HSBC Life

International Exclusive Policy

Section 1: Introduction

This **policy** has been designed to set out all the features and benefits of the International Exclusive **plan**. On the next few pages, **you** will find details of **your** cover, terms, conditions, exclusions, limitations, and definitions relevant to **your plan**.

1.1 What your healthcare insurance cover is designed to do

International Exclusive plan covers **you** for costs arising from an unforeseen and unexpected event. For healthcare insurance this means the cost of **medically necessary eligible treatment** resulting from an unexpected **illness** or **accident.**

1.2 A personal service

At HSBC Life **we** are always aware that behind every claim there is a person who needs help and assistance. If there is anything **you** do not understand please do not hesitate to call **our** HSBC Life Customer Care Centre.

1.3 What our customer service team does

It is the role of **our** HSBC Life Customer Care Centre to assist **you**, wherever possible, within the terms and limits of **your** International Exclusive **plan**. For **your** own protection, calls may be recorded.

Have **you**r membership card with **you** whenever **you** call **our** HSBC Life Customer Care Centre. The information on **your** card will help them attend to **your** query as quickly as possible.

1.4 Your policy

This document sets out **your** policy terms and conditions and it must be read in conjunction with any supplementary documentation **we** provide to **you** from time to time (e.g., **your policy schedule** and membership card etc.). **We** have tried to keep this as simple as possible however, if there is anything **you** do not understand or would like to clarify, please contact **us**. Decisions regarding **your** benefits and/or changes to the terms of **your** policy cannot be made verbally but must be confirmed by **us** in writing. **We** may record and/or monitor calls for quality assurance, training, and as a record of **our** conversation.

The **benefit tables** and benefit clarifications must be read in conjunction with the terms of **your policy**.

This **policy** is not a Medisave-approved **policy,** and **you** may not use **your** Medisave to pay for premium for this **policy**.

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** thirty (30) days' notice in writing.

Section 2: Eligibility

To be eligible for cover under this policy, and when accepted by us in writing and shown in the **policy schedule**:

(a) Members who are fifteen (15) days old and above

Members must be **aged** between at least fifteen (15) days old and not more than **aged** eighty (80) years old at the time of application to be eligible to be covered under this **policy.**

(i) Members who are aged between fifteen (15) days and five (5) years old

- This refers to children **aged** between fifteen (15) days old and five (5) years old (both ages inclusive) at the time of application, with or without one parent or guardian as an insured **member** under the same **International Exclusive policy**.
- However, children who are eligible for cover without one parent or guardian covered under any **International Exclusive policy**, the child/children's premiums will be subject to premium loading.

Note: The **policy** issued must be to a parent or guardian who is aged eighteen (18) years old and above at the time of application.

(ii) Members who are aged six (6) to seventeen (17) years old

- This refers to children **aged** between six (6) years to seventeen (17) years old (both ages inclusive) at the time of application who are eligible for cover with or without one parent or guardian covered under any **International Exclusive policy**. However, the **policy** issued must be to a parent or guardian who is **aged** eighteen (18) years old and above at the time of application.

(iii) Members who are aged eighteen (18) to eighty (80) years

- The policy may be issued to a member aged between eighteen (18) to eighty (80) years (both ages inclusive) at the time of application.

Note: For avoidance of doubt, each of the **member** to be insured in this **policy** under Section 2 (a) (i) to (iii) above must submit evidence of insurability and must be accepted by **us**.

(b) For a newborn baby

Any newborn baby maybe added to the parent's **policy** by paying the applicable premium and may enjoy cover commencing at the time of birth provided:

(i) **we** are requested to add that baby to the parent's **policy** within thirty (30) days from the time of birth; and
(ii) the parent has been continuously covered under the **policy** for at least three hundred sixty-five (365) days at the time the baby is born.

- If the requirements stated in 2 (b) (i) and (ii) above are not met, a new born baby may only be added to the **policy** and be **eligible** for benefit after the baby has been fully discharged from the **hospital** and has submitted evidence of insurability, and after **we** accepted the cover for the baby writing.

Note: A child cannot stay on the **policy** after the **policy anniversary** following his twenty-first (21st) birthday. However, cover for a child on the **member**'s **policy** may be renewed up to twenty-five (25) years old provided that he is unmarried and unemployed. For the **policy** to be re-issued to the **member's** child as the **policyholder**, he will not be required to submit further evidence of insurability provided there is no change in the **plan** and the **member** child has been continuously insured in this **policy** without any break in cover.

(c) Members who are aged eighty-one (81) years old and above

We will offer renewal for a **member** who is **aged** eighty-one (81) years old and above so that a **member** can enjoy the peace of mind of continuing his cover for as long as possible subject to **you** are paying the applicable premium and; the terms and conditions are met as stated in Section 5.11 – 'Joining and renewing'.

(d) For babies born after fertility treatment, or following assisted reproduction, or who you have adopted

There may be 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 from a single or **multiple birth** and were born after assisted reproduction; or
- **you** have adopted the baby.

You can add a baby born after fertility treatment, or following assisted reproduction (such as IVF), or whom **you** have adopted, to your **policy**. 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 conception/assisted pregnancy**:

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

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

Section 3: Definitions

Some words and phrases have special meanings. These meanings are set out below.

(a) **accident** - a sudden, unforeseen and unexpected event during the Period of Insurance that is independent of any other cause and is the sole and direct cause of physical bodily **injury,** and excludes any illnesses and diseases are not accident.

(b) **active treatment of cancer – medically necessary treatment** intended to shrink, stabilise, or slow the spread of the **cancer**, and not given solely to relieve symptoms or for palliative care.

(c) **acute medical condition** - a disease, **illness** or injury that is likely to respond quickly to **treatment** which aims to return ~~you~~ the **member** to the state of health the **member** was in immediately before suffering from the disease, **illness** or **injury**; or which leads to the **member**'s full recovery.

(d) **age/aged** – age last birthday

(e) **alternative practitioner** - refers to a person (other than the **policyholder**, or the **member** or the **policyholder's**/**member's** immediate family **member** or the **policyholder's/ member's** business associates including any business partners, employers or employees) who, being recognised by **us**, is registered and qualified to practice by the relevant licensing authority where the **treatment** is given for any of the following alternative forms of medicine such as and limited to acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, podiatry, traditional Chinese medicine and nutritional advice.

(f) **area/area of cover** - one of the following:
Worldwide: worldwide; or
Worldwide excluding USA: worldwide excluding the USA and US Minor Outlying Islands; or
Asia: Australia, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Nepal, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, Vietnam.

(g) **appointed medical practitioner** - a **medical practitioner** chosen by **us** to advise **us** on **your medical condition**.

(h) **assisted conception/assisted pregnancy** - the use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra-uterine insemination (IUI), In vitro fertilisation (IVF), Intracytoplasmic sperm injection (ICSI) or the use of any form of **treatment** to induce or increase ovulation.

(i) **associated (related) medical condition** - any symptom, disease, injury, or **illness** that has one or more of the following characteristics:
- **medical condition(s)** caused by or related to directly or indirectly to a **pre-existing condition**; or
- **medical condition(s)** in which the underlying condition (disease, injury, or illness) is generally known to be same with the underlying disease that caused a **pre-existing** condition; or
- risk factor(s) that is generally or directly known to be a **medical condition** that may cause a **pre-existing condition** or arises from a **pre-existing medical condition**.

(j) **benefits table** - the table applicable to **your plan** showing the maximum benefits **we** will pay for each **member**.

(k) **cancer** - a malignant tumour, tissues, or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

(l) **co-insurance** - this is a share calculated in percentage of the **eligible** medical expenses that the **member** needs to pay as shown in the **benefits table** and/or **policy schedule** before **we** make any payment to **you**.

(m) **chronic condition** - a disease, **illness** or injury that has one or more of the following characteristics:
- it needs ongoing or long-term monitoring through consultations, examinations, check- ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires the **member**'s rehabilitation or for the **member** to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

(n) **conventional treatment** - **treatment** that:
- is established as best medical practice where the **treatment** is taking place; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided; and
- has been proven to be effective and safe for the **treatment** of the **member**'s **medical condition** through high quality clinical trial evidence; and
- does not cost more than an equivalent **treatment** that delivers similar therapeutic or diagnostic outcome; and
- is not provided, used, or undertaken for the convenience or financial advantage of the **member** and/or his/her **medical practitioner**, **hospital**, clinic, or medical institution; and
- is not any other **treatment** that is unnecessary or irrelevant in treating an **eligible medical condition**.

If the **treatment** is a drug, the drug must be licensed for use by:
(i) the Medicines and Healthcare products Regulatory Agency (MHRA), if the **treatment** is to be provided in the United Kingdom; or
(ii) the European Medicines Agency (EMA), if the **treatment** is to be provided in Europe, but outside the United Kingdom; or
(iii) the US Food and Drug Administration (FDA) or by the relevant Governmental Medicines and Healthcare products Regulatory Agency or Authority in the country where **treatment** takes place, if the **member** is receiving **treatment** anywhere else in the world; and
such drug must be used within the terms of its license and dosage for which it is approved for.

Conventional treatment will also apply to the use of related medical equipment or consumables.

(o) **congenital condition** - a congenital condition is a genetic, physical or biochemical defect, malformation or anomaly, present at birth and whether or not manifested within five (5) years from date of birth, regardless of whether it is diagnosed or known about at birth. **We** reserve the right to refer to a **medical condition** classified as a **congenital condition** in the International Classification of Diseases (ICD) chapter on **congenital condition**, anomaly, malformations, and chromosomal abnormalities.

(p) **currency** - the currency in which claims reimbursed to the **member** will be paid and in which premiums must be paid.

(q) **day-care treatment** - **eligible** treatment (excluding **out-patient treatment**) at a **hospital** or day-care unit (where a discharge summary is issued by the **hospital**), and the **member** needs a medically supervised recovery but does not occupy a bed overnight. This excludes all forms of alternative treatment such as but not limited to traditional Chinese medicine and acupuncture.

(r) **deductible** - refers to the part of the benefit **you** are claiming that **you** must pay before **we** will pay any benefit. The deductible is shown

in **your policy schedule** (where applicable).

(s) **dental practitioner (dentist)** - a person who is qualified as a **dental practitioner (dentist)** with a degree in dentistry, duly licensed and registered with the relevant statutory dental board or council in the country where the dental **treatment** is provided. This person must be other than the **policyholder**, the **member** or the **policyholder's/member's** immediate family member or the **policyholder's/member's** employer.

(t) **diagnostic procedures** - consultations and investigations needed to establish a diagnosis for an **eligible treatment** where there are symptoms.

(u) **international directory of hospitals** - refers to **hospitals** which **we** have direct settlement facilities with. **Members** are still responsible for any **deductible** and/or **co-insurance** applicable, which must be settled directly with the **hospitals** at the time of **treatment**.

(v) **eligible** - those **treatments** and charges which are covered by **your policy** before the application of any **deductible**, **co-insurance** that will be borne by **you**. In order to determine whether a **treatment** or charge is covered, all sections of **your policy** should be read together, and are subject to all the terms, benefits and exclusions set out in this **policy**.

(w) **emergency** - a sudden, unexpected acute **medical condition** which, in **our** opinion, constitutes a serious or life threatening emergency which will require immediate surgical or medical attention within twenty-four (24) hours of onset to avoid death or permanent and irreversible total loss of function or permanent impairment to the body system.

(x) **emergency treatment -** immediate **treatment** required as a result of an **accident** or if the **member** suffers a sudden or unforeseen illness that the **member** has never suffered before. For the avoidance of doubt, **we** do not cover immediate **treatment** for **pre-existing conditions** or **pre-existing associated (related) medical conditions.**

(y) **enrolment/time of enrolment** - with effect from 00:01 hours on the date that a **member** is accepted by **us** and premium for the **member's plan** has been received and accepted by **us**.

(z) **experimental** - **treatment** modality or medication in **our** reasonable opinion whose efficacy and safety are yet to be established and lack the authoritative evidence-based high quality clinical studies. These are also **treatment** modalities or medicines which are not generally accepted by the medical community as proven to be effective or recognised by the professional medical organisations as conforming to accepted medical practice. This definition also includes off-label drugs, or equipment used for purposes other than those defined under their license, or which is undergoing study, research, or testing.

(aa) **family member** - **your** partner and/or unmarried children (or those of **your** partner) living with **you** when **you** take out the **policy** or when it is renewed, whichever is later. By partner **we** mean **your** husband or wife registered under civil law or a partner under a domestic partnership with whom **you** live permanently .

(bb) **hospital** - any establishment which is licensed as a medical or surgical hospital in the country where it operates, and which is recognised by **us,** and it meets all the following requirements:

- it operates primarily for the reception, care, and **treatment** of sick, ailing, or injured persons as in-patients;
- it provides twenty-four (24) hours a day nursing service by registered **nurses** or qualified **nurses**;
- it has a staff of one or more licensed **medical practitioners** available at all times;
- it provides organised facilities for diagnosis and major surgical facilities;
- it is not primarily a nursing home, rest homes or convalescent home or similar establishment, geriatric wards, it is not institutions for **treatment** of substance abuse, such as but not limited to a place for alcoholics or drug addicts' rehabilitation or for any similar purpose.

(cc) **illness** - refers to a physical condition marked by a pathological deviation from the normal healthy state.

(dd) **included –** (specific to the **benefits table** reference only) refers to the amount of **eligible** claims that will be paid in full by **us** in accordance with the terms and conditions of this **policy** and must be within the **member**'s annual maximum benefits stated in the **benefits table**.

(ee) **in-patient treatment** - **eligible treatment** at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights. This excludes all forms of alternative treatment such as but not limited to traditional Chinese medicine and acupuncture.

(ff) **injury** - refers to bodily injury caused solely and directly by an **accident**.

(gg) **lifetime** - the period in which the **member** is alive or remains as a **member** under the terms of this policy. **We** will only pay the maximum limit shown in the **benefits table** for eligible benefits in aggregate during the lifetime of the **member**.

(hh) **medical condition** - any disease, **illness ,**or **injury**, including psychiatric **illness**.

(ii) **medical practitioner**- a person (other than the **policyholder** or the **policyholder's**/**member's** immediate family **member** or the **policyholder's/member's** business associates including any business partners, employers, or employees) who, being recognised by **us**, has the primary degrees in the practice of medicine and surgery following attendance at a recognised medical school and who is licensed to practice western medicine by the relevant licensing authority where the **treatment** is given. By 'recognised medical school' **we** mean "a medical school which is listed in the current World Directory of Medical Schools published by the World Health Organisation."

(jj) **medically necessary** - any **treatment**, test, medication, or stay in **hospital** or part of a stay in **hospital** which

- is required for the medical management of an **eligible illness** or **injury** suffered by the **member**;
- must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a **medical practitioner**;
- must conform to the professional standards widely accepted;
- is not provided, used, or undertaken for the convenience or financial advantage of the **member** and/or or his/her **medical practitioner**, **hospital** or clinic or medical institution, or any other **treatment** that is unnecessary or irrelevant treating an **eligible medical condition**;
- shall be considered and approved by **us** and **our** medical advisors as most appropriate, cost effective, **conventional treatment** and not of an **experimental**, investigative, research or preventive nature.

(kk) **member** - the person for whom the insurance coverage is made for, with an insurable interest or insurable interest relation with the **policyholder** and as stated in the **policy schedule**.

(ll) **multiple birth** - the birth of more than one baby from a single pregnancy.

(mm) **natural tooth/teeth -** a natural tooth/ teeth that functions normally in chewing and is free of active clinical decay, no gum disease, no dentures, no caps, or crowns, or veneers and not a dental implant.

(nn) **notice of Cancellation at policy renewal/Anniversary Date** – unless **we** and/or **you** have agreed before the end of the **year** to renew the **policy**, cover will cease on the **policy** renewal/anniversary date. This will happen whether or not written notice of cancellation has been given by **us** to **you**.

(oo) **nurse** – a qualified nurse who is registered and licensed to practice as such where the **treatment** is given and is recognised by **us**.

(pp) **out-patient treatment** - **eligible** treatment by a **medical practitioner** at an out-patient clinic, a **medical practitioner's** consulting rooms or in a **hospital** where the **member** is not admitted to a bed. For the avoidance of doubt, this excludes all forms of alternative treatment such as but not limited to traditional Chinese medicine and acupuncture.

(qq) **period of insurance**- The duration of one (1) calendar Year from the Commencement Date or from each Policy Anniversary if this **policy** is renewed, during which this Policy is in force.

(rr) **permissible claim period** - the period in which **policyholder** is able to submit claims for **our** assessment which is stated as within ninety (90) days from the date of **treatment** for **out-patient** claims, or from date **hospital** discharge for **in-patient** claims.

(ss) **physiotherapist** – a person who is qualified and licensed to practice at a legally licensed physiotherapy centre or at a medical facility as a physiotherapist where the **treatment** is given and who is recognised by **us**.

(tt) **plan** – an International Exclusive plan.

(uu) **policy** – the insurance contract between **you** and **us**. Its full terms are set out in the current versions of the following documents as sent to **you** from time to time:

- any application form **we** ask **you** to fill in
- these terms and the **benefits table** setting out the cover under **your plan**
- **your policy schedule**, and/or endorsements

Changes to these terms must be confirmed in writing and **we** will write to **you** to confirm any changes, undertakings or promises that **we** make.

(vv) **policy anniversary** - the same date and month following a **year** from the **policy commencement date** or last **policy anniversary**.

(ww) **policy commencement date** - the date on which the insurance coverage starts as set forth in the **policy schedule.**

(xx) **policy schedule** – the agreement **we** have with **you** which allows **you** to be registered as the **policyholder**. That agreement sets out who can be covered, when cover begins, how it is renewed, and how the premiums are paid. It also sets out the table applicable to **your plan** showing the maximum benefits **we** will pay for each **member**.

(yy) **pre-authorisation/pre-approval -** a confirmation of coverage provided by **us** under this **policy** before the **member** incurs any cost or receives any **treatment**.

(zz) **pre-existing condition** - any **medical condition** which preceding the **member plan's policy commencement date**, or **policy** reinstatement date, whichever date is later:

a. has been diagnosed; or
b. for which the **member** has received medication, advice, or **treatmen**t, or
c. which the **policyholder** and/or **member** should reasonably, in **our** opinion, have known about; or
d. for which the **member** has experienced symptoms even if the **member** has not consulted a **medical practitioner**.

(aaa) **prescription** – **out-patient** drugs and dressings as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** covered by the **member's policy**. It excludes vitamins, traditional Chinese medicine, supplements, over the counter medication, even if they are prescribed by a **medical practitioner**; as well as the delivery charges for any medication prescribed through telephone consultation/tele-medicine.

(bbb) **principal country of residence** – the country where the **member** lives or intend to live for most of the **year** being one hundred eighty-five (185) days or more and which will be shown as **member**'s address and place of residence in **our** records.

(ccc) **reasonable and customary** – 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 will refer to 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 **medical practitioners'** in the same specialty for the same surgical intervention or **treatment**.

In the event of any differences in opinions between **our** medical advisers or **medical practitioners** and **your medical practitioners**, **our** medical advisers or **medical practitioners'** opinion shall prevail.

(ddd) **surgical procedure** – an operation or other invasive surgical intervention.

(eee) **special care baby unit**- refers to specialist care units (SCBU / NICU) (Neonatal Intensive Care Unit) for newborn baby who is having or needs intensive medical care immediately following birth.

(fff) **terminal medical condition -** The conclusive diagnosis of an **illness** that is expected to result in the death of the **member** within three hundred sixty-five (365) days. This diagnosis must be supported by a specialist and confirmed by **our medical practitioner**. Terminal medical condition in the presence of Human Immunodeficiency Virus infection is excluded.

(ggg) **treatment** – a **surgical procedure** or medical procedure carried out by a **medical practitioner** that is **conventional treatment**. This may include:

- **diagnostic procedures** - consultations and investigations needed to establish a diagnosis.
- **in-patient treatment – treatment** at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights.
- **daycare treatment – treatment** (excluding **out-patient treatment**) at a **hospital** or daycare unit where the **member** is admitted to a **hospital** bed but does not stay overnight.
- **out-patient treatment – treatment** at an **out-patient** clinic, a **medical practitioner**'s consulting room or in a **hospital** where the **member** is not admitted to a hospital bed.

For avoidance of doubt, any of the above listed **treatment** is subject to the **benefits table** according to the **member's plan** stated on the **policy schedule**. Certain benefits may exclude an entire class of **treatment**.

