INTERNATIONAL SWISS MEDICAL HONG KONG

International Swiss Medical Hong Kong

Valid from 2020 • USD/EUR/CHF

Welcome

Welcome to your Bupa Global Quick Reference Guide on how to use your insurance.

Important insurance documents
The product guide including the List of Reimbursements, Policy Conditions and Glossary must be read alongside your policy schedule, as together they set out the terms and conditions of your insurance and form your insurance documentation.

Quick Reference Guide
This booklet explains how to use your insurance, including how to make a claim and other important information.

It also contains a summary of all your important contact information, the sort of information you are likely to use on a regular basis.

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Contact us

Healthline
+45 70 23 24 65

Our Healthline's multilingual staff can assist you with:

- General medical information
- Advice from health professionals
- Finding local medical facilities and physicians
- Referral to second medical opinion service

Bupa Global Assistance

For medical emergencies and verification of benefits 24/7 contact our multilingual staff:

Tel: +45 70 23 24 60
Email: emergency@ihi.com

In case of an emergency, we recommend you to call your local emergency number (eg 911 or 112) for immediate assistance.

General enquiries
+852 2531 8505

Bupa (Asia) Limited
18/F Berkshire House
25 Westlands Road, Quarry Bay
Hong Kong

Service Relationship Management Team can assist you with:

- information about your cover and about your policy
- payment queries
- claims information

email: service.hk@bupaglobal.com
online chat on ihi.com

Open 7am - 7pm (HKT) Mon-Fri
7am - 4pm (HKT) Weekend and public holiday

Calls are recorded for training and quality purposes and may be shared when legally required to.

Please note that we cannot guarantee the security of email as a method of communication. Some companies, employers and/or countries do monitor email traffic, so please bear this in mind when sending us confidential information.

Authorised person

Please notice that in case you need another person to contact Bupa Global on your behalf in relation to policy administration, including but not limited to claims assessment and verification of benefits for treatment, we will always need that person to be formally authorised by yourself before we share information about you and your insurance plan with that person.

Please inform Bupa Global about your authorised person and give your consent to Bupa Global to exchange information, including medical information, with the authorised person.

Please contact us to request a consent form.

Contact details changed?

It's very important that you let us know when you change your contact details (correspondence address, email or telephone). We need to keep in touch with you so we can provide you with important information regarding your plan or your claims. Simply log onto myPage or call, email or write to us.

Easier to read information

Braille, large print or audio
We want to make sure that customers with special needs are not excluded in any way. We also offer a choice of braille, large print or audio for our letters and literature. Please let us know which you would prefer.

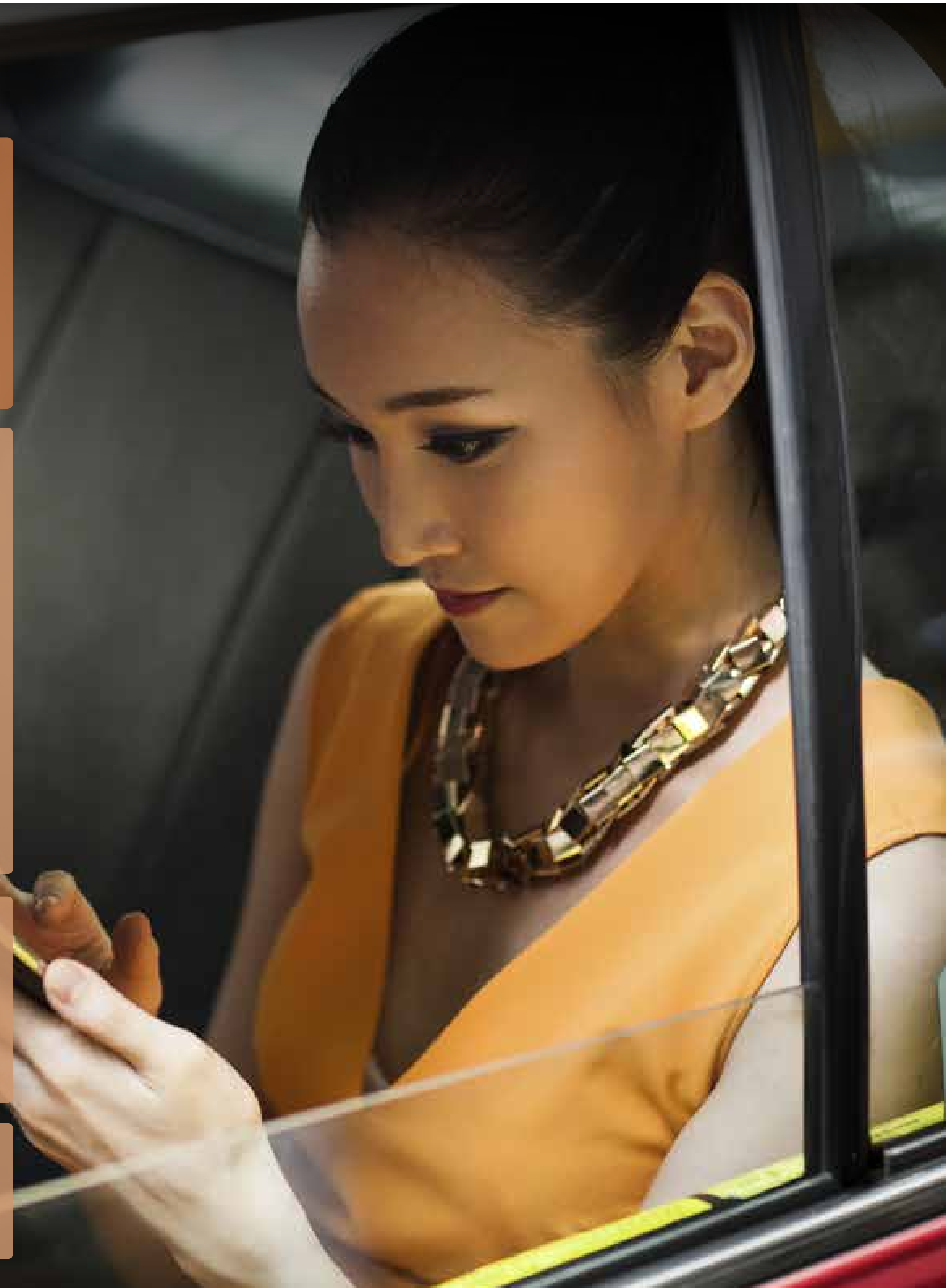
Making a complaint

We are always interested I hearing your opinion about our products and services.

Should you at any time experience a situation involving your insurance that gives rise to a compliment or a complaint, all you need is to call the Bupa Global Customer Service on +45 70 23 00 42.

Alternatively you can email via Complaints-Global@ihi.com or write to us at our correspondence address.

Verification of Benefits



Please remember to obtain a Verification of Benefits for your inpatient treatment

Call: +45 70 23 24 60
Fax: +45 70 20 70 56
Email: emergency@ihi.com

Calls are recorded for training and quality purposes and may be shared when legally required to.

If we send you a verification of benefits of your treatment, it means that we will pay reasonable and customary costs up to the limits of your insurance plan provided that all the following requirements are met:

- the treatment is eligible treatment in accordance with your insurance cover (we will confirm eligibility before sending a verification of benefits)
- you have an active insurance cover at the time that treatment takes place
- your premiums are paid up to date
- the treatment carried out matches the treatment authorized
- you have provided a full disclosure of the condition and treatment required
- you have enough benefit entitlement to cover the cost of the treatment
- the treatment is medically necessary.

Case management

Should you be in need of longer and/or continuous treatment or hospitalisation we will follow you closely doing our utmost to ease your journey through Bupa Global. We will secure that your case is being dedicated to few people who will know your case in depth to be able to assist you the best way possible.

Important rules: please note that a verification of benefits is only valid if all the details of the approved treatment, including dates and locations, match those of the treatment received. If there is a change in the treatment required, if you need to have further treatment, or if any other details change, then you or your relatives or doctor/ hospital staff must contact us to verify those benefits separately. We make our decision to approve your treatment based on the information given to us. We reserve the right to withdraw our decision if additional information is withheld or not given to us at the time the decision is being made.

In case any patient responsibilities such as deductible are not stated in the verification of benefits sent to the hospital the insured will be charged with these costs once the Company receives the bill for reimbursement from the treatment provider.

This is a summary, please ensure you read the full details of your cover in the List of Reimbursements, Policy Conditions and your policy schedule.

How to claim

Direct Settlement
Inpatient treatment

Contact:
Bupa Global Assistance
+45 70 23 24 60
emergency@ihi.com

Request a verification of benefits

Required information:

- Patient's name, date of birth and policy number
- Hospital's/clinic's name
- Date for surgery/treatment
- Diagnosis
- Contact details for treating doctor
- Contact details for general practitioner

You are required to submit copies of your medical reports relating to the diagnosis or a signed consent form permitting Bupa Global Assistance to request the information on your behalf.

