Bowtie StillCover Medical Plan (Advance)

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 — when 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 capitalized words used in this agreement

It is very important that you check the following documents 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 Plan.
2. **Benefit Schedule** – It provides a general description of the benefits offered under this Plan.
3. **Designated Surgery List** – This is the list of our designated surgical procedures which is from time to time published and subject to regular review by us.
4. **Designated Medical Network List**– This is the list of our designated health services providers whom we appoint from time to time to provide health services and subject to regular review by us.

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

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 or changing occupation.

As long as you pay your premiums and abide by the Plan Terms and Conditions, you will receive the insurance outlined in this agreement. The Plan is effective from the Policy Effective Date until the moment you or we cancel it (see Sections 6.5, 6.6 and 7.7 respectively) or it is terminated (see Section 7.6).

1.1.2 What is covered

We cover you for medical and other expenses for related services provided by a Hospital and/or a Designated Medical Network provider. This includes:

- Eligible Expenses or actual expenses (as applicable) incurred due to treatment of a Disability. These include:
    - Staying in a Hospital and receiving treatment (i.e. as an Inpatient) or undergoing surgical procedures in a Hospital as an Inpatient or Day Patient – see Sections 2.2 and 2.3;
- Eligible Expenses charged on Prescribed Diagnostic Imaging Tests under a Designated Medical Network provider – see Section 2.4;
- Consultation fees under the Designated Medical Network for confirming a diagnosis or treatment plan that is made by a Registered Medical Practitioner as a second opinion to treat a Disability – see Section 2.5;
- Expenses on self-financed medications and medical items purchased under the HA Drug Formulary – see Section 2.6;
- Expenses on obtaining supporting documents from a Hong Kong Public Hospital for the purposes of making a claim under this Plan – see Section 2.7;

We also cover you with a lump sum benefit upon the Death of the Insured Person – See Section 2.8.

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 Plan covers you in Hong Kong and the Greater Bay Area ("**GBA**") only.

1.1.3 How much is covered

We provide coverage up to certain dollar amounts for each category of expense. These amounts, often known as benefit limits, are generally applied on either a “per visit”, “per Policy Year”, “per surgery” or “per day” basis. There may also be a limit to the number of visits each Policy Year.

There is also a total benefit limit for each Policy Year.

You may also need to pay a percentage of the expenses as the Coinsurance.

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

1.2 Benefit Summary

Coverage	**Medical Services incurred from a Disability** — payable for the actual expenses for Medical Services which are incurred from a Disability.
Area cover	**Hong Kong and the Greater Bay Area ("GBA")**
Claim method	**There are three claim methods under this Plan:** **1. Reimbursement** (applicable to all benefits except for the Inpatient and Day Case Procedure (GBA Hospital) benefit and the compassionate death benefit) — a. We will reimburse the expenses incurred up to the benefit limit according to the benefit items listed in the table below. b. The same Eligible Expenses item will only be reimbursable under one benefit item. c. If the Insured Person is entitled to a reimbursement of all or part of such expenses from other sources, we will only be liable for an amount in excess of the amount recovered from such other sources. **2. Direct settlement by us** (applicable to Inpatient and Day Case Procedure (Hong Kong Private Hospital and GBA Hospital) benefits and the Designated Medical Network Prescribed Diagnostic Imaging Tests benefit) – Subject to our pre-approval, we will directly settle the expenses for Medical Services to the relevant Hong Kong Private Hospital, GBA Hospital or Designated Medical Network providers. **3. Lump sum** (applicable to the compassionate death benefit) — We will pay in lump sum to the Beneficiary in the event of the Insured Person's death.
Waiting period	**90 days** – Any Disability occurring during the first 90 days after Policy Effective Date is not covered.

Benefit limits	Limit 1 : Each benefit item has an individual benefit limit as listed in the table below Limit 2 : **HKD500,000** aggregate limit per Policy Year across benefit items (a), (b), (c) and (e) below Bowtie fully covers all benefits items, as long as the reimbursement does not exceed the above limits and subject to your Coinsurance (if applicable) – Learn more about how Bowtie covers them below and in the next section.