We define **conventional treatment** as treatment that:

- is established as best medical practice where the **treatment** is taking place; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided; and
- has been proven to be effective and safe for the **treatment** of the **member**'s **medical condition** through high quality clinical trial evidence; and
- does not cost more than an equivalent **treatment** that delivers similar therapeutic or diagnostic outcome; and
- is not provided, used, or undertaken for the convenience or financial advantage of the **member** and/or his/her **medical practitioner**, **hospital**, clinic, or medical institution; and
- is not any other **treatment** that is unnecessary or
- irrelevant in treating an **eligible medical condition**.

If the **treatment** is a drug, the drug must be licensed for use by:
(i) the Medicines and Healthcare products Regulatory Agency (MHRA) if the **treatment** is to be provided in the United Kingdom; or
(ii) the European Medicines Agency (EMA) if the **treatment** is to be provided in Europe, but outside the United Kingdom; or
(iii) the US Food and Drug Administration (FDA) or by the relevant Governmental Medicines and Healthcare products Regulatory Agency or Authority in the country where **treatment** takes place, if the **member** is receiving **treatment** anywhere else in the world; and
(iv) such drug must be used within the terms of its license and dosage for which it is approved for.

Conventional treatment will also apply to the use of related medical equipment or consumables.

(hhh) **terrorist act** - refers to any use of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal. Terrorism shall also include any act, which is verified or recognised by the relevant Government as an act of terrorism.

(iii) **visit** –each separate occasion a **member** meets with a **medical practitioner** and receives a consultation and/or **treatment** for a **medical condition**. Where applicable, this may also refer to any telephone consultation/tele-medicine benefit if extended under the **member**'s **plan**.

(jjj) **waiting period** - refers to period the benefit concerned will not be payable. This **waiting period** is calculated initially from the **member's** date of joining the **plan**, or from the date of **plan** upgrade, or reinstatement date, whichever date is later.

(kkk) **we/us/our** – HSBC Life (Singapore) Pte. Ltd., being the HSBC Life company issuing **your policy**.

(lll) **year** – twelve (12) Gregorian calendar months from when **your policy** began or was last renewed unless **we** have agreed something different.

(mmm) **you/your/policyholder** – the **policyholder** named on **your policy schedule,** who is responsible for paying premiums and who may exercise all rights under this **policy**.

Section 4: What you are covered for

4.1 What we pay for

This **policy** insures the **members** against the cost of **medically necessary eligible conventional treatment** carried out by a **medical practitioner**. **We** will only pay:

(a) for charges actually incurred for items listed in **your respective member's benefits table** subject to the limits shown there. If the **member** incurs costs in excess of these limits, **you** will have to pay the difference;

(b) for **treatment** of a **medical condition** which is commonly known to respond quickly to **treatment**. When the **medical condition** has been stabilised **we** may stop making payments. **We** reserve the right to determine when a **medical condition** has become **chronic** or recurrent in nature or has stabilized;

(c) for charges by the **medical practitioner,** laboratory or other such medical services which are **reasonable and customary**. **We** may delay paying the claim until **we** are satisfied that the charges are appropriate. If the charges made by the **medical practitioner** are higher than **reasonable and customary**, **we** will only pay the amount which is **reasonable and customary**, and the **member** will have to pay the rest;

(d) for **eligible** costs subject to the terms and conditions of this **policy**;

(e) for **eligible conventional treatment** incurred during a period for which the premium has been paid;

(f) for **treatment** of **medical conditions** that existed, and were specifically declared to and accepted by **us**, prior to inception of this **plan**. **We** do not pay for **treatment** related to or as a result of a condition that has previously been excluded or subject to a moratorium/**waiting period** imposed by **us** or any previous insurer and such exclusion or moratorium has not expired; or as allowed for by **your plan**. For avoidance of doubt, the **pre-existing condition** exclusion/limitation shall apply to all benefits for a **member's plan** unless otherwise stated;

(g) for the initial diagnosis and stabilisation of a **chronic** condition (a **medical condition** that does not respond quickly to **treatment** or recurs). Stabilisation means, in the event of such a **medical condition** entering an acute phase (flaring-up), **treatment** to return the **medical condition** to a stable state.

4.2 Your plan benefits

Deductible and **co-insurance** will be applied where applicable.

Please refer to the **benefits table** on Section 11 for further information on the availability, benefit levels and **waiting periods** of **your plan**.

Benefits	Clarifications
Yearly maximum	**We** will pay up to the maximum amount shown for each **member** each **policy year.** All benefits paid during the **policy** period will count against the yearly maximum limit. Cover does not extend beyond the **area** shown for **your plan** unless **you** are **eligible** for 'outside **area of cover**' benefit.
Outside **area of cover**	This is to cover **emergency treatment** which arises suddenly whilst outside the **member's area of cover** up to the amount shown in **member's benefits table**. **We** will, in consultation with the treating **medical practitioner**, retain the right to determine what constitutes **'emergency treatment.'** This benefit does not provide cover for **treatment** for any condition if a **membe**r has travelled outside his **area of cover** to get **treatment** (whether or not that was the only reason) or for any **treatment** which was or may have reasonably been known about before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth. Once **we** have determined, in conjunction with the treating **medical practitioner** that the **eligible medical condition** is stabilised or the health status of the **member** allows him to travel back into his **area of cover**, **we** will stop paying for **emergency treatment**. Section 4.3 - 'International **Emergency** Medical Assistance' shall also apply. For avoidance of doubt, the maximum benefit payable shall be limited to the amount applicable on the **"Pre-existing Conditions**" benefit for **members** insured under Plan A or B after a **waiting period** of two hundred seventy (270) days if the **emergency treatment** is for an **eligible pre-existing condition**. For **members** insured under Plan C, no benefit shall be payable for **emergency treatment** arising from a **pre-existing condition**. All **policy** terms, conditions, limitations, and exclusions shall apply to this benefit.
Annual **deductible** and **co-insurance**	In exchange of annual premium discount, the **policyholder** can opt to include an annual **deductible** and **co-insurance**. Please refer to the **benefits table** on Section 11 for details on the level of annual **deductible** and **co-insurance** applicable to **your plan.** The annual **deductible** is the aggregate amount of **eligible** expenses claimed that the **member** will have to bear each **year** before any benefits (this excludes the Cash Benefit) are payable under this **plan**. This amount will be collected by whoever provides for the **member's treatment** (for direct billing) or deducted from any reimbursement made to **you** by **us**. The amount shown for **your plan** applies to each **member** each **year**. When an **eligible** claim is made, such claim is subject to the applicable **deductible** and **co-insurance**.

In-patient and daycare treatment – general information

By **in-patient treatment**, **we** mean **eligible conventional treatment** at a **hospital** where the **member** has to stay in a **hospital** bed for one or more nights. By **daycare treatment**, **we** mean **eligible treatment** at a **hospital** or daycare unit where the **member** requires a **treatment** (excluding **out-patient treatment**), necessitating admission to a **hospital** bed because they need medical supervision but not requiring an overnight stay.

For all non-emergency admissions, you are required to obtain our written pre-authorisation before admission. This is to protect you from an unexpected cost.

For direct settlement for an **eligible treatment**, the approval **we** give to the service provider will indicate the amount which is **reasonable and customary** (R&C) for the proposed **treatment**. Please refer to 'Understanding how to get the best from **your plan**' in Section 7 of this **policy** for more details.

All benefits are subject to assessment on the basis of what is **reasonable and customary (R&C)** within **our international directory of hospitals**. This assessment will apply even when the **medical practitioner** treating the **member** refers the **member** for **treatment** outside **our international directory of hospitals** if that **treatment** would have been available within **our international directory of hospitals**. If in doubt, please contact **us** before receiving **treatment**. There are **hospitals** or medical institutions which **we** would not pay for **treatment** because they do not meet **our** billing criteria or because **we** do not recognise them. If the **member** has **treatment** that may be covered for at a **hospital** or medical institution that is not in **our international directory of hospitals**, always contact **us** before the **member** receives the **treatment**. **We** would not reimburse **you** for the **treatment you** pay for the **member** if the **treatment** were not provided by a **hospital** or medical institution recognised or approved by **us**.

Please refer to the **benefits table** on Section 11 for further information on the availability, benefit levels and **waiting periods** of **your member's plan**.

Benefits	Clarifications
Daily accommodation charges, per night	While admitted as an **in-patient** or daycare, **we** will pay for the costs of **member's** accommodation in the type of room shown in **your benefits table**. **We** will only pay for the **hospital** room and board costs when the length of stay is **medically necessary** and is considered by **us** as clinically appropriate for the **member**'s **medical condition**. Wherever a **member** receives **treatment**, if the **hospital** offers several classes for the room type, he is entitled for, **we** will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that **hospital** for that type of room. If a **member** stays in a room which is more expensive than the standard room, the **member** may have to pay for the difference in room charges. The **member** may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with **us** prior to admission to avoid unnecessary out of pocket expenses.
Hospital charges	Subject to the limits shown for **your plan,** the **member** is covered for **eligible** hospital charges incurred for **eligible treatment** given between admission and discharge such as: • **diagnostic procedures**, • **surgical procedures**, • operating theatre charges, • nursing care, drugs, and dressings, • surgeons' and anaesthetists' charges, • intensive care unit charges, • consultations and physiotherapy while admitted for **treatment** of an **eligible medical condition** and when such **treatment** directly relates to it, • oncology **treatment** including radiotherapy and chemotherapy, • kidney dialysis, • computerised tomography, magnetic resonance imaging, x-rays, and other such proven medical imaging techniques, special nursing in **hospital**
Organ transplant	**We** will pay for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an **eligible medical condition** and provided the organ is from a certified and verified source of donation and the procurement and transplantation of such organ is in accordance with the World Health Organisation (WHO) Guiding Principles on Human Cell, Tissue and Organ Transplantation. The **policy** does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor.

Benefits	Clarifications
Living organ donor	**We** will pay up to the annual limits shown in the benefit schedule for **reasonable and customary** charges incurred for a live **member** to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung, or bone marrow) of this **policy**, provided: (a) the operation and transplant are for the **member's** family member (parent, sibling, child, spouse, or partner); (b) the transplant is in line with appropriate regulatory guidelines; (c) the recipient of the organ was first diagnosed by a doctor; or symptoms first appeared after a **waiting period** of twenty-four (24) months from the **policy commencement date**; or the date after this Living Organ Donor (**member**) Transplant benefit first became effective under this **policy**; or the last reinstatement date (if any) whichever is the latest; and Shall include **eligible** expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalisation **treatment**. Both pre and post-hospitalisation benefits are limited to one hundred and twenty (120) days prior or after **treatment,** respectively. This benefit requires **pre-authorisation** from **us**. This benefit does not pay for the cost of collecting donor organs or tissue, administration costs, its complications, and illegal organ transplants.
Reconstructive surgery	**We** will pay for the initial reconstructive surgery which is **medically necessary** and provided that (i) it is carried out to restore function after an **accident** or following surgery for an **eligible medical condition**; and (ii) that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened. Benefit for reconstructive surgery is subject to **our pre-authorisation** and must be done at a medically appropriate stage (as determined by **our medical practitioner**) after the **accident** or surgery. In the case of breast cancer, the initial reconstructive surgery must be part of the **eligible treatment** following the **cancer treatment** which includes one planned surgery to reconstruct the diseased breast and one further planned surgery to the other breast when it has not been operated on to improve symmetry. If the **member** chooses not to have reconstructive surgery following treatment of **breast** cancer, no further reconstructive surgery will be covered by **us** on either the diseased breast or the unaffected breast.
Surgical implants	**We** will pay for medical devices surgically implanted into the body as part of the **treatment** (excluding any dental implants).
Companion accommodation	**We** will pay up to the amount shown in **your benefits table** for companion's accommodation in the same **hospital** room with the **member** or at a hotel/motel near the **hospital** within the **area of cover** when the **member** is receiving an **eligible in-patient treatment** in the **hospital** within the **area of cover**. This is paid from **your member's** benefit.
Cash benefit	This benefit is payable for **eligible in-patient treatment** only when the **member** receives **treatment**, within the **area of cover**, provided no cost is borne by **us**. **We** will pay a cash benefit up to the '**Pre-existing Conditions**' benefit limit, if applicable to **your plan**, when the **in-patient treatment** is resulting from a covered **pre-existing condition**. 'Cash Benefit' is only payable when no other benefit is claimed for under this **policy** for **in-patient treatment** and it will be payable up to 30 nights per **year**.
Pre- and post-hospitalisation 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 **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 twenty-eight (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 one hundred eighty (180) days.
Pre-hospitalisation **treatment**	**We** will pay for consultation, prescribed investigations and essential medications by a **medical practitioner** received as an out-patient within one hundred twenty (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.**

Post-hospitalisation **treatment**	**We** will pay for follow-up **out-patient** consultation and **treatment** following an **eligible in-patient treatment** 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 one hundred twenty (120) days immediately following the date of discharge from hospital for which the member was confined as an in-patient 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**.

Out-patient treatment – general information

Out-patient treatment is **treatment** given by a **medical practitioner** at an **out-patient** clinic, in a **medical practitioner's** consulting room or in a **hospital** where the **member** is not admitted. A **member** is covered, subject to the limits shown, for:

- **medical practitioner** charges for consultations;
- **diagnostic procedures**;
- **prescriptions** (note any prescribed drug or other medication required for more than 30 days should be **pre-authorised** by **us**);
- hormone replacement therapy **(pre-authorisation** is recommended)
- physiotherapy, occupational therapy and/or speech therapy for an **eligible medical condition** received as an **out-patient** (**pre-authorisation** is recommended);
- computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans received as an **out-patient** (**pre-authorisation** is required);
- proton beam therapy (PBT), advanced therapies (available under the terms of this **policy**), radiotherapy and chemotherapy received as an **out-patient** (**pre-authorisation** is required);
- kidney dialysis received as an **out-patient**;
- **surgical procedures** received as an **out-patient**;
- consultation and **treatment** provided and prescribed by a qualified and registered chiropractor, podiatrist, dietitian, naturopath, acupuncturist, homeopath, osteopath, **physiotherapist,** and traditional Chinese medicine practitioner;
- **emergency treatment** due to **accident;**

Please note: We require **you** to obtain our written **pre-authorisation/pre-approval** for **your** planned treatments beforehand. Refer to Section 7, Understanding how to get the best from **your plan**. This is to protect **you** or the **member** from unexpected costs. Please refer to the **benefits table** on Section 11 for further information on the availability of benefits, benefit levels and **waiting periods** of **your plan.**

Benefits	Clarifications
Primary and specialist care (Plan A and B only)	A consultation is a visit to any **medical practitioner** for the **treatment** of an **eligible medical condition**. **We** will pay for the **medical practitioner** charges for consultations, **prescriptions,** and **diagnostic procedures**. Diagnostic tests include and are limited to laboratory, x-rays, and ultrasound. The number of visits are limited to once per day with a medical practitioner, for the same medical condition. **Second opinion for the same medical condition:** • **pre-authorisation/pre-approval** is recommended **Thereafter subsequent opinions and referrals for the same condition:** • written **pre-authorisation** is required.
Surgical procedures	**We** will pay for any **surgical procedure** received as part of an **out-patient treatment**. This includes one post-surgery consultation within ninety (90) days from the date of the **surgical procedure**.
Emergency treatment due to **accident**	**We** will pay for **out-patient treatment** due to **accident** required immediately (within twenty-four (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 thirty (30) days from the date of the **accident**.
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**. There is limited cover for Proton Beam Therapy (PBT) and small number of advanced therapies (ATMPs), including gene therapies and CAR-T **treatment** available under the terms of this **policy. You** must call **us** before the **member** starts **treatment** to make sure this is covered by the **policy**. Please refer to the specific section below on the details of these benefits.
Proton Beam Therapy (PBT)	This is a type of radiation therapy which uses protons rather than x-rays to treat **cancer**. **We** will pay PBT for: • malignant solid cancers in members aged twenty- one (21) and under • central nervous system (brain and spinal cord) **cancer** • chordomas or chondrosarcomas (types of spine **cancer**) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) • high naso-ethmoid, frontal and sphenoid tumours with base of skull involvement

<table>
<tr><th>Benefits</th><th>Clarifications</th></tr>
<tr><td></td><td>• adenoid cystic carcinoma with perineural invasion
• esthesioneuroblastoma
• cancer of the iris, ciliary body, or choroid parts of the eye (uveal melanoma) which has not spread (metastasised)
• conjunctival melanoma
• choroidal haemangioma

Pre-authorisation/pre-approval is required. Please call us before the member starts any treatment.

There is limited cover for Proton Beam Therapy in the circumstances shown above.

Other forms of accelerated charged particle therapies, which is a therapy where charged particles are targeted into the tumour tissue at an increased speed is not covered.</td></tr>
<tr><td>Advanced Therapy Medicinal Products (ATMPs), Cellular and Gene Therapy Products (CGTPs) and Regenerative Medicine Advanced Therapy (RMATs)</td><td>We only cover a small number of ATMPs/CGTPs/RMATs under your policy, these are shown in the below table. They are a complex set of advanced therapies, including gene therapies and CAR-T treatment for cancer. They are known by different names across the world, for example Advanced therapy medicinal products (ATMPs), Cellular and gene therapy products (CGTPs) or Regenerative medicine advanced therapy (RMAT).

Pre-authorisation/pre-approval is required for this benefit. Please contact us before the member starts any treatment to make sure it is covered.

If the member requires any ATMPs/ CGTPs/ RMAT that were not pre-authorised/pre-approved or are not on the list of covered therapies at the time the member needs the treatment, such treatments including any associated hospital or specialist costs shall be excluded and not payable under this policy. The current list of advanced therapies under the scope of this Policy are as follows and is subject to change, so the member must always check and call us before starting any treatment otherwise we will not cover any ATMPs/CGTPs/RMATs.

<table>
<tr><th>Therapy name</th><th>Where licensed and used within the terms of that licence and in operation on 01 April 2023, We cover for:</th></tr>
<tr><td>Yescarta</td><td>Diffuse large B-cell lymphoma (DLBLC) and primary mediastinal large B-cell lymphoma (PMBCL) in adults</td></tr>
<tr><td>Kymriah</td><td>B-cell acute lymphoblastic leukaemia (ALL) in children and young adults and diffuse large B-cell lymphoma (DLBLC) in adults</td></tr>
<tr><td>Tecartus</td><td>Mantle cell lymphoma (MCL) in adults</td></tr>
<tr><td>Abecma</td><td>Multiple myeloma in adults</td></tr>
<tr><td>Imlygic</td><td>Malignant melanoma (a skin Cancer) in adults</td></tr>
<tr><td>Alofisel</td><td>Complex perianal fistula problems in Crohn’s disease in adults</td></tr>
<tr><td>Holocar</td><td>Limbal stem cell deficiency in adults following physical or chemical burns of the eye</td></tr>
</table>

By licensed, we mean granted marketing authorisation by the Medicines & Healthcare Products Regulatory Agency (MHRA) if the treatment is to be provided in the United Kingdom, the European Medicines Agency (EMA) if you or your member are receiving treatment in Europe but outside of the United Kingdom or the Food and Drug Administration (FDA) if your member is receiving treatment anywhere else in the world.</td></tr>
<tr><td>Kidney dialysis</td><td>We will pay for kidney dialysis received as an out-patient for an eligible medical condition at a registered medical facility recognised by us.</td></tr>
<tr><td>Computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans</td><td>We will pay for computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an eligible out-patient treatment.
Such treatment must be under the medical supervision of a medical practitioner. Medical supervision means that the reason for referral, where applicable, has been initiated by the medical practitioner who has requested such diagnostic scans.
For clarity, this benefit does not cover charges for consultations, prescriptions, and other diagnostic procedures such as laboratory tests, x-rays, and ultrasound.</td></tr>
<tr><td>Hormone replacement therapy</td><td>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 hormone replacement therapy 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 benefits table applicable to your member’s plan.</td></tr>
</table>

Benefits	Clarifications
Physiotherapy, occupational therapy and speech therapy	Such treatment must be given by a qualified practitioner who is recognised by **us** and registered to practice this where the **eligible treatment** is given. Benefit is payable only following **in-patient treatment** for an **eligible medical condition**, provided that the **member** has been continuously covered under the **policy** since before the **in-patient treatment** commenced. Cover for post-hospital **treatment** must be received within the one hundred and eighty (180) day period following the date the **member** is discharged from **hospital**. Treatment given by any of these practitioners (**physiotherapist**, occupational therapist, speech therapist) must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has defined a diagnosis. There must be a clear and complete **treatment** plan detailing the start to the end of the **treatment** by the **physiotherapist**, speech therapist or occupational therapist with an expected outcome to restore the **member**'s normal form and/or function after an **acute** illness or **injury**.

