HSBC Life International Exclusive

Make the world your home

HSBC Life

Living in a different country can be the experience of a lifetime and it is important that you have access to quality healthcare treatments wherever you want, while being protected against rising medical costs worldwide. With access to premium coverage for private medical care worldwide, **HSBC Life International Exclusive** has got your healthcare needs covered.

Flexible protection options for your healthcare needs worldwide

Access to medical coverage anywhere of your choice

- Choice of worldwide, worldwide excluding USA or Asia cover plans

No upfront payment

- We will cover your hospital bills for all approved treatments at any hospital in our international directory of hospitals, with high overall annual limits ranging from **S$2.8 million to S$5 million**
- Enjoy **cashless facility** within our local out-patient network of general practitioners and specialist clinics

Protect yourself based on your needs and budget

- Choose the extent of your protection based on your anticipated medical needs, self-insurance capability and budget
- Each plan has annual deductible and co-insurance options available for you to optimise your cover

Options	Annual deductible	Co-insurance
1	S$700	20%
2	S$2,000	20%
3	S$7,000	20%

- No matter which international health plan you choose, you will have access to:
  - **Direct settlement** for hospitalisation within our international directory of hospitals
  - **Worldwide cover** for emergency medical expenses
  - **International medical emergency assistance** including medical evacuation
  - **A Singapore-based team of health experts** offering personalised customer support and professional claims management
- For Plan A, there is an optional add-on benefit to cover normal (routine) pregnancy and childbirth subject to payment of additional premium. This benefit is available for females age 18 and above. A waiting period is applicable for this benefit.

Benefits at a glance

This policy is not a MediSave-approved policy and you may not use MediSave to pay the premium for this policy.

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Please note: Benefit values are per member each year unless otherwise specified and are reduced each time the member claims only by the net amount (less any annual deductible or co-insurance) we have actually paid. Please refer to the policy wordings on full terms applying to these benefits.				
Overall annual limit				
Yearly maximum limit This is the maximum we will pay for each member each policy year. All benefits paid during the policy period will count against the yearly maximum.	S$5,000,000	S$4,000,000	S$2,800,000	
Area of cover				
Area of cover	**Options:** 1. Worldwide, or 2. Worldwide excluding USA, or 3. Asia			
Outside area of cover This benefit pays for emergency treatment, or treatment of a medical condition which arises suddenly whilst outside the selected area of cover.	Emergency treatment only up to S$250,000			Annual deductible
In-patient and daycare treatment				
Daily accommodation charges (per night) While admitted as an in-patient or day-patient, we will pay for the costs of your accommodation in the type of room shown in your benefits table.	Standard single room			Annual deductible

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
In-patient and daycare treatment				
Hospital charges This benefit pays for hospital charges given between admission and discharge including: 1. Diagnostic procedures 2. Surgical procedures 3. Operating theatre charges 4. Nursing care, drugs and dressings 5. Surgeons' and anaesthetists' charges 6. Intensive care unit charges 7. Consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it 8. Oncology treatment including radiotherapy and chemotherapy 9. Kidney dialysis 10. Computerised tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques 11. Special nursing in hospital	Included			Annual deductible
Organ transplant This benefit pays for transplantation of kidneys, heart, liver, lung or bone marrow.	Included			Annual deductible
Living organ donor This benefit pays for transplantation of kidney, heart, liver, lung or bone marrow when a live member donate an organ or tissue to the family member (parent, sibling, child spouse or partner). This benefit does not pay for the cost of collecting donor organs or tissue, administration costs, its complications, and illegal organ transplants.	Up to S$60,000 Available only after 24 consecutive months membership			Annual deductible

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
In-patient and daycare treatment				
Reconstructive surgery This benefit pays for the initial reconstructive surgery and only when it is medically necessary and carried out to restore function after an accident or following surgery for an eligible medical condition.	Included			Annual deductible
Surgical implants This benefit pays for medical device surgically implanted into the body as part of the treatment (excluding any dental implants).	Included			Annual deductible
Companion accommodation We will pay for companion accommodation when the member is receiving eligible in-patient treatment within the area of cover.	S$190 per night			Annual deductible
Newborn accommodation This benefit pays for the child who is less than 16 weeks to stay in the hospital to receive nursery care while the insured mother is receiving eligible in-patient treatment.	Included			Annual deductible
Cash benefit (up to a maximum of 30 nights per year) Payable for eligible in-patient treatment only when the member receives treatment within area of cover and provided no cost for that treatment is claimed under this plan.	S$300 per night	S$200 per night	S$140 per night	N/A

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
In-patient and daycare treatment				
In-patient rehabilitation This benefit pays for in-patient rehabilitation when: a) it is a result of an acute brain injury, such as stroke; and b) it is an integral part of the eligible treatment covered by the member's policy; and c) it is carried out by a medical practitioner specialising in rehabilitation; and d) it is carried out in a rehabilitation hospital or unit which is recognised by us; and e) the treatment could not be carried out on an out-patient basis; and f) the costs have been agreed, in writing, by us before the rehabilitation begins. We will not pay for in-patient rehabilitation for more than 28 days except in cases such as in severe central nervous system damage caused by external trauma. For cases such as in severe central nervous system damage caused by external trauma, we will not pay for in-patient rehabilitation for more than 180 days.	Included			Annual deductible
Pre-hospitalisation treatment (up to 120 days before admission) We will pay for consultation, prescribed investigations and essential medications received as an out-patient within 120 days prior to a hospitalisation, where such hospitalisation is eligible for cover under member's plan and where the need for such hospitalisation has arisen as a direct result of the medical examination and investigation findings drawn from that consultation. The number of visits covered by this benefit is limited to once per day, for the same medical condition.	Included			Annual deductible

