



Innovation for Wellbeing

**SOMPO** HONG KONG

# Business Health Employee Handbook

For Employees Resident in  
Hong Kong

William<sup>o</sup>  
Russell

For members with a business health  
plan whose period of cover starts on  
or after **01 March 2020**

Welcome to William Russell	3
<hr/>	
Your plan handbook	4
<hr/>	
Your area of cover	5
<hr/>	
What you're covered for	6
<hr/>	
What you're not covered for	21
<hr/>	
If you need to make a claim	25
<hr/>	
Other information about your plan	28
<hr/>	
Definitions	31
<hr/>	

# Welcome to William Russell

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Welcome to William Russell! **We** want to provide **you** with an insurance policy **you** can rely on, so it is important that **you** fully understand the scope of the cover **we** provide. This **plan handbook** explains what is and what is not covered by **your plan**, and how **your claims** will be administered.

Please take time to read this **plan handbook** along with **your Certificate of Insurance** and **application form**.

Certain words **we** use within this **plan handbook** have a special meaning to which **we** would like to draw **your** attention. For example: -

- **'We, us, our'** – means William Russell Ltd., on behalf of the **insurer**
- **'You, your'** – means **you** and all **insured persons** on this **plan**, as shown on **your Certificate of Insurance**
- **'Policyholder'** – means **your** company or **employer** who holds the policy with **us**

These words appear in **bold** type, and **we** provide their precise meanings in the *Definitions* section of this **plan handbook**.

**We** are, of course, always at the end of a telephone to answer queries or deal with **your claim**. **You** can find **our** contact details below.

## William Russell

William Russell Ltd is the administrator of **your plan**. **Your plan** is underwritten by Sompo Insurance (Hong Kong) Co., Ltd. William Russell Ltd is an Appointed Insurance Agency of Sompo Insurance (Hong Kong) Co, Ltd, Hong Kong Federation of Insurers, Agent Registration Number 14975092.

## Sompo

Sompo Insurance (Hong Kong) Co, Ltd, is the **insurer** of your **plan**.

Sompo Insurance (Hong Kong) Co., Ltd. is a member of SOMPO Holdings, one of the largest globally competitive insurance groups and listed on the Tokyo Stock Exchange. Having its origins in 1888, **our** shareholding company–Sompo Japan Nipponkoa Insurance Inc.–is the oldest fire insurance company in Japan and one of Japan's largest Property & Casualty (P&C) insurance companies in terms of premiums written on a stand-alone basis, with an A+ rating from Standard & Poor's.

## Contact details

If you have an enquiry about your plan or insurance

**Phone** 852-3702-6162

**Email** [hkadmin@william-russell.com](mailto:hkadmin@william-russell.com)

If you need to make a claim

**Phone** 852-3702-6162

**Email** [hkclaims@william-russell.com](mailto:hkclaims@william-russell.com)

If you need to contact our 24-hour emergency medical Assistance Service

**For emergency medical assistance please call the following number: -**  
+44 1243 621 155

**For non-emergencies, please contact us by email: -**  
[william.russell@cegagroup.com](mailto:william.russell@cegagroup.com)

**Web** [william-russell.com/emergency-contact](http://william-russell.com/emergency-contact)

If you'd like to write to us

**William Russell Ltd.**  
Suite 1304, 13/F Office Plus  
No. 303 Hennessy Road  
Wan Chai, Hong Kong

# Your plan handbook

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This **plan handbook** is subject to the terms, conditions, and exclusions of the **policy terms & conditions document** and the **Master Certificate of Insurance** we issue to **your employer**, together with **your application form** (if applicable) and **your Certificate of Insurance**.

The terms of this **plan handbook** apply to **you** and to all of **your eligible dependants** as stated in the schedule of **insured persons** on your **Certificate of Insurance**.

## Eligibility to join your employer's plan

Eligibility to join **your employer's plan** is as agreed between **us** and **your employer** and is shown on **your employer's master Certificate of Insurance**.

If **you** are eligible to join, **you** must join within 30 days of becoming eligible to do so.

**Your eligible dependants** must also join the **plan** at the same time as **you** join, or, within 30 days of becoming eligible to do so if they only become eligible to join at a later date.

If **you** or **your** dependants do not join within 30 days of becoming eligible to do so **we** may refuse to offer cover, or only offer cover subject to **special terms**.

## The purpose of your plan

**Your plan** provides **you** with benefit for the cost of treating eligible medical conditions which arise after **your date of entry**.

**We** will pay for the **reasonable and customary** costs of **medically necessary treatment** of medical conditions covered by **your plan**. **We** will only pay for such **treatment** if it is received during **your period of cover**, and provided **your premium** payments have been kept up to date.

Any reimbursement **we** make may be subject to an **excess** and/ or **co-insurance**, and certain benefits are subject to a benefit limit. **Your excess** amount will be stated on **your Certificate of Insurance**. Any **co-insurance** and benefit limits will be as stated in the **table of benefits** for **your plan**.

## Your obligation to provide information relating to you and your dependants' medical history

**We** rely on the information **you** supply to **us** in **your application form** when **we** decide whether or not to accept **your application**, and whether or not **we** need to apply **special terms**.

If **your application form** omits facts or contains materially incorrect or incomplete facts, **we** have the right to declare **your plan** void. Alternatively **we** may impose **special terms** on **your** particular **plan** which will apply from **your date of entry**.

If **your** state of health, or the state of health of any of **your eligible dependants** changes between the time **you** complete **your application form** and **your date of entry**, **you** must tell **us** in writing about the change, and **we** may only be able to accept **your application** with **special terms**.

## Pre-existing medical conditions and related conditions

Unless **we** have agreed otherwise, **your plan** will not cover any **pre-existing medical conditions** or related conditions.

## Age limits

**You** must be under 70 years of age at **your date of entry**.

If dependants are eligible to join the **plan**, then **your** spouse or partner must also be aged under 70 on their **date of entry**. Children must be unmarried and under the age of 18, or less than 25 years old if in continuous full-time education.

## Commencement of your cover

**Your** cover will commence from the **date of entry** stated on **your Certificate of Insurance**. **We** will not commence **your** cover until **we** have accepted **your application** and **your employer** has paid the **premium**.

## Interpretation of your plan handbook

This **plan handbook** is designed to describe **your plan**. The final interpretation of any specific term, condition or exclusion and its applicability is subject to the terms, conditions, and exclusions of the **policy terms & conditions document** and the **Master Certificate of Insurance** we issue to **your employer**.

# Your area of cover

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The cover provided by **your plan** is restricted to the **area of cover** stated on **your Certificate of Insurance**. The **areas of cover**, and their corresponding territorial limits, are stated below.

## Zone 1

Worldwide, excluding the United States of America.

## USA cover options

The following two options provide limited cover in the United States of America. They are only available if they have been selected by **your employer**.

If **you** have one of the options for limited cover in the United States of America, it will be stated on **your Certificate of Insurance**.

### Cover in the USA limited to temporary trips of up to 45 days (USA-45)

We will cover **you** in the United States of America for **temporary trips** of up to 45 days' duration from the date on which **you** enter the country. Any trip of longer than 45 days will not be covered, but there is no limit to the number of **temporary trips you** can make to the United States of America during any one **period of cover**.

The overall maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US\$250,000 per **insured person**, per **period of cover**. Within this amount, **we** will pay: -

- up to US\$100,000 for elective **treatment**; and
- up to US\$250,000 for **accident & emergency treatment** of a condition that **you** have not previously suffered from prior to commencing **your temporary trip**.

**We** do not cover emergency evacuation to, from or within the United States of America, even if **you** have selected the USA-45 option.

### Cover in the USA limited to temporary trips of up to 90 days (USA-90)

We will cover **you** in the United States of America for **temporary trips** of up to 90 days' duration from the date on which **you** enter the country. Any trip of longer than 90 days will not be covered, but there is no limit to the number of **temporary trips you** can make to the United States of America during any one **period of cover**.

The overall maximum amount **we** will pay in respect of **treatment you** receive in the United States of America is US\$250,000 per **insured person**, per **period of cover**.

This overall maximum amount includes both elective **treatment** and **accident & emergency treatment** that **you** receive.

**We** do not cover emergency evacuation to, from or within the United States of America, even if **you** have selected the USA-90 option.

# What you're covered for

The following **table of benefits** sets out the cover provided by each **plan**. The **plan you** have is as shown on **your Certificate of Insurance**. We will pay only for the **treatment** or services stated in the **table of benefits** relating to **your plan**.

Each benefit limit in the **table of benefits** is expressed in HK dollars and US dollars. The currency of the benefit limits that **we** will apply to **your plan** is shown on **your Certificate of Insurance**.

The limits shown in the **table of benefits** are the maximum amounts **we** will pay after the application of any **excess** and **co-insurance**, and will be subject to the annual benefit limit and any other specified applicable benefit limits.

Certain benefits in the **table of benefits** specify a **waiting period**. **You** must be covered by the same **plan** for the full duration of the specified **waiting period** before **you** can **claim**

for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**.

Wherever the term *Full cover* appears in the **table of benefits**, this means a full refund of **reasonable and customary** charges, less any **excess** or **co-insurance** applicable to **your plan**, and subject to any limits that are specified anywhere else in the **table of benefits** for the type of **treatment** or care **you** receive.

Where there is a lifetime benefit limit, this is the maximum amount **we** will pay in respect of that particular benefit during **your** lifetime.

Certain benefits in the **table of benefits** are optional. **You** are only eligible for these benefits if **your employer** has selected them and they are stated on **your Certificate of Insurance**.

There are certain benefits in the **table of benefits** for which **you** must obtain pre-authorization. If **you** do not obtain pre-authorization for these benefits, **we** will only pay 80% of the

**reasonable and customary cost of treatment**.

If **you** choose a **private room** for **your in-patient** or **day-patient treatment** at a **restricted hospital in Hong Kong** (listed below), the cover **we** provide for all **your treatment** and accommodation costs will be subject to a 20% **co-insurance**. This means that **you** will need to contribute 20% of **your treatment** and accommodation costs.

- Matilda International Hospital
- Hong Kong Adventist Hospital
- Hong Kong Sanatorium & Hospital

This restriction applies even if **your employer** did not select the **semi-private room** or **general ward** options on their **business application form**.

The **table of benefits** should be read in conjunction with the *What you're not covered for* section of this **plan handbook**.

**Key**       Full cover within annual benefit limit       Partial or limited cover       No cover       Optional cover

	Bronze	Silver	Gold
<b>Annual benefit limit</b>	HK\$11,625,000 or US\$1,500,000	HK\$19,375,000 or US\$2,500,000	HK\$38,750,000 or US\$5,000,000

<b>Hospital costs</b>	Bronze	Silver	Gold
Important notes: -			
• <b>You</b> must obtain pre-authorization for all benefits in this section.			
• All <b>in-patient</b> and <b>day-patient treatment</b> and accommodation costs at a <b>restricted hospital in Hong Kong</b> are subject to a 20% <b>co-insurance</b> if <b>you</b> choose a <b>private room</b> .			

<b>Hospital accommodation</b>	Bronze	Silver	Gold
The cost of a standard single room with an en-suite bath or shower room, when <b>you</b> are an <b>in-patient</b> or <b>day-patient</b> .	 Full cover	 Full cover	 Full cover

<b>Hospital treatment</b>	Bronze	Silver	Gold
<b>Treatment you</b> receive while <b>you</b> are an <b>in-patient</b> or <b>day-patient</b> , including surgeons' and anaesthetists' and <b>doctors'</b> fees, nursing care, drugs and surgical dressings, operating theatre charges and intensive care, pathology, X-rays, scans, <b>diagnostic tests</b> and physiotherapy. <b>We</b> will also pay for <b>pre-admission tests</b> that <b>you</b> undergo on an <b>out-patient</b> basis for <b>hospital treatment you</b> are scheduled to receive that is covered by <b>your plan</b> .	 Full cover	 Full cover	 Full cover
<b>We</b> will also pay for <b>in-patient</b> surgical removal of impacted, buried or unerupted wisdom teeth. This is subject to a 12-month <b>waiting period</b> and covered only when the surgery is performed by a <b>medical doctor</b> (not a dentist) in a <b>hospital</b> (not a dental surgery) and under general anaesthetic.			

