InternationalExclusive Policy

1. Introduction

This membership agreement has been designed to set out all the features and benefits of the AXA **International**Exclusive **plan**. On the next few pages **you** will find details of **your** cover followed by the membership agreement which includes definitions relevant to **your plan**.

1.1 What your healthcare insurance cover is designed to do

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

1.2 A personal service

At AXA **we** are always aware that behind every claim there is a person who needs help and assistance. If there is anything **you** do not understand please do not hesitate to call **our** AXA Health Customer Care Centre on: +65 6880 4944 which is also shown on the reverse of **your** membership card.

1.3 What our service team is there to do

It is the role of **our** Health Customer Care Centre to assist **you**, wherever possible, within the terms and limits of **your** AXA **International**Exclusive **plan**. **You** will find the number of **our** Health Customer Care Centre on the reverse of **your** membership card. Please also see Section 11 of this handbook for details of **your** AXA office. For **your** own protection, calls may be recorded in case of subsequent query.

Please take a note of this and keep your membership card in a safe place where **you** can find it easily. Please have your membership card with **you** whenever **you** call **our** Health Customer Care Centre. The information on **your** card will help them to deal with **your** enquiry as quickly as possible.

1.4 What this membership agreement means

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

In any insurance document **you** will find detailed definitions, terms and exclusions forming part of the contract between **you** and **us**. Please read them carefully and ask **us** if there is anything **you** do not understand.

1.5 Persons eligible

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

1.5.1 For a member who is aged between fifteen (15) days to five (5) years old inclusive

For a child **aged** between fifteen (15) days old to five (5) years old at time of application, the child is eligible for cover without one parent or guardian covered on any **International**Exclusive **policy** with premium loading. The **policy** issued must be to a parent or guardian who is **aged** eighteen (18) years old and above.

1.5.2 For a member who is aged six (6) to seventeen (17) years old inclusive

Child who is **aged** six (6) years to seventeen (17) years old, is eligible for cover without one parent or guardian covered on any **International**Exclusive **policy**. The **policy** issued must be to a parent or guardian who is **aged** eighteen (18) years old and above.

1.5.3 For a member who is aged eighteen (18) to eighty (80) years inclusive

The **policy** may be issued to the **member.**

Please note:
For avoidance of doubt, each of the **member** to be insured in this **policy** mentioned in Section 1.5.1 to 1.5.3 must submit evidence of insurability, and accepted by **us** in writing.

1.5.4 For a new born baby

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

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

If the requirements stated in point Section 1.5.4 (a) and (b) above are not met, a new born baby may only be added to the **policy** and be **eligible** for benefit after the baby has been fully discharged from the **hospital** and has submitted evidence of insurability, with his cover been accepted by **us** in writing.

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

1.5.5 For a member who is aged eighty-one (81) years old and above

We will offer renewal for a **member** who is **aged** eighty-one (81) years old and above so that a **member** can enjoy the peace of mind of continuing his cover for as long as possible subject to **you** paying the applicable premium and also, the terms and conditions stated in Section 4.11 – 'Joining and renewing'.

1.5.6 For babies born after fertility treatment, or following assisted reproduction, or who you have adopted

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

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

You can add a baby born after fertility treatment, or following assisted reproduction (such as IVF), or who **you** have adopted, to your policy. As with most health insurance, our cover for **treatment** has a few limits in these situations. If you have adopted a baby, or if you have a single or **multiple birth** after fertility treatment or following **assisted conception/assisted pregnancy**:

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

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

1.6 Important Notes

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

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

Note: The clarifications and **benefits table** must be read in conjunction with the terms of **your policy**.

2. Definitions

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

(a) **accident** - a sudden, unforeseen external and unexpected event during the Period of Insurance that independently of any other cause is the sole and direct cause of physical bodily **injury** and excludes any illnesses or diseases.

(b) **active treatment of cancer - treatment** intended to shrink, stabilise, or slow the spread of the **cancer**, and not given solely to relieve symptoms.

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

(d) **age/aged** - age on last birthday, and any premium tables or other material **we** provide in this connection shall be read accordingly.

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

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

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

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

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

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

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

(l) **co-insurance** - this is a share of the **eligible** medical expenses that **you** need to pay. Please refer to **your benefits table** and/or **policy schedule** on the co-insurance percentages.

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

(n) **conventional treatment** - **treatment** that:
- is established as best medical practice and is practised widely; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided; and has either:
- been shown to be effective for **your medical condition** through substantive peer reviewed clinical evidence in published authoritative medical journals; or
- been approved by NICE (The National Institute for Health and Care Excellence) or the relevant government authorities and/or recognized medical association of the country where the treatment is sought and as a treatment which may be used in routine practice.

If the **treatment** is a drug, the drug must be:
- licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency or Authority in the locality where treatment is provided or Food and Drug Administration (FDA) in the US; and
- used according to that license and dosage for which it is approved for.

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

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

(p) **congenital condition** - a congenital condition is a genetic physical or biochemical defect, malformation or anomaly, present at birth and whether or not manifest within five (5) years from date of birth, regardless whether it is diagnosed or known about at birth.

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

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

(s) **deductible** - refers to the part of the benefit **you** are claiming that **you** must pay before **we** will pay any benefit. The deductible is shown in **your policy schedule** (where applicable).

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

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

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

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

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

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

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

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

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

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

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

(dd) **lifetime** - the period in which the **member** is alive. This does not refer to the duration of the **policy**.

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

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

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

- is required for the medical management of the **illness** or **injury** suffered by the **member**;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a **medical practitioner**;
- must conform to the professional standards widely accepted.

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

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

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

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

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

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

(oo) **plan** – any AXA **International**Exclusive plan.

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

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

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

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

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

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

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

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

(uu) **prescription** – out-patient drugs and dressings as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** covered by the **member's policy**.

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

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

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

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

If the charges are higher than is customary, **we** will only pay the amount which is, in **our** experience, customarily charged and **you** will have to pay the rest.

If your **treatment** requires more than one specialist or surgeon present at the same operative (surgical) session, we shall review the medical necessity in the management of such surgical problem or medical condition in terms of the different trained skills and complexity of the services provided as an identification to cover the total services. No additional benefits or cost is payable for surgical assistants.

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

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

(xx) **schedule of procedures** – a document **we** maintain which lists the **surgical procedures we** pay benefits for and classifies them according to their complexity.

(yy) **surgical procedure** – an operation or other invasive surgical intervention listed in the **schedule of procedures**.

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

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

- **diagnostic procedures**
- **in-patient treatment**
- **daycare treatment**
- **out-patient treatment**

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

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

- is established as best medical practice and is practised widely; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the **treatment** is provided; and has either:
- been shown to be effective for **your** or insured **family member's medical condition** through substantive peer reviewed clinical evidence in published authoritative medical journals or;
- been approved by NICE (The National Institute for Health and Care Excellence) as a **treatment** which may be used in routine practice.

