SUPPLEMENT 1

SmartViva Flexi VHIS
(This is to supplement Part 6 of Benefit Provisions of the Terms and Benefits)

This Supplement 1 is attached to and forms part of these Terms and Benefits. The terms stated and/or defined in these Terms and Benefits shall have the meanings herein unless the context requires otherwise.

Enhanced Benefits Provisions

1. **General provisions**

The Company shall reimburse the Eligible Expenses which are Reasonable and Customary or other expenses in accordance with the benefit items under Section 2 of this Supplement 1 below. Any amounts payable under this Supplement 1 are subject to the benefit limits set out in the Benefit Schedule and the amount of expenses so payable shall not exceed the actual expenses incurred.

2. **Enhanced benefits covered**

(a) **Private nursing**
This benefit shall be payable for the Eligible Expenses charged on the services rendered by Qualified Nurse(s) hired by the Policy Holder or the Insured Person in respect of nursing care received during Confinement (in addition to the general nursing services provided by the Hospital) or at the Insured Person's residential home rendered within one hundred eighty (180) days immediately after discharge from a Hospital. Such nursing care received must be recommended in writing by the attending Registered Medical Practitioner and is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement. This benefit shall be payable on a daily basis regardless of the number of Qualified Nurse(s) hired or the number of time slots/shifts provided on the same day, subject to the maximum benefit limit per day and maximum number of days per Policy Year as stated in the Benefit Schedule.

(b) **Companion bed**
If room and board or intensive care is payable under Section 3(a) or Section 3(e) of Part 6 of the Terms and Benefits, this benefit shall be payable for the charges of one (1) companion bed in the event the Insured Person is being Confined. For the avoidance of doubt, this benefit shall only cover the cost of companion bed but not any expenses incurred on meal.

(c) **Emergency outpatient treatment for Accidents**
This benefit shall be payable if the Insured Person sustains an Injury due to Accident or Emergency condition and receives Emergency Treatment at an outpatient department or accident and emergency department of a Hospital on an outpatient basis. The onset of the Accident or the Emergency condition and the treatment received should not be separated by more than forty-eight (48) hours.

This benefit shall cover the following charges incurred by the Insured Person –

(i) consultation fee of a Registered Medical Practitioner;
(ii) western medication prescribed by a Registered Medical Practitioner and consumed during outpatient treatment and post treatment up to the ensuing four (4) weeks;
(iii) laboratory examination and reports;
(iv) diagnostic imaging services, including ultrasound and X-ray, and their interpretation; and
(v) other medical related fee covering the costs of dressing and intravenous ("IV") infusions, including IV fluids.

For the avoidance of doubt, this benefit shall only be payable for the Eligible Expenses for outpatient visit or Emergency Treatment not resulting in a Confinement or Day Case Procedure. In any event, where Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Benefits, such Eligible Expenses shall not be payable under this benefit.

(d) **Day Patient kidney dialysis**
This benefit shall be payable for the Eligible Expenses charged on haemodialysis or peritoneal dialysis in a setting for providing Medical Services to a Day Patient recommended in writing by the attending Registered Medical Practitioners, provided that the Insured Person is suffering from chronic and irreversible kidney failure.

(e) **Complications of pregnancy**
This benefit shall be payable for the Eligible Expenses incurred for the benefit items described in Sections 3(a) to (i) of Part 6 of the Terms and Benefits where a surgical procedure is performed by a Surgeon during Confinement or in a setting for providing Medical Services to a Day Patient as a result of the following pregnancy related complications arising during antepartum stages of pregnancy or childbirth –

(i) abruptio placentae;
(ii) placenta previa;
(iii) hydatidiform mole;
(iv) ectopic pregnancy; or
(v) retained placenta or membranes.

This benefit shall only be payable provided that such complication must be resulted from a conception occurred after the first twelve (12) months of the Policy Effective Date.

