Your Policy Contract

AIA HealthShield Gold Max
(For Foreigners)

aia.com.sg

HEALTHIER, LONGER, BETTER LIVES

Table of Contents

GENERAL PROVISIONS

Notwithstanding any other provision to the contrary, any mandatory revision of the minimum deductibles, minimum co-insurance or new guidelines and conditions that may be introduced by the Ministry of Health of Singapore, CPF Board or other relevant government authorities on Medisave-approved medical insurance plans, shall apply to this Policy, provided that such mandatory revisions or new guidelines and conditions are determined by us to be relevant to this Policy.

OUR AGREEMENT

Your Policy is a legally enforceable agreement between you and us. We agree to pay the benefits set out in your Policy in exchange for the premiums paid by you.

We shall rely on the information you and the Insured gave us in your application in deciding whether or not to accept your application. All statements made in your application are, in the absence of fraud, regarded as representations and not warranties. In other words, both you and the Insured must answer all the questions in your application accurately and reveal all the facts both of you know, or ought to know. Otherwise, we can void your Policy, deny a claim under your Policy or impose additional terms and conditions on your Policy.

Your Policy is governed by and interpreted according to the laws of the Republic of Singapore.

MODIFICATIONS

Your Policy's provisions cannot be changed or varied by any of our employees, independent contractors or agents unless such change is contained in an endorsement signed by our duly authorised officer.

The clauses in your policy are subject to the provisions of the Insurance Act (Cap. 142) and other relevant laws, including subsequent changes or replacements of such provisions from time to time. In response to regulatory requirements or changes beyond our control required by law, we may amend the terms and conditions of your Policy by informing you of the relevant changes and such changes will become effective from a date specified.

NON-ADMISSION

Neither the Insured nor you shall make any admission, offer promise or payment to any third party without our prior written consent. We may at our discretion take over and conduct in the Insured's or your name the defence of any claim or commence any claim for indemnity or damages against any third party, and shall have full discretion in the conduct of any proceeding in the settlement of any claim and both the Insured and you shall give all such information and assistance as we may require.

SUBROGATION

If we shall make any payment or otherwise make good any loss applying under this Policy, we shall be subrogated to all of the Insured's and your rights of recovery against any other person or persons and you shall complete, sign and deliver any document necessary to secure such rights. Both the Insured and you shall not take any action following a loss to prejudice such rights of subrogation.

OWN INSURER

If at the time of any loss or damage, the policy limit of any benefit is less than the total amount of claim, you and/or the Insured shall be considered his own insurer for the difference.

AGE

If the age of the Insured indicated on your application is incorrectly stated, we shall, subject to the satisfaction of our terms and conditions, adjust the premiums payable according to the correct age. We shall accept the correct age if we are satisfied with the evidence produced.

If the adjusted premiums are higher, you shall be required to pay the underpaid premiums. If the adjusted premiums are lower, we shall refund the overpaid premiums without interest. Any refund shall be made to your Medisave account or to you directly, as the case may be.

If at the correct age, the Insured would not have been eligible for coverage under this Policy, no benefits shall be payable and your Policy shall be cancelled.

We may require proof of age at the time of processing any claim under your Policy.

CURRENCY OF PAYMENT

The amounts to be paid by us or to us shall be in the currency shown on the Policy Schedule.

FREE-LOOK PERIOD

We shall give you 21 days from the date of receipt of the Policy to decide whether you want to continue with your Policy. If you do not want to continue, you may cancel this Policy in writing to us and we shall refund the premiums paid for this Policy without interest. Any refund shall be made to your Medisave account or to you directly, as the case may be.

If you opted for an electronic copy of your Policy, the 21-day free-look period will start when you receive our SMS or email notification, informing you that the policy contract documents are available for your viewing on our customer portal (AIA eCare or such other name as we may choose for our customer portal from time to time).

If we have posted the Policy to you, the 21-day free-look period shall start seven (7) days after we have posted the Policy to you.

CANCELLATION

You may cancel your Policy by giving us 30 days' notice after the Free-Look Period. Cancellation shall be without prejudice to any claim arising prior to the effective date of cancellation.

We shall refund to you the portion of the premiums paid in respect of the period from the effective date of cancellation up to the next policy anniversary. After such refund of premiums, we shall not be liable for any reimbursement of any claim incurred for the remaining period of the Policy Year immediately following the effective date of cancellation.

RIGHTS OF THIRD PARTIES

The Contracts (Rights of Third Parties) Act (Cap. 53B) and any subsequent changes or replacement of its provisions shall not apply to your Policy.

NON-PARTICIPATING

This Policy shall be Non-Participating.

AVOIDANCE OF POLICY

Your Policy shall be void if any declaration or any written statement provided to us is untrue in any respect or if any material fact affecting the risk is incorrectly represented, stated or if you or the Insured have omitted such written statement.

Your Policy is treated as void:

(a) on the Policy Date if the misrepresentation, omission, or fraudulent statement was made to us on a proposal of insurance; or
(b) on the last reinstatement date (if any) or the effective date of change of plan (if any) if the misrepresentation, omission, or fraudulent statement was made to us on an application for reinstatement of insurance or change of plan.

Except in the case of fraud, when this Policy is treated as void pursuant to the above:

(a) If there are no claims made under this Policy, all premiums paid for insurance which became effective on or after the date on which this Policy is treated as void will be refunded.
(b) If there were claims made under this Policy, only the premiums paid for the Policy Year(s) following the Policy Year in which the last claim was made will be refunded.

Your Policy shall be void if any claim is fraudulent or exaggerated or if any false declaration or statement in support of any such claim is made. In this case, the Policy will be void immediately and there will be no refund of premiums. We reserve the right to recover such fraudulent or exaggerated claims that we have paid under this Policy.

CHANGE OF POLICY TERMS AND CONDITIONS

We may vary the premiums, benefits and/or cover or amend any privilege, term or condition of this Policy by giving you 31 days prior written notice, provided that such changes apply to all policies within the same class of insurance.

CHANGE OF CITIZENSHIP/ RESIDENCY/ VALID PASS STATUS

You must inform us in writing immediately of any change in the citizenship or residency status of the Insured or when he ceases to hold a Valid Pass.

If the Insured is a Foreigner and does not have a Valid Pass for a continuous period of more than 60 days after his pass is expired or terminated, the Policy shall be terminated by us in accordance with the Termination Clause of this Policy. If the expiry or the termination of the pass is due to the Insured becoming a Singapore Citizen or Singapore Permanent Resident, upon receipt of notification of the change, we reserve the right to convert the Policy to a Medisave-approved integrated medical insurance plan that is jointly insured by the CPF Board for the MediShield Life Scheme component and us for the medical enhancement scheme covering the Insured, subject to the availability of such plan.

For conversion of plan, any claim for expenses incurred before the effective date of the conversion of plan shall be payable in accordance with the benefit limits of the plan in-force prior to the conversion of plan.

CHANGE OF PLAN

You may request for a change of plan which includes plan upgrade, plan downgrade or plan conversion in accordance with our terms and conditions for a change of plan by writing to us.

Any change of plan is subject to our approval and if approved, shall take effect on such date as notified by us to you.

For change of plan, any claim for expenses incurred before the effective date of the change of plan shall be payable in accordance with the benefit limits of the plan in-force prior to the change of plan.

In relation to a plan upgrade, claims that arise on or after the effective date of plan upgrade from a pre-existing condition (physical impairment, illness or disease) developed during the period of insurance of the prior plan will be assessed and payable based on the terms and conditions and benefits limits of the plan in-force prior to the effective date of the plan upgrade, unless the Insured makes a declaration of such pre-existing condition in the application for the plan upgrade and such application is specifically accepted by us. For the avoidance of doubt, any Pre-existing Condition that was not covered under the plan in-force prior to the effective date of plan upgrade will continue to be excluded under the upgraded plan.

TERMINATION

Your Policy shall automatically terminate on the earliest occurrence of the following:

(a) if any premium of your Policy remains unpaid at the end of the Grace Period;
(b) on the commencement date of another medical insurance plan covering the Insured where the premium is paid using the Medisave funds maintained by the CPF Board, in the event the premium for this Policy is also paid using Medisave funds;
(c) on the death of the Insured;
(d) on the day immediately following the 60th day of the expiry or termination of the Insured's Valid Pass or on the day when the Policy is converted to a Medisave-approved integrated medical insurance plan due to the Insured becoming a Singapore Citizen or Singapore Permanent Resident, whichever is earlier; or
(e) on the effective date of cancellation.

Termination of this Policy shall not affect any claim arising prior to such termination of this Policy. In no instance shall any benefit be payable for expenses incurred on or after the date of termination, regardless of whether the incurred expense is a direct result of a covered condition which occurred before the termination of this Policy. Our acceptance of any premium after termination shall not create a liability for us.

If the Policy is terminated due to occurrence of (b), (c), (d) or (e), we shall refund to you the portion of the premiums paid for the Policy Year in respect of the period from the date of termination up to the next policy anniversary.

BENEFITS PROVISIONS

LIMITS ON ELIGIBLE EXPENSES

Eligible Expenses are:

(a) limited to Reasonable and Customary charges for medical expenses or fees incurred; and
(b) subject to the Limit of Compensation under each respective benefit stated in the Schedule of Benefits of this Policy in accordance with the plan type applicable at the time such medical expenses or fees are incurred.

BENEFITS

While this Policy is in-force, we shall pay up to the Limits of Compensation for each respective benefit under this Policy for any Eligible Expenses incurred, less any Deductible and/or Co-insurance as stated in the Schedule of Benefits and subject to the terms and conditions of this Policy.

In relation to the following benefits we shall pay up to the Limits of Compensation for each respective benefit under this Policy for any Eligible Expenses incurred:

(a) Part (F)(ii) – Congenital Abnormalities of Insured's Biological Child from Birth under Congenital Abnormalities Benefits;
(b) Part (G)(i) – Insured (as the Living Donor) Donating an Organ under Living Donor Organ Transplant Benefits;
(c) Part (G)(ii) – Non-insured (as the Living Donor) Donating an Organ to the Insured under Living Donor Organ Transplant Benefits;
(d) Part (I)(i) – In-Hospital Psychiatric Treatment under Psychiatric Treatment Benefits; and
(e) Part (I)(ii) – Post-Hospitalisation Psychiatric Treatment under Psychiatric Treatment Benefits.