Benefit item	**Benefit limit (in HKD)**
(a) **Inpatient and Day Case Procedure (Hong Kong Public Hospital)** – include: (i) room and board; (ii) miscellaneous charge (iii) attending doctor's visit fees; (iv) Specialist's fee; (v) intensive care; (vi) Surgeon's fee; (vii) Anaesthetist's fees; (viii) operating theatre charges; (ix) Prescribed Diagnostic Imaging Tests; (x) Prescribed Non-surgical Cancer Treatments; and (xi) pre- and post Confinement/Day Case Procedure Outpatient care **in a Hong Kong Public Hospital only**	**Full coverage** subject to the following conditions: 1. **Standard Ward Room only** 2. **2 prior Outpatient visits or Emergency consultation per Confinement/Day Case Procedure** 3. **3 follow-up Outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)** 4. **Your Coinsurance of** 20% of the charges E.g. If the relevant charge amount is $5,000, your Coinsurance will be: $5,000 × 20% = $1,000;

	The maximum charge to be reimbursed will be: $5,000 × 80% = $4,000
(b) **Inpatient and Day Case Procedure (Hong Kong Private Hospital and GBA Hospital**) – include: (i) room and board; (ii) miscellaneous charge (iii) attending doctor's visit fees; (iv) specialist's fee; (v) intensive care; (vi) surgeon's fee; (vii) anaesthetist's fees; (viii) operating theatre charges; (ix) Prescribed Non-surgical Cancer Treatments; and (x) pre- and post Confinement/Day Case Procedure Outpatient care **for a Designated Surgery (except for Prescribed Non-surgical Cancer Treatments); and** **in a Hong Kong Private Hospital or GBA Hospital under the Designated Medical Network only.**	**Full coverage** subject to the following conditions: **1. Ward class adjustment** ● Standard Ward Room: Full Coverage ● Standard Semi-Private Room: 50% of Eligible Expenses ● Standard Private Room or Above Standard Private Room: 25% of Eligible Expenses **2. 2 prior outpatient visits or Emergency consultation per Confinement/Day Case Procedure** **3. 3 follow-up outpatient visits per Confinement/Day Case Procedure (within 90 days after discharge from Hospital or completion of Day Case Procedure)** **4. Your Coinsurance of** ● 50% of the charges on the first and second Policy Year; or ● 20% of the charges from the third Policy Year and thereafter **5. Pre-approval from us has been obtained**

(c) **Designated Medical Network Prescribed Diagnostic Imaging Tests**	**Full coverage** subject to the following conditions: **1. Your Coinsurance of** ● 50% of the charges on the first and second Policy Year; or ● 20% of the charges from the third Policy Year and thereafter **2. Pre-approval from us has been obtained**
(d) **Medical second opinion** — include consultation in a Hong Kong Private Hospital under the Designated Medical Network for confirming a diagnosis or treatment plan that was made by a Registered Medical Practitioner as a second opinion to treat a Disability.	○ **$800** per visit **;** ○ **2 visits** per Policy Year
(e) **Hong Kong Public Hospital self-financed medications and medical items**	**Full coverage** subject to **your Coinsurance of** 20% of the charges
(f) **Hong Kong Public Hospital reporting support** – include charges for obtaining medical reports for making a claim under this Plan.	**$1,000** per Policy Year
(g) **Compassionate death benefit**	**$5,000**

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 or other expenses set out in Sections 2.2 to 2.7 where the conditions set out in (a), (b) and (c) below are met:

(a) The Insured Person:

(i) sustains a Disability, and

(ii) that Disability requires one of the below:

(1) Inpatient Medical Services or Day Case Procedures in a Hong Kong Public Hospital (see Section 2.2 below);

(2) Inpatient Medical Services or Day Case Procedures in a Hong Kong Private Hospital or a GBA Hospital (see Section 2.3 below);

(3) Prescribed Diagnostic Imaging Tests in a Designated Medical Network provider (see Section 2.4 below);

(4) Medical second opinion (see Section 2.5 below);

(5) Hong Kong Public Hospital self-financed medications and medical items (see Section 2.6 below);

(6) Hong Kong Public Hospital reporting support (see Section 2.7 below);

AND

(b) The Eligible Expenses or other expenses are:

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

(ii) for medical and other services:

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

(2) set out in Sections 2.2 to 2.7 below; and

(iii) Reasonable and Customary;

AND

(c) The amount of Eligible Expenses or other expenses payable does not exceed:

(i) the actual costs for the medical services; and

(ii) the limits specified in the Benefit Summary set out in Section 1.2 above.

2.1.2 Ward class restriction

All benefits described in these Plan Terms and Conditions are subject to the ward class of Standard Ward Room only.

If the Insured Person is Confined in a room of a higher level than Standard Ward Room, the amount of any benefit payable under Sections 2.2 and 2.3 during Confinement shall be reduced to a percentage of the benefit that would otherwise have been payable. The percentage is set out in the following table:

Level of room in which the Insured Person is Confined	**Percentage of benefit payable under Section 2.2 during Confinement** **(Hong Kong Public Hospital)**	**Percentage of benefit payable under Section 2.3 during Confinement** **(Hong Kong Private Hospital and GBA Hospital)**
Standard Ward Room	100%	100%
Standard Semi-Private Room	0%	50%
Standard Private Room	0%	25%
Above Standard Private Room	0%	25%

2.2 What are your Inpatient and Day Case Procedure (Hong Kong Public Hospital) benefits

2.2.1 The Eligible Expenses for Hong Kong Public Hospital Inpatient Medical Services and Day Case Procedure payable pursuant to Section 2.1 above are as follows:

(a) Room and board

The Eligible Expenses charged by the Hospital on the cost of accommodation and meals where the Insured Person is Confined or undergoes any Day Case Procedure.

