, we will reduce the benefit payable based on what the premiums paid would have provided at the Insured Person’s correct Age and sex.
(b) Where a lower premium would have applied, we will refund any surplus premium paid without interest.
(c) Where the Insured Person would not have satisfied our insurability requirements on the basis of the correct Age and sex, we may declare this Plan void from the Policy Effective Date. If this happens, our liability under this Plan will be limited to returning the premiums paid without interest. We may recover any benefit previously paid to you.

5.2.2 We may require proof of the Insured Person’s Age to our satisfaction at your cost at the time of processing the Application and any claim or payment of any benefit under this Plan.

5.3 What if there is a misstatement of smoking habit

5.3.1 This Plan is issued on the basis of the Insured Person's declared smoking habits. If the Insured Person is a smoker as at the date of Application, but is not disclosed in the Application, we may declare this Plan void from the Policy Effective Date. If this happens, our liability under this Plan will be limited to returning the premiums paid without interest. We may recover any benefit previously paid to you.

5.4 Premium payment, default and grace period

5.4.1 While the Insured Person is alive, all premiums are payable to us on or before their due dates.

5.4.2 After payment of the first premium, failure to pay a subsequent premium on or before its due date constitutes a default in premium payment.

5.4.3 We allow a grace period of thirty-one (31) days after the premium due date for payment of each premium. This Plan will continue to be in effect during the grace period, but no benefits shall be payable unless the premium is paid. If the premium is still unpaid in full at the expiration of the grace period, this Plan shall be terminated immediately on the date on which the unpaid premium is first due.

5.5 Change in Place of Residence

5.5.1 You must inform us of any change of Place of Residence (i.e. the jurisdiction(s) in which a person legally has the right of abode) of the Insured Person by giving us at least thirty (30) days' notice prior to the date of the next Renewal.

5.5.2 Upon our receipt of the notification given pursuant to Section 5.5.1 above, we will endorse the change of Place of Residence of the Insured Person in writing, subject to:

(a) Section 5.5.3 below; and

(b) the application of any new Premium Loading to your policy upon Renewal to reflect any change in risks associated with the change of Place of Residence of the Insured Person.

5.5.3 If the new Place of Residence of the Insured Person is subject to Sanctions or war (declared or undeclared), civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power, we will consider the notification given pursuant to Section 5.5.1 above on a case-by-case basis, and may, at our absolute discretion:

(a) endorse the change of Place of Residence of the Insured Person, subject to the application of any new Premium Loading upon Renewal to reflect any change in risks associated with the change of Place of Residence of the Insured Person; or

(b) decide not to Renew the Plan and refund any premium(s) paid for the period in which no cover will be in place without interest.

5.5.4 Unless otherwise specified, this Plan contains no restrictions with respect to where the Insured Person travels to, studies or works.

Part 6: What changes you can make to this Plan

This part sets out what you can change as the owner of this Plan, including changing owners and beneficiaries.

6.1 Who is the owner of the Plan

6.1.1 You are the only person entitled to exercise any right or privilege provided under this Plan.

6.2 How to change ownership of the Plan

6.2.1 You may request transfer of the ownership of this Plan by notifying us. Approval of such request is entirely at our discretion.

6.2.2 Any change of ownership shall not be effective until we have approved it and notified you and the transferee of the approval in electronic or written form.

6.2.3 If the Policy Holder dies, the ownership of this Plan shall be transferred to the administrator or executor of the estate of the Policy Holder.

6.2.4 The transfer of ownership of this Plan:

(a) in accordance with Section 6.2.1 above shall be conditional upon our receipt of the proposed transferee's consent to be bound by the Plan Terms and Conditions; and
(b) in accordance with Section 6.2.3 shall be conditional upon our receipt of satisfactory evidence of your death and the proposed transferee's consent to be bound by the Plan Terms and Conditions.

6.2.5 From the effective date of the change of ownership, the transferee will become the Policy Holder, and will be subject to all the Plan Terms and Conditions. The transferee will become the absolute owner of this Plan and be responsible for the payment of premiums, including any outstanding premiums.

6.3 Whom we make payment of benefits to

6.3.1 During the lifetime of the Insured Person, all benefits (except death benefits) payable under this Plan will be paid to you if you are alive, or otherwise to your estate.