If the **treatment** is a drug, the drug must be:

- licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency; and
- used according to that license for which it is approved for.

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

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

(ddd) **we/us/our** – AXA Insurance Pte Ltd, being the AXA company issuing **your policy**.

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

(fff) **you/your/policyholder** – the policyholder named on **your policy schedule**.

3. What you are covered for

3.1 What we pay for

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

(a) for charges actually incurred for items listed in **your benefits table** subject to the limits shown there. Note: if **you** incur costs in excess of the limits **you** will have to pay the difference;

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

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

(d) provided the costs are not for something excluded by the terms of this **policy**;

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

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

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

3.2 Your plan benefits

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

Please refer to the **benefits table** on Section 10 for further information on the availability, benefit levels and **waiting periods** of **your plan**.

Benefits	Clarifications
Yearly maximum	**We** will pay up to the maximum shown for each **member** each **policy year.** All benefits paid during the **policy** period will count against the yearly maximum. Cover does not extend beyond the **area** shown for **your plan** unless **you** are **eligible** for 'outside **area of cover**' benefit.
Outside **area of cover**	This is to cover **emergency treatment** which arises suddenly whilst outside the **member's area of cover** up to the amount shown in **your benefits table**. **We** will, in consultation with the treating **medical practitioner**, retain the right to determine what constitutes **'emergency treatment'**. This benefit does not provide cover for **treatment** for any condition if a **member** has travelled outside his **area of cover** to get **treatment** (whether or not that was the only reason) or for any **treatment** which was, or may have reasonably been known about, before travel commenced. Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth. Once **we** have determined, in conjunction with the treating **medical practitioner** that the **eligible medical condition** is stabilized or the health status of the **member** allows him to travel back into his **area of cover**, **we** will stop paying for **emergency treatment**. Please also refer to Section 3.3 - 'International **Emergency** Medical Assistance'. For avoidance of doubt, the maximum benefit payable shall be limited to the amount applicable on the **"Pre-existing Conditions**" benefit for **members** insured on Plan A or B after a **waiting period** of two hundred seventy (270) days if the **emergency treatment** is for an **eligible pre-existing condition**. For **members** insured on Plan C, no benefit shall be payable for **emergency treatment** arising from a **pre-existing condition**. Please note that all **policy** terms, conditions, limitations and exclusions, apply to this benefit exactly as for all other benefits under this **policy**.
Annual **deductible** and **co-insurance**	In exchange of annual premium discount, the **policyholder** can opt to include an annual **deductible** and **co-insurance**. Please refer to the **benefits table** on Section 10 for details on the level of annual **deductible** and **co-insurance** applicable to **your plan.** The annual **deductible** is the aggregate amount of **eligible** expenses claimed that the **member** will have to bear each **year** before any benefits (including Cash Benefit) are payable under this **plan**. This amount will be collected by whoever provides **your treatment** (for direct billing) or deducted from any reimbursement made to **you** by **us**. The amount shown for **your plan** applies to each **member** each **year**.

In-patient and daycare treatment – general information

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

Please note: For all non-emergency admissions, it is recommended that you obtain our written pre-authorization before admission. This is to protect you from unexpected cost.

For direct settlement for an **eligible treatment**, the approval **we** give to the service provider will indicate the amount which is **reasonable and customary** (R&C) for the proposed **treatment**. Please refer to 'Understanding how to get the best from **your plan**' on Section 6 of this membership agreement.

Please refer to the **benefits table** on Section 10 for further information on the availability, benefit levels and **waiting periods** of **your plan**.

<table>
<tr><th>Benefits</th><th>Clarifications</th></tr>
<tr><td>Daily accommodation charges</td><td>While admitted as an in-patient or daycare, we will pay for the costs of member's accommodation in the type of room shown in your benefits table.

Wherever a member receive treatment, if the hospital offers several classes for the room type he is entitled for, we will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that hospital for that type of room.

If a member stays in a room which is more expensive than the standard room, the member may have to pay for the difference in room charges. The member may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with us prior to admission to avoid unnecessary out of pocket expenses.</td></tr>
<tr><td>Hospital charges</td><td>Subject to the limits shown for your plan, members are covered for hospital charges incurred for eligible treatment given between admission and discharge such as:

• diagnostic procedures,
• surgical procedures,
• operating theatre charges,
• nursing care, drugs and dressings,
• surgeons' and anaesthetists' charges,
• intensive care unit charges,
• consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it,
• radiotherapy and chemotherapy,
• kidney dialysis,
• computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques,
• special nursing in hospital.</td></tr>
<tr><td>Organ transplant</td><td>We will pay for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an eligible medical condition and provided these organ(s) has come from a relative or a certified and verified source of donation. The policy does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor or if the organ(s) is not from a relative or a certified and verified source of donation.</td></tr>
<tr><td>Living organ donor</td><td>We will pay up to the annual limits shown in the benefit schedule for reasonable and customary charges incurred for a live member to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung or bone marrow) of this policy, provided:

a) the operation and transplant is for the member's family member (parent, sibling, child, spouse or partner) ;

b) the transplant is in line with appropriate regulatory guidelines;

c) the recipient of the organ was first diagnosed by a doctor or have symptoms which first appeared after a waiting period of twenty-four (24) months from the policy commencement date or the date after this Living Organ Donor (member) Transplant benefit first became effective under this policy or the last reinstatement date (if any) whichever is the latest; and

Shall include eligible expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalization treatment. Both pre- and post-hospitalisation benefit are limited to ninety (90) days prior or after treatment respectively.

This benefit requires pre-authorization from us.

This benefit does not pay for the cost of collecting donor organs or tissue, administration costs, its complications, and illegal organ transplants.</td></tr>
<tr><td>Reconstructive surgery</td><td>We will pay for the initial reconstructive surgery and only when it is medically necessary and carried out to restore function after an accident or following surgery for an eligible medical condition, and provided that the member has been continuously covered under the policy since before the accident or surgery happened.

Benefit for reconstructive surgery is subject to our pre-authorization and must be done at a medically appropriate stage after the accident or surgery.</td></tr>
<tr><td>Surgical implants</td><td>We will pay for medical devices surgically implanted into the body as part of the treatment (excluding any dental implants).</td></tr>
<tr><td>Companion accommodation</td><td>We will pay up to the amount shown in your benefits table for companion's accommodation in the same hospital room with the member or at a hotel/motel near the hospital within the area of cover when the member is receiving an eligible in-patient treatment in the hospital within the area of cover. This is paid from the member's benefit.</td></tr>
<tr><td>Cash benefit</td><td>This is payable for eligible in-patient treatment only when the member receives treatment, within the area of cover, provided no cost is borne by us.

