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Avo Cancer (Reimbursement) Protection Policy

Welcome to the Avo family! This document (hereinafter known as "this Policy") contains your Avo Cancer (Reimbursement) Protection Insurance Policy Terms and Conditions. Please read it carefully with the Benefit Schedule, Policy Schedule (also known as the Certificate of Insurance) and Endorsements or Attachments (if any) to ensure that you fully understand what cover is being provided.

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TERMS AND CONDITIONS

PART 1 – INSURING CLAUSE AND THE POLICY

Insuring Clause

These Terms and Conditions together with the Benefit Schedule and any related Supplement(s) (hereafter "Terms and Benefits") apply to the following plan offered by the Company -

Type of the plan - ["Lite plan / Plus plan"]
Name of the plan - ["Avo Cancer (Reimbursement) Protection"]

During the period of time these Terms and Benefits are in force, if the Insured Person suffers from a Covered Cancer, the Company shall pay the Eligible Expenses accordingly.

All benefits payable to the Policy Holder shall be on a reimbursement basis of the actual amounts of Eligible Expenses incurred and are subject to the maximum limits and cost-sharing arrangement (if any) as stated in these Terms and Benefits and the Policy Schedule.

The Policy

The Policy Holder and the Company agree that -

1. No alteration to these Terms and Benefits shall be valid unless it is made in accordance with these Terms and Conditions.
2. All statements made by or for the Insured Person in the Application shall be treated as representations and not warranties.
3. All information provided and all statements made by or for the Insured Person as required under this Policy and the Application shall be provided to the best of his knowledge and in his utmost good faith.
4. These Terms and Benefits come into force on the Policy Effective Date as specified in the Policy Schedule on the condition that the Policy Holder has paid the first premium infull.
5. The Company acknowledges that, as part of the underwriting process, it is the obligation of the Company to ask the Policy Holder and the Insured Person in the Application all requisite information for the Company to make the underwriting decision. If the Company requires the Policy Holder and/or the Insured Person to disclose any updates of or changes to such requisite information after the time of submission of Application and before the Policy Issuance Date or the Policy Effective Date (whichever is the earlier), the Company must make such a request prominently to the Policy Holder and the Insured Person (including without limitation in the Application form), in which case the Policy Holder and/or the Insured Person shall have the obligation to inform the Company on such updates and changes. Each of the Policy Holder and the Insured Person shall have the obligation to respond to the questions, and to disclose such material facts as requested in the questions. The Company agrees that if any such questions are not included in the Application, the Company shall be deemed to have waived the disclosure obligation of the Policy Holder and the Insured Person in respect of the information that was not requested.
6. If the Policy Holder or the Insured Person fails to make the relevant disclosures under Section 5 of this Part 1, and such failure has materially affected the underwriting decision of the Company, the Company shall have the right to exercise as provided in Sections 12 and 13 of Part 2.

PART 2 – GENERAL CONDITIONS

1. Interpretation

(a) Throughout these Terms and Benefits, where the context so requires, words embodying the masculine gender shall include the feminine gender, and words indicating the singular case shall include the plural and vice-versa.
(b) Headings are for convenience only and shall not affect the interpretation of these Terms and Benefits.
(c) A time of day is a reference to the time in Hong Kong.
(d) Unless otherwise defined, capitalised terms used in these Terms and Benefits shall have the meanings ascribed to them under Part 8.

2. Cancellation

The Company may cancel these Terms and Benefits at any time by sending Policy Holder 14 days' written notice and refund pro-rata premium to the Policy Holder. The cancellation will not prejudice any claim originating prior to cancellation.
The Policy Holder can request cancellation of these Terms and Benefits by giving 30 days prior written notice to the Company, provided that there has been no claims submission and/or benefit payment under these Terms and Benefits during the relevant Policy Year.
Monthly Payment: Such cancellation shall become effective on the next premium due date after the effective date of termination as stated in the cancellation notice given by the Policy Holder or the date which the Company receives the cancellation notice, whichever is later; no premium is refunded in the relevant Policy Year.
Annual Payment: Policy will be cancelled on the effective date of termination as stated in the cancellation notice given by the Policy Holder or the date which we receive the cancellation notice, whichever is later; The Company will refund premium on pro-rata basis to Policy Holder.
The cancellation right under this Section shall also apply after these Terms and Benefits have been Renewed upon expiry of its first (or subsequent) Policy Year.

3. Benefit entitlement

If Eligible Expenses are incurred for Medical Services provided to the Insured Person, the Terms and Benefits applicable shall be those prevailing at the time that such Eligible Expenses are incurred.

4. Assignment

The rights, benefits, obligations and duties of the Policy Holder under these Terms and Benefits shall not be assignable and the Policy Holder warrants that any amounts payable under these Terms and Benefits shall not be subject to any trust, lien or charge.

5. Clerical error

Clerical errors in keeping the records shall neither invalidate coverage which is validly in force nor justify continuation of coverage which has been validly terminated.

6. Currency

Any claim for Eligible Expenses made by the Insured Person in any foreign currency shall be converted to HKD at the opening indicative counter exchange selling rate published by The Hong Kong Association of Banks in respect of that foreign currency for the date on which the claim is settled by the Company. If such rate is not available on the date concerned, reference shall be made to the rate as soon as it is available afterwards. If no such rate exists, the Company shall convert the foreign currency at the rate certified as
appropriate by the Company's bankers which shall be deemed to be final and binding.

7. Interest

Save as otherwise specified, no benefit and expenses payable under these Terms and Benefits shall carry interest.

8. Company's obligation

The Company shall at all times perform its obligations in this Policy in utmost good faith and comply with the relevant guidelines issued by the Insurance Authority, and all applicable laws and regulations.

9. Governing law

This Policy shall be governed by and construed in accordance with the laws of the Hong Kong Special Administrative Region.

If any dispute or difference of any kind whatsoever ("Dispute") shall arise between the Company and the Insured Person in connection with this Policy, both parties shall attempt, for a period of thirty (30) calendar days after the receipt of written notice from either party of the existence of the Dispute by the other party, to settle such Dispute in the first instance by mutual discussions between both parties.