Other benefits – general information

These are the additional features of **your plan**. Please note that all **deductibles** or **co-insurances**, limitations and terms apply to these benefits exactly as for the main in-patient/daycare and out-patient benefits depending on whether **treatment** is received as part of an out-patient, in-patient or **daycare treatment**.

Please refer to the **benefits table** on Section 11 for further information on the availability of benefits, benefit levels and **waiting periods** of **your plan**.

Benefits	Clarifications
Alternative and Wellbeing 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 (Plan A and B only)	**We** will pay for consultation and **treatment** given by a qualified **alternative practitioner** and **physiotherapist** who is recognised by **us** and registered to practice this where the **treatment** is given. There must be a clear and complete **treatment** plan from the chiropractor, osteopath, homeopath, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, physiotherapist, and the traditional Chinese medicine practitioner detailing the start to the end of the **treatment** with an expected outcome that is restorative in nature to help the **member** to carry out his/her normal activities of daily living. Within this benefit and up to the limits applicable to the **member's plan**, **we** will also pay for vitamins, supplements, and traditional Chinese medicine when the **alternative practitioner** or **medical practitioner** prescribes such. The **member** should obtain a non-contra-indication for the use of alternative treatment from their treating **medical practitioner** as **we** will not pay for any complications arising from such alternative treatment in excess of the limit shown for this benefit.
Vaccination (Plan A and B only)	This benefit becomes available and eligible claims will be payable for expenses incurred after the **member** has been continuously covered under Plan A or B for ninety (90) days in the first **policy year**. **We** will pay for the combined cost of administering necessary vaccines given by a **medical practitioner** or **nurse** and the cost of the vaccines, including the consultation charges.
Health Screen (Plan A and B only)	The limit shown includes the cost of any **eligible** consultation needed as part of the screening process. This benefit covers health screen or medical screening examination in the absence of a **medical condition** including follow-up consultation, where the **member** did not experience signs or symptoms. This benefit is not payable if the **member** is receiving a medical screening examination for **treatment** of a **medical condition**. Please note, this is a preventive health check benefit specifically designed for early detection for disease prevention.
Dental Treatment	
Accidental damage to natural teeth	Under accidental damage to teeth, **we** will pay for **treatment** required within thirty (30) days following accidental damage to **natural teeth** caused by extra-oral impact when a dental practitioner gives that **treatment,** provided that the **member** has been continuously covered under the **policy** since before the **accident** happened. Benefit is not payable if: (a) the damage was caused by normal wear and tear (b) the **injury** was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn (c) the damage was caused by tooth brushing or any other oral hygiene procedure (d) the damage was not apparent within seven (7) days of the oral impact which caused the **injury.** Please note: There is no cover for **treatment** required as the result of the consumption of food or drink or any foreign bodies contained in such food or drink.

Oral and maxillofacial surgery	This benefit pays for the following procedures performed by an oral and maxillofacial surgeon: (a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms; (b) Surgical removal of complicated buried roots which are diseased or causing symptoms; (c) Enucleation (removal) of cysts of the jaw; (d) **Treatment** of cancers (For lesion or lump in the mouth); (e) **Treatment** of Temporal Mandibular Joint (TMJ) (except physiotherapy for Temporal Mandibular Joint (TMJ) which is paid under the 'Alternative Treatment' benefit as provided for by **your member's plan**). For avoidance of doubt, the maximum benefit payable shall be limited to the amount applicable on the **"Pre-existing Conditions**" benefit for **members** insured on Plan A or B after a **waiting period** of two hundred seventy (270) consecutive days if the oral and maxillofacial surgery is required for an **eligible pre-existing condition**. For **members** insured on Plan C, no benefit shall be payable for oral and maxillofacial surgery required as a result of a **pre-existing condition**. Please note, this benefit does not cover routine dental care.
Routine dental care (Plan A and B only)	**We** will pay up to the limit shown for dental examination, extraction, fillings, root canal treatment, scaling/polishing, bridgework, crowns, implants, dentures, x-ray, sealant, inlays and onlays, fluoride treatment and the **treatment** of gum disease. **We** do not cover costs for **treatment** that have not yet taken place, even if it is being provided as part of a **treatment** package. The limitations applied to **pre-existing conditions** are not applicable to this benefit.
Optical Benefit	
Routine optical care (Plan A only)	This benefit provides for the fees charged for corrective spectacle lenses, contact lenses and associated spectacle frames prescribed by the ophthalmologist or optometrist up to the limit shown for **your member's plan**. This benefit also pays for the eye examinations carried out by an ophthalmologist or optometrist. This benefit does not pay for tinted/ reactive lenses, sunglasses, non-corrective contact lenses, Lasik/laser eye surgery and/or similar, whether prescribed or not.
Emergency Evacuation and Repatriation	
International Emergency Medical Assistance ('IEMA')	Please refer to Section 4.3 for more details on International **Emergency** Medical Assistance.
New born cover	
New born cover - acute **medical condition**	This benefit pays for the **treatment** of **acute medical condition**, provided there is no underlying **congenital condition** developed in a new born baby including nursing of pre-mature baby (i.e., where birth is prior to thirty-seven (37) weeks gestation) in Neonatal Intensive Care Unit (NICU). The common acute **medical conditions** for new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: (a) the parent of the new born baby has been covered under this **International Exclusive policy** for three hundred sixty-five (365) consecutive days or more when the baby is born; and (b) the new born baby is added into the insured parent's **policy** within thirty (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 new born baby during the first thirty (30) days after birth. After thirty (30) days, **treatment** can be covered under the main benefits of the insured baby's **plan**. Please see, Section 2. Eligibility.

New born cover – **congenital conditions** (Plan A only)	This benefit pays for **treatment** of **congenital conditions.** The benefit becomes available if: (a) the parent of the new born baby has been covered under **International Exclusive** Plan A for three hundred sixty-five (365) consecutive days or more when the baby is born; and (b) the new born baby is added into the insured parent's **policy** within thirty (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' **plan**. Please note: (i) **Treatment** for **congenital conditions** which do not fulfil all of the above criteria will be paid from '**Pre-existing Conditions**/**Congenital Conditions**' benefit. (ii) 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**.

Other benefits	
Home nursing	Under this benefit, **we** will pay charges incurred by an attending registered and qualified **nurse** for a **member** and only when the following conditions are met: (a) after his 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 (b) agreed in writing by **us** beforehand that it is **medically necessary** and appropriate, and (c) it is prescribed by the treating **medical practitioner** for the continued **treatment** for the **eligible medical condition** which the **member** was hospitalised for, and (d) when such services are essential for medical purposes as distinct from domestic, personal, or social reasons. For avoidance of doubt, the charges refer to the fees for the service of the **nurse** incurred for nursing the **member** at home. For **terminal medical condition**, this benefit is payable under 'Hospice and Palliative Care' and subject to the limitations applicable to that benefit.
Pre-existing conditions (Plan A and B only)	Where applicable, **we** will pay for **treatment** required for **pre-existing conditions** up to the limit shown for **your member's plan**. **Treatment** of declared and accepted **pre-existing conditions** will be paid for from this benefit after the **member** has been continuously covered under the **policy** for two hundred seventy (270) consecutive days **waiting period**. All **pre-existing conditions** must, in good faith, be declared to **us**, in writing, at the time of application. Please note that it is important that the **member** give **us** full details of any medical history on an application. Failure to declare any **medical condition** of which the **member** 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**. **Your policy schedule** will clearly show the **medical conditions** for which a **member** is covered under the "**Preexisting Conditions**" benefit for **treatment**. **We** may ask for a medical report, at **your** own cost, to clarify the status of any **medical condition**. '**Pre-existing Conditions**' benefit and '**Congenital Conditions**' benefit share the same aggregate annual limit, thus any benefit paid under one of those two benefits reduce the remaining benefit available for both.
Congenital conditions (Plan A and B only)	**We** will pay for **treatment** required for **congenital conditions** up to the limit shown for your plan, after the (Plan A and B only) **member** has been continuously covered under the policy for two hundred seventy (270) consecutive days **waiting period**. All **congenital conditions** must, in good faith, be declared to **us**, in writing, at the time of application. Please note that it is important that the **members** give **us** full details of any medical history on an application. Failure to declare any **medical condition** of which the **members** 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**. For the avoidance of doubt, the exclusions below remain applicable to this benefit: 6.1(t) **treatment** relating to neurological development, cognitive development, learning disorders, speech delay, educational problems, behavioural problems, developmental milestones, physical development, or psychological development, including assessment or grading of such problems. This includes but not limited to problems such as dyslexia, dyspraxia, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech and language problems. 6.2(a) cosmetic (aesthetic) surgery or treatment; 6.2(b) any **treatment** which relates to or is needed because of previous cosmetic **treatment** or reconstructive surgery or any cosmetic operation to reconstructed breasts. '**Pre-existing Conditions**' benefit and '**Congenital Conditions**' benefit share the same aggregate annual limit, thus any benefit paid under one of those two benefits reduce the remaining benefit available for both.

Benefits	Clarifications
Other benefits	
Local road ambulance transport	This is to pay for a local road ambulance for **medically necessary emergency** transport to or between **hospitals**. The **medical practitioner** of the **member** will determine if this is medically essential or when the **medical practitioner** says that the **member** needs to have medical supervision whilst being transported. **We** reserve the right to ultimately determine whether such transportation was medically appropriate. (This does not form part of the International Emergency Medical Assistance service).
Psychiatric **treatment**	The limit shown applies to **in-patient**, daycare, and **out-patient treatment** (subject to availability of **out-patient** benefit for **your member's plan**) of psychiatric **illnesses** in aggregate, unless otherwise stated. This benefit must be **pre-authorised** by **us**. All **medically necessary treatment** administered by registered psychologists, psychotherapists, or any individuals other than a registered psychiatrist must also be **pre-authorised** by **us**. All such **treatment** must be under the medical supervision of a registered psychiatrist.
Treatment for HIV/AIDS (Plan A only)	**We** will pay for **treatment** for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) as a result of occupational **accident** or blood transfusion up to the limit shown for **your plan**: (a) Infection with the HIV through a blood transfusion, provided that all of the following conditions are met: i. the blood transfusion was **medically necessary** or given as part of a medical **treatment**; ii. the blood transfusion was received after this **policy** was incepted; iii. the source of infection is established to be from the **hospital** and the **hospital** is able to trace the origin of the HIV tainted blood; iv. the **member** does not suffer from thalassaemia major or haemophilia; and v. HIV infection is not resulted from any other means including sexual activity and/or from transmission from the insured **member's** parent and/or the use of intravenous drugs. (b) Infection with HIV which resulted from an **accident** occurring after this **policy** is incepted, whilst the **member** was carrying out the normal professional duties of his or her occupation in the **principal country of residence,** provided that all of the following are proven to **our** satisfaction: i. proof of the **accident** giving rise to the infection must be reported to **us** within thirty (30) days of the **accident** taking place; ii. proof that the **accident** involved a definite source of the HIV infected fluids; iii. proof of sero-conversion from HIV negative to HIV positive occurring during the one hundred eighty (180) days after the documented **accident**. This proof must include a negative HIV antibody test conducted within five (5) days of the **accident**; and iv. HIV infection resulting from any other means including sexual activity and/or the use of intravenous drugs are excluded. This benefit becomes available when signs or symptoms for HIV/AIDS are present for the first time after the **member** is insured for at least thirty-six (36) consecutive months in this **policy**.
Artificial limbs (Plan A and B only)	**We** will pay this benefit up to the limit stated on the **benefits table** for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or **surgical procedures**. Benefit is only payable following a surgery or an **accident** for **an eligible medical condition** provided that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened.
Artificial ears & eyes (Plan A and B only)	**We** will pay the costs of 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** provided the **member** has been continuously covered under the **policy** since before the surgery or **accident** happened that has led to the need for the replacement of ears and eyes. The claims must be made within 12 (twelve) months of the removal of the ears and eyes and to subject to our **pre-authorisation**. This benefit is payable up to the **lifetime** limit shown for **your member's plan.**

Medical aids and durable medical equipment (Plan A and B only)	**We** will pay for instruments or devices or durable medical equipment 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-surgical mastectomy bra • compression stocking • hearing aids • speaking aids (electronic larynx) • wheelchairs • crutches • corrective splint • air boots • arm sling • brace
Hospice and palliative care	Benefit only becomes available and **eligible** claims payable for expenses incurred after the **member** has been continuously covered under his chosen **plan** for three hundred sixty-five (365) consecutive days and has effected the annual renewal of that **plan** for the coming **policy year**. 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(s)** and its associated conditions. The benefit should be **pre-authorised**, in writing, by **us** in advance of admission. Once the **member** is admitted, all costs of care and any **treatment** related to an **eligible terminal medical condition(s)** and related conditions will be taken from this benefit and may not be claimed from any other benefit applicable to **your member's plan**. Any **eligible medical conditions** not related to the **member's terminal medical condition** will be covered under the **member's** main benefits. **We** reserve the right to determine, on the advice of **our** medical panel, whether a **medical condition** is or is not related to the **terminal medical condition**. This benefit is payable, up to the **lifetime** limit shown for the **member's plan** in aggregate for all such conditions. The **member** must maintain the same level of cover throughout the palliative or hospice care admission. This means that, if the period of palliative or hospice care falls across a **policy anniversary**, the **member** must pay the premium for the subsequent **year** or benefit will cease at the **policy anniversary**. In the event that the costs of the **member's** admission reach the limit shown for this benefit no further benefit will be payable. Once the limit of this benefit is reached no benefit of any kind will be payable in respect of any **medical condition** for which palliative and/or hospice care has been received. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than three hundred sixty-five (365) consecutive days and has effected the annual renewal of the upgraded **plan**. The **waiting period** will apply in the event of an upgrade in cover.
Investigation into Infertility (Plan A only)	**We** will pay for investigation and **treatment** of the cause of infertility. This benefit becomes available and **eligible** claims payable for expenses incurred after the **member** has been continuously covered under **Plan** A for at least eighteen (18) months.
Pre- and post-natal complications	This benefit becomes available and **eligible** claims payable for expenses incurred after the female **member** over the **age** of eighteen (18) years has been continuously covered under their chosen **plan** for three hundred sixty-five (365) consecutive days and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit pays for **treatment** of an **eligible medical condition** which is due to and occurs to the female **member** during the pregnancy prior to or after the childbirth. The list of eligible pre- and post- natal complications include the following: • Antiphospholipid syndrome, • Cervical incompetence, • Ectopic pregnancy, • Gestational diabetes, • Hydatidiform mole – molar pregnancy, • Hyperemesis gravidarum, • Obstetric cholestasis, • Pre-eclampsia / Eclampsia, • Rhesus (RH) factor, • Miscarriage requiring immediate surgical intervention, • Post partum haemorrhage, • Retained placental membrane

	Under post-natal complications, **we** will only pay for **treatment** received within ninety (90) days following the childbirth. This benefit does not cover: • the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or • any pre- and post-complication arising from elective or non-**medically necessary** caesarean section birth. • **treatment** of any **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted means or **assisted conception/assisted pregnancy.** Whilst **we** recognise that caesarean section may sometimes be a medical necessity, caesarean section can only be covered under the Optional add-on 'Normal (Routine) Pregnancy and childbirth' benefit for member insured on Plan A only, subject to compulsory co-insurance 20% per claim.
New born accommodation	This benefit will pay for the child who is less than sixteen (16) weeks old to stay in the **hospital** with the mother (being an insured **member**) while she is receiving **eligible in-patient treatment** at such **hospital**. This is paid from the mother's benefit. The benefit pays for new born nursery accommodation of a standard class, where the new born only receives nursery care during the stay in the **hospital**. This benefit is not payable if the new born is hospitalised for **treatment** of any **medical condition**.
Normal (Routine) pregnancy and childbirth (Plan A only, subject to **co-insurance**)	This benefit becomes available and **eligible** claims are payable for expenses incurred after the **member** has been continuously covered under Plan A for three hundred sixty-five (365) consecutive days **waiting period** and has effected the annual renewal of that **plan** for the coming **policy year**. **We** will pay eighty (80%) percent of the **eligible** expenses up to the benefit limit for routine pre-natal care, **inpatient** childbirth, and routine post-natal care up to forty-two (42) days following the birth. This benefit is only available for female **member** over the age of eighteen (18) years. **We** will also pay for normal, routine pregnancy and inpatient childbirth even when such pregnancy was established through **assisted conception/assisted pregnancy**. This benefit does not cover any expenses related to **assisted conception/assisted pregnancy** including any complications. The limit shown is the maximum **we** will pay under this benefit for each: • **policy year**, even if there is more than one pregnancy in that **policy year**, • pregnancy, even if a pregnancy, which is **eligible** for benefit, falls across the **policy anniversary**, and provided the **policy**, including this benefit, has been renewed for the subsequent **policy year.** For **inpatient** birth through vaginal childbirth and **medically necessary** caesarean section, **we** will pay for the **reasonable and customary** childbirth costs of a standard single room, up to the limit shown for this benefit in the **benefits table**. Any complications of pregnancy will be paid from "Pre- & post-natal complications" benefit. For **inpatient** birth through elective and **non-medically necessary** caesarean section, **we** will pay for the **reasonable and customary** childbirth costs up to the costs of a natural childbirth in a standard single room. 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 limit. Please take note: This benefit is payable when 365 consecutive days membership is achieved by **your member** under this **plan** from the date this cover is attached to **your member**'s plan (whichever is later). This benefit excludes any **treatment** costs that has not yet taken place, even if it being provided as part of a treatment package. This benefit excludes any **treatment** costs that has not yet taken place, even if it being provided as part of a treatment package.

4.3 INTERNATIONAL EMERGENCY MEDICAL ASSISTANCE ('IEMA')

1. This is one of the benefits of **your plan** for an **eligible medical condition**. The **service** is provided by an international assistance company who acts for **us**.

2. The terms and definitions in **your plan** also apply to the **service**, and any limitation of cover for the **service** shown in the **policy schedule** will apply.

   For this section only **we** have given some more words and phrases special meanings. These are:

   (a) **appointed doctor**: a **medical practitioner** chosen by **us** to advise **us** on the **member's medical condition** and/or need for the **service** and/or the suitability and adequacy of the medical facilities in the country where the **member** has been admitted to **hospital**.

   (b) **service**: moving the **member** to another **hospital** which has the necessary medical facilities either in the country where the **member** is taken ill or in another nearby country (evacuation) or bringing them back to their **principal country of residence.**

   (c) **home country**: the country as shown in **our** records which the **member** regards as home, and which issues the **member's** passport.

3. The **service** is available **worldwide** to any **member** who is injured or becomes ill suddenly due to an **eligible medical condition** and needs immediate **hospital treatment** as an **in-patient**. The **service** is only available in these circumstances and as follows:

   (a) if the **member** is admitted to **hospital** while abroad from their **principal country of residence** then, if in the opinion of the **appointed doctor** the medical facilities there are not suitable or adequate, they will be entitled to evacuation or repatriation;

   (b) if the **member** is admitted to **hospital** while in their **principal country of residence** then, if in the opinion of the **appointed doctor** the medical facilities in the **principal country of residence** are not suitable or adequate, the **member** will be evacuated to the nearest place where appropriate **treatment** is available;

   (c) following evacuation, in accordance with 4.3.3(a) or 4.3.3(b) above, the **member** concerned shall be entitled to be returned, by regular scheduled airline unless **we** agree that another means of transport is necessary to his **principal country of residence**.

   Please note: The **member** is not entitled to be repatriated to his **home country** when admitted to **hospital** in his **principal country of residence**. Evacuation will always be to the nearest place where the necessary facilities are available. It follows that a **member** may be evacuated to the **home country** but only if **we** conclude that, on the basis of the medical facts, this is the nearest appropriate destination.

4. The exclusions in the **policy** do not apply to the **service** but will apply to any **treatment** received following repatriation to the **principal country of residence**, or any country to which the **member** has been evacuated. If the **service** is needed, **you** must contact the **emergency** control centre so that immediate help or advice can be given over the phone. Arrangements may then be made for an **appointed doctor** to make all necessary enquiries and arrange to move them if necessary. If an **appointed doctor** thinks it is necessary, then the **service** will be carried out under medical supervision.

5. We must make all the arrangements. The **member** may be transported by air ambulance, by a regular airline or by any other method of transport **we** consider appropriate. **We** will decide on the method of transport and the date and time.

6. (a) In all cases where the **member** is below the **age** of eighteen (18) years, another person, who must be eighteen (18) years or over, may accompany the **member** while they are being moved. **We** will pay the **reasonable and customary** costs of this, including any additional accommodation costs (up to ten (10) nights), when approved by **us**.