For such purposes, we reserve the right to:

(a) determine whether any particular Hospital or medical charge is a Reasonable and Customary charge with reference (but not limited) to our claim data, relevant publications or information on schedule of fees prescribed by the government, relevant authorities and recognized medical associations in the locality; and
(b) adjust any and all sums payable in relation to any Hospital or medical charge, which is in our opinion or in the opinion of our medical advisor, is not a Reasonable and Customary charge.

In the event of treatment for conditions for which guidelines on fees and medical practice (which outline the most appropriate course of care for a specific condition, operation or procedure) may be published by the Ministry of Health of Singapore or official medical body in Singapore, we will take reference from these when assessing and paying claims.

Further, there are specific clinical situations where we may require additional criteria to be met in order for a claim to be admitted. Refer to the list of clinical situations in Appendix A.

If you are receiving treatment that involves the use of high-cost technologies, you must obtain approval from us prior to your treatment. Where approval from us has not been obtained, charges for the use of such technology may not be covered under this Policy and we may not make payment for such charges. Refer to the list of high-cost technologies in Appendix B.

In no instance shall any benefit be payable for any expense which is incurred before the Policy Date or occurs after the termination or cancellation of the Policy, regardless of whether the incurred expense is a direct result of a covered condition which occurred before the termination or cancellation of the Policy.

(A) Hospitalisation and Surgical Benefits

(i) Daily Room and Board Benefit

This benefit shall be equal to the Eligible Expenses incurred for room and board charges for a Standard Room including high dependency ward charges, and includes meals, prescriptions, professional charges, investigations and miscellaneous medical charges incurred per day during the period for which the Insured requires Confinement due to an Illness or Injury.

(ii) Daily Intensive Care Unit (ICU) Benefit

This benefit shall be equal to the Eligible Expenses incurred for ICU charges, and includes meals, prescriptions, professional charges, investigations and miscellaneous medical charges incurred per day during the period for which the Insured requires Confinement at the ICU of a Hospital due to an Illness or Injury.

(iii) Community Hospital Benefit

This benefit shall be equal to the Eligible Expenses incurred for room and board charges for a Standard Room and includes meals, inpatient prescriptions, professional charges, investigations, laboratory tests, rehabilitation services and the miscellaneous medical charges incurred per day during the period the Insured requires to be treated as an inpatient in a Community Hospital due to an Illness or Injury and provided such hospitalisation is immediately preceded by:

(a) Confinement in a Hospital; or
(b) treatment from a Restructured Hospital's Accident and Emergency Unit in Singapore,

and is referred by a Physician or Specialist of the Hospital or recommended by the Restructured Hospital's Accident and Emergency Unit in Singapore, to continue the treatment for the Illness or Injury.

Such hospitalisation in the Community Hospital must be for a continuous period of not less than six (6) hours.

(iv) Surgical Benefit

This benefit shall be equal to the Eligible Expenses incurred for Surgical Procedures, surgical implants, Approved Medical Consumables and stereotactic radiosurgery including operation theatre and anaesthesia fees as required by the Physician or Specialist during Confinement due to an Illness or Injury.

(v) Organ Transplant Benefit

In the event of a full or partial human organ transplantation of the kidney(s), heart, liver, lung, pancreas, cornea(s), skin or a bone marrow transplant where the Insured is the recipient of organ or bone marrow, we shall reimburse the Eligible Expenses incurred per transplant for the Surgical Procedure relating to the transplant including operation theatre and anaesthesia fees as required by the Physician or Specialist during Confinement in a Hospital due to an Illness or Injury.

We shall also reimburse the Eligible Expenses incurred for recovering such organs or bone marrow as may be approved from time to time under the MediShield Life Scheme from a non-living human organ donor (cadaveric donor) for the purpose of facilitating the Insured's transplant.

The organ or bone marrow recovery costs arising from or in relation to or incidental to the recovery of any organ or bone marrow or related parts of such organs or bone marrow approved from time to time under the MediShield Life Scheme from a non-living human organ or bone marrow donor (cadaveric donor) for the purpose of facilitating the Insured's transplant shall be limited to the following costs:

(a) charges for the donor's extended stay, after he is certified dead, in a Hospital as necessitated by the donation of his organ or bone marrow;
(b) charges for any surgical operation to remove the specified organ or bone marrow from the donor's body;
(c) charges for any pre-harvesting laboratory test and investigation related to the medical status of the donor and the viability of the organ or bone marrow to be transplanted;
(d) charges for any counselling provided by medical social workers to the donor's family in connection with the donation of his organ or bone marrow; and
(e) charges for the storage and transport of the specified organ or bone marrow after the organ or bone marrow is removed from the donor's body.

However, the organ or bone marrow transplant surgery has to be performed on the Insured in a Hospital in Singapore before the relevant organ or bone marrow recovery cost can be submitted for claim. We shall only reimburse the costs which are listed in items (a) to (e) above. All other costs arising from or in relation to or incidental to the recovery of any organ or bone marrow or related parts of such organ or bone marrow approved from time to time under the MediShield Life Scheme from a non-living human organ or bone marrow donor (cadaveric donor) for the purpose of facilitating the Insured's transplant are expressly excluded.

For the avoidance of doubt, we shall not pay for any cost if the organ or bone marrow transplant is illegal or arises from any illegal transaction or practice.

(vi) Stem Cell Transplant Benefit

In the event of a stem cell transplant surgery, we shall reimburse the Eligible Expenses incurred for the stem cell transplant Surgical Procedure including operation theatre and anaesthesia fees as required by the Physician or Specialist during Confinement in a Hospital due to an Illness or Injury.

For the avoidance of doubt, in relation to stem cell transplants, outpatient therapies such as injection or extraction where the Insured does not require Confinement in a Hospital shall not be covered.

(B) Pre-Hospitalisation Benefit

If the Insured requires Confinement to undergo medical or surgical treatment due to an Illness or Injury, we shall reimburse the Eligible Expenses for pre-hospitalisation treatment and test including Specialist consultations, diagnostic x-rays or laboratory tests that the Insured is required to undergo upon the written recommendation or approval of a Physician or Specialist for the same Illness or Injury that causes the Confinement and within such period specified in the Schedule of Benefits prior to such Confinement.

(C) Post-Hospitalisation Benefits

If the Insured requires Confinement to undergo medical or surgical treatment due to an Illness or Injury, we shall reimburse the Eligible Expenses incurred for post-hospitalisation treatment and test for the same Illness or Injury treated during the Confinement as set out under this Part (C)(i) – Post-Hospitalisation Treatment and Part (C)(ii) – Extended Post-Hospitalisation Treatment for 30 Critical Illnesses.

No payment under this benefit shall be made for any routine medical check-up which is not part of the post-hospitalisation medical treatment as recommended by the Physician or Specialist and is not related to the Confinement. No payment shall be made for any treatments, medical services, supplies and/or medication purchased within the period specified in the Schedule of Benefits for the Post-Hospitalisation Benefits which are not utilised within the same period.

(i) Post-Hospitalisation Treatment

We shall reimburse the Eligible Expenses incurred for any post-hospitalisation medical treatment and test that the Insured is required to undergo upon the written recommendation or approval of the Physician or Specialist provided they are done for the same Illness or Injury that causes the Confinement and within such period specified in the Schedule of Benefits following the day such Confinement ends.

(ii) Extended Post-Hospitalisation Treatment for 30 Critical Illnesses

We shall continue to reimburse the Eligible Expenses incurred for any post-hospitalisation medical treatment and test that the Insured is required to undergo as a direct result of one (1) of the 30 Critical Illnesses (as defined in Part (M) – Extra Cover for 30 Critical Illnesses Benefit) for an additional 100 days immediately following the expiry of 100 days from the day the Confinement ends for post-hospitalisation treatment covered under Part (C)(i) – Post-Hospitalisation Treatment.

Such extended post-hospitalisation treatments and tests must be upon written recommendation or approval of a Physician or Specialist for the critical illness where the extended post-hospitalisation treatments and tests are done for the same critical illness for which the Confinement was required under Part (C)(i) –- Post-Hospitalisation Treatment.

This Extended Post-Hospitalisation Treatment for 30 Critical Illnesses shall not apply and shall not be payable if Part C(i) - Post-Hospitalisation Treatment has been claimed for a period of 200 or more days following the day such Confinement ends.

(D) Accidental Inpatient Dental Treatment Benefit

If the Insured requires Confinement to repair the Insured's own sound natural teeth (dentures and all related expenses are expressly excluded) necessitated by an Injury caused by an Accident, we shall reimburse such Eligible Expenses incurred.

For the avoidance of doubt, Eligible Expenses incurred in respect of and in connection with the Accidental Inpatient Dental Treatment Benefit are eligible to be reimbursed under Parts (A), (B) and (C) under the Benefits Provisions of this Policy.

(E) Pregnancy Complications Benefit

We shall reimburse the Eligible Expenses incurred if the Insured requires Confinement in a Hospital to undergo medical or surgical treatment due to one of the following pregnancy complications as defined herein:

(a) Ectopic pregnancy – Diagnosis by an obstetrician of a condition in which implantation of a fertilised ovum occurs outside the uterine cavity, and its subsequent complications;
(b) Pre-eclampsia or eclampsia – Diagnosis of pre-eclampsia or eclampsia by an obstetrician;
(c) Disseminated intravascular coagulation – Diagnosis of disseminated intravascular coagulation by an obstetrician;

(d) Miscarriage – Diagnosis by an obstetrician of the death of the foetus of the Insured after 13 weeks of pregnancy as a result of a sudden unforeseen and involuntary event and must not be due to a voluntary or malicious act;
(e) Acute fatty liver pregnancy – Diagnosis by an obstetrician of severe acute fatty liver occurring during pregnancy and where at least three (3) of the following criteria must be fulfilled:
    (1) Imaging studies consistent to the diagnosis of a fatty liver;
    (2) Bilirubin is persistently elevated above 150 umol/L (10 mg/dL) for a period of at least five (5) days;
    (3) Renal impairment; and/or
    (4) Coagulopathy.