Eligible cover will be confirmed

We pay hospital/clinic

Pay and Claim
Outpatient treatment

Submit your claims online on our website ihi.com/healthclaim

Alternatively, you can also send your claims by email to eclaim@ihi.com

If you have any questions, please contact Service Relationship Management Team:
+852 2531 8505

Request reimbursement of claims

Required information:

- Patient's name and date of birth indicated on each invoice
- Diagnosis or reason for treatment/consultation
- Date of service
- Type of service
- If medicine/pharmacy invoice: copy of doctor's prescription

Please remember to always state your policy number when sending a claim to us as well as your preferred payment type for reimbursement with the respective details (eg. reimbursement to a bank account with the name and address of the bank account number/IBAN number and SWIFT/ABA code).

We pay your claims covered by your insurance

We send your reimbursement statement to you

You settle any shortfall (eg outstanding deductible) with hospital, clinic or doctor

Your Cover

Your cover consists of your chosen insurance plan and any deductible, loading or exclusions which might be applied. For full details, please read the List of Reimbursements and the policy conditions of your insurance product together with your personal policy schedule.

If you are uncertain about what your cover includes, please contact your service team using the email address or direct telephone number on your insurance card.

How will my deductible affect my reimbursement?
The deductible is the contribution you make towards the cost of your treatment each policy year before receiving any reimbursement. This means that the total cost of the claims you submit must exceed your chosen deductible amount before we are able to make any reimbursement payments to you. Every year when you renew your policy a new deductible will be applied. The deductible applies separately for each person on your insurance policy.

Information regarding the status of your deductible is included on your reimbursement statement.

Please see next page for a guide to understand your reimbursement statement.

It is important that you send all your claims to us, even if the value of the claim is less than the remaining deductible. In that case we will not make any payment, but the claim will count towards your deductible and thereby reduce the remaining deductible.

If you have an insurance policy with another health insurer (eg a local plan) you can send us copies of any bills covered by the other insurer and the corresponding reimbursement statements/explanation of benefits. We can then count these towards your deductible if the benefits would have been covered under your Bupa Global insurance plan.

How do I make a maternity claim?
If you or any insured on your policy become pregnant, please let us know and we will send you a maternity form which must be completed and returned to us before any maternity-related claims can be processed.

Reimbursement statement example

Reimbursement Statement
Health Insurance
Name Surnameson

Policy number: 1234567-1234
Service offer: SNE
February 4, 2018
Page 1 of 1

Cover: Hospital Plan + Module 1+2

Claim type: Other medical assistance
Service: Laboratory test, analysis and

Date (1)	Unit/Days (2)	Invoice amount (3)	Exchange rate (4)	Converted amount (5)	Maximum (6)	Applied to Deductible (7)	Co-insurance (8)	Reim-bursement (9)
01.01.2018		USD 600,00	USD 100,000000	USD 600,00	USD 500	USD 400,00	USD 0,00	USD 100,00
Total USD				600,00		400,00	0,00	100,00

Name Surnameson: The deductible for the period 01.01.2018 - 01.01.2019 is now USD 0,00.

Amount: USD 100,00 (10)
Exchange rate: 100,0000000 (11)
Date of settlement: 04.02.2018 (12)

1. **Date:** Date of service eg the day you went to the doctor.
2. **Units/Days:** Eg number of days admitted to the hospital or number of physiotherapy sessions.
3. **Invoice amount:** The bill amount in the original currency.
4. **Exchange rate:** The exchange rate used to exchange the amount from the original currency into the base currency of the insurance plan. The exchange rates for major currencies are updated daily according to Danske Bank.
5. **Converted amount:** The cost of the service converted into the base currency of the insurance plan. It is the converted amount that applies to any possible deductible or maximum.
6. **Maximum:** This shows if there is a maximum cover.

The maximum can be an amount or a percentage depending on which insurance plan you have. If nothing is stated in this field it means that there is no maximum.

7. **Applied to Deductible**: The amount in base currency applied to a possible deductible. At the end of the reimbursement statement you can see your deductible status. If you do not have a deductible it will always say 0,00 in this column.
8. **Co-insurance:** Co-insurance is a type of patient responsibility. If co-insurance applies to your insurance plan this will clearly be stated in your List of Reimbursement and Policy Conditions. If there is no co-insurance on your insurance plan it will always say 0,00 in this column.
9. **Reimbursement:** The actual reimbursement in the base currency of your insurance plan which we pay out either to you, the hospital or a 3rd party as per your choice.
10. **Amount:** The reimbursed amount in the currency chosen for the reimbursement payment.
11. **Exchange rate:** The exchange rate from the base currency of the insurance plan to the currency chosen for the reimbursement payment.
12. **Date of settlement:** The date the claim was processed.

Your website: myPage

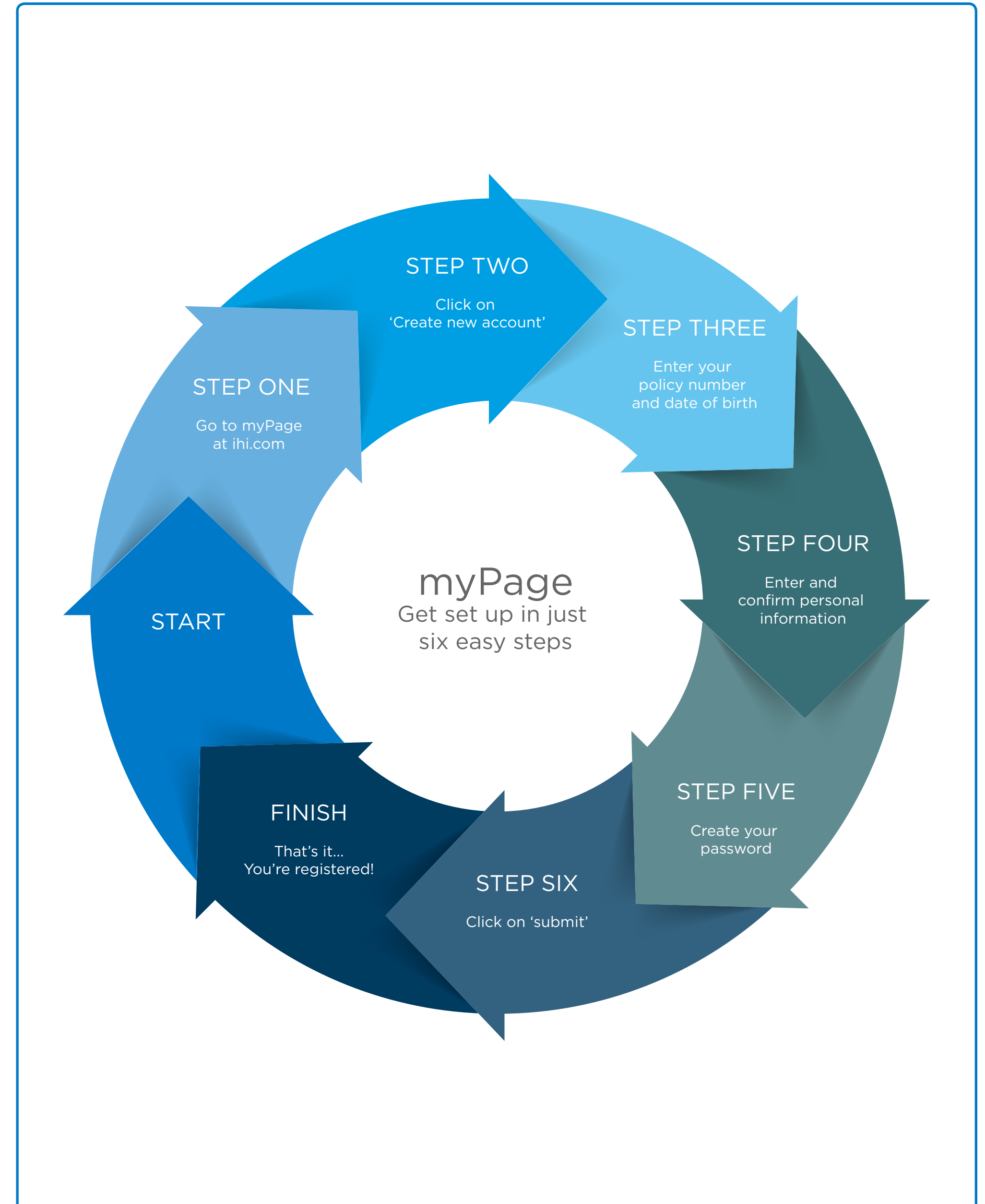
MyPage is an exclusive and secure website for our customers designed to make your life easier and save you time and hassle.

You can log on to myPage from anywhere in the world to manage your policy, see your claims and reimbursements and access your personal documents.