   (b) In all cases where, in the opinion of the **appointed doctor**, it is **medically necessary**, another person, who must be eighteen (18) years or over, may accompany the **member** while they are being evacuated. **We** will pay the cost of return travel by regular scheduled airline to the **principal country of residence** (but not **home country**) and accommodation costs (up to ten (10) nights) for one accompanying person. The accompanying person must be one of the **family members** included within this **policy** or, alternatively, the **member's** uninsured partner, brother, sister, parent, or adult child (in which case return will be to the **member's principal country of residence**).

7. If a **member** dies abroad, **we** will bring the body or ashes back to a port or airport in the **principal country of residence** or home country, if the death is caused by an **eligible medical condition.**
   For avoidance of doubt, **we** will not pay for any benefit for IEMA if the **member's** companion or **family member** has not obtained **pre-authorisation** from **us**.

8. The **service** is not available to cover the following:

   (a) any **medical condition** which does not need immediate in-patient **hospital treatment,** or which does not prevent the **member** from continuing to travel or to work; or

   (b) any costs incurred as a result of engaging in or training for any sport for which the **member** receive a salary or monetary reimbursement, including grants or sponsorship (unless the **member** receive travel costs only); or

   (c) **treatment** of injuries sustained from racing of any kind (except foot racing), motorcycling (except daily use for transportation on a paved road), base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.

   (d) if the **member** needs to be moved from a ship, oilrig platform, or similar offshore location;

   (e) if, at the time the need for the **service** arises, the **member** is insured or, if this insurance did not exist, would be insured against those costs by an existing insurance policy or policies;

   (f) any costs that **we** do not approve beforehand;

   (g) if **we** have not been told about the **accident** or **illness** for which the **service** is needed within thirty (30) days of ~~it~~ the condition happening;

   (h) at the time of travel the **member** is travelling to a country or area that the Singapore Ministry of Foreign Affairs or UK Foreign and Commonwealth Office lists as a place which, for any reason, it advises against all travel or advises against all travel on holiday or non-essential business.

   (i) any costs incurred which arise from or are directly or indirectly caused by a deliberately self-inflicted injury, suicide, or an attempt at suicide.

   (j) any costs incurred which arise from or are in any way connected with, alcohol abuse, drug abuse or substance abuse.

(k) any cost incurred as a result of nuclear, biological, or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed or contributed by an act of terrorism.

9. (a) **We** will not be liable for any failure to provide the **service** or for any delays in providing it unless the failure or delay is caused by **our** negligence.

(b) **We** will not be liable for failure or delay in providing the **service**:
(i) if, by law, the **service** cannot be provided in the country in which it is needed; or
(ii) if the failure or delay is caused by any reason beyond **our** control including but not limited to strikes, flight conditions and/or visa restrictions.
(iii) **We** are not liable for **injury** or death caused to the **member** while he or she is being moved unless it is caused by **our** negligence.

10. Benefits for any **treatment** received by the **member** following repatriation or evacuation will be paid as set out in terms and condition of the **member's plan**.

11. Any unused portion of a **member's** travel ticket, and that of any accompanying person, will immediately become **our** property and must be given to **us**.

How the service works:

When the member is away from his principal country of residence

In the event of **member** suffering sudden **illness** or **injury** whilst away from his **principal country of residence** and requiring immediate **in-patient treatment**, the **member** should contact the emergency control centre.

The emergency control centre will assess the situation and advise if evacuation of the **member** is appropriate.

If the emergency control centre advises that evacuation of the **member** is appropriate, they will make all the arrangements to get the **member** to the nearest place where appropriate services are available and where he/she will be treated in accordance with the benefits of his **plan**.

If the **member** is under eighteen (18) years of **age**, or in other cases where the emergency control centre considers that the **member's medical condition** makes it appropriate, another person over the **age** of eighteen (18) years may accompany the **member** while they are being moved.

When the member is in his principal country of residence

In the event of the **member** requiring **in-patient treatment** which is not available within his **principal country of residence**, the **member** should contact the emergency control centre.

The emergency control centre will assess the situation and decide if it is necessary to evacuate the **member** to another **hospital** where the necessary services are available.

If the emergency control centre considers it is necessary to evacuate the **member**, it will make all the arrangements to get the **member** to a suitable place for the **treatment** to take place. This may be in another country.

Once evacuated the **member** will be treated in accordance with the benefits of his **plan**.

If the **member** is under eighteen (18) years of **age**, or in other cases where the emergency control centre considers that the **member's medical condition** makes it appropriate, another person over the **age** of eighteen (18) years may accompany the **member** while he is being moved.

Important

All cases must be assessed by the emergency control centre to be deemed necessary for evacuation and/or repatriation, and all arrangements must be made by the emergency control centre in order to ensure that related costs are covered by the **service**.

If **member** (or his **family member**) makes his own arrangements, its costs will not be covered. Entitlement to the **service** does not mean that the **member's treatment** following evacuation or repatriation will be **eligible** for benefit. Any such **treatment** will be subject to the terms and conditions of **your plan**.

The emergency control centre

Member can contact the emergency control centre **24 hours** a day, **7 days** a week, **52 weeks** of the year.

When in contact with the emergency control centre, the **member** will need to state that they are a **member** of International Exclusive **plan** and give their **policy** number.

24-Hours Hotline: **+65 6880 4944**

This **service** is provided by an international assistance company who acts for **us**.

Section 5: Important information about the member's plan

5.1 Our policy on changing the member's level of cover or moving to another plan

We will not allow **members** to upgrade or downgrade their level of cover or change the **deductible** except at each **policy anniversary** and if requested, it must be informed to **us** in writing.

You may apply to **us** to change the **plan** type or **deductible** of **your policy** by sending **us** a written request on **our** prescribed form. Such application must be made at least thirty (30) days prior to any policy anniversary, provided that:

- the **plan** type or **deductible** applied for is still available at the time of **your** application:
- the **member** is within the eligibility age limit for that **plan** type; and
- the **member** pays any additional premiums applicable for the new **plan** type.

We reserve the right to refuse any request to upgrade or amend cover. **We** will not pay upgraded benefit levels for **treatment** of any **medical condition** which arose or should reasonably have been foreseen by the **member** prior to the upgrade becoming effective.

Members are required to declare any such **medical condition** to **us** when requesting the upgrade. Where such a **medical condition** is, or becomes apparent, benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade.

In any event, final acceptance of any amendment by **us** and particularly the application of upgraded benefits (must be confirmed by **us** in writing) will only be made at the next renewal following such a request. Neither amendments nor upgrades can be made during the **year**.

5.2 What to do if you wish to add or delete members to your policy

If **you** want to add someone else to an existing **policy** or delete an existing **member, you** must inform **us** in writing and give all the information **we** request. For eligibility of cover, please refer to Section 2- 'Eligibility'.

All applications for adding **members** are subject to **our** acceptance. The additional **member's policy anniversary** will be the same as that of the original **policy** issued to the **policyholder** if the inclusion of the additional **member is** a newborn child or a newly married spouse. For deletion of **member**, **we** will refund premium for such **member** if he has not incurred any claim.

5.3 What happens if members change their principal country of residence

You must tell **us** if **members** change their **principal country of residence** (where **member** lives for most of the **year**), even if they are staying in the same **area of cover** as this may affect their eligibility. **You** must inform **us** within thirty (30) days of such change.

When **you** or **your member** moves to a **principal country of residence** outside the current **area of cover** and provided, **we** can continue to cover such **member**, **we** will change the **member's plan** accordingly as soon as **we** receive the information of change of country of residence. A pro-rata premium adjustment will be made.

If **you** do not tell **us**, **we** can refuse to pay benefits and /or terminate the **policy**.

5.4 What happens if members return to their home country?

Members who are Singaporean nationals will be able to renew policy if they return to home country (Singapore).

Members who are not Singaporean nationals and are returning to their home country to live, will not be able to keep on renewing the **policy. We** will provide cover until the policy expiry date where **members** cease to be **eligible** under the **policy.**

5.5 What happens if you wish to cancel your policy

You have a free-look period of fourteen (14) business days from the date that **you** receive this **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** documents 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. This free-look period shall not apply to policies with terms of less than one (1) **year** and **policy** renewals.

In addition, **you** may cancel **your policy** at any time by giving **us** no less than thirty (30) days' notice in writing. This is an annual contract and, **we** will not refund premiums if any claim, however small, has been made in the current **policy year**. In the event that **we** do agree to make a refund (and this will be at **our** sole discretion), **we** will only refund premiums on a pro-rata basis from the end of the Gregorian calendar month in which cancellation takes effect and provided **you** have returned to **us** the **policy** documents.

Please note:

(a) no claim of any kind will be considered after notification by **you** and acceptance by **us** of any cancellation; and

(b) for members covered under Plan A, any cancellation may affect the claim payout of 'Pregnancy and Childbirth' benefit.

5.6 What happens if we wish to cancel your policy

We may cancel **your policy** at any time by giving **you** no less than thirty (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**.

There shall be no premium refund if the **policy** has been in-force for more than one hundred and eighty (180) consecutive days irrespective if a claim has been made under the **policy**.

5.7 When the terms of your policy might change

We have the right to cancel or change all or any part of **your policy** from any **policy anniversary**. **We** will not change the terms of **your policy** alone simply as a result of **your** personal claims. However, **we** will make changes only to reflect any past or foreseeable changes in medical practice or procedures and the type, and frequency of claims. The purpose of such changes will be to seek, as far as possible, to maintain substantially the same level and type of cover in place while ensuring that the **plan** remains affordable.

We may also change premiums if costs, taxation, regulations, or benefit changes makes this necessary. In the event that **we** are required by law to make a change during the **policy year**, for example if a new tax is introduced, **we** will be obliged to do so before the next renewal date.

We do reserve the right to apply underwriting terms to **your policy** at any time if a **medical condition** that should reasonably have been declared comes to **our** attention.

5.8 Our approach to cancer care

Where oncology **treatment** and related **eligible** expenses apply to a **medical condition** arising after the date of acceptance of a **member**, by **us**, such costs will be payable out of the overall limits 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** is 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 the **member** first being accepted by **us** for cover, 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 are not classed as active **treatments**) will be paid for under the **out-patient treatment** benefit where available under **your plan**. Preventative medical examinations or routine follow-up consultations when the **member** does not have symptoms of **cancer** will be paid under the 'Health screen' benefit.

Plan C does not provide cover for maintenance of any **treatment** received as an **out-patient**.

Other than Radiotherapy and Chemotherapy, **we** cover:

- Proton Beam Therapy (PBT) under limited circumstances, and these are mentioned in Section 4 – What you are covered for.
- Advanced therapies, which is a complex set of **cancer treatment**, these therapies are also known by different names across the world, for example Advanced therapy medicinal products (ATMPs), Cellular and gene therapy products (CGTPs) or Regenerative medicine advanced therapy (RMAT). There is a small number of ATMPs/ CGTPs/ RMATs **we** can cover under your policy, and these are mentioned in Section 4 – What you are covered for.

We do not cover any other proton accelerated therapies, ATMPs/CGTPs/RMATs and CAR-T treatment that are not on the list at the time **your member** needs the treatment, including any associated hospital or specialist costs. The lists are subject to change so you should always check and call **us** before **your member** starts any treatment.

5.9 Full cover for kidney dialysis

Where kidney dialysis **treatment** and related **eligible** expenses apply to a **medical condition** arising after the date of acceptance of a **member**, by **us**, such costs will be payable out of the overall limits 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 the **member** first being accepted by **us** for cover, will be subject to the terms and limits applying to the benefit for '**Pre-existing conditions**' shown in the clarifications and **benefits table**.

5.10 Full cover for chronic conditions

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.

Plan A and B provide cover for the maintenance of **chronic** conditions first arising after **you** have been accepted as a **member** and received as an **out-patient**.

Plan C provides only Hospitalisation cover including pre- and post-hospitalisation, therefore, generally does not provide cover 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**.

5.11 Joining and renewing

(a) All **pre-existing conditions** must, in good faith, be declared to **us**, in writing, at the time of application unless **we** had agreed otherwise that there was no need for **you** / the **member** to tell **us**. Please also note that the entire application may be declined in view of the **member**'s **pre-existing conditions**.

We will tell **you** in writing about the date **your policy** starts, any special terms which apply to it and if **we** refuse to give cover.

(b) Only those people listed in the **policy schedule** are considered **members** of this **policy**. All cover applicable to a **member** ends, if **you** decide to end the cover.

(c) **Your policy** is for one **year** unless **we** have agreed something different. At the end of that time, provided the **plan you** and **your members** 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. **You** will be bound by those terms. This shall not apply in the event that the **policy** expires or is terminated or cancelled in accordance with the terms of this **policy** and **you** can subsequently wish to reapply for insurance cover under this **policy**. If **we** are unable to renew **your policy** at any **policy anniversary**, **we** will provide **you** thirty (30) days' notice and will send the details to the address **we** have on **our** records.

(d) Premium rates are not guaranteed and the premium payable at each renewal shall be determined 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. **You** must pay the premium when it is due, and the premium paid shall not be less than the premium amount stated in the renewal notice. The renewal notice is for **your** information only and does not prejudice **your** liability to pay the renewal premium on or before the **policy anniversary**. **We** will decide the amount at the start of each **year** and tell **you** how much it is. **You** can pay it in the way **you** have agreed with **us**. It is hereby agreed and declared that the total premium due must be paid and actually received in full by **us** (or the intermediary through whom this **policy** was effected), on or before the inception date of the coverage under the **policy**, Renewal Certificate, Cover Note or Endorsement.

In the event that the total premium due is not paid and actually received in full by **us** (or the intermediary through whom this **policy** was effected),on or before the inception date referred to above, then the **policy**, Renewal **policy**, and Endorsement (if any) shall be deemed to be cancelled immediately and no benefits whatsoever shall be payable by **us**. Any payment received thereafter shall be of no effect whatsoever on the cancellation of the **policy**, Renewal **policy**, and Endorsement.

(e) **We** can change all or any part of the **policy** including the **policy schedule** or these terms, and the changes will only apply upon renewal unless **we** are obliged by law to apply any change with immediate effect. **We** will provide **you** thirty (30) days' notice of the changes and will send the details to **your** address in **our** records. The changes will take effect even if, for any reason, any **member** did not receive these details.

5.12 Reinstatement

The **policy** will terminate if the premium due is not paid.

If the **policy** or any cover issued to a **member** is terminated, the **policyholder** may write to **us** to apply for reinstatement within ninety (90) days from the last premium due date. Please note that such reinstatement is subject to **our** approval. If the application for reinstatement is approved, **we** may impose conditions on the reinstated **policy** or cover and also, **you** must pay all the outstanding premium **you** owe to **us** before **we** reinstate **your policy**. **We** will only pay for eligible claim incurred after **we** have reinstated your **policy** i.e., no benefit shall be payable for any eligible claim incurred between the last premium due date and the date **we** approve **your** reinstatement application.

If **you** have opted to pay **your** premiums on an annual basis, the last premium due date is on the renewal date.

We may also refuse to reinstate **your** policy and **we** will inform **you** in writing if **we** do so.

5.13 General Conditions

Notwithstanding anything to the contrary contained in this **policy** , these General Conditions apply to **you** and the **members,** and they are, where their nature permits, condition precedent to the right to recover from **us**:

(a) If **you** or the **member** breaches any of the terms of the **policy** or makes, or attempts to make, any dishonest claim, **we** can:

- refuse to make any payment; and
- refuse to renew **your policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- terminate **your policy** including all covers under it immediately, and the premiums **you** have paid will be retained by **us**.

When fraud is detected, **we** shall also recover any claims paid.

(b) **You** must make sure that all the information given to **us** is true, accurate and complete. If it is not, then **we** can cancel the **policy** or apply different terms of cover.

(c) **You**, the **member** or his representatives shall co-operate fully with **us** and **our** medical team (including the independent **appointed medical practitioner**) and fully and faithfully disclose all material facts which **you** and/or the **member** knows or ought to know. If **we** request for relevant information, document or a report from any **medical practitioner** or **hospital** or clinic or other source, any expense incurred as a result of such result shall be borne by **you** or **your member**.

(d) The **policy** will not provide compensation cover other than on a proportionate basis if **you** or the **member** has any other insurance in force or is entitled to indemnity from any other source in respect of the same **injury** or **illness**.

(e) **We** have full rights of subrogation and may take proceedings in the **policyholder** or **member's** name, but at **our** expense, to recover the amount of any payment made under the **policy** and/or to secure an indemnity from a third party.

(f) It is hereby declared that as a condition precedent to **our** liability, the **policyholder** and the **member** have agreed that any personal information in relation to the **policyholder** and the **member** provided by or on behalf of the **members** to **us** may be held, used, and disclosed to enable **us** or individuals/organisations associated with **us** or any independent thirty party (within or outside Singapore) to:

i. process and assess the **member**'s application or any matter arising from the **policy** and any other application for insurance cover, and/or

ii. provide all services under the **policy**.

(g) **We** shall not be bound to take notice of any trust, charge, lien, assignment, or other dealing with or relating to this **policy**, but the payment by **us** to the **policyholder/member**, his nominee or legal representative, as the case may be, of any compensation or benefit under the **policy** shall in all cases be an effectual discharge to **us**.

(h) You must notify **us** in writing if **you** or **your member** change address. If **you** are acting on behalf of **your member** covered under the **policy**, **we** will send all correspondence about the **policy** to **your** address.

(i) In an event of a dispute, **you** or the **member** must refer to the complaints procedure set out in Section 9 - 'if any problems arise'.

(j) This **policy** is governed by the laws of Singapore.

(k) All disputes arising out of this **policy** may be submitted to the Financial Industry Disputes Resolution Centre Ltd (FIDReC) for settlement by mediation and/ or adjudication in accordance with the mediation and/or adjudication procedure for the time being in force if the parties so agree. The parties must agree to take part in the mediation and/or adjudication in good faith and undertake to honour the terms of any settlement reached.

If any dispute is not referred to FIDReC or if mediation and adjudication fails in FIDReC, the dispute has to be referred to arbitration. Arbitration shall be conducted in accordance with the Arbitration Rules of the Singapore International Arbitration Centre.
The arbitration shall be in English and heard by a single arbitrator to be agreed by the parties within fourteen (14) days from the notice of arbitration failing which the arbitrator shall be appointed in accordance with and subject to the provisions of the Arbitration Rules (as may be amended from time to time).

Where any dispute is by this condition to be referred to arbitration, the making of an award shall be binding to **you** and **us**.

(l) The terms of **your policy** cannot be changed nor claims authorisation given by any verbal communication between **you** and **us** will be accepted. Any changes, approvals, or other statements relating to **your policy** must be confirmed, in writing, by **us**. **We** are not bound by any verbal commitment not confirmed by **us** in writing.

(m) The validity of this **policy** is subject to the condition precedent that:
   i. for the risk insured, the **member** has never had any insurance terminated in the last twelve (12) months due solely or in part to a breach of any premium payment condition; or
   ii. if **you** have declared that **you** have breached any premium payment condition in respect of a previous policy taken up with another insurer in the last twelve (12) months; **you** should:
      (aa) have fully paid all outstanding premium for time on risk calculated by the previous insurer based on the customary short period rate in respect of the previous policy; and
      (bb) provide a copy of the written confirmation from the previous insurer to this effect is first provided by **you** to **us** before cover incepts.

(n) Subject to the other terms of this **policy**, cover under this **policy** for the respective **member** shall also automatically terminate on the earliest occurrence of any of the following events:
   i. the date the **policy** is terminated;
   ii. the date a **member's** coverage is terminated;
   iii. death of such **member**;
   iv. the **principal country of residence** of the **policyholder** or **member** is no longer Singapore unless otherwise agreed by **us** in writing;
   v. non-payment of premium for this **policy**;
   vi. if there shall be any misrepresentation, non-disclosure, or fraud on the part of the **policyholder** and/or **member**;
   vii. if there is a breach of any regulation and/or law and/or economic sanctions.

Termination of **your policy** shall automatically terminate cover for all **members** as well.

5.14 Legal Actions

You cannot bring an action at law or in equity to recover under this **Policy**:

(a) within ninety (90) days from the date on which a claim is made and all documentary proof and information have been submitted to **us** in accordance with the requirements of Section 7- 'Understanding how to get the best from your plan', below; or

(b) after one (1) Year from the expiry of the **permissible claim period**.