(f) **Rehabilitation**
This benefit shall be payable each day for the Eligible Expenses and other expenses charged for institutional rehabilitation treatment provided to the Insured Person provided that there is a minimum of twelve (12) consecutive hours of stay at the rehabilitation centre during such day which is within one hundred eighty (180) days after discharge from a Hospital provided further that the rehabilitation treatment is directly related to and as a result of the condition arising from the same cause (including any and all complications therefrom) necessitating such Confinement. Such rehabilitation centre shall be recognised, constituted and registered as a rehabilitation centre under the laws of the territory in which it is situated to provide institutional rehabilitation services.

Where Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Benefits, such Eligible Expenses shall not be payable under this benefit.

This benefit shall only be payable with the pre-approval pursuant to the approval procedure specified in the membership guide. For the avoidance of doubt, this rehabilitation benefit shall not be payable if no pre-approval is obtained.

(g) **Hospice and palliative care**
This benefit shall be payable for the expenses charged on the Insured Person in receiving institutional palliative care in a hospice or palliative care center. Such institution shall be recognised, constituted and registered as a hospice or palliative care centre under the laws of the territory in which it is situated to provide institutional palliative care. The Insured Person must be diagnosed to have terminal Sickness or Disease by the attending Registered Medical Practitioner and the Registered Medical Practitioner has indicated a prognosis that no curative treatment which will lead to a recovery and the life expectancy of the Insured Person is highly likely to be twelve (12) months or less. This benefit shall cover the following charges incurred by the Insured Person –

(i) accommodation and meals;
(ii) nursing care provided by Qualified Nurse(s);
(iii) western medication prescribed by a Registered Medical Practitioner and consumed during the stay; and
(iv) physical and psychological support care.

Where Eligible Expenses under this benefit are also covered under Section 3 of Part 6 of the Terms and Benefits, such Eligible Expenses shall not be payable under this benefit.

(h) **Consultation or acupuncture by a Registered Chinese Medicine Practitioner after Confinement or specific treatments**
Provided that benefits are payable under Section 3(a), (f) or (j) of Part 6 of the Terms and Benefits or Section 2(d) of this Supplement 1, this benefit shall be payable to cover the expenses charged by a Registered Chinese Medicine Practitioner for rendering treatments which are directly related to and as a result of the condition arising from the same cause (including all complications therefrom) necessitating such Confinement or specific treatment under Section 3(a), (f) or (j) of Part 6 of the Terms and Benefits or Section 2(d) of this Supplement 1.

This benefit shall cover the following charges incurred by the Insured Person –

(i) consultation fee of a Registered Chinese Medicine Practitioner;
(ii) charges for acupuncture performed by a Registered Chinese Medicine Practitioner; and
(iii) charges for Chinese Medicines prescribed at the time of consultation by the Registered Chinese Medicine Practitioner and obtained from a legitimate source on the same day of the consultation mentioned under Section 2(h)(i) above.

(i) **Prosthetic Device**

Upon the written recommendation of the attending Registered Medical Practitioner, the Company shall pay for the costs of Prosthetic Device placed inside or on the surface of the Insured Person's body which is Medically Necessary for the purpose of replacing wholly, or in part, any permanently inoperative or malfunctioning body part or Prosthetic Device during Confinement, Day Case Procedure or after discharge from a Hospital.

For the avoidance of doubt, if the expenses under this benefit are also covered under Section 3(b) of Part 6 of the Terms and Benefits, the expenses for such items shall be exclusively paid under Section 2(i) of this Supplement 1 and no benefit shall be payable for the Prosthetic Device under Section 3(b) of Part 6 of the Terms and Benefits.