Some of the benefits waiting for you online:

- You can sign up as an online customer. All your documents will be available on myPage and we will send an email when a new document is uploaded.
- No need to carry documents around with you - access your documents 24 hours a day anywhere in the world.
- Purchased your policy via a broker? You now have the possibility to grant your broker access to view certain policy information.
- You can edit your personal information and eg. ask us to register a preferred reimbursement address - useful if you have multiple addresses or are travelling.
- If you want a second medical opinion, just send an email to emergency@ihi.com stating 'Second medical opinion' in the subject line and provide information regarding your request. For more information, please click the tab 'Private' and under 'Bupa Global Assistance' find the link to the second medical opinion details.
- Webchat - instant access, to our experienced advisers, who will be able to chat with you in real time, wherever you are and whatever your needs.

There are many more benefits online; log in to see for yourself.



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Choice of Deductible

There is only one deductible per person per policy year, and this applies to all services, except for the Medical Evacuation & Repatriation and Dental & Optical covers. The premium level is determined by the deductible chosen, and the higher the deductible, the lower the premium will be.

The following deductibles are available:
USD: Nil / 150* / 200 / 400 / 1,350 / 2,700 / 3,350
EUR: Nil / 150* / 200 / 400 / 1,350 / 2,700 / 3,350
CHF: Nil / 230* / 300 / 600 / 2,000 / 4,000 / 5,000

*Only applicable for existing clients before 1 Jan 2004

Under the Hospital Plan, you are free to choose between deductibles of:
USD: Nil / 400 / 1,350 / 2,700 / 3,350
EUR: Nil / 400 / 1,350 / 2,700 / 3,350
CHF: Nil / 600 / 2,000 / 4,000 / 5,000

List of Reimbursements

The List of Reimbursements forms part of the *Policy Conditions*. It is therefore necessary to read both the List of Reimbursements and the *Policy Conditions* (including Glossary) carefully. Words written in italic in the List of Reimbursements are "defined terms" which are specific terms relevant to your cover. Please check their meaning in the Glossary at the end of this product guide.

Valid from commencement date or policy renewal in 2020. All amounts are in USD/EUR/CHF.

The currency chosen for the *insurance* at point of *application* is the currency all your reimbursements will be based on. This means that eg. when your base currency is EUR all your reimbursements will be based on the EUR benefit limits stated in the below List of Reimbursements although you might have been treated in eg. Switzerland or the USA.

Complete Plan and Hospital Plan

Reimbursements of inpatient benefits are 100% of the expenses, unless otherwise stated.

If you have chosen a *deductible*, please note that the *reimbursement rates* for the benefits listed in the List of Reimbursements will be reduced by any remaining *deductible*. Once your *deductible* has been reached, all covered expenses will be paid in line with your *reimbursement rates*, up to the maximum cover.

Maximum Cover	Hospital Plan	Complete Plan
Annual maximum cover per person per policy year	USD 2 mill / EUR 2 mill / CHF 3 mill	USD 2 mill / EUR 2 mill / CHF 3 mill

Hospitalisation	Hospital Plan	Complete Plan
Private room (cf Glossary: '*Hospital accommodation*')	100%	100%
Intensive care room	100%	100%
Room and board for a parent or legal guardian accompanying an insured child (cf Glossary: '*Hospital accommodation*')	100%	100%
Surgery	100%	100%
Initial reconstruction *surgery*, immediate or delayed, following an injury or illness (excluded corrective reconstruction *surgery* for enhancement of appearance and replacement of implant/ prosthesis)	100%	100%
Pacemaker, max.	USD 25,000 / EUR 25,000 / CHF 37,000	USD 25,000 / EUR 25,000 / CHF 37,000
Medical *treatment*, laboratory tests, X-rays	100%	100%
Endoscopic examination	100%	100%
Medicine for use during *hospitalisation* and relevant only for the insured condition being treated	100%	100%
Cancer *treatment** Once cancer has been diagnosed this benefit includes fees that are related specifically to planning and carrying out *active treatment for cancer*. This includes tests, diagnostic imaging, consultations and prescribed medicines (when receiving anti-hormonal drug as sole *treatment* for cancer, only the anti-hormonal drug expenses are covered)	100%	100%
Dialysis (including home dialysis), intravenous drug infusion which is only available as an infusion (must be pre-approved by the *Company*)	100%	100%
Emergency room *treatment* in connection with acute illness or accident	100%	100%
Outpatient surgery at hospital or clinic*	100%	100%

Complete Plan and Hospital Plan (continued)

Hospitalisation	**Hospital Plan**	**Complete Plan**
Psychiatric *treatment*	100%	100%
Outpatient treatment in connection with *hospitalisation* Pre-examinations that are medically necessary in order to perform the *surgery* or *treatment* which is to take place during *hospitalisation* are covered up to 30 days prior to *hospitalisation*. Check-ups that are medically necessary in order to verify that the insured is recovering successfully from the *surgery* or *treatment* received while hospitalised are covered up to 90 days after *hospitalisation*. Physiotherapy following *surgery* must be evaluated and pre-approved by the *Company*.	100%	100%
Acute emergency dental *treatment* due to serious accident requiring *hospitalisation* In case of doubt, the decision will be left with the *Company*'s dental consultant	100%	100%

*Pre-examinations that are medically necessary in order to perform the *treatment/surgery* are covered up to 30 days prior to *treatment/surgery*. Check-ups that are medically necessary in order to verify that the insured is recovering successfully from the *treatment/surgery* are covered up to 90 days after *treatment/surgery*. Physiotherapy following *treatment/surgery* must be evaluated and pre-approved by the *Company*.

Organ Transplant	**Hospital Plan**	**Complete Plan**
Organ Transplant	100%	100%
Per diagnosis and course of *treatment* per lifetime, to include all related costs up to the financial maximum The *insurance* policy must be valid throughout the course of *treatment* Only human organs The procurement of the organ must be pre-approved by the *Company*	USD 500,000 / EUR 500,000 / CHF 750,000	USD 500,000 / EUR 500,000 / CHF 750,000

Inpatient Rehabilitation	**Hospital Plan**	**Complete Plan**
Medically prescribed inpatient rehabilitation in connection with *treatment* at an authorised medical facility following *hospitalisation* for *treatment* covered by this *insurance* (must be pre-approved by the *Company*). The rehabilitation has to include *treatment* in the form of therapy such as physical, occupational and/or speech therapy aimed at restoring as much function as possible. Max. three months per policy year	Covered 100% Max per day USD 600 / EUR 600 / CHF 900	Covered 100% Max per day USD 600 / EUR 600 / CHF 900

Local medical transport	**Hospital Plan**	**Complete Plan**
Ground transport to and from hospital when it is medically necessary that special medical services and/or medical equipment are provided	100%	100%

Complete Plan and Hospital Plan (continued)

Home Nursing	Hospital Plan	Complete Plan
Expenses incurred for medically prescribed assistance in your private home, by a certified nurse (must be pre-approved by the *Company*)	Covered up to USD 65 / EUR 65 / CHF 100 per day Covered up to USD 2,000 / EUR 2,000 / CHF 3,000 per policy year	Covered up to USD 65 / EUR 65 / CHF 100 per day Covered up to USD 2,000 / EUR 2,000 / CHF 3,000 per policy year

Hospice and Palliative Care	Hospital Plan	Complete Plan
Hospice and palliative care, max per lifetime	USD 30,500 / EUR 30,500 / CHF 45,750	USD 30,500 / EUR 30,500 / CHF 45,750

Childbirth (subject to a 12 month waiting period)	Hospital Plan	Complete Plan
Normal delivery or medically prescribed ceasarean operation at a hospital or clinic	100%	100%
Home delivery or delivery at *birthing centre* with physician/*specialist*, midwife and/or home nursing in connection with home delivery Per birth, max.	USD 2,700 / EUR 2,700 / CHF 4,000	USD 2,700 / EUR 2,700 / CHF 4,000

Non-medically prescribed caesarean operation will be reimbursed up to a max. of the customary charges for normal delivery of one child at a hospital or clinic

Pre- and postnatal examinations are reimbursed under the Complete Plan as consultations (cf however Art. 8.2 h), see Complete Plan

Delivery (whether (1) by normal delivery at home, at a *birthing centre* or at a hospital or clinic or (2) by medically prescribed or non-medically prescribed caesarean operation) following fertility *treatment* will be reimbursed up to a max. of the customary charges for normal delivery of one child at a hospital or clinic

Complete Plan

Under the Complete Plan *outpatient* benefits are reimbursed 90%, unless otherwise stated. If you have chosen a *deductible*, please note that the *reimbursement rates* for the benefits listed in the List of Reimbursements will be reduced by any remaining *deductible*. Once your *deductible* has been reached, all covered expenses will be paid in line with your *reimbursement rates*, up to a maximum of USD 40,000/EUR 40,000/CHF 60,000 per policy year.