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
In-patient and daycare treatment				
Post-hospitalisation treatment (within 120 days after discharge) This benefit pays for follow-up out-patient consultation and treatment following an eligible in-patient or daycare surgery when such consultation is carried out by the in-patient treating medical practitioner or a referred medical practitioner and provided such consultation or treatment occurs within 120 days following the discharge from hospital or the date of the daycare surgery. The number of visits covered by this benefit is limited to once per day, for the same medical condition.	Included			Annual deductible
Out-patient treatment				
Primary and specialist care This benefit pays for consultation, diagnostic procedures, prescribed drugs and dressings received as part of an out-patient treatment. Diagnostic tests include and are limited to laboratory, x-rays and ultrasound.	Included		Included if it is part of pre-hospitalisation treatment or post-hospitalisation treatment Subject to the limitations applied for 'pre-hospitalisation treatment' or 'post-hospitalisation treatment' benefit	20% co-insurance
Surgical procedures We will pay for any eligible surgical procedures received as an out-patient for an eligible medical condition.	Included		Included This benefit includes one post-surgery consultation within 90 days from the date of the surgical procedure	20% co-insurance

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Out-patient treatment				
Emergency treatment due to accident This benefit pays for out-patient treatment due to accident required immediately (within 24 hours) following bodily injury arising from an accident, provided the member has been continuously covered under the policy since before the accident happened. Follow-up treatment for the same bodily injury will be covered up to 30 days from the date of the accident.	Included			20% co-insurance
Radiotherapy and chemotherapy We will pay for radiotherapy and chemotherapy received as an out-patient for an eligible medical condition at a registered medical facility recognised by us as part of active cancer treatment.	Included			Annual deductible
Advanced Therapy Medicinal Products (ATMPs), Cellular and Gene Therapy Products (CGTPs) and Regenerative Medicine Advanced Therapy (RMAT) This benefit requires pre-authorisation before the member starts treatment. There is a small number of approved ATMPs/CGTPs/RMATs that we cover. Please refer to your policy benefits clarifications for the current list of ATMPs/CGTPs/RMATs (which is subject to change).	Included			Annual deductible

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Out-patient treatment				
Proton Beam Therapy (PBT) Radiation therapy which uses protons to treat cancer. We will pay PBT for: 1. Malignant solid cancers in members aged 21 and under 2. Central nervous system (brain and spinal cord) cancer 3. Chordomas or chondrosarcomas (types of spine cancer) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) 4. High naso-ethmoid, frontal and sphenoid tumours with base of skull involvement 5. Adenoid cystic carcinoma with perineural invasion 6. Esthesioneuriblastoma 7. Cancer of the iris, ciliary body, or choroid parts of the eye (uveal melanoma) which has not spread (metastasised) 8. Conjunctival melanoma 9. Choroidal haemangioma Please note: There is limited cover for PBT in the circumstances shown above.	Included			Annual deductible
Kidney dialysis We will pay for kidney dialysis received as an out-patient for an eligible medical condition at registered medical facility recognised by us.	Included			Annual deductible
Computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans	Included			20% co-insurance

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Out-patient treatment				
Hormone Replacement Therapy (HRT) We will pay for the consultations and the cost of the implants, injections, patches or tablets when it is medically necessary and resulting from a medical intervention rather than for the relief of physiological symptoms. Where HRT is only required for the relief of menopausal symptoms, this benefit will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the policy schedule	Included (HRT for relief of menopausal symptoms - up to S$200)		Included if it is part of post-hospitalisation treatment Subject to the limitations applied for 'post-hospitalisation treatment' benefit	20% co-insurance
Physiotherapy, occupational therapy and speech therapy Treatment given by any of these practitioners (physiotherapist, occupational therapist, speech therapist) must be referred and supervised by the medical practitioner who has defined a diagnosis and under the medical supervision of a medical practitioner. Benefit is payable only following in-patient treatment for an eligible medical condition.	Included (up to 180 days following the date the member is discharged from hospital)		Included if it is part of post-hospitalisation treatment Subject to the limitations applied for 'post-hospitalisation treatment' benefit	20% co-insurance
Alternative and well-being medicine				
Consultation and treatment provided and prescribed by a qualified and registered chiropractor, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, homeopath, osteopath, physiotherapist and traditional Chinese medicine practitioner This benefit pays for the specified complementary and alternative therapist and practitioners.	Up to S$2,000		N/A	20% co-insurance
Vaccination This benefit pays for necessary vaccinations. Consultation charge made in conjunction with vaccination can be claimed from this benefit where applicable.	Up to S$2,000	Up to S$500	N/A	20% co-insurance
	Available only after 90 consecutive days membership in the first policy year			

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Alternative and well-being medicine				
Health screen This benefit includes the cost of any eligible consultation needed as part of the screening process, where the member did not experience signs or symptoms.	Up to S$1,350	Up to S$250	N/A	20% co-insurance
Dental treatment				
Accidental damage to natural teeth This benefit pays for dental treatment required (within 30 days) following accidental damage to natural teeth caused by extraoral impact.	Included			20% co-insurance
Oral and maxillofacial surgery This benefit pays only for the following procedures performed by an oral and maxillofacial surgeon: 1. Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms 2. Surgical removal of complicated buried roots which are diseased or causing symptoms 3. Enucleation (removal) of cysts of the jaw 4. Treatment of cancers (for lesion or lump in the mouth) 5. Treatment of Temporal Mandibular Joint (TMJ) Pre-existing condition limitations apply to this benefit.	Included			20% co-insurance
Routine dental care This benefit pays for routine dental examination, extraction, fillings, scaling/ polishing, x-ray, sealant, fluoride treatment, root canal treatment, implants, bridgework, crowns, treatment of gum disease, dentures, inlays and onlays. Pre-existing condition limitations are not applicable to this benefit.	Up to S$2,500	Up to S$250	N/A	20% co-insurance