Any Dispute, controversy, difference or claim arising out of or relating to this policy contract, including the existence, validity, interpretation, performance, breach or termination thereof or any dispute regarding non-contractual obligations arising out of or relating to it cannot be resolved by mutual agreement as described above within thirty (30) calendar days, shall be referred to and finally resolved by arbitration administered by the Hong Kong International Arbitration Centre (HKIAC) under the HKIAC Administered Arbitration Rules in force when the Notice of Arbitration is submitted. The seat of arbitration shall be Hong Kong Special Administrative Region. The number of arbitrators shall be one. If the parties are unable to agree on the choice of a sole arbitrator, the choice of arbitrator shall be submitted to the then Chairman of the HKIAC for decision.

10. Dispute resolution

If any dispute, controversy or disagreement arises out of this Policy, including matters relating to the validity, invalidity, breach or termination of this Policy, the Company and Policy Holder shall use their endeavours to resolve it amicably, failing which, the matter may (but is not obliged to) be referred to any form of alternative dispute resolution, including but not limited to mediation or arbitration, as may be agreed between the Company and the Policy Holder, before it is referred to a Hong Kong court.

Each party shall bear its own costs of using services under alternative dispute resolution.

11. Liability

The Company shall not accept any liability under this Policy unless the terms of this Policy relating to anything to be done or not to be done are duly observed and complied with by the Policy Holder and the Insured Person, and the information and representations made in the Application and declaration are correct. Notwithstanding the above, the Company shall not disclaim liability unless any non-observance or non-compliance with the terms of this Policy, or the inaccuracy of the information and representations made in the Application and declaration, shall materially and adversely affect the interests of the Company.

12. Misstatement of personal information

Without prejudice to the Company's right to declare this Policy void in the case of misrepresentation on health related information or fraud as provided in Section 13 of this Part 2, if the non-health related information of the Insured Person that may impact the risk assessment by the Company (including but not limited to Age, sex or smoking habit) is misstated in the Application or in any subsequent information or document submitted to the Company for the purpose of the Application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1), the Company may adjust the premium, for the past, current or future Policy Years, on the basis of the correct information. Where additional premium is required, no benefit shall be payable unless the additional premium has been paid. If the additional required premium is not paid within a grace period of 30 days after the due date as notified by the Company to the Policy Holder, the Company shall have the right to terminate this Policy with effect from such due date, in which case Section 14 of this Part 2 shall apply. Where there has been an overpayment of premium by the Policy Holder, the Company shall refund the overpaid premium.

Where the Company, based on the correct information of the Insured Person and the Company's underwriting guidelines, considered that the Application of the Insured Person should have been rejected, the Company shall have the right to declare this Policy void as from the Policy Effective Date and notify the Policy Holder that no cover shall be provided for the Insured Person. In such circumstances, the Company shall have –

(a) the right to demand refund of the benefits previously paid; and

(b) the obligation to refund the premium received,

in each case for the current Policy Year only, subject to a reasonable administration charge payable to the Company. This refund arrangement shall be the same as that in Section 13 of this Part 2.

13. Misrepresentation

This Policy is a contract of utmost good faith. The Policy Holder and the Insured Person must disclose all material facts truthfully and completely at the time of application and throughout the policy term. Material facts include but are not limited to health-related or non-health related information.

Any misrepresentation, whether innocent, negligent, or fraudulent, may entitle the Company to take action in accordance with the Misrepresentation Ordinance (Cap. 284) and the Insurance Ordinance (Cap. 41). The Company may rescind the Policy, deny claims, or adjust the terms of coverage based on the nature and materiality of the misrepresentation.

If any information provided in the Application or in any subsequent document submitted to the Company is found to be false, inaccurate, misleading, or incomplete – whether relating to health (medical history, diagnoses, treatments) or non-health related personal information (e.g., age, sex, or smoking habit) – the Company may take the following actions:

- Adjust the premium for the past, current, or future Policy Years based on the correct information;
- Require payment of any additional premium before any benefit becomes payable;
- Terminate the Policy if the additional premium is not paid within 30 days of the due date;
- Refund any overpaid premium to the Policy Holder.

Based on the correct information and the Company's underwriting guidelines, the Application should have been rejected, the Company reserves the right to declare the Policy void from the Policy Effective Date and notify the Policy Holder that no cover shall be provided for the Insured Person. In such cases:

- The Company may demand a refund of any benefits previously paid; and
- The Company shall refund the premium received for the current Policy Year only, subject to a reasonable administration charge.

14. Termination of Policy

This Policy shall be automatically terminated on the earliest of the followings –

(a) where this Policy is terminated due to non-payment of premiums after the grace period as specified in Section 12 of this Part 2 or Section 3 of Part 3;

(b) the day immediately following the death of the Insured Person; or

(c) the Company has ceased to have the requisite authorisation under the Insurance Ordinance to write or continue to write this Policy

If this Policy is terminated pursuant to this Section 14, the termination shall be effective at 00:00 hours of the effective date of termination.

Immediately following the termination of this Policy, insurance coverage under this Policy shall cease to be in force. No premium paid for the current Policy Year and previous Policy Years shall be refunded, unless specified otherwise.

15. Notices to Company

All notices which the Company requires the Policy Holder to give shall be in writing, or in other forms acceptable by the Company, addressed to the Company.

16. Notices from Company

Any notice to be given under this Policy shall be sent by post to the latest address of the Policy Holder as notified to the Company, or sent by email to the latest email address of the Policy Holder as notified to the Company. Any notice so served shall be deemed to have been duly received by the Policy Holder as follows –

(a) if sent by post, two (2) working days after posting; or
(b) if sent by email, on the date and time transmitted.

17. Other insurance coverage

If the Policy Holder has taken out other insurance coverage besides this plan, the Policy Holder shall have the right to claim under any such other insurance coverage or this plan. However, if the Policy Holder or the Insured Person has already recovered all or part of the expenses from any such other insurance coverage, the Company shall only be liable for such amount of Eligible Expense, if any, which is not compensated by any such other insurance coverage.

18. Rights of third parties

Any person or entity who is not a party to this Policy shall have no rights under the Contracts (Rights of Third Parties) Ordinance (Cap. 623 of the Laws of Hong Kong) to enforce any terms of this Policy.