5.15 Illegality Clause

Under no circumstances shall this **policy** be deemed to provide cover and no liability be incurred to pay or provide any benefit hereunder to the extent that the provision of such Cover, payment of such claim or provision of such benefit would cause **us** to be in breach of, or expose **us** to any prohibition, or restriction under the laws or regulations of Singapore.

5.16 Sanction Clause

This **policy** may provide cover for **members** residing outside of Singapore, however, in most cases **we** cannot cover the **member** if he/she is a national of his/her resident country (other than Singapore). In addition, country specific regulations may impact a person's eligibility to be a **member**. HSBC Life may be required to apply legitimate international sanctions to this policy. In such a case HSBC Life may be unable to meet its full obligations under the terms of this policy where to do so would render it subject to legal action under international or domestic law. HSBC Life may be required to apply legitimate international law. **We** and other service providers will not provide cover or pay claims under this policy if doing so would expose **us** or the service provider to a breach of international economic sanctions, laws, or regulations, including but not limited to those provided for by the European Union, United Kingdom, United States of America, Singapore or under a United Nations resolution. If a potential breach is discovered, where possible **we** will advise **you** in writing as soon as **we** can.

5.17 Tax Compliance

You acknowledge **you** are solely responsible for understanding and complying with **your** tax obligations (including but not limited to, payment of any tax deduction or withholding tax or filing of returns or other required documentation relating to the payment of all relevant taxes) and other payment obligations in accordance with the applicable laws in all jurisdictions in which those obligations arise and relating to the opening and use of account(s) and/or **Services** provided by **us** and/or members of the **HSBC Group**. Certain countries may have tax legislation with extra-territorial effect regardless of **your** place of domicile, residence, citizenship, or incorporation. **We** and/or any member of the **HSBC Group** do not provide tax advice. **You** are advised to seek independent legal and/or tax advice. **We** and/or any member of the **HSBC Group** have no responsibility in respect of your tax obligations in any jurisdiction which they may arise including, without limitation, any that may relate specifically to the opening and use of account(s) and/or **Services** provided by **us** and/or members of the **HSBC Group**.

With regard to **your** obligation to pay any tax deduction or withholding tax under any applicable law at any time with respect to **your** payment of premium or other amounts made to **us**, then **you** are liable (i) to pay **us** the premium and/or such other amounts as if no such deduction or withholding have been made; (ii) to pay the full amount of such deduction or withholding to the relevant taxation authority or other authority in accordance with applicable law; and (iii) to provide **us** with the evidence of such payment. **Your** payment of premium and other amounts made to **us** hereunder shall be made without any deduction or withholding and free of any set off or counterclaim.

5.18 Financial Crime Risk Management Activity

We, and members of the **HSBC Group**, are required, and may take any action considered appropriate, to meet **Compliance Obligations** in connection with the detection, investigation, and prevention of **Financial Crime** ("**Financial Crime Risk Management Activity**"). Such action may include, but is not limited to:

i. screening, intercepting, and investigating any instruction or communication by **you** or a **Connected Person**, or on **your** or a **Connected Person**'s behalf;

ii. investigating the source of or intended recipient of funds;

iii. combining **Customer Information** with other related information in the possession of the **HSBC Group**; and/or

iv. making further enquiries as to the status of a person or entity, whether they are subject to a sanction's regime or confirming **your** or **Connected Person**'s identity and status.

To the extent permissible by law, neither **we** nor any other member of **HSBC Group** shall be liable to **you** or any third party in respect of any loss whether incurred by **you** or a third party in connection with the delaying, blocking, or refusing of any payment or the provision of all or part of the **Services** or otherwise as a result of **Financial Crime Risk Management Activity**.

For the purpose of the clauses 5.17, 5.18 and 5.21 under this section, the following additional definitions shall apply:

(a) **Authorities** - any judicial, administrative, or regulatory body, any government, or public or government agency, instrumentality or authority, any **Tax Authority**, securities or futures exchange, self-regulatory organization, trade repositories, court, central bank or law enforcement body, or any agents thereof, having jurisdiction over any part of the **HSBC Group**.

(b) **Beneficiary** - The person or entity entitled to receive the benefits as they become due.

(c) **HSBC Group -** HSBC Holdings plc, and/or any of its affiliates, subsidiaries, associated entities and any of their branches and offices, and any member of the **HSBC Group** has the same meaning.

(d) **Compliance Obligations** - Obligations of any member of the **HSBC Group** to comply with: (i) any applicable local or foreign statute, law, regulation, ordinance, rule judgement, decree, voluntary code, directive, guidelines, administrative requirements, sanctions regime, court order, agreement between any member of the **HSBC Group** and an **Authority**, or agreement or treaty between **Authorities** and applicable to HSBC or a member of the **HSBC Group** ("**Laws**"), or international guidance and internal policies or procedures, (ii) any demand from **Authorities** or reporting, regulatory trade reporting, disclosure or other obligations under **Laws**, and (iii) **Laws** requiring HSBC to verify the identity of **our** customers.

(e) **Connected Person** - A person or entity other than **you** whose information (including **Personal Data** or **Tax Information**) is provided by, or on behalf of, **you** to any member of the **HSBC Group** or otherwise received by any member of the **HSBC Group** in connection with the provision of the **Services**. A **Connected Person** may include, but is not limited to, any person identified as a **Beneficiary** under the policy, any person who is, or may be entitled to receive a payment under the policy, a director or officer of a company, partners or members of a partnership, any **Substantial Owner**, **Controlling Person**, or beneficial owner, director, trustee, settlor or protector of a trust holding or controlling (directly or indirectly) the policy, any of **your** representatives, agents or nominees, or any other persons or entities having a relationship to **you** that is relevant to **your** relationship with **HSBC Group**.

(f) **Controlling Person** - Individuals who exercise control over an entity (for a trust, these are the settlor, the trustees, the protector, the **Beneficiaries** or class of **Beneficiaries**, and any other individual who exercises ultimate effective control over the trust and in the case of a legal entity other than a trust, such term means persons in equivalent or similar positions of control).

(g) **Customer Information** - Either **your Personal Data**, confidential information, and/or **Tax Information** or that of **your Connected Person**.

(h) **Data Privacy Policy-** Our policy on how **we** collect, use and disclose **Customer Information**, which may be found on **our** website, and as may be amended from time to time.

(i) **Financial Crime** - Money laundering, terrorist financing, bribery, corruption, tax evasion, fraud, evasion of economic or trade sanctions, and/or violations, or attempts to circumvent or violate any **Laws** or regulations relating to these matters.

(j) **Financial Crime Risk Management Activity** - As defined in Clause 5.18 above.

(k) **Personal Data** - Any data relating to an individual, whether true or not, from which the individual can be identified, whether with other data or other information **we** are likely to have access to or otherwise, including, without limitation, sensitive personal data.

(l) **Services** - (Without limitation) (i) the sale, underwriting, acceptance and maintaining of the policy, (ii) the provision of services relating to the policy and its termination or expiry, and (iii) the maintenance of **our** overall relationship with **you**, including reinsurance, insurance, audit, and administrative purposes.

(m) **Substantial Owner** - Any individual entitled to more than 10% of the profits of or with an interest of more than 10% in an entity either directly or indirectly.

(n) **Tax Authorities** - Domestic or foreign tax, revenue, fiscal or monetary authorities or agencies.

(o) **Tax Certification Forms** - Any forms or other documentation as may be issued or required by a **Tax Authority** or by **us** from time to time to confirm **your**, or a **Connected Person**'s, tax status.

(p) **Tax Information** - Any documentation or information (and accompanying statements, waivers and consents) relating, directly or indirectly, to **your**, or a **Connected Person**'s tax status (regardless of whether **you** or such **Connected Person** is an individual or a business, non-profit or other corporate entity) and any owner, **Controlling Person**, **Substantial Owner** or beneficial owner of **you** or a **Connected Person**, that **we** consider, acting reasonably, is needed to comply (or demonstrate compliance, or avoid non-compliance) with any **HSBC Group** member's obligations to any **Tax Authority**. **Tax Information** includes, but is not limited to, information about: tax residence and/or place of organisation (as applicable), tax domicile, tax identification number, **Tax Certification Forms**, certain **Personal Data** (including name(s), residential address(es), age, date of birth, place of birth, nationality, citizenship).

5.19 Accuracy of Information

If the age or date of birth or other relevant facts relating to the **member** shall be found to have been misstated and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of this **policy**, the true age and facts shall be used in determining whether insurance is in force under the terms of this **policy** and the benefits payable therefrom, and an equitable adjustment of premiums shall be made.

Where a misstatement of age or other relevant facts has caused the **member** to be insured hereunder where he is otherwise ineligible for any insurance, or where such statement has caused the **member** to remain insured when he would otherwise be disqualified in accordance with the terms and limitations of this **policy**, the **member's** entire cover shall be void and there shall be a refund of premiums paid in respect of the **member**, provided always that where there is fraud on the part of the **you** or the **member**, no premiums paid are to be refunded.

5.20 Incontestability

Without prejudice to Section 5, Clause 5.21, where more than two (2) years have passed since:

i. (in respect of **you**) the later of the **policy commencement date** and the last reinstatement Date (if any); and
ii. (in respect of the **member**) the later of the relevant **member**'s **policy commencement date** and the last reinstatement date (if any) of such relevant **member**,

we will not contest the validity of the **policy** or the cover of a relevant **member** (as the case may be) and any valid claim for payment of benefits for such relevant member unless:

(a) there is fraud involved;
(b) there is material non-disclosure and/or misrepresentation as described under Section 5, Clause 5.19;
(c) there is any outstanding premium(s); or
(d) the claim is excluded under this policy.

5.21 Data Privacy

We, other members of the **HSBC Group** and/or **HSBC Group's** authorised service providers may collect, use and share **customer information** (including relevant information about **you**, the **member**, a **Connected Person**, **your** and the **members'** use of HSBC's products and services, and **your** and the **member** relationships with the **HSBC Group**) for the purposes set out in **our Data Privacy Policy** (the "Purposes"). **Customer Information** may be requested from **you**, the **member** or a **Connected Person** (or a person acting on **your** and the **members'** behalf or on behalf of a **Connected Person**), or may also be collected by or on behalf of **us**, or members of the **HSBC Group**, from other sources (including from publically available information), generated or combined with other information available to **us** or any member of the **HSBC Group**.

You and the **members** agree to inform **us** promptly, and in any event, within 30 days in writing if there are any changes to **Customer Information** supplied to **us** or a member of the **HSBC Group** from time to time, and to respond to any request from, **us**, or a member of the **HSBC Group**. **You** and the **members** confirm and warrant that every **Connected Person** whose information (including **Personal Data** or Tax Information) has been provided to **us** or a member of the **HSBC Group** has been notified of and agreed to the collection, use and disclosure of their information as set out in **our Data Privacy Policy**. **You** and the **member** shall advise **Connected Persons** that they may have rights of access to, and correction of, their **Personal Data**. **We** reserve the right to require **you** and the **member** to produce documentary proof of the consents obtained from such **Connected Persons**, upon **our** reasonable request made from time to time.

Notwithstanding Section 5, Clause 5.20, where:

(a) **You**, the **member** or a **Connected Person** fail to provide **Customer Information** that **we** reasonably request; or
(b) **You**, the **member** or a **Connected Person** withhold or withdraw any consents which **we** may need to process, transfer or disclose **Customer Information** for the Purposes; or
(c) **We** or a **member** of the **HSBC Group** has suspicions regarding the possible commission of Financial Crime or **you** and the **member** present a potential **Financial Crime** risk to a member of the **HSBC Group**,

We may:

(a) be unable to provide new, or continue to provide all or part of the, Services to **you** and the **member**;
(b) take actions necessary for **us** or a member of the **HSBC Group** to meet the **Compliance Obligations**; and/or
(c) terminate the policy or the **member's** cover if **we** reasonably consider that by continuing the policy and/or the relationship with **you** and/or the **member**, **we** may break any Laws or **we**, or a member of the HSBC Group, may be exposed to action or censure from any Authority. Any termination will take effect as a surrender of the policy.

In addition, **your** and the **members'** failure to supply **your**, the **members'** or a **Connected Person's**, **Tax Information** and accompanying statements, waivers and consents, may result in **us** making **our** own decision with respect to **your**, the **members**' or a **Connected Person's** status, including whether to report **you**, the **member** or such **Connected Person** to a **Tax Authority**, and may require **us** or other persons to withhold amounts as may be legally required by any **Tax Authority** and paying such amounts to any **Tax Authority**.

Section 6: Exclusions and Limitations - What is not covered

6.1 The following tests, investigations, **treatments**, items, charges, conditions, activities and their related or consequential expenses are excluded from this **policy,** and **we** shall not be liable for:

(a) **pre-existing condition** as defined, including any **treatment** and complication arising from the **pre-existing condition**, and its **associated medical conditions** unless allowed for by the **benefits table** and accepted by **us** in writing;

(b) non-surgical **treatment** of a **medical condition** which does not respond quickly to **treatment,** or which continues or recurs unless allowed for and stated in the **benefits table** and accepted by **us** in writing;

(c) any **treatment** which only offers temporary relief of symptoms rather than dealing, when it is reasonable to do so, with the underlying **medical condition**;

(d) normal pregnancy or childbirth (unless **you** have opted for the Optional add-on Benefit); caesarean section and any complications related to it;

(e) pregnancy, childbirth (delivery) or caesarean section unless this is specifically included in the **benefits table** of this policy, or pregnancy as a result of any form of **assisted conception** and any complications;

(f) **treatment** begun, or for which the need had arisen, during the first ninety (90) days after birth for any child conceived by **assisted conception/assisted pregnancy**;

(g) termination of pregnancy or any consequences of it, except where **eligible** under the 'Pre- and post-natal complications' benefit;

(h) investigations, diagnostics and **treatment** of infertility, impotence, contraception, assisted pregnancy, sterilization (or its reversal) or any consequence of any of them or of any **treatment** for them or any **treatment** at any fertility and/or reproductive clinic or medical facility unless allowed for by the **benefits table** and accepted by **us** in writing;

(i) investigations, diagnostics, and treatment of asymptomatic varicocele, or when varicocele treatment is not medically necessary or is considered by **us** as a personal choice or when it is traceable whether directly or indirectly to infertility;

(j) **treatment** of sexually transmitted diseases;

(k) gender dysphoria or gender identity disorder, gender re-assignment or gender confirmation including treatment which arises from or is directly or indirectly made necessary by a gender re-assignment or gender confirmation in any way that includes psychiatric, psychological and physical health conditions, hormone therapy, psychotherapy, any counselling or similar services, gender affirming procedures, operations or surgical treatment, the recovery from these operations, any associated hospital or specialist costs and other forms of treatment and preparation. Any complications arising out of such treatment is also excluded;

(l) **treatment** of any **medical condition** which arises in any way from Human Immunodeficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS) unless allowed for by the **benefits table** and accepted by **us** in writing;

(m) investigations or **treatment** of obesity (Body Mass Index or BMI equal to 35 and above) or any **medical condition** which arises from, or is related to, obesity in any way including but not limited to the use of gastric banding or stapling;

(n) the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons; weight improvement; supplements or medications for weight loss or weight improvement or any slimming aids;

(o) the costs of collecting donor organs for transplant surgery or any administration costs involved even if such transplants are allowed by the terms of this **plan**; ; transplants involving mechanical, or animal organs are also excluded;

(p) **treatment** which arises from or is directly or indirectly caused by a deliberately self-inflicted **injury** or an attempt at suicide; misuse or over dosage or excessive use of drugs/medicine; consumption of alcohol, drugs or solvents impairing physical ability or judgement;

(q) course, program, or **treatment** which arises from or is in any way connected with alcohol abuse, drug abuse, nicotine or smoking dependence, abuse, misuse or over dosage of medicine or any kind of substance;

(r) any **treatment** to correct refractive defects of the eyes such as long or short-sightedness or astigmatism, laser / Lasik eye surgery unless allowed for by **your plan**;

(s) parenting classes or other teaching classes such as but not limited to slimming, ante or post-natal classes; all types of courses or programs;

(t) **treatment** relating to neurological development, cognitive development, learning disorders, speech delay, educational problems, behavioural problems, developmental milestones, physical development, or psychological development, including assessment or grading of such problems. This includes but not limited to problems such as dyslexia, dyspraxia, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech and language problems;

(u) preventive (i.e.: prophylactic) **treatment**

(v) **treatment** to relieve symptoms commonly associated with any bodily change arising from any physiological or natural cause such as ageing, menopause or puberty and which is not due to any underlying disease, **illness,** or **injury**;

(w) vaccinations and routine or preventative medical examinations, hearing examination and corrective **treatment,** including routine follow-up consultations, unless allowed for by the **benefits table** and accepted by **us** in writing;

(x) costs of providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment unless allowed for by the **benefits table**;

(y) **out-patient** drugs or dressings except those defined as **prescriptions**, and where **your policy** provides this cover;

(z) orthodontics, periodontics, endodontics, preventative dentistry, and general dental care including fillings, no matter who gives the **treatment** unless provided for by **your plan** and agreed, in writing, by **us**;

(aa) claims in respect of **treatment** received outside the **area of cover** or if the **member** travelled against medical advice even if it is within the **area of cover**;

(bb) any costs incurred as a result of engaging in or training for any sport for which the **member** receives a salary or monetary reimbursement, including grants or sponsorship (unless the **member** receives travel costs only);

(cc) **treatment** of injuries sustained from racing of any kind (except foot racing), motorcycling (except daily use for transportation on a paved road), base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, hot air balloon, diving to a depth of more than twenty (20) metres, trekking to a height of over three thousand and five hundred (3,500) metres, free climbing, mountaineering with or without ropes, bungee jumping, canyoning, hang gliding, paragliding or microlighting, parachuting, potholing;

We will not pay for **treatment** of injuries sustained from martial arts, scuba diving to a depth of more than ten (10) metres, trekking to a height of over two thousand and five hundred (2,500) metres, or skiing off piste or any other winter sports carried out off piste, unless:

i. the **member** is not performing such activity alone and;
ii. the **member** is accompanied by a locally qualified and accredited guide or instructor or if the **member** is qualified, he or she is performing this activity within the guidelines of the relevant agency or organisation and;
iii. the **member** is not engaging in such activity against medical advice and;
iv. the **member** is not engaging in such activity against local authoritative warning or advice and;
v. the **member** is taking all reasonable precautions and using appropriate equipment when engaging in such activity;

(dd) any **treatment** specifically excluded by the terms shown on **your** policy schedule/endorsement forming part of this **policy**; any charges for items not listed in the **benefits table** and/or **policy schedule** applicable to **your plan** or failure by the **member** to obtain **pre-authorisation/pre-approval** from **us** prior to **treatment** (where applicable);

(ee) any charges which are incurred for personal, social, or domestic reasons or for reasons which are not directly connected with **treatment**;

(ff) any charges for **treatment** incurred before the **policy commencement date**, even if the period of hospitalisation or related **treatment** occurred on or after the policy commencement;

(gg) any charges from health hydros, spas, fitness centre, or any similar place, even if it is registered as a **hospital**;

(hh) any charges from nature cure clinics (or practitioners) or any similar place, even if it is registered as a **hospital** unless provided for by **your plan;**

(ii) any claim or part of a claim for which **you/**the **member** have to pay an excess (or **deductible** or **co-insurance**). In this case **we** will only pay the balance of the claim after **we** have deducted the excess (or **deductible** or **co-insurance**) amount;

(jj) **in-patient** charges for any **hospital** which are not **reasonable and customary** (R&C). **We** will pay only for the reasonable cost of the lowest cost category of the room applicable to **your plan** as the accommodation charge associated with the **treatment** given;

(kk) any charges for **treatment** related to and/or the correction of **congenital conditions** and/or deformities whether or not manifested and/or diagnosed or known about at birth unless allowed for by the **benefits table** and accepted by **us** in writing;

(ll) any administration costs or reports of any kind (unless otherwise advised by **us**) or any other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services;

(mm) All bank or credit charges;

(nn) costs of **treatment** rendered and drugs or medicine prescribed by a **medical practitioner** which is not related to the **treatment** provided to the **member**;

(oo) vitamins, supplements, or any traditional Chinese medicine whether prescribed or not unless the **member** is **eligible** for 'Alternative Treatment' benefit, and it is prescribed by an **alternative practitioner** or **medical practitioner** who is qualified to do so and subject to the limits and availability of the 'alternative treatment' benefit from the **member's plan**;

(pp) psychiatric **treatment** including insomnia, stress and anxiety unless allowed for by the **benefits table**;

(qq) cryopreservation or harvesting or storage of stem cells as a preventative measure against possible future disease/**illness**/**injury** or implantation or re-implantation of living cells or living tissues whether autologous or provided by a donor unless this has been agreed by **us** in writing. **We** will pay for **medically necessary** skin grafts; bone grafts and blood transfusions provided it was not due to a **pre-existing** condition nor have **we** applied any specific medical exclusions on the **member**'s cover stated in the **policy schedule**;

(rr) **treatment** which is not considered **medically necessary,** or which may be considered as a matter of personal choice;

(ss) **in-patient treatment** for **medical condition** which can be properly treated as an **out-patient**;

(tt) any charges for **treatment** required as a result of any illegal action on the part of the **member** requiring **treatment**;

(uu) microbial studies or genetic testing including any counselling made necessary following the tests, even when those tests are undertaken to establish whether or not the **member** may be genetically disposed to the development of a **medical condition** in future;

Please note: **We** may pay for genetic testing only when it is proven to help choose the best course of drug **treatment** that will be covered by the **member**'s **policy** and is recommended in the drug license for a specific targeted therapy;

(vv) toiletries such as, but not limited to shampoos, soaps, toothpastes , mouthwash, lotions, moisturisers, cleanser, shower gels, regardless of whether **medically necessary** or prescribed by a **medical practitioner**; contraceptives, proprietary headache and cold cures, artificial tear drop/ gel, vitamins which may be bought over the counter, without **prescription**, at a local pharmacy nor do **we** pay for telephone calls. However, **we** will cover the costs of vitamins to be administered by injection or infusion in case of a confirmed vitamin deficiency that requires medical management provided it was not due to a **pre-existing condition** nor have **we** applied any specific medical exclusions on the **member**'s cover stated in the **policy schedule**.