We will pay a cash benefit up to the 'Pre-existing Conditions' benefit limit, if applicable to your plan, when the in-patient treatment is resulting from a covered pre-existing condition.

'Cash Benefit' is only payable when no other benefit is claimed for under this policy per in-patient treatment.</td></tr>
</table>

Benefits	Clarifications
Pre and post-hospitalization treatment	
In-patient rehabilitation	This benefit pays for in-patient rehabilitation when: a) it is carried out by a **medical practitioner** specialising in rehabilitation; and b) it is carried out in a rehabilitation **hospital** or unit which is recognised by **us**; and c) the **treatment** could not be carried out on an out-patient basis, and d) the costs have been agreed, in writing by us before the rehabilitation begins. **We** will not pay for in-patient rehabilitation for more than twenty-eight (28) days except in cases such as in severe central nervous system damage caused by external trauma. For cases such as in severe central nervous system damage caused by external trauma, **we** will not pay for in-patient rehabilitation for more than one hundred eighty (180) days
Pre-hospitalization **treatment**	**We** will pay for consultation, prescribed investigations and essential medications by a **medical practitioner** received as an out-patient within ninety (90) days prior to a hospitalization, where such hospitalization is **eligible** for cover under **member's plan** and where the need for such hospitalization has arisen as a direct result of the medical examination and investigation findings drawn from that consultation.
Post-hospitalization **treatment**	**We** will pay for follow-up out-patient consultation and **treatment** following an **eligible in-patient treatment** or daycare surgery when such consultation is carried out by the in-patient treating **medical practitioner** or a referred **medical practitioner** and provided such consultation or **treatment** occurs within ninety (90) days immediately following the date of discharge from **hospital** for which the **member** was confined as an in-patient or the date of the daycare surgery.

Out-patient treatment – general information

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

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

Please note: We recommend that you obtain our written pre-authorization of planned treatment. This is to protect you from unexpected costs.

Please refer to the **benefits table** on Section 10 for further information on the availability, benefit levels and **waiting periods** of **your plan**.

Benefits	Clarifications
Primary and specialist care (Plan A and B only)	A consultation is a visit to any **medical practitioner** for the **treatment** of an **eligible medical condition**. **We** will pay for the **medical practitioner** charges for consultations, **prescriptions** and **diagnostic procedures**. Diagnostic tests include and are limited to laboratory, X-ray and ultrasound. **Second opinion for the same medical condition:** • pre-authorization is recommended **Thereafter subsequent opinions and referrals for the same condition:** • written pre-authorization is required
Surgical procedures	**We** will pay for any **surgical procedure** received as part of an **out-patient treatment**. This include one post-surgery consultation within ninety (90) days from the date of the surgical procedure.
Emergency treatment due to **accident**	**We** will pay for **out-patient treatment** due to **accident** required immediately (within twenty-four (24) hours) following bodily **injury** arising from an **accident**, provided the **member** has been continuously covered under the **policy** since before the **accident** happened. Follow up **treatment** for the same bodily **injury** will be covered up to thirty (30) days from the date of the **accident**.
Radiotherapy and chemotherapy	**We** will pay for radiotherapy and chemotherapy received as an out-patient for an **eligible medical condition** at a registered medical facility recognised by **us.**
Kidney dialysis	**We** will pay for kidney dialysis received as an out-patient for an **eligible medical condition** at a registered medical facility recognised by **us**.
Computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans	**We** will pay for computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an **eligible out-patient treatment**.
Hormone replacement therapy	**We** will pay for the consultations and the cost of the implants, injections, patches or tablets when it is **medically necessary** and resulting from a medical intervention rather than for the relief of physiological symptoms. Where hormone replacement therapy is only required for the relief of menopausal symptoms, this benefit will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the **benefits table** applicable to the **member's** plan.

Benefits	Clarifications
Physiotherapy, occupational therapy and speech therapy	Such treatment must be given by a qualified practitioner who is recognised by **us** and registered to practice this where the **eligible treatment** is given. Benefit is payable only following **in-patient treatment** for an **eligible medical condition**, provided that the **member** has been continuously covered under the **policy** since before the **in-patient treatment** commenced. Treatment given by any of these practitioners must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has defined a diagnosis. There must be a clear treatment plan from the practitioner with an end point and expected outcome.

Other benefits – general information

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

Please refer to the **benefits table** on Section 10 for further information on the availability, benefit levels and **waiting periods** of **your plan**.

Benefits	Clarifications
Alternative and Wellbeing Medicine	
Consultation and **treatment** provided and prescribed by a qualified and registered chiropractor, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, homeopath, osteopath, **physiotherapist** and traditional Chinese medicine practitioner (Plan A and B only)	**We** will pay for consultation and treatment given by a qualified **alternative practitioner** and **physiotherapist** who is recognized by **us** and registered to practice this where the **treatment** is given. Within this benefit and up to the limits applicable to the **member's plan**, **we** will also pay for vitamins, supplements, and traditional Chinese medicine when such are prescribed by the **alternative practitioner** or **medical practitioner**. The **member** should obtain a non-contra-indication for the use of alternative treatment from their treating **medical practitioner** as **we** will not pay for any complications arising from such alternative treatment in excess of the limit shown for this benefit.
Vaccination (Plan A and B only)	This benefit becomes available and eligible claims payable for expenses incurred after the **member** has been continuously covered under Plan A or B for 90 days in the first policy year.
Health Screen (Plan A and B only)	The limit shown includes the cost of any **eligible** consultation needed as part of the screening process. This benefit covers health screen or medical screening examination in the absence of a **medical condition** including follow-up consultation, where the **member** did not experience signs or symptom. This benefit is not payable if the member is receiving a medical screening examination for **treatment** of a **medical condition**.
Dental Treatment	
Accidental damage to natural teeth	Under accidental damage to teeth, **we** will pay for **treatment** required (within thirty (30) days) following accidental damage to natural teeth caused by extra-oral impact when that **treatment** is given by a **dental practitioner,** provided that the **member** has been continuously covered under the **policy** since before the **accident** happened. Benefit is not payable if: (a) the damage was caused by normal wear and tear (b) the **injury** was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn (c) the damage was caused by tooth brushing or any other oral hygiene procedure (d) the damage is not apparent within seven (7) days of the impact which caused the **injury** Please note: There is no cover for **treatment** required as the result of the consumption of food or drink or any foreign bodies contained in such food or drink.
Oral and maxillofacial surgery	This benefit pays for the following procedures performed by an oral and maxillofacial surgeon: (a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms; (b) Surgical removal of complicated buried roots which are diseased or causing symptoms; (c) Enucleation (removal) of cysts of the jaw; (d) **Treatment** of cancers (For lesion or lump in the mouth); (e) Treatment of Temporal Mandibular Joint (TMJ) (except physiotherapy for Temporal Mandibular Joint (TMJ) which is paid under the 'Alternative Treatment' benefit as provided for by **your plan**) For avoidance of doubt, the maximum benefit payable shall be limited to the amount applicable on the **"Pre-existing Conditions**" benefit for **members** insured on Plan A or B after a **waiting period** of two hundred seventy (270) consecutive days if the oral and maxillofacial surgery is required for an **eligible pre-existing condition**. For **members** insured on Plan C, no benefit shall be payable for oral and maxillofacial surgery required as a result of a **pre-existing condition**. Please note: this benefit does not cover routine dental care.
Routine dental care (Plan A and B only)	**We** will pay up to the limit shown for dental examination, extraction, fillings, root canal treatment, scaling/polishing, bridgework, crowns, implants, dentures, x-ray, sealant, inlays and onlays, fluoride treatment and the **treatment** of gum disease. The limitations applied to **pre-existing conditions are** not applicable to this benefit.