General Practitioners	
Office consultation	90%
Telephone/prescription consultation	90%
Visit to a patient's domicile	90%
Max. 15 consultations within a 30-day period	

Specialists*	
Eye and ear specialists, psychiatrists, other specialists	90%

Complete Plan (continued)

Psychologist*	
Psychologist, per consultation	90%

*A combined max. of 15 consultations within a 30-day period for Specialists and Psychologist

Therapists / Other Medical Assistance	
Physiotherapy, ergotherapy	90%
Speech therapy Max. 12 consultations per policy year	90%
Acupuncture, homeopathic *treatment*, kinesiology, neuraltherapy, phytotherapy and antroposophic *treatment* if performed by a physician Per policy year max.	Covered 90% up to USD 1,500 / EUR 1,500 / CHF 2,200
Minor procedures or interventions (eg removal of a wart) performed at the clinics of the General Practitioners or Specialists in connection with visits to such medical practitioners	90%
Laboratory test, X-ray, analysis, scan, injection	90%
Hearing aids, when prescribed by a physician	50%
Full health screening, per policy year max.	Covered 90% up to USD 600 / EUR 600 / CHF 910

Chiropractor / Osteopath	
Examination, *treatment*, X-ray	50%

Medicine	
Prescribed medicine Dressings, *appliances*, vaccinations and injections	90%
Homeopathic and naturopathic medicine when prescribed by a licensed physician or a member of NVS (Naturheilpraktikerverband Schweiz) (cf. also art. 8.2 k)	90%

Supplementary Covers

Medical Evacuation & Repatriation

Medical Evacuation & Repatriation covers transportation to the nearest appropriate place of *treatment* if you have a seriousillness or injury.

Medical Evacuation & Repatriation	
Transportation expenses by aeroplane or helicopter	100%
Accompanying person	100%
Return journey to residential address abroad/home country within three months after completion of *treatment*	100%
Statutory arrangements in case of death, such as embalming and zinc coffin Transportation of the urn/coffin	100%
Expenses are covered up to the overall annual insurance sum of your policy In all circumstances, *we* must be notified before transport takes place, either directly or through the attending physician Medical Evacuation & Repatriation must be pre-approved by the *Company*	

Dental & Optical

Expenses for dental care are reimbursed 75%, whereas expenses for glasses and contact lenses are reimbursed 50% up to max. USD 270/EUR 270/CHF 400 per person per policy year. Eye checks performed by an optician/optometrist are reimbursed with 75% with a maximum of two visits per person per policy year.

A collective annual max. of USD 3,000/EUR 3,000/CHF 4,500 per person per policy year applies to the Dental & Optical supplement.

Dentist	**Subject to a 6 month waiting period**
○ Examination ○ Tooth-cleaning ○ Individual preventive *treatment* ○ Filling: not compound, compound, double compound, enamel cement, plastic, single surfaced, plastic, multi surfaced ○ Root *treatment*: coronal amputation, apical amputation, root filling, acute opening of root canal and following canals ○ Tooth extraction ○ *Surgery* ○ X-ray, simple and panoramic ○ Emergency *treatment* ○ Local anaesthesia ○ Occlusion bar ○ Retaining pivots, root screws and pivots ○ Prescription	75%

Crowns and Gold Inlay	**Subject to a 12 month waiting period**
○ Gold, jacket, porcelain crowns, etc. ○ Gold inlay, pivot teeth, plastic crowns ○ Build-up and recementation ○ Temporary crowns and implants	75%

Dental & Optical (continued)

Bridgework	Subject to a 12 month waiting period
Bridgework and repairs	75%

Treatment of Periodontitis	Subject to a 12 month waiting period
○ *Treatment* of gingivitis and periodontitis, preventive *treatment* included ○ Rootscaling ○ Periodontal *surgery* and membrane *treatment*	75%

Tooth adjustments and Dentures	Subject to a 12 month waiting period
Tooth adjustments	75%
Dentures and repairs	75%

Glasses / Contact Lense	No waiting period applies
Normal or bifocal lenses and contact lenses, max. Lenses for sunglasses and frames will not be reimbursed	Covered 50% up to USD 270 / EUR 270 / CHF 400

Eye check	No waiting period applies
Eye check performed by an optician/optometrist (max. two visits per policy year)	75%

Policy Conditions

Valid from commencement date or policy renewal in 2020.

Words written in italic in the Policy Conditions are "defined terms" which are specific terms relevant to your cover. Please check their meaning in the Glossary at the end of this product guide.

Art. 1 Acceptance of the *insurance*
Art. 2 *Commencement date*
Art. 3 Waiting periods in connection with new *insurance* contracts and extension of cover
Art. 4 Who is covered by the *insurance*?
Art. 5 Where is cover provided?
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Art. 7 Medical Evacuation & Repatriation
Art. 8 Exceptions to cover
Art. 9 How to report a claim
Art. 10 Cover by third parties
Art. 11 Payment of premium
Art. 12 Information necessary to the *Company*
Art. 13 Assignment, cancellation and expiry
Art. 14 Complaints
Art. 15 Applicable law
Art. 16 No Third Parties Rights

Glossary

Art. 1
Acceptance of the insurance

1.1: The *insurance* policy is insured and underwritten by Bupa (Asia) Limited., hererinafter called the *Company* and administered by the *Company* and *Bupa Global*. The *Company* shall decide whether the *insurance* can be accepted. In order for the *insurance* to be accepted and the *Company* to become the insurer, the *application* must be approved by the *Company* and the necessary premium paid to the *Company*.

1.2: In order for the *insurance* to be accepted by the *Company* on *standard terms*, the *applicant* must be of sound health at the time of acceptance and must not suffer nor have suffered from any recurring disease, illness, injury, bodily infirmity or physical disability (cf also glossary term '*pre-existing conditions*'), and the *applicant* must not have attained 60 years of age at the time of acceptance.

If the conditions in Art. 1.2 are not met and the *applicant* has not attained 80 years of age at the time of acceptance, the *Company* may offer the *insurance* on *special terms*. If the *Company* decides to offer the *insurance* on *special terms*, the *policyholder* will receive a *policy schedule* in which these terms are stated.

1.2.1: All underwriting and issuance of policy schedules are made by the *Company*. The *Company* may choose to have data processed in or outside the EU.

1.3: In the event of a change in the *applicant*'s state of health after the *application* has been signed and before the *Company*'s approval thereof, the *applicant* shall be under the obligation to notify the *Company* of such change immediately.

1.4: The currency chosen for the *insurance* cannot be changed after the *Company*'s acceptance of the *application*.

Art. 2
Commencement date

2.1: The *insurance* shall be valid as of the date on which the *application* is approved by the *Company*. The *commencement date* is stated in the *policy schedule*. The *Company* may agree on another date with the *policyholder*.

Art. 3
Waiting periods in connection with new insurance contracts and extension of cover

3.1: When a new *insurance* contract is entered into, the right to reimbursement under the new *insurance* contract shall only take effect four weeks after the *commencement date* of the *insurance*. However, this does not apply when the *policyholder* can prove simultaneous transference from an equivalent *insurance* with another international health *insurance company*.

3.1.1: In the event of *acute serious illness* and *serious injury*, the right to reimbursement shall, however, take effect concurrently with the *commencement date* of the *insurance*.

3.1.2: In addition, the waiting periods listed below shall apply for the *insurance* contract:

a) For expenses incurred in connection with pregnancy and childbirth and consequences thereof, the right to reimbursement shall only take effect 12 months after the *commencement date* of the *insurance*.

b) For expenses incurred in connection with dental care (supplementary dental *treatment*), the right to reimbursement shall only take effect six months after the *commencement date* of the *insurance*. For expenses incurred for crowns, gold inlay, bridgework, *treatment* for periodontitis and orthodontics, the right to reimbursement shall only take effect 12 months after the *commencement date* of the *insurance*.

3.2: The *policyholder* may change his/her *insurance* cover to another type of cover (eg change of *deductible*, adding/removing additional cover) as from a *policy anniversary* by giving one month's notice by email, letter or phone to the *Company* and subject to proof of insurability according to Art. 1.

3.3: The *Company* will process the extension of cover as a new *application* in accordance with Art. 1.

3.4: If extended cover is taken out under the *insurance* contract, the right to reimbursement under such extension shall only become effective four weeks after the *commencement date* of the extension. However, Art. 3.1.2 a) and b) shall still apply. During the *waiting period*, the previous cover shall apply.

3.4.1: In the event of *acute serious illness* and *serious injury*, the right to reimbursement under the extended cover shall, however, take effect concurrently with the *commencement date* of the extension.

Art. 4
Who is covered by the insurance?

4.1: The *insurance* shall cover the insured person(s) named in the *policy schedule*.

4.2: An *application* must be submitted for each person the *policyholder* wishes to add to the *insurance*, including newborn children.

4.2.1: If the *insurance* of one of the parents has been valid for a minimum of 12 months, newborn children of the parent can be insured irrespective of Art. 1.2 without submitting an *application*, cf however Art. 8.2 h). A copy of the birth certificate must, however, be submitted within three months after the birth:

- if one of the insured persons has legal custody of the child, and
- if the child is registered at the same address as the insured having legal custody of the child.