(b) Miscellaneous charges

The Eligible Expenses charged on miscellaneous charges where the Insured Person is Confined or on the day he undergoes any Day Case Procedure for receiving Medical Services. These charges shall cover the followings –

- Road ambulance service to and/or from the Hospital;
- Anaesthetic and oxygen administration;
- Administration charges for blood transfusion;
- Dressing and plaster casts;
- Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;
- Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
- Additional surgical appliances, equipment and devices other than those inclusively paid under Section 2.2.1(h) below, and implants, disposables and consumables used during surgical procedure;
- Medical disposables, consumables, equipment and devices;
- Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Section 2.2.1(i) below;
- Intravenous ("**IV**") infusions including IV fluids;
- Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
- Rental of walking aids and wheelchair for Inpatients; and
- Physiotherapy, occupational therapy and speech therapy during Confinement.

(c) Attending doctor's visit fees

The Eligible Expenses charged by the attending Registered Medical Practitioner for such visit or consultation if the Insured Person is treated by a Registered Medical Practitioner on any day of Confinement.

(d) Specialist's fees

The Eligible Expenses charged by the Specialist for such visit or consultation if the Insured Person is treated by a Specialist (not being the attending Registered Medical Practitioner under Section 2.2.1(c) above) as recommended in writing by the attending Registered Medical Practitioner on any day of Confinement.

(e) Intensive care

The Eligible Expenses charged on the intensive care services if the Insured Person is admitted to an Intensive Care Unit on any day of Confinement.

The Eligible Expenses so incurred and payable under this benefit shall not be payable under Section 2.2.1(a) above.

(f) Surgeon's fees

The Eligible Expenses charged by the attending Surgeon on a surgical procedure performed during Confinement or in a setting for providing Medical Services to a Day Patient.

(g) Anaesthetist's fees

Where a Surgeon's fee is payable under Section 2.2.1(f) above, the Eligible Expenses charged by the Anaesthetist in relation to the surgical procedure.

(h) Operating theatre charges

Where a Surgeon's fee is payable under Section 2.2.1(f) above, the Eligible Expenses charged for the use of an operating theatre, a treatment room and/or recovery room during the surgical procedure.

Any Eligible Expenses charged for surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be payable only under Section 2.2.1(b) above.

(i) Prescribed Diagnostic Imaging Tests

The Eligible Expenses charged on Prescribed Diagnostic Imaging Test performed during Confinement or in a setting for providing Medical Services to a Day Patient recommended in writing by the attending Registered Medical Practitioner for the investigation or treatment of a Disability.

(j) Prescribed Non-surgical Cancer Treatments

The Eligible Expenses charged on the Prescribed Non-surgical Cancer Treatment performed during Confinement or in a setting for providing Medical Services to a Day Patient, Outpatient consultation by a Specialist in treatment planning, and monitoring of prognosis and development during the course of Prescribed Non-surgical Cancer Treatment.

The Eligible Expenses for the Prescribed Diagnostic Imaging Tests performed as part of or necessitated by the Prescribed Non-surgical Cancer Treatment shall be payable under Section 2.2.1(i) above.

(k) Pre- and post-Confinement/Day Case Procedure Outpatient care

The Eligible Expenses for –

(i) Outpatient visit or Emergency consultation resulting in a Confinement or Day Case Procedure (including but not limited to consultation, western medication prescribed or diagnostic test); and

(ii) Follow-up Outpatient visit (including but not limited to consultation, western medication prescribed, dressings, physiotherapy, occupational therapy, speech therapy or diagnostic test) to, or recommended in writing by, the attending Registered Medical Practitioner, within the period stated in the Benefit Schedule after discharge from Hospital or the date of Day Case Procedure, provided that such Outpatient visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

The Eligible Expenses for Prescribed Diagnostic Imaging Tests and Prescribed Non-surgical Cancer Treatments incurred during the Outpatient visit or follow-up Outpatient visit referred to in Section 2.2.1(k) above shall be payable under Sections 2.2.1(i) and 2.2.1(j) above respectively.

2.2.2 The Eligible Expenses referred to in Section 2.2.1 above are subject to the benefit limits set out in the Benefit Summary set out in Section 1.2 above.