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Hospital costs (continued)

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.
- All in-patient and day-patient treatment and accommodation costs at a restricted hospital in Hong Kong are subject to a 20% co-insurance if you choose a private room.

### Parent accommodation

The cost of one parent staying in hospital with a child under 18 years of age while the child is receiving eligible treatment covered by their plan.

Full cover

Full cover

Full cover

### Road ambulance

The cost of a private road ambulance if you need hospital treatment covered by your plan and if it is medically necessary for you to travel to hospital by ambulance.

Full cover

Full cover

Full cover

### Hospital cash benefit

Payable for each night spent in a hospital when you receive treatment eligible for cover by your plan for which no charge is made by the hospital. Benefit is paid for up to a maximum of 60 nights per period of cover.

If selected, your excess will not be applied to this benefit.

HK\$1,163 or US\$150 per night

HK\$1,550 or US\$200 per night

HK\$2,713 or US\$350 per night

### Acute flare-ups of chronic conditions

Short-term treatment to treat acute flare-ups of a chronic condition covered by your plan.

In-patient, day-patient, and post-hospital treatment received within the 90-day period following the date you are discharged from hospital

Full cover

Full cover

## Cancer treatment

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.
- All in-patient and day-patient treatment and accommodation costs at a restricted hospital in Hong Kong are subject to a 20% co-insurance if you choose a private room.

### Cancer treatment

Cancer treatment, including chemotherapy, radiotherapy, immunotherapy, consultations, tests, scans, and drugs. We will also pay for restorative dental treatment following chemotherapy or radiotherapy.

Full cover

Full cover

Full cover

### Cancer genome tests

The cost of tests to sequence the genes of cancer cells.

Up to HK\$46,500 or US\$6,000 per period of cover

Up to HK\$46,500 or US\$6,000 per period of cover

Up to HK\$46,500 or US\$6,000 per period of cover

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Cancer treatment (continued)

Important notes: -

- You must obtain pre-authorization for all benefits in this section.
- All in-patient and day-patient treatment and accommodation costs at a restricted hospital in Hong Kong are subject to a 20% co-insurance if you choose a private room.

### Cash benefit upon diagnosis of cancer (6-month waiting period)

Payable if you are diagnosed with cancer. By *cancer* we mean the presence of tumours that consist of cells that are malignant, due to characteristics which can be shown microscopically. These cells can multiply and spread to other parts of the body uncontrollably (e.g. cancers such as breast cancer, lung cancer, bowel cancer, and cancers of the blood (also known as leukaemia).

The following are not covered: -

- non-melanoma skin cancer unless it has spread to lymph nodes or organs
- prostate cancer unless it has spread to other glands or organs

This benefit will not be paid if you were first diagnosed with any cancer before you were covered under the Gold plan for a period of six consecutive months.

No cover

No cover

HK\$38,750 or US\$5,000 with a lifetime limit of one claim per insured person

### Wigs

Help towards the cost of a wig following chemotherapy, covered by your plan.

Lifetime limit of HK\$1,163 or US\$150

Lifetime limit of HK\$1,163 or US\$150

Lifetime limit of HK\$1,163 or US\$150

### Counselling

Consultations with a registered psychologist/counsellor when you have received cancer treatment covered by your plan, up to a lifetime limit of 10 consultations.

We do not cover any drugs prescribed under this benefit.

Lifetime limit of HK\$3,875 or US\$500

Lifetime limit of HK\$3,875 or US\$500

Lifetime limit of HK\$3,875 or US\$500

### Dietitian

Consultation with a registered dietitian when you have received cancer treatment covered by your plan, up to a lifetime limit of 2 consultations.

Lifetime limit of HK\$775 or US\$100

Lifetime limit of HK\$775 or US\$100

Lifetime limit of HK\$775 or US\$100

## Organ, bone marrow or tissue transplants

Important notes: -

- You must obtain pre-authorization for all benefits in this section.
- We only cover transplants carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with WHO (World Health Organisation) guidelines.
- We do not cover any costs associated with the acquisition of the organ.
- All in-patient and day-patient treatment and accommodation costs at a restricted hospital in Hong Kong are subject to a 20% co-insurance if you choose a private room.

### Transplant and related treatment

Costs incurred while hospitalised, including anti-rejection drugs, and all related out-patient treatment required prior to and after the transplant.

Full cover

Full cover

Full cover

### Donor costs

Medical costs associated with the donor as an in-patient or day-patient.

Up to HK\$193,750 US\$25,000 per transplant

Up to HK\$193,750 US\$25,000 per transplant

Up to HK\$193,750 US\$25,000 per transplant

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Kidney dialysis

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

Treatment for kidney dialysis while you are an **in-patient**, **day-patient** or **out-patient**.

Full cover

Full cover

Full cover

## Reconstructive surgery

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

A maximum of two surgeries per lifetime to restore **your** appearance after an **accident** or after surgery for cancer, provided the original **treatment** for the **accident** or cancer was paid for by **us**, and provided the reconstructive surgery takes place within two years of the **accident** or the original cancer surgery.

**In-patient, day-patient and post-hospital treatment** received within the 90-day period following the date you are discharged from **hospital**

Full cover

Full cover

## Congenital conditions or hereditary conditions

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

Treatment for a **congenital condition** or hereditary condition (whether diagnosed as a **chronic condition** or not) and **treatment** for any **related condition**.

This benefit does not extend to mental health treatment, complementary medicine or traditional Chinese medicine.

There is no cover for **congenital conditions** or hereditary conditions if, prior to commencement of **your** cover, **you** have had any abnormal signs, symptoms or test results related to the **congenital condition** or hereditary condition (whether or not a specific diagnosis has been made). However, there may be some cover for newborn babies under the *maternity costs* section of the **table of benefits**.

**Your** lifetime limit for this benefit will be reduced by any payments **we** have made under the emergency treatment for newborn babies benefit with respect to birth defects, **congenital conditions** or hereditary conditions. The lifetime limit shown applies irrespective of the number of **congenital conditions** and hereditary conditions.

**In-patient, day-patient and post-hospital treatment** received within the 90-day period following the date you are discharged from **hospital**, up to a lifetime limit of HK\$155,000 or US\$20,000

Lifetime limit of HK\$310,000 or US\$40,000

Lifetime limit of HK\$620,000 or US\$80,000

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Mental health treatment

Important notes: -

- You must obtain pre-authorization for all benefits in this section.
- All **treatment** must be administered under the direct control of a registered psychiatrist or psychologist.
- We do not cover investigations or **treatment** related to phobias, hypnotherapy, postnatal depression or marriage counselling, or psycho-geriatric conditions including Alzheimer's disease or dementia.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

### Lifetime mental health treatment limit

The overall maximum limit to the amount that **you** can **claim** for all benefits in the *mental health treatment* section that are covered by **your plan** during **your lifetime**.

HK\$387,500 or  
US\$50,000

HK\$581,250 or  
US\$75,000

HK\$775,000 or  
US\$100,000

### In-patient and day-patient mental health treatment (24-month waiting period)

**In-patient** and **day-patient treatment** received in a recognised mental health unit of a **hospital**.

Up to 30 days per  
**period of cover**

Up to 30 days per  
**period of cover**

Up to 30 days per  
**period of cover**

### Out-patient mental health treatment (24-month waiting period)

**Specialist** mental health consultations with a registered psychiatrist or psychologist when **you** have been referred by a **medical doctor**.

We do not pay for drugs prescribed for **out-patient** mental health **treatment**.

Up to 10 consultations  
per **period of cover**  
for **post-hospital  
treatment** received  
within the 90-day  
period following  
the date **you** are  
discharged from  
**hospital**

Up to 10  
consultations per  
**period of cover**

Up to 10  
consultations per  
**period of cover**

## HIV/AIDS treatment

Important notes: -

- You must obtain pre-authorization for all benefits in this section.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

### (24-month waiting period)

**Treatment** arising from or related to Human Immunodeficiency Virus (HIV) and/or HIV-related illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) for a maximum period of 5 years.

We do not provide cover if the virus was contracted before **your date of entry**.

**In-patient** and  
**day-patient  
treatment** only,  
up to HK\$38,750  
or US\$5,000 per  
**period of cover**

Up to HK\$581,250  
or US\$75,000 per  
**period of cover**

Up to HK\$775,000  
or US\$100,000 per  
**period of cover**

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

	Bronze	Silver	Gold
<b>Medical appliances</b>			
<p><b>Medical aids</b></p> <p>Supplying, fitting or hiring instruments, apparatuses or devices which are medically prescribed as a medical aid to <b>you</b> (for example crutches, wheelchairs, orthopaedic supports/braces, orthotics, stoma supplies, compression stockings) when it immediately follows <b>in-patient, day-patient</b> or emergency ward <b>treatment</b> covered by <b>your plan</b>.</p> <p>We do not cover medical aids that form part of the care of a <b>chronic condition</b>. We do not cover unprescribed medical aids such as gym equipment, even if <b>you</b> have been advised to use such an aid.</p>	<p>Up to HK\$1,938 or US\$250 per medical condition per <b>period of cover</b></p>	<p>Up to HK\$3,875 or US\$500 per medical condition per <b>period of cover</b></p>	<p>Up to HK\$7,750 or US\$1,000 per medical condition per <b>period of cover</b></p>
<p><b>Prosthetic implants</b></p> <p>Surgically-implanted, artificial body parts necessary to replace a joint or ligament, a heart valve, the aorta or an arterial blood vessel, a sphincter muscle, the lens or cornea of the eye, or to control urinary incontinence, or to act as a heart pacemaker, or to remove excess fluid from the brain.</p> <p>As part of this benefit, <b>we</b> will also pay for a knee brace if it is an essential part of a surgical operation for the repair to a knee ligament, and for a spinal support if it is an essential part of a surgical operation to the spine.</p>	Full cover	Full cover	Full cover
<p><b>Prosthetic devices</b></p> <p>External prosthetic body parts, such as prosthetic limbs, fitted after the healing of an amputation covered by <b>your plan</b>.</p>	Up to HK\$3,875 or US\$500 per device	Up to HK\$7,750 or US\$1,000 per device	Up to HK\$11,625 or US\$1,500 per device
<b>Out-patient treatment</b>			
<p>Important notes: -</p> <ul style="list-style-type: none"> <li>You must obtain pre-authorisation for certain benefits in this section.</li> <li>Certain benefits in this section are subject to the annual limit for <b>out-patient treatment</b>.</li> </ul>			
<p><b>Annual limit for out-patient treatment</b></p> <p>The overall maximum limit to the amount <b>you</b> can <b>claim</b> for certain <b>treatments you</b> receive as an <b>out-patient</b> during any one <b>period of cover</b>.</p>	No annual limit	HK\$155,000 or US\$20,000	HK\$232,500 or US\$30,000
<p><b>Primary medical care</b></p> <p>Visits to a GP or <b>doctor, specialist</b> consultations, prescribed drugs and dressings, pathology, scans, radiology and <b>diagnostic tests</b> received as an <b>out-patient</b>. We do not cover home visits.</p>	<p><b>Post-hospital treatment</b> received within the 90-day period following the date <b>you</b> are discharged from <b>hospital</b> (subject to a 15% <b>co-insurance</b>)</p>	25 consultations, subject to the annual limit for <b>out-patient treatment</b> and a 15% <b>co-insurance</b>	30 consultations, subject to the annual limit for <b>out-patient treatment</b>
<p><b>Emergency ward treatment</b></p> <p><b>Emergency treatment</b> that <b>you</b> have received at a <b>hospital</b>.</p>	Essential and immediate <b>treatment</b> necessary as the result of an <b>accident</b> , plus one follow-up appointment with a <b>medical doctor</b>	Full cover	Full cover

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Out-patient treatment (continued)

Important notes: -

- You must obtain pre-authorisation for certain benefits in this section.
- Certain benefits in this section are subject to the annual limit for **out-patient treatment**.