If the birth certificate is not submitted to the *Company* within three months after the birth, a Medical Questionnaire must be submitted for the child who has to undergo the standard underwriting procedure according to Art. 1.2. Registration of the child will take place from the date the Medical Questionnaire has been signed.

4.2.2: In case of adoption and for children born as a result of fertility *treatment* and/or born by a surrogate, the insured must submit a Medical Questionnaire for such children.

Art. 5
Where is cover provided?

5.1: The *insurance* shall provide worldwide cover unless otherwise stated in the *policy schedule*.

Art. 6
What is covered by the insurance?

6.1: The *insurance* shall cover the medical expenses incurred by the insured in accordance with the cover chosen and the applicable List of Reimbursements. The benefits for which expenses are covered and the *reimbursement rates* are stated in the List of Reimbursements.

6.2: Reimbursement shall be paid following the *Company*'s approval of the expenses as being covered by the *insurance* after the receipted and itemised bills, provided with the policy number, have been received by the *Company* (cf also 'Quick Reference Guide').

6.3: Once the covered expenses have met the annual *deductible*, the reimbursable amount will be paid. The *deductible* shall be reduced by amounts not exceeding the maximum rates specified in the valid List of Reimbursements. The *deductible* shall apply per person per policy year.

6.3.1: In case of accident where three or more *family members* insured with the *Company* are involved, only one *deductible*, the highest, is applied.

6.4: Medical practitioners performing *treatment* must have authorisation in the country of practice. Medical providers and facilities must also be authorised (cf also art. 8.2 p).

6.5: In no event shall the amount of reimbursement exceed the amount shown on the bill. If the insured receives reimbursement from the *Company* in excess of the amount to which he/she is entitled, the insured shall be under the obligation to repay the *Company* the excess amount immediately, otherwise the *Company* will set off the excess amount in any other account between the insured and the *Company*.

6.6: Reimbursements shall be limited to the usual, *reasonable and customary* charges in the area or country in which *treatment* is provided.

6.7: Any discount, which has been negotiated directly between the *Company* and providers, will be specifically used by the *Company* for the overall benefit of the insured persons within the *insurance* product as a whole.

6.8: Any ex-gratia payments are at the *Company*'s discretion. If the *Company* makes a payment to which the insured is not entitled under the *insurance*, this will still count toward the annual maximum cover per person per policy year.

6.8.1 The *Company* is not required to pay for any *treatment* or condition that is not covered by the insured's *insurance* cover, even if the *Company* has paid an earlier claim for similar or identical *treatments* or conditions, including where such earlier payment was made at the *Company*'s error.

6.9: The *Company*'s global health *insurance* products are non-*US insurance* products and accordingly are not designed to meet the requirements of the *US* Patient Protection and Affordable Care Act (the Affordable Care Act). The *Company*'s *insurance* products may not qualify as minimum essential coverage or meet the requirements of the individual mandate for the purposes of the Affordable Care Act, and the *Company* is unable to provide tax reporting on behalf of those *US* taxpayers and other persons who may be subject to it. The provisions of the Affordable Care Act are complex and whether or not the insured is subject to its requirements will depend on a number of factors. The insured should consult an independent professional financial or tax advisor for guidance. For customers whose coverage is provided under a group *insurance*, the insured should speak to the group health *insurance* administrator for more information.

Art. 7
Medical Evacuation & Repatriation

7.1: If the *insurance* has been extended to include Medical Evacuation & Repatriation cover, the following terms listed shall also apply:

7.1.1: Medical Evacuation & Repatriation cover can only be taken out as a supplement to the Complete Plan/the Hospital Plan. The sum insured for the Medical Evacuation & Repatriation cover is stated in the List of Reimbursements.

7.1.2: Reimbursement shall be paid for reasonable expenses incurred for the insured's medical evacuation/repatriation in the event of *acute serious illness*, *serious injury* or death. Transportation shall be to the nearest appropriate place of *treatment* and only if no appropriate *treatment* can be obtained locally.

7.1.3: Cover shall be provided subject to the attending physician and the *Company*'s medical consultant agreeing on the necessity of transferring the insured and agreeing on whether the insured should be transferred to his/her *country of residence*, home country or to the nearest appropriate place of *treatment*. In case of disagreement, the decision of the *Company*'s medical consultant shall prevail.

The evacuation expenses for an eligible transportation are only covered if the transportation is arranged or pre-approved by the *Company*.

7.1.4: The expenses for transportation covered under the *insurance*, but not arranged by the *Company*, shall only be compensated with an amount equivalent to the expenses the *Company* would have incurred, had the *Company* arranged the transportation.

7.1.5: The cover shall cover reasonable and necessary transportation expenses for one person accompanying the insured.

7.1.6: Only one transportation is covered in connection with one course of an illness.

7.1.7: The Medical Evacuation & Repatriation cover shall only apply if the illness is covered under the *insurance*.

7.1.8: In the event that the insured is evacuated for the purpose of receiving *treatment*, he/she and the accompanying person, if any, shall be reimbursed for the expenses for a return journey to the insured's place of residence/home country. The return journey shall be made within three months after *treatment* has been completed. Cover shall only be provided for travelling expenses equivalent to the cost of an aeroplane ticket on economy class, as a maximum.

7.1.9: In the event that the insured has received *treatment* covered by the *insurance*, but now has reached the *terminal phase*, he/she and the accompanying person, if any, shall be reimbursed for the expenses of the return journey to the insured's place of residence.

7.1.10: In the event of death, expenses shall be reimbursed for home transportation of the deceased and for statutory arrangements such as embalming and a zinc coffin.

The next of kin have the following options:

a) cremation of the deceased and home transportation of the urn or

b) home transportation of the deceased.

7.1.11: The *Company* cannot be held liable for any delays or restrictions in connection with the transportation caused by weather conditions, mechanical problems, restrictions imposed by public authorities or by the pilot or any other condition beyond the *Company*'s control.

Art. 8
Exceptions to cover

8.1: The *insurance* shall not cover expenses incurred for any disease, illness or injury known to the *policyholder* and/or the insured at the time of *application*, unless agreed upon with the *Company*.

8.2: Furthermore, the *Company* shall not be liable for any expenses which concern, are due to or are incurred as a result of:

a) non-medically essential or cosmetic *surgery* and *treatment*,

b) obesity *surgery* and *treatment* (including diet pills),

c) venereal diseases, AIDS, AIDS-related diseases and diseases relating to HIV antibodies (HIV positive). However, diseases relating to AIDS and HIV antibodies (HIV positive) are covered, if proven to be caused by a blood transfusion received after the commencement of the policy. The HIV-virus will also be covered if proven to be contracted as the result of an accident occurring during the course of only the following occupations: doctors, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, policemen/-women, and prison officers. The insured shall notify the *Company* within one week days after such accident and at the same time provide a negative HIV antibody test,

d) any use or misuse of alcohol, drugs and/or medicines unless it can be documented that the illness or injury is unrelated thereto,

e) intentional self-inflicted bodily injury,

f) contraception, included sterilisation,

g) induced abortion unless medically prescribed,

h) any kind of fertility test and/or *treatment*, including hormone *treatment*, insemination or examinations and any procedures related hereto, including expenses for pregnancy, pre- and postnatal *treatments* of the mother and the newborn child/children. An *application* must therefore be submitted for children born as a result of fertility *treatment* and/or born by a surrogate mother. The *application* will undergo the standard underwriting procedure, according to Art. 1,

i) sexual problems and gender issues: sexual problems, such as impotence, whatever the cause, or sex changes or gender reassignments,

j) hospital stay when it is used solely or primarily for any of the following purposes: receiving general nursing care or any other services which do not require the insured to be in a hospital and could be provided in a nursing home or other establishment that is not a hospital; receiving services which would not normally require trained medical professionals (eg help in walking and bathing) and pain management,

k) *treatment* by naturopaths or homoeopaths and naturopathic or homoeopathic medications and other alternative methods of *treatment*, unless *treatment* is performed and/or medication is prescribed by a licensed physician or member of NVS (Naturheilpraktikerverband Schweiz),

l) health certificates,

m) *treatment* of diseases during military service,

n) *treatment* for sickness or injuries directly or indirectly caused by the insured putting him/herself in danger by entering a *known area of conflict* as listed below:

war, invasion, acts of a foreign enemy, hostilities (whether war has been declared or not), civil war, terrorist acts, rebellion, revolution, insurrection, civil commotion, military or usurped power, martial law, riots or the acts of any lawfully constituted authority, or army, naval or air services operations (whether war has been declared or not),

o) nuclear reactions or radioactive fallout,

p) *treatment* performed by an *unrecognised medical practitioner*, *provider or facility*,

q) *treatment* for or arising from any *epidemic* disease and/or *pandemic* disease, including vaccinations, medicines or preventive *treatment* for or related to any *epidemic* disease and/or *pandemic* disease,

r) *treatment* or *surgery* to correct refractive errors in the eyesight (due to eg myopia, hyperopia/ hypermetropia, astigmatism and presbyopia) such as laser *treatment*, refractive keratotomy and photorefractive keratectomy, clear lens extraction, or accommodative intraocular lenses,

s) any diagnostic investigation, testing or *treatment* (including medicine) which is experimental due to lack of *acceptable current clinical evidence*,

t) any *treatment* or medicine which is not proven to be effective based on *acceptable current clinical evidence*,

u) medication and equipment used for purposes other than those defined under their licence.