2.2.3 The Eligible Expenses referred to in Section 2.2.1 above are subject to your Coinsurance specified in the Benefit Summary set out in Section 1.2 above.

2.2.4 The Eligible Expenses referred to in Section 2.2.1 above must be incurred in a Hong Kong Public Hospital.

2.3 What are your Inpatient and Day Case Procedure (Hong Kong Private Hospital and GBA Hospital) benefits

2.3.1 The Eligible Expenses for Hong Kong Private Hospital and GBA Hospital Confinement and Day Case Procedure payable pursuant to Section 2.1 above are as follows:

(a) Room and board

The Eligible Expenses charged by the Hospital on the cost of accommodation and meals where the Insured Person is Confined or undergoes any Day Case Procedure.

(b) Miscellaneous charges

The Eligible Expenses charged on miscellaneous charges where the Insured Person is Confined or on the day he undergoes any Day Case Procedure for receiving Medical Services. These charges shall cover the followings –

- Road ambulance service to and/or from the Hospital;

- Anaesthetic and oxygen administration;
- Administration charges for blood transfusion;
- Dressing and plaster casts;
- Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;
- Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
- Additional surgical appliances, equipment and devices other than those inclusively paid under Section 2.3.1(h) below, and implants, disposables and consumables used during surgical procedure;
- Medical disposables, consumables, equipment and devices;
- Diagnostic imaging services, including ultrasound and X-ray, and their interpretation, other than Prescribed Diagnostic Imaging Tests which shall be covered under Section 2.3.1(i) below;
- IV infusions including IV fluids;
- Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement or any Day Case Procedure;
- Rental of walking aids and wheelchair for Inpatients; and
- Physiotherapy, occupational therapy and speech therapy during Confinement.

(c) Attending doctor's visit fees

The Eligible Expenses charged by the attending Registered Medical Practitioner for such visit or consultation if the Insured Person is treated by a Registered Medical Practitioner on any day of Confinement.

(d) Specialist's fees

The Eligible Expenses charged by the Specialist for such visit or consultation if the Insured Person is treated by a Specialist (not being the attending Registered Medical Practitioner under Section 2.3.1(c) above as recommended in writing by the attending Registered Medical Practitioner on any day of Confinement.

(e) Intensive care

The Eligible Expenses charged on the intensive care services if the Insured Person is admitted to an Intensive Care Unit on any day of Confinement.

The Eligible Expenses so incurred and payable under this benefit shall not be payable under Section 2.3.1(a) above.

(f) Surgeon's fees

The Eligible Expenses charged by the attending Surgeon on a surgical procedure performed during Confinement or in a setting for providing Medical Services to a Day Patient.

(g) Anaesthetist's fees

Where a Surgeon's fee is payable under Section 2.3.1(f) above, the Eligible Expenses charged by the Anaesthetist in relation to the surgical procedure.

(h) Operating theatre charges

Where a Surgeon's fee is payable under Section 2.3.1(f) above, the Eligible Expenses charged for the use of an operating theatre, a treatment room and/or recovery room during the surgical procedure.

Any Eligible Expenses charged for surgical appliances, equipment and devices used in the operating theatre that are separately charged shall be payable only under Section 2.3.1(b) above.

(i) Prescribed Non-surgical Cancer Treatments

The Eligible Expenses charged on the Prescribed Non-surgical Cancer Treatment performed during Confinement or in a setting for providing Medical Services to a Day Patient, Outpatient consultation by a Specialist in treatment planning, and monitoring of prognosis and development during the course of Prescribed Non-surgical Cancer Treatment.

The Eligible Expenses for the Prescribed Diagnostic Imaging Tests performed as part of or necessitated by the Prescribed Non-surgical Cancer Treatment shall be payable under Section 2.4 below.

(j) Pre- and post-Confinement/Day Case Procedure Outpatient care

The Eligible Expenses for –

(i) Outpatient visit or Emergency consultation resulting in a Confinement or Day Case Procedure (including but not limited to consultation, western medication prescribed or diagnostic test); and

(ii) Follow-up Outpatient visit (including but not limited to consultation, western medication prescribed, dressings, physiotherapy, occupational therapy, speech therapy or diagnostic test) to, or recommended in writing by, the attending Registered Medical Practitioner, within the period stated in the Benefit Schedule after discharge from Hospital or the date of Day Case Procedure, provided that such Outpatient visit is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement or Day Case Procedure.

The Eligible Expenses for Prescribed Diagnostic Imaging Tests and Prescribed Non-surgical Cancer Treatments incurred during the Outpatient visit or follow-up Outpatient visit referred to in Section 2.3.1(j) above shall be payable under Sections 2.4 below and 2.3.1(i) above respectively.