### Out-patient surgical procedures

Surgical procedures where it is not **medically necessary** for you to be admitted to **hospital** as an **in-patient** or **day-patient**.

Full cover

Full cover

Full cover

### Advanced diagnostic tests

MRI and CAT (CT) scans performed on the advice of a **medical doctor** and PET scans performed on the advice of a **specialist**. Your **medical referral letter** will be required.

We will pay for one consultation only to obtain the results of the **diagnostic test**.

You must obtain pre-authorisation for all advanced **diagnostic tests**.

Full cover

Up to the annual limit for **out-patient treatment**

Up to the annual limit for **out-patient treatment**

### Complementary treatments

**Treatment** by a chiropractor, osteopath, chiropodist, podiatrist, homeopath or acupuncturist on the advice of a **medical doctor**.

Your **medical referral letter** will be required for any **treatment** by a chiropractor, osteopath, chiropodist or podiatrist. If your condition is

(or becomes) a **chronic condition** and ongoing **treatment** is aimed at maintaining it rather than curing it, no further payments will be made. Cover is limited to the maximum number of **sessions** shown per **period of cover** in respect of all **treatment** types.

**Treatment** must be performed by a **medical practitioner**. Medication provided by complementary therapists is not covered under this benefit.

Up to 10 **sessions** per **period of cover** for **post-hospital treatment** received within the 90-day period following the date you are discharged from **hospital**

Up to 10 **sessions** per **period of cover**, subject to the annual limit for **out-patient treatment**

Up to 15 **sessions** per **period of cover**, subject to the annual limit for **out-patient treatment**

### Traditional Chinese medicine

Cover is limited to the maximum number of **sessions** shown per **period of cover**. **Treatment** must be performed by a **medical practitioner**.

No cover

Up to HK\$388 or US\$50 per **session**, up to a maximum of 15 **sessions**, subject to the annual limit for **out-patient treatment**

Up to HK\$388 or US\$50 per **session**, up to a maximum of 20 **sessions**, subject to the annual limit for **out-patient treatment**

### Physiotherapy

**Medically necessary** physiotherapy when you have been referred on the advice of your **medical doctor** to a physiotherapist who is registered to practice physiotherapy in the country where the **treatment** is administered. You must send us your **medical referral letter** in support of your **claim**.

After your first 6 **sessions** of physiotherapy, if you need more **sessions** you must contact us for pre-authorisation. We will write to your **doctor** for a medical report in order to assess your **claim** further. After your first 6 **sessions**, we will not pay for any physiotherapy that we have not pre-authorised.

If your condition is (or becomes) a **chronic condition** and ongoing **treatment** is aimed at maintaining rather than curing it, no further payments will be made.

Post-hospital **treatment** received within the 90-day period following the date you are discharged from **hospital**, up to HK\$7,750 or US\$1,000 per **period of cover**

Up to the annual limit for **out-patient treatment**

Up to the annual limit for **out-patient treatment**

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Out-patient treatment (continued)

Important notes: -

- You must obtain pre-authorization for certain benefits in this section.
- Certain benefits in this section are subject to the annual limit for **out-patient treatment**.

### Hormone replacement therapy

When prescribed by a **medical doctor** following **your** diagnosis with premature ovarian failure (i.e. loss of ovarian function before the age of 40).

No cover

Maximum period of 12 months from the date of diagnosis

Maximum period of 18 months from the date of diagnosis

### Monitoring and maintenance of chronic conditions

Regular consultations, tests, and prescribed medication required to monitor and maintain the stability of a **chronic condition**.

No cover

Up to the annual limit for **out-patient treatment** (subject to a 15% **co-insurance**)

Up to the annual limit for **out-patient treatment**

## Well-being benefits

Important notes: -

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.

### Preventive health and well-being (6-month waiting period)

**Preventive health checks** and tests for adults, including: -

- health screens (e.g. tests for cholesterol, high blood pressure, diabetes, anaemia, lung/kidney/liver function, cardiac risk)
- Papanicolaou (PAP) test
- mammogram, prostate cancer, and colon cancer screens
- flu jabs
- hearing test
- eye examination

If **your employer** has selected the enhanced preventive health and well-being option, **you** are eligible for the higher benefit limit on **your plan**.

No cover

Up to HK\$2,325 or US\$300 per **period of cover**

Up to HK\$5,813 or US\$750 per **period of cover**

Up to HK\$3,875 or US\$500 per **period of cover** (only if selected by **your employer**)

Up to HK\$10,075 or US\$1,300 per **period of cover** (only if selected by **your employer**)

### Vaccinations for adults

Immunisations and booster injections required under regulation of the country in which **treatment** is being given, and any **medically necessary** travel vaccinations and malaria prophylaxis.

No cover

Up to HK\$1,163 or US\$150 per **period of cover**

Up to HK\$1,938 or US\$250 per **period of cover**

### Well-child benefit (12-month waiting period)

Routine vaccinations and developmental check-ups for children.

No cover

Up to HK\$1,550 or US\$200 per **period of cover**

Up to HK\$3,100 or US\$400 per **period of cover**

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

### Rehabilitation treatment

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.

Rehabilitation treatment you receive as an **in-patient**, carried out under the control and supervision of a **specialist** in a recognised **rehabilitation hospital or unit**, and only when it immediately follows **in-patient treatment** for illness or injury covered by **your plan**.

This benefit is payable only when the admission takes place on the written recommendation of **your treating specialist** and the admission must take place immediately following **your discharge from hospital**.

Up to 7 days per medical condition

Up to 15 days per medical condition

Up to 30 days per medical condition

### Home nursing costs

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.

The medical services of a **qualified nurse** to treat **you** in **your own home** when it is **medically necessary** and relates directly to an illness or injury covered by **your plan**.

Up to 12 weeks per medical condition

Up to 12 weeks per medical condition

Up to 12 weeks per medical condition

### Lifetime care

Important notes: -

- You must obtain pre-authorisation for all benefits in this section.

#### Lifetime limit for all lifetime care

The overall maximum limit to the amount that **you** can **claim** for all benefits in the *lifetime care* section that are covered by **your plan** during **your lifetime**.

HK\$193,750 or US\$25,000

HK\$387,500 or US\$50,000

HK\$775,000 or US\$100,000

#### Hospice and palliative care

On diagnosis of a **terminal medical condition** covered by **your plan**, all costs for **treatment** received on the advice of a **medical practitioner** or **specialist** for the purpose of offering relief of symptoms. This includes all **hospital** or hospice accommodation, and nursing care by a **qualified nurse**.

Up to the lifetime limit for all lifetime care

Up to the lifetime limit for all lifetime care

Up to the lifetime limit for all lifetime care

#### Artificial life maintenance

Treatment you require after you have already been on **artificial life maintenance** for 8 weeks.

Up to the lifetime limit for all lifetime care

Up to the lifetime limit for all lifetime care

Up to the lifetime limit for all lifetime care

#### Persistent vegetative state and neurological damage

Treatment you require after you have been in **hospital** for 8 weeks for permanent neurological damage or if **you** are in a persistent vegetative state.

Up to the lifetime limit for all lifetime care

Up to the lifetime limit for all lifetime care

Up to the lifetime limit for all lifetime care

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Optical care

Important notes: -

- You are eligible for the benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.

We will pay up to HK\$1,550 or US\$200 per **period of cover** for an annual optical test. Within this benefit, we will pay for lenses and contact lenses only upon a change of prescription. ○ No cover

We do not pay for LASIK eye surgery or any other surgical correction of short-sightedness (myopia), long-sightedness (hyperopia) or irregular-shaped cornea (astigmatism).

You are eligible for the optical care benefit only if it has been selected by **your employer**.

○ Up to HK\$1,550 or US\$200 per **period of cover** (only if selected by **your employer**)

○ Up to HK\$1,550 or US\$200 per **period of cover** (only if selected by **your employer**)

## Dental costs

Important notes: -

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.
- All **dental treatment** must be carried out by a **dentist** in a **hospital** emergency room or dental surgery.
- Treatment** for damaged crowns, dentures, bridge work or false teeth is only covered under the Dental Plus benefit.
- We do not cover orthodontic consultations or **treatment** of any kind.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

### Emergency restorative treatment you receive as an in-patient

**In-patient treatment** required to restore sound and natural teeth following an **accident** covered by **your plan**, provided that **treatment** is received within 15 days of the **accident**.

○ Full cover

○ Full cover

○ Full cover

### Emergency restorative treatment you receive as an out-patient

**Out-patient treatment** required to treat or replace sound and natural teeth which are lost or damaged following an **accident**, provided that **treatment** is received within 72 hours of the **accident**.

○ No cover

○ Up to HK\$3,875 or US\$500 per **period of cover**

○ Up to HK\$7,750 or US\$1,000 per **period of cover**

### Dental Basic (6-month waiting period)

We will pay for the following basic dental costs: -

- screening (e.g. the checking for and/or the assessment of any diseased, missing and filled teeth including X-rays where necessary) twice per year
- scaling and polishing and sealing (twice per year)
- fillings (both composite and amalgam)
- simple extractions
- root canal **treatment**

The Dental Basic benefit on the Silver **plan** is limited to HK\$7,750 or US\$1,000, or HK\$11,625 or US\$1,500, depending on which option **your employer** has selected. **You** are not eligible for cover if neither option is selected.

○ No cover

○ **Option A** Up to HK\$7,750 or US\$1,000 per **period of cover**, subject to a 10% **co-insurance** (only if selected by **your employer**)

○ Up to HK\$11,625 or US\$1,500 per **period of cover**

○ **Option B** Up to HK\$11,625 or US\$1,500 per **period of cover**, subject to a 10% **co-insurance** (only if selected by **your employer**)

Key

 Full cover within annual benefit limit

 Partial or limited cover

 No cover

 Optional cover

Bronze

Silver

Gold

### Dental costs (continued)

Important notes: -

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.
- All **dental treatment** must be carried out by a **dentist** in a **hospital** emergency room or dental surgery.
- **Treatment** for damaged crowns, dentures, bridge work or false teeth is only covered under the Dental Plus benefit.
- We do not cover orthodontic consultations or **treatment** of any kind.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject to a 20% **co-insurance** if you choose a **private room**.

### Dental Plus (12-month waiting period)

We will pay for the following advanced dental costs: -

- denture repair
- full/partial dentures
- dental bridges
- crowns, inlays, and onlays
- dental implants

 No cover

 Up to HK\$11,625 or US\$1,500 per **period of cover**, subject to a 10% **co-insurance** (only if selected by **your employer**)

 Up to HK\$15,500 or US\$2,000 per **period of cover**, subject to a 10% **co-insurance** (only if selected by **your employer**)

This benefit is optional on the Silver and Gold **plans**. You are not eligible for cover if neither option is selected by **your employer**.