6.3.2 If the Insured Person dies, then any death benefit payable under this Plan will be paid to the Beneficiary (unless otherwise provided under applicable law). If no Beneficiary survives the Insured Person then the death benefit and all other benefits (if any) will be paid to you if you are alive, or otherwise to your estate.

6.3.3 Payment of the death benefit and all other benefits payable under this Plan to the above person(s) in the manner pursuant to this Section 6.3 shall be deemed a good and full discharge of our obligations under this Plan.

6.4 How to change the Beneficiary

6.4.1 While this Plan is in force, and to the extent permitted by law, you may change the designated Beneficiary by sending an electronic or written notice to us using our prescribed form. A change of Beneficiary will not be valid unless:

(a) such change has been confirmed by us in electronic or written notice; and
(b) you are able to provide sufficient evidence to satisfy us that there are no existing statutory or other trusts that have arisen or been created;[1] and
(c) both you and the Insured Person are alive at the date of such confirmation; and
(d) such change is evidenced by a written endorsement issued by us.

6.5 What are your cancellation rights within the cooling-off period

6.5.1 You may cancel the Plan and receive a full refund of premium so long as:

(a) We receive a notice from you requesting that we cancel the Plan within twenty-one (21) days after the Policy Issuance Date; and
(b) No benefit payment has been made, is to be made, or is pending during the twenty-one (21) day period noted in (a) above .

6.5.2 Your right to cancel under Section 6.5.1 above does not apply at Renewal.

6.5.3 If you cancel the Plan in accordance with Section 6.5.1 above:

(a) we will consider the Plan void from the Policy Effective Date;
(b) the premium paid will be fully refunded to you without interest;
(c) we will not be liable to make any payment under the Plan Terms and Conditions.

[1] This is to protect the position where a statutory trust arises under section 13 of the Married Persons Ordinance.

6.6 What are your cancellation rights after the cooling-off period

6.6.1 You may cancel the Plan at any time by giving us at least ten (10) working days' notice.

6.6.2 If you give us notice under Section 6.6.1 above, we will consider the Plan void from the Plan Monthiversary after the month in which the 10-working-day period noted above expires, and your Plan will remain effective before the noted Plan Monthiversary.

6.7 What is your guaranteed Renewal right

6.7.1 Subject to Section 5.5.3(b), you have a guaranteed right to Renew this Plan during the lifetime of the Insured Person if:

(a) you have complied with all of the Plan Terms and Conditions;
(b) you accept the changes in the Plan Terms and Conditions for Renewal that we offer having regard to the prevailing terms and conditions that we apply to the entirety of all of our customers covered under a plan that is the same or substantially similar.

6.7.2 We have the right to adjust the premium upon Renewal according to the prevailing premium schedule adopted by us on an overall Portfolio basis, but irrespective of the individual claim experience or any changes in the health conditions of the Insured Person. Any adjustment to the premium will be effective upon Renewal.

6.7.3 Except for conditions specified under Sections 5.5.2(b) and 5.5.3(a), we shall notify you of any proposed adjustment to the premium at the next Renewal by giving you at least thirty (30) days' notice prior to the date of the next Renewal.

Part 7: What else makes this a valid legal agreement

This part sets out the other important information needed to form a valid and legal agreement between you and Bowtie.

7.1 Enforceable agreement

7.1.1 This Plan is an insurance policy and is a legally enforceable agreement between you as the Policy Holder and us (Bowtie) as the insurer. The Plan comes into force on the Policy Effective Date provided that you have paid the full amount of the first premium or we have notified you that we have waived your first premium.

7.2 Compliance with conditions

7.2.1 It is a condition precedent to any of our liability to make any payment under this Plan that you and/or the Insured Person (or anyone acting on your behalf) duly observed and fulfilled all the Plan Terms and Conditions insofar as they relate to anything to be done or complied with by you and/or the Insured Person.

7.3 Interpretation

7.3.1 In this Plan, where the context requires, words using the masculine gender shall include the feminine gender, and words referring to the singular case shall include the plural and vice-versa.

7.3.2 Unless otherwise stated, headings, heading descriptions, summary and charts in this Plan are for convenience only and shall not affect its interpretation.