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Optical benefit				
Routine optical care This benefit pays for corrective spectacle lenses, contact lenses and associated spectacle frames prescribed by an ophthalmologist or optometrist. Ophthalmologist or optometrist eye examination is claimable from this benefit. Lasik/laser surgery and tinted lenses are not covered under this benefit.	Up to S$380	N/A		20% co-insurance
Emergency evacuation and repatriation				
International Emergency Medical Assistance (IEMA) This benefit pays for the following services: - Evacuation where the local medical facilities are not adequate according to our appointed doctor - Evacuation will be to the nearest medical facility where treatment is adequate - Transportation for returning to the principal country of residence following the evacuation - Cost of one accompanying person while the covered person is being evacuated - Hotel accommodation of one accompanying person up to 10 days - Bring the body/ashes back to a port or airport in the principal country of residence or home country, if the covered person dies abroad	Included			N/A

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Newborn cover				
Acute medical condition (excluding congenital conditions) This benefit pays for the treatment of acute medical condition, provided there is no underlying congenital condition, developed in a newborn baby including nursing of pre-mature baby (i.e. where birth is prior to 37 weeks gestation) in Neonatal Intensive Care Unit (NICU). Common acute medical conditions for newborn babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: a) the parent of the newborn baby has been covered under this HSBC Life International Exclusive policy for 365 consecutive days or more when the baby is born; and b) the newborn baby is added into the insured parent's policy within 30 days from birth; and c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received. This benefit is paid from the insured baby's plan. This benefit covers treatment received by a newborn baby during the first 30 days after birth. After 30 days, treatment can be covered under the main benefits of the insured baby's plan.	Included			Annual deductible

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Newborn cover				
Treatment of congenital conditions This benefit pays for treatment of congenital conditions. The benefit becomes available if: a) the parent of the newborn baby has been covered under HSBC Life International Exclusive Plan A for 365 days or more when the baby is born; and b) the newborn baby is added into the insured parent's policy within 30 days from birth; and c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received. This benefit is paid from the insured baby's plan. Please note: 1) Treatment for congenital conditions which do not fulfill all above criteria will be paid from 'pre-existing condition/congenital conditions' benefit. 2) Once the limit for this benefit is reached, no other benefit (including 'pre-existing conditions/congenital conditions' benefit) will be payable for the congenital condition(s) which was (were) claimed from this benefit for the remaining policy year.	Up to S$65,000	N/A		Annual deductible

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Other benefits				
Home nursing This benefit pays for charges incurred by an attending registered and qualified nurse for nursing at home provided; (i) after discharge from hospital which the member has been warded in the intensive care unit for an eligible medical condition or undergone for an eligible daycare surgery; and (ii) agreed in writing by us beforehand that it is medically necessary and appropriate; and (iii) it is prescribed by the treating medical practitioner for the continued treatment for the eligible medical condition which the member was hospitalised for; and (iv) when such services are essential for medical purposes as distinct from domestic, personal or social reasons. For terminal medical condition, this benefit is payable under 'hospice and palliative care' and subject to the limitations applicable to that benefit.	Included			20% co-insurance
Local road ambulance transport This benefit pays for medically necessary emergency road ambulance transport to or between hospitals or when the medical practitioner says that the member needs to have medical supervision whilst being transported.	Included			20% co-insurance
Psychiatric treatment This benefit pays for in-patient, daycare and out-patient treatment (subject to availability of out-patient benefit for your plan) of psychiatric illnesses in aggregate. All medically necessary treatments administered by registered psychologists, psychotherapists, or any individuals other than a registered psychiatrist must be under the medical supervision of the psychiatrist and pre-authorised by us.	Up to S$11,000	Up to S$7,000	Up to S$5,400	20% co-insurance

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Other benefits				
Pre-existing conditions and congenital conditions This benefit pays for: a) treatment of congenital conditions (whether existing before or after the commencement of cover), and/or b) all other declared and accepted eligible conditions that existed or for which there were symptoms before the commencement of cover, or reinstatement date, or the introduction of this benefit, whichever is later.	Year 1 & 2: up to S$3,000 Available only after 270 consecutive days membership Subsequent years: up to S$6,000		N/A	Whether it is co-insurance or annual deductible will depend on the treatment received and what is stated on each benefit.
Treatment for HIV/AIDS as a result of occupational accident or blood transfusion. This benefit becomes available when signs or symptoms are present for the first time after 36 months of continuous membership.	Up to S$13,000 Available after 36 consecutive months membership	N/A		20% co-insurance
Artificial ears & eyes This benefit pays for all the costs associated with the fitting of artificial ears and eyes as an external substitute or replacement for the part of the body needed following a surgery or an accident for an eligible medical condition covered by the plan.	Up to S$3,800 in a member's lifetime	Up to S$1,300 in a member's lifetime	N/A	20% co-insurance
Artificial limbs This benefit pays for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or surgical procedures.	Up to S$3,800 every 3 years	Up to S$1,300 every 3 years	N/A	20% co-insurance