2.3.2 The Eligible Expenses referred to in Section 2.3.1 above are subject to the benefit limits set out in the Benefit Summary set out in Section 1.2 above.

2.3.3 The Eligible Expenses referred to in Section 2.3.1 above are subject to your Coinsurance specified in the Benefit Summary set out in Section 1.2 above.

2.3.4 Eligible Expenses referred to in Section 2.3.1 above must be incurred in a Hong Kong Private Hospital or a GBA Hospital under the Designated Medical Network.

2.3.5 This benefit shall only be payable when the Insured Person receives a surgery listed in the Designated Surgery List (except for Prescribed Non-surgical Cancer Treatments).

2.3.6 This benefit shall only be payable when the surgery referred to in Section 2.3.5 above:

(a) if it is performed in a Hong Kong Private Hospital, is approved by us in writing in advance; and

(b) if it is performed in a GBA Hospital, is recommended in writing by the attending Registered Medical Practitioner from a Hong Kong Public Hospital or a Specialist (not necessarily from a Hong Kong Public Hospital) and approved by us in writing in advance.

2.4 What is your Designated Medical Network Prescribed Diagnostic Imaging Tests benefit

2.4.1 The Eligible Expenses charged on Prescribed Diagnostic Imaging Test for the investigation or treatment of a Disability.

2.4.2 The Eligible Expenses referred to in Section 2.4.1 above are subject to the benefit limits set out in the Benefit Summary set out in Section 1.2 above.

2.4.3 The Eligible Expenses referred to in Section 2.4.1 above are subject to your Coinsurance specified in the Benefit Summary set out in Section 1.2 above.

2.4.4 The Eligible Expenses referred to in Section 2.4.1 above must be charged by the Hong Kong providers under the Designated Medical Network.

2.4.5 This benefit shall only be payable when the Prescribed Diagnostic Imaging Test is:

(a) for confirming a diagnosis or treatment plan made by a Registered Medical Practitioner from a Hong Kong Public Hospital or a Specialist (not necessarily from a Hong Kong Public Hospital); and

(b) recommended in writing by the attending Registered Medical Practitioner from a Hong Kong Public Hospital or a Specialist (not necessarily from a Hong Kong Public Hospital).

2.5 What is your medical second opinion benefit

2.5.1 The actual expenses for an Outpatient consultation for confirming a diagnosis or treatment plan made by a Registered Medical Practitioner (not necessarily from a Hong Kong Public Hospital) in Hong Kong to treat a Disability.

2.5.2 The consultation referred to in Section 2.5.1 above must be performed in a Hong Kong Private Hospital under the Designated Medical Network.

2.5.3 Expenses referred to in Section 2.5.1 above are subject to the benefit limits set out in the Benefit Summary set out in Section 1.2 above.

2.5.4 This benefit shall only be payable when the Outpatient consultation is recommended in writing by the attending Registered Medical Practitioner from a Hong Kong Public Hospital or a Specialist (not necessarily from a Hong Kong Public Hospital).

2.6 What is your Hong Kong Public Hospital self-financed medications and medical items benefit

2.6.1 The actual expenses for prescribed medication and other medical items prescribed by a Registered Medical Practitioner from a Hong Kong Public Hospital under the HA Drug Formulary including any items supported by the "**Samaritan Fund**" and "**Community Care Fund Medical Assistance Programme**" as updated from time to time by the HA.

2.6.2 The expenses referred to in Section 2.6.1 above must be incurred in a Hong Kong Public Hospital.

2.6.3 Actual expenses referred to in Section 2.6.1 above are subject to your Coinsurance set out in the Benefit Summary set out in Section 1.2 above.

2.7 What is your Hong Kong Public Hospital reporting support benefit

2.7.1 The actual expenses for obtaining any supporting documents from a Hong Kong Public Hospital relating to a Disability. The documents include but are not limited to –

(a) Attending physician's statement;
(b) Medical report;
(c) Hospital admission or discharge summary;
(d) Surgical report;
(e) Laboratory test report; and
(f) Pre-approval letter.

2.7.2 The expenses referred to in Section 2.7.1 above are subject to the benefit limits specified in the Benefit Summary set out in Section 1.2 above.

2.7.3 This benefit shall only be payable where the requested supporting documents referred to in Section 2.7.1 above are obtained solely for the purpose of making a claim under your Plan.