    Liver damage in the presence eclampsia, pre-eclampsia and viral hepatitis shall be excluded.
(f) Choriocarcinoma and hydatidiform mole – occurrence of a histologically confirmed choriocarcinoma and/or molar pregnancy, and its subsequent complications;
(g) Postpartum haemorrhage requiring hysterectomy – the ongoing bleeding secondary to an unresponsive and atonic uterus, a ruptured uterus, or a large cervical laceration extending into the uterus requiring hysterectomy. Proof of actual undergoing of hysterectomy is required;
(h) Still birth - Diagnosis by an obstetrician of the death of the foetus of the Insured after 26 weeks of pregnancy which meets the definition of still birth in the Registry of Births and Deaths Act, and is a result of a sudden unforeseen and involuntary event and not any voluntary or malicious act on the part of the Insured;
(i) Cervical incompetency - Diagnosis by an obstetrician of cervical incompetency requiring cervical cerclage;
(j) Accreta placenta - Diagnosis by an obstetrician of abnormal trophoblast invasion into the myometrium of the uterine wall, requiring cesarean hysterectomy during delivery;
(k) Placental abruption - Diagnosis by an obstetrician of partial or complete placental detachment prior to delivery of the foetus in a pregnancy over 20 weeks in duration;
(l) Placenta praevia - Diagnosis by an obstetrician of the presence of placental tissue extending over the internal cervical os, resulting in an indication for cesarean delivery;
(m) Antepartum, intrapartum and postpartum haemorrhage - Diagnosis by an obstetrician of severe abnormal bleeding from the female genital tract at or after 20 weeks of pregnancy before or during childbirth;
(n) Placental insufficiency and intrauterine growth restriction - Diagnosis by an obstetrician of placental insufficiency leading to intrauterine growth restriction;
(o) Gestational diabetes mellitus - Diagnosis by an obstetrician of gestational diabetes mellitus. The Diagnosis must have been made through a 75g oral glucose tolerance test;
(p) Obstetric cholestasis - Diagnosis by an obstetrician of obstetric cholestasis;
(q) Twin to twin transfusion syndrome - Diagnosis by an obstetrician of twin to twin transfusion syndrome. There should be ultrasonic evidence of a single monochorionic placenta with twin oligohydroamnios / polyhydramnios sequence;
(r) Infection of amniotic sac and membranes - Diagnosis by an obstetrician of infection of the amniotic sac or membranes;
(s) Amniotic fluid embolism - a life threatening obstetric emergency characterised by sudden cardiorespiratory collapsed and disseminated intravascular coagulation. The Diagnosis of amniotic fluid embolism must be confirmed by an obstetrician;
(t) Fourth degree perineal laceration - Diagnosis by an obstetrician of a perineal laceration following vaginal delivery which involves the perineal structures, external anal sphincter, internal anal sphincter, and rectal mucosa. Perineal laceration less than fourth degree or without identified degree are excluded;
(u) Uterine rupture - Diagnosis by an obstetrician of the uterine rupture, defined as the complete disruption of all uterine layers, including the serosa, leading to change in maternal or fetal status;
(v) Postpartum inversion of uterus - Diagnosis by an obstetrician of a condition in which the uterine fundus collapses into the endometrial cavity, turning the uterus partially or completely inside out;
(w) Obstetric injury or damage to pelvic organs - Diagnosis by an obstetrician of injuries to the pelvic organs or surrounding structures as a consequence of vaginal delivery;

(x) Complications resulting in a caesarean hysterectomy - removal of the uterus during a caesarean section delivery in cases where removal of the uterus is solely due to complications that have arisen during the pregnancy or delivery;
(y) Retained placenta and membranes - Diagnosis by an obstetrician of the retention of the placenta or other products of conception in the uterus after delivery;
(z) Abscess of breast - abscess of breast associated with childbirth.

These pregnancy complications must have been first Diagnosed after the Insured has been insured under this Policy for a continuous period of 10 months from the Policy Date the last reinstatement date (if any) or effective date of plan upgrade (if any) of this Policy, whichever is latest.

For the avoidance of doubt, Eligible Expenses incurred in respect of and in connection with the Pregnancy Complications Benefit are eligible to be reimbursed under Parts (A), (B) and (C) under the Benefits Provisions of this Policy.

(F) Congenital Abnormalities Benefits

(i) Congenital Abnormalities of Insured's Biological Child from Birth

We shall reimburse the Eligible Expenses incurred by the Insured's biological child if the child is required to be Confined in a Hospital to undergo medical or surgical treatment due to birth defects, including hereditary conditions and congenital sickness or abnormalities during the first 24 months from date of birth of the child.

These conditions relating to the Insured's biological child must be first Diagnosed by a Physician or Specialist after the Insured has been insured under this Policy for a continuous period of 10 months from the Policy Date, the last reinstatement date (if any) or the effective date of plan upgrade (if any) of this Policy, whichever is latest.

This benefit applies only if the Insured is a female.

(ii) Congenital Abnormalities of Insured

We shall reimburse the Eligible Expenses incurred by the Insured if he is required to be Confined in a Hospital to undergo medical or surgical treatment due to his own birth defects, including hereditary conditions and congenital sickness or abnormalities.

For the avoidance of doubt, the Eligible Expenses incurred in respect of and in connection with Part (F)(i) – Congenital Abnormalities of Insured's Biological Child from Birth and Part (F)(ii) – Congenital Abnormalities of Insured are eligible to be reimbursed under Parts (A), (B) and (C) under the Benefits Provisions of this Policy.

For the avoidance of doubt, all Eligible Expenses incurred in respect of an in connection with Part (F)(i) – Congenital Abnormalities of Insured's Biological Child from Birth and Part (F)(ii) – Congenital Abnormalities of Insured, shall be accumulated towards its respective Limit of Compensation under the Congenital Abnormalities Benefits stated in the Schedule of Benefits.

(G) Living Donor Organ Transplant Benefits

In relation to Living Donor Organ Transplant Benefits, we shall not pay for any cost related to the surgery to remove the organ from a living donor if the organ transplant is illegal or arises from any illegal transaction or practice.

(i) Insured (as the Living Donor) Donating an Organ

We shall reimburse the Eligible Expenses incurred by the Insured, who is the living donor to remove his kidney or a part of his liver, for purpose of its transplantation into the body of a living recipient, subject to the following:

(a) the surgery to remove the organ from the living Insured is approved under MediShield Life Scheme and regulated under HOTA and is performed in a Hospital in Singapore;
(b) the date the recipient of the organ is first Diagnosed of an organ failure is after 24 months from the Policy Date, the last reinstatement date (if any), or the effective date of the plan upgrade (if any) of this Policy, whichever is latest; and
(c) the expenses incurred must be directly attributed to the Insured's organ donation surgery for the recipient's organ transplant surgery and shall be limited to the following costs:
    (1) charges for any pre-hospitalisation treatment and test incurred by Insured including Specialist consultations, diagnostic x-rays or laboratory tests including pre-harvesting laboratory tests and investigations;
    (2) charges for the Insured's Confinement in Hospital as necessitated by the donation of his organ;
    (3) charges for the Surgical Procedure to remove the specified organ from the Insured's body;
    (4) charges for the storage and transport of the specified organ after the organ is removed from the Insured's body; and
    (5) charges for any post-hospitalisation treatment or test incurred by the Insured including any post-transplant complication arising thereafter following the organ donation surgery on the Insured.

Any counselling provided by medical social workers to the Insured's family in connection with the donation of his organ shall not be covered by this Policy.

(ii) Non-insured (as the Living Donor) Donating an Organ to the Insured

We shall reimburse the Eligible Expenses incurred by a living donor who is not the Insured under this Policy to remove his kidney or a part of his liver, for purpose of its transplantation into the body of the Insured, who is the recipient of the organ, subject to the following:

(a) the surgery to remove the organ from the living donor is approved under MediShield Life Scheme and regulated under HOTA and is performed in a Hospital in Singapore;
(b) the living donor is not eligible to be reimbursed for his organ donation surgery under MediShield Life Scheme, a Medisave-approved integrated medical insurance plan or any other insurance plan;
(c) the Insured, with the agreement from the living donor, agrees to claim under his Policy to reimburse the living donor for the organ donation surgery; and
(d) the expenses incurred must be directly attributed to the organ donation surgery of the living donor for the Insured's own organ transplant surgery and shall be limited to the following costs:
    (1) charges for the living donor's Confinement in Hospital as necessitated by the donation of the organ;
    (2) charges for the Surgical Procedure to remove the specified organ from the living donor's body; and
    (3) charges for the storage and transport of the specified organ after the organ is removed from the living donor's body.

The following expenses are expressly excluded from the above Part (G)(ii) – Non-insured (as the Living Donor) Donating an Organ to the Insured:

(a) charges for any pre-hospitalisation treatment or test incurred by the living donor including Specialist consultation, diagnostic x-rays or laboratory tests including pre-harvesting laboratory tests and investigations;
(b) charges for any post-hospitalisation treatment or test incurred by the living donor including any post-transplant complication arising thereafter following the organ donation surgery on the living donor; and
(c) charges for any counselling provided by medical social workers to the living donor's family in connection with the donation of his organ.

For the avoidance of doubt, all Eligible Expenses incurred in respect of and in connection with Part (G)(i) –– Insured (as the Living Donor) Donating an Organ and Part (G)(ii) – Non-insured (as the Living Donor) Donating an Organ to the Insured, shall be accumulated towards its respective Limit of Compensation under the Living Donor Organ Transplant Benefits stated in the Schedule of Benefits.

(H) Emergency Overseas (Outside Singapore) Medical Treatment Benefit

We shall reimburse the Eligible Expenses incurred for overseas medical or surgical treatment if the Insured is Confined in a Hospital outside Singapore as a result of an Emergency outside of Singapore, limited to Reasonable and Customary charges which would have been incurred for similar medical treatment or surgery carried out in a private Hospital in Singapore.

If we admit the claims for the Eligible Expenses incurred for a Confinement in a Hospital outside of Singapore, we shall convert all bills rendered to the contract currency based on such prevailing exchange rate as may be determined by us to be in effect on the date of leaving the Hospital or date the overseas medical or surgical treatment is incurred.

Eligible Expenses incurred in respect of and in connection with the Emergency Overseas (Outside Singapore) Medical Treatment Benefit are eligible to be reimbursed:
(i) under Part (A) under the Benefits Provisions of this Policy; and
(ii) under Part (C) under the Benefits Provisions of this Policy, provided that the post-hospitalisation treatment and tests are done in Singapore and within such period specified in the Schedule of Benefits following the day such Confinement ends.