3. **Definitions**

Under this Supplement 1, words and expressions used shall have the following meanings –

"Chinese Medicines"	shall mean Chinese medicines legally registered by the Chinese Medicines Board under the Chinese Medicine Council of Hong Kong pursuant to the Chinese Medicine Ordinance (Chapter 549, Laws of Hong Kong) or the equivalent legal authority of any other place providing Chinese medicines treatment.
"Prosthetic Device"	shall mean artificial ears, eyeballs, and/or body limb placed inside or on the surface of the Insured Person's body.
"Registered Chinese Medicine Practitioner"	shall mean a Chinese medicine practitioner, (a) who is duly qualified and is registered with the Chinese Medicine Council of Hong Kong pursuant to the Chinese Medicine Ordinance (Cap. 549 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering Chinese medicine treatment or service in Hong Kong or the relevant jurisdiction outside Hong Kong where the treatment or service is provided to the Insured Person, but in no circumstances shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the practitioner is not duly qualified or registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith), the Company shall exercise reasonable judgment to determine whether such practitioner shall nonetheless be considered qualified and registered.
"Qualified Nurse"	shall mean a nurse, (a) who is duly qualified and is registered with the Nursing Council of Hong Kong pursuant to the Nurses Registration Ordinance (Cap. 164 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering nursing treatment or service in Hong Kong or the relevant jurisdiction outside Hong Kong where the treatment or service

is provided to the Insured Person,

but in no circumstances shall include the following persons – the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the nurse is not duly qualified or registered under the laws of Hong Kong or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith), the Company shall exercise reasonable judgment to determine whether such nurse shall nonetheless be considered qualified and registered.

SUPPLEMENT 2

SmartViva Flexi VHIS

(This is to supplement Part 6 of Benefit Provisions of the Terms and Benefits)

This Supplement 2 is attached to and forms part of these Terms and Benefits. The terms stated and/or defined in these Terms and Benefits shall have the meanings herein unless the context requires otherwise.

Compassionate Death Benefit Provisions

1. General provisions

(a) If the Insured Person dies while these Terms and Benefits are in force, this benefit as shown in the Benefit Schedule shall be payable to the Beneficiary upon receipt of a written proof of claim by the Company.

If the Insured Person commits suicide, while sane or insane at the material time, within one (1) year from the Policy Effective Date of these Terms and Benefits, no compassionate death benefit shall be payable.

(b) All benefits payable under this Supplement 2 are not subject to any Deductible.

2. Beneficiary provisions

Beneficiary shall mean a person or persons (if any) designated by the Policy Holder to receive the compassionate death benefit payable under these Terms and Benefits upon the Insured Person's death.

In relation to the requirements concerning the payment to the Beneficiary, please refer to below:

(a) Whenever a Beneficiary is designated either in these Terms and Benefits or by a declaration in writing by the Policy Holder, such Beneficiary will be deemed to be beneficially entitled to the compassionate death benefit under these Terms and Benefits if the Insured Person dies while these Terms and Benefits are in force.

(b) During the lifetime of the Insured Person and while these Terms and Benefits are in force, subject to the approval of the Company at its discretion, the Policy Holder may change the Beneficiary of these Terms and Benefits by completing the prescribed form and sending it to the Company.

(c) If the Policy Holder is also the Insured Person and the Beneficiary dies before the Policy Holder or within thirty (30) days after the death of the Policy Holder, the compassionate death benefit will be payable to the estate of the Policy Holder.

(d) If the Policy Holder is not the Insured Person and the Beneficiary dies before the Insured Person or within thirty (30) days after the Insured Person's death, the compassionate death benefit shall be paid to the Policy Holder, estate or personal representatives of the Policy Holder, or other persons entitled to receive the same as the Company considers appropriate at its reasonable discretion. If the Beneficiary dies beyond thirty (30) days after the Insured Person's death, the compassionate death benefit shall be payable to the Beneficiary's estate.

(e) If the Insured Person and Beneficiary or Beneficiaries die in circumstances rendering it uncertain that anyone of them, or which of them survived the other or others, the Insured Person shall be deemed to have survived the Beneficiary or Beneficiaries.

(f) A change of Beneficiary shall be effective only if the request is made by written notification which is subject to the approval of the Company at its discretion. The Insured Person does not have to be living when the request for change of Beneficiary is put into effect by the Company. The Company will not be responsible for any payment it has made or other action it has taken before the change takes effect.