19. Subrogation

After the Company has paid a benefit under this Policy, the Company shall have the right to proceed at its own expense in the name of the Policy Holder and/or the Insured Person against any third party who may be responsible for events giving rise to such benefit claim under this Policy. Any amount recovered from any such third party shall belong to the Company to the extent of the amount of benefits which has been paid by the Company in respect of the relevant benefit claim under this Policy. The Policy Holder and/or the Insured Person must provide full details in his possession or within his knowledge on the fault of the third party and fully cooperate with the Company in the recovery action. For the avoidance of doubt, the above subrogation right shall only apply if the third party is not the Policy Holder or the Insured Person.

20. Suits against third parties

Nothing in this Policy shall oblige the Company to join, respond to or defend (or indemnify in respect of the costs for) any suit or alternative dispute resolution process for damages for any cause or reason which may be instituted by the Policy Holder or the Insured Person against any Registered Medical Practitioner, Hospital or healthcare services provider, including but not limited to any suit or alternative dispute resolution process for negligence, malpractice or professional misconduct or any other causes in relation to or arising out of the medical investigation or treatment of the diagnosis of the Insured Person under the terms of this Policy.

21. Waiver

No waiver by any party of any breach by any other party of any provisions of this Policy shall be deemed to be a waiver of any subsequent breach of that or any other provision of this Policy, and any forbearance or delay by any party in exercising any of its rights under this Policy shall not be construed as a waiver of such rights. Any waiver shall not take effect unless it is expressly agreed, and the rights and obligations of the Company and Policy Holder under this Policy shall remain in full force and effect except and only to the extent that they are waived.

22. Compliance with law

If this Policy is or becomes illegal under the law applicable to the Policy Holder or the Insured Person, the Company shall have the right to terminate this Policy from the date it becomes illegal and the Company shall refund the relevant premium paid for the Policy Year in which this Policy is terminated, on a pro rata basis.

23. Personal data privacy

The Company shall comply with the Personal Data (Privacy) Ordinance (Cap. 486 of the Laws of Hong Kong) and the related codes, guidelines and circulars.

24. Duplicate Insurance

If there is more than one (1) policies of the same kind which are underwritten by the Company for the same Insured Person, the Company shall only be liable for the Policy first issued. Any additional policies will be deemed void.

PART 3 – PREMIUM PROVISIONS

1. Premium payable

The premium payable for these Terms and Benefits shall only include –

(a) the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company; and
(b) the Premium Loading, if applicable.

2. Premium payment and unpaid premium

Premium and the manner of payment including whether premium shall be payable on a monthly, annual or otherwise shall be stated in the Policy Schedule. Premium shall be payable on each premium due date by charging Policy Holder's nominated credit card. If Policy Holder chooses monthly payment, monthly premium will be due on the same date as the first Policy effective date, or on the last day of the month if that date does not exist in a given month. If Policy Holder chooses annual payment, the annual premium will be due on the next renewal date.
Any unpaid premium, including the outstanding and/or uncharged premium payments in the same policy year, may be deducted by the Company from any claim payment, at the Company's absolute discretion.

3. Grace period

The Company will allow the Policy Holder ten (10) days grace period for the payment of each premium. During grace period the Company will keep this Policy in force. If after that time the premium remains unpaid, this Policy will be deemed to have lapsed from the date when the unpaid premium was due.

PART 4 – RENEWAL PROVISIONS

1. Renewal

The Company reserves the right to amend the premiums or other terms and conditions at the Company's absolute discretion if the Company renews the Policy, and will give a thirty (30) days' written notice of such amendment to the Policy Holder by email, and the change will be effective from the next renewal date of the Policy. The Company will not be obligated to reveal Our reasons for such amendments.

If, instead of accepting the renewal invitation, Policy Holder or any other person takes out a new policy of the same kind with the Company for the same Insured Person, and the policy period of the new policy either overlaps, commences immediately, or commences within thirty (30) days after this Policy, The Company reserves the right to deem the new policy void at the Company's absolute discretion.

This Policy will be renewed automatically upon successful payment of the renewal premium. For non-renewal policy, the Company will notify Policy Holder the policy not to invite renewal at the Company's absolute discretion thirty (30) days prior to the expiration of this Policy by written notification.

2. Adjustment of premium

Irrespective of whether the Company revises these Terms and Benefits upon Renewal, the Company shall have the right to adjust the Standard Premium according to the prevailing Standard Premium schedule adopted by the Company on an overall Portfolio basis. For the avoidance of doubt, if the Premium Loading is set as a percentage of the Standard Premium (i.e. rate of Premium Loading), the amount of Premium Loading payable shall be automatically adjusted according to the change in Standard Premium.

3. Notification of Renewal

Irrespective of whether the Company revises these Terms and Benefits upon Renewal, the Company shall in accordance with the terms of this Section 3 give the Policy Holder a written notice of the revised Terms and Benefits to the Policyholder of not less than 30 days prior to the Renewal Date.

The written notice shall specify the premium for Renewal and Renewal Date. If the Company revises these Terms and Benefits upon Renewal, the Company shall make available the revised Terms and Benefits to the Policy Holder together with the written notice. The revised Terms and Benefits and premium for Renewal shall take effect on the Renewal Date.

4. Re-underwriting

While these Terms and Benefits are in force, the Company shall have the right to re-underwrite these Terms and Benefits after the Policy Issuance Date or the Policy Effective Date, whichever is the earlier.

The Company shall have the right to re-underwrite these Terms and Benefits under the following circumstances –

(a) Where the Policy Holder requests the Company to re-underwrite these Terms and Benefits at the time of Renewal for reduction in Premium Loading or removal of Case-based Exclusion(s) according to the Company's underwriting practices;

(b) At any time where the Policy Holder requests to subscribe additional benefits (if any) or switch to another insurance plan which provides upgrade or addition of benefits;

(c) Where the Company decides to Offer these Terms and Benefits at the time of Renewal according to the Company's underwriting practices; or

(d) Where there is change in the Place of Residence of the Insured Person.

The Company and Policy Holder acknowledge that –

(a) if under the terms of this Part 4, the Company has the right, or is required, to re-underwrite these Terms and Benefits based on certain factors at Renewal, the Company shall, in accordance with the terms of this Part 4 and its prevailing underwriting guidelines, take into account only such relevant factors to carry out the re-underwriting; and

(b) as a result of re-underwriting, these Terms and Benefits may be terminated, new Premium Loading may be applied, existing Premium Loading may be adjusted upwards or downwards, new Case-based Exclusion(s) may be applied, and existing Case-based Exclusion(s) may be revised or removed.