Benefits	Clarifications
Optical Benefit	
Routine optical care (Plan A only)	This benefit provides for the fees charged for corrective spectacle lenses, contact lenses and associated spectacle frames prescribed by the ophthalmologist or optometrist up to the limit shown for **your plan**. This benefit also pays for the eye examinations carried out by an ophthalmologist or optometrist. This benefit does not pay for tinted/ reactive lenses, sunglasses, non-corrective contact lenses, lasik/laser eye surgery and/or similar, whether prescribed or not.
Emergency Evacuation and Repatriation	
International **Emergency** Medical Assistance ('IEMA')	Please refer to Section 3.3 for more details on International **Emergency** Medical Assistance.
New born cover	
New born cover - acute **medical condition**	This benefit pays for the **treatment** of acute **medical condition**, provided there is no underlying **congenital condition** developed in a new born baby including nursing of pre-mature baby (i.e. where birth is prior to thirty-seven (37) weeks gestation) in Neonatal Intensive Care Unit (NICU). The common acute **medical conditions** for new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: (a) the parent of the new born baby has been covered under **International**Exclusive for three hundred sixty-five (365) consecutive days or more when the baby is born; and (b) the new born baby is added into the insured parent's **policy** within thirty (30) days from birth; and (c) both parent and baby have been continuously covered under the **policy** and the **policy** is in force when the **treatment** is received. This benefit is paid from the insured baby's **plan**. This benefit covers **treatment** received by a new born baby during the first thirty (30) days after birth. After thirty (30) days, **treatment** can be covered under the main benefits of the insured baby's **plan**. Please see Section 1.5 - 'Persons eligible' for details on eligibility.
New born cover – **congenital conditions** (Plan A only)	This benefit pays for **treatment** of **congenital conditions** The benefit becomes available if: (a) the parent of the new born baby has been covered under **International**Exclusive Plan A for three hundred sixty-five (365) consecutive days or more when the baby is born; and (b) the new born baby is added into the insured parent's **policy** within thirty (30) days from birth; and (c) both parent and baby have been continuously covered under the **policy** and the **policy** is in force when the **treatment** is received. This benefit is paid from the insured baby's **plan**. Please note: (i) **Treatment** for **congenital conditions** which do not fulfil all of the above criteria will be paid from '**Pre-existing Conditions**/**Congenital Conditions**' benefit. (ii) Once the limit for this benefit is reached, no other benefit (including '**Pre-existing Conditions**/**Congenital Conditions**' benefit) will be payable for the **congenital condition**(s) which was (were) claimed from this benefit for the remaining **policy year**.
Other benefits	
Home nursing	Under this benefit, **we** will pay charges incurred by an attending registered and qualified **nurse** for a **member** and only when the following conditions are met: (a) after his discharge from **hospital** which the **member** has been warded in the intensive care unit for **an eligible medical condition** or undergone for an **eligible** daycare surgery, and (b) agreed in writing by **us** beforehand that it is **medically necessary** and appropriate, and (c) it is prescribed by the treating **medical practitioner** for the continued **treatment** for the **eligible medical condition** which the **member** was hospitalised for, and (d) when such services are essential for medical as distinct from domestic reasons. For avoidance of doubt, the charges refer to the fees for the service of the **nurse** incurred for nursing at home. For **terminal medical condition**, this benefit is payable under 'Hospice and Palliative Care' and subject to the limitations applicable to that benefit.
Pre-existing conditions (Plan A and B only)	Where applicable, we will pay for **treatment** required for **pre-existing conditions** up to the limit shown for the **member's plan**. **Treatment** of declared and accepted **pre-existing conditions** will be paid for from this benefit after the **member** has been continuously covered under the **policy** for two hundred seventy (270) consecutive days **waiting period**. All **pre-existing conditions** must, in good faith, be declared to **us**, in writing, at the time of application. Please note that it is important that the **member** give **us** full details of any medical history on an application. Failure to declare any **medical condition** of which the **member** should reasonably have been aware may result in **treatment** of that condition being excluded from all future cover with **us** or cancellation of **your policy**. **Your policy schedule** will clearly show the **medical conditions** for which a **member** is covered under the "**Pre-existing Conditions**" benefit for **treatment**. **We** may ask for a medical report, at **your** own cost, to clarify the status of any **medical condition**. '**Pre-existing Conditions**' benefit and '**Congenital Conditions**' benefit share the same aggregate annual limit, thus any benefit paid under one of those two benefits reduce the remaining benefit available for both.