(g) If there is more than one Beneficiary, the compassionate death benefit shall be paid to the Beneficiaries in the proportion specified by the Policy Holder. If the Policy Holder has not specified the proportion of the compassionate death benefit to be paid to each Beneficiary or all the proportions add up to a figure other than

100%, the Company shall have the discretion to pay the compassionate death benefit to all the Beneficiaries in equal shares or in such proportion as the Company thinks appropriate.

(h) If there is no living Beneficiary or no Beneficiary has been designated by the Policy Holder, the compassionate death benefit shall be paid to the Policy Holder, estate or personal representatives of the Policy Holder, or other persons entitled to receive the same.

SUPPLEMENT 3

SmartViva Flexi VHIS

(This is to supplement Part 6 of Benefit Provisions of the Terms and Benefits)

This Supplement 3 is attached to and forms part of these Terms and Benefits. The terms stated and/or defined in these Terms and Benefits shall have the meanings herein unless the context requires otherwise.

Medical Check-up Benefit Provisions

1. **General provisions**

   (a) The benefit under this Supplement 3 is applicable to an Insured Person who has been continuously covered under the Terms and Benefits (regardless of its Deductible option) for a period of twelve (12) months or more. On each Renewal Date, the Insured Person may select either one (1) of the benefits below –

   (i) benefit payable under Section 2 of this Supplement 3 (applicable to Insured Person Aged eighteen (18) or above as at the relevant Renewal Date); or
   (ii) benefit payable under Section 3 of this Supplement 3.

   (b) All benefits payable under this Supplement 3 are not subject to any Deductible.

2. **Free medical check-up service at designated healthcare services providers**

   (a) If the Insured Person has attained Age eighteen (18) or above on the relevant Renewal Date, the Company shall send a redemption letter to the Policy Holder for free medical check-up service within ninety (90) days after the relevant Renewal Date.

   (b) Upon presentation of the redemption letter, the Insured Person can receive one (1) preventative medical check-up service at the Company's designated healthcare services providers in Hong Kong within the timeframe as specified in the redemption letter which shall not expire earlier than ninety (90) days after the relevant Renewal Date.

   (c) The scope of the check-up service provided shall be determined by the Company at its reasonable discretion, but shall include at least the following –

   (i) height and weight measure;
   (ii) chest X-ray;
   (iii) complete blood count test;
   (iv) renal function tests; and
   (v) full medical report with follow-up doctor consultation for explanation.

3. **Reimbursement of medical check-up expenses**

   (a) This benefit shall be payable for the fees charged for one (1) medical check-up service received by the Insured Person at a legally registered healthcare services provider on an out-patient basis in any area excluding the United States ("U.S.") within the Policy Year. The Company shall reimburse the actual medical check-up expenses incurred up to the benefit limit as stated in the Benefit Schedule.

   (b) Benefit payable under this Section 3 is not subject to any Age restriction of the Insured Person.

   (c) For the avoidance of doubt, this benefit shall not be payable for any medical check-up service received in the U.S..

4. **No double reimbursements of medical check-up expenses**

In the same Policy Year, the Company shall pay the benefit either under Section 2 or Section 3 of this Supplement 3. If the Insured Person has received the benefits under both Sections 2 and 3 of this Supplement 3 within the same Policy Year, the Policy Holder shall repay the reimbursed amount under Section 3 of this Supplement 3 to the Company immediately upon the Company's reasonable request.

SUPPLEMENT 4

SmartViva Flexi VHIS

(This is to supplement Part 4 of Renewal Provisions of the Terms and Benefits)

This Supplement 4 is attached to and forms part of these Terms and Benefits. The terms stated and/or defined in these Terms and Benefits shall have the meanings herein unless the context requires otherwise.