7.3.3 A time of day is a reference to the time in Hong Kong. A day or days in this Plan is a reference to a calendar day, unless otherwise specified.

7.3.4 Unless otherwise defined, capitalised terms used in this Plan and certain lower-case terms shall have the meanings ascribed to them in Part 8 of the Plan.

7.3.5 If there is any inconsistency between the English and Chinese versions of the Plan Terms and Conditions, the English version shall prevail.

7.4 Modifications

7.4.1 No variation to this Plan (or any waiver of any term or condition of this Plan) will be binding unless evidenced by an endorsement issued by us.

7.5 Currency

7.5.1 Any amount payable under this Plan will be made in HKD. Any Eligible Expenses incurred in a foreign currency shall be converted to HKD at a reasonable foreign currency exchange rate chosen by us. We are not legally responsible for any exchange rate-related losses incurred.

7.6 Termination

7.6.1 This Plan shall automatically terminate on the occurrence of the earliest of the following:

(a) the death of the Insured Person;
(b) the termination of this Plan pursuant to Section 5.4 above; and
(c) the date the total amount paid for benefits under this Plan reaches the Lifetime Benefit Limit.

7.6.2 Termination of this Plan shall be without prejudice to any claim arising prior to such termination unless otherwise stated. The payment to or acceptance of any premium hereunder subsequent to termination of this Plan shall not create any liability upon us but we will refund any such premium.

7.7 Incontestability

7.7.1 We will not contest the validity of this policy during the lifetime of the Insured Person or treat it as void after it has been in force for two (2) years from the Policy Effective Date, except for fraud or instances as stated in:

(a) Section 5.4.3 (e.g. non-payment at the expiration of the grace period);
(b) Section 5.5.3(b) (e.g. new Place of Residence subject to Sanctions or war); and
(c) Section 7.15.1 (e.g. the Plan becomes illegal).

7.7.2 This “Incontestability” Section does not apply to any Supplement(s).

7.8 Notices to us

7.8.1 All notices that we require you to give shall be sent to us by electronic or written means.

7.9 Notices from us

7.9.1 Any notice to be given by us under this Plan shall be sent by electronic means to the latest contact you have notified to us. Any notice so served shall be deemed to have been duly received to the Policy Holder on the date and time transmitted.

7.10 Waiver

7.10.1 No waiver by you or by us (each a party) of any breach by the other party of any provision of this Plan will be construed to be a waiver of any subsequent breach of that or any other provision of this Plan and any delay or forbearance by any party in exercising any of its rights under this Plan shall not be construed as a waiver of such rights.

7.10.2 Only those waivers expressly agreed upon will be effective, and the rights and obligations of Bowtie and the Policy Holder under this Plan will remain in full force and effect except and only to the extent that they are expressly waived.

7.11 No third party rights

7.11.1 Any person or entity who is not a party to this Plan (including, but not limited to, the Insured Person or the Beneficiary) shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap. 623 of the Laws of Hong Kong) to enforce any of the Plan Terms and Conditions.

7.12 Subrogation

7.12.1 We will have the right to proceed, in your name or in the name of the Insured Person, against any third party who may be responsible for circumstances giving rise to a claim under this Plan. Exercising of this right will be at our own expense and after we have made a payment under this Plan.

7.12.2 You will provide us with all necessary information and assistance relating to the fault of any such third party and any action we take.

7.12.3 We will be entitled to keep the amount recovered from any such third party to the extent of the amount of benefits we have paid under this Plan.

7.13 Legal action

7.13.1 No legal action shall be brought by you to recover any claim amount payable under these Plan Terms and Conditions within the first sixty (60) days from the date when we received all proof of claims required by these Plan Terms and Conditions.

7.13.2 Subject to applicable law, any action at law or in equity to recover under this Plan shall only be brought within two (2) years from the date of our final decision in respect of any claim herein.