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Other benefits				
Medical aids and durable medical equipments This benefit pays for instruments or devices or durable medical equipments which are prescribed by the medical practitioner as a medically necessary aid to the function or capacity such as and limited to abdominal binder, post-surgery mastectomy bra, compression stocking, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint, air boots, arm sling, and brace.	Up to S$1,000	Up to S$500	N/A	20% co-insurance
Hospice and palliative care This benefit becomes available when the member is admitted to a specialist palliative care centre or hospice, recognised by us, following diagnosis, written confirmation (including medical evidence) by a medical practitioner that the member is suffering from an eligible terminal medical condition or conditions.	Up to S$65,000 in a member's lifetime Available only after 365 consecutive days membership	Up to S$50,000 in a member's lifetime Available only after 365 consecutive days membership	Up to S$25,000 in a member's lifetime Available only after 365 consecutive days membership	Annual deductible
Investigation into infertility This benefit pays for investigation and treatment of the cause of infertility.	Up to S$2,500 in a member's lifetime Available only after 18 consecutive months membership	N/A		20% co-insurance

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Other benefits				
Pre and post-natal complications This benefit pays for treatment of an eligible medical condition which is due to complications of pregnancy and occurs during the pregnancy, prior to the childbirth (delivery) or after the childbirth (delivery) for female members age 18 and above. Under post-natal complications, we will only pay for treatment received within 90 days following the childbirth (delivery). Please take note : - We do not provide cover under this benefit for childbirth (which includes any caesarean section) - We do not provide cover under this benefit for a pregnancy established through any assisted reproduction (eg. in vitro fertilisation (IVF), etc.)	Included Available only after 365 consecutive days membership	S$5,000 Available only after 365 consecutive days membership	S$2,500 Available only after 365 consecutive days membership	20% co-insurance

Benefits at a glance

Benefits table	Plan A	Plan B	Plan C	Only applicable when annual deductible/ co-insurance option is chosen
Optional add-on rider (available for Plan A only)				
Normal (routine) pregnancy and childbirth cover This benefit pays for in-patient routine pre-natal care, childbirth and routine post-natal care up to 42 days following childbirth (delivery). This benefit is applicable for a female member age 18 and above. The limit shown is the maximum benefit for each policy year (even if there is more than one pregnancy) or for each pregnancy (even if an eligible pregnancy falls across the policy anniversary) provided the policy with this benefit has been renewed. The limit shown also applies in aggregate for pre-natal, childbirth and post-natal care. For birth through vaginal childbirth and medically necessary caesarean section, we will pay for the reasonable and customary childbirth costs of a standard single room within the limit shown in the benefits table. Any complications of pregnancy will be paid from "pre & post-natal complications" benefit. For birth through non-medically necessary caesarean section, we will pay for the reasonable and customary childbirth costs of a standard single room up to the costs of a natural childbirth. If we are not able to determine that a caesarean section is medically necessary, we will consider it is not medically necessary. The complications arising from such childbirth will be paid up to the remainder of the "normal (routine) pregnancy and childbirth cover" limit.	Up to S$22,000 Available only after 365 consecutive days membership when this benefit add-on was attached to the member's plan Subject to: 1) Compulsory 20% co-insurance 2) Payment of additional premium	N/A	N/A	N/A

Key product provisions

Who is eligible for cover under HSBC Life International Exclusive?

A customer must be aged at least 15 days old and not more than 80 years old at the time of application to be eligible for cover under this product.

For a child aged between 15 days old to 5 years old to enrol on a standalone policy, 20% premium loading on the prevailing brochure premium rates will apply at the time of application or renewal (whichever is applicable). The policyholder must either be the child's parent or legal guardian.

When the parent of a newborn baby is already covered under an HSBC Life International Exclusive policy, the baby may be added to the parent's policy without further underwriting by paying the applicable premium and enjoy cover commencing at the time of birth provided:

(a) we are requested to add that baby to the parent's policy within 30 days from the time of birth; and

(b) the parent has been continuously covered under the policy for at least 365 days when the baby is born.

If the requirements stated in point (a) and (b) above are not met, a newborn baby may only be added to the policy subject to the normal application process.

There may also be some limits to our cover if any of the following apply:

- either parent has had any kind of fertility treatment and the babies are either from a single or multiple birth; or
- the babies are either a single or multiple birth and were born after assisted reproduction; or
- you have adopted the baby; or
- the birth by a surrogate.

You can add a baby to your policy after birth following fertility treatment, or assisted reproduction (such as IVF), or who you have adopted or as a result of surrogacy, provided we have reviewed and completed our medical underwriting assessment of the application. As with most health insurance, our cover for treatment has a few limits in these situations. If you have adopted a baby, or if you have a single or multiple birth after fertility treatment or following assisted reproduction:

- we may ask for more details of the baby's medical history; or
- we will not cover treatment in a Special Care Baby Unit or paediatric intensive care immediately after the birth; or
- we may add other conditions to the baby's cover. For example, we may limit their cover for pre-existing conditions.

We count fertility treatment as either parent taking any prescription or non-prescription drug or other treatment to increase fertility.

For a female customer age 18 and above who requires cover for normal (routine) pregnancy and childbirth, you can buy an optional add-on rider (applicable to Plan A only).

We will offer renewal beyond age 80 so that members can enjoy the peace of mind of continuing their cover subject to payment of applicable premium.

HSBC Life International Exclusive is underwritten by HSBC Life (Singapore) Pte. Ltd. and reinsured by AXA PPP Healthcare. HSBC Life International Exclusive is designed for customers residing in Singapore, whether they are Singapore citizens, permanent residents or foreigners, and for expatriates that we defined as people residing outside of their home country as stated in their passport. When a customer ceases to be an expatriate or a Singapore resident, HSBC Life (Singapore) Pte. Ltd. will have to stop renewing this policy.

Health insurance regulations vary a lot from country to country. It is important to note that HSBC Life International Exclusive may not be recognised by any local insurance regulators outside of Singapore. As such you may need to purchase a local health insurance product in your country of residence to comply with local regulations.