v) inpatient *treatment* for more than 90 continuous days for permanent neurological damage or when the insured is in a persistent vegetative state. This article only applies to insurances with a *commencement date* on or after 1 January 2017.

w) Artificial Life Maintenance, including mechanical ventilation, when the patient is in a state of profound unconsciousness and/or with no sign of awareness or a functioning mind, where such *treatment* will not or is not expected to result in the insured's recovery or restore the insured to the insured's previous state of health. This means, eg cover is not provided when the insured is unable to feed or breathe independently and requires percutaneous endoscopic gastrostomy (PEG) or nasal feeding for a period of more than 90 continuous days. This article only applies to insurances with a *commencement date* on or after 1 January 2017.

x) any genetic testing, unless medically necessary

- as the result of the test will directly impact the *treatment* of an existing covered disease, or
- for prenatal testing due to suspicion of fetal abnormality

Art. 9
How to report a claim

9.1: Any claim for reimbursement of expenses incurred for *treatment* by a physician or *specialist* as well as hospital *treatment* and medicine shall be reported by submitting original, receipted and itemised bills provided with the policy number to the *Company*. (cf also 'Quick Reference Guide').

The *Company* scans submitted bills upon receipt. Any retrieval of the submitted bills is not possible.

The *Company* reserves the right at any time to require provision of original bills from the insured. If an original bill is not provided upon request the *Company* may deny reimbursement of the expenses to which the bill relates.

9.2: Any claim shall be reported to the *Company* immediately and no later than three months after the circumstances underlying the claim have become known to the insured.

9.3: The *Company* shall be notified immediately of any stays in hospital, and such notification must include the physician's diagnosis. All notifications should be made by telephone, fax or email; the *Company* will defray all expenses incurred in this connection.

Art. 10
Cover by third parties

10.1: Where there is cover by another *insurance* policy or healthcare plan, this must be disclosed to the *Company* when claiming reimbursement, and the cover under this *insurance* shall be secondary to any such other *insurance* policy or healthcare plan.

10.1.1: Upon receipt of an itemized statement from another insurer and a copy of the reimbursed bills the *Company* will apply the amount reimbursed by that other insurer to write down the existing *deductible* and/or co-*insurance* on the health *insurance* plan(s) which the insured has with the *Company* if the reimbursed benefits would have been covered by the *Company*.

In order to have the *deductible* written down with the amount covered by the local insurer, it is a requirement that the *deductible* has not already been used in connection with earlier claims. *Bupa Global* does not correct previous reimbursements in order to assess expenses related to a local insurer.

10.2: In these circumstances, the *Company* will co-ordinate payments with other companies and the *Company* will not be liable for more than its rateable proportion.

10.3: If the claim is covered in whole or in part by any scheme, programme or similar, funded by any Government, the *Company* shall not be liable for the amount covered.

10.4: The *policyholder* and any insured person undertake to co-operate with the *Company* and to notify the *Company* immediately of any claim or right of action against third parties.

10.5: Furthermore, the *policyholder* and any insured person shall keep the *Company* fully informed and shall take any reasonable step in making a claim upon another party and to safeguard the interests of the *Company*.

10.6: In any event, the *Company* shall have the full right of *subrogation*.

Art. 11
Payment of premium

11.1: Premiums are determined by the *Company* and shall be payable in advance. The *Company* adjusts the premiums once a year as from the *policy anniversary* on the basis of changes in the cover and/or the loss experience in the *insurance* class during the previous calendar year.

11.2: The premium is age-related and will therefore also be adjusted on the first *policy anniversary* after the insured's birthday.

11.3: The initial premium shall fall due on the *commencement date*. The *policyholder* may choose between semi-annual and annual payment.

11.4: Changes in the terms of payment can only be made at 30 days' notice by email, letter or phone prior to the *policy anniversary*.

11.5: The premium is due on the *due date* stated in the premium notice.

11.6: The *policyholder* shall be responsible for punctual payment of the premium to the *Company*. If the premium has not been received by the *Company* on the *due date*, the *Company*'s liability shall cease.

11.7: The *policyholder*'s attention is drawn to Art. 6.5 regarding payment of outstanding amounts.

11.8: Other charges, such as *Insurance* Premium Tax (IPT), or other taxes, levies or charges, depending on the laws of the *policyholder*'s *country of residence* may apply. If they apply to the *policyholder*'s *insurance* premium, they will be included within the total that has to be paid on the premium notice. The charges may apply each time when the premium payment is due, from the *commencement date*, the anniversary of the *commencement date* or the date of registration of a new insured on the policy. The *policyholder* must pay these charges to *us* when paying the premiums or when adding a new insured to the policy, unless otherwise required by law.

Art. 12 Information necessary to the Company

12.1: The *policyholder* and/or the insured shall be under the obligation to notify the *Company* by email, letter or phone of any changes of name or address, change in residency and changes in health *insurance* cover with another *company*, including a consolidated *company*. The *policyholder* is required to immediately notify the *Company* if any of the insured become a permanent resident of the USA, as described under Article 13.7. The *Company* must also be notified in the event of death of the *policyholder* or an insured. The *Company* shall not be liable for the consequences if the *policyholder* and/or the insured fails to notify the *Company* in such events.

12.2: The *policyholder* and/or the insured shall also be under the obligation to provide the *Company* with all information reasonably required for the *Company*'s handling of the *policyholder*'s and/or the insured's claims against the *Company*, including provision of original bills upon request from the *Company*.

12.3: In addition, the *Company* shall be entitled to seek information about the insured's state of health and to contact any hospital, physician, etc. who is treating or has been treating the insured for physical or mental illnesses or disorders. Furthermore, the *Company* shall be entitled to obtain any medical records or other written reports and statements concerning the insured's state of health.

12.4: The *Company* fully complies with applicable data protection legislation (see also art. 17.1). Generally, *we* therefore cannot disclose any personal or sensitive information (eg. medical information) nor discuss cases with anyone not authorised by the insured in question. It is therefore recommended that the insured authorises any person he or she wants to share information with. A third party authorisation form will be provided by the *Company* on request.

Art. 13 Assignment, cancellation and expiry

13.1: Without the prior written consent of the *Company*, no party shall be entitled to create a charge on or assign the rights under the *insurance*.

13.2: The *insurance* is automatically renewed on each *policy anniversary*.

13.2.1: The *insurance* may be terminated by the *policyholder* with effect from the end of a calendar month with one month's prior notice by email, letter or phone.

13.2.2: The *policyholder* can cancel the *insurance*, and that of any additional insured covered under the *insurance*, within 28 days of receiving the first policy *documents*. Should the *policyholder* wish to cancel the *insurance* upon receipt of the first policy *documents*, the *policyholder* needs to do that in writing (by letter, fax or email) or by phone. The address and contact information can be found on the back page of this product guide. If the *policyholder* or any additional insured have not made any claims, the *Company* will refund any premium payment already paid.

13.3: Where, upon taking out the *insurance* or subsequently, the *policyholder* and/or the insured has fraudulently changed original *documents* or disclosed incorrect information or withheld facts which may be regarded as being of importance to the *Company*, the *insurance* contract shall be void and shall not be binding on the *Company*.

13.4: Where, upon taking out the *insurance* or subsequently, the *policyholder* and/or the insured has disclosed incorrect information, the *insurance* contract shall be void, and the *Company* shall not be liable if the *Company* would not have accepted the *insurance* if the correct information had been disclosed. If the *Company* would have accepted the *insurance*, but on other terms, the *Company* shall be liable to the extent to which the *Company* would have undertaken the obligations in accordance with the agreed premium.

13.4.1: In the event that the *insurance* contract is considered void, according to Art. 13.3 or Art. 13.4, the *Company* shall be entitled to a service charge which is set as a specified percentage of the premium paid.

13.5: Where, upon taking out the *insurance*, the *policyholder* and/or the insured neither knew nor should have known that the information disclosed by him/her was incorrect, the *Company* shall be liable as if such incorrect information had not been disclosed.

13.6: The *Company* can stop or suspend an *insurance* product at three months' notice prior to the *policy anniversary*, and offer the insured an equivalent *insurance* cover.