(I) Psychiatric Treatment Benefits

(i) In-Hospital Psychiatric Treatment

We shall reimburse the Eligible Expenses incurred for medical or surgical treatment including room and board charges for a Standard Room, meals, prescriptions, professional charges, investigations and miscellaneous medical charges incurred per day during the period the Insured is Confined in a Hospital to receive psychiatric treatment provided by a Psychiatrist. Such hospitalisation and psychiatric treatment must be advised in writing for the Insured by a Psychiatrist and administered to the Insured under the direct supervision of a Psychiatrist.

(ii) Post-Hospitalisation Psychiatric Treatment

If the Insured requires Confinement in a Hospital for psychiatric treatment, we shall reimburse the Eligible Expenses incurred for post-hospitalisation psychiatric treatments and tests that the Insured is required to undergo, within the period specified in the Schedule of Benefits following the day such Confinement ends. Such post-hospitalisation psychiatric treatment must be for the same condition that

necessitates the Confinement for which In-Hospital Psychiatric Treatment is payable under Part (I)(i) – In-Hospital Psychiatric Treatment.

No payment shall be made for any routine medical check-up which is not part of the post-hospitalisation psychiatric medical treatment by the Physician or Specialist.

No payment shall be made for any treatments, medical services, supplies and/or medication purchased within the period specified in the Schedule of Benefits for the Post-Hospitalisation Psychiatric Treatment which is not utilised within the same period.

For the avoidance of doubt, all Eligible Expenses incurred in respect of and in connection with Part (I)(i) – In-Hospital Psychiatric Treatment and Part (I)(ii) – Post-Hospitalisation Psychiatric Treatment are accumulated towards its respective Limit of Compensation under Psychiatric Treatment Benefits as stated in the Schedule of Benefits.

(J) Outpatient Benefit

This benefit shall be equal to the Eligible Expenses incurred during the following course of treatments:

(a) radiotherapy for cancer;
(b) stereotactic radiotherapy for cancer;
(c) chemotherapy for cancer;
(d) immunotherapy for cancer;
(e) renal dialysis;
(f) erythropoietin;
(g) immunosuppressant drugs approved by the Health Sciences Authority which are prescribed to the Insured following an organ transplant; and
(h) long-term parenteral nutrition.

In relation to immunosuppressant drugs, we shall not reimburse the immunosuppressant drugs if the organ transplant is illegal or arises from any illegal transaction or practice.

In relation to long-term parenteral nutrition, we will cover for the parenteral nutrition bags and consumables necessary for the administration of parenteral nutrition, and the Insured must fulfill all the clinical criteria for long-term parenteral nutrition under the MediShield Life Scheme.

Confinement is not required for this benefit to be payable. The Eligible Expenses incurred under the Outpatient Benefit are not subject to Deductible but are subject to Co-insurance.

(K) Final Expense Benefit

The Final Expense Benefit shall be reimbursed to waive the Deductible and Co-Insurance incurred in that Policy Year, in the event the Insured dies:

(a) during Confinement in a Hospital; or
(b) within 30 days following discharged from the Hospital after Confinement, provided the death is as result of an Illness or Injury that has led to the Confinement.

The total amount payable as Final Expense Benefit is subject to the Limit of Compensation stated in the Schedule of Benefits.

(L) Waiver of Premium for 1 Year Benefit (Upon Total and Permanent Disability)

If the Insured, before policy anniversary occurring on or immediately following the Insured's 70th birthday, sustains Total and Permanent Disability while this Policy is in-force, we will waive the premium for one (1) year, starting from the next premium due immediately following the date of commencement of such Total and Permanent Disability. Subsequent premiums due, following the waiver of one (1) year of premium, shall be payable by you.

For the purpose of this benefit, Total and Permanent Disability shall refer to **"TPD 1"**, **"TPD 2"** and **"TPD 3"**.

"TPD 1" means disability sustained by the Insured before the policy anniversary occurring on or immediately following the Insured's 65th birthday, such that from the time the disability commences and at any time thereafter:

(a) the Insured is not capable of doing or carrying out any work, occupation or profession, to earn or obtain any wages, compensation or profit; and
(b) such disability must continue uninterrupted for at least six (6) consecutive months **("TPD Period")** and there is no possibility of improvement for an indefinite time.

"TPD 2" means disability sustained by the Insured on and after the policy anniversary occurring on or immediately following the Insured's 65th birthday, such that from the time the disability commences and at any time thereafter:

(a) the Insured is not capable of performing at least two (2) of the following six (6) "Activities of Daily Living" even with the aid of special equipment, and always to require the physical assistance of another person throughout the entire activity; and
(b) such disability must continue uninterrupted for at least six (6) consecutive months (**"TPD Period"**).

Notwithstanding any of the above, we shall immediately recognise the occurrence of any of the following as **"TPD 3"**:

(a) total and irrecoverable loss of sight of both eyes; or
(b) loss by complete severance or the total and irrecoverable loss of use of two (2) limbs at or above the wrist or ankle; or
(c) total and irrecoverable loss of sight of one (1) eye; and
    (i) loss by complete severance of one (1) limb at or above the wrist or at or above the ankle; or
    (ii) total and irrecoverable loss of use of one (1) limb at or above the wrist or at or above the ankle.

In the case of a juvenile, we will only admit a claim for this benefit as a result of **TPD 3**.
For purpose of this benefit, an Insured will be considered a juvenile until such time he:

(a) reaches the age of 16 and he becomes gainfully employed or self-employed; or
(b) attains the age of 21, whichever is earlier.

For purpose of this benefit, "Activities of Daily Living" are:

Washing	the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
Dressing	the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
Transferring	the ability to move from a bed to an upright chair or wheelchair and vice versa;
Mobility	the ability to move indoors from room to room on level surfaces;

Toileting	the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
Feeding	the ability to feed oneself once food has been prepared and made available.

The diagnosis of the Total and Permanent Disability must be confirmed and certified by a Physician.

(M) Extra Cover for 30 Critical Illnesses Benefit

In the event the Insured requires medical or surgical treatment as a direct result of one of the following 30 Critical Illnesses listed below, the limits (Critical Illnesses Limit Per Policy Year and Critical Illnesses Limit Per Lifetime) under the Extra Cover for 30 Critical Illnesses Benefit stated in the Schedule of Benefits shall be provided as additional limits above the limits (Maximum Limit Per Policy Year and Maximum Limit Per Lifetime) under the Maximum Claim Limit stated in the Schedule of Benefits. The Eligible Expenses incurred shall be first accumulated towards the Critical Illnesses Limit Per Policy Year (for the applicable Policy Year). If the Eligible Expenses exceeds the Critical Illnesses Limit Per Policy Year (for the applicable Policy Year), the excess amount shall be accumulated towards the Maximum Limit Per Policy Year (for the applicable Policy Year).

This Extra Cover for 30 Critical Illnesses Benefit shall not be provided as an additional limit above the Maximum Limit Per Policy Year of S$2,000,000 under the Maximum Claim Limit.

List of 30 Critical Illnesses:

1. Heart Attack of Specified Severity
2. Stroke
3. Coronary Artery By-pass Surgery
4. HIV Due to Blood Transfusion and Occupationally Acquired HIV
5. Angioplasty & Other Invasive Treatment for Coronary Artery
6. Major Cancers
7. Fulminant Hepatitis
8. Primary Pulmonary Hypertension
9. Kidney Failure
10. Major Organ / Bone Marrow Transplantation
11. Multiple Sclerosis
12. Blindness (Loss of Sight)
13. Paralysis (Loss of Use of Limbs)
14. Muscular Dystrophy
15. Alzheimer's Disease / Severe Dementia
16. Coma
17. Deafness (Loss of Hearing)
18. Heart Valve Surgery
19. Loss of Speech
20. Major Burns
21. Surgery to Aorta
22. Terminal Illness
23. End Stage Lung Disease
24. End Stage Liver Failure
25. Motor Neurone Disease
26. Parkinson's Disease
27. Aplastic Anaemia
28. Benign Brain Tumor
29. Bacterial Meningitis
30. Viral Encephalitis

Definitions of 30 Critical Illnesses

1. Heart Attack of Specified Severity

Death of heart muscle due to obstruction of blood flow, that is evident by at least three (3) of the following criteria proving the occurrence of a new heart attack:

(a) History of typical chest pain;
(b) New characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block;
(c) Elevation of the cardiac biomarkers, inclusive of CKMB above the generally accepted normal laboratory levels or cardiac troponin T or I at 0.5ng/ml and above;
(d) Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. The imaging must be done by cardiologist specified by us.

For the above definition, the following are excluded:

(a) Angina;
(b) Heart attack of indeterminate age; and
(c) A rise in cardiac biomarkers or troponin T or I following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

Explanatory note: 0.5ng/ml = 0.5ug/L = 500pg/ml.

2. Stroke

A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis resulting in permanent neurological deficit with persisting clinical symptoms. This Diagnosis must be supported by all of the following conditions:

(a) Evidence of permanent clinical neurological deficit confirmed by a neurologist at least six (6) weeks after the event; and
(b) Findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques consistent with the Diagnosis of a new stroke.

The following are excluded:

(a) Transient ischaemic attacks;
(b) Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease;
(c) Vascular disease affecting the eye or optic nerve; and
(d) Ischaemic disorders of the vestibular system.

Permanent means expected to last throughout the lifetime of the Insured.

Permanent neurological deficit with persisting clinical symptoms means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Insured. Symptoms that are covered include numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

3. Coronary Artery By-pass Surgery

The actual undergoing of open-chest surgery or minimally invasive direct coronary artery by-pass surgery to correct the narrowing or blockage of one (1) or more coronary arteries with bypass grafts. This Diagnosis must be supported by angiographic evidence of significant

coronary artery obstruction and the procedure must be considered Medically Necessary by a consultant cardiologist.

Angioplasty and all other intra-arterial, catheter based techniques, 'keyhole' or laser procedures are excluded.

4. HIV Due to Blood Transfusion and Occupationally Acquired HIV

(a) Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

- The blood transfusion was Medically Necessary or given as part of a medical treatment;
- The blood transfusion was received in Singapore after the Policy Date, endorsement date or reinstatement date of this Policy, whichever is the later;
- The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
- The Insured does not suffer from thalassaemia major or haemophilia.