Finally, as much as we would want to provide cover to customers residing outside of Singapore, there are some countries where we won't be able to sell or renew HSBC Life International Exclusive. When such situation occurs and to give our customers enough time to organise their coverage, HSBC Life (Singapore) Pte. Ltd. will be able to provide cover until the policy expiry date where the customer ceases to be eligible under HSBC Life International Exclusive. In countries where AXA PPP Healthcare is licensed to sell private medical insurance, customers may be able to transfer to an equivalent product on no worse terms basis and subject to applicable premiums.

Key product provisions

Key product features

This is only a brief summary of the key features and we encourage you to refer to the actual terms and conditions in the contract. Please consult your financial planner should you require further explanation.

a) A unique pre-existing conditions benefit

As you would expect, private healthcare is designed primarily to provide cover for treatment of new medical problems arising after joining.

HSBC Life International Exclusive Plans A and B provide cover for treatment of conditions declared on the application form, whether chronic or not, which existed before a member becomes eligible for benefits under a particular plan. This is subject to a waiting period of 270 consecutive days of membership under the same plan. In those first 270 days of cover, treatment of specific medical conditions may be excluded. However, treatment of certain conditions, which are unlikely to recur, may be covered from the date a member is first eligible for benefits under a particular plan.

For us to be able to determine whether treatment of a condition will be covered in the first 270 days and/or to be eligible for benefit thereafter, each member must have completed a full medical declaration, in detail, when first applying for cover. After the application process is complete, we will send you a membership statement that will clearly show the medical conditions for which you are not covered for treatment during the first 270 days. We may ask for a medical report, at your own cost, to clarify the status of any medical condition.

No treatment of any pre-existing condition, whether chronic or not, will be eligible for benefit at any time if the condition has not been declared to us on the member's original application form.

Please note that it is important you give us full details of any member's medical history on an application. Failure to declare any medical condition of which you should reasonably have been aware may result in treatment of that condition being excluded from all future cover with us or cancellation of your policy.

b) Our approach to cancer care

Where oncology treatment and related eligible expenses apply to a medical condition arising after the date of our acceptance of a member for cover, such costs will be payable out of the overall limit of the plan under which the member is covered at the time of first diagnosis of the condition. Any out-patient drugs or other drugs prescribed by a medical practitioner will be covered under the 'primary and specialist care' benefit where available under the member's plan.

Oncology treatment and related eligible expenses, where applicable to a medical condition or symptoms that existed prior to our acceptance of the member for cover, this will be subject to the terms and limits applying to the benefit for 'pre-existing conditions' shown in the clarifications and benefits table.

Please note that the maintenance phase of any treatment (such as the administering of Herceptin or similar drugs which we do not consider as active cancer treatments) will be paid under the out-patient treatment benefit provided this is available under your plan. Please note HSBC Life International Exclusive Plan C does not provide cover for maintenance of any treatment received as an out-patient. For preventative medical examinations or routine follow-up consultations when the member does not have symptoms of cancer this will be paid under the 'health screen' benefit.

c) Full cover for kidney dialysis

Where kidney dialysis treatment and related eligible expenses apply to a medical condition arising after the date of our acceptance of a member for cover, such costs will be payable out of the overall limit of the plan under which the member is covered at the time of first diagnosis of the condition.

Kidney dialysis treatment and related eligible expenses, where applicable to a medical condition or symptoms that existed prior to our acceptance of the member for cover, this will be subject to the terms and limits applying to the benefit for 'pre-existing conditions' shown in the clarifications and benefits table.

d) Full cover for chronic conditions

HSBC Life International Exclusive covers the maintenance of chronic conditions as well as treatments for complications arising from chronic conditions for which first symptoms became apparent after the member was accepted, by us, for cover on a particular plan.

Maintenance of chronic conditions refers to consultation charges, medications, and routine investigations. HSBC Life International Exclusive's Plans A and B does provide cover for the maintenance of chronic conditions which first began after you have been accepted by us and receive treatment as an out-patient. However, Plan C only provides hospitalisation cover including pre- and post-hospitalisation, therefore, does not provide coverage for the maintenance of chronic conditions.

If there were any symptoms prior to inception of your policy these must have been declared to us, in good faith, on the member's original application form. Provided such a declaration was made and accepted by us, treatment of the condition would be covered under the 'pre-existing conditions' benefit (if available) under your plan.

e) Psychiatric illness

Your policy covers treatment of psychiatric illness, whether received as an in-patient, daycare or out-patient (except for Plan C), up to the level shown in the benefits table for your plan.

f) Waiting period

Some benefits under your plan are subject to waiting periods which are stated in the benefits table. Only treatment costs incurred after the waiting period are eligible for consideration.

For your easy reference, here is a summary of the benefits with waiting periods. The following benefits will not be payable during the specified waiting periods:

Benefits	**Waiting period** (from a member's date of commencement of cover, or from the date of plan upgrade, or reinstatement date, whichever date is later)
Pre and post-natal complications, hospice and palliative care	365 days
Pre-existing conditions	270 days
Congenital conditions	270 days
Investigation into infertility	18 months
Treatment for HIV/AIDS (as a result of occupational accident or blood transfusion)	36 months
Vaccination	90 days
Living organ donor	24 months
Optional add-on rider: normal (routine) pregnancy and childbirth*	365 days

* Waiting period is applicable if you are covered under Plan A and you have opted for this optional add-on rider.