PART 5 – CLAIM PROVISIONS

1. Submission of claims

All claims incurred in respect of these Terms and Benefits shall be submitted to the Company within 90 days after the date on which the Insured Person is discharged from the Hospital, or (where there is no Confinement) the date on which the relevant Medical Service is performed and completed. For this purpose, a claim shall be deemed not valid or complete and benefit shall not be payable unless –

(a) all original receipts and/or original itemised bills together with the diagnosis, type of treatment, procedure, test or service provided shall have been submitted to the Company; and

(b) all relevant information, certificates, reports, evidence, referral letter and other data or materials as reasonably required by the Company shall have been furnished to the Company for processing of such claim.

The Policy Holder shall notify the Company if claims cannot be submitted within the above timeframe, otherwise the Company shall have the right to reject claims submitted after the above timeframe.

All certificates, information and evidence that are reasonably required by the Company and which can be reasonably provided by the Policy Holder shall be furnished at the expenses of the Policy Holder. The Company shall bear all expenses incurred in obtaining further certificates, information and evidence for the purposes of verification of the claim after the Policy Holder has submitted all required information pursuant to (a) and (b) above.

2. Claimable amount estimate

Before the Insured Person receives a Medical Service, the Policy Holder may request the Company to provide an estimate on the amount that may be claimed under these Terms and Benefits. The Policy Holder shall provide the Company with the estimated fees to be incurred as furnished by the Hospital and/or attending Registered Medical Practitioner as required by the laws and regulations regulating the private healthcare facilities in Hong Kong at the time of request. Upon receiving the request, the Company shall inform the Policy Holder of the claimable amount estimate under these Terms and Benefits based on the estimation furnished by the Hospital and/or attending Registered Medical Practitioner. The Company's estimate is for reference only, and the actual amount claimable by the Policy Holder shall be subject to the final expenses as evidenced in (a) and (b) of Section 1 of this Part 5.

3. Legal action

No legal action shall be brought by the Policy Holder to recover any claim amount payable under these Terms and Benefits within the first 60 days from which all proof of claims as required by these Terms and Benefits has been received by the Company.

4. Medical examination

Where a claim occurs, the Company shall have the right to require the Insured Person to be examined by a Registered Medical Practitioner appointed by the Company at the Company's cost.

PART 6 – BENEFIT PROVISIONS

1. General

(a) Territorial scope of cover
All benefits described in these Terms and Benefits shall be applicable to Hong Kong, Macau and Mainland China. The Insured Person in China must be hospitalized, diagnostic, surgery or/and treatment at Grade 3A Hospitals designated by National Health Commission of the People's Republic of China.

(b) Lifetime Benefit Limit
All benefits described in these Terms and Benefits are subject to Lifetime Benefit Limit.

(c) Choice of healthcare services providers
All benefits described in these Terms and Benefits are not subject to any restriction in the choice of healthcare services providers, including but not limited to Registered Medical Practitioner and Hospital.

(d) Choice of ward class
All benefits described in these Terms and Benefits are not subject to any restriction in the choice of ward class in Hospital.

2. Coverage of Confinement and non-Confinement services

While this Policy is in force and subject to the terms and conditions set out hereunder, in the event of the Insured Person is first diagnosed to be suffering from a Cancer of the Covered Organs, upon receipt of due proof of such Cancer of the Covered Organ in accordance with the claims procedures, the Company shall reimburse the Eligible Expenses which are Reasonable and Customary charges in accordance with benefit items under Section 3 of this Part 6 incurred for the treatment of such Cancer when the Insured Person:

(a) is Confined to a Hospital as a bed patient; or

(b) undergoes any Day Case Procedure, prescribed diagnostic imaging test or prescribed non- surgical cancer treatment,

The amount of Eligible Expenses payable under these Terms and Benefits shall not exceed the actual costs for Medical Services provided to the Insured Person, subject to the limits as stated in the Benefit Schedule. The Company reserves the right to determine whether any particular medical charge is a Reasonable and Customary charge and shall not reimburse any charge, which in the opinion of the Company is not Reasonable and Customary.

For the avoidance of doubt, where an Insured Person is Confined in a Hospital but the Confinement is considered not Medically Necessary, the expenses incurred as a result of such Confinement shall not be regarded as Eligible Expenses. However, the Policy Holder shall still have the right to claim for the relevant Eligible Expenses incurred during such Confinement on Medical Services under (b) above.

The Company shall only be liable for medical expenses incurred for the actual services provided to the Insured Person. Any expenses incurred for services rendered to anyone other than the Insured Person shall not be covered, unless it was specified otherwise.

In the following events, the Company shall classify the latest as a new Cancer and pay the latest Cancer in accordance with the benefits amount set forth in the Benefit Schedule where all benefits payable and benefit limits applicable in respect of the latest Covered Cancer shall be subject to the separate Covered Cancer Limit and maximum number of visits and/or the maximum benefit amount per visit or per Covered Cancer of the Covered Cancer:

(i) the latest Cancer and the preceding Cancer are of a different histopathology, and the latest Cancer is not a recurrence or metastasis of the preceding Cancer (Which has to be verified by a Specialist and supported by tissue of origin tests as well as clinical, imaging or other laboratory investigations); and

(ii) In the event that the latest Cancer and the preceding Cancer are of the same histopathology, and the latest Cancer is a recurrence or metastasis of the preceding Cancer, and date of diagnosis of confirming the existence, continuation, metastasis or recurrence of the latest Cancer is at least three (3) years after the Insured Person had completed all standard treatment regime as recommend by at attending Registered Medical Practitioner and in complete remission.

For the avoidance of doubt, any preceding Cancer of the same histopathology relapsed or metastasis within three (3) years of remission, the Company shall treat the latest Cancer as the same Cancer and pay in accordance with the benefits amounts subject to the same and one Covered Cancer Limit and maximum number of visits and/or the maximum benefit amount per visit or per Covered Cancer of the preceding Cancer.