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Maternity costs

Important notes: -

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.
- You must obtain pre-authorisation for all benefits in this section.
- Dependant children included in **your plan** are not eligible for these benefits.
- We do not cover the **treatment** of any newborn child born following **assisted reproduction** (e.g. IVF) in the event of the birth occurring within 36 weeks of conception.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and childbirth benefit.
- We do not cover pregnancy testing, or pre-natal classes and doulas.
- We do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy.
- We do not cover breast pumps.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

### Routine maternity care and routine care of newborns (12-month waiting period)

We will pay for the following routine maternity costs: -

- pre-natal tests and examinations
- post-natal **treatments** and examinations
- natural childbirth
- childbirth by **planned caesarean section**
- any **hospital** accommodation costs for the newborn baby
- basic newborn healthcare (physical examination, vitamin K, hepatitis B vaccine, BCG vaccine, one hearing test, blood tests for PKU, congenital hypothyroidism and G6PD, prior to discharge from the **hospital**)
- home birth, where a midwife is present
- supplements and vitamins as recommended by a **medical doctor**

The limits shown for this benefit apply to each pregnancy, regardless of the number of children born. Any **hospital** or birthing center accommodation costs will be limited to the cost of a standard **hospital** room.

The routine maternity care and childbirth benefit on the Silver **plan** is limited to HK\$38,750 or US\$5,000, or HK\$58,125 or US\$7,500, or HK\$77,500 or US\$10,000, depending on which option **your employer** has selected. **You** are not eligible for cover if no option is selected.

No cover

**Option A** Up to HK\$38,750 or US\$5,000 per pregnancy, subject to a 20% **co-insurance**

Up to HK\$116,250 or US\$15,000 per pregnancy

**Option B** Up to HK\$58,125 or US\$7,500 per pregnancy, subject to a 20% **co-insurance**

**Option C** Up to HK\$77,500 or US\$10,000 per pregnancy, subject to a 20% **co-insurance**

### Complications of pregnancy (12-month waiting period)

**In-patient** or **day-patient treatment** necessary as a direct result of a **complication of pregnancy**.

We do not provide cover for childbirth under this benefit.

We do not provide cover under this benefit for complications arising from a pregnancy established through **assisted reproduction** (e.g. IVF) until after the standard 12-week scan, irrespective of how long **you** have been covered by **your plan**.

The benefit limit on the Silver **plan** is extended to full cover if the complex maternity option is selected by **your employer**.

Up to HK\$37,200 or US\$4,800 per **period of cover**

Up to HK\$116,250 or US\$15,000 per **period of cover**

Full cover

Full cover (only if selected by **your employer**)

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

**Maternity costs (continued)**

Important notes: -

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.
- You must obtain pre-authorisation for all benefits in this section.
- Dependant children included in **your plan** are not eligible for these benefits.
- We do not cover the **treatment** of any newborn child born following **assisted reproduction** (e.g. IVF) in the event of the birth occurring within 36 weeks of conception.
- Any charges incurred during normal childbirth (including a **planned caesarean section**) will be paid from the routine maternity care and childbirth benefit.
- We do not cover pregnancy testing, or pre-natal classes and doulas.
- We do not cover termination of pregnancy or any **treatment** or investigations that arise as a result of complications relating to termination of pregnancy.
- We do not cover breast pumps.
- All **in-patient** and **day-patient treatment** and accommodation costs at a **restricted hospital in Hong Kong** are subject of a 20% **co-insurance** if you choose a **private room**.

**Childbirth necessitating an emergency surgical procedure (12-month waiting period)**

Surgeons' anaesthetists' and theatre fees for childbirth that necessitates an emergency surgical procedure and any additional accommodation charges incurred as the result of the surgical procedure. This includes childbirth by **emergency caesarean section**.

Cover on the Silver **plan** is only available if the complex maternity option is selected by **your employer**.

No cover

Up to HK\$155,000  
or US\$20,000 per  
pregnancy (only if  
selected by **your  
employer**)

Full cover

**Emergency medical treatment for newborn babies (12-month waiting period)**

We will pay for **in-patient** or **day-patient treatment** that **your** newborn baby receives during their first 90 days of life, provided you have added **your** newborn baby to **your plan** within 30 days of their date of birth.

During this 90-day period, we will pay for **treatment of congenital conditions** or hereditary conditions.

This benefit is subject to the following conditions: -

- We won't pay for any emergency medical **treatment** for **your** newborn baby if they are born within the 12-month **waiting period** for this benefit
- Any benefit we pay during the 90-day period in respect of **treatment** for **congenital conditions** or hereditary conditions will be deducted from the newborn baby's lifetime limit for **congenital conditions** or hereditary conditions and any related conditions
- **Your** newborn baby must have the same **plan** as **you** when **you** add them to **your plan**

The limits shown apply to each pregnancy, regardless of the number of children born.

The benefit limit on the Silver **plan** is extended if the complex maternity option is selected by **your employer**.

No cover

Up to HK\$77,500  
or US\$10,000 per  
pregnancy

Up to HK\$775,000  
or US\$100,000 per  
pregnancy

Up to HK\$387,500  
or US\$50,000 per  
pregnancy (only if  
selected by **your  
employer**)

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

**Expat benefits**

Important notes: -

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.
- You must obtain pre-authorisation for all benefits in this section.

**24-hour medical assistance helpline**

If **you** have a medical emergency which requires immediate medical assistance, **you** must contact **our** 24-hour helpline (provided by CEGA) at +44 (0) 1243 621 155 or [william.russell@cegagroup.com](mailto:william.russell@cegagroup.com).

Full cover

Full cover

Full cover

**Medevac Basic**

If **you** (or any child covered by the newborn benefit within its first 90 days of life) have a life-threatening or limb-threatening condition covered by **your plan** which requires immediate **in-patient treatment** that cannot be adequately provided locally, the **Assistance Service** will arrange for **you** to be moved by air and/or by surface transportation to the nearest **hospital** within **your area of cover** where appropriate medical **treatment** is available.

**We** do not cover any other costs under this benefit such as hotel accommodation charges. **We** do not cover emergency evacuation to, from or within the United States of America. The **Assistance Service** retains the absolute right to decide whether **your** medical condition is eligible for evacuation, where **you** are evacuated to, and the means and method of the evacuation.

Full cover

Full cover

Full cover

**Return airfare**

Following an emergency evacuation covered by **your plan**, **we** will pay for **your** economy return airfare to **your place of residence**.

Full cover

Full cover

Full cover

**Travel expenses of a companion**

The transportation costs of another person to accompany **you** on **your** emergency evacuation, and their economy-class ticket back. If it is not possible for them to accompany **you** on **your** medical evacuation because of the method of evacuation, **we** will pay either for their economy-class round-trip airfare on a scheduled flight, or their suitable round-trip surface transportation, whichever is the most appropriate.

Full cover

Full cover

Full cover

**Accommodation expenses of a companion**

If **your** companion is then staying with **you** while **you** are hospitalised following **your** emergency evacuation, **we** will pay towards the costs of their hotel accommodation (limited to a maximum of 15 nights per **period of cover**).

Up to HK\$558 or US\$72 per night

Up to HK\$744 or US\$96 per night

Up to HK\$1,938 or US\$250 per night

**Compassionate home visit (12-month waiting period)**

If a **close family member** dies during **your period of cover** and after **you** have been insured by **your plan** for a continuous period of 12 months, **we** will pay for **your** economy-class round-trip airfare to attend the funeral. **Your** travel must take place within 28 days of the date of death.

Lifetime limit of one claim per insured person

Lifetime limit of one claim per insured person

Lifetime limit of one claim per insured person

Key



Full cover within annual benefit limit



Partial or limited cover



No cover



Optional cover

Bronze

Silver

Gold

## Expat benefits (continued)

Important notes: -

- You are eligible for certain benefits in this section only if they have been selected by **your employer** and they are stated on **your Certificate of Insurance**.
- You must obtain pre-authorisation for all benefits in this section.

### Repatriation of mortal remains

If **you** die as the result of a condition that is covered by **your plan** while **you** are outside **your country of nationality**, we will pay for **your** body or ashes to be transported to **your country of nationality** or **place of residence**. This benefit is not available if a **claim** is made for the burial or cremation benefit at the place where **you** died.

Full cover

Full cover

Full cover

### Burial or cremation

If **you** die as the result of a condition that is covered by **your plan** while **you** are outside **your country of nationality**, we will pay for **you** to be buried or cremated at the place where **you** died.

This benefit is not available if a **claim** is made under the repatriation of mortal remains benefit. We do not provide cover under this benefit if **you** die in **your country of nationality**. We do not provide cover under this benefit for the costs of a religious practitioner.

Up to HK\$12,400 or US\$1,600

Up to HK\$12,400 or US\$1,600

Up to HK\$12,400 or US\$1,600

### Medevac Plus

The following benefits apply in addition to those under the Medevac Basic benefit.

Evacuation if **you** (or any child covered by the newborn benefit within its first 90 days of life) need **advanced diagnostics** or cancer **treatment** such as radiotherapy or chemotherapy that cannot be adequately provided locally. All eligible evacuations will include repatriation to **your country of nationality** if it is within **your area of cover**, or to **your place of residence**. We do not cover emergency evacuation or repatriation to, from or within the United States of America.

If **you** request repatriation to **your country of nationality** or to **your place of residence**, it may, in some cases, not be appropriate immediately due to **your** medical condition. In such cases, we will first evacuate **you** to the nearest place within **your area of cover** where appropriate **treatment** is available. Once **you** have been stabilised, we will then repatriate **you** to **your country of nationality** if it is within **your area of cover**, or **your place of residence**.

If **you** are evacuated to a place or country which is not **your place of residence** and not **your country of nationality**, and **you** do not have anyone to accompany **you**, we will pay the economy-class round-trip airfare to have one companion flown from anywhere in the world to be with **you** while **you** receive **your treatment**. We will also pay up to HK\$1,163 or US\$150 per day (for a maximum of 30 days per **period of cover**) towards their hotel accommodation expenses whilst **you** have **your treatment**, or until the date on which **you** return to your **country of nationality** or your **place of residence** (whichever is the sooner).

Cover is only available if the Medevac Plus option is selected by **your employer**.

 Full cover (only if selected by **your employer**) Full cover (only if selected by **your employer**) Full cover (only if selected by **your employer**)

# What you're not covered for

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The following are not covered by **your plan**, as well as any specific exclusions stated on **your Certificate of Insurance**, and other exclusions stated within the **table of benefits**. Other benefits, as stated within the **table of benefits**, may also be restricted or excluded depending on **your plan**.

All conditions, tests, **treatments** or increased **treatment** costs **you** incur because of complications that occur directly or indirectly as a consequence of **treatment** of any excluded condition will also not be covered.

We will also not pay for the fees and charges listed below. **You** will be responsible for them.

- fees for the completion or providing of **claim** forms or any other medical reports or forms such as **medical referral letters**, even if **we** have requested them
- bank charges incurred as a result of **us** transferring money
- losses **you** may incur due to fluctuations in exchange rates
- charges incurred as the result of payment errors that arise as the result of **you** having provided **us** with incorrect information
- administration, registration, or cancellation fees charged by **hospitals, doctors**, or other providers of medical services
- any charges made by **your** bank or credit card company

## Addictive conditions or disorders, and alcohol, drug, and solvent abuse

**You** are not covered for **treatment** related to: -

- addictions (such as alcohol or drug addiction) or substance abuse (such as alcohol, drug or solvent abuse)
- any illness or injury caused directly or indirectly as a result of any such abuse or addiction
- any illness or injury caused directly or indirectly as a result of being under the influence of any substance (such as alcohol, drugs or solvents)

## Allergy testing and/or desensitisation

**You** are not covered for **treatment** related to: -

- allergy testing by hair analysis
- allergy desensitisation or food neutralising injections

We will only pay for patch testing if **you** have been referred by a **medical doctor**. Patch testing is limited to one patch testing investigation over the lifetime of **your plan**. **Your medical referral letter** will be required.