(b) Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the Policy Date, endorsement date or reinstatement date of this Policy, whichever is the later whilst the Insured was carrying out the normal professional duties of his or her occupation in Singapore, provided that all of the following are proven to our satisfaction:

- Proof of the accident giving rise to the infection must be reported to us within 30 days of the accident taking place;
- Proof that the accident involved a definite source of the HIV infected fluids;
- Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident. This proof must include a negative HIV antibody test conducted within five (5) days of the accident; and
- HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

This benefit is only payable when the occupation of the Insured is a medical practitioner, housemen, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic (in Singapore).

This benefit will not apply under either section (a) or (b) where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

5. Angioplasty & Other Invasive Treatment for Coronary Artery

The actual undergoing of balloon angioplasty or similar intra arterial catheter procedure to correct a narrowing of minimum 60% stenosis, of one (1) or more major coronary arteries as shown by angiographic evidence. The revascularisation must be considered Medically Necessary by a consultant cardiologist.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Diagnostic angiography is excluded.

6. Major Cancers

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue.

The term malignant tumour includes leukemia, lymphoma and sarcoma.

For the above definition, the following are excluded:

(a) All tumours which are histologically classified as any of the following:
- Pre-malignant;
- Non-invasive;
- Carcinoma-in-situ;
- Having borderline malignancy;
- Having any degree of malignant potential;
- Having suspicious malignancy;
- Neoplasm of uncertain or unknown behavior; or
- Cervical dysplasia CIN-1, CIN-2 and CIN-3;

(b) Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
(c) Malignant melanoma that has not caused invasion beyond the epidermis;
(d) All prostate cancers histologically described as T1N0M0 (TNM classification) or below; or prostate cancers of another equivalent or lesser classification;
(e) All thyroid cancers histologically classified as T1N0M0 (TNM classification) or below;
(f) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification) or below;
(g) All gastro-intestinal stromal tumours histologically classified as T1N0M0 (TNM classification) or below and with mitotic count of less than or equal to 5/50 HPFs;
(h) Chronic lymphocytic leukaemia less than RAI stage 3; and
(i) All tumours in the presence of HIV infection.

7. Fulminant Hepatitis

A submassive to massive necrosis of the liver by the hepatitis virus, leading precipitously to liver failure. This Diagnosis must be supported by all of the following:

(a) Rapid decreasing of liver size as confirmed by abdominal ultrasound;
(b) Necrosis involving entire lobules, leaving only a collapsed reticular framework;
(c) Rapid deterioration of liver function tests;
(d) Deepening jaundice; and
(e) Hepatic encephalopathy.

8. Primary Pulmonary Hypertension

Primary pulmonary hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterisation, resulting in permanent physical impairment of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

The NYHA Classification of Cardiac Impairment:

Class I:	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea or anginal pain.
Class II:	Slight limitation of physical activity. Ordinary physical activity results in symptoms.
Class III:	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
Class IV:	Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

9. Kidney Failure

Chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.

10. Major Organ / Bone Marrow Transplantation

The receipt of a transplant of:
(a) Human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or
(b) One (1) of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end stage failure of the relevant organ.

Other stem cell transplants are excluded.

11. Multiple Sclerosis

The definite occurrence of multiple sclerosis. The Diagnosis must be supported by all of the following:

(a) Investigations which unequivocally confirm the Diagnosis to be multiple sclerosis;
(b) Multiple neurological deficits which occurred over a continuous period of at least six (6) months; and
(c) Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

Other causes of neurological damage such as SLE and HIV are excluded.

12. Blindness (Loss of Sight)

Permanent and irreversible loss of sight in both eyes as a result of illness or accident to the extent that even when tested with the use of visual aids, vision is measured at 3/60 or worse in both eyes using a snellen eye chart or equivalent test, or visual field of 20 degrees or less in both eyes. The blindness must be confirmed by an ophthalmologist.

13. Paralysis (Loss of Use of Limbs)

Total and irreversible loss of use of at least two (2) entire limbs due to injury or disease persisting for a period of at least six (6) weeks and with no foreseeable possibility of recovery. This condition must be confirmed by a consultant neurologist.

Self-inflicted injuries are excluded.

14. Muscular Dystrophy

A group of hereditary degenerative diseases of muscle characterised by weakness and atrophy of muscle. The Diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist. The condition must result in the inability of the Insured to perform (whether aided or unaided) at least three (3) of the following six (6) "Activities of Daily Living" for a continuous period of at least six (6) months:

Activities of Daily Living:

Washing	the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
Dressing	the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
Transferring	the ability to move from a bed to an upright chair or wheelchair and vice versa;
Mobility	the ability to move indoors from room to room on level surfaces;
Toileting	the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
Feeding	the ability to feed oneself once food has been prepared and made available.

For the purpose of this definition, “aided” shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

15. Alzheimer’s Disease / Severe Dementia

Deterioration or loss of intellectual capacity as confirmed by clinical evaluation and imaging tests, arising from alzheimer's disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured. This Diagnosis must be supported by the clinical confirmation of an appropriate consultant and supported by our appointed Physician.

The following are excluded:

(a) Non-organic diseases such as neurosis and psychiatric illnesses; and
(b) Alcohol related brain damage.

16. Coma

A coma that persists for at least 96 hours. This Diagnosis must be supported by evidence of all of the following:

(a) No response to external stimuli for at least 96 hours;
(b) Life support measures are necessary to sustain life; and
(c) Brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

Coma resulting directly from alcohol or drug abuse is excluded.

17. Deafness (Loss of Hearing)

Total and irreversible loss of hearing in both ears as a result of illness or accident. This Diagnosis must be supported by audiometric and sound-threshold tests provided and certified by an Ear, Nose, Throat (ENT) Specialist.

Total means “the loss of at least 80 decibels in all frequencies of hearing”.

18. Heart Valve Surgery

The actual undergoing of open-heart surgery to replace or repair heart valve abnormalities. The Diagnosis of heart valve abnormality must be supported by cardiac catheterisation or echocardiogram and the procedure must be considered Medically Necessary by a consultant cardiologist.

19. Loss of Speech

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This Diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) Specialist.

All psychiatric related causes are excluded.

20. Major Burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Insured’s body.

21. Surgery to Aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

Surgery performed using only minimally invasive or intra arterial techniques are excluded.

22. Terminal Illness

The conclusive Diagnosis of an illness that is expected to result in the death of the Insured within 12 months. This Diagnosis must be supported by a Specialist and confirmed by our appointed Physician.

Terminal illness in the presence of HIV infection is excluded.

23. End Stage Lung Disease

End stage lung disease, causing chronic respiratory failure. This Diagnosis must be supported by evidence of all of the following:

(a) FEV_1 test results which are consistently less than one (1) litre;
(b) Permanent supplementary oxygen therapy for hypoxemia;
(c) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO_2 \leq$ 55mmHg); and
(d) Dyspnea at rest.

The Diagnosis must be confirmed by a respiratory Physician or Specialist.

24. End Stage Liver Failure

End stage liver failure as evidenced by all of the following:

(a) Permanent jaundice;
(b) Ascites; and
(c) Hepatic encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

25. Motor Neurone Disease

Motor neurone disease characterised by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis. This Diagnosis must be confirmed by a neurologist as progressive and resulting in permanent neurological deficit.

26. Parkinson's Disease

The unequivocal Diagnosis of idiopathic parkinson's disease by a consultant neurologist. This Diagnosis must be supported by all of the following conditions:

(a) The disease cannot be controlled with medication;
(b) Signs of progressive impairment; and
(c) Inability of the Insured to perform (whether aided or unaided) at least three (3) of the following six (6) "Activities of Daily Living" for a continuous period of at least six (6) months:

Activities of Daily Living:

Washing	the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
Dressing	the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
Transferring	the ability to move from a bed to an upright chair or wheelchair and vice versa;
Mobility	the ability to move indoors from room to room on level surfaces;
Toileting	the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
Feeding	the ability to feed oneself once food has been prepared and made available.

Drug-induced or toxic causes of parkinsonism or all other causes of parkinson's disease are excluded.

For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

27. Aplastic Anaemia

Chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one (1) of the following:

(a) Blood product transfusion;
(b) Marrow stimulating agents;
(c) Immunosuppressive agents; or
(d) Bone marrow transplantation.

The Diagnosis must be confirmed by a haematologist.

28. Benign Brain Tumor

Benign brain tumour means a non-malignant tumour located in the cranial vault and limited to the brain, meninges or cranial nerves where all of the following conditions are met:

(a) It is life threatening;
(b) It has caused damage to the brain;
(c) It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit; and
(d) Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques.

The following are excluded:

(a) Cysts;
(b) Granulomas;
(c) Vascular malformations;
(d) Haematomas; and
(e) Tumours of the pituitary gland or spinal cord.

29. Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least six (6) weeks. This Diagnosis must be confirmed by:

(a) The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and
(b) A consultant neurologist.

Bacterial meningitis in the presence of HIV infection is excluded.

30. Viral Encephalitis

Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) caused by viral infection and resulting in permanent neurological deficit. This Diagnosis must be certified by a consultant neurologist and the permanent neurological deficit must be documented for at least six (6) weeks.

Encephalitis caused by HIV infection is excluded.

LIMIT PER POLICY YEAR

The Limit Per Policy Year is the maximum claimable amount that the Insured can claim in one (1) Policy Year from under this Policy.

In the event of any benefit payment by us for a loss insured under this Policy (including any reimbursed amount exceeding the Critical Illnesses Limit Per Policy Year which is accumulated towards the Maximum Limit Per Policy Year (for the applicable Policy Year)), such amount paid shall be accumulated towards the Maximum Limit Per Policy Year (for the applicable Policy Year).

The remaining balance of the Maximum Limit Per Policy Year for a particular Policy Year is computed by deducting all accumulated benefit payments (including any reimbursed amount exceeding the Critical Illnesses Limit Per Policy Year which is accumulated towards the Maximum Limit Per Policy Year (for the applicable Policy Year)) in that same Policy Year from the Maximum Limit Per Policy Year.

In the event that the Insured is admitted into a Hospital in a Policy Year and the Confinement in a Hospital or outpatient consultations and treatments (if any) arising from the Confinement in a Hospital extends into the following Policy Year, the Eligible Expenses payable will be subject to the Policy Year Limit of the Policy Year in which the Confinement commenced.

In the event there is no Confinement, the claim amount payable for outpatient consultations and treatments will be determined based on the Policy Year Limit applicable on the date the medical expenses are incurred regardless of the actual date of usage of such medical services.

Deductibles shall be applied in each Policy Year before any benefit becomes payable under this Policy.