Benefits	**Clarifications**
Other benefits	
Congenital conditions (Plan A and B only)	**We** will pay for **treatment** required for **congenital conditions** up to the limit shown for your plan, after the (Plan A and B only) **member** has been continuously covered under the policy for two hundred seventy (270) consecutive days **waiting period**. All **congenital conditions** must, in good faith, be declared to **us**, in writing, at the time of application. Please note that it is important that the **members** give **us** full details of any medical history on an application. Failure to declare any **medical condition** of which the **members** should reasonably have been aware may result in **treatment** of that condition being excluded from all future cover with **us** or cancellation of **your policy**. For the avoidance of doubt, the exclusions below remain applicable to this benefit: 5.1 **treatment** relating to neurological development, cognitive development, learning disorders, speech delay, educational problems, behavioural problems, developmental milestones, physical development or psychological development, including assessment or grading of such problems. This includes but not limited to problems such as dyslexia, dyspraxia, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech and language problems. 5.2 (a) cosmetic (aesthetic) surgery or treatment; 5.2 (b) any **treatment** which relates to or is needed because of previous cosmetic **treatment** or reconstructive surgery. '**Pre-existing Conditions**' benefit and '**Congenital Conditions**' benefit share the same aggregate annual limit, thus any benefit paid under one of those two benefits reduce the remaining benefit available for both.
Local road ambulance transport	This is to pay for a local road ambulance for **medically necessary emergency** transport to or between **hospitals.** The **medical practitioner** of the **member** will determine if this is medically essential. **We** reserve the right to ultimately determine whether such transportation was medically appropriate. **(This does not form part of the International Emergency** Medical Assistance service**)**
Psychiatric **treatment**	The limit shown applies to **in-patient**, **daycare** and **out-patient treatment** (subject to availability of out-patient benefit for **your plan**) of psychiatric **illnesses** in aggregate, unless otherwise stated. This benefit must be pre-authorized by **us**. All **treatments** given by psychologists, psychotherapists or any individuals other than a registered psychiatrist must be pre-authorized by **us**.
Treatment for HIV/AIDS (Plan A only)	**We** will pay for **treatment** for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) as a result of occupational **accident** or blood transfusion up to the limit shown for **your plan**: (a) Infection with the HIV through a blood transfusion, provided that all of the following conditions are met: (i) the blood transfusion was **medically necessary** or given as part of a medical **treatment**; (ii) the blood transfusion was received after this **policy** was incepted; (iii) the source of infection is established to be from the **hospital** and the **hospital** is able to trace the origin of the HIV tainted blood; (iv) the **member** does not suffer from thalassaemia major or haemophilia; and (v) HIV infection is not resulted from any other means including sexual activity and/or from transmission from the insured **member's** parent and/or the use of intravenous drugs. (b) Infection with HIV which resulted from an **accident** occurring after this **policy** is incepted, whilst the **member** was carrying out the normal professional duties of his or her occupation in the **principal country of residence,** provided that all of the following are proven to **our** satisfaction: (i) proof of the **accident** giving rise to the infection must be reported to **us** within thirty (30) days of the **accident** taking place; (ii) proof that the **accident** involved a definite source of the HIV infected fluids; (iii) proof of sero-conversion from HIV negative to HIV positive occurring during the one hundred eighty (180) days after the documented **accident**. This proof must include a negative HIV antibody test conducted within five (5) days of the **accident**; and (iv) HIV infection resulting from any other means including sexual activity and/or the use of intravenous drugs are excluded. This benefit becomes available when signs or symptoms for HIV/AIDS are present for the first time after the **member** is insured for at least thirty-six (36) consecutive months in this **policy**.
Artificial limbs (Plan A and B only)	**We** will pay this benefit up to the limit stated on the **benefits table** for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or **surgical procedures**. Benefit is only payable following a surgery or an **accident** for **an eligible medical condition** provided that the **member** has been continuously covered under the **policy** since before the **accident** or surgery happened.
Medical aids and durable medical equipments (Plan A and B only)	**We** will pay for instruments or devices or durable medical equipment which are prescribed by the **medical practitioner** as a **medically necessary** aid to the function or capacity, such as and limited to: • abdominal binder, • post-surgical mastectomy bra • compression stocking • hearing aids • speaking aids (electronic larynx) • wheelchairs • crutches • corrective splint • air boots • arm sling • brace

Benefits	Clarifications
Other benefits	
Hospice and palliative care	Benefit only becomes available and **eligible** claims payable for expenses incurred after the **member** has been continuously covered under his chosen **plan** for three hundred sixty-five (365) consecutive days and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit becomes available when the **member** is admitted to a specialist palliative care centre or hospice, recognized by **us**, following diagnosis, written confirmation (including medical evidence) by a **medical practitioner** that the **member** is suffering from an **eligible terminal medical condition(s)** and its associated conditions. The benefit should be pre-authorized, in writing, by **us** in advance of admission. Once the **member** is admitted, all costs of care and any **treatment** related to an **eligible terminal medical condition(s)** and related conditions will be taken from this benefit and may not be claimed from any other benefit applicable to the **member's plan**. Any **eligible medical conditions** not related to the **member's terminal medical condition** will be covered under the **member's** main benefits. **We** reserve the right to determine, on the advice of **our** medical panel, whether a **medical condition** is or is not related to the **terminal medical condition**. This benefit is payable, up to the **lifetime** limit shown for the **member's plan** in aggregate for all such conditions. The **member** must maintain the same level of cover throughout the palliative or hospice care admission. This means that, if the period of palliative or hospice care falls across a **policy anniversary**, the **member** must pay the premium for the subsequent **year** or benefit will cease at the **policy anniversary**. In the event that the costs of the **member's** admission reach the limit shown for this benefit no further benefit will be payable. Once the limit of this benefit is reached no benefit of any kind will be payable in respect of any **medical condition** for which palliative and/or hospice care has been received. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the **member** has been covered under the upgraded **plan** for a period of not less than three hundred sixty-five (365) consecutive days and has effected the annual renewal of the upgraded **plan**. The **waiting period** will apply in the event of an upgrade in cover.
Investigation into Infertility (Plan A only)	**We** will pay for investigation and **treatment** of the cause of infertility. This benefit becomes available and **eligible** claims payable for expenses incurred after the **member** has been continuously covered under Plan A for at least eighteen (18) months.
Pre and post-natal complications	Benefit only becomes available and **eligible** claims payable for expenses incurred after the female **member** over the **age** of eighteen (18) years has been continuously covered under their chosen **plan** for three hundred sixty-five (365) consecutive days and has effected the annual renewal of that **plan** for the coming **policy year**. This benefit pays for **treatment** of an **eligible medical condition** which is due to and occurs to the female **member** during the pregnancy prior to or after the childbirth. The list of eligible pre- and post- natal complications include the following: • Antiphospholipid syndrome, • Cervical incompetence, • Ectopic pregnancy, • Gestational diabetes, • Hydatidiform mole – molar pregnancy, • Hyperemesis gravidarum, • Obstetric cholestasis, • Pre-eclampsia / Eclampsia, • Rhesus (RH) factor, • Miscarriage requiring immediate surgical intervention, • Post partum haemorrhage, • Retained placental membrane Under post-natal complications, **we** will only pay for **treatment** received within ninety (90) days following the childbirth. This benefit does not cover: • the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or • any pre- and post-complication arising from elective or non-**medically necessary** caesarean section birth. • **treatment** of any **medical condition** which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted means or **assisted conception/assisted pregnancy.** Whilst **we** recognize that caesarean section may sometimes be a medical necessity, caesarean section can only be covered under the Optional add-on 'Normal (Routine) Pregnancy and childbirth' benefit for member insured on Plan A only, subject to compulsory co-insurance 20% per claim. Please note: If **we** are not able to determine that a caesarean section is **medically necessary we** will consider it as not **medically necessary**.
New born accommodation	This benefit will pay for the child who is less than sixteen (16) weeks old to stay in the **hospital** with the mother (being an insured **member**) while she is receiving **eligible in-patient treatment** at such **hospital**. This is paid from the mother's benefit. The benefit pays for new born nursery accommodation of a standard class, where the new born only receives nursery care during the stay in the **hospital**. This benefit is not payable if the new born is hospitalised for **treatment** of any **medical condition**.