## Alternative treatment and therapies

**You** are not covered for alternative **treatments** and therapies, including, but not limited to, aqua physiotherapy, bone-setting, colonic irrigation, hydrotherapy, Intervertebral Differential Dynamics (IDD), kinesiology, naturotherapy, Ayurveda and massage therapy.

## Artificial life maintenance

**You** are not covered for **artificial life maintenance**, other than any benefit **you** are eligible for in the *lifetime care* section of the **table of benefits**.

## Birth control, sexual problems and gender reassignment

**You** are not covered for **treatment** directly or indirectly arising from or connected with: -

- contraception or sterilisation
- sexual problems (including impotence and decreased libido)
- gender reassignment

## Chemical exposure and contamination

**You** are not covered for investigations or **treatment** related to any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

## Circumcision

**You** are not covered for **treatment** related to circumcision, unless it is required for **treatment** of an **acute medical condition** covered by **your plan**.

## Consultations or investigations when you are not physically present

**You** are not covered for consultations or investigations where **you** are not physically present, without prior agreement from **us**. This includes, for example, interviews by medical practitioners with other medical practitioners or with family members.

## Convalescence, rehabilitation, nursing homes, and health spas or hydros

**You** are not covered for: -

- **hospital** accommodation if the reason **you** are hospitalised is for the purpose of convalescence, **rehabilitation** or supervision
- relaxation or rest **treatments**, or **treatments** in nature cure clinics, health spas and health hydros
- private beds registered as nursing homes attached to such establishments or a **hospital** where the **hospital** has effectively become **your** home or permanent abode

Other than **treatment** **you** are eligible for under the rehabilitation **treatment** benefit.

## Cosmetic surgery and treatment

**You** are not covered for investigations or **treatment** related to: -

- cosmetic or aesthetic **treatment** to enhance **your** appearance, even when medically prescribed
- the removal of fat or surplus tissue
- breast enlargement or reduction
- sclerotherapy for spider veins, **treatment** of superficial

varicose veins

- Botox, dermal fillers, or **treatment** of vitiligo or any skin pigmentation disorder

### Criminal activity

**You** are not covered for **treatment** arising from or related to injuries sustained while **you** are engaged in a criminal, illegal or unlawful act.

### Dietitian

**You** are not covered for **treatment** or advice by a dietitian or nutritionist (unless covered under **your plan** under the dietitian benefit in the *cancer treatment* section of the **table of benefits**).

### Drugs prescribed for out-patient mental health treatment

**You** are not covered for drugs prescribed for **out-patient** mental health **treatment**.

### Experimental drugs and treatments

**You** are not covered for **treatment** or medicine which in **our** reasonable opinion is experimental or unproven based on generally accepted current clinical evidence and generally accepted medical practice.

### Eyesight

**You** are not covered for: -

- **treatment** to correct **your** eyesight, such as laser **treatment**, refractive keratotomy and photorefractive keratotomy
- upgraded lenses as part of an eye operation, such as cataract surgery
- spectacles, and other visual aids, **treatment** of strabismus (squint) or amblyopia (lazy eye)
- sight tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**)

### Failure to follow medical advice

**You** are not covered for: -

- **treatment** arising from or related to **your** unreasonable failure to seek or follow medical advice and/or prescribed **treatment**, or **your** unreasonable delay in seeking or following such medical advice and/or prescribed **treatment**
- complications arising from ignoring such advice

### Foetal surgery

**You** are not covered for surgery undertaken on a child while it is in its mother's womb.

### Genetic testing or genetic engineering

**You** are not covered for genetic testing or genetic engineering, other than **treatment** **you** are eligible for under the cancer genome tests benefit in the *cancer treatment* section of the **table of benefits**.

### Hearing

**You** are not covered for: -

- **treatment** for or arising from deafness caused by maturing or

ageing

- **treatment** for or arising from deafness caused by a **congenital condition** if either the abnormality was diagnosed, or **you** were showing signs or symptoms of the abnormality, before **your date of entry** (unless covered under **your plan** under the emergency treatment for newborn babies benefit in the *maternity costs* section of the **table of benefits**)
- hearing aids
- hearing tests (unless covered under **your plan** in the *well-being benefits* section of the **table of benefits**)

### Infertility, IVF, and assisted reproduction

**You** are not covered for: -

- testing or diagnosis related to infertility
- infertility **treatment**, **assisted reproduction** (e.g. IVF **treatment**), including establishing pregnancy

### Learning and educational difficulties

**You** are not covered for learning and educational difficulties, including, but not limited to, dyslexia and speech disorders.

### Nasal septum deviation

**You** are not covered for **treatment** related to nasal septum deviation and nasal concha resection.

### Natural changes as a result of ageing

**You** are not covered for: -

- **treatment** to relieve the symptoms commonly associated with physiological or natural changes as a result of ageing e.g. menopause or puberty
- bone densitometry
- reproductive hormone testing, reproductive hormone therapy or hormone replacement therapy (unless covered under **your plan** under the hormone replacement therapy benefit in the *out-patient treatment* section of the **table of benefits**)

### Palliative care

**You** are not covered for palliative care other than cover available to **you** for the palliative care of a **terminal medical condition** in the *lifetime care* section of the **table of benefits**.

### Persistent vegetative state and neurological damage

**You** are not covered for **treatment** received after: -

- **you** have been in a **vegetative state** for a period of eight weeks
- **you** have sustained permanent neurological damage and remained in **hospital** for a period of eight weeks

Except for any **treatment** **you** are eligible for under the lifetime care benefit.

### Physical development, learning difficulties, speech disorders, and behavioural problems

**You** are not covered for any consultations, tests required to diagnose or exclude a diagnosis, or **treatment** of or related to: -

- developmental delays
- learning and education difficulties, including, but not limited to, dyslexia and speech disorders

- behavioural problems, including, but not limited to, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), and Tourette's syndrome
- physical development of any kind
- teething
- bed wetting

### Pre-existing medical conditions or related conditions

You are not covered for **treatment** related to: -

- any **pre-existing medical conditions** of the following types and any **related conditions**, if **you** have ever had them at any time before **your date of entry**, unless **we** have agreed otherwise: -
  - *brain or nervous system conditions*
  - *cancer, tumours or growths*
  - *heart or circulatory conditions*
  - *mental health conditions, drug and alcohol issues or sleep disorders*
  - *joint replacements; and*
- any other **pre-existing medical conditions** and **related conditions** that **you** have had during the five years before **your date of entry**, unless **we** have agreed otherwise.

### Preventive surgery

You are not covered for surgery when no physical signs or symptoms are shown, or no diagnosis has been made.

### Professional sports and motorised racing as an amateur or a professional

You are not covered for **treatment** for an illness or injury related to: -

- participation in (including training for or practising for) any kind of professional sport or professional racing (by professional, **we** mean sport where **you** are being paid to participate and/or **you** are receiving sponsorship or other benefits as a result of **your** participation)
- participation in (including training for or practising for) any kind of racing (whether amateur or professional) which involves the use of a motorised vehicle

### Scalp conditions

You are not covered for: -

- **treatment** specifically related to scalp conditions, including, but not limited to, alopecia
- wigs (unless covered under **your plan** in the *cancer treatment* section of the **table of benefits**)

### Search and/or rescue

You are not covered for: -

- search and/or rescue operations, including, but not limited to, mountain rescue or rescue from ski slopes or pistes
- evacuations from offshore installations such as oil rigs, or from any type of sea going vessel such as a ship, ferry or yacht

### Second opinions or duplicate tests

You are not covered for second or subsequent opinions from a **medical doctor**, **medical practitioner** or **specialist** or for duplicate tests for the same condition.

### Self-inflicted injuries

You are not covered for **treatment** of self-inflicted injuries or **treatment** of any injury or illness directly or indirectly caused by self-inflicted injuries.

### Sexually-transmitted infections

You are not covered for **treatment** related to sexually-transmitted infections including genital/anal warts.

### Sleep disorders

You are not covered for **diagnostic tests** for or **treatment** of any sleep related disorder, including, but not limited to, insomnia, snoring and sleep apnoea.

### Stem-cell harvesting

You are not covered for stem cell harvesting other than prior to a stem cell transplant, or any **treatment** undertaken in anticipation of, prior to, or following such harvesting.

### Sundry medical supplies

You are not covered for non-prescribed items such as hot and cold packs and support bandages, unless these are required as a result of **treatment** received during a medical emergency.

### Travel costs

You are not covered for travel costs including airfares and hotel accommodation (unless covered under **your plan** in the *expat benefits* section of the **table of benefits**).

### Treatment by a related party

You are not covered for **treatment** provided by and/or under the control of and/or on referral from: -

- any family member, including, but not limited to, a **spouse**, **partner**, parent, brother, sister, child, grandparent, grandchild, uncle or aunt
- any **medical services provider**, **medical practitioner** or **specialist** where the **insured person** has a financial interest and/or a professional interest, including, but not limited to, employees, employers, consultants and owners

### Vitamins, dietary supplements, natural substances, and creams

You are not covered for commercially available substances that can be purchased without prescription, including, but not limited to, vitamins, minerals, organic substances, moisturisers, oils, creams, or other pharmaceutical products, other than any **treatment** available to **you** under the routine maternity care and childbirth benefit in the *maternity costs* section of the **table of benefits**.

### **War and terrorism**

**You** are not covered for **treatment** arising directly or indirectly from war, foreign enemy hostility, terrorism, rebellion, civil war, revolution, military coup, riot, strike, martial law, state of siege or attempted overthrow of a government, in a country or region that the British Foreign & Commonwealth Office has advised its citizens to leave, or advised its citizens against all travel to, unless **you** are an **innocent bystander**.

### **Weight-related conditions and eating disorders**

**You** are not covered for investigations or **treatment** related to: -

- obesity, or which is necessary because of obesity
- weight monitoring or control, such as slimming classes, aids and drugs
- bariatric surgery, or complications resulting from bariatric surgery
- eating disorders of any kind, such as anorexia nervosa or bulimia

### **Wilful exposure to needless danger**

**You** are not covered for **treatment** of any conditions arising directly or indirectly from **your** gross negligence and/or **your** wilful exposure to needless danger except in an attempt to save a human life.

# If you need to make a claim

As stated in the **table of benefits**, there are certain benefits and **treatments** for which **you** must obtain pre-authorisation.

If **you** need to claim for a benefit or **treatment** for which **you** must obtain pre-authorisation, **you** must contact **us** in advance of starting **your treatment** and give **us** all the information **we** require to assess if **your** proposed **treatment** will be eligible for cover under **your plan**. If **your** proposed **treatment** is eligible for cover, **we** will pre-authorise all eligible expenses. **We** will not pay for any **treatment** costs or expenses that have not been pre-authorised by **us** in advance.

## Eligible medical services providers

**You** have the freedom to choose when and where **you** receive **your medical treatment** within **your area of cover**. Please note that **we** will only pay up to the **reasonable and customary** monetary amount which is typically charged in the country where **treatment** is being received.

## If you have optional USA cover and you seek treatment in the USA

All **treatment you** receive in the United States of America must be pre-authorised in advance by **us** or by the **Assistance Service**. **We** will not pay for any **treatment** in the United States of America that has not been pre-authorised.

If **we** instruct a local agent to arrange the billing or cost adjustment of **your medical treatment** expenses in the United States of America, any fees charged by the local agent will be deducted from the USA benefit limit available under **your plan**, as stated in the *Your area of cover* section of this **plan handbook**.

## If you are admitted to hospital

All **in-patient** and **day-patient hospital treatment** must be pre-authorised by **us** or by the **Assistance Service**.

Please contact **us** as soon as **you** know that **you** need **in-patient** or **day-patient treatment**. **You** must let **us** know that **you** need **in-patient** or **day-patient treatment** at least 5 days in advance of **your admission**. This gives **us** sufficient time to contact the **hospital** to obtain the necessary medical information.