GENERAL EXCLUSIONS

Any Pre-existing Condition from which the Insured is suffering prior to the Policy Date or reinstatement date, whichever is later, shall not be covered unless the Insured makes a declaration in the application for this Policy or on reinstatement and such application is specifically accepted by us.

This Policy also does not cover any claims incurred directly or indirectly as a result of any of the following, whether or not a declaration has been submitted and accepted by us:

(a) Any medical treatment which commences before the Policy Date;

(b) Experimental or pioneering medical devices, drugs and therapeutic products not approved by the Health Sciences Authority;

(c) Experimental or pioneering medical or surgical techniques, as determined by our medical advisor;

(d) Serious Illness for which the Insured has received medical treatment and advice, including follow-ups and consultations, during twelve (12) months prior to the Policy Date or reinstatement date, whichever is later;

(e) Treatment for congenital abnormalities including hereditary conditions and physical defects from childbirth (except where expressly covered by Part (F) – Congenital Abnormalities Benefits under the Benefits Provisions of this Policy);

(f) Treatment arising from pregnancy, miscarriages, abortion, childbirth, sterilisation, contraception (except where expressly covered by Part (E) – Pregnancy Complications Benefit under the Benefits Provisions of this Policy);

(g) Treatment for infertility, sub-fertility, assisted conception or any contraceptive operation and sex change operations;

(h) Any injury or illness caused directly or indirectly, by self-destruction or intentional self-inflicted injury, abuse or misuse of drugs or alcohol, drug overdose (whether intentional, accidental or otherwise) or injuries sustained as a direct result of a criminal act or attempted suicide, whether the Insured is sane or insane;

(i) Treatments attributable to any sexually transmitted disease, including Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related complications (except where HIV Due to Blood Transfusion and Occupationally Acquired HIV is expressly covered by Part (M) – Extra Cover for 30 Critical Illnesses Benefit under the Benefits Provisions of this Policy). For the purpose of this Policy:

   (i) The definition of AIDS shall be that used by the World Health Organisation in 1987, or any subsequent revision by the World Health Organisation of that definition;
   (ii) Infection shall be deemed to have occurred where blood or other relevant tests indicate in our opinion or in the opinion of our medical advisor either the presence of any Human Immunodeficiency Virus or antibodies to such a virus;

(j) Treatment for mental illnesses and psychiatric disorders (except where expressly covered by Part (I) – Psychiatric Treatment Benefits under the Benefits Provisions of this Policy);

(k) Treatment for obesity, weight reduction or weight improvement;

(l) Treatment arising from injuries sustained during wars (whether war be declared or not), civil commotion, riots, revolutions, strikes, nuclear reaction or any war-like operations;

(m) Buying or renting, for use at home or as an outpatient, of special medical appliances, braces, prostheses, durable medical equipment or machines, corrective devices, wheelchairs, walking aids, home aids, kidney dialysis machines, iron-lungs, oxygen machines, hospital beds or any hospital equipment;

(n) Any form of cosmetic or plastic surgery (except if it is for the correction of a functional defect or breast reconstruction following mastectomy);

(o) Dental treatment, (except where expressly covered by Part (D) – Accidental Inpatient Dental Treatment Benefit under the Benefits Provisions of this Policy);

(p) Correction for refractive errors of the eye;

(q) Costs for routine eye and ear examinations, including costs of spectacles, contact lenses and hearing aids;

(r) Rest cures, hospice care, home or outpatient nursing, convalescent care in convalescent or nursing home, sanatoriums or similar establishments;

(s) Transport-related services including ambulance fee, emergency evacuation, repatriation assistance and repatriation of mortal remains;

(t) Preventive, screening and health-enhancing treatments; any treatments, medical services and / or supplies which are preventive, screening or health-enhancing in purpose, including but not limited to genetic tests, vitamins, health supplements, dietary replacements and non-prescribed drugs;

(u) Treatments for acne, pigmentation, keloids, skin tags, moles, alopecia, and circumcision (except where it is Medically Necessary);

(v) Vaccination;

(w) Costs incurred from the acquisition of an organ or related parts of an organ from a living donor for an organ transplant and expenses incurred by the living donor of such organ or related parts (except where expressly covered by Part (G) – Living Donor Organ Transplant Benefits under the Benefits Provisions of this Policy);

(x) Overseas (outside Singapore) medical treatment or hospitalisation (except where expressly covered by Part (H) – Emergency Overseas (Outside Singapore) Medical Treatment Benefit under the Benefits Provisions of this Policy);

(y) All other exclusions for MediShield Life Scheme set out in the CPF Act and its regulations, unless otherwise provided under this Policy;

(z) Non-medical items such as, but not limited to, parking fees, Hospital administration and registration fees and, laundry, rental of television, newspaper and, medical report fees;

(aa) Alternative or complementary treatments, including traditional chinese medicine, podiatric, chiropractic or osteopathic treatment or a stay in any health-care establishment for social or non-medical reasons;

(bb) Medical services, including hospital confinement, primarily for diagnosis, preventive purpose, x-ray examinations, general physical or medical check-up;

(cc) Violation or attempted violation of law, resistance to lawful arrest or any resultant imprisonment;

(dd) Uses of therapeutic products and medical devices for indication which have not been approved by a regulatory authority in Singapore. This exclusion shall not apply in the event that **both of the following are true**:

(i) the therapeutic product or medical device has been approved by the regulatory authority in Singapore; and
(ii) an overseas regulatory agency recognised by the Health Sciences Authority as one of its reference drug regulatory agencies has approved the product or device for that indication;

(ee) Medical services that are not directly for the treatment of the Illness or Injury which is the cause of the Confinement;

(ff) Surgical procedures not specified within the "Table of Surgical Procedures" (TOSP) Table 1 to 7 under the Medisave Scheme operated by the Ministry of Health of Singapore, including procedures classified as "Minor Surgical Procedures" (MSP) in the TOSP schedule;

(gg) Confinement at Non-MediShield Life Accredited Medical Institutions (except where expressly covered by Part (H) – Emergency Overseas (Outside Singapore) Medical Treatment Benefit under the Benefits Provisions of this Policy); or

(hh) Confinement that is not Medically Necessary.

PREMIUM PROVISIONS

PAYMENT

All premiums are inclusive of the prevailing GST and shall be payable to us on or before the Premium Due Date. If you meet the eligible conditions set down by CPF Board on using Medisave funds to pay for premiums of a medical insurance plan, premiums may be deducted from your Medisave account maintained with the CPF Board. If not, the premium due must be paid in cash, cheque or any other payment methods as approved by us.

In the case where the premium exceeds the maximum Medisave withdrawal amount allowed for any medical insurance plan covering the Insured where premium is paid using Medisave funds maintained by the CPF Board, or the balance in your Medisave account is insufficient to pay in full the premium due on the Premium Due Date, the shortfall in the premium shall be paid in cash within the Grace Period failing which this Policy shall automatically terminate.

We shall inform you of the premiums payable under this Policy, based on such rates as may be determined by us from time to time.

PREMIUM RATE

Premium rates payable for this Policy are not guaranteed and are expected to be adjusted from time to time in line with our claims experience, medical inflation and general cost of treatments, supplies or medical services in Singapore.

We have the right to change the premium rate, provided that we send you a written notification at least 31 days in advance of such change in premium rate.

RENEWAL

Subject to the Cancellation Clause and Termination Clause set out in this Policy, your Policy is guaranteed yearly renewable on the policy anniversary date by payment of the premiums in advance, before the end of the Grace Period, subject to our acceptance and the following:

(a) your Policy is in-force on the date of renewal; and
(b) we receive and accept payment of your Policy's premium in accordance with the premium rates then applicable to the Insured's attained age at next birthday on the date of renewal.

REINSTATEMENT

If your Policy lapses due to non-payment of premium, you may reinstate this Policy within two (2) years from the date this Policy lapses subject to underwriting (including producing evidence of insurability) and such other requirements we may have to our satisfaction. Additional terms, including exclusions, may be imposed and are subject to our review at the time of reinstatement. Such reinstatement, if approved by us, shall only cover hospitalisation, surgery and treatment occurring after the reinstatement date.

CLAIMS PROCEDURES

HOSPITALISATION

We must be notified through the submission of a completed hospitalisation (or accident) claim form and other proof of loss documents as may be determined by us to our satisfaction. Such claim submission must be filed with us within 60 days from the date of discharge from the Hospital or the date of receiving treatment as an out-patient, and there must be sufficient particulars to enable us to identify the Insured and the occurrence, nature and extent of the loss.

The occurrence of a claim must be proven to our satisfaction at your own expense, and any such proof shall include the following:

(a) proof of treatment or surgery;
(b) the Hospital's original and final statement of accounts, bills and receipts;
(c) a certified true copy of the Insured's Valid Pass and travel document or passport; and
(d) such other documents as we may require.

In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, we shall have the right to call for an examination of the Insured and the evidence used in arriving at such opinion. An independent acknowledged medical specialist in the relevant field concerned shall conduct this examination and we shall select this medical specialist.

TOTAL AND PERMANENT DISABILITY

We must be notified through the submission of a disability claim form and other proof of loss documents as may be determined by us to our satisfaction. Such claim submission and proof of loss must be filed with us within 60 days from the date the Insured satisfies the TPD definition and there must be sufficient particulars to enable us to identify the Insured and the occurrence, nature and extent of the loss.

The Diagnosis and occurrence of disability resulting in the Insured satisfying the TPD definition must be proven to our satisfaction at your expense, and any such proof shall include the following:

(a) evidence provided by the appropriate Physician;
(b) appropriate medical investigations and/or reports including, but not limited to, clinical, radiological, histological and laboratory evidence;
(c) a certified true copy of the Insured's Valid Pass and travel document or passport; and
(d) such other documents as we may require.

Any payment or continued payment of any benefit shall always be subject to:

(a) the Diagnosis and occurrence of disability resulting in the Insured satisfying the TPD definition being proven to our satisfaction;
(b) at our request from time to time, and at your sole cost and expense,
    (i) the undertaking of any examination or re-examination of the evidence submitted under this clause;
    (ii) the undertaking of any examination or re-examination of the Insured; and/or
    (iii) the provision of any further document, evidence or regular medical evidence;
(c) in the event of a dispute, the examination or re-examination of the Insured by an independent expert as selected by us should we deem that such examination or re-examination is required. The opinion of such expert shall be binding on you and us and the cost and fees of such independent expert shall be borne by you. We shall have the right to examine the body of the Insured and to require an autopsy to be conducted in the case of death.