13.7 The *policyholder* is required to immediately notify the *Company* by email, letter or phone if any of the insured become a permanent resident of the USA, failing which the *Company* may terminate the *insurance* with immediate effect or (where permitted to continue the *insurance* until such date) with effect from the *policy anniversary*. The *Company* may terminate the *insurance* with immediate effect or (where permitted to continue the *insurance* until such date) with effect from the *policy anniversary*, if the law of the country in which the insured is located, or the insured's *country of residence* or nationality, or any other law which applies to the *Company* or this *insurance*, prohibits the provision of healthcare cover by the *Company* to local nationals, residents or citizens.

Without limitation to the foregoing, the *insurance* shall not be renewed at the next *policy anniversary* if the *policyholder* becomes a permanent resident of the USA, and, if an insured who is not the *policyholder* becomes a resident of the USA, their cover under the *insurance* shall not be renewed at the next *policy anniversary*. 'Permanent resident' shall mean a person residing in the USA who is a citizen of or who is permitted under applicable laws to live and work, on a permanent basis, in the USA, and 'USA' shall include the Commonwealth of Puerto Rico for this purpose.

This Art. 13.7 only applies to insurances with a *commencement date* after 31 December 2015.

13.8: Sanction clause
The *Company* will not provide cover nor pay claims under this *insurance* policy if the *Company*'s obligations (or the obligations of the *Company*'s group companies and administrators) under the laws of any relevant jurisdiction, including UK, European Union, the United States of America, or international law, prevent the *Company* from doing so. The *Company* will normally tell the *policyholder* if this is the case unless this would be unlawful or would compromise the *Company*'s reasonable security measures. This *insurance* policy does not provide cover to the extent that such cover would expose the *Company* (or the *Company*'s group companies and administrators) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, UK or United States of America, or under other relevant international law. This Art. 13.8 only applies to insurances with a *commencement date* on or after 1 January 2016.

13.9: The *Company*'s liability in connection with the *insurance*, including liability for reimbursement for medical expenses for ongoing *treatment*, after-effects or consequential damages in connection with an injury or illness incurred or treated during the

insurance period, shall automatically cease upon expiry, cancellation or termination of the *insurance*.

Accordingly, upon expiry, cancellation or termination of the *insurance*, an insured's right to claim reimbursement shall cease. Claims for reimbursement of medical expenses incurred during the *insurance* period must be filed within six months of the date of expiry, cancellation or termination of the *insurance* in order to be eligible for reimbursement.

Art. 14
Complaints

14.1: How to file a complaint
We are always pleased to hear about any aspect of the *insurance* cover that the insured has particularly appreciated, or which may have caused the insured any problems.

If something does go wrong, *we* have a simple procedure to ensure that all concerns are dealt with as quickly and effectively as possible.

For any comments or complaints, the *Bupa Global* Customer Service can be contacted at the phone number +45 70 23 00 42, by email at Complaints-Global@ihi.com, or by writing to *us* at:

Bupa Global
Palægade 8
DK-1261 Copenhagen K
Denmark

14.2: Taking it further
If *we* have not been able to resolve the problem and the insured wishes to take the complaint further, please contact the insurer using the following contact details:

Bupa (Asia) Limited
18/F Berkshire House
25 Westlands Road, Quarry Bay
Hong Kong
Tel: +852 2531 8505
Email: service.hk@bupaglobal.com

If *we* can't settle your complaint you may be able to refer your complaint to the *Insurance* Complaints Bureau whose address is at:

29/F, Sunshine Plaza
353 Lockhart Road
Wanchai
Hong Kong
www.icb.org.hk

Art 15
Applicable Law

15.1: The policy is governed by the laws of Hong Kong. Any dispute that cannot otherwise be resolved will be dealt with by courts in Hong Kong. If any dispute arises as to the interpretation of this document, then the English version of this document shall be deemed to be conclusive and taking precedence over any other language version of this document.

Art. 16
No Third Parties Rights

16.1: Any person or entity who is not the *policyholder* under this *insurance* shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Chapter 623, Laws of Hong Kong) to enforce any terms of this *insurance*.

Art 17
Confidentiality

17.1: The confidentiality of patient and customer information is of paramount concern to the companies in the Bupa group. To this end, *Bupa Global* fully complies with applicable data protection legislation and medical confidentiality guidelines. Please see the *Bupa Global* Privacy Notice above the glossary section.

Privacy notice

Bupa (Asia) Limited (the "*Company*")

Personal Information Collection Statement ("Statement") relating to the Personal Data (Privacy) Ordinance (the "Ordinance")

In compliance with the Ordinance, the *Company* would like to inform you of the following:

1. From time to time, it is necessary for you, or other members covered under your policy (each a "Member"), to supply the *Company* with certain personal information (including where relevant, credit information and claims history) relating to you, or the Member, when you apply for *insurance* or financial products and services from the *Company*, or when you apply to make changes to your policy, or when you renew a policy.

2. Failure to supply personal information requested by the *Company* may result in the *Company* being unable to process your *Application* and/or provide products, services and other related services to you, or the Member.

3. During the course of your relationship with the *Company*, further personal information relating to you, or the Member, may also be collected in the ordinary course of *our* business, for example, when you lodge *insurance* claims with the *Company* in relation to yourself or the Member.

4. The *Company* may collect, use or disclose personal information relating to you, or the Member, for the following purposes:

a) processing, assessing and determining any Applications for *insurance* products and services;

b) offering and providing products and services to you, or the Member, and processing requests made by you, or the Member, from time to time, including but not limited to requests for addition, alteration, deletion, maintenance, management and operation of *insurance* benefits or insured Members;

c) any purposes in connection with any claims made by or against or otherwise involving you, or the Member, in respect of any products and/or services provided by the *Company* including, without limitation, making, defending, analysing, investigating, detecting and preventing fraud (whether or not relating to the policy issued in respect of any *application* or claim) processing, assessing, determining, settling or responding to such claims;

d) performing any functions and activities related to the products and/or services provided by the *Company* including, without limitation, audit, reporting, market research, general servicing, maintenance of online and other services, identity verification, data matching, research and statistical analysis, and reinsurance arrangements;

e) provision and design of products and services of the *Company*;

f) exercising the *Company*'s rights in connection with provision of *insurance* products and services to you, or the Member, from time to time, for example, to determine any amount of indebtedness from you, and collecting and recovering owing from you or any person who has provided any security or undertaking for your liabilities;

g) communication with you or the Member (or with you on behalf of the Member) in relation to any of the purposes set out in this Statement;

h) enabling an actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the *Company*'s rights or business to evaluate the transaction intended to be the subject of the assignment, transfer, participation or sub-participation; and

i) making disclosure to satisfy the requirements of any laws, rules and regulations, codes of practice, guidance notes or guidelines binding on the *Company*.

5. Personal information collected or held by the *Company* relating to you, or the Member, will be kept confidential but the *Company* may transfer such personal information inside or outside the Hong Kong Special Administrative Region, for the purposes specified in paragraph (4) and (6) to the following classes of transferees:

a) the *Company*'s group companies ("Group *Company*");

b) any *insurance* adjusters, agents and brokers;

c) any re-*insurance* companies authorised by the *Company*;

d) employers (for members of corporate policy only);

e) healthcare professionals and hospitals;

f) any agent, contractor or third party service providers who provide administrative, telecommunications, computer, payment, data processing or storage, printing, research or other services to the *Company* in connection with the operation of business, (including without limitation insurers; banks; lawyers; accountants; claims investigators; fraud prevention organisations; other *insurance* companies (whether directly or through fraud prevention organisations or other persons named in this paragraph); organisations that consolidate claims and underwriting information for the *insurance* industry; the police and databases or registers (and their operators) used by the *insurance* industry to analyse and check information provided against existing information; debt collection agencies; data processing companies; research agencies and professional advisors);

g) any actual or proposed assignee, transferee, participant or sub-participant of all or a substantial part of the *Company*'s rights or business; and

h) any person to whom the *Company* is under an obligation to make disclosure under the requirements of any law, rules, regulations, codes of practice or guidelines binding on the *Company* including, without limitation, any applicable regulators, governmental bodies, industry recognised bodies, credit reference agencies, the Courts, and where otherwise required by law.

6. Only with your consent or with your indication of no objection, the *Company* may use your personal information collected from time to time, including name, contact details, gender, health and family status, to provide you with marketing communications (including by email, SMS or instant messenger) relating to the following products and services:

a) *Insurance*, medical, healthcare, wellness, personal development, beauty, lifestyle, entertainment, financial, and related services and products;

b) rewards, benefits, discounts, member activities, loyalty or privileges programmes and related services and products; and

c) donations and contributions for charitable and/or non-profit making purposes.

The *Company* will not disclose personal information relating to you, to third parties for them to use for their own direct marketing purposes without your consent.

For the avoidance of doubt, whether or not you consent to receive marketing communications of the type described in this paragraph 6, the *Company* may still communicate with you regarding the administration, features and *renewal* of your *insurance* policy.