3. Benefits covered

Eligible Expenses covered under Section 2 of this Part 6 shall be payable according to the following benefit items –

(a) Diagnostic Benefit
Subject to the Covered Cancer Limit and Lifetime Benefit Limit, we shall reimburse the Reasonable and Customary charges actually incurred for any Medically Necessary diagnostic test(s) which directly confirms the positive diagnosis of Covered Cancer undergone by the Insured Person in a Hospital or a clinic under the supervision of a Registered Medical Practitioner.
Diagnostic procedures and/or investigations shall include laboratory tests, X-rays, computerised tomography (“CT” scan), magnetic resonance imaging (“MRI” scan), positron emission tomography (“PET” scan), fine needle aspiration for cytology or histopathology, excisional biopsy for histopathology and any other diagnostic tests for establishing the positive diagnosis of Covered Cancer.
For the avoidance of doubt, any charges incurred in respect of routine health screenings which are not for the specific purpose of identifying the existence, nature or extent of a Covered Cancer shall not be covered, regardless of the results of the related tests or procedures.
If the Insured Person is Confined in Hospital for performance of a diagnostic test and such Confinement is Medically Necessary for performing the diagnostic test, we shall also reimburse the Reasonable and Customary charges actually incurred for such Confinement.

(b) Treatment Benefit
Subject to the Covered Cancer Limit and Lifetime Benefit Limit, we shall reimburse the Reasonable and Customary charges actually incurred for consultation and/or treatment for the Insured Person, either on an In-patient or out-patient basis, for Active Treatment or Palliative Treatment of a Covered Cancer and/or any complication(s) thereof, including the following:

(i) Active and Palliative Treatment Benefit
This benefit shall be payable for the Eligible Expenses incurred in relation to radiotherapy, chemotherapy, targeted therapy, hormonal therapy and immunotherapy for any Covered Cancer during Confinement or on a Day Case basis.

(ii) Hospital Room and Board
This benefit shall be payable for the Eligible Expenses charged by the Hospital on the cost of accommodation and meals where the Insured Person is Confined in a Hospital.

(iii) Attending Doctor’s Visit Fee
If on any day of Confinement, the Insured Person is treated by a Registered Medical Practitioner, this benefit shall be payable for the Eligible Expenses charged by the attending Registered Medical Practitioner for such visit or consultation.

(iv) Specialist’s Fee
If on any day of Confinement, the Insured Person is treated by a Specialist (not being the attending Registered Medical Practitioner under Section 3(b)(iii) of this Part 6) as recommended in writing by the attending Registered Medical Practitioner, this benefit shall be payable for the Eligible Expenses charged by the Specialist for such visit or consultation.

(v) Intensive Care
If on any day of Confinement, the Insured Person is admitted to an Intensive Care Unit, this benefit shall be payable for the Eligible Expenses charged on the intensive care services.
For the avoidance of doubt, the Eligible Expenses so incurred and payable under this benefit shall not be payable under Section 3(b)(ii) of this Part 6.

(vi) Surgical Expense
This benefit shall be payable for the Eligible Expenses charged by the attending Surgeon and Anaethetist on a surgical procedure performed during Confinement.

(vii) Miscellaneous Hospitalization Expense

This benefit shall be payable for the Eligible Expenses charged on miscellaneous charges where the Insured Person is Confined in a Hospital for receiving Medical Services including:-

- Anaesthetic and oxygen administration;
- Administration charges for blood transfusion;
- Dressing and plaster casts;
- Medicine and drug prescribed and consumed during Confinement or any Day Case Procedure;
- Medicine and drug prescribed upon discharge from Confinement or completion of Day Case Procedure for use up to the ensuing four (4) weeks;
- Additional surgical appliances, equipment and devices and implants, disposables and consumables used during surgical procedure;
- Medical disposables, consumables, equipment and devices;
- Intravenous ("IV") infusions including IV fluids;
- Laboratory examinations and reports, including the pathological examination performed for the surgery or procedure during the Confinement;
- Rental of walking aids and wheelchair for Inpatients; and
  Physiotherapy, occupational therapy and speech therapy during Confinement

(viii) Companion Bed

This benefit includes one (1) extra bed for one (1) person who accompanies the Insured Person in the Hospital.

(ix) Pre- and Post-treatment Outpatient Benefit

This benefit shall be payable for the Eligible Expenses for -

- Pre-Hospitalization or Day Case Procedure outpatient visit (including and limited to consultation, western medication prescribed or diagnostic test); and
- Follow-up outpatient visit (including and limited to consultation, western medication prescribed, or diagnostic test) to, or recommended in writing by, the attending Registered Medical Practitioner, limited to one consultation per day, provided that such outpatient visit is directly related to and as a result of the condition arising from the same Disability (including any and all complications therefrom) necessitating such Confinement.

(c) Reconstructive Surgery Benefit

Subject to the Covered Cancer Limit and Lifetime Benefit Limit, we shall reimburse the Reasonable and Customary charges actually incurred for Reconstructive Surgery performed on the Insured Peron which is required as a result from the treatment of the Covered Cancer and recommended in writing by the Insured Person's attending Registered Medical Practitioner.

If the Insured Person's Confinement in the Hospital is Medically Necessary for such Reconstructive Surgery, subject to the Covered Cancer Limit and Lifetime Benefit Limit, we shall also reimburse the Reasonable and Customary charges actually incurred for such Confinement.

(d) Monitoring Benefit

Subject to the Covered Cancer Limit and Lifetime Benefit Limit, the Company shall reimburse the Reasonable and Customary charges for the actual expenses incurred in relation to consultation and Diagnostic Test(s) recommended by a Registered Medical Practitioner in writing, to monitor the response to treatment and progress of the Insured Person's recovery after completion of Active Treatment. In case Confinement is Medically Necessary for performing the Diagnostic Test(s), the Company shall also reimburse the Reasonable and Customary charges for the actual expenses incurred for such Confinement pursuant to Part 6 Section 3(b) – Treatment Benefit.

Monitoring Benefit is payable for a maximum of five (5) years from the date of completion of Active Treatment.

Any routine health screening carried out not directly due to the Covered Cancer shall not be covered.

(e) Extended Caring Benefit

(i) Alternative Treatment Benefit:

Subject to the maximum benefit amount per visit and maximum visits per Covered Cancer for Alternative Treatment Benefit, with reference to the plan Level as specified in the Benefit Schedule, the Company shall reimburse the Reasonable and Customary charges for the actual expenses incurred for Traditional Chinese Medicines Treatment, Acupuncture, physiotherapy, occupational therapy, speech therapy, dietician consultation and chiropractic treatment provided that:

- the consultations, treatments and/or prescribed medicine are Medically Necessary during or after Active Treatment or when undergoing Palliative Treatment;
- a referral letter from the attending Registered Medical Practitioner is provided for any treatment for physiotherapy, occupational therapy, speech therapy, dietician consultation and chiropractic treatment; and
- the treatments are given by qualified practitioner(s) who shall be an Independent Person and is legally authorized by the government of the location or country of his or her practice to render such services and/or perform such treatments.