Medical terms used, unless otherwise specified, will have the technical meaning as generally understood and used by medical specialists in the relevant field.

PAYMENT OF BENEFITS

All benefits under this Policy are payable to you (except for Part (L) – Waiver of Premium for 1 Year Benefit (Upon Total and Permanent Disability)), your legal representative, the Hospital, the Community Hospital or such other authorised parties (as the case may be) and such payment shall be a valid discharge of our liability under this Policy.

DEFINITIONS

In your Policy, the following definitions shall apply (where applicable):

Accident refers to an unforeseen and involuntary event.

AIA Preferred Providers refer to all Government / Restructured Hospitals and to medical service providers in Singapore listed in our website, such list as approved and may be amended by us at our discretion from time to time.

Approved Medical Consumables refer to:
(a) Intravascular electrodes used for electrophysiological procedures.
(b) Percutaneous Transluminal Coronary Angioplasty (PTCA) balloons.
(c) Intra-aortic balloons (or balloon catheters).

Co-insurance refers to the amount you need to co-pay on the Eligible Expenses which is a fixed percentage (as specified in the Schedule of Benefits) of the Eligible Expenses in excess of the Deductible (if any).

Community Hospital refers to a community hospital approved by the Ministry of Health of Singapore to provide an intermediate level of care for individuals who have simple ailments and do not require Specialist medical treatment and nursing care. For the avoidance of doubt, hospices, convalescent centres, Hospitals and homes are not Community Hospitals.

Confined or **Confinement** refers to:
(a) any period of hospitalisation in a Hospital for which a daily room and board charge is incurred for medical treatment as an inpatient;
(b) admission into a short stay ward for medical treatment, examination or observation at the Accident and Emergency Department in a Hospital (for a period of not less than six (6) hours); or
(c) admission of any duration in a Hospital or medical institution which is lawfully operated in Singapore, approved under the MediShield Life Scheme and accredited by the Ministry of Health of Singapore, for the purpose of a Surgical Procedure.

CPF refers to the Central Provident Fund established under the Central Provident Fund Act (Cap. 36).

Deductible refers to the deductible amount as specified in the Schedule of Benefits, which is the total amount of Eligible Expenses incurred per Policy Year which is borne by you before any benefit becomes payable under this Policy. Part (J) – Outpatient Benefit and Part (K) – Final Expense Benefit are not subject to a Deductible.

Diagnosed or **Diagnosis** refers to a definitive conclusion made by a Physician or Specialist based upon such specific evidence as referred to in this Policy in the definition of the particular condition, or, in the absence of such specific evidence, based upon radiological, clinical, histological, or laboratory evidence acceptable by us. Such Diagnosis must be supported by our medical advisor who may base his/her opinion on the medical evidence submitted by you, the Insured, and/or any additional evidence that he/she may require.

DP refers to plan type which covers an Insured who is a Foreigner and dependant of a Singapore Citizen or Singapore Permanent Resident.

Eligible Expenses refer to the expenses incurred for medical or surgical treatment under the Benefits Provisions of this Policy during the period the Policy is in-force.

Emergency refers to a sudden or unexpected occurrence of a serious medical condition or Injury during the course of the overseas travel, which in our opinion or in the opinion of our medical advisor requires urgent remedial treatment to avoid death or serious impairment to the Insured's immediate or

long-term health. For this purpose, we shall reserve the absolute right to determine if such sudden or unexpected occurrence of a serious medical condition or Injury is deemed as an Emergency.

Family Members refer to your or the Insured's lawful spouse, father, mother, brother, sister and/or legal children.

Foreigner refers to a person who is not a Singapore Citizen or Singapore Permanent Resident.

Government / Restructured Hospital refers to the Singapore government hospitals and Singapore government medical institutions which are approved by the Ministry of Health of Singapore under the MediShield Life Scheme.

Grace Period refers to the extra 60 days that we give you from the Premium Due Date, for you to pay your premiums.

GST refers to the goods and services tax according to the GST Act (Cap. 117).

HOTA refers to the Human Organ Transplant Act (Chapter 131A), as amended, extended or re-enacted from time to time.

Hospital refers to a lawfully operated institution in Singapore registered as a hospital and accredited by the Ministry of Health of Singapore, under the MediShield Life Scheme, for the care and treatment of injured or ill persons and which provides facilities for diagnosis, major surgery and full-time nursing service, including Government/Restructured Hospitals and is not primarily a rest or convalescent home, Community Hospital or similar establishment or, other than incidentally, a place for alcoholics or drug addicts. Our medical advisor must recognise a facility outside Singapore as being equivalent in status.

Illness refers to a physical condition marked by a pathological deviation from the normal healthy state.

Injury refers to bodily injury effected directly and independently of all other causes by Accident.

Insured refers to the person as named in the Policy Schedule of your Policy.

Intensive Care Unit or **ICU** refers to a section within a Hospital which is designated as an intensive care unit by such Hospital and which is operating on a 24-hour basis solely for treatment of patients in critical medical condition and which is equipped to provide special nursing and medical services not available elsewhere in such Hospital. For purpose of this definition, Intensive Care Unit or ICU shall also refer to a Coronary Care Unit, Cardiac Care Unit or Critical Care Unit in a Hospital.

Issue Date refers to the date when the Policy was issued to you and is shown on your Policy Schedule or endorsement.

Limits of Compensation refers to the limits of compensation stated in the Schedule of Benefits for which each respective benefit is subject to in accordance to the plan type and Hospital ward entitlement.

Limit Per Lifetime refers to the maximum total amount of all reimbursements that we shall make for the Eligible Expenses which are accumulated towards the Critical Illnesses Limit Per Lifetime under Part (M) – Extra Cover for 30 Critical Illnesses Benefit and the Maximum Limit Per Lifetime under the Maximum Claim Limit during the Insured's lifetime and which are the limits stated in the Schedule of Benefits.

Limit Per Policy Year refers to the maximum reimbursement that we shall make for the Eligible Expenses which are accumulated towards the Critical Illnesses Limit Per Policy Year under Part (M) – Extra Cover for 30 Critical Illnesses Benefit and the Maximum Limit Per Policy Year under the Maximum Claim Limit in any one Policy Year and which are the limits stated in the Schedule of Benefits. Eligible Expenses which are incurred in the current Policy Year where the payout is made in

the subsequent Policy Year shall be accumulated under the current Policy Year's limit. Such payouts shall not be accumulated towards the Policy Year limit in the subsequent Policy Year.

Medically Necessary refers to a medical service treatment, service and/or supply which is:
(a) consistent with the Diagnosis and customary medical treatment, service and/or supply for an Illness or Injury;
(b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and proven medical benefits;
(c) not for the convenience of the Insured or the Physician or Specialist, and unable to be reasonably rendered out of a Hospital, an Outpatient Centre or a Community Hospital;
(d) not of an experimental, investigational or research nature, preventive or screening nature; and
(e) unable to be omitted without negatively affecting the medical condition which the Insured is Diagnosed for.

MediShield Life Scheme refers to the scheme administered by the CPF Board, and is governed by the MediShield Life Scheme Act 2015 as amended from time to time.

NDP refers to plan type which covers an Insured who is a Foreigner and not a dependant of a Singapore Citizen or Singapore Permanent Resident.

Non-Participating refers to a policy that does not share in the divisible surplus of our participating life fund.

Outpatient Centre refers to a Medisave / MediShield accredited centre for treatments covered under Part (J) – Outpatient Benefit.

Physician refers to any person qualified as a medical practitioner by a medical degree in western medicine and who is legally registered with, authorised and/or licensed by the relevant authority in the geographical area of his practice to render medical or surgical treatment and who in rendering treatment is practicing within the scope of his licensing and training in the geographical area of practice, but excluding you, the Insured and respective spouses and Family Members of such persons.

Policy consists of:
(a) this Policy;
(b) the Policy Schedule;
(c) the application; and
(d) the endorsements (if any).

Policy Date refers to the date shown on your Policy Schedule for your Policy and is the date from which policy anniversary, policy years and months and Premium Due Dates are determined and is the date from which your insurance coverage starts.

Policy Schedule refers to the schedule that is issued with your Policy that includes the plan name, product and/or code names of your Policy. This includes renewal certificate or endorsement.

Policy Year refers to 12 months starting from the Policy Date of this Policy and in the case of Policy renewal, each consecutive 12 months period following the renewal date of this Policy.

Pre-existing Condition refers to any physical condition, impairment or the existence of any illness or disease that was diagnosed, treated, or for which a Physician or Specialist was consulted at any time prior to the Policy Date or last reinstatement date of this Policy (if any), whichever is later. For this purpose, an illness or disease has occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested which would cause an ordinary prudent person to seek Diagnosis, care or treatment.

Premium Due Date refers to the date when your premium payment is due.

Psychiatrist refers to any person qualified as a medical practitioner by a medical degree in psychiatric treatment who is legally registered with, authorised and/or licensed by the relevant authority in the geographical area of his practice to render psychiatric treatment, and who in rendering treatment is practicing within the scope of his licensing and training, but excluding you, the Insured and respective spouses and Family Members of such persons.

Reasonable and Customary refers to any fee or expense which is charged for treatment, supplies or medical service that is Medically Necessary to treat the condition and which is in accordance with the standards of good medical practice for the care of an injured or ill person under the supervision or order of a Physician or Specialist and which does not in our opinion or in the opinion of our medical advisor:

(a) exceed the usual level of charges for similar treatment, supplies or medical services in Singapore; and
(b) include fees or charges that would not have been made if no insurance had existed.

We will not consider charges in excess of the fee benchmarks and bill amounts information published by the Ministry of Health of Singapore, as Reasonable and Customary unless we receive written justification from the Physician, Specialist, Hospital or clinic as the case may be and we deem that justification to be reasonable.

Serious Illness refers to any of the following Illness:

(a) Blood disorder
(b) Cancer
(c) Cerebrovascular accidents (stroke)
(d) Chronic liver cirrhosis
(e) Chronic obstructive lung disease
(f) Chronic renal disease, including renal failure
(g) Coronary artery disease
(h) Degenerative disease
(i) Ischaemic heart disease
(j) Rheumatic heart disease
(k) Systemic lupus erythematosus
(l) Any Illness, disorder or condition which is life threatening or terminal.