Key product provisions

g) Exclusions

There are certain conditions under which no benefit will be payable. These are stated as exclusions in the policy contract. The following is a list of some of the exclusions applicable under this product. You are advised to read the policy contract for the full list of exclusions. These exclusions include but are not limited, to the following:

- We will not pay for any treatment, or for international emergency medical assistance, if they are needed as a result of nuclear contamination, biological contamination or chemical contamination, whilst engaging in or taking part in war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons, illegal activities or any event similar to one of those listed. This includes any treatment needed as a result of the member exposing himself to needless peril, such as going to a place of unrest as an active onlooker or a spectator.
  Please note, for clarity: There is cover for treatment required as a result of a terrorist act providing that terrorist act does not result in nuclear, biological or chemical contamination.
- Claims in respect of treatment received outside the area of cover or if the member travelled against medical advice even if it is inside the area of cover.
- Treatment which arises from or is directly or indirectly caused by a deliberately self-inflicted injury or an attempt at suicide.

h) Pre-authorisation

The pre-authorisation process is to protect the policyholder and the members from unexpected costs which are not eligible for payment of reimbursement by us. When we issue a pre-authorisation/pre-approval, we confirm the following:

- the planned treatment is eligible under your policy;
- the planned treatment is medically necessary;
- the planned treatment is within reasonable and customary (R&C) cost;
- the planned treatment cost falls within the remaining benefit limit of your plan.

The information we require for pre-authorisation includes:

- diagnosis; and
- description of the required medical treatment; and
- name and address of the hospital where the treatment will be given; and
- expected length of stay in the hospital; and
- estimated cost of the treatment.

You must seek our written pre-authorisation for the following treatment and services at least 5 working days prior to commencement of the treatment for which authorisation is required:

In-patient and daycare

- All in-patient and daycare admissions;
- All non-emergency tests, diagnostics, treatment, surgery and other medical services;
- All in-patient maternity services (if this is applicable under the member's plan);
- All in-patient dental services;
- Special nursing in hospital and/or any nursing at home after discharge;
- Hospice and palliative care;
- Reconstructive surgery;
- Psychiatric treatment;
- Robotic surgery;
- Cancer treatment - advanced therapies, proton beam therapy, radiotherapy, chemotherapy;
- In-patient rehabilitation;
- Reconstructive surgery.

Key product provisions

Out-patient

- Psychiatric treatment;
- Second opinion for the same medical condition (if this is applicable under the member's plan);
- prescriptions covering drugs and consumables for 30 days or more;
- non-emergency diagnostic scans such as Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), x-rays, gait scans, other internal diagnostics such as but not limited to endoscopy, colonoscopy, gastroscopy, etc.

If the claims are eligible under the policy, we will issue a pre-authorisation/pre-approval to the hospital directly and to you where applicable. Failure to obtain pre-authorisation may prevent us from settling all or part of any claim.

i) Claims condition

There are stipulated time limits, procedures and submission of documents required to comply for claim submission.

i) A claim form is obtainable from us upon request and we will require all necessary supporting documents covering the nature and extent of loss, within 90 days from the date the treatment starts.

ii) Costs related to obtaining the necessary certificates, receipts, information and evidence required for assessing the claim, are to be borne by the policyholder, and given to us in the form we require.

For further information, you can visit or contact us at the following designations:
Website: https://www.insurance.hsbc.com.sg/help/forms-and-documents/claims-insp/
Telephone: (+65) 6880 4944

j) Free-look period

You have a free-look period of 14 business days from the date that you receive the policy document via email to review it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions and returning the policy and membership card(s) to us within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you in full without interest. Free-look period will not apply to policy renewals.

k) Policy renewal/renewal premium

This is a short-term accident and health policy and we are not required to renew this policy. We may terminate this policy by giving you 30 days notice in writing.

Your policy is valid for one year unless we have agreed on a different validity period. At the end of that time, provided the plan you are on is still available, you have a right to renew this policy on the terms and conditions applicable at that time by paying the premium applicable at the time of renewal.

Premium rates are not guaranteed and the premium payable at renewal shall be determined at each renewal based on the attained age of each member, the premium rates then in effect, and any other factors which may materially affect the risks insured.

We can change all or any part of the policy including the policy schedule or these terms, but only for the reasons shown in our policy, and the changes will only apply to you when you renew unless we are obliged by law to apply any change with immediate effect. We will provide you 30 days notice of the changes and will send details of them to the address we have for you on our records. The changes will take effect from when you renew or when applied by law even if, for any reason, any member does not receive details of them.

Key product provisions

l) Cancellation clause

We have the right to cancel this policy at any time by giving you no less than 30 days notice in writing. We will refund you premiums on a pro-rata basis from the end of Gregorian calendar month in which cancellation takes effect provided you have returned to us the policy documents including the membership card(s). We will not refund premiums if any claim, however small, has been made in the current year.

m) Reasonable & customary charges

This refers to charges for medical care which shall be considered by us or by our medical advisers to be reasonable and customary to the extent that they do not exceed the general level of charges being made by others of similar standing in the locality where the charges are incurred when giving like or comparable treatment.

We will base that calculation on a combination of our global experience, statistical information provided by local health authoritative body and information collected from medical specialists and surgeons practicing in the country or area where the treatment is received.

For the avoidance of doubt when comparing treatment, we will take into account the complexity of the procedure and the standard of the medical facility where the treatment is received.

If the charges are higher than is customary, we will only pay the amount which is, in our experience, customarily charged and you will have to pay the rest. If your treatment requires more than one specialist or surgeon present at the same operative (surgical) session, we shall review the medical necessity in the management of such surgical problem or medical condition in terms of the different trained skills and complexity of the services provided as an identification to cover the total services. No additional benefits or cost is payable for surgical assistants.