When **you** contact **us**, **we** will ask **you** to complete a pre-authorisation form and a consent form that permits the **hospital** to release the necessary medical information to **us**. Once **we** have received all the medical information that **we** require, both from the **hospital** and **yourself** (including any other information **we** might need), **we** will advise **you** if the proposed medical **treatment** will be covered by **your plan**.

If **you** contact **us** less than 5 days in advance of **your** admission, **we** may be unable to pre-authorise **your treatment** in time. This means **you** may have to pay for the **treatment yourself** and submit a **claim** for reimbursement to **us** later. In some instances, **we** may decline **your** reimbursement **claim** or **we** may subject **your** reimbursement **claim** to a 20% **co-insurance**.

If **you** are admitted to **hospital** in an emergency and it's not reasonably possible for **you** to contact **us** in advance of **your**

admission, **we** will consider **your claim** provided that **you** contact **us** within 24 hours of **your** admission. If **you** do not contact **us** within 24 hours, **we** may decline **your claim** or subject **your claim** to a 20% **co-insurance**.

## If you do not obtain pre-authorisation for treatment that we have specified must be pre-authorised

For eligible **treatment** which has not been pre-authorised, **we** will only reimburse 80% of the eligible costs.

## How to claim back your eligible treatment costs

If **you** are claiming for a medical condition, **you** will need to download a claim form from **our** website.

Please complete Section A of the claim form. If the total amount of **your claim** is likely to exceed HK\$3,875 or US\$500 (or the foreign currency equivalent), please take the **claim** form with **you** when **you** visit **your doctor** and ask him or her to complete and sign Section B of the claim form.

Scan the completed **claim** form and the fully itemised invoices and receipts for the **treatment you** have received, and send to [hkclaims@william-russell.com](mailto:hkclaims@william-russell.com).

Even if **your claim** is less than HK\$3,875 or US\$500 **we** may in some cases require **your doctor** to complete and sign Section B of **your** claim form before **we** can settle **your claim**.

**We** can only reimburse **your claim** when **we** have fully itemised invoices and receipts which give a breakdown of the **treatment** and medical services **you** have received, and any drugs **you** have been prescribed.

Please retain **your** original invoices, receipts and **claim** forms for 12 months. **We** may require these for auditing purposes.

**Claim** forms are not required however when **you** are claiming for the following benefits: -

- If **you** are claiming for the well-being benefit or dental benefit please send **us** the fully itemised invoices and receipts for which **you** are claiming reimbursement, together with **your** bank account details.
- If **you** are claiming for the compassionate home visit benefit please send **us** a copy of the death certificate of **your close family member**, together with a copy of the invoice for **your** round-trip airfare, stating the class of travel, and **your** bank account details.

## Claims for which a medical referral letter is required

If **you** are claiming for **out-patient** physiotherapy, any **treatment** by a chiropractor, **out-patient** mental health **treatment**, osteopath, chiropodist or podiatrist, a dietitian consultation or an MRI or CAT (CT) scan **you** must also send **us your medical referral letter**. If **you** are claiming for a PET scan, **you** must also send **us your specialist's medical referral letter**.

## Supplying the information required to process your claim

We can accept the information required to process **your claim** via email. Simply, scan in PDF format **your** itemised invoices, receipts, **medical referral letter** (when required) and **your** fully completed claim form and email them all to [hkclaims@william-russell.com](mailto:hkclaims@william-russell.com). Please always retain the original copies of everything for a period of 12 months as **we** reserve the right to receive these documents before **we** assess **your claim**. **We** may also require them at any time for auditing purposes. Or, **you** can send the information required to process **your claim** by post.

**You** must submit **your claim** within 6 months of **your treatment** date, unless it was not reasonably possible for **you** to submit the **claim** within this time. **We** will not pay any invoices received by **us** more than 12 months after the **treatment** date.

**We** will not pay fees charged by a **medical practitioner**, or anyone else, for completing a claim form.

## Paying your claim

Where possible **we** will settle invoices for **in-patient** or **day-patient treatment** direct with the **hospital** or **medical services provider**. **We** will deduct any **excess** or **co-insurance** amount, as well as any other ineligible items, and **you** will be responsible for paying the shortfall direct to the **hospital** or **medical services provider**.

If **we** are paying **you** direct, **our** preferred method of payment is bank transfer. If **you** provide us with incorrect payment details and **we** cannot recover the payments, **we** will not make the payment again to **you**.

**We** will only make payment to **you** or to the **medical services provider** that provided **your treatment**. Payment will not be made for **treatment** that has not been received yet.

If **we** or the **Assistance Service** pre-authorise costs which subsequently turn out to have been related to a condition which is not covered by **your plan**, **you** will be responsible for all the costs incurred, and if **we** have made any settlement on **your** behalf, **you** will be responsible for repaying to **us** the amount **we** have paid.

## Using the direct billing service

To be eligible to receive the direct billing service, **you** must have completed an application for the service and have paid any additional premium invoiced by **us**.

If you are eligible for the direct billing service this will be stated on **your Certificate of Insurance**, and **you** will be issued with a membership card which bears the letters **DB**. This card, together with photographic identification, will enable **you** to receive eligible **treatment** at **direct billing medical services providers** within **our medical network**. The **direct billing medical services provider** will bill **us** directly for **your treatment**.

If the cost of **your treatment** is greater than HK\$3,875 or US\$500, the **direct billing medical services provider** will contact **us** for pre-authorisation of the **treatment**. To avoid delays, **we** recommend that **you** contact **us** in advance of **your treatment**. Once **we** have verified that the **treatment** is eligible for cover, **we** will let the **direct billing medical services provider** know.

It is important to note that the **direct billing medical services provider** is not aware of the terms and benefits provided by **your plan**. They will provide **treatment** in accordance with a separate agreement between **us** and them.

This means that, for **claims** of less than HK\$3,875 or US\$500 where the **direct billing medical services provider** is not obliged to contact **us** for pre-authorisation, it is **your** responsibility to claim only for **treatment** that is eligible for cover under **your plan**.

**We** have an obligation to settle all bills for **treatment** received from **direct billing medical services providers** within **our medical network**, provided that they fall within the terms of the contract between **us** and them.

If **you** receive **treatment** for a medical condition that is not covered by **your plan**, **we** will invoice **you** for the ineligible expenses **you** have claimed. This will also result in direct billing being withdrawn from **your plan**. If **you** do not repay to **us** these ineligible expenses within 30 days, **we** will not renew **your plan**.

If **you** cancel **your plan**, **you** must return **your** membership card to **us**. **We** will cancel **your** cover with effect from the date **we** receive **your** membership card. **We** can accept a photograph of a cut card.

The membership cards are **our** property and **we** can ask **you** to return the cards to **us** at any time.

**We** have the right to remove direct billing from **your plan** at any time within **your period of cover**, at **our** discretion.

## Exchange rates

**We** will settle **your claim** in the currency that **your employer** pays **your premium** (unless **you** instruct **us** to settle **your claim** in another currency **we** can administer).

If **we** make a currency conversion for a **claim** with a single invoice, **we** will use the exchange rate applicable on the date stated on the invoice.

For multiple invoices **you** submit for one **claim**, **we** will use the exchange rate applicable on the **claim** payment date.

**We** import exchange rates from [oanda.com](http://oanda.com) into **our** IT system each night. **We** use the exchange rates at the time of the import, which may differ slightly from the historic exchange rates shown on [oanda.com](http://oanda.com). Historic exchange rates are based on the average exchange rate for any particular day.

## Excesses, co-insurance, and benefit limits

The **excess** shown on **your Certificate of Insurance** is the amount each **insured person** will have to pay towards the cost of their **treatment**.

If **your plan** has an **excess** and the benefit **you** are claiming for has **co-insurance** or limits, **we** will apply the **co-insurance** first, then the **excess**, then the limit.

If **you** have a **plan** which has an **excess** per **claim**, this is the amount **you** will have to pay each time **you** make a new **claim** for **treatment** of a condition that is covered by **your plan**. If **you** subsequently suffer a new occurrence of that condition, this will be treated as a new **claim**, and **we** will apply the **excess** again to that new **claim**. If your course of **treatment** spans two **periods of cover**, **we** will apply the **excess** again when **your plan** renews.

If **your claim** is in respect of the well-being benefits, **your excess** will be applied once per **period of cover**.

If **your excess** is per annum it will be applied once per **period of cover**. For example, if **your excess** is US\$500 per annum, **we** will not pay for the first US\$500 of eligible expenses **you** incur during **your period of cover**. **We** will apply one **excess** per **period of cover** irrespective of the number of **claims** **you** make. **You** must

submit all eligible **claims** to **us** - even **claims** within **your** annual **excess**, as **we** will only be able to reimburse **you** when the value of the eligible expenses **you** incur exceeds the amount of **your** annual **excess**. When **you** renew the **plan**, the annual **excess** will apply again in respect of **your** new **period of cover**.

### **Our right to request additional information**

**We** may request additional medical information to enable **us** to assess **your claim**, such as medical reports or tests. These must be provided at **your** own expense. **We** may also request an independent medical examination. If **you** do not agree to supply **us** with additional medical information that **we** reasonably request, **we** will not be able to assess **your claim**.

If **you** require ongoing **treatment we** may ask for further medical information, and if **we** do, the cost of providing this information must be borne by **you**. **We** are unable to return original documents such as invoices or medical letters, but **we** will send **you** copies upon request.

### **Our right to request a treatment review**

**We** will not pay for **treatment** which in **our** opinion is inappropriate based on established medical and clinical practice and **we** are entitled to conduct a review of **your treatment** when it is reasonable for **us** to do so.

### **Illness or injury caused by a third party**

If **you** are claiming for an illness or injury that was caused by some other person or organisation (a third party) **you** must let **us** know in writing straight away, or tell **us** on **your** claim form. **We** will then pay benefit in accordance with the terms of this **plan handbook** provided that **you** take all necessary steps **we** ask **you** to take to assist **us** in recovering **our** costs from the person or organisation at fault (such as through their insurance company) the cost of the **treatment** paid for by **us**, plus interest, at **your** own expense.

If **you** pursue a personal **claim** for damages against the third party, **you** must provide **us** with the full name and address of the solicitor handling the action. **We** will then contact the solicitor to register **our** interest and seek to recover **our** own costs, plus interest, in addition to any damages that **you** may recover or be awarded. **We** reserve the right to appoint **our** own solicitor to act on **your** behalf in this matter and to take over the conduct of the action.

If **you**, or any **insured person**, are able to recover from the third party (whether or not through legal action) compensation that includes any **treatment** costs **we** have paid, **you** must repay that amount to **us**. Any interest that **you** or any **insured person** may also have been awarded that relates to the recovered **treatment** costs **we** have paid for must also be repaid to **us**. If **you** only receive a proportion of **your claim** for damages then **you** must repay to **us** the same proportion of **our** costs.

### **If you are covered by another insurance plan**

If **you** have any other insurance that covers the same costs as **we** do, **we** will only pay **our** proportionate share of the **claim**. In this event, **you** must provide **us** with full details of the other insurance, including the name and address of the other insurer, their policy and **claim** number and any other relevant information, when **you** first submit **your claim**. **We** will then contact the other insurance company to ensure that **we** only pay **our** proportion of the **claim**. This may involve **us** sending **your** personal information regarding **your claim** to the other insurer.

**We** will also allow sums paid by another insurer to be offset against the **excess** payable under **your plan** with **us**, subject to receiving confirmation from the other insurer of any amounts already paid by them, and subject to the **treatment** costs being eligible for cover under **your plan** with **us**.