Specialist refers to a qualified and licensed Physician, possessing the necessary additional qualifications and expertise to practice as a recognised specialist of diagnostic techniques, treatment and prevention by the Ministry of Health of Singapore, but excluding you, the Insured and respective spouses and Family Members of such persons.

Standard Room refers to a room equipped with a minimum standards, like the following:

(a) suitable bed, mattress, pillow, a chair and locker facility;
(b) bed screening facilities;
(c) adequate lighting and ventilation;
(d) an effective nurse-to-patient call bell system; and
(e) adequate toilet facilities / wash basin.

It shall exclude deluxe rooms, luxury suites, superior room, super rooms and other special rooms that may also be available at the Hospital (or at a Community Hospital, with regards to Part A (iii) – Community Hospital Benefit).

For a single room in a Private Hospital, we shall only pay the room and board rates up to the rates charged for a standard single room.

Surgical Procedures refer to the types of surgical operations listed in the "Table of Surgical Procedures" under the Medisave Scheme operated by the Ministry of Health of Singapore (Table 1 to Table 7) excluding (a) all surgical operations stated in the General Exclusions and (b) any other surgical operations that are not specified in the said "Table of Surgical Procedures".

Valid Pass refers to a valid pass issued and recognised by the Immigration and Checkpoint Authority or the Ministry of Manpower of Singapore and deemed acceptable by us.

We, **us** or **our** refers to the AIA Singapore Private Limited (Reg. No. 201106386R) ("AIA Singapore").

You or **your** refers to the Policy Owner as shown in the Policy Schedule of your Policy.

Wherever the context requires, masculine form shall apply to the feminine and singular term shall include the plural and vice versa.

SCHEDULE OF BENEFITS		
		Limits of Compensation (figures are in Singapore Dollars and inclusive of GST)
Plan Type		**AIA HealthShield Gold Max A**
Hospital Ward Entitlement		**Standard Room in Private Hospital and below**
(A)	**Hospitalisation and Surgical Benefits**	
(i)	Daily Room and Board Benefit[1]	As Charged
(ii)	Daily ICU Benefit[1]	As Charged
(iii)	Community Hospital Benefit	As Charged
(iv)	Surgical Benefit (including Organ Transplant Benefit and Stem Cell Transplant Benefit) • Surgical Procedures[2] • Surgical Implants and Approved Medical Consumables • Stereotactic Radiosurgery[3]	As Charged As Charged As Charged
(B)	**Pre-Hospitalisation Benefit**	As Charged Within 100 days before Confinement If admitted to / treated by AIA Preferred Providers[4,5]: Within 13 months before Confinement
(C)	**Post-Hospitalisation Benefits**	
(i)	Post-Hospitalisation Treatment	As Charged Within 100 days after Confinement if admitted to / treated by AIA Preferred Providers[4,5]: Within 13 months after Confinement
(ii)	Extended Post-Hospitalisation Treatment for 30 Critical Illnesses (within 100 days following expiry of Post-Hospitalisation Treatment)	As Charged[6]
(D)	**Accidental Inpatient Dental Treatment Benefit**	Subject to the respective Limits of Compensation applicable to Benefits under Parts (A), (B) and (C)
(E)	**Pregnancy Complications Benefit**	As Charged
(F)	**Congenital Abnormalities Benefits**	
(i)	Congenital Abnormalities of Insured's Biological Child from Birth (for female Insured)[7]	20,000 per lifetime Limited to 5,000 per child
(ii)	Congenital Abnormalities of Insured	Subject to the respective Limits of Compensation applicable to Benefits under Parts (A), (B) and (C)
(G)	**Living Donor Organ Transplant Benefits**	
(i)	Insured (as the Living Donor) Donating an Organ[7]	60,000 per organ transplant
(ii)	Non-insured (as the Living Donor) Donating an Organ to the Insured[7]	60,000 per organ transplant
(H)	**Emergency Overseas (Outside Singapore) Medical Treatment Benefits[8]**	Subject to the respective Limits of Compensation applicable to Benefits under Parts (A) and (C)

SCHEDULE OF BENEFITS	
	Limits of Compensation (figures are in Singapore Dollars and inclusive of GST)
Plan Type	**AIA HealthShield Gold Max A**
Hospital Ward Entitlement	**Standard Room in Private Hospital and below**
(I) Psychiatric Treatment Benefits	
(i) In-Hospital Psychiatric Treatment[1],[7]	5,000 per Policy Year
(ii) Post-Hospitalisation Psychiatric Treatment (within 200 days after Confinement)[7]	5,000 per Policy Year
(J) Outpatient Benefit[9]	
• Radiotherapy for cancer	As Charged
• Stereotactic Radiotherapy for cancer	As Charged
• Chemotherapy for cancer	As Charged
• Immunotherapy for cancer	As Charged
• Renal Dialysis	As Charged
• Erythropoietin	As Charged
• Approved Immunosuppressant prescribed for Organ Transplant[10]	As Charged
• Long-Term Parenteral Nutrition	As Charged
(K) Final Expense Benefit[9]	5,000 per Policy
(L) Waiver of Premium for 1 Year Benefit (Upon Total and Permanent Disability)[9]	Waiver of one year premium
(M) Extra Cover for 30 Critical Illnesses Benefit[11]	
• **Critical Illnesses Limit Per Policy Year**	100,000
• **Critical Illnesses Limit Per Lifetime**	Unlimited
Maximum Claim Limit	
• **Maximum Limit Per Policy Year**	1,000,000 If admitted to / treated by AIA Preferred Providers[5],[12]: 2,000,000
• **Maximum Limit Per Lifetime**	Unlimited
Deductible (per Policy Year)	
• **Below age 82 next birthday**	
Inpatient	
C Class Ward	1,500
B2 Class Ward	2,000
B1 Class Ward	2,500
A Class Ward	3,500
Private Hospital (All ward types except day surgery and short stay ward)	3,500
Day Surgery/Short Stay Ward	2,000
• **Ages 82 next birthday and above**	
Inpatient	
C Class Ward	1,500

SCHEDULE OF BENEFITS	
	Limits of Compensation
	(figures are in Singapore Dollars and inclusive of GST)
Plan Type	**AIA HealthShield Gold Max A**
Hospital Ward Entitlement	**Standard Room in Private Hospital and below**
B2 Class Ward	2,250
B1 Class Ward	3,000
A Class Ward	4,500
Private Hospital (All ward types except day surgery and short stay ward)	4,500
Day Surgery/Short Stay Ward	3,000
Co-insurance	10%
Maximum Coverage Period	Lifetime

[1] Inclusive of meals, prescriptions, professional charges, investigations and other miscellaneous medical charges.

[2] Surgical Procedures refer to the types of surgical operations listed in the "Table of Surgical Procedures" under the Medisave Scheme operated by the Ministry of Health of Singapore excluding (a) all surgical operations stated in the General Exclusions and (b) any other surgical operations that are not specified in the said "Table of Surgical Procedures". The costs of any surgical implants, Approved Medical Consumables and/or stereotactic radiosurgery procedure are not included in this portion of the benefit.

[3] Stereotactic radiosurgery means the gamma knife treatment or the novalis shaped beam treatment of neurosurgical or neurological disorders.

[4] To be eligible for the 13 months cover for Pre-Hospitalisation Benefit and Post-Hospitalisation Benefit (Post-Hospitalisation Treatment), the Confinement following the pre-hospitalisation treatment and the Confinement prior to the post-hospitalisation treatment respectively must be administered by AIA Preferred Providers.

[5] In the event where there are more than one (1) treating Physicians or Specialists for the same Confinement and/or Surgical Procedures, the main treating Physician or Specialist must be an AIA Preferred Provider.

[6] The Extended Post-Hospitalisation Treatment for 30 Critical Illnesses shall not apply and shall not be payable if the Post-Hospitalisation Treatment has been claimed for a period of 200 or more days following the day such Confinement ends.

[7] The maximum amount reimbursed under the following benefits shall be equal to the amount stated under the Limits of Compensation:
(a) Part (F)(i) – Congenital Abnormalities of Insured's Biological Child from Birth (for female Insured) under Congenital Abnormalities Benefits
(b) Part (G)(i) – Insured (as the Living Donor) Donating an Organ under Living Donor Organ Transplant Benefits
(c) Part (G((ii) – Non-insured (as the Living Donor) Donating an Organ to the Insured under Living Donor Organ Transplant Benefits
(d) Part (I)(i) - In-Hospital Psychiatric Treatment under Psychiatric Treatment Benefits
(e) Part (I)(ii) – Post-Hospitalisation Psychiatric Treatment under Psychiatric Treatment Benefits

[8] The Deductible applied to Eligible Expenses incurred under the Emergency Overseas (Outside Singapore) Medical Treatment Benefits shall be equivalent to that of an A Class Ward/Private Hospital in Singapore. Benefit payable under the Emergency Overseas (Outside Singapore) Medical Treatment Benefits shall be limited to the level of Reasonable and Customary charges in a Singapore Private Hospital.

[9] Eligible Expenses incurred under the Outpatient Benefit are not subject to the Deductible but are subject to Co-insurance. The Final Expense Benefit and Waiver of Premium for 1 Year Benefit (upon TPD) are not subject to either the Deductible or Co-insurance.

[10] In the event of an organ transplant surgery, we shall reimburse the charges for any of the immunosuppressants approved by Health Sciences Authority for organ transplant.

[11] The Limit Per Policy Year under the Extra Cover for 30 Critical Illnesses Benefit shall be provided as additional limits above the Limit Per Policy Year under the Maximum Claim Limit. This Extra Cover for 30 Critical Illnesses Benefit shall not be provided as an additional limit above the Maximum Limit Per Policy Year of $2,000,000 under the Maximum Claim Limit.

[12] To be eligible for the S$2,000,000 Maximum Limit Per Policy Year, all Confinement and treatments under Part (J) – Outpatient Benefit for the same Policy Year must be administered by AIA Preferred Providers.

APPENDIX A

The list of clinical situation(s) referred to under the Benefit Provisions of this Policy is / are:

- Ptosis surgery

The details on the additional criteria, which may be amended from time to time, for the above clinical situations are available in our website (www.aia.com.sg/healthshieldsupport).

APPENDIX B

The list of high-cost technologies referred to under the Benefit Provisions of this Policy are:

- Proton beam therapy
- CAR T-cell therapy

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HSG0003 (07/2018 04/2019 11/2019)