Subject to the maximum benefit amount per visit and maximum visits per Covered Cancer for Alternative Treatment Benefit, with reference to the plan Level as specified in the Benefit Schedule, the Company shall reimburse the Reasonable and Customary charges for the actual expenses incurred for psychological counselling for the Insured Person and one (1) Immediate Family Member in relation to the Insured Person's Covered Cancer. The psychological counselling services have to be given by qualified psychologist or psychiatrist who shall be an Independent Person and is legally authorized by the government of the location or country of his or her practice to render such services and/or perform such treatments.

Subject to the maximum benefit amount per visit and maximum visits per Covered Cancer for Alternative Treatment Benefit, with reference to the plan Level as specified in the Benefit Schedule, the Company shall reimburse the Reasonable and Customary charges for the expenses incurred for Medically Necessary nursing services provided to the Insured Person by a Nurse in the Insured Person's home during or after Active Treatment or when undergoing Palliative Treatment. This benefit must be prescribed in writing by the attending Registered Medical Practitioner and is restricted to nursing services provided by a maximum of one (1) Nurse at any given time.

This Alternative Treatment Benefit is subject to one (1) visit per day for each type of the treatments or services specified under Alternative Treatment Benefit, the maximum benefit amount per visit and the maximum number of visits per Covered Cancer with reference to the plan Level as specified in the Benefit Schedule. For the avoidance of doubt, for psychological counselling, one (1) visit for the Insured Person and one (1) visit for one (1) Immediate Family Member per day are allowed.

(ii) Medical Devices Benefit:

Subject to the maximum benefit amount per Covered Cancer with reference to the plan Level as specified in the Benefit Schedule, the Company shall reimburse all Reasonable and Customary charges for the actual expenses incurred for purchasing or renting medical devices which are Medically Necessary in relation to the Covered Cancer and recommended by the Insured Person's attending Registered Medical Practitioner.

PART 7 – GENERAL EXCLUSIONS

Under these Terms and Benefits, the Company shall not pay any benefits in relation to or arising from the following expenses -

1. Any tumour which is histologically classified as benign or pre-malignant;
2. Any drug or alcohol abuse;
3. Any Pre-existing Conditions;

4. Any (i) experiences symptoms or signs for (even if the Insured Person has not consulted a Medical Practitioner), or (ii) receives treatment, medication or investigation for, or (iii) is diagnosed with, any covered illness within the Waiting Period of the policy;
5. Nuclear, biological or chemical contamination (NBC) and;
6. The Confinement, treatment, surgery and/or charges relating to or caused directly or indirectly, wholly or partly, by any of the following:
   (a) General check-up (whether with or without any positive findings(s) on the Insured Person), convalescence, custodial or rest care not related to the Covered Cancer; screening or checkups looking for the presence of Covered Cancer on a preventative basis or where there are no symptoms or history of Covered Cancer; vaccines for the prevention of Covered Cancer;
   (b) Disease or infection with any human immunodeficiency virus (HIV) and/or any HIV-related illness;
   (c) Any treatment, tests, service or supplies which is not Medically Necessary or any charges which exceed the Reasonable and Customary Charges;
   (d) Narcotics used by the Insured Person unless taken as prescribed by a Registered Medical Practitioner;
   (e) any services primarily for physiotherapy or for the investigation or signs and/ or symptoms with diagnostic imaging, laboratory investigation or other diagnostic procedures;
   (f) Non-medical services, including but not limited to guest meals, radio, telephone, photocopy, taxes, personal items, medical report charges and the like;
   (g) Any experimental, unproven or unconventional medical technology/ procedure/ therapy or novel drugs/ medicines/ stem cell therapy not yet approved by the government, relevant authorities and/ or recognized medical association of the country or region where the treatment is sought;
   (h) Genetic testing undertaken to test for a genetic predisposition to Covered Cancer;
   (i) Any treatment modality undergone without a definite diagnosis of the presence of Covered Cancer in the Insured Person's body as per the definition specified; and
   (j) Over-the counter medication and nutrient supplement nor prescribed by a Registered Medical Practitioner.

PART 8 - DEFINITIONS

Under these Terms and Benefits, words and expressions used shall have the following meanings -

"Active Treatment"	shall mean any therapeutic intervention with the aim of improving the length of Insured Person's survival, including but not limited to radiotherapy, chemotherapy, targeted therapy, hormonal therapy, immunotherapy and surgery for a Covered Cancer, including any complications thereof (if applicable).
"Age"	shall mean the attained age of the Insured Person.
"Application"	shall mean the Application submitted to the Company in respect of this plan, including the application form, questionnaires, evidence of insurability, any documents or information submitted and any statements and declarations made in relation to such Application, including any updates of and changes to such requisite information (if so requested by the Company under Section 6 of Part 1).
"Benefit Schedule"	shall mean a schedule of benefits attached to these Terms and Benefits which sets out, among others, the benefit items and maximum benefit limit covered.
"Cancer"	shall mean a malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The cancer should be confirmed by histological evidence of malignancy on a pathology report. For this purpose of this Policy, Cancer includes: (a) All stages of malignant cancer, and (b) Carcinoma-in-situ The following would be excluded: (a) All tumours which are histologically described as benign or pre-malignant; (b) All tumours in the presence of any Human Immunodeficiency Virus (HIV) and/or any HIV-related illness; (c) Cervical intraepithelial neoplasia grade I (CIN I) and grade II (CIN II); (d) Any Cancer which is not developed primarily in the Covered Organs; and (e) Any Cancer which spreads from other part of the body to Covered Organs.
"Carcinoma-in-situ"	shall mean a histologically proven, localized pre-invasion lesion where cancer cells have not yet penetrated the basement membrane or invaded (in the sense of infiltrating and / or actively destroying) the surrounding tissues or stroma.
"Case-based Exclusion"	shall mean the exclusion of a particular sickness or disease from the coverage of these Terms and Benefits that may be applied by the Company based on a Pre-existing Condition or factors affecting the insurability of the Insured Person
"Company"	shall mean Avo Insurance Company Limited.
"Confinement" or "Confined"	shall mean an admission of the Insured Person to a Hospital that is recommended by a Registered Medical Practitioner for Medical Service and as an Inpatient as a result of a Medically Necessary condition. No minimum period is required for Confinement in connection with any emergency treatment in a Hospital as a result of an Emergency for the performance of a surgical procedure or other Medical Service in a Hospital. Confinement shall be evidenced by a daily room charge invoiced by the Hospital and the Insured Person must stay in the Hospital continuously for the entire period of Confinement.
"Congenital Condition(s)"	shall mean (a) any medical, physical or mental abnormalities existed at the time of or before birth, whether or not being manifested, diagnosed or known at birth; or (b) any neo-natal abnormalities developed within six (6) months of birth.
"Covered Cancer"	shall mean Cancer of the Covered Organs. For this purpose, a Cancer is regarded as having occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested which will cause an ordinary prudent person to seek diagnosis, care or treatment. In the event of any conflict or discrepancy of opinions relating to the signs or symptoms of a Cancer and their manifestation between a Registered Medical Practitioner or Surgeon and the Insured Person, we will adopt and follow the Registered Medical Practitioner's or Surgeon's professional opinion.
"Covered Cancer Limit"	shall mean the maximum aggregate amount paid or payable in respect of the benefits under Part 6 - Benefit Provision for any Covered Cancer suffered by the Insured Person stated in the Benefit Schedule.