2.7.4 The expenses referred to in Section 2.7.1 above must be incurred in a Hong Kong Public Hospital.

2.8 What is your compassionate death benefit

2.8.1 While this Plan is in force, upon the death of the Insured Person, whether due to an Accident or natural causes, this benefit shall be payable in the amount specified in the Benefit Summary 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 2.8 above, no payment will be made under the Plan for expenses caused directly or indirectly, wholly or partly by any of the following (unless agreed by a special endorsement as provided under Section 7.4.1 below):

(a) **Waiting period:** the Insured Person suffers from any Disability the sign(s) and/or symptom(s) of which are manifested within ninety (90) days following the Policy Effective Date (except for a Disability caused directly by an Accident and diagnosed within ninety (90) days from the date of the Accident);

(b) **Medically Necessary:** treatments, procedures, medications, tests or services which are not Medically Necessary, except for services referred to in Sections 2.5 and 2.7;

(c) **Solely diagnostic procedures:** the whole (or part) of the Confinement solely for the purpose of diagnostic procedures or allied health services. This includes, but is not limited to, X-Ray, advanced imaging, laboratory tests and physiotherapy (except 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);

(d) **HIV and AIDS:** Human Immunodeficiency Virus ("**HIV**") and its related Disabilities, including AIDS and/or any mutations, derivations or variations thereof, contracted or occurring before the Policy Effective Date, will be excluded from coverage under these Plan Terms and Conditions. This exclusion applies regardless of whether the Policy Holder or the Insured Person is aware of the condition at the time of submitting the Application.

If evidence regarding the time of contraction or occurrence of such Disabilities is unavailable, any manifestation of the Disability within the first five (5) years following the Policy Effective Date shall be presumed to have occurred before the Policy Effective Date. Conversely, any manifestation after this five-year period shall be presumed to have occurred after the Policy Effective Date.

However, this exclusion shall not apply where the HIV/AIDS-related Disability is caused by sexual assault, medical assistance, organ transplant, blood transfusions, blood donation, or infection at birth;

(e) **Drugs, suicide and illegal activities:** Medical Services as a result of Disability arising from, or consequential upon the dependence, overdose or influence of any of the following:
   (i) drugs, alcohol, narcotics or similar drugs or agents;
   (ii) intentional self-inflicted injuries;
   (iii) attempted or threatened suicide, while sane or insane;
   (iv) illegal activity;
   (v) violation or attempted violation of the law, or resistance to arrest; and

(vi) venereal and sexually transmitted Disease or its sequelae (except for HIV/AIDS and its related Disability, where Section 3.1.1(d)applies);

(f) **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;

(g) **Cosmetic treatments:** beautification or cosmetic purposes, unless necessitated by Injury caused by an Accident and the Insured Person receives the Medical Services within ninety (90) days of the Accident;

(h) **Prophylactic treatment or preventive care:** prophylactic treatment or preventive care, including but not limited to general check-ups, routine tests, screening procedures for asymptomatic conditions, screening or surveillance procedures based on the health history of the Insured Person and/or family members, Hair Mineral Analysis ("**HMA**"), immunisation or health supplements. For the avoidance of doubt, this Section (h) does not apply to –

(i) treatments, monitoring, investigation or procedures with the purpose of avoiding complications arising from any other Medical Services provided;

(ii) removal of pre-malignant conditions; and

(iii) treatment for prevention of recurrence or complication of a previous Disability;

(i) **Dental treatments:** dental treatment and oral and maxillofacial procedures performed by a dentist except for Emergency Treatment and surgery during Confinement arising from an Accident. Follow-up dental treatment or oral surgery after discharge from Hospital shall not be covered;

(j) **Maternity:** maternity conditions and its complications, including but not limited to diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage; birth control or reversal of birth control; sterilisation or sex reassignment of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction or pre-mature ejaculation, regardless of cause;

(k) **Other medical services:** the purchase of durable medical equipment or appliances including but not limited to wheelchairs, beds and furniture, airway pressure machines and masks, portable oxygen and oxygen therapy devices, dialysis machines, exercise equipment, spectacles, hearing aids, special braces, walking aids, over-the-counter drugs, air purifiers or conditioners and heat appliances for home use. For the avoidance of doubt, this Section 3.1.1(k) shall not apply to rental of medical equipment or appliances during Confinement or on the day of the Day Case Procedure;

(l) **Traditional Chinese medicine treatments:** traditional Chinese medicine treatment, including but not limited to herbal treatment, bone-setting, acupuncture, acupressure and tui na, and other forms of alternative treatment including but not limited to hypnotism, qigong, massage therapy, aromatherapy, naturopathy, hydropathy, homeotherapy and other similar treatments;

(m) **Unproven procedures:** experimental or unproven medical technology or procedure in accordance with the common standard, or not approved by the recognised authority, in the locality where the treatment, procedure, test or service is received;

(n) **Congenital Conditions:** Medical Services provided as a result of Congenital Condition(s) which have manifested or been diagnosed before the Insured Person attained the Age of eight (8) years;

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

(p) **War and terrorism:** treatment for Disability arising from war (declared or undeclared), civil war, invasion, acts of foreign enemies, hostilities, rebellion, revolution, insurrection, or military or usurped power or acts of terrorism; and

(q) **Armed forces:** participation in any armed force or peace-keeping activities.