Change of Deductible Provisions

1. **General provisions**

After the first Renewal Date, the Policy Holder may apply to the Company in writing at least thirty (30) days before each subsequent Renewal Date for a variation of the Deductible under the Terms and Benefits. If the Company approves the application for variation of Deductible, claims for expenses incurred after variation of the Deductible shall be subject to the varied Deductible from the relevant Renewal Date.

2. **Increasing Deductible**

The Company shall approve the application for increasing Deductible without any re-underwriting.

3. **Reducing or removing Deductible**

(a) Except for exercising the right under Section 3(b) of this Supplement 4 below, all applications for reducing or removing Deductible are subject to re-underwriting of the Company. Approval shall be given subject to the prevailing underwriting guideline of the Company.

(b) The Policy Holder can exercise a one-off right to reduce or remove the Deductible without re- underwriting, provided that –

(i) the request is made not less than thirty (30) days prior to the Renewal Date on or immediately following the date that the Insured Person attains the Age of fifty (50), fifty-five (55), sixty (60), sixty-five (65), seventy (70), seventy-five (75), eighty (80) or eighty-five (85);
(ii) such right to reduce or remove the Deductible without re-underwriting can only be exercised once during the lifetime of the Insured Person; and
(iii) the Insured Person has not reduced the Deductible within the previous two (2) Policy Years and this condition does not apply when the Insured Person exercises the right to remove or reduce the Deductible without re-underwriting at the Age of eighty-five (85).

The Policy Holder can choose whether or not to exercise such right and the Age to exercise such right.

SUPPLEMENT 5

SmartViva Flexi VHIS

(This is to supplement Part 6 of Benefit Provisions of the Terms and Benefits)

This Supplement 5 is attached to and forms part of these Terms and Benefits. The terms stated and/or defined in these Terms and Benefits shall have the meanings herein unless the context requires otherwise.

Limitations and Claims Provisions

1. **Territorial scope of cover**

   (a) For organ transplant surgery performed in any area excluding the United States ("U.S.") and Hong Kong, all benefits described in these Terms and Benefits are subject to the limitation and benefit reduction as stated in Section 2 of this Supplement 5 below.

   (b) For any Eligible Expenses and other expenses incurred in the U.S., the final amount payable under these Terms and Benefits shall be calculated according to the formula as stated in Section 4(b) of this Supplement 5, and in so doing,
   (i) the benefit limits under Sections 3(a) to (k) of Part 6 of the Standard Plan Terms and Benefits shall apply;
   (ii) no benefit shall be payable under Sections 3(l) of Part 6, Section 2 of Supplement 1 and Section 3 of Supplement 3 of these Terms and Benefits; and
   (iii) the restrictions on the choice of ward class as stated in Section 3 of this Supplement 5 shall not apply.

   For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall refer to the version as is referred to under Sections 1(a), (b) or (c) of Part 4 of the Terms and Benefits.

   (c) Section 2 of Supplement 3 of these Terms and Benefits shall be payable for eligible expenses incurred at designated healthcare services providers in Hong Kong only.

2. **Additional geographical limitation and reduction of benefits for organ transplant surgery performed in any area excluding the U.S. and Hong Kong**

   (a) The reduction of benefits under this Section 2 only applies to organ transplant surgery performed in any area excluding the U.S. and Hong Kong.

   (b) If the Insured Person has obtained pre-approval pursuant to the approval procedure specified in the membership guide and Eligible Expenses and other expenses are incurred for organ transplant surgery performed in any area excluding the U.S. and Hong Kong under Sections 3(a) to (i) and (k) of Part 6 of the Terms and Benefits and Sections 2(a), (b), (f), (g), (h) and (i) of Supplement 1, the calculation of benefit payment under Section 4(a) of this Supplement 5 shall apply, and in so doing,

   (i) the aggregate benefit limit for organ transplant surgery performed in any area excluding the U.S. and Hong Kong as stated in the Benefit Schedule shall apply; and
   (ii) the respective benefit limits under Sections 2(a), (b), (f), (g), (h) and (i) of Supplement 1 shall still apply.