"Covered Organs"	shall mean the body organs stated in the Benefit Schedule.
"Day Case Procedure"	shall mean a Medically Necessary surgical procedure for investigation or treatment to the Insured Person performed in a medical clinic, or day case procedure centre or Hospital with facilities for recovery as a Day Patient.
"Day Patient"	shall mean an Insured Person receiving Medical Services or treatments given in a medical clinic, Day Case Procedure centre or Hospital where the Insured Person is not in Confinement.
"Diagnosis"	shall mean a sickness or disease, including any and all complications arising therefrom.
"Eligible Expenses"	shall mean expenses incurred for Medical Services rendered with respect to a Diagnosis.
"Government"	shall mean the Hong Kong Special Administrative Region Government.
"HKD"	shall mean Hong Kong dollars.
"Hong Kong"	shall mean the Hong Kong Special Administrative Region of the People's Republic of China.
"Hospital"	shall mean an establishment duly constituted and registered as a hospital under the laws of the relevant territory in which it is established, which is for providing Medical Service for sick and injured persons as Inpatients, and which – (a) has facilities for diagnosis and major operations; (b) provides twenty-four (24) hours nursing services by licensed or registered nurses; (c) has one (1) or more Registered Medical Practitioners; (d) and is not primarily a clinic, a place for alcoholics or drug addicts, a nature care clinic, a health hydro, a nursing, rest or convalescent home, a hospice or palliative care centre, a rehabilitation centre, an elderly home or similar establishment.
"Inpatient"	shall mean an Insured Person who is Confined.
"Insurance Authority"	shall mean the Insurance Authority of Hong Kong established pursuant to section 4AAA of the Insurance Ordinance.
"Insurance Ordinance"	shall mean the Insurance Ordinance (Cap. 41 of the Laws of Hong Kong).
"Insured Person"	shall mean any person whose risks are covered by these Terms and Benefits, and named as the "Insured Person" in the Policy Schedule.
"Intensive Care Unit"	shall mean that part or unit of a Hospital established for and devoted to providing intensive medical and nursing care for Inpatients.
"Lifetime Benefit Limit"	shall mean the maximum amount of benefits paid by the Company to the Policy Holder cumulatively since the inception of these Terms and Benefits, irrespective whether any limits of any benefit items stated in the Benefit Schedule have been reached or whether the Covered Cancer Limit has been reached.
"Medical Services"	shall mean Medically Necessary services, including, as the context requires, Confinement, treatments, procedures, tests, examinations or other related services for the investigation or treatment of a Diagnosis.
"Medically Necessary"	shall mean the need to have medical service for the purpose of investigating or treating the relevant Diagnosis in accordance with the generally accepted standards of medical practice and such medical service must – (a) require the expertise of, or be referred by, a Registered Medical Practitioner; (b) be consistent with the Diagnosis and necessary for the investigation and treatment of the Diagnosis; (c) be rendered in accordance with standards of good and prudent medical practice, and not be rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner; (d) be rendered in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice for the medical services; and (e) be furnished at the most appropriate level which, in the prudent professional judgment of the attending Registered Medical Practitioner, can be safely and effectively provided to the Insured Person. For the purpose of these Terms and Benefits, without prejudice to the generality of the foregoing, circumstances where a Confinement is considered Medically Necessary include, but not limited to – (i) the Insured Person is having an Emergency that requires urgent treatment in Hospital; (ii) surgical procedures are performed under general anaesthesia; (iii) equipment for surgical procedure is available in Hospital and procedure cannot be done on a Day Patient basis; (iv) there is significantly severe co-morbidity of the Insured Person; (v) taking into account the individual circumstances of the Insured Person, the attending Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, the medical service should be conducted in Hospital; (vi) in the prudent professional judgment of the attending Registered Medical Practitioner, the length of Confinement of the Insured Person is appropriate for the medical service concerned; and/or (vii) in the case of diagnostic procedures or allied health services prescribed by a Registered Medical Practitioner, such Registered Medical Practitioner has exercised his prudent professional judgment and is of the view that for the safety of the Insured Person, such procedures or services should be conducted in Hospital. For the purpose of exercising his prudent professional judgment in (v) to (vii) above, the attending Registered Medical Practitioner shall have regard to whether the Confinement – (aa) is in accordance with standards of good and prudent medical practice in the locality for the medical service rendered, and, in the prudent professional judgment of the attending Registered Medical Practitioner, not rendered primarily for the convenience or the comfort of the Insured Person, his family, caretaker or the attending Registered Medical Practitioner; and (bb) is in the setting that is most appropriate in the circumstances and in accordance with the generally accepted standards of medical practice in the locality for the medical service rendered.