7.14 Governing law and arbitration

7.14.1 This Plan is governed by, and shall be construed in accordance with, the laws of Hong Kong.

7.14.2 We hope to avoid disagreements with you, and prefer to work with you to settle any disagreements. Therefore, any dispute, difference or claim relating to this Plan, including the existence, validity, interpretation, breach or any other dispute regarding non-contractual obligations arising relating to this Plan, shall be referred to and finally resolved by arbitration administered by the Hong Kong International Arbitration Centre (HKIAC) under the HKIAC Administered Arbitration Rules in force when the Notice of Arbitration is submitted. The seat of arbitration shall be Hong Kong and proceedings shall be conducted in English.

7.14.3 If you would like to make a complaint, please contact us anytime at cs@bowtie.com.hk.

7.15 Compliance with law

7.15.1 We may declare this Plan void, if it is or becomes illegal under the law applicable to you and/or the Insured Person, from the date it becomes illegal.

7.15.2 If we declare the Plan void under 7.15.1 above, we will refund the premium we received for the period the Plan is void on a pro rata basis without interest.

7.15.3 In the event any part of this Plan is found to be invalid of unenforceable, the remainder shall remain in full force and effect.

7.15.4 This Plan is intended for sale only in Hong Kong. If you, or anyone else with authority over or otherwise connected to this Plan (such as the Insured Person or the Beneficiary) is temporarily or permanently:

(a) outside of Hong Kong; or
(b) otherwise subject to the laws of any other place,

such that we reasonably believe that by complying with a particular term or condition we would breach any laws of Hong Kong or such other place, then we are entitled not to comply with such term or condition for any period of time we deem necessary, regardless of what such term or condition may provide.

This might include declining to service some of your requests related to this Plan. You agree we will not be liable for any losses, damages, claims, liabilities or costs you or any other relevant person may suffer from our exercise of our rights under this Section. The prior sentence continues to apply even if this Plan is cancelled or terminated for any reason.

Part 8: What terms mean

Under these Plan Terms and Conditions, except as otherwise defined, words and expressions used shall have the following meanings -

“Active Treatment”	shall mean any therapeutic intervention with the aim of prolonging the Insured Person’s life, including but not limited to radiotherapy, chemotherapy, targeted therapy, hormonal therapy, immunotherapy, proton therapy and surgery for a Covered Cancer, including any complications thereof (if applicable). It does not include any treatment given solely as Palliative Treatment.
“Age”	shall mean the attained age of the Insured Person.
“Application”	shall mean the application submitted to us in respect of this Plan. This includes the application form, questionnaires, any documents or information submitted, and any statements and declarations made in relation to the application. This also includes any updates and changes to such information.
“Beneficiary”	shall mean the person or persons designated in the Application as the beneficiary under this Plan (as may be amended from time to time in accordance with this Plan).
“Benefit Summary”	shall mean the summary of benefits contained in Section 1.2 of the Plan which sets out, among other things, the benefit items and maximum benefits covered.
“Cancer”	shall mean any malignant tumor positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. For the purpose of this Plan, "Cancer" shall include all stages of malignant cancer, and Carcinoma-in-situ, but will specifically exclude the following: (a) any tumour which is histologically classified as pre-malignant; (b) abnormal lesions of cervix uteri classified as cervical intra-epithelial neoplasia grade I (CIN I) and grade II (CIN II); and (c) any cancer where HIV infection is also present.
“Carcinoma-in-situ”	shall mean a histologically proven, localized 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.
“Case-based Exclusion”	shall mean the exclusion of a particular Cancer from the coverage of these Plan Terms and Conditions that may be applied by us based on a Pre-existing Condition or factors affecting the insurability of the Insured Person.

"Confinement" or "Confined"	shall mean: (a) an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Services as a result of a Medically Necessary condition for a period of no less than six (6) consecutive hours; or (b) an admission of the Insured Person to a Hospital for Emergency Treatment for the performance of surgical procedures or other Medical Services (no minimum duration is required in this case), where the Insured Person stay in the Hospital continuously for the entire period of admission and as evidenced by a daily room charge invoice issued by the Hospital.
"Congenital Condition(s)"	shall mean: (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.
"Covered Cancer"	shall mean a Cancer which: (a) the Insured Person has been Diagnosed with; and (b) occurs more than ninety (90) days after the Policy Effective Date. For this purpose, a Cancer is regarded as having occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested to the extent which will cause an ordinary prudent person to seek diagnosis, care or treatment In the event of any conflict or discrepancy of opinions relating to the signs or symptoms of a Cancer and their manifestation between a Registered Medical Practitioner and the Insured Person, the Registered Medical Practitioner's opinion prevails.
"Covered Cancer Limit"	shall mean the maximum aggregate amount paid or payable by us under Sections 2.2 to 2.5 for every three (3) consecutive years starting on the date of first Diagnosis of a Covered Cancer, provided that Covered Cancer Limit shall be deemed to be zero upon the total aggregate amount paid under Sections 2.2 to 2.5 during the lifetime of the Insured Person reaching the Lifetime Benefit Limit. The amount of Covered Cancer Limit is specified in Section 1.2.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the Insured Person is not in Confinement.
"Diagnosis" or "Diagnosed"	shall mean the definitive diagnosis of a Cancer made by a Registered Medical Practitioner and approved by us.