(ww) **treatment** for all types of sleep disorder including sleep apnoea, sleep study test, snoring;
Please note: **We** will make an exception for surgical **treatment** on sleep apnoea including an initial sleep study test (maximum one sleep study test per **member**'s **lifetime**) provided all of the following criteria are met:
(i) the obstructive sleep apnoea is not a **pre-existing condition**, and
(ii) the **member** has been prescribed by the specialist other forms of **treatment**, but all these **treatment**(s) have not been successful to treat the **member**'s obstructive sleep apnoea, and
(iii) the specialist confirmed that the surgery is **medically necessary** otherwise, it is life threatening, and
(iv) at the time of surgery for the obstructive sleep apnoea, the **member** has been insured with **us** consecutively for more than two (2) policy years on this policy, and
(v) the surgery has been approved by **us** in advance.

(xx) investigations into, and **treatment** of, loss of hair and any hair replacement; all forms of acne;

(yy) ear or body piercing and tattooing including any **treatment** needed as a result of any of these;

(zz) **treatment** whilst staying in a **hospital** for more than ninety (90) continuous days for permanent neurological damage or if **member** is in a persistent vegetative state. **We** define persistent vegetative state as condition of profound no responsiveness, with no sign of awareness or consciousness or a functioning mind, even if the person can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery.

(aaa) artificial life maintenance for more than sixty (60)continuous days if the **member** is in a persistent vegetative state and only kept alive by medical intervention such as mechanical ventilation.

(bbb) **treatment** which has not been established as being effective or which is experimental or pioneering medical or surgical techniques and medical devices not approved by the relevant authorities, government regulatory board and under clinical trials for medicinal products which **you** or a **family member** choose to receive even though usual, customary, and **conventional treatment** for the condition is available. However, **we** will pay if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and **we** have agreed in writing, with the **medical practitioner**, what the fees will be. For established **treatment**, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies;

(ccc) **treatment** directly related to surrogacy. This applies to **you** if **you** act as a surrogate or as the intended parent, or to anyone else acting as a surrogate for **you**.

(ddd) **treatment** provided to the **member** by any of the following people related to a **member** by blood, marriage, or adoption:

(i) parents and parents-in law;
(ii) siblings, brothers-in-law, and sisters-in-law;
(iii) spouse; and
(iv) children of the member; or self-treatment by the member, including the prescription of drugs.

(eee) robotic assisted surgery unless this has been **pre-authorised/pre-approved** and agreed by **us** in writing;

(fff) costs where the **member** is required to be quarantined but have no medical need for **treatment** or care as an **in-patient**. This includes state mandated quarantine, even if it takes place in a **hospital;**

(ggg) Proton Beam Therapy (PBT), Advanced Therapeutic Medicinal Products (ATMPs), Cellular and gene therapy products (CGTPs) or Regenerative medicine advanced therapy (RMATs) and CAR-T **treatment** including any associated **hospital** and specialist costs unless this is provided in the **member**'s **benefit table**, and **we** have agreed in writing (i.e., **pre-authorised/pre-approved**) on the cover and costs before the **member**'s **treatment** starts.

6.2 Special terms apply in the following cases.
The following tests, investigations, **treatments**, items, conditions, activities and their related or consequential expenses are excluded from this **policy,** and **we** shall not be liable for:

(a) cosmetic (aesthetic) surgery or **treatment**;

(b) any **treatment** which relates to or is needed because of previous cosmetic **treatment** or reconstructive surgery, or any cosmetic operation to reconstructed breasts;

(c) any dental procedure unless provided for by **your plan**;

(d) special nursing in **hospital** unless **we** have agreed in writing beforehand that it is necessary and appropriate;

(e) **treatment** or medicine which in **our** reasonable opinion has not been established as being effective or is **experimental** or unproven. However, **we** will pay if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and **we** have agreed in writing, with the **medical practitioner**, what the fees will be. 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.

(f) the use of a drug or any off-label drugs which has not been established as being effective or which is **experimental** or within clinical trials. **We** will not consider individual case reports, studies of a small number of people, nor for clinical trials which are not registered. This means the drugs must be licensed by the Health Sciences Authority if the **member** is receiving **treatment** in Singapore, or by the European Medicines Agency (EMA) if the **member** Assured is receiving **treatment** in Europe, or by the Medicines and Healthcare products Regulatory Agency (MHRA) if the **treatment** is to be provided in the United Kingdom or by the US Food and Drug Administration (FDA) if the **member** is receiving **treatment** anywhere else in the world, and these drugs must be used within the terms of that license for which they were approved for;

(g) any charges for **treatment** incurred during a period for which the **premium** due has not been paid.

6.3 **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, 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.

We do cover **treatment** as a result of a **terrorist act** so long as that **terrorist act** does not cause nuclear, biological, or chemical contamination.

6.4 **We** will not pay benefits for:

(a) any **treatment** needed as a result of work-related **accident** or **injury** where the cost of such **treatment** is recoverable under a Workman's Compensation policy, or a similar cover required by Government Act prevailing in the country where the work-related **accident** or **injury** took place or elsewhere at the time of **injury** or **accident;** or

(b) **treatment** required as a result of negligence or malpractice of a third party. **You** and/or the **member** must take all reasonable steps to recover the loss from the third party or third-party insurer;

You and/or the **member** must advise **us** if any claim is work related or resulted from the negligence or malpractice of a third party. **We** may, at **our** absolute discretion, consider the claims, provided **we** are able to recover such **costs**.

Section 7: Understanding how to get the best from your plan

The following notes deal with some specific aspects and commonly asked questions relating to **your** cover. Please contact **us** for advice on any Section of **your policy** that **you** do not understand.

Before you go for treatment

What to do before receiving in-patient and daycare treatment

- Before receiving any planned **in-patient** or **daycare treatment** recommended by the **member's medical practitioner**, **you**/the **member** or the treating **hospital** should contact **our** HSBC Life Customer Care Centre to obtain **our** authorisation for such **member's** proposed **treatment**.
- **We** will confirm, in writing, to **you**/the **member** and/or the **hospital** the extent of the cover for the proposed **treatment** and the amount **we** are prepared to pay for it. In the unlikely event that there is any difference between **our** confirmed level of cover and what is requested by the **hospital** when such **member** is discharged, **you**/the **member** must make arrangements to pay this when the **member** is leaving the **hospital**.
- If **you** choose to receive unconventional **treatment** by **your** specialist (treating doctor) even though the conventional treatment for **your** diagnosis is available, such **treatments** must be **pre-authorised** and approved by **us** before such **treatment** takes place. HSBC Life must agree that such **treatment** is a suitable equivalent to **conventional treatment**.

The restriction on what we pay for unconventional, unproven, experimental treatment

If the unproven **treatment** costs more than the equivalent **conventional treatment**, **we** may pay up to the **reasonable and customary** costs **we** would have paid for the equivalent **conventional treatment**.

Important note: Even if **we** decide to pay for such unconventional and experimental treatment, all complications arising therefrom shall continue to be excluded and deemed not payable under the **policy**.

You must contact **us** at least ten (10) to fifteen (15) working days before **you** book that unconventional and experimental treatment so **we** can:

(i) obtain full details of the **treatment**;

(ii) support **you** with additional information and questions for **your** specialist (treating doctor) before **you** receive that **treatment**;

(iii) agree on what costs (if any) **we** may pay. All unconventional and experimental treatment must be agreed by **us** in writing, so **you** are aware before having **treatment** of any shortfall **you** may have to pay to the **hospital** and/or specialist (treating doctor).

Pre-authorisation / Pre-approval

The pre-authorisation process is to protect **you** and the member(s) from unexpected costs which are not eligible for payment or 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,
- description of the required medical **treatment**,
- name and address of the Hospital where the **treatment** will be given,
- expected length of stay in the **hospital,**
- estimated cost of the **treatment**.

Please contact **us** within five (5) working days with the above information or any other information **we** require to access the claim prior to the commencement of the planned **treatment**. 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.

You must seek **our** written **pre-authorisation/pre-approval** for the following **treatment** and services (if this is applicable under **your** or **member's** plan):

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**
- cancer **treatment** – radiotherapy, chemotherapy, proton beam therapy (PBT), advanced therapies (as listed in the **benefits table**)
- **in-patient** rehabilitation
- reconstructive Surgery
- robotic surgery

Out-patient

- psychiatric **treatment** (if this is applicable under the **member's plan**)
- second opinion for the same **medical condition**
- prescriptions covering drugs and consumables for thirty (30) days or more
- non-emergency diagnostic scans and other medical procedures such as but not limited to computerised tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), x-rays, gait scans, endoscopy, colonoscopy, gastroscopy, and other types of scans and scopes.

Failure to obtain **pre-authorisation/pre-approval** may result in **us** not settling all or part of any claim and for **cancer treatment, we** shall not pay for any benefits even if it was for an eligible medical condition. In the event that **we** paid for any item not covered by **our** confirmation, you are obliged to pay us back any amount we incurred immediately. In any event any cost that is not directly related to **treatment,** such cost shall be borne by the **member**.

In-patient and direct billing

The direct billing and Letter of Guarantee (LOG) facility is a value-added service applicable when **members** are seeking eligible **In-patient** and **Day Surgery treatment** within **our international directory of hospitals**. Any **pre-authorisation/pre-approval** request needs to be forwarded to HSBC Life at least five (5) working days prior to commencement of the treatment for which **pre-authorisation** is required.

Members can contact HSBC Life Customer Care Centre to submit the **pre-authorisation /pre-approval** request. **Members** should confirm with the **hospital** that it has received **our** written authorisation (Letter of Guarantee) before he/she undergoes **treatment**. If it has not, the **member** must contact **us** immediately.

We may in some circumstances ask for additional information to assess the **member's** application for LOG facility.

We may not approve the LOG request for any of the following reasons:

- For elective admission/treatment, when there is a late notification to **us** of less than five (5) working days prior to the scheduled admission/**treatment**;
- The completed LOG forms are not made available to **us** prior to **your hospital** discharge;
- When **your member**'s medical case requires further medical review by **our** claims team;
- When there are ineligible items or non-covered **treatment**/**medical condition(s)** under the **policy**; or
- When **we** do not have a credit arrangement or direct billing facility with the **hospital** or medical provider.

Where **members** receive **treatment** for a **medical condition** that is not covered within the terms of the policy, the **member** is liable for the costs of such **treatment**, which must be settled in full upon request. Failure to act accordingly will result in the suspension or cancellation of cover, without the refund of **premium**.

In the event **we** are obliged to pay for any items not covered by **our** confirmation, **we** will recover that amount from **you**/the **member,** and this may include any other costs which are not directly related to **treatment**.

Treatment outside network of hospitals

If **you** are planning or have decided to receive **treatment** in a hospital which is not listed in our **international directory of hospitals**, **you** need to contact **us** before the **member** has his/her **treatment** so **we** can check if the **treatment** is covered under the terms of this **policy**. There are some **treatment** costs incurred in these hospitals or medical institutions which **we** would not pay because they do not meet **our** billing criteria or because **we** do not recognise them. **We** may not be able to reimburse **you**/the **member** for **treatment you**/the **member** paid with one of these hospitals or medical institutions. There may be situations **we** will agree for **you** to pay for **your member**'s **treatment** costs first and then submit the claim incurred to **us** for reimbursement of the eligible charges. Upon approval of the claim reimbursement of eligible charges, **we** will reimburse to the Medisave account (**treatments** incurred in Singapore) that was used to pay the bill(s) (if applicable), or to the **policyholder**, or in the event of **policyholder**'s death or mental incapacity, to the **policyholder**'s legal representative.

In the event that **we** paid for any item not covered by the **policy**, **you** are obliged to pay **us** back any amount we incurred immediately.

There may be situations where **we** can assist in the direct billing for an outside network hospital, but this is only possible when **we** receive the LOG pre-authorisation request forms at least five (5) working days prior to the commencement of **treatment**, and **we** are able to discuss the matter with the chosen hospital who must agree to accept such arrangement.

Decisions about your treatment

We do not decide whether the **treatment** a **member** receives is given on an **in-patient**, **daycare**, or **out-patient** basis. The attending **medical practitioner** decides this. **We** will not usually question this unless, in the opinion of **our** medical team, it would have been more appropriate for **treatment** to have been given differently. In the unlikely event of this happening, **we** will ask for an explanation of why the particular method of **treatment** was chosen. **We** recognise that there may have been a valid reason for the choice made by the **medical practitioner**. **Our** intention in questioning such matters is to be able to assess any claim fairly and accurately.

In the event of any differences in opinion between **our** medical team and the attending **medical practitioner**, **our** medical teams' opinion shall prevail.

The decision on **your** treatment options will be **your**/the **member**'s personal choice and should **you/**the **member** require any immediate **treatment**, please make that **your** priority. The availability of cover under the **policy** according to the **medical condition** will be subject to the policy terms, conditions, and exclusions.

Our right to ask for an independent medical opinion

We can ask an independent **medical practitioner** to advise **us** about the medical facts relating to a claim or to examine the **member** concerned in connection with the claim and provide **us** with a report. The **member** must co-operate with the independent **medical practitioner**. This is needed only very rarely, and **we** use this right only where there is uncertainty as to the nature or extent of the **medical condition** and/or **our** liability under the **policy**. In the event of any differences between **our** medical team and the attending **medical practitioner**, **our** medical team's opinion shall prevail.

If you need treatment abroad

If **you/**the **member** needs **treatment** abroad, **you** will need to call **our** service provider.

Pre-authorisation/Pre-approval for treatment and medical services received in the United States of America (U.S.A.), if the member has U.S.A cover

- Before any **in-patient treatment** or daycare **treatment**, **cancer treatment**, or MRI, CT, and PET scans in U.S.A., **you** must contact **us** for **pre-authorisation/pre-approval** of such **treatment** and medical services. **Our** team will confirm the **member's** entitlement to the benefit for the proposed **treatment**/medical services, help find a suitable network provider for the **member** and arrange direct billing with them.
- If the **member** chooses to have **in-patient treatment**, or daycare Treatment, **cancer treatment**, MRI, CT, and PET scans done in U.S.A without our **pre-authorisation/pre-approval**, the eligible benefit may not be paid beyond 50% of **reasonable and customary** costs after deduction of any applicable **co-insurance** and **deductible.**

Emergency treatment

If the **treatment** requires an **emergency** admission, **you** or the **member** may not be able to contact **us** beforehand. Do, however, ask somebody to contact **us** as soon as possible and make sure that, when the **member** is admitted to **hospital**, the **hospital** is given the **member's** membership card and proof of identity so that they can contact **us** straight away.

While **you** are having **treatment**

Identifying yourself as an HSBC Life member

In any event, if a **member** is receiving **treatment** in any part of **our hospital** within **our international directory of hospitals,** the **member** must always identify himself/herself as a **member** to ensure that his **eligible treatment** enjoys the advantages of **our** negotiated rates. Failure to do this may expose **you**/the **member** to additional costs which **you**/the **member** will have to bear.

Please note that HSBC Life reserves the right to recover from **you**/the **member** any ineligible expenses it has incurred on behalf of that **member** under this **policy**.

Claim forms for reimbursement claims

Members can visit **our** website at www.hsbclife.com.sg to obtain a printable claim form if they need one or call **our** HSBC Life Customer Care Centre.

Members must take a claim form with them (also available from **our** website) and make sure it is filled in and signed by themselves and the **medical practitioner** treating such **member** and send back to **us** as quickly as possible, giving **us** all the information, **we** request. Only original receipted invoices can be accepted with **your** claim.

A fully completed claim form will ensure that the claim will be processed promptly. An incomplete or unsigned claim form may delay settlement of the claim and in some cases may lead to the claim form being returned to **you**/the **member** for completion.

It may be necessary for **us** to obtain a medical report from the attending **medical practitioner**. If the **medical practitioner** does not respond quickly to such a request the claim may be delayed.

We do not pay for medical reports.

For **treatment** where the **member** is seeking **our pre-authorisation/pre-approval**, such authorisation must be received from **us**, in writing, prior to **treatment** commencing. A copy of that authorisation must be included in the **member's** subsequent claim.

Please note that, for reimbursement claims, **we** will only consider claims made within ninety (90) days of **treatment** being received.

Where to send your claims

Any bills, together with your completed claim form, should be sent to:

HSBC Life (Singapore) Pte. Ltd.

Robinson Road Post Office P.O Box 1538, Singapore 903038

Currency

Your premiums are payable in Singapore Dollars.

Claim reimbursement will be paid in the same **currency** unless **we** have previously agreed otherwise in writing. If **we** agree to reimburse benefits to a **member** in a different currency, **we** will send **you our** written confirmation in advance, with the exchange rate used stated. Any exchange costs incurred will be payable by the **member** and will be subtracted from any payment made to the **member** in respect of such a claim.

Claims incurred in any other currency will be converted using the spot rates prevailing at the time **we** assess the claim. **We** shall not be liable for any bank charges or credit charges.

What we expect from you

The **member** must tell **us** on the claim form if they think any of the cost can be claimed from anyone else or under another insurance policy or source (such as but not limited to any Workman's Compensation policy). If so, then:

- if another insurance policy is involved, **we** will only pay for the excess of the amount recovered from such other insurance policy; or
- if benefits are claimed for **treatment** to a **member** whose **injury** or **medical condition** was caused by some other person (the "third party"), **we** will pay only those benefits the **member** can claim under the **policy** (unless these are covered by another insurance policy, when **we** will only pay **our** proper share of the benefits). However, in paying those benefits **we** obtain both through the terms of the **policy** and by law a right to recover the amount of those benefits from the third party. In this case the following shall apply:

(a) **you** or the **member** must tell **us** as quickly as possible that the **injury** or **medical condition** was caused by, or was the fault of, a third party. **We** will then send **you** a form on which the **member** can give **us** full written details;

(b) if **you** or the **member** is making a claim, or has not made (or refuses to make) a claim against the third party, **you** and/or the **member** must act in good faith and do all the things **we** shall require to ensure that monies are recovered from the third party and are repaid to **us** up to the amount of the benefits **we** have paid (and any interest). **You** and/or the **member** will be asked to sign a written undertaking to this effect; and

(c) if **you** or the **member** do not repay to **us** monies recovered from the third party up to the amount of benefits (and any interest), **we** shall be entitled to recover the same from **you** and/or the **member**.

Our rights

If a **member** makes a claim which is in any way dishonest:

- **we** will not pay any benefits for that claim; and
- if **we** have already paid benefits for that claim before **we** discovered the dishonesty, **we** can recover those benefits from **you** (or the **member**); and
- **we** can take any of the actions listed in Section 5.13 – 'General Conditions', clause (a).

Specific claims conditions

(a) The payment of any claim does not discharge **you**/**member's** obligations on the fulfillment of the terms and conditions under this **policy**; and

(b) **We** are not obliged to pay the ongoing costs of continuing, or similar **treatment**, even where **we** have previously paid for this type of or similar **treatment**, if it is subsequently noted that this claim is not an **eligible treatment**; and

(c) If **we** transfer money to **you**/the **member** in error or accidentally overpay **you**/the **member**, **you** must return it to **us** immediately. If **you**/the **member** become aware of an accidental payment or overpayment, **you/**the **member** must let **us** know straight away so that **we** can arrange for the money to be returned to **us**.