"Palliative Treatment"	treatment intended to improve the quality of the Insured's life in the case of a Covered Cancer that is highly likely to lead to the Insured's death within twelve (12) Calendar Months, by relieving pain or alleviating other symptoms of the Covered Cancer, or the side effects of its treatment, without any attempt at its/their cure.
"Place(s) of Residence"	shall mean the jurisdiction(s) in which a person legally has the right of abode. A change in the Place(s) of Residence refers to the situation where a person has been granted the right of abode of additional jurisdiction(s), or has ceased to have the right of abode of existing jurisdiction(s). The above definition of "Place(s) of Residence" is used solely for the purpose of these Terms and Benefits. For the avoidance of doubt, a jurisdiction in which a person legally has the right or permission of access only but without the right of abode, such as for the purpose of study, work or vacation, shall not be treated as a Place of Residence.
"Policy"	shall mean this policy underwritten and issued by the Company, which is the contract between the Policy Holder(s) and the Company in respect of this plan including but not limited to these Terms and Conditions, Benefit Schedule, Application, declarations, Policy Schedule and any Supplement(s) attached to this Policy, if applicable. Where this Policy contains additional terms and benefits other than those of this plan, the meaning of Policy shall also cover such additional terms and benefits.
"Policy Effective Date"	shall mean the commencement date of these Terms and Benefits which is specified as "Policy Effective Date" in the Policy Schedule.
"Policy Holder"	shall mean the person who is a legal holder of this Policy and is named as the "Policy Holder" in the Policy Schedule.
"Policy Issuance Date"	shall mean the date of first issuance of these Terms and Benefits.
"Policy Schedule"	shall mean a schedule attached to these Terms and Benefits, which sets out, among others, the Policy Effective Date, thename and the relevant particulars of the Policy Holder and the Insured Person, premium and other relevant details in respect of these Terms and Benefits.
"Policy Year"	shall mean the period of time these Terms and Benefits are in force. The first Policy Year shall be the period from the Policy Effective Date to the day immediately preceding the first Renewal Date as specified in the Policy Schedule (both days inclusive) within one (1) year period; and each subsequent Policy Year shall be the one (1) year periodfrom each Renewal Date.
"Portfolio"	shall mean all policies of the same terms and conditions and the Benefit Schedule.
"Pre-existing Condition(s)"	shall mean, in respect of the Insured Person, any Sickness, Disease, Injury, physical, mental or medical condition or physiological degradation, including Congenital Condition, that has existed prior to the Policy Issuance Date or the Policy Effective date, whichever isthe earlier. An ordinary prudent person shall be reasonably aware of a Pre-existing Condition, where – (a) it has been diagnosed; (b) it has manifested clear and distinct signs or symptoms; or (c) medical advice or treatment has been sought, recommended or received.
"Premium Loading"	shall mean the additional premium on top of the Standard Premium charged by the Company to the Policy Holder according to the additional risk assessed for the Insured Person.
"Reasonable and Customary"	shall mean, in relation to a charge for Medical Service, such level which does not exceed the general range of charges being charged by the relevant service providers in the locality where the charge is incurred for similar treatment, services or supplies to individuals with similar conditions, e.g. of the same sex and similar Age, for a similar diagnosis, as reasonably determined by the Company in utmost good faith. The Reasonable and Customary charges shall not in any event exceed the actual charges incurred. In determining whether a charge is Reasonable and Customary, the Company shall make reference to the followings (if applicable) - (a) treatment or service fee statistics and surveys in the insurance or medical industry; (b) internal or industry claim statistics; (c) gazette published by the Government; and/or (d) other pertinent source of reference in the locality where the treatments, services or supplies are provided.
"Reconstructive Surgery"	shall mean the actual undergoing of plastic or reconstructive surgery on the head or on the breast which are defective or damaged due to Covered Cancer. This surgery must be deemed to be Medically Necessary to restore function or appearance following previous surgery on the head or breast done for treatment of a Covered Cancer. Surgery solely for isolated dental restorations is excluded.
"Registered Medical Practitioner", "Specialist", "Surgeon" and "Anaesthetist"	shall mean a medical practitioner of western medicine, (a) who is duly qualified and is registered with the Medical Council of Hong Kong pursuant to the Medical Registration Ordinance (Cap. 161 of the Laws of Hong Kong) or a body of equivalent standing in jurisdictions outside Hong Kong (as reasonably determined by the Company in utmost good faith); and (b) legally authorised for rendering relevant Medical Service in Hong Kong or the relevant jurisdiction outside Hong Kong where the Medical Service is provided to the Insured Person, but in no circumstance shall include the following persons - the Insured Person, the Policy Holder, or an insurance intermediary, employer, employee, immediate family member or business partner of the Policy Holder and/or the Insured Person (unless approved in advance by the Company in writing). If the practitioner is not duly qualified and 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.
"Renewal", "Renew", "Renewed" or "Renewable"	shall mean renewal of these Terms and Benefits in accordance with their terms without any discontinuance.
"Renewal Date"	shall mean the effective date of Renewal. The first Renewal Date shall be the first anniversary of the Policy Effective Date and the subsequent Renewal Date(s) shall be the anniversary(ies) of the first Renewal Date. The relevant Renewal Date shall be specified in the notification of Renewal in accordance with Section 3 of Part 4.

"Standard Premium"	shall mean the basic premium for the coverage under this plan, as charged by the Company to the Policy Holder on an overall Portfolio basis, which may be adjusted in accordance with the Age, gender and/or lifestyle factors of the Insured Person.
"Supplement(s)"	shall mean any document which may add, delete, amend or replace the terms and benefits of this Policy. Supplement(s) shall include but is not limited to endorsement, rider, annex, schedule or table attached and issued with this Policy.
"Terms and Benefits"	shall mean the Terms and Conditions together with the Benefit Schedule and any related Supplement(s) under this plan.
"Terms and Conditions"	shall mean Part 1 to Part 8 of this plan.
" Traditional Chinese Medicines Treatment" or " Acupuncture"	shall mean the treatments being given by Chinese Medicine Practitioner. Chinese Medicine Practitioner is Chinese herbalist, Chinese bonesetter or acupuncturist who is legally registered with The Chinese Medicine Council of Hong Kong according to the Chinese Medicine Ordinance.
"Waiting Period"	shall mean 90 days after the Policy Effective Date of this Policy. The Waiting Period is not applicable for Renewed Policy.