Benefits	Clarifications
Other benefits	
Normal (Routine) pregnancy and childbirth (Plan A only and subject to compulsory co-insurance)	Benefit is available and **eligible** claims are payable for expenses incurred after the **member** has been continuously covered under Plan A for three hundred sixty-five (365) consecutive days **waiting period** and has effected the annual renewal of that **plan** for the coming **policy year**. **We** will pay eighty (80%) percent of the **eligible** expenses up to the benefit limit for routine pre-natal care, inpatient childbirth and routine post-natal care up to forty-two (42)days following the birth. This benefit is only available for female **member** over the age of eighteen (18) years. We will also pay for normal, routine pregnancy and inpatient childbirth even when such pregnancy was established through **assisted conception/assisted pregnancy**. This benefit does not cover any expenses related to **assisted conception/assisted pregnancy** including any complications. The limit shown is the maximum we will pay under this benefit for each: • **policy year**, even if there is more than one pregnancy in that **policy year**, • pregnancy, even if a pregnancy, which is **eligible** for benefit, falls across the **policy anniversary**, and provided the **policy**, including this benefit, has been renewed for the subsequent **policy year** For inpatient birth through vaginal childbirth and **medically necessary** caesarean section, **we** will pay for the **reasonable and customary** childbirth costs of a standard single room, up to the limit shown for this benefit in the **benefits table**. Any complications of pregnancy will be paid from “Pre- & post-natal complications” benefit. For inpatient birth through **non-medically necessary** caesarean section, we will pay for the **reasonable and customary** childbirth costs up to the costs of a natural childbirth in a standard single room. If we are not able to determine that a caesarean section is medically necessary, we will consider it is not **medically necessary**. The complications arising from such childbirth will be paid up to the remainder of the Normal (Routine) Pregnancy and Childbirth limit. Please take note: This benefit is payable when 365 consecutive days membership is achieved by the **member** under this plan / cover from the date this cover is attached to the **member**’s plan.

3.3 INTERNATIONAL EMERGENCY MEDICAL ASSISTANCE (‘IEMA’)

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

2. The terms and definitions in **your plan** also apply to the **service**, and any limitation of cover for the **service** shown in the **policy schedule** will apply. For this section only **we** have given some more words and phrases special meanings. These are:
   (a) **appointed doctor**: a **medical practitioner** chosen by **us** to advise **us** on the **member’s medical condition** and/or need for the **service** and/or the suitability and adequacy of the medical facilities in the country where the **member** has been admitted to **hospital**.
   (b) **service**: moving the **member** to another **hospital** which has the necessary medical facilities either in the country where the **member** is taken ill or in another nearby country (evacuation) or bringing them back to their **principal country of residence.**
   (c) **home country**: the country as shown in **our** records which the **member** regards as home and which issues the **member’s** passport.

3. The **service** is available **worldwide** to any **member** who is injured or becomes ill suddenly due to an **eligible medical condition** and needs immediate **hospital treatment** as an in-patient. The **service** is only available in these circumstances and as follows:
   (a) if the **member** is admitted to **hospital** while abroad from their **principal country of residence** then, if in the opinion of the **appointed doctor** the medical facilities there are not suitable or adequate, they will be entitled to evacuation or repatriation;
   (b) if the **member** is admitted to **hospital** while in their **principal country of residence** then, if in the opinion of the **appointed doctor** the medical facilities in the **principal country of residence** are not suitable or adequate, the **member** will be evacuated to the nearest place where appropriate **treatment** are available;
   (c) following evacuation, in accordance with (3.a.) or (3.b.) above, the **member** concerned shall be entitled to be returned, by regular scheduled airline unless **we** agree that another means of transport is necessary, to his **principal country of residence**.

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

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

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

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

7. If a member dies abroad, **we** will bring the body or ashes back to a port or airport in the **principal country of residence** or home country, if the death is caused by an **eligible medical condition.**

   For avoidance of doubt, **we** will not pay for any benefit for IEMA if the **member’s** companion or **family member** has not obtain pre-authorisation from **us**.

8. The **service** is not available to cover the following:
   (a) any **medical condition** which does not need immediate in-patient **hospital treatment** or which does not prevent the **member** from continuing to travel or to work; or
   (b) any costs incurred as a result of engaging in or training for any sport for which the **member** receive a salary or monetary reimbursement, including grants or sponsorship (unless the **member** receive travel costs only); or
   (c) **treatment** of injuries sustained from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.
   (d) if the **member** needs to be moved from a ship, oil-rig platform or similar off-shore location;
   (e) if, at the time the need for the **service** arises, the **member** is insured or, if this insurance did not exist, would be insured against those costs by an existing insurance policy or policies;
   (f) any costs that **we** do not approve beforehand;
   (g) if **we** have not been told about the **accident** or **illness** for which the **service** is needed within thirty (30) days of its happening;
   (h) at the time of travel the **member** is travelling to a country or area that the Singapore Ministry of Foreign Affairs or Foreign and Commonwealth Office lists as a place which, for any reason, it advises against.
   (i) any costs incurred which arise from, or are directly or indirectly caused by a deliberately self-inflicted injury, suicide or an attempt at suicide.
   (j) any costs incurred which arise from or are in any way connected with, alcohol abuse, drug abuse or substance abuse.

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

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

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

How the service works:

When the member is away from his principal country of residence

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

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

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

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

When the member is in his principal country of residence

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

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

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

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

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

Important

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

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

The emergency control centre

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

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

24-Hours Hotline: +65 6880 4944

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

4. Important information about your plan

4.1 Our **policy** on changing your level of cover or moving to another **plan**

We will not allow **members** to upgrade or downgrade their level of cover except at each **policy anniversary** and only when requested, in writing, to do so. **We** reserve the right to refuse any request to upgrade or amend cover. **We** will not pay upgraded benefit levels for **treatment** of any **medical condition** which arose or should reasonably have been foreseen by the **member** prior to the upgrade becoming effective. **Members** are required to declare any such **medical condition** to **us** when requesting the upgrade. Where such a **medical condition** is, or becomes apparent, benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade.

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

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

If **you** want to add someone else to an existing **policy** or delete an existing **member you** must inform us in writing and give all the information **we** request. For eligibility of cover, please refer to Section 1.5 - 'Persons eligible'.