For medical treatment and services incurred in Singapore, we shall also reference the guidelines and published fee benchmarks provided by Singapore Ministry of Health (MOH). In the event that the particular eligible treatment or service is not stated on the MOH published fee benchmark, we reserve the right to base the reference charge or proportionately reduce any claim to reflect the average charge of 2 physicians in the same specialty for the same surgical intervention or treatment. In the event of any differences in opinions between our medical advisers or physicians and your physicians, our medical advisers or physicians opinion shall prevail.

n) Distribution cost

The total distribution cost of this product is between 0% - 23% of the premium. Such costs include cash payments in the form of commission, costs of benefits and services paid to the distribution channel. We assure you that the total distribution cost is not an additional cost to you, as it was already accounted in the calculation of your premium.

Our note to you:

When switching from one health insurance product to another, you should consider carefully as there may be disadvantages in doing so. The new policy may cost more or have fewer benefits at the same cost.

Annual deductible and co-insurance

Annual deductible and co-insurance options		Premium discount*	
		Plan A & B	Plan C
Option 1	S$700 and 20% co-insurance where applicable	15%	7%
Option 2	S$2,000 and 20% co-insurance where applicable	25%	25%
Option 3	S$7,000 and 20% co-insurance where applicable	35%	50%

Please refer to the benefits table for more details.
* Premium discount is not applicable to the optional add-on: normal (routine) pregnancy and childbirth cover.

Secure your health insurance with these tips

- **Buy the coverage you need**
  Speak with your Financial Planner to understand how much health coverage you require, based on your needs and budget.
- **Be prepared for rising healthcare costs**
  Ensure that you and your loved ones are covered with health insurance to protect you against high expenses should any unfortunate events happen.
- **Avoid additional out-of-pocket expenses**
  Check that you are covered for Co-insurance or Deductibles to avoid making additional payments if you have to make a claim.
- **Know the panel healthcare providers**
  Choose from the list of panel hospitals or clinics covered under your plan for seamless claims processing.

Manage your health policies anytime, anywhere, with the HSBC Life SG app

- Submit, track, and view your claims online
- Show your E-medical card at HSBC Life panel clinics for cashless visits
- Read your policy benefits online
- Find doctors and clinics near you

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Frequently asked questions

1. **What are the plan options for HSBC Life International Exclusive?**

   There are 3 plans available along with 3 areas of cover and 3 levels of deductible giving you multiple ways to meet your healthcare needs and budget.

   - Plan A - comprehensive in-patient and out-patient treatment, pre and post-natal complications, optical care benefit, dental benefit, health screening, other essential benefits and the optional add-on normal (routine) pregnancy and childbirth cover
   - Plan B - comprehensive in-patient and out-patient treatment including vaccination
   - Plan C - comprehensive in-patient treatment and essential out-patient treatment

2. **What is the last entry age for application? Is there a maximum expiry age?**

   The last entry age is 80 years old.

   There is no maximum expiry age for cover. Provided the plan you have chosen is still available, you can continue to renew the policy at the terms and conditions applicable at each policy anniversary.

3. **What is an annual deductible, co-insurance and how does the annual deductible and co-insurance works?**

   A deductible is an amount you need to pay towards the covered expenses before we start paying for your treatment. A co-insurance is a share of the eligible medical expenses that you need to pay.

   There are 3 levels of deductible and co-insurance available as an option for you to reduce your premium. Please refer to the Benefits table for details on whether the annual deductible or co-insurance is applicable.

   An example illustration

   Based on eligible expenses for a member insured under Plan A with option 1 S$700 deductible and 20% co-insurance.

	If it is a non pre-existing condition	If it is a pre-existing condition
Hospital charges	Annual deductible of S$700 will apply	Annual deductible of S$700 will apply and we will pay up to a max of S$3,000 under pre-existing condition benefit in the 1st year after 270 days waiting period.
Specialist care	20% co-insurance will apply on each and every claim	20% co-insurance will apply on each and every claim up to a max of S$3,000 under the pre-existing condition benefit in the 1st year after the 270 days waiting period.

4. **Can my family members take up different plans under the same policy?**

   Yes. However the principal member (the main applicant) cannot be insured on a plan lower than the other members enrolled under the same policy.

5. **Is there any family discount* if I sign up together with my family members?**

   We offer 10% family discount if there are 3 or more family members who are covered under the same policy. This discount is on top of the premium discount for annual deductible and co-insurance options.

Frequently asked questions

6. **How does a family plan combination and family discount* works?**

   Here are some examples of how the application of the combination of plans and family discount works under a family plan.

	Plan of principal member (applicant)	Plan of family member 1	Plan of family member 2	Plan of family member 3	Total no. of members under the same policy	Can principal member and family member(s) take up this plan combination?	Is the family discount applicable to all the members?
Example 1	B	A	-	-	2	No, as the principal member is insured on a lower plan.	Not applicable as there are only 2 members under the same policy.
Example 2	B	B	C	-	3	Yes, as the principal member is insured on the same plan.	Applicable as there are 3 members covered under the same policy.
Example 3	A	A	B	C	4	Yes, as the principal member is insured on a same/higher plan.	Applicable as there are 3 or more members covered under the same policy.

7. **Does the family discount* apply to the optional add-on benefit?**

   Yes, family discount is applicable to the optional add-on benefit as long as there are 3 or more family members covered under the same policy.

8. **Do we continue to apply family discount* at every policy renewal?**

   Yes, family discount is available at every policy renewal as long as there are 3 or more family members covered under the same policy.

9. **My spouse and I already have insurance coverage with another insurer. Can I take up the HSBC Life International Exclusive policy to cover only my child?**

   Yes, you can. A 20% premium loading on the prevailing brochure premium rates will apply if your child is aged 15 days old to 5 years at the time we accept your application or renewal (whichever is applicable). However, the parent or the guardian must still be the policyholder.