# Other information about your plan

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## Plan premiums

**Your employer** is responsible for paying the **premium**. **We** must be in receipt of the **premium** before **we** will commence **your** cover.

**Your plan** will only remain in force while **you** are employed by **your employer**. **We** will not pay for any **treatment** expenses incurred after **your** cover has ended, even if it was previously authorised.

## Unpaid or late premiums

**We** will automatically cancel **your** cover if **your employer** fails to pay **your premium** on or before the **premium due date**.

**We** may allow **your** cover to continue without **you** having to complete a new **application form** and health declaration if **your employer** pays the outstanding **premium** within 30 days of the **premium due date**. During this 30-day period **we** will not accept any **claims** for **treatment** incurred on or after the **premium due date** until **your employer** has paid the **premium** due. This also applies to **treatment** that **we** have already pre-authorised.

If **your employer** does not pay the **premium** within 30 days of the **premium due date**, **we** will cancel **your plan** from midnight on the day before **your premium due date**. Once **we** have cancelled **your plan**, **your employer** will have to reapply for cover and **you** will have to complete a new **application form**, which will be subject to **medical underwriting**.

## Changing your cover

Any changes to **your** cover must be requested by **your employer**, and may be subject to further requirements such as requiring **you** to complete a new **application form** which will be subject to **medical underwriting**. **We** cannot accept requests from **you** to change cover for **you** or **your** dependants.

## Adding dependants to your plan

If the **plan** includes cover for **employees' dependants** **you** must apply for cover on behalf of **your** spouse or partner, if they are under 70 years of age on their **date of entry**.

**You** must also apply for cover for **your eligible** dependent children if they are under 18 years old, or under 25 years old if they are in continuous full-time education. **We** reserve the right to request proof of a child being in full-time education.

**We** will not commence cover for a new **eligible dependant** until **we** have accepted their **application** and **we** have received payment of their **premium** from **your employer**.

## Adding newborn babies to your plan

If the **plan** includes cover for **employees' dependants** **you** may add **your** newborn child to **your plan**, without any **medical underwriting**, provided **you** notify **us** of their full name and date of birth, and **your employer** pays the additional **premium** required, within 30 days of their date of birth. If **you** have been insured with **us** for a continuous period of twelve months or more at the date of birth, the **date of entry** can be backdated to their date of birth. The child's cover will be restricted to the cover

provided by **your employer's plan**.

If **you** do not inform **us** about the birth of **your** child within 30 days of their birth, and/or **your employer** does not pay the additional **premium** within 30 days of their date of birth, **you** will have to make a new **application** for **your** child to be added to **your plan**, and this **application** will be subject to **medical underwriting**.

Newborn children who have been born as a result of **assisted reproduction treatment** and born within 36 weeks of conception are always subject to **medical underwriting**.

## In the event of the death of an insured person

If **you** (the **employee**) die and have **eligible dependants** insured under **your plan**, they will no longer be entitled to be insured on the **plan** and will be removed from the date of **your** death. However, they may apply to be insured on their own individual **plan**, provided they are over the age of 18 years.

To enable **us** to do this **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your** date of death. Provided **we** receive the new **application form**, and the required **premium**, **we** will continue their cover as before but subject to **our** Individual **premium** rates.

If **your eligible dependants** want to continue with cover that is enhanced in anyway in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **your eligible dependants** are under the age of 18, their legal guardian will have to sign the **application form** on their behalf.

If an insured **eligible dependant** dies, please inform **us** as soon as possible.

## Divorce and separation

If **you** have **your** spouse or partner included under **your plan** and **you** become separated or divorced, **we** will have to transfer **your** insured spouse or partner on to their own **plan** as they will no longer be entitled to be covered on **your employer's plan**. To enable **us** to do this **we** will require **your** spouse or partner to complete a new **application form** which must be completed and returned to **us** within 30 days of **your** date of divorce or separation.

Provided **we** receive the new **application form**, and provided **premiums** are paid by the new plan holder, **we** will continue to cover **your** insured ex-spouse or partner as before, but subject to **our** individual **premium** rates. If **your** ex-spouse or partner wants to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

## When a child dependant is no longer eligible to be covered under the plan

If one of **your** children has married, or has reached the age of 18 (or the age of 25 if they are in full time education) they will no

longer be able to be included on the **plan** from the **renewal date** following their marriage/birthday. However, they may apply to be insured on their own individual **plan**.

To enable **us** to continue their cover as before **we** will require a new **application form** which must be completed and returned to **us** within 30 days of **your renewal date** along with the appropriate **premium** due, which will be subject to **our** individual **premium** rates.

If **your** child wants to continue with cover that is enhanced in any way in comparison to their previous cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

If **we** do not receive **your** child's **application form** and **premium** within 30 days of **your renewal date**, their cover will automatically cease from midnight on the day before **your renewal date**. If they subsequently wish to apply for cover, they will have to complete a new **application form** and this new **application** will be subject to **medical underwriting**.

### Changing your address, place of residence or country of nationality

**You** must inform **us** if **you** change **your** address and provide **us** with the new details.

If **you** change **your** place of residence or **you** change **your** country of nationality, **you** must tell **us** straight away.

### If you cease to be a Hong Kong resident

**You** must tell **us** as soon as **you** or any of your **dependants** cease to be **Hong Kong resident**. **Your** plan will automatically cease from the **renewal date** following the date on which **you** cease to be a **Hong Kong resident**. **We** may be able to offer to continue **your** cover under a similar plan if the laws of the country in which **you** become resident allow **us** to do so. **We** reserve the right to refuse to offer cover in certain countries.

### If you leave your employment

If **you** leave **your** employment **you** are no longer eligible to be included on **your employer's plan** and **you** will be removed on the date **your** employment ceases. In some circumstances **you** may be allowed to continue cover with **us** on an individual **plan** with no additional **medical underwriting**, but subject to **our** individual **premium** rates. If **you** would like more information about this then please contact **us**.

### When we can cancel your plan

**We** have the right to cancel **your** plan immediately if: -

- **your employer** does not pay **your premium** and other charges such as insurance **premium** tax within 30 days of any **premium due date**
- **your** employment with the **employer** ceases (and **you** have not submitted an **application form** and paid the required **premium** within 30 days of the date on which it ceased)
- **you** are no longer a **Hong Kong resident**
- **you** have not provided **us** with medical information **we** have requested to enable **us** to assess a **claim** or any potential **claim** that may arise in the future
- **you** have not repaid to **us** fully any ineligible **claim** payments **we** have invoiced **you** with
- **you**, any **insured person** or any person acting on **your** behalf has made any threatening or abusive comment, or used any

unacceptable language towards **us** or any member of **our** staff, or any service provider acting on **our** behalf, whether verbally (including any telephone conversation) or in writing (including any electronic communication)

- **we** reasonably suspect that any **insured person** has misled **us** or attempted to mislead **us**, whether intentionally or carelessly, either at the time of joining or when making a **claim**, by: -
- making a **claim** under this policy knowing it to be dishonest, intentionally exaggerated or fraudulent in any way
- providing **us** with incomplete or false information
- working with another party to provide false information to **us**
- changing original documents

If **we** cancel **your** plan for any of the above reasons **we** may also report the matter to the relevant authorities, if appropriate.

**We** have the right to cancel **your** plan from **your renewal date** if you move to a country where **we** are unable to offer continued cover due to compliance, and/or legal reasons.

### When we can change your plan

**We** have the right to apply **special terms** to **your** plan if **you** give **us** inaccurate or incomplete information. Such **special terms** will be applied from **your date of entry**.

### When we may apply special terms to your plan

**We** may change the benefits offered by **your** plan and/or **your excess**. If **we** do, **we** will write to **your employer** before the **renewal date** to confirm these benefit changes and/or change in **excess**. Any changes **we** make to the benefits or **excess** will come into effect from the **renewal date** of **your** plan.

From time to time, **we** may decide to discontinue the **plan** **you** are a member of and/or change the **excesses** available. If this happens, **we** will transfer **your** membership to similar **plan**.

### Our liability under this plan

**Our** liability under this **plan** is limited to paying for **treatment** or services in respect of eligible **claims** under this **plan**. The choice of provider of the **treatment** or services for which **you** are claiming under this **plan** is **your** responsibility. **We** make no representations or recommendations regarding the availability and standard of any **treatment** or services offered or provided by any **hospital** or **medical services provider**. **We** will not be held liable to **you** or any **insured person** for any loss, harm or damage of any description resulting from lack of availability or from a defect in the quality of any **treatment** or service offered or provided by any **hospital** or **medical services provider**. This **plan** represents the whole and only **agreement** between **your employer** and the **insurer** relating to the provision of **your** private medical insurance.

### Your responsibilities as an employee

It is **your** responsibility to: -

- inform **us** if **your** personal details, or the personal details of any **insured person**, change
- keep **us** advised of **your** current email address
- inform **us** if **you** change **your** address, **place of residency** or **country of nationality**

### Arbitration and applicable law

All disputes arising out of or in connection with the present contract shall be governed by and construed in accordance with the laws of Hong Kong.

### **Contracts (Rights of Third Parties) Ordinance**

Any person or entity that is not a party to this contract or an **insured person** under it shall have no right to enforce any term in this contract pursuant to the Contracts (Rights of Third Parties Ordinance).

### **Governing law**

This **plan** is issued in Hong Kong Special Administrative Region. This **plan** shall be governed by and construed in accordance with the laws of Hong Kong Special Administrative Region.

### **Personal data privacy**

We shall comply with the Personal Data Privacy Ordinance (Chap. 486) of the Law of Hong Kong and the related codes, guidelines, and circulars.

# Definitions

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This section explains what **we** mean by certain emboldened words and phrases bolded in this **plan handbook**.

## Accident

A sudden, unexpected, unusual, specific, violent, external event which occurs at a single identifiable time and place independently of all other causes, which results directly, immediately and solely in physical bodily injury which results in a loss. In no event shall the contracting of any disease and/or illness (including, but not limited to, heart attack, stroke or cancer), nor the injection or ingestion of any substance, be considered an **accident**. An event which directly or indirectly exacerbates a previously existing physical bodily injury shall not be considered an **accident**.

## Acute medical condition

A disease, injury or illness that is likely to respond quickly to **treatment** which aims to return **you** to the state of health **you** were in immediately before suffering the disease, illness or injury, or which leads to **your** full recovery.

## Advanced diagnostics

Diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).

## Application or application form

The **application form** **you** have completed and signed on behalf of **yourself** and on behalf of any **eligible dependants** for whom cover is requested. Please note that on some occasions an alternative form such as a health declaration or an upgrade form may be required to be completed instead of a full **application form**. **We** will advise **you** when this is the case. The alternative form will then be classed as the **application** or **application form** for the purpose of this **plan handbook**. Information on previously completed **application forms**, if applicable, may also be used by **us** for underwriting and **claims** assessment reasons.

## Area of cover

The territorial limits of **your plan**.

## Artificial life maintenance

When **you** require medical equipment that assists or replaces important bodily functions, including mechanical ventilation, percutaneous endoscopic gastronomy (PEG), and nasal feeding.

## Assistance Service

The emergency assistance company contracted by **us** to provide assistance services to **plan** members at the time of **your claim**. The contact details for the **Assistance Service** can be found at the beginning of this **plan handbook**.

## Assisted reproduction

The use of medical techniques, including, but not limited to, in-

vitro fertilisation (IVF) with or without intra-cytoplasmic sperm injection (ICSI), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), egg donation and intra-uterine insemination (IUI) with ovulation induction, received during the 3-month period prior to conception.

## Certificate of Insurance

The confirmation of **your** insurance cover issued by **us**. It confirms the **plan** **your employer** has chosen, the **plan** currency, **your area of cover**, **period of cover**, **date of entry**, **renewal date**, **excess amount**, **special terms**, **your place of residence**, **your country of nationality**, and the schedule of **insured persons**. The schedule of **insured persons** lists the persons insured by **us** under **your employer's agreement** with **us**. If there are any changes to the details on **your Certificate of Insurance** **we** will issue **you** with a new one confirming the changes.