7. Under and in accordance with the terms of the Ordinance, you have the following rights:

a) to check whether the *Company* holds personal information relating to you or the Member and to access such personal information;

b) to require the *Company* to correct any personal information relating to you or the Member which is inaccurate;

c) to ascertain *our* policies and practices in relation to personal data and to be informed of the kind of personal data held by the *Company*, and

d) to request the *Company* to cease using your personal information for direct marketing purposes.

Requests can be made in writing to the *Company*'s Data Protection Officer at the following address:

Data Protection Officer
18/F, Berkshire House
25 Westlands Road, Quarry Bay, Hong Kong

8. In accordance with the terms of the Ordinance, the *Company* has the right to charge a reasonable fee for the processing of any personal information access or correction request.

9. For any enquiries about this Statement, please do not hesitate to contact *our* Customer Service Team at +852 2531 8505.

10. Nothing in this Statement shall limit the rights of customers under the Ordinance.

11. In case of discrepancies between the English and Chinese versions of this Statement, the English version shall prevail.

Glossary

This Glossary with definitions is part of the *Policy Conditions*.

Defined term	Description
Acceptable current clinical evidence:	International medical and scientific evidence which include peer-reviewed scientific studies published in or accepted for publication by medical journals that meet internationally recognised requirements for scientific manuscripts. This does not include individual case reports, studies of a small number of people and clinical trials which are not registered.
Active treatment for cancer	*Active treatment for cancer* is chemotherapy, radiotherapy and immunotherapy.
Acute serious illness:	An "*acute serious illness*" shall be determined to exist only after review and agreement by both the attending physician and the *Company*'s medical consultant.
Appliances:	Durable medical equipment that: ○ can be used more than once ○ is not disposable ○ is used to serve a medical purpose ○ is not used in the absence of a disease, illness or injury ○ is fit for use in the home.
Applicant:	A person named on the *Application* Form and the Medical Questionnaire as an *applicant* for *insurance*.
Application:	The *Application* Form and Medical Questionnaire.
Birthing centre:	A medical facility often associated with a hospital that is designed to provide a homelike setting during childbirth.
Bupa Global:	Bupa (Asia) Limited (a limited liability *company* incorporated in Hong Kong, *company* number 103048, registered office at 18th Floor, Berkshire House, 25 Westlands Road, Quarry Bay, Hong Kong) – the sole insurer of this *insurance* plan.
Commencement date:	The date indicated in the *policy schedule* on which the *insurance* commences, unless otherwise stated in the *Policy Conditions*.

Defined term	Description
Company, the (incl. *we/us/our*)	Bupa (Asia) Limited
Country of residence:	The country where the insured is living/spending most of his/her time. This should be the country in which the relevant authorities (such as tax authorities) will consider the insured to be resident for the duration of the *insurance*.
Deductible:	The total amount of money noted in the *policy schedule* which each insured agrees to pay each policy year before being reimbursed by the *Company*.
Documents:	Any written information related to the *insurance* including bills, policy schedules and the like.
Due date:	Date on which a premium is due to be paid.
Epidemic:	An outbreak of a contagious and infective disease that spreads quickly, affecting more persons than expected in a given time period, in a locality where the disease is not permanently prevalent or its normal prevalence have been exceeded.
Family members:	Persons of a family relationship (related to you by blood or by law or otherwise). A full list of the family relationships falling within this definition is available on request.
Hospital accommodation:	Coverage of a room that is no more expensive than the hospital's standard single room with a private bathroom. Charges for the insured's standard meals and refreshments are also covered. The charges will be paid for the length of stay that is medically appropriate for the procedure the insured is admitted for and any accompanying relative (if covered under the *insurance* plan).
Hospitalisation:	*Surgery* or medical *treatment* in a hospital or clinic as an in-patient when it is medically necessary to occupy a bed overnight.
Insurance:	The *Policy Conditions* and *policy schedule* representing the *insurance* contract with the *Company* and setting out the scope of the *insurance* terms, the premium payable, *deductible* and *reimbursement rates*.

Defined term	Description
Insured	The *policyholder* and/or all other insured persons as listed in the valid *policy schedule*.
Known area of conflict	*Known area of conflict* is a country or part of a country, which the insured's resident country's Foreign Ministry classify in the red category (or equivalent category) and warns its people not to go. If in doubt, the advice of the UK government's website prevails.
Outpatient:	*Treatment* provided at a hospital, *outpatient* clinic or associated facility where it is not medically necessary to occupy a bed overnight.
Pandemic:	An *epidemic* occurring over a widespread area (multiple countries or continents) and usually affecting a substantial proportion of the population.
Persistent vegetative state	*Persistent vegetative state*: • state of profound unconsciousness, with no sign of awareness or a functioning mind, even if the person can open their eyes and breathe unaided, and • the person does not respond to stimuli such as calling their name, or touching. The state must have remained for at least four weeks with no sign of improvement, when all reasonable attempts have been made to alleviate this condition.
Policy anniversary	Each anniversary of the date the *policyholder* joined the *insurance*.
Policy Conditions:	The terms and conditions of the *insurance* purchased.
Policy schedule:	Policy details showing the type of *insurance* purchased, *deductible* and any *special terms*.
Policyholder:	The person identified as the *policyholder* on the *Application* Form.
Pre-existing condition:	The medical history, including the illnesses and conditions listed in the Medical Questionnaire, which may affect the *Company*'s decision to insure or not to insure or to impose *special terms*

Defined term	Description
Reasonable and Customary	The 'usual', or 'accepted standard' amount payable for a specific healthcare *treatment*, procedure or service in a particular geographical region, and provided by *treatment* providers of comparable quality and experience. These charge levels may be governed by guidelines published by relevant government or official medical bodies in the particular geographical region, or may be determined by *our* experience of usual, and most common, charges in that region.
Reimbursement rates:	The maximum amount of money which will be paid by way of reimbursement of medical expenses as further detailed in the List of Reimbursements.
Renewal:	The automatic *renewal* of the *insurance* as per the *policy anniversary*.
Serious injury:	A "*serious injury*" shall be determined to exist only after review and agreement by both the attending physician and the *Company*'s medical consultant.
Special terms:	Restrictions, limitations or conditions applied to the *Company*'s *standard terms* as detailed in the *policy schedule*.
Specialist	A surgeon, anaesthetist or physician who: ○ is legally qualified to practise medicine or *surgery* following attendance at a recognised medical school, and ○ is recognised by the relevant authorities in the country in which the *treatment* is received as having specialised qualification in the field of, or expertise in, the *treatment* of the disease, illness or injury being treated. By 'recognised medical school' *we* mean a medical school which is listed in the World Directory of Medical Schools, as published from time to time by the World Health Organisation.

Defined term	Description
Standard terms:	The *Company*'s standard *insurance* terms with no special restrictions, limitations or conditions.
Subrogation:	The insurer's right to enforce a remedy which the insured has against a third party and the insurer's right to require the insured to repay the insurer if the insurer has paid expenses recouped by the insured from a third party.
Surgery:	A medical procedure that involves the use of instruments or equipment which are inserted into the body. This does not apply to minor surgical procedures e.g. removal of wart.
Terminal phase:	When the advent of death is highly probable and medical opinion has rejected active therapy in favour of the relief of symptoms and support of both patient and family. This decision must be confirmed by the *Company*'s medical consultants.
Treatment:	Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a condition, disease, illness or injury.
Unrecognised medical practitioner, provider or facility:	An *unrecognised medical practitioner, provider or facility* includes: ○ *treatment* provided by a medical practitioner, *provider or facility* who is not recognised by the relevant authorities in the country where the *treatment* takes place as having specialised knowledge, or expertise in, the *treatment* of the disease, illness or injury being treated. ○ *treatment* by any medical practitioner, provider or in any facility to whom *we* have sent a written notice that *we* no longer recognise them for the purposes of *our* plans. ○ *treatment* provided by *family members* or anyone with the same residence as the insured, including the insured him-/herself.
Waiting period:	A period of time from the *commencement date* where the *insurance* provides no cover unless as per specification in Art. 3.

Bupa (Asia) Limited
18/F Berkshire House
25 Westlands Road, Quarry Bay
Hong Kong

Call our Customer Service for questions on your policy, payment, coverage etc.

Open 7am - 7pm (HKT) Mon-Fri
7am - 4pm (HKT) Weekend and public holiday
Tel: +852 2531 8505
Email: service.hk@bupaglobal.com

Call Bupa Global Assistance for 24-hour emergency service and medical help

Tel: +45 70 23 24 60
Fax: +45 70 20 70 56
Email: emergency@ihi.com

Calls are recorded for training and quality purposes and may be shared when legally required to.

The *insurance* plans are insured by Bupa (Asia) Limited and administered by *Bupa Global*. *Bupa Global* is a trading name adopted by Bupa (Asia) Limited in relation to its portfolio of International Private Medical *Insurance* products and services. Bupa (Asia) Limited is authorised and regulated by the Hong Kong *Insurance* Authority.

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