10. **Can I still maintain my policy when I return to my home country?**

    If you are a Singapore citizen, you will be able to renew your policy if you return to Singapore, your home country.

    If you are not a Singapore Citizen and you are returning to your home country to live, you will not be able to keep on renewing this policy. We will provide cover until the policy expiry date where the customer ceases to be eligible under HSBC Life International Exclusive.

    Whenever you change your principal country of residence, you must notify us about any change as this may impact your premium. Failure to notify us about any change in principal country of residence may impact the level of cover.

* Family discount is applicable to the spouse and children of the policy owner only. For details, please refer to the policy wording.

Frequently asked questions

11. Can I upgrade/downgrade my plan?

Yes. You can change your plan level or area of cover upon policy renewal. The upgrade of plan/cover, including any optional add-on benefit, will subject the applicant/member to be fully medical underwritten. Any waiting periods may be re-applied on the new plan/cover.

12. Can I change area of cover due to company relocation or when my child is pursuing studies abroad, even before policy renewal?

We may consider such request. Please complete an upgrade form together with the supporting documents for our review.

13. Do you re-underwrite my policy at policy renewal? Will I be penalised if I had made a claim in my current year?

We will not change the terms of your policy alone simply as a result of your personal claims. The premium payable at each policy renewal is determined based on the attained age of each member and may change according to past or foreseeable changes in medical practice or procedures and the type and frequency of claims made generally by all those of our members covered under the same plan as you.

14. Am I covered if I travel outside my chosen area of cover?

Yes, you are covered up to the amount shown in your benefits table for emergency treatment which arises suddenly when you are outside your area of cover. You will not be covered if you have travelled outside your area of cover to get treatment, or if it is not an emergency treatment. Under no circumstance do we consider any expenses incurred for pregnancy or childbirth as emergency treatment.

15. Are pre-existing conditions covered?

Our Plan A & B provides cover for pre-existing conditions after 270 days of consecutive membership, provided that you have declared the pre-existing conditions on the application form and your application is accepted by us, and also, provided the pre-existing conditions are not part of the exclusions/limitations.

16. Can I choose the doctor/country for my treatment?

Yes, you are free to choose any recognised doctor for your treatment in any country within your chosen area of cover subject to reasonable and customary charges. The chosen treatment must be established as being effective and not experimental or pioneering medical or surgical techniques including medicines and medical devices not approved by the relevant authorities, government regulatory board.

For established treatment, this means procedures and practices that have undergone appropriate high quality clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies.

You are recommended to use the hospitals and medical facilities listed in our international hospital directory. If you choose to seek treatment outside our network, please contact us to protect yourself from any unexpected costs.

17. Will there be any penalty if I receive treatment outside the HSBC Life direct settlement network of hospitals?

There are hospitals, medical facilities, or medical institutions which we would not pay for treatment at because they do not meet our billing criteria or because we do not recognise them. We will also not be able to reimburse you if the treatment was provided by a hospital, medical facility, or medical institution that is not recognised or approved by us. It is important that you contact us before you proceed with your treatment.

18. What are the benefits of seeking pre-authorisation for my treatment?

By seeking our authorisation in advance, we will confirm if your treatment is eligible under your policy and if the cost is within the remaining benefit limit of your plan. You will be protected from any unexpected costs.

Frequently asked questions

19. Can I cover my baby who is conceived through assisted conception?

Babies conceived through assisted conception/assisted pregnancy maybe eligible to be covered subject to our approval. Upon our acceptance of the application, they are subject to special terms including waiting period and all other general terms, conditions and exclusions of the policy.

20. Does the policy pay for congenital conditions?

Yes. The policy pays for treatment of congenital conditions up to the limit shown in “newborn cover – congenital conditions” on Plan A or “pre-existing conditions and congenital conditions” on Plan A or B.

21. Is pre and post-hospitalisation covered?

Yes. For pre-hospitalisation, we will pay for consultations (including prescribed investigations and essential medications) from which the need for hospitalisation is concluded.

Post-hospitalisation treatment is covered up to 120 days from the date of discharge from the hospital for an eligible in-patient treatment or daycare treatment.

Any other eligible out-patient consultation and treatments related to the same condition but not resulting in hospitalisation are covered under primary and specialist care (only available under Plan A & B).

22. What is covered under HIV/AIDS?

Treatment for HIV/AIDS is covered on Plan A as a result of occupational accident or blood transfusion. This is available when signs or symptoms for HIV/AIDS are present for the first time after the member is insured on Plan A after 36 months of continuous membership.

About HSBC Life Singapore

HSBC Life (Singapore) Pte. Ltd. is a wholly owned subsidiary of HSBC Insurance (Asia Pacific) Holdings Limited, which is ultimately owned by HSBC Holdings plc, the London-based holding company of the HSBC Group. HSBC Life Singapore has received an A+ rating by Standard & Poor's, most recently affirmed in February 2024. It provides a wide range of solutions that cater to life, health, retirement, protection, education, legacy planning, and wealth accumulation needs of retail and corporate clients.

Important notes

International Exclusive is underwritten by HSBC Life (Singapore) Pte. Ltd. (Reg. No.199903512M).

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This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact us or visit the GIA/LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

This policy is not a MediSave-approved policy and you may not use MediSave to pay the premium for this policy. This is a short-term accident and health policy and the insurer is not required to renew this policy. The insurer may terminate this policy by giving you 30 days' notice in writing.

This advertisement has not been reviewed by the Monetary Authority of Singapore. Information is correct as at 1 February 2025.

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