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 we allege that, by reason of this clause, 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 4.1.1 and 4.1.2 above if it is shown that:

(a) it was not reasonably possible to give such 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 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 any third party to obtain a benefit from this Plan, we may immediately 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 may recover any benefit previously paid to you. Alternatively, we may preserve this Plan and reserve the right to recover from you any benefit we previously paid to you 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 your Place of Residence and occupation, 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 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.

5.1.3 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 and/or sex to our satisfaction at the time of processing the Application and any claim or payment of any benefit under this Plan at your cost.

5.3 Premium payment, default and grace period

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

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

5.3.3 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.

5.4 Change in Place of Residence

5.4.1 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.

5.4.2 Upon our receipt of the notification given pursuant to Section 5.4.1 above, we will endorse the change of Place of Residence of the Insured Person in writing, subject to:

(a) Section 5.4.3 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.

5.4.3 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 5.4.1 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.

5.4.4 If you fail to notify us of a Place of Residence change and subsequently makes a claim, no benefit will be payable.

5.5 Change of occupation

5.5.1 The Insured Person must immediately notify us of any change in his/her occupation, duties or other pursuits.

5.5.2 If the Insured Person incurs Eligible Expenses or dies:

(a) after having changed his/her occupation, or
(b) while doing for compensation anything pertaining to an occupation,

and the occupation noted in (a) or (b) above is one which, in our opinion, falls under any of the categories in (i), (ii) or (iii) below, then the consequences set out in the respective category applies:

(i) more hazardous than that stated in the Application or any endorsement: you pay the premium rate accordingly from the date of change of occupation for such more hazardous occupation;

(ii) less hazardous than that stated in the Application or any endorsement: we, upon receipt of proof of such change of occupation, reduce the premium rate accordingly from the date of change of occupation or from Plan Monthiversary immediately preceding receipt of such proof, whichever is later;

(iii) not insurable: we are not liable to pay any benefits for any Eligible Expenses or death pertaining to that occupation.

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 your change request and the proposed transferee's consent to be bound by the Plan Terms and Conditions; and

(b) in accordance with Section 6.2.3 above 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 compassionate 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 compassionate 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;
(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]
(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 during the Cooling-off Period and receive a full refund of premium so long as:

(a) We receive a notice from you requesting that we cancel the Plan within the Cooling-off Period i.e. 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 Cooling-off Period.

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; and
(c) we will not be liable to make any payment under the Plan Terms and Conditions.

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 Renewal right

6.7.1 You have a guaranteed right to Renew this Plan, without issuance of a new policy contract, on each Plan Anniversary prior to the Insured Person's one-hundredth (100th) birthday by payment of the relevant premium in advance based on the premium rate in force at the time of Renewal if:

(a) you have complied with all of the Plan Terms and Conditions; and
(b) you accept the changes in the Plan Terms and Conditions for Renewal that we offer (if any) 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

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

similar to this Plan.

6.7.2 We shall notify you of the following at least sixty (60) days' notice prior to the end of each Policy Year:

(a) the effective date of Renewal;
(b) the Renewal premium;
(c) due date of the premium payment; and
(d) revisions in the terms and conditions upon Renewal (if any).

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 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 observe and fulfil 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 Headings and heading descriptions 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 signed (including signing by way of electronic signature) by our duly authorized officer.

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 5.3.3 above;
(c) the Plan Anniversary of this Plan immediately following the one-hundredth (100th) birthday of the Insured Person; and
(d) the date on which this Plan is cancelled or terminated.

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 Cancellation

7.7.1 We reserve the absolute right to cancel this Plan at any time by giving you notice stating when such cancellation shall be effective. The effective date of cancellation stated in the notice shall be not less than thirty (30) days from the date of the notice and shall be considered the end of the Plan period. The unearned portion of the premium at the date of cancellation shall be refunded.

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 when we have 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 on 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 Section 7.15.1 above, we will refund the premium we received for the period the Plan is void on a pro rata basis.

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

7.15.4 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.