“Diagnostic Test(s)”	shall mean: (a) Medically Necessary test or investigation modality leading to the Diagnosis of a Covered Cancer, including but not limited to laboratory tests, X-rays, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), fine needle aspiration for cytology or histopathology, and excisional biopsy for histopathology; or (b) genetic testing to aid the identification of appropriate chemotherapy drugs in respect of the Covered Cancer.
“Disability”	shall mean a Covered Cancer and all complications arising therefrom.
“Eligible Expenses”	shall mean expenses incurred for Medical Services rendered with respect to a Disability.
“Emergency”	shall mean an event or situation that Medical Service is needed immediately in order to prevent death, permanent impairment or other serious consequences of the Insured Person's health.
“Emergency Treatment”	shall mean Medical Services required in an Emergency, the performance of which is within a reasonable period of time from the Emergency.
“HKD”	shall mean Hong Kong dollars.
“Hong Kong”	shall mean the Hong Kong Special Administrative Region of the People’s Republic of China.
“Hospital”	shall mean a lawfully operated institution licensed as a hospital for the care and treatment of injured or ill persons which provides facilities for diagnosis, major surgery and 24-hour nursing service and is not primarily a rest or convalescent home, or similar establishment or, other than incidentally, a place for treatment of alcoholics or drug addicts.
“Inpatient”	shall mean a person who is Confined; and Inpatient medical service(s) shall mean medical services provided to a person who is Confined.
“Insured Person”	shall mean any person whose risks are covered by these Plan Terms and Conditions, and named as the “Insured Person” in the **Policy Schedule**.
“Intensive Care Unit”	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
“Lifetime Benefit Limit”	shall mean the maximum amount of benefits payable by us to you cumulatively since the Policy Effective Date. The limit is specified in the Benefit Summary in Section 1.2 above.
“Medical Services”	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Disability.

"Medically Necessary"	shall mean in respect of Confinement, treatment, procedure, supplies or other medical services, which are, in our opinion – (a) required for, appropriate and consistent with the symptoms and findings or diagnosis and treatment of the Disability; (b) in accordance with generally accepted medical practice and not of an experimental or investigative nature; (c) not for the convenience of the Insured Person, the Policy Holder, the Registered Medical Practitioner or any other person; and (d) not able to be omitted without adversely affecting the Insured Person's medical condition.
"Outpatient"	shall mean a person who is not Confined; and Outpatient medical service(s) shall mean medical services provided to a person who is not Confined.
"Palliative Treatment"	shall mean treatment intended only to improve the quality of the Insured Person's life in the case of a life threatening Covered Cancer by relieving pain or alleviating other symptoms of the Covered Cancer and/or complication(s) thereof, or the side effects of its/their treatment, without any attempt at its/their cure.
"Place of Residence"	shall mean the jurisdiction(s) in which a person legally has the right of abode. A change in the Place of Residence shall mean the situation where a person has been granted the right of abode of additional jurisdiction(s),or has ceased to have the right of abode of existing jurisdiction(s). For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, shall not be treated as a Place of Residence.
"Plan"	shall mean the insurance policy set out in the Plan Terms and Conditions underwritten and issued by us, which is the agreement between you and us.
"Plan Monthiversary"	shall mean the same day as the Policy Effective Date in each succeeding month after the Policy Effective Date while this Plan remains in force. If the day does not exist in the respective month, this shall refer to the last day of that month.
"Plan Terms and Conditions"	shall mean Part 1 to Part 8 of this Plan and including **Policy Schedule** and any Supplement(s).
"Policy Effective Date"	shall mean the first day when these Plan Terms and Conditions become effective as specified in the **Policy Schedule**.
"Policy Issuance Date"	shall mean the date of first issuance of these Plan Terms and Conditions, which is specified in the **Policy Schedule**.
"Policy Schedule"	shall mean the document entitled "Policy Schedule" which contains, among other things, the information you provided to us.
"Policy Year"	shall mean each twelve-month period starting on the Policy Effective Date.