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

4.3 What happens if **members** change their **principal country of residence**

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

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

If **you** do not tell **us we** can refuse to pay benefits.

InternationalExclusive is also available from AXA in several other Asian countries and AXA PPP healthcare also offers similar plans both in the UK and elsewhere. Please contact **us** for information on availability and terms and conditions.

4.4 What happens if **members** return to their home country?

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

4.5 What happens if **you** wish to cancel your **policy**

You have a free-look period of fourteen (14) business days from the date that **you** receive this **policy** to review it. **You** are deemed to have received the **policy** within three (3) days after **we** have dispatched it. If **you** decide that this **policy** does not suit **your** needs, **you** may request to cancel it by giving **us** clear, written instructions and returning the **policy** documents and membership card(s) to **us** within the free-look period. Provided that no claims have been made during this period, **we** shall refund the premiums paid by **you**, in full, without interest. This free-look period shall not apply to policies with terms of less than one (1) **year**. It will also not apply to **policy** renewals.

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

Please note:
(a) no claim of any kind will be considered after notification by **you** and acceptance by **us** of any cancellation;
(b) for members covered under Plan A, any cancellation may affect the claim payout of 'Pregnancy and Childbirth' benefit.

4.6 What happens if **we** wish to cancel your **policy**

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

4.7 When the terms of your **policy** might change

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

We may also change premiums if costs, taxation, regulations or benefit changes make this necessary. In the event that **we** are required by law to make a change during the **policy year**, for example if a new tax is introduced, **we** will be obliged to do so before the next renewal date. **We** do reserve the right to apply underwriting terms to **your policy** at any time if a **medical condition** that should reasonably have been declared comes to **our** attention.

4.8 Our approach to cancer care

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

Oncology **treatment** and related **eligible** expenses, where applicable to a **medical condition** or symptoms that existed prior to the **member** first being accepted by **us** for cover, will be subject to the terms and limits applying to the benefit for '**Pre-existing conditions**' shown in the clarifications and **benefits table**.

Please note that the maintenance phase of any **treatment** (such as the administering of herceptin or similar drugs which are not classed as active **treatments**) will be paid for under the **out-patient treatment** benefit where available under **your plan**. Preventative medical examinations or routine follow-up consultations when the **member** does not have symptoms of **cancer** will be paid under the 'Health screen' benefit.

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

4.9 Full cover for kidney dialysis

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

Kidney dialysis **treatment** and related **eligible** expenses, where applicable to a **medical condition** or symptoms that existed prior to the **member** first being accepted by **us** for cover, will be subject to the terms and limits applying to the benefit for '**Pre-existing conditions**' shown in the clarifications and **benefits table**.

4.10 Full cover for **chronic** conditions

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

Maintenance of **chronic** conditions refers to consultation charges, medications and routine investigations.

Plan A and B provide cover for the maintenance of **chronic** conditions first arising after **you** have been accepted as a **member**, received as an out-patient. Plan C provides only Hospitalization cover including pre and post-hospitalization, therefore, generally does not provide cover for the maintenance of **chronic** conditions.

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

4.11 Joining and renewing

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

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

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

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

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

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

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

4.12 General Conditions

(which apply to the whole **policy** and to be observed by **you** and all the **members** insured under the **policy**)

It is important part of **our** contract that **you** observe the following General Conditions and they are, where their nature permit, condition precedents to the right to recover from **us**:

(a) If any **member** breaches any of the terms of the **policy** or makes, or attempts to make, any dishonest claim, **we** can:
- refuse to make any payment; and
- refuse to renew **your policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- terminate **your policy** and all cover under it immediately.

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

(c) **You**, the **member** or his representatives shall co-operate fully with **us** and **our** medical team (including the independent **appointed medical practitioner**) and **you**, the **member** or his representatives will fully and faithfully disclose all material facts and matters which **you** and/or the **member** knows or ought to know and will upon request to execute any document to empower **us** to obtain the relevant information, at **your** or the **member's** expense from any **medical practitioner** or **hospita**l or clinic or other source.

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

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

(f) It is hereby declared that as a condition precedent **our** liability, the **policyholder** and the **member** have agreed that any personal information in relation to the **policyholder** provided by or on behalf of the **members** to **us** may be held, used and disclosed to enable **us** or individuals/organizations associated with **us** or any independent thirty party (within or outside Singapore) to:
i. process and assess the **member**'s application or any matter arising from the **policy** and any other application for insurance cover, and/or
ii. provide all services under the **policy**.

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

(h) **You** must write and tell **us** if **you** (or any **member**) change address. **You** are acting on behalf of any **member** covered by **your policy** so **we** will send all correspondence about the **policy** to **your** address.

(i) If there is a dispute between **you** and **us, we** have a complaints procedure, set out in Section 8 – 'if any problems arise', which the **member** must follow so that **we** can resolve it.

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

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

If any dispute is not referred to FIDReC or if mediation and adjudication fails in FIDReC, the dispute has to be referred to arbitration. Arbitration shall be conducted in accordance with the Arbitration Rules of the Singapore International Arbitration Centre.

The arbitration shall be in English and heard by a single arbitrator to be agreed by the parties within fourteen (14) days from the notice of arbitration failing which the arbitrator shall be appointed in accordance with and subject to the provisions of the Arbitration Rules (as may be amended from time to time).

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

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

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

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

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

4.13 Illegality Clause

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

4.14 Sanction Clause

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

5. What are you not covered for

Exclusions and limitations

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

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

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

(c) any **surgical procedure** which is not listed in the **schedule of procedures**, unless **we** have agreed, in writing, beforehand;

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

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

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

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

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

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

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

(k) sex change including **treatment** which arises from or is directly or indirectly made necessary by a sex change;

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

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

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

(o) the costs of collecting donor organs for transplant surgery or any administration costs involved even if such transplants are allowed by the terms of this **plan**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(dd) any **treatment** specifically excluded by the terms shown on **your** membership statement or the schedules/endorsement forming part of this **policy**; any charges for items not listed in the **benefits table** and/or **policy schedule** applicable to **your plan**;

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

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

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

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

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

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

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

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

(mm) all bank or credit charges;

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

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

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

(qq) Cryopreservation, or harvesting or storage of stem cells as a preventative measure against possible future disease/**illness**/**injury** or implantation or re-implantation of living cells or living tissues whether autologous or provided by a donor unless this has been agreed by us in writing. **We** will pay for skin grafts, bone grafts and blood transfusions provided it was not due to a **pre-existing** condition nor have we applied any personal medical exclusion shown on the certificate of insurance or membership certificate;

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

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

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

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

Note: **We** may pay for genetic testing only when it is proven to help choose the best course of drug treatment and is recommended in the drug license for a specific targeted therapy;

(vv) toiletries such as, but not limited to shampoos, soaps, tooth-pastes , mouthwash, lotions, moisturizers, cleanser, shower gels, regardless whether medically necessary or prescribed by a medical practitioner; contraceptives, proprietary headache and cold cures, artificial tear drop/ gel, vitamins which may be bought over the counter, without **prescription**, at a local pharmacy nor do **we** pay for telephone calls;

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

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

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

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

(aaa) artificial life maintenance for more than 60 continuous days if **you** are in a persistent vegetative state and only kept alive by medical intervention such as mechanical ventilation;

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

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

(ddd) **treatment** provided to the **member** by any of the following people related to a **member** by blood, marriage or adoption:
(i) parents and parents-in law;
(ii) siblings and brothers-in-law and sisters-in-law;
(iii) spouse; and
(iv) children of the **member**;
or self-treatment by the **member**, including the prescription of drugs.