Section 8: Health at Hand

Through **our** telephone health information service, **our members** have access to ~~a~~ qualified and experienced teams of healthcare professionals 24 hours a day, 365 days a year.

Whether the **members** are calling because of late night worries about a child's health, or the **members** have some questions that they forgot to ask their medical practitioner, it is likely that Health at Hand will be able to provide the **members** with the help they need.

Teams of medical professionals' are on hand to give **members** the benefit of their expertise. They can answer **members'** questions and provide information on specific illnesses, treatments, and medications as well as details of local and national organisations. They can also send **members** free fact sheets and leaflets on a wide range of medical issues, conditions, and treatments, and will happily discuss any further questions **members** may have from what they have read.

Please note: Health at Hand does not diagnose or prescribe and is not designed to take the place of a **member's medical practitioner**. However, it can provide **members** with valuable information to help put their mind at rest.

As Health at Hand is a confidential service, any information discussed is not shared with **our** HSBC Life Customer Care Centre. **We** will not be liable for any damage or losses **members** may suffer or incur as a result of their usage of such services.

If **members** wish to obtain **pre-authorisation**/**pre-approval** for a **treatment**, enquire about a claim or have a membership query, **our** HSBC Life Customer Care Centre will be happy to help them.

Section 9: If any problems arise..

We will make every effort to provide high level of service expected by all **our policyholders**. If on any occasion **our** service falls below the standard of **your** expectation, the procedure below explains what **you** can do:

Your first point of contact should always be **your** insurance agent or broker. Alternatively, you may submit **your** feedback to **us** by sending an email to: intlx@mail.life.hsbc.com.sg.

We will acknowledge receipt of **your** feedback within three (3) working days whilst **we** look into the matter **you** raised. **We** will contact **you** for further information if required within seven (7) working days and provide **you** with a full reply within fourteen (14) working days.

If **our** resolution is not to **your** satisfaction, **we** will refer **you** to a dispute resolution organisation, Financial Industry Disputes Resolution Centre Ltd (FIDReC) who is an independent organisation. FIDReC's contact details are:

Financial Industry Disputes Resolution Centre Ltd

36 Robinson Road #15-01 City House Singapore 068877

Telephone : 63278878, Fax : 63278488, Email : info@fidrec.com.sg, Website : www.fidrec.com.sg

Please remember to quote **your policy** number on all correspondence.

Section 10: Your Customer Charter

As a valued customer of HSBC Life, **you** have important rights and entitlements. **You** are entitled to expect:

Courtesy. Your requirements will always be dealt with promptly, considerately, and courteously. No customer query is too trivial or too much trouble to sort out.

Helpful advice and guidance. HSBC Life staff will help **you**, if **you** have any doubts, to understand the terms of **your** contract and any other factors which affect **your** cover. They will help **you** to make proper use of **your** cover should **you** need to make a claim.

Confidential handling of your personal details and affairs wherever possible. Any medical details **we** require will always be kept confidential as much as possible. HSBC Life may be required to provide information regarding claims **you** make or have made in the past or other details **you** have given **us** to **your** sponsor or employer or a government department if they are paying for all or part of this **policy** or are entitled by law to require this of **us**. No liability will be accepted by **us** for any outcome resulting from the provision of such information to any of the aforementioned parties.

Advance notification of change in cover. Essential changes to the terms of the cover (including benefits and premiums) will be notified to **you**, in writing, in advance of the date from which the changes take effect.

Professional and efficient service. All requests for assistance and any claims **you** submit will be considered impartially (without any bias or preference) in accordance with the benefits under **your plan**.

Section 11: Benefits Table

Benefits Table (Plan A)

Benefits Table	Plan A	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	
Area of cover		
Area of cover This is the geographical area where **you** can choose to receive **treatment**. **You** can select **your area of cover** at time of application. **Your** chosen **area of cover** has an impact on **your** premium.	**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. We will only pay for the **hospital** room and board costs when the length of stay is **medically necessary** and is considered by **us** as clinically appropriate for the **member**'s **medical condition**. Wherever a **member** receives **treatment**, if the **hospital** offers several classes for the room type, he is entitled for, **we** will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that **hospital** for that type of room. If a **member** stays in a room which is more expensive than the standard room, the **member** may have to pay for the difference in room charges. The **member** may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with **us** prior to admission to avoid unnecessary out of pocket expenses.	Standard single room	Annual **deductible**
Hospital charges This benefit pays for **eligible** hospital charges given between admission and discharge including: a) Diagnostic procedures b) Surgical procedures c) Operating theatre charges d) Nursing care, drugs, and dressings e) Surgeons' and anaesthetists' charges f) Intensive care unit charges g) Consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it h) Oncology treatment including radiotherapy and chemotherapy i) Kidney dialysis j) Computerised tomography, magnetic resonance imaging, x-rays, and other such proven medical imaging techniques k) Special nursing in **hospital**	Included	Annual **deductible**
Organ transplant This **benefit** pays for transplantation of kidneys, heart, liver, lung, or bone marrow required as a result of an **eligible medical condition** and provided that the organ is from a certified and verified source of donation and the procurement and transplantation of such organ is in accordance with the World Health Organisation (WHO) Guiding Principles on Human Cell, Tissue and Organ Transplantation. The **policy** does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor.	Included	Annual **deductible**

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
In-patient and Daycare Treatment		
Living organ donor This benefit pays up to the annual limits shown in the benefit schedule for **reasonable and customary** charges incurred for a live **member** to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung, or bone marrow) of this **policy**, provided : a) the operation and transplant are for the **member**'s family member (parent, sibling, child, spouse, or partner); b) the transplant is in line with appropriate regulatory guidelines; c) the recipient of the organ was first diagnosed by a doctor or have symptoms which first appeared after a **waiting period** of twenty-four (24) months from the **policy commencement date** or the date after this Living Organ Donor (**member**) Transplant benefit first became effective under this **policy** or the last reinstatement date (if any) whichever is the latest; and Shall include eligible expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalisation treatment. Both pre- and post-hospitalisation benefit are limited to one hundred and twenty (120) days prior or after treatment, respectively. This benefit requires **pre-authorisation** from **us**. 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**
Reconstructive Surgery This benefit pays for the initial reconstructive surgery which is **medically necessary** and provided that (i) it is carried out to restore function after an **accident** or following surgery for an eligible **medical condition**; and (ii) that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened. In the case of breast c**ancer**, the initial reconstructive surgery must be part of the eligible **treatment** following the **cancer treatment** which includes one planned surgery to reconstruct the diseased breast and one further planned surgery to the other breast when it has not been operated on, to improve symmetry. If the **member** chooses not to have reconstructive surgery following **treatment** of breast **cancer**, no further reconstructive surgery will be covered by **us** on either the diseased breast or the unaffected breast. Benefit for reconstructive surgery is subject to **our pre-authorisation** and must be done at a medically appropriate stage (as determined by **our medical practitioner**) after the **accident** or surgery.	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**.	up to S$190 per night	Annual **deductible**
New Born accommodation This benefit pays for the child who is less than 16 weeks to stay in the **hospital** while the insured mother is receiving eligible **in-patient treatment**.	Included	Annual **deductible**
Cash benefit 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 (up to a maximum of 30 nights per **year**)	Not Applicable
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 **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 twenty-eight (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 one hundred eighty (180) days.	Included	Annual **deductible**

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
In-patient and Daycare Treatment		
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**
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. The number of visits covered by this benefit is limited to once per day with a **medical practitioner,** for the same **medical condition**.	Included	20% **co-insurance**
Surgical procedures **We** will pay for any eligible **surgical procedures** received as an **out-patient** for an eligible **medical condition**.	Included	20% **co-insurance**
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 a**ccident**, 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 (RMAPs) This benefit requires **pre-authorisation** before the **member** starts **treatment**. **We** cover a small number of approved ATMPs/CGTPs/RMATs. For the current list of ATMPs/CGTPs/RMATs, that **we** cover, please refer to benefit clarifications section for details.	Included	Annual **deductible**
Proton Beam Therapy (PBT) Radiation therapy which uses protons to treat **cancer**. **We** will pay PBT for: • malignant solid cancers in members aged twenty- one (21) and under • central nervous system (brain and spinal cord) cancer • chordomas or chondrosarcomas (types of spine cancer) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) • high naso-ethmoid, frontal and sphenoid tumours with base of skull involvement • adenoid cystic carcinoma with perineural invasion • esthesioneuriblastoma • cancer of the iris, ciliary body, or choroid parts of the eye (uveal melanoma) which has not spread (metastasised) • conjunctival melanoma • choroidal haemangioma Please note: There is limited cover for Proton Beam Therapy in the circumstances shown above. Refer to benefit clarifications section for details.	Included	Annual **deductible**
Kidney dialysis **We** will pay for kidney dialysis received as an **out-patient** for an eligible **medical condition** at a registered medical facility recognised by **us**.	Included	Annual **deductible**

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
Out-patient Treatment		
Computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans **We** will pay for computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an eligible **out-patient treatment**. Such **treatment** must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has requested such diagnostic scans. For clarity, this benefit does not cover charges for consultations, **prescriptions**, and other **diagnostic procedures** such as laboratory tests, x-ray, and ultrasound.	Included	20% **co-insurance**
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 hormone replacement therapy is only required for the relief of menopausal symptoms, **we** will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the **benefit table** applicable to **member**'s **plan**.	Included (Hormone replacement therapy for relief of menopausal symptoms - up to S$200)	20% **co-insurance**
Physiotherapy, occupational therapy, and speech therapy **Treatment** given by any of these practitioners must be referred by the **medical practitioner** who has defined a diagnosis. Benefit is payable only following **in-patient treatment** for an eligible **medical condition**, provided that the **member** has been continuously covered under the **policy** since before the **in-patient treatment** commenced. **Treatment** given by any of these practitioners must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the medical **practitioner** who has defined a diagnosis. There must be a clear and complete treatment plan detailing the start to the end of the **treatment** by the **physiotherapist**, speech therapist or occupational therapist with an expected outcome to restore the normal form and/or function after an **acute** illness or **injury**.	Included (up to 180 days following the date the **member** is discharged from **hospital**)	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. There must be a clear and complete **treatment** plan from the chiropractor, osteopath, homeopath, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, physiotherapist, and the traditional Chinese medicine practitioner detailing the start to the end of the **treatment** with an expected outcome that is restorative in nature to help the **member** to carry out his/her normal activities of daily living.	up to S$2,000	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. **We** will pay for the combined cost of administering necessary vaccines given by a **medical practitioner** or **nurse** and the cost of the vaccines, including the consultation charges.	up to S$2,000 Available only after 90 consecutive days membership in the first **policy year**	20% **co-insurance**
Health screen This benefit includes the cost of any eligible consultation needed as part of the screening process. This is a preventive health check benefit specifically designed for early detection for disease prevention.	up to S$1,350	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 extra-oral impact. Benefit is not payable if: a) the damage was caused by normal wear and tear b) the i**njury** was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn c) the damage was caused by tooth brushing or any other oral hygiene procedure d) the damage is not apparent within seven (7) days of the **oral** impact which caused the **injury** This benefit is available only if the **member** has been continuously covered under the **policy** since before the **accident** happened.	Included	20% **co-insurance**
Oral and maxillofacial surgery This benefit pays only for the following procedures performed by an oral and maxillofacial surgeon: a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms b) Surgical removal of complicated buried roots which are diseased or causing symptoms c) Enucleation (removal) of cysts of the jaw d) **Treatment** of **cancers** (For lesion or lump in the mouth). **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. **We** do not cover costs for **treatment** that have not yet taken place, even if it is being provided as part of a **treatment** package. **Pre-existing condition** limitations are not applicable to this benefit.	up to S$2,500	20% **co-insurance**

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	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	20% **co-insurance**
Emergency Evacuation and Repatriation		
International Emergency Medical Assistance (IEMA) This benefit pays for the following services: a) Evacuation where the local medical facilities are not adequate according to our appointed doctor b) Evacuation will be to the nearest medical facility where **treatment** is adequate c) Transportation for returning to the **principal country of residence** following the evacuation d) Cost of one accompanying person while the covered person is being evacuated e) Hotel accommodation of one accompanying person up to 10 days f) Bringing the body or ashes back to a port or airport in the **principal country of residence** or home country if the covered person dies abroad as a result of an eligible **medical condition**.	Included	Not Applicable
New Born Cover		
Acute medical condition (excluding **congenital conditions**) This benefit pays for the **treatment** of **acute medical condition**, providing there is no underlying **congenital condition,** developed in a new born 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 new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: a) the parent of the new born baby has been covered under consecutive days or more when the baby is born; and for 365 consecutive days or more when the baby is born; and b) the new born 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 new born 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**
Treatment of congenital conditions This benefit pays for treatment of **congenital conditions**. The benefit becomes available if: a) the parent of the new born baby has been covered under consecutive days or more when the baby is born; and **Plan** A for 365 days or more when the baby is born; and b) the new born 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	Annual **deductible**

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	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 a **member** and only when the following conditions are met: a) after his 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 b) agreed in writing by **us** beforehand that it is **medically necessary** and appropriate, and c) it is prescribed by the treating **medical practitioner** for the continued **treatment** for the eligible **medical condition** which the **member** was hospitalised for, and d) when such services are essential for medical purposes as distinct from domestic, personal, or social reasons. For avoidance of doubt, the charges refer to the fees for the service of a **nurse** incurred for nursing the **member** at his home. 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 member's 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	20% **co-insurance**
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.	Years 1 & 2 : up to S$3,000 Available only after 270 consecutive days membership Subsequent years: up to S$6,000	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	20% **co-insurance**
Artificial ears and eyes This benefit pays for all the costs of 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** provided the **member** has been continuously covered under the **policy** since before the surgery or **accident** happened that has led to the need for the replacement of ears and eyes. The initial claim must be made within 12 (twelve) months of the removal of the ears and eyes and to subject to **our pre-authorisation**.	up to S$3,800 in a **member**'s **lifetime**	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. Benefit is only payable following a surgery or an **accident** for an eligible **medical condition** provided that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened.	up to S$3,800 every 3 years	20% **co-insurance**
Medical aids and durable medical equipment This benefit pays for instruments or devices or durable medical equipment which are prescribed by the **medical practitioner** as a **medically necessary** aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint, and orthopaedic supports.	up to S$1,000	20% **co-insurance**

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
Other Benefits		
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	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	20% **co-insurance**
Pre- and post-natal complications This benefit pays for **treatment** of an eligible **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth for female **member** over the age of 18 years. Under post-natal complications, **we** will only pay for **treatment** received within 90 days following the childbirth. This benefit does not cover: a) the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or b) any complication arising from non-medically necessary caesarean section birth. c) **treatment** of any **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted conception. Whilst **we** recognise that caesarean section may sometimes be a **medical necessity**, caesarean section is only payable if the **member** insured has paid for the Optional add-on 'Normal (Routine) Pregnancy and childbirth benefit,' available for Plan A only, subject to compulsory **co-insurance** 20% per claim. For avoidance of doubt, this benefit shall not be payable if the: • childbirth is through non-medically necessary caesarean birth, and/or • conception of the child is conceived by artificial means or any form of assisted conception. Please note: If we are not able to determine that a caesarean section is medically necessary, we will consider it as not medically necessary.	Included Available only after 365 consecutive days membership	20% **co-insurance**

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
Optional Add-On Benefits		
The following Optional add-on benefit is subject to **your** payment of additional premium and will be indicated in **your** policy schedule if **you** have applied for this add-on benefit. **Normal (Routine) Pregnancy and childbirth** (Plan A only and subject to compulsory co-insurance) This benefit pays for routine pre-natal care, **inpatient** childbirth, and routine post-natal care up to forty-two (42) days following birth. This benefit is applicable for female **member** over the age of 18 years. The limit shown is the maximum benefit for each **policy year** (even if there is more than one pregnancy) or each pregnancy (even if an eligible pregnancy falls across the policy anniversary) provided the **policy** with this benefit has been renewed. The limit shown 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, up to the limit shown for this benefit 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 **inpatient** childbirth costs up to the **reasonable and customary** costs of a natural childbirth in a standard single room. 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 limit. Please note: This benefit is payable when 365 consecutive days membership is achieved by the **member** under this **plan** /cover from the date this cover is attached to the **member's plan**. This benefit excludes any **treatment** costs that has not yet taken place, even if it being provided as part of a **treatment** package.	up to S$22,000 Available only after 365 consecutive days Membership Compulsory 20% co-insurance	Not Applicable

Benefits Table (Plan B)

Benefits Table	Plan B	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$4,000,000	
Area of cover		
Area of cover This is the geographical area where **you** can choose to receive **treatment**. **You** can select **your area of cover** at time of application. **Your** chosen **area of cover** has an impact on **your** premium.	**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. We will only pay for the **hospital** room and board costs when the length of stay is **medically necessary** and is considered by **us** as clinically appropriate for the **member**'s **medical condition**. Wherever a **member** receives **treatment**, if the **hospital** offers several classes for the room type, he is entitled for, **we** will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that **hospital** for that type of room. If a **member** stays in a room which is more expensive than the standard room, the **member** may have to pay for the difference in room charges. The **member** may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with **us** prior to admission to avoid unnecessary out of pocket expenses.	Standard single room	Annual **deductible**
Hospital charges This benefit pays for **eligible** hospital charges given between admission and discharge including: a) Diagnostic procedures b) Surgical procedures c) Operating theatre charges d) Nursing care, drugs, and dressings e) Surgeons' and anaesthetists' charges f) Intensive care unit charges g) Consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it h) Oncology treatment including radiotherapy and chemotherapy i) Kidney dialysis j) Computerised tomography, magnetic resonance imaging, x-rays, and other such proven medical imaging techniques k) Special nursing in **hospital**	Included	Annual **deductible**
Organ transplant This benefit pays for transplantation of kidneys, heart, liver, lung, or bone marrow required as a result of an **eligible medical condition** and provided that the organ is from a certified and verified source of donation and the procurement and transplantation of such organ is in accordance with the World Health Organisation (WHO) Guiding Principles on Human Cell, Tissue and Organ Transplantation. The **policy** does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor.	Included	Annual **deductible**

Benefits Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
In-patient and Daycare Treatment		
Living organ donor This benefit pays up to the annual limits shown in the benefit schedule for **reasonable and customary** charges incurred for a live **member** to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung, or bone marrow) of this **policy**, provided : a) the operation and transplant are for the **member**'s family member (parent, sibling, child, spouse, or partner); b) the transplant is in line with appropriate regulatory guidelines; c) the recipient of the organ was first diagnosed by a doctor or have symptoms which first appeared after a **waiting period** of twenty-four (24) months from the **policy commencement date** or the date after this Living Organ Donor (**member**) Transplant benefit first became effective under this **policy** or the last reinstatement date (if any) whichever is the latest; and Shall include eligible expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalisation treatment. Both pre- and post-hospitalisation benefit are limited to one hundred and twenty (120) days prior or after treatment, respectively. This benefit requires **pre-authorisation** from **us**. 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**
Reconstructive Surgery This benefit pays for the initial reconstructive surgery which is **medically necessary** and provided that (i) it is carried out to restore function after an **accident** or following surgery for an eligible **medical condition**; and (ii) that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened. In the case of breast c**ancer**, the initial reconstructive surgery must be part of the eligible **treatment** following the **cancer treatment** which includes one planned surgery to reconstruct the diseased breast and one further planned surgery to the other breast when it has not been operated on, to improve symmetry. If the **member** chooses not to have reconstructive surgery following **treatment** of breast **cancer**, no further reconstructive surgery will be covered by **us** on either the diseased breast or the unaffected breast. Benefit for reconstructive surgery is subject to **our pre-authorisation** and must be done at a medically appropriate stage (as determined by **our medical practitioner**) after the **accident** or surgery.	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**.	up to S$190 per night	Annual **deductible**
New Born accommodation This benefit pays for the child who is less than 16 weeks to stay in the **hospital** while the insured mother is receiving eligible **in-patient treatment**.	Included	Annual **deductible**
Cash benefit 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$200 per night (up to a maximum of 30 nights per **year**)	Not Applicable
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 **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 twenty-eight (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 one hundred eighty (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**