"Portfolio"	shall mean all policies of the same Plan Terms and Conditions and the Benefit Summary.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any sickness, disease, injury, physical, mental or medical condition or physiological degradation, including a Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective Date, whichever is the earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where – (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received relating to it.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by us on you according to the additional risk assessed for the Insured Person.
"Reasonable and Customary"	shall mean, in relation to charges for Medical Services, 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 such as of the same sex and similar Age, for a similar Disability, as reasonably determined by us in utmost good faith. In determining whether a charge is Reasonable and Customary, we will make reference to any or all of the following (if applicable) - (a) treatment or service fee statistics and surveys in the insurance or medical industry; (b) internal or industry claim statistics; (c) gazette published by the Government; (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.
"Registered Chinese Medicine Practitioner", "Registered Clinical Psychologist", "Registered Dietician", "Registered Occupational Therapist" "Registered Physiotherapist", "Registered Psychiatrist", "Qualified Nurse" and "Registered Speech Therapist"	shall mean a person who is legally recognized to perform services in the specialist area of their titled profession by the relevant government-recognised registration body in Hong Kong, or a body of equivalent standing in at the place of treatment (as reasonably determined by us in utmost good faith) if such treatment is received outside Hong Kong. If the practitioner is neither duly recognized as specified above, we have the discretion to exercise reasonable judgement to determine whether such practitioner shall nonetheless be considered qualified and registered. Notwithstanding the above, in no circumstance "Registered Chinese Medicine Practitioner", "Registered Clinical Psychologist", "Registered Dietician", "Registered Occupational Therapist", "Registered Physiotherapist", "Registered Psychiatrist", "Qualified Nurse" and "Registered Speech Therapist" shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by us in electronic or written form).

"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"	shall mean a medical practitioner of western medicine, (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by us in utmost good faith); and (b) legally authorized for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person If the practitioner is neither duly qualified and registered under the laws of Hong Kong nor a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by us in utmost good faith), we have the discretion to exercise reasonable judgement to determine whether such practitioner shall nonetheless be considered qualified and registered. Notwithstanding the above, "Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist" in no circumstance shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by us in electronic or written form).
"Renewal", "Renew", "Renewed" or "Renewable"	shall mean renewal of these Plan Terms and Conditions without any discontinuance.
"Sanctions"	shall mean any United Nations resolutions, or the trade or economic sanctions, laws or regulations of Hong Kong, Canada, the European Union, the United Kingdom or the United States of America
"Standard Premium"	shall mean the basic premium for the coverage under this Plan, as charged by us to you on an overall Portfolio basis, which may be adjusted in accordance with the Age, sex and/or lifestyle factors of the Insured Person.
"Standard Private Room"	shall mean a standard single occupancy room with an adjoining bathroom for the Insured Person's use during his or her Confinement but does not include any Hospital room that has its own kitchen, dining or sitting room.
"Standard Semi-Private Room"	shall mean a single or double occupancy room in a Hospital, with a shared bath or shower room.
"Standard Ward Room"	shall mean a room type in a Hospital that is of a quality below a Standard Semi-Private Room.

“Supplement(s)”	shall mean any document which may add, delete, amend or replace the Plan Terms and Conditions. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Plan.
“we”, “us”, “our” or “Bowtie”	shall mean Bowtie Life Insurance Company Limited, and “We, “Us” or “Our” will have the same meaning.
“you”, “your” or “Policy Holder”	shall mean the person who is a legal holder of this Plan and is named as the Policy Holder set out in the **Policy Schedule** or a transferee in the event there is a change of ownership that is effective; “You” or “Your” will have the same meaning.