   (c) If the Insured Person has not obtained pre-approval in receiving organ transplant surgery performed in any area excluding the U.S. and Hong Kong pursuant to the approval procedure specified in the membership guide and Eligible Expenses are incurred for organ transplant surgery performed in any area excluding the U.S. and Hong Kong, the calculation of benefit payment under Section 4(b) of this Supplement 5 shall apply, and in so doing,
   (i) the benefit limits under Sections 3(a) to (i) and (k) of Part 6 of the Standard Plan Terms and Benefits shall apply;
   (ii) no benefit shall be payable under Sections 2(a), (b), (f), (g), (h) and (i) of Supplement 1; and
   (iii) the restrictions on the choice of ward class as stated in Section 3 of this Supplement 5 and the aggregate benefit limit for organ transplant surgery performed in any area excluding the U.S. and Hong

Kong as stated in the Benefit Schedule shall not apply.

For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall refer to the version as is referred to under Sections 1(a), (b) or (c) of Part 4 of the Terms and Benefits.

(d) For the avoidance of doubt, the final amount payable for Eligible Expenses incurred for organ transplant surgery performed in the U.S. shall be calculated according to the formula as stated in Section 4(b) of this Supplement 5. The restrictions on the choice of ward class as stated in Section 3 of this Supplement 5 and the aggregate benefit limit for organ transplant surgery performed in any area excluding the U.S. and Hong Kong as stated in the Benefit Schedule shall not apply.

(e) For the avoidance of doubt, the final amount payable for Eligible Expenses incurred for organ transplant surgery performed in Hong Kong shall be calculated according to the formula as stated in Section 4(a) of this Supplement 5. The aggregate benefit limit for organ transplant surgery performed in any area excluding the U.S. and Hong Kong as stated in the Benefit Schedule shall not apply.

3. **Choice of ward class and adjustment for voluntary upgrade**

(a) The benefits described in these Terms and Benefits are subject to the restriction in choice of ward class at the designated geographical locations as stated in the Benefit Schedule.

(b) For the purpose of Section 4 and subject to Section 3(c) of this Supplement 5 below, if the Insured Person is Confined in room of class higher than the restricted ward class at the designated geographical location specified in the Benefit Schedule for any treatment or service, benefits payable under the Terms and Benefits in relation to such days of Confinement shall be subject to the adjustment as follows –

Restricted ward class	Actual Confined ward class	Adjustment
Standard Private Room	Above Standard Private Room including suite, VIP or deluxe room	The benefit limits of the Standard Plan Terms and Benefits shall apply

(c) The benefits payable under the Terms and Benefits shall not be subject to the adjustment in Section 3(b) above if the Insured Person is Confined in a room at a higher level ward class as a result of –
   (i) unavailability of a restricted or lower ward class due to room shortage at the Hospital for Emergency Treatment;
   (ii) Confinement in isolation that requires a specific ward class; or
   (iii) any other reason not involving the Insured Person's own individual preference for the Confined ward class.

(d) For the avoidance of doubt, the applicable Standard Plan Terms and Benefits shall refer to the version as is referred to under Sections 1(a), (b) or (c) of Part 4 of the Terms and Benefits, and the benefit amount payable thereunder shall be subject to any applicable remaining balance of Deductible.

(e) For the purpose of these Terms and Benefits, "Standard Private Room" shall mean a room categorised as single, private or first class room by a Hospital with a private bathroom, but without any kitchen, dining room or sitting room.