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. The number of visits covered by this benefit is limited to once per day with a **medical practitioner**, for the same **medical condition**.	Included	20% **co-**insurance
Surgical procedures **We** will pay for any eligible **surgical procedures** received as an **out-patient** for an eligible **medical condition**.	Included	20% **co-insurance**
Emergency treatment due to accident This benefit pays for **out-patient treatment** due to **acciden**t required immediately (within 24 hours) following bodily injury arising from an a**ccident**, 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 (RMAPs) This benefit requires **pre-authorisation** before the **member** starts **treatment**. **We** cover a small number of approved ATMPs/CGTPs/RMATs. For the current list of ATMPs/CGTPs/RMATs, that **we** cover, please refer to benefit clarifications section for details.	Included	Annual **deductible**
Proton Beam Therapy (PBT) Radiation therapy which uses protons to treat **cancer**. **We** will pay PBT for: • malignant solid cancers in members aged twenty-one (21) and under • central nervous system (brain and spinal cord) cancer • chordomas or chondrosarcomas (types of spine cancer) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) • high naso-ethmoid, frontal and sphenoid tumours with base of skull involvement • adenoid cystic carcinoma with perineural invasion • esthesioneuriblastoma • cancer of the iris, ciliary body, or choroid parts of the eye (uveal melanoma) which has not spread (metastasised) • conjunctival melanoma • choroidal haemangioma	Included	Annual **deductible**
Kidney dialysis **We** will pay for kidney dialysis received as an **out-patient** for an eligible **medical condition** at a registered medical facility recognized by **us**.	Included	Annual **deductible**
Computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans **We** will pay for computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an eligible **out-patient treatment**. Such **treatment** must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has requested such diagnostic scans. For clarity, this benefit does not cover charges for consultations, **prescriptions**, and other **diagnostic procedures** such as laboratory tests, x-ray, and ultrasound.	Included	20% **co-insurance**

Benefits Table (Plan B) (Continued)

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 hormone replacement therapy is only required for the relief of menopausal symptoms, **we** will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the **benefit table** applicable to **member**'s **plan**.	Included (Hormone replacement therapy for relief of menopausal symptoms - up to S$200)	20% **co-insurance**
Physiotherapy, occupational therapy, and speech therapy **Treatment** given by any of these practitioners must be referred by the **medical practitioner** who has defined a diagnosis. Benefit is payable only following **in-patient treatment** for an eligible **medical condition**, provided that the **member** has been continuously covered under the **policy** since before the **in-patient treatment** commenced. **Treatment** given by any of these practitioners must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has defined a diagnosis. There must be a clear and complete treatment plan detailing the start to the end of the **treatment** by the **physiotherapist**, speech therapist or occupational therapist with an expected outcome to restore the normal form and/or function after an acute illness or **injury**.	Included (up to 180 days following the date the **member** is discharged from **hospital**)	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. There must be a clear and complete **treatment** plan from the chiropractor, osteopath, homeopath, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, physiotherapist, and the traditional Chinese medicine practitioner detailing the start to the end of the **treatment** with an expected outcome that is restorative in nature to help the **member** to carry out his/her normal activities of daily living.	up to S$2,000	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. **We** will pay for the combined cost of administering necessary vaccines given by a **medical practitioner** or **nurse** and the cost of the vaccines, including the consultation charges.	up to S$500 Available only after 90 consecutive days membership in the first **policy year**	20% **co-insurance**
Health screen This benefit includes the cost of any eligible consultation needed as part of the screening process. This is a preventive health check benefit specifically designed for early detection for disease prevention.	up to S$250	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 extra-oral impact. Benefit is not payable if: a) the damage was caused by normal wear and tear b) the **injury** was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn c) the damage was caused by tooth brushing or any other oral hygiene procedure d) the damage is not apparent within seven (7) days of the oral impact which caused the **injury** This benefit is available only if the member has been continuously covered under the **policy** since before the **accident** happened.	Included	20% **co-insurance**

Benefits Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
Dental Treatment		
Oral and maxillofacial surgery This benefit pays only for the following procedures performed by an oral and maxillofacial surgeon: a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms b) Surgical removal of complicated buried roots which are diseased or causing symptoms c) Enucleation (removal) of cysts of the jaw d) **Treatment** of **cancers** (For lesion or lump in the mouth) **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. **We** do not cover costs for **treatment** that have not yet taken place, even if it is being provided as part of a **treatment** package. **Pre-existing condition** limitations are not applicable to this benefit.	up to S$250	20% **co-insurance**
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.	No benefit	20% **co-insurance**
Emergency Evacuation and Repatriation		
International Emergency Medical Assistance (IEMA) This benefit pays for the following services: a) Evacuation where the local medical facilities are not adequate according to our appointed doctor b) Evacuation will be to the nearest medical facility where **treatment** is adequate c) Transportation for returning to the **principal country of residence** following the evacuation d) Cost of one accompanying person while the covered person is being evacuated e) Hotel accommodation of one accompanying person up to 10 days f) Bringing the body or ashes back to a port or airport in the **principal country of residence** or home country if the covered person dies abroad as a result of an eligible **medical condition**.	Included	Not Applicable
New Born Cover		
Acute medical condition (excluding **congenital conditions**) This benefit pays for the **treatment** of **acute medical condition**, providing there is no underlying **congenital condition**, developed in a new born 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 new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: a) the parent of the new born baby has been covered under consecutive days or more when the baby is born; and for 365 consecutive days or more when the baby is born; and b) the new born 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 new born 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 Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
New Born Cover		
Treatment of congenital conditions This benefit pays for treatment of **congenital conditions**. The benefit becomes available if: a) the parent of the new born baby has been covered under consecutive days or more when the baby is born; and **Plan** A for 365 days or more when the baby is born; and b) the new born 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**.	No benefit (this benefit is available under **Plan** A only)	Annual **deductible**
Other Benefits		
Home nursing This benefit pays for charges incurred by an attending registered and qualified **nurse** for a **member** and only when the following conditions are met: a) after his discharge from **hospital** which the **member** had been warded in the intensive care unit for an eligible **medical condition** or undergone for an eligible daycare surgery, and b) agreed in writing by **us** beforehand that it is **medically necessary** and appropriate, and c) it is prescribed by the treating **medical practitioner** for the continued **treatment** for the eligible **medical condition** which the **member** was hospitalised for, and d) when such services are essential for medical purposes as distinct from domestic, personal, or social reasons. For avoidance of doubt, the charges refer to the fees for the service of the **nurse** incurred for nursing the **member** at home. 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** member's **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$7,000	20% **co-insurance**
Pre-existing conditions and congenital conditions This benefit pays: 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.	Years 1 & 2 : up to S$3,000 Available only after 270 consecutive days membership Subsequent years: up to S$6,000	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.	No benefit	20% **co-insurance**

Benefits Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
Out-patient Treatment		
Artificial ears and eyes This benefit pays for all the costs of 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** provided the **member** has been continuously covered under the **policy** since before the surgery or **accident** happened that has led to the need for the replacement of ears and eyes. The initial claim must be made within 12 (twelve) months of the removal of the ears and eyes and subject to **our pre-authorisation**.	up to S$1,300 in a **member**'s **lifetime**	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. Benefit is only payable following a surgery or an **accident** for an eligible **medical condition** provided that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened.	up to S$1,300 every 3 years	20% **co-insurance**
Medical aids and durable medical equipment This benefit pays for instruments or devices or durable medical equipment which are prescribed by the **medical practitioner** as a **medically necessary** aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint, and orthopaedic supports.	up to S$500	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$50,000 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.	No benefit	20% **co-insurance**
Pre- and post-natal complications This benefit pays for **treatment** of an eligible **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth for female **member** over the age of 18 years. Under post-natal complications, **we** will only pay for **treatment** received within 90 days following the childbirth. This benefit does not cover: a) the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or b) any complication arising from non-medically necessary caesarean section birth. c) **treatment** of any **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted conception. Whilst **we** recognise that caesarean section may sometimes be a **medical necessity**, caesarean section is only payable if the **member** insured has paid for the Optional add-on 'Normal (Routine) Pregnancy and childbirth benefit,' available for Plan A only, subject to compulsory co-insurance 20% per claim. No upgrade of **plan** is allowed without prior approval from **us** and subject to the terms and conditions of the **policy**. For avoidance of doubt, this benefit shall not be payable if the: • childbirth is through non-medically necessary caesarean birth, and/or • conception of the child is conceived by artificial means or any form of assisted conception. Please note: If **we** are not able to determine that a caesarean section is **medically necessary**, **we** will consider it as not medically necessary.	S$5,000 Available only after 365 consecutive days membership	20% **co-insurance**

Benefits Table (Plan C)

Benefits Table	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$**2,800,000**	
Area of cover		
Area of cover This is the geographical area where **you** can choose to receive **treatment. You** can select **your area of cover** at time of application. **Your** chosen **area of cover** has an impact on **your** premium.	**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 charge, 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**. **We** will only pay for the **hospital** room and board costs when the length of stay is **medically necessary** and is considered by **us** as clinically appropriate for the **member**'s **medical condition**. Wherever a **member** receives **treatment**, if the **hospital** offers several classes for the room type, he is entitled for, **we** will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that **hospital** for that type of room. If a **member** stays in a room which is more expensive than the standard room, the **member** may have to pay for the difference in room charges. The **member** may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with **us** prior to admission to avoid unnecessary out of pocket expenses.	Standard single room	Annual **deductible**
Hospital charges This benefit pays for **eligible** hospital charges given between admission and discharge including: a) Diagnostic procedures b) Surgical procedures c) Operating theatre charges d) Nursing care, drugs, and dressings e) Surgeons' and anaesthetists' charges f) Intensive care unit charges g) Consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it h) Oncology treatment including radiotherapy and chemotherapy i) Kidney dialysis j) Computerised tomography, magnetic resonance imaging, x-rays, and other such proven medical imaging techniques k) Special nursing in **hospital**	Included	Annual **deductible**
Organ transplant This **benefit** pays for transplantation of kidneys, heart, liver, lung, or bone marrow required as a result of an **eligible medical condition** and provided that the organ is from a certified and verified source of donation and the procurement and transplantation of such organ is in accordance with the World Health Organisation (WHO) Guiding Principles on Human Cell, Tissue and Organ Transplantation. The **policy** does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor.	Included	Annual **deductible**

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
In-patient and Daycare Treatment		
Living organ donor This benefit pays up to the annual limits shown in the benefit schedule for reasonable and customary charges incurred for a live **member** to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung, or bone marrow) of this **policy**, provided: a) the operation and transplant are for the member's family member (parent, sibling, child, spouse, or partner); b) the transplant is in line with appropriate regulatory guidelines; c) the recipient of the organ was first diagnosed by a doctor or have symptoms which first appeared after a **waiting period** of twenty-four (24) months from the **policy** commencement date or the date after this Living Organ Donor (member) Transplant benefit first became effective under this **policy** or the last reinstatement date (if any) whichever is the latest; and Shall include **eligible** expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalisation treatment. Both pre- and post-hospitalisation benefit are limited to one hundred and twenty (120) days prior or after treatment, respectively. This benefit requires pre-authorisation from us. 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**
Reconstructive Surgery This benefit pays for the initial reconstructive surgery which is **medically necessary** and provided that (i) it is carried out to restore function after an **accident** or following surgery for an eligible **medical condition**; and (ii) that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened. In the case of breast c**ancer**, the initial reconstructive surgery must be part of the eligible **treatment** following the **cancer treatment** which includes one planned surgery to reconstruct the diseased breast and one further planned surgery to the other breast when it has not been operated on, to improve symmetry. If the **member** chooses not to have reconstructive surgery following **treatment** of breast **cancer**, no further reconstructive surgery will be covered by **us** on either the diseased breast or the unaffected breast. Benefit for reconstructive surgery is subject to **our pre-authorisation** and must be done at a medically appropriate stage (as determined by **our medical practitioner**) after the **accident** or surgery.	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**.	up to S$190 per night	Annual **deductible**
New Born accommodation This benefit pays for the child who is less than 16 weeks to stay in the **hospital** while the insured mother is receiving eligible **in-patient treatment**.	Included	Annual **deductible**
Cash benefit 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$140 per night (up to a maximum of 30 nights per **year**)	Not Applicable
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 **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 twenty-eight (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 one hundred eighty (180)days	Included	Annual **deductible**

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
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**
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** pre-/post hospitalisation **treatment.** Diagnostic tests include and are limited to laboratory, x-rays, and ultrasound. The number of visits covered by this benefit is limited to once per day with a **medical practitioner** for the same **medical condition**	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 This benefit includes one post-surgery consultation within 90 days from the date of the surgical procedure	20% **co-insurance**
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 p**olicy** 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 (RMAPs) This benefit requires **pre-authorisation** before the **member** starts **treatment**. **We** cover a small number of approved ATMPs/CGTPs/RMATs. For the current list of ATMPs/CGTPs/RMATs, that **we** cover, refer to benefit clarifications section for details.	Included	Annual **deductible**
Proton Beam Therapy (PBT) Radiation therapy which uses protons to treat cancer. **We** will pay PBT for: • malignant solid cancers in members aged twenty-one (21) and under • central nervous system (brain and spinal cord) cancer • chordomas or chondrosarcomas (types of spine cancer) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised) • high naso-ethmoid, frontal and sphenoid tumours with base of skull involvement • adenoid cystic carcinoma with perineural invasion • esthesioneuriblastoma • cancer of the iris, ciliary body, or choroid parts of the eye (uveal melanoma) which has not spread (metastasised) • conjunctival melanoma • choroidal haemangioma Please note: There is limited cover for **Proton Beam Therapy** in the circumstances shown above. Refer to benefit clarifications section for details.	Included	Annual **deductible**

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
Out-patient Treatment		
Kidney dialysis **We** will pay for kidney dialysis received as an **out-patient** for an eligible **medical condition** at a registered medical facility recognised by **us**.	Included	Annual **deductible**
Computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans **We** will pay for computerised tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an eligible **out-patient treatment**. Such **treatment** must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has requested such diagnostic scans. For clarity, this benefit does not cover charges for consultations, **prescriptions**, and other **diagnostic procedures** such as laboratory tests, x-ray, and ultrasound.	Included	20% **co-insurance**
Hormone replacement therapy (HRT) **We** will pay for the consultations and the cost of the implants, injections, patches, or tablets as part of post-hospitalisation **treatment** when it is **medically necessary** and resulting from a medical intervention rather than for the relief of physiological symptoms. Where hormone replacement therapy is only required for the relief of menopausal symptoms, **we** will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the benefit table applicable to member's **plan.**	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 **Treatmen**t given by any of these practitioners must be referred by the **medical practitioner** who has defined a diagnosis. Benefit is payable only following **in-patient treatment** for an eligible **medical condition**, provided that the **member** has been continuously covered under the **policy** since before the **in-patient treatment** commenced. **Treatment** given by any of these practitioners must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has defined a diagnosis. There must be a clear and complete treatment plan detailing the start to the end of the **treatment** by the **physiotherapist**, speech therapist or occupational therapist with an expected outcome to restore the normal form and/or function after an acute illness or **injury.**	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. There must be a clear and complete **treatment** plan from the chiropractor, osteopath, homeopath, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, physiotherapist, and the traditional Chinese medicine practitioner detailing the start to the end of the **treatment** with an expected outcome that is restorative in nature to help the **member** to carry out his/her normal activities of daily living.	No benefit	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. **We** will pay for the combined cost of administering necessary vaccines given by a **medical practitioner** or nurse and cost of the vaccines, including the consultation charges.	No benefit	20% **co-insurance**
Health screen This benefit includes the cost of any eligible consultation needed as part of the screening process. This is a preventive health check benefit specifically designed for early detection for disease prevention.	No benefit	20% **co-insurance**

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
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 extra-oral impact. Benefit is not payable if: a) the damage was caused by normal wear and tear b) the **injury** was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn c) the damage was caused by tooth brushing or any other oral hygiene procedure d) the damage is not apparent within seven (7) days of the oral impact which caused the injury This benefit is available only if the **member** has been continuously covered under the **policy** since before the **accident** happened.	Included	20% **co-insurance**
Oral and maxillofacial surgery This benefit pays only for the following procedures performed by an oral and maxillofacial surgeon: a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms b) Surgical removal of complicated buried roots which are diseased or causing symptoms c) Enucleation (removal) of cysts of the jaw d) Treatment of cancers (For lesion or lump in the mouth) **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. **We** do not cover costs for **treatment** that have not yet taken place, even if it is being provided as part of a **treatment** package. **Pre-existing condition** limitations are not applicable to this benefit.	No benefit	20% **co-insurance**
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.	No benefit	20% **co-insurance**
Emergency Evacuation and Repatriation		
International Emergency Medical Assistance (IEMA) This benefit pays for the following services: a) Evacuation where the local medical facilities are not adequate according to our appointed doctor b) Evacuation will be to the nearest medical facility where **treatment** is adequate c) Transportation for returning to the **principal country of residence** following the evacuation d) Cost of one accompanying person while the covered person is being evacuated e) Hotel accommodation of one accompanying person up to 10 days f) Bringing the body or ashes back to a port or airport in the **principal country of residence** or home country if the covered person dies abroad as a result of an **eligible medical condition**.	Included	Not Applicable

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
Maternity Benefit		
Investigation into infertility This benefit pays for investigation and treatment of the cause of infertility.	No benefit	20% **co-insurance**
Pre- and post-natal complications This benefit pays for **treatment** of an eligible **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth for female **member** over the age of 18 years. Under post-natal complications, **we** will only pay for **treatment** received within 90 days following the childbirth. This benefit does not cover: a) the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or b) any complication arising from non-medically necessary caesarean section birth. c) **treatment** of any **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted conception. Whilst **we** recognise that caesarean section may sometimes be a medical necessity, caesarean section is only payable if the **member** insured has paid for the Optional add-on 'Normal (Routine) Pregnancy and childbirth benefit,' available for **Plan** A only, subject to compulsory co-insurance 20% per claim. No upgrade of **plan** is allowed without prior approval from **us** and subject to the terms and conditions of the **policy**. For avoidance of doubt, this benefit shall not be payable if the: • childbirth is through non-medically necessary caesarean birth, and/or • conception of the child is conceived by artificial means or any form of assisted conception. Please note: If **we** are not able to determine that a caesarean section is **medically necessary**, **w**e will consider it as not medically necessary.	S$2,500 Available only after 365 consecutive days membership	20% **co-insurance**
New Born Cover		
Acute medical condition (excluding congenital conditions) This benefit pays for the **treatment** of **acute medical condition**, providing there is no underlying **congenital condition**, developed in a new born 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 new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: a) the parent of the new born baby has been covered under **International Exclusive** for 365 consecutive days or more when the baby is born; and b) the new born 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 new born 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 Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
New Born Cover		
Treatment of congenital conditions This benefit pays for treatment of **congenital conditions**. The benefit becomes available if: a) the parent of the new born baby has been covered under consecutive days or more when the baby is born; and **Plan** A for 365 days or more when the baby is born; and b) the new born 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 **treatmen**t 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**.	No benefit	Annual **deductible**
Other Benefits		
Home nursing This benefit pays for charges incurred by an attending registered and qualified **nurse** for a **member** and only when the following conditions are met: a) after his discharge from **hospital** which the **member** had been warded in the intensive care unit for an eligible **medical condition** or undergone for an eligible daycare surgery, and b) agreed in writing by **us** beforehand that it is **medically necessary** and appropriate, and c) it is prescribed by the treating **medical practitioner** for the continued **treatment** for the eligible **medical condition** which the **member** was hospitalised for, and d) when such services are essential for medical purposes as distinct from domestic, personal, or social reasons. For avoidance of doubt, the charges refer to the fees for the service of the **nurse** incurred for nursing the **member** at home. 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$5,400	20% **co-insurance**
Pre-existing conditions and congenital conditions This benefit pays: a) treatment of **congenital conditions** (whether existing before or after the commencement of cover), and/or b) 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.	No benefit	Whether it is **co-insurance** or annual deductible will depend on the treatment received and what is stated on each benefit.

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
Other Benefits		
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.	No benefit	20% c**o-insurance**
Artificial ears and eyes This benefit pays for all the costs of 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** provided the **member** has been continuously covered under the **policy** since before the surgery or **accident** happened that has led to the need for the replacement of ears and eyes. The initial claim must be made within 12 (twelve) months of the removal of the ears and eyes and to subject to our **pre-authorisation**.	No benefit	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.	No benefit	20% **co-insurance**
Medical aids and durable medical equipment This benefit pays for instruments or devices or durable medical equipment which are prescribed by the **medical practitioner** as a **medically necessary** aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint, and orthopaedic supports.	No benefit	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$25,000 in a member's lifetime Available only after 365 consecutive days membership	Annual **deductible**