7.15.5 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 -

"Accident"	shall mean a sudden and unforeseen event of violent, accidental, external and visible means which occurs entirely beyond the control of the Insured Person while this Plan is in force.
"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 others, the benefit items and maximum benefits covered.
"Case-based Exclusion"	shall mean the exclusion of a particular Sickness or Disease 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.
"Coinsurance"	shall mean a percentage of Eligible Expenses the Policy Holder must contribute as specified in the Benefit Summary. For the avoidance of doubt, Coinsurance does not refer to any amount that the Policy Holder is required to pay if the actual expenses exceed the benefit limits under these Terms and Conditions.
"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.
"Cooling-off Period"	shall mean a period of twenty-one (21) days after the Policy Issuance Date.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean a person receiving Medical Services or treatments given in a medical clinic, day case procedure centre or Hospital where the person is not Confined; and Day Patient medical services shall mean medical services provided to a Day Patient.
“Designated Medical Network”	shall mean the health service providers specified in the **Designated Medical Network List** whom we appoint from time to time to provide health services and subject to regular review by us.
“Designated Surgery ”	shall mean the surgical procedures specified in the **Designated Surgery List** which is from time to time published and subject to regular review by us.
“Disability”	shall mean a Sickness or Disease or Injury, including any 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 a 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.
“GBA” or “Greater Bay Area”	shall mean the area comprising Hong Kong, the Macao Special Administrative Region, and the municipalities of Guangzhou, Shenzhen, Zhuhai, Foshan, Huizhou, Dongguan, Zhongshan, Jiangmen and Zhaoqing in the Guangdong Province.
"GBA Hospital"	shall mean a Hospital in the GBA.
“HA”	shall mean the Hospital Authority of Hong Kong.

“HA Drug Formulary”	shall mean the HA Drug Formulary published by the HA and from time to time updated by the HA.
"HKD"	shall mean Hong Kong dollars.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People’s Republic of China.
“Hong Kong Public Hospital”	shall mean a public hospital as defined in the Hospital Authority Ordinance (Cap. 113 of the Laws of Hong Kong).
“Hong Kong Private Hospital”	shall mean a Hospital in Hong Kong other than a Hong Kong Public Hospital.
“Hospital”	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which – (a) has facilities for diagnosis and major operations; (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; and (d) is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Injury"	shall mean bodily injury sustained by the Insured Person of which there is evidence of a visible contusion or wound on the exterior of the body, or of internal contusion, wound or injury, or a combination of these injuries which is solely caused by an Accident and independently of any other cause.
"Inpatient"	shall mean a person who is Confined; and Inpatient medical services 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.
"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 an Insured Person who has not been Confined and who receives medical services in a private medical clinic, or in the outpatient department or emergency treatment room of a Hospital; and Outpatient medical services shall mean medical services provided to an Outpatient in a private medical clinic or in the outpatient department or emergency treatment room of a Hospital.
"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 Anniversary"	shall mean the same day and month as the Policy Effective Date in each succeeding year after the Policy Effective Date while this Plan remains in force.
"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**, **Benefit Schedule**, **Designated Medical Network List, Designated Surgery List** 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 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.
"Prescribed Non-surgical Cancer Treatment"	shall mean chemotherapy, radiotherapy, targeted therapy, immunotherapy and hormonal therapy for cancer treatment.
"Prescribed Diagnostic Imaging Tests"	shall mean any of the follows: (a) computed tomography ("**CT**" scan); (b) magnetic resonance imaging ("**MRI**" scan); (c) positron emission tomography ("**PET**" scan); (d) PET-CT combined; (e) PET-MRI combined.
"Reasonable and Customary"	shall mean, in relation to charges for treatments, 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. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred. 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 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 the Company 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.
"Renewal Date"	shall mean the effective date of Renewal. The first Renewal Date shall be the date as specified in the **Policy Schedule** (which shall not be later than the first anniversary of the Policy Effective Date) and the subsequent Renewal Date(s) shall be the anniversary(ies) of the first Renewal Date.
“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.
"Sickness" or "Disease"	shall mean a physical, mental or medical condition arising from a pathological deviation from the normal healthy state, including but not limited to the circumstances where signs and symptoms occur to the Insured Person and whether or not any diagnosis is confirmed.
"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 room categorised as a single or private room by a Hospital. In case the Hospital does not have any room categorisation, a Standard Private Room shall mean a standard single bedded room in a Hospital with a private bathroom, but without any kitchen, dining room or sitting room, and excluding a suite, VIP or deluxe room.
“Standard Semi-Private Room”	shall mean a room categorised as a semi-private room by a Hospital. In case the Hospital does not have any room categorisation, a Standard Semi-Private Room shall mean a single or twin-bedded room in a

	Hospital shared by no more than two (2) people with a shared bathroom but excluding any Standard Private Room or above.
“Standard Ward Room”	shall mean a room categorised as a general ward by a Hospital. In case the Hospital does not have any room categorisation, a Ward Room shall mean a room in a Hospital with more than two (2) patient beds but excluding any Standard Semi-Private Room or above.
“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 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.