4. **The calculation of benefit payment under the Terms and Benefits**

(a) For any expenses incurred in any area excluding the U.S., except where any of the Standard Plan Applicable Situations (as defined under Section 4(b) below) is applicable, the final amount payable under the Terms and Benefits shall be calculated according to the formula below –

[Amount of Eligible Expenses or other expenses payable according to the Terms and Conditions and Supplements, after applying exclusion and before applying the benefit limits	subject to	Remaining balance of the benefit limits as stated in the Benefit Schedule (if applicable)]	less	Any remaining balance of Deductible (if applicable)

(b) For benefits payable –
(i) in accordance with Section 1(b) above for any Eligible Expenses incurred in the U.S.;
(ii) in accordance with Section 2(c) above; or
(iii) where the adjustment under Section 3(b) above is applicable
(collectively referred to as "Standard Plan Applicable Situations"),
the final amount payable under the Terms and Benefits shall be calculated according to the formula below –

[Amount of Eligible Expenses payable according to Sections 3(a) to (l) of Part 6 of the Standard Plan Terms and Benefits, after applying exclusion of the Standard Plan Terms and Benefits and before applying the benefit limits of the Standard Plan Terms and Benefits	subject to	Remaining balance of the benefit limits as stated in the benefit schedule of the Standard Plan Terms and Benefits (if applicable) ##]	less	Any remaining balance of Deductible (if applicable)

In the case of Section 4(b)(i) above, the applicable benefit limits as stated in Section 1(b)(i); and in the case of Section 4(b)(ii) above, the applicable benefit limits as stated in Section 2(c)(i).

If the benefits payable under the Standard Plan Applicable Situations (before application of any applicable remaining balance of Deductible) have exhausted the applicable benefit limits of the relevant Policy Year as specified in the benefit schedule of Standard Plan Terms and Benefits, no further benefit shall be payable under any Standard Plan Applicable Situations.

For the avoidance of doubt, when Standard Plan Terms and Benefits apply, no benefit shall be payable for

(iv) any psychiatric treatments received outside Hong Kong under Section 3(l) of Part 6 of the Standard Plan Terms and Benefits; and
(v) any benefits under Supplement 1 and Supplement 3 of these Terms and Benefits.

(c) For expenses arising from unknown Pre-existing Condition(s) for the second and third Policy Year, the Company shall use the amount immediately before deducting the remaining balance of Deductible as shown in Sections 4(a) and 4(b) above to apply the reimbursement percentage specified in Section 4 of Part 6 of the Terms and Benefits. The Company shall then apply the remaining balance of the Deductible in the relevant Policy Year (if applicable).

(d) If there are any Eligible Expenses or other expenses payable under the Terms and Benefits that have been reimbursed under any other insurance coverage or as otherwise described in Section 13 of Part 7 of the Terms and Benefits, the remaining balance of Deductible in the relevant Policy Year, if applicable, shall be reduced by such reimbursed amount.

(e) All benefits payable in accordance with the Terms and Benefits (including the Standard Plan Terms and

Benefits, if applicable), shall be subject to the application of any applicable remaining balance of Deductible, and such benefits payable before the application of any applicable remaining balance of Deductible shall be counted towards the Annual Benefit Limit of the relevant Policy Year as specified in the Benefit Schedule.

SUPPLEMENT 6

Inclusion of VAT and GST as Eligible Expenses

This Supplement shall be attached to and form part of the Terms and Benefits. Unless otherwise defined, words and expressions used in the Terms and Benefits shall have the same meanings when they are used in this Supplement.

This Supplement shall take effect from 27 September 2021 ("**Effective Date**").

With effect from the Effective Date, the following terms and conditions shall be applied to the Terms and Benefits –

1. With respect to any Eligible Expenses incurred on or after the Effective Date, the terms and conditions in this Supplement shall be applicable, and Eligible Expenses shall include the VAT and GST (if any) charged or imposed on the expenses incurred for Medical Services rendered with respect to a Disability.

2. For the purpose of Section 13 of Part 7 of the Terms and Benefits, any VAT and GST which is refunded to the Policy Holder or Insured Person (as the case may be) shall be excluded pursuant to such Section 13, and shall not be recoverable under the Terms and Benefits.

Definition

"VAT and GST "	shall mean value added taxes, goods and services taxes or other taxes, duties or levies of a similar nature, which may be charged or imposed by the relevant tax or similar authorities or governmental departments on the expenses incurred for Medical Services rendered with respect to a Disability