## Chronic condition

A disease, illness or injury that has one or more of the following characteristics: -

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- **you** need to be rehabilitated or specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

## Claim

A course of **treatment** for a specific illness, injury, medical condition, dental condition or pregnancy, or the use of a benefit in the *Expat benefits* section of the **table of benefits**.

## Close family member

**Your spouse**, civil or co-habiting **partner**, parent, brother, sister, child or grandchild.

## Co-insurance

A contribution that **you** must make towards the eligible costs of **your claim**.

## Complications of pregnancy

**Treatment** received for a medical condition which arises because of the antenatal or postnatal stages of pregnancy.

## Congenital condition

Whether hereditary or not, any abnormality, deformity, disease, illness or injury present at birth, whether diagnosed or not, or any deformity arising during the antenatal stages of pregnancy, or caused during childbirth.

## Country of nationality

Your country of origin, for which you hold a passport. If you hold more than one passport your country of nationality will be the country you have declared on your application form.

## Date of entry

The date on which cover for you, and each of your dependants, first commenced. Your date of entry is as stated on your Certificate of Insurance.

## Day-patient

A patient admitted to a hospital or day-patient unit for a medical procedure which for medical reasons could not have been performed on an out-patient basis and which requires them to occupy a hospital bed for a period of medically supervised recovery, but it is not medically necessary for them to occupy a bed overnight.

## Dental treatment

Dental procedures undertaken by your dental practitioner which are clinically necessary for the maintenance and/or restoration of oral health, and are provided in accordance with accepted standards of dental practice.

## Dentist or dental practitioner

A qualified person legally carrying out this profession in the country in which he or she is located.

## Diagnostic tests

Investigations, such as x-rays or blood tests to diagnose the cause of your symptoms.

## Direct billing medical services provider

A hospital, out-patient clinic or medical doctor with whom we hold a current direct billing agreement.

## Doctor

See medical doctor.

## Eligible dependants

Your spouse or partner, provided they are under age 70 at their date of entry, and your unmarried children (i.e. your son, daughter, step-son, step-daughter, adopted children and children subject to legal guardianship) provided the unmarried children are aged less than 18 years old, or less than 25 years old if in continuous full-time education. If a child is adopted or the subject of legal guardianship we may require proof. We may also require proof of a dependent child being in full-time education. Your dependants must also be Hong Kong residents.

## Emergency caesarean section

A caesarean section, which must take place immediately and cannot be planned.

## Emergency treatment

Essential treatment, covered by your plan, that is immediately required if you suffer an accident or a sudden and unforeseen illness you have never suffered from before, which is not a pre-existing medical condition, or a related condition, or a condition

for which you have a personal medical exclusion.

## Employee

You, the member of the health plan provided by your employer.

## Employer

The policyholder specified as your company/employer on your Certificate of Insurance.

## Excess

The amount stated as the excess in your Certificate of Insurance, being the amount you must contribute to each claim.

## Hospital

An establishment which is legally licensed as a medical or surgical hospital under the laws of the country in which it is situated.

## Innocent bystander

Someone who is not involved with, participating in or reporting on war, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege, or attempted overthrow of government, or any acts of terrorism, or actively participating in operations countering any such activities.

## In-patient

A patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons.

## Insured person

You and any eligible dependants specified in your Certificate of Insurance as being included in the plan.

## Insurer

The insurance company that provides the insurance cover for your plan. The insurer is Sompoo Insurance (Hong Kong) Co., Ltd.

## Life-threatening condition

A critical medical condition covered by your plan, which in the opinion of the Assistance Service constitutes a life-threatening situation which requires immediate in-patient treatment.

## Medical doctor

A person who is legally qualified in medical practice following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation) to provide medical treatment and who is licensed to practise medicine in the country where the treatment is received.

## Medically necessary

Treatment that is medically necessary and appropriate. The treatment must be: -

- essential to diagnose or treat a patient's condition, illness or injury;
- consistent with the patient's symptoms, diagnosis or treatment of the underlying condition;
- in accordance with generally accepted medical practice and

professional standards of medical care at the time;

- required for reasons other than the comfort or convenience of the patient or his or her physician
- proven and been demonstrated to have medical value, with international medical and scientific evidence of the effectiveness and safety of the **treatment**;
- considered to be the most appropriate type and level of **treatment** taking patient safety and cost effectiveness into consideration;
- provided at an appropriate facility, in an appropriate setting, and at an appropriate level of care for the **treatment** of the patient's medical condition;
- provided only for an appropriate duration of time.

### Medical practitioner

A person who has full registration under the Medical Acts of the country where they practice and who specialises in nursing, homeopathy, acupuncture, orthopaedic medicine, traditional Chinese medicine, osteopathy, chiropractic, chiropody, podiatry or physiotherapy **treatment**, and to whom **you** have been referred by a **medical doctor**.

### Medical referral letter

A letter from **your medical doctor** or **specialist** which refers **you** to another **medical practitioner** for **treatment** covered by **your plan**. **We** will only pay for **treatment** when the start date of **your treatment** is within 3 months of the date of **your medical referral letter**.

### Medical services provider(s)

A **hospital**, **out-patient clinic**, **medical practitioner**, **dental practitioner**, **optician** or **pharmacy**.

### Medical underwriting

The process of **you** providing and **us** assessing the health and medical information **we** ask for to decide the terms under which **we** will accept **your application** for cover, or for enhanced cover. Based on the information **you** give **us**, **we** may decide to place **special terms** on **your** cover, such as **personal medical exclusions**, or **we** may decide not to offer **you** cover.

### Out-patient

A patient who attends a **hospital** consulting room, emergency room or **out-patient clinic**, when it is not **medically necessary** for them to be admitted as a **day-patient** or an **in-patient**.

### Out-patient surgical procedure

An **out-patient** procedure where one or more of the following is **medically necessary**: -

- general or local anaesthesia or intravenous sedation
- manipulation or relocation of a fractured bone or dislocated joint by a **medical doctor**
- invasive surgical procedures
- invasive diagnostic procedures involving venous cannulation
- the use of endoscopic equipment

### Partner

Someone in a long-term, civil or domestic partnership with **you**.

### Period of cover

A period of 12 months from **your date of entry** or from any subsequent **renewal date**. **Your period of cover** is as shown on **your Certificate of Insurance**.

### Personal medical exclusions

A restriction on **your** cover that is stated on **your Certificate of Insurance** and specifically excludes **treatment** of a certain medical condition or conditions and any **related conditions**.

### Place of residence

The country or region in which **you** are habitually resident, as specified on **your application form** or subsequently advised to **us** in writing.

### Plan

The **Bronze plan**, **Silver plan** or **Gold plan** on which **you** and **your eligible dependants** are covered.

### Plan handbook

The contents of this document.

### Planned caesarean section

A caesarean section which has been scheduled to take place more than 24 hours in advance, whether this be for medical or elective reasons.

### Post-hospital treatment

**Medically necessary** follow-up consultations, physiotherapy, **diagnostic tests** and/or **treatment** required on an **out-patient** basis following **in-patient** or **day-patient treatment** covered by **your plan**.

### Pre-admission tests

An **out-patient** assessment during which **your** health is assessed in order to confirm that **you** are medically fit to undergo the planned **treatment** and that **you** are sufficiently prepared for it. The assessment may include an electrocardiogram, blood and/or urine tests and a chest x-ray.

### Pre-existing medical conditions

Any disease, illness or injury, whether the condition has been diagnosed or not before **your date of entry**, for which: -

- **you** have received medication, advice or **treatment**; or
- **you** have experienced symptoms

### Premium

The amount(s) **your employer** is required to pay to **us** either annually, half-yearly, quarterly or monthly for **your insurance plan**.

### Premium due date

The date on which **your premium** is due to be paid by **your employer**.

### Preventive health checks

Health tests, screening and/or clinical procedures specifically designed for disease prevention and early detection.

### Qualified nurse

A nurse whose name is currently on any official register of nurses maintained by a statutory nursing registration body within the country where **treatment** is provided.

### Reasonable and customary

The charge that would typically be made for **your treatment** by **medical services providers** in the country where **you** receive **your treatment**, and for the **medically necessary** length of stay required. If the cost of **your treatment** is not **reasonable and customary**, **we** will only pay up to the amount which is typically charged in that country. If the length of stay is not **reasonable and customary**, **we** will only pay for the **medically necessary** length of stay required.

### Rehabilitation

**Treatment** in the form of a combination of therapies such as physical, occupational and speech therapy aimed at restoring full function after an acute event such as a stroke.

### Rehabilitation hospital or unit

A medical facility licensed under the regulations of the country in which it operates and designed for patients who no longer need acute **hospital** care but who still require medical or nursing supervision and/or assistance with activities of daily living because of their medical disability.

### Related condition

Any disease, illness or injury that is caused by a **pre-existing medical condition** or results from the same underlying cause as a **pre-existing medical condition**.

### Renewal date

The **renewal date** of **your employer's plan** as shown on **your Certificate of Insurance**.

### Restricted hospitals in Hong Kong

- Matilda International Hospital
- Hong Kong Adventist Hospital
- Hong Kong Sanatorium & Hospital

### Session

A single continuous consultation during which time **you** may receive advice, **treatment** and/or prescribed medication.

### Specialist

A **medical practitioner** who is fully registered by the regulatory body of the country in which he or she practices following attendance at a recognised medical school (as listed in the World Directory of Medical Schools as published from time to time by the World Health Organisation). They must be on a **specialist** register appropriate for the condition for which **treatment** is sought. Where regulation demands, the **medical practitioner** must also have a licence to practice. **We** reserve the right to withhold or remove recognition of any **specialist** for reasons such as suspension of registration, fraud or unreasonable charges.

### Special terms

Any **personal medical exclusions**, restrictions or **premium adjustments** **we** may apply to **your plan**. Any **special terms** relating to **your plan** will appear on **your Certificate of Insurance**.

### Spouse

**Your** husband or wife.

### Table of benefits

The table in this **plan handbook** that sets out the benefits covered by each **plan**.

### Temporary trip

A trip for business and/or recreational purposes, which has a defined return date and is for a period that is no longer than the maximum duration specified for **your USA** cover option. If **your treatment** extends beyond the end of **your trip's** specified return date, **your cover** will cease at the end of the term defined in **your USA** cover option wording. For example, if **you** have selected the USA-45 option and **you** are on a 30-day trip to the United States of America, which becomes extended to 60 days, **your** cover in the United States of America will cease 45 days after **your** date of entry to the United States of America.

### Terminal medical condition

A condition that has become incurable and all the **treatments** given are to prolong life.

### Treatment

Surgical or medical services (including **diagnostic tests**) that are needed to diagnose, relieve or cure a disease, illness or injury.

### Us, we, our

William Russell Ltd on behalf of the **insurer**.

### Vegetative state

A state where there is no sign of awareness or any cognitive function, even if the person can open their eyes and/or breathe unaided. If the person is in a **vegetative state** for a continuous period of eight weeks, they will be considered to be in a persistent **vegetative state**.

### Waiting period

When specified, the amount of time **you** must be covered by the same **plan** before **you** can **claim** for that benefit. No benefit is payable for any **treatment** costs incurred during the **waiting period**. When a **waiting period** is not specified there is no **waiting period** applicable.

### You, your, yourself

Any and all persons named in the schedule of **insured persons** on **your Certificate of Insurance**.

# We're here to help



Call us on  
**852-3702-6162**



Visit  
**[william-russell.com.hk](http://william-russell.com.hk)**

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