(eee) robotic surgery unless this has been pre-approved and agreed by us in writing.

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

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

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

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

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

(e) **treatment** or medicine which in our reasonable opinion has not been established as being effective or is experimental or unproven. However **we** will pay if, before the **treatment** begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and **we** have agreed in writing, with the **medical practitioner**, what the fees will be. For established **treatment**, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies.

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

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

5.3 **We** will not pay for any **treatment**, or for International **Emergency** Medical Assistance, if they are needed as a result of nuclear contamination, biological contamination or chemical contamination, whilst engaging in or taking part in war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons, or any event similar to one of those listed. This includes any **treatment** needed as a result of the **member** exposing himself to needless peril, such as going to a place of unrest as an active onlooker or a spectator.

Please note, for clarity: There is cover for **treatment** required as a result of a **terrorist act** providing that **terrorist act** does not result in nuclear, biological or chemical contamination.

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

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

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

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

6. Understanding how to get the best from your plan

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

Before **you** go for **treatment**

What to do before receiving in-patient and daycare treatment

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

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

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

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

You must contact **us** at least 10 to 15 working days before **you** book that unconventional, experimental or unproven treatment so **we** can:

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

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

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

Pre-authorization

The reason that **we** recommend pre-authorization of planned **treatment** is to protect **you/members** from unexpected costs. When issuing confirmation of cover in this way, **we** confirm the following:

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

You should seek **our** written pre-authorization for the following **treatment** and services:

In-patient and daycare

- all in-patient and daycare admissions
- all non-**emergency** tests, diagnostics, **treatment**, surgery and other medical services
- all in-patient maternity services
- all in-patient dental services
- special nursing in **hospital** and/or any nursing at home after discharge
- hospice and palliative care
- reconstructive surgery
- psychiatric **treatment**
- robotic surgery

Out-patient

- psychiatric **treatment**
- second opinion for the same **medical condition**

Failure to obtain pre-authorization may prevent **us** from settling all or part of any claim. In the event that **we** are obliged to pay for any item not covered by **our** confirmation **we** will recover that amount from **you**. In any event any cost that is not directly related to **treatment** will be borne by the **member**.

In-patient and direct billing

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

Members can contact AXA Health Customer Care Centre to submit the pre-authorization request. Please refer to Section 11-'Your AXA office/Important Contact details' of the policy document for more details. **Members** should confirm with the **hospital** that it has received our written authorization (Letter of Guarantee) before he/she undergoes treatment. If it has not the **member** must contact us immediately.

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

The LOG request may not be approved by us for any of the following reasons:

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

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

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

Treatment outside network of **hospitals**
If you are planning or have decided to receive **treatment** in a **hospital** which is not listed in our **international directory of hospitals**, **you** will have to pay for your **treatment** costs first and then submit to **us** the claim incurred for reimbursement of the eligible charges. **We** recommend **you** contact us before any proposed **treatment** begins, as failure to allow us to manage your care may expose **you** or the **member** to possible additional costs for which **we** will not be liable under the **policy**.

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

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

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

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

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

If **you** need **treatment** abroad
If **you** need **treatment** abroad, **you** will need to call **our** Health Customer Care Centre on the number shown on the reverse of **your** membership card.

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

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

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

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

Claim forms for reimbursement claims
Members can visit **our** website at www.axa.com.sg to obtain a printable claim form if they need one or call **our** Health Customer Care Centre at the number shown on the reverse of **your** membership card.

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

Only original receipted invoices can be accepted with **your** claim.

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

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

We do not pay for medical reports.

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

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

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

AXA Insurance Pte Ltd

8 Shenton Way, #24-01 AXA Tower, Singapore 068811

Currency
Your premiums are payable in Singapore Dollars.

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

Claims incurred in any other currency will be converted using the spot rates prevailing at the time **we** assess the claim.

We shall not be liable for any bank charges or credit charges.

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

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

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

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

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

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

- **we** will not pay any benefits for that claim; and
- if **we** have already paid benefits for that claim before **we** discovered the dishonesty **we** can recover those benefits from **you** (or the **member**); and
- **we** can take any of the actions listed in Section 4.12 – 'General Conditions', clause (a).

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

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

7. Health at Hand
Through **our** telephone health information service, Health at Hand, **our members** have access to a qualified and experienced team of healthcare professionals 24 hours a day, 365 days a year.

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

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

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

As Health at Hand is a confidential service, any information discussed is not shared with **our** AXA Health Customer Care Centre. Please refer to Section 11 – 'Your AXA office/Important Contact details' of this policy document for more details.

If **members** wish to obtain pre-authorization for a **treatment**, enquire about a claim or have a membership query, **our** AXA Health Customer Care Centre will be happy to help them.

Please note that **we** will not be liable for any damage or losses **members** may suffer or incur as a result of their usage of such services.

8. If any problems arise...

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

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

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

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

Financial Industry Disputes Resolution Centre Ltd
36 Robinson Road #15-01 City House Singapore 068877
Telephone : 63278878, Fax : 63278488, Email : info@fidrec.com.sg, Website : www.fidrec.com.sg

Please remember to quote **your policy**/membership numbers on all correspondence.

9. Your Customer Charter

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

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

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

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

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

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

For further information contact **your** AXA office, details of which can be found on Section 11 – '**Your** AXA office'.

10. Benefits Table

Benefits Table (Plan A)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
Please note: Benefit values are per member each year unless otherwise specified and are reduced each time the member claims only by the net amount (less any annual deductible or co-insurance) we have actually paid. Please refer to the policy wordings on full terms applying to these benefits.		
Overall Annual Limit		
Yearly maximum limit This is the maximum we will pay for each member each policy year. All benefits paid during the policy period will count against the yearly maximum.	S$4,500,000	
Area of cover		
Area of cover This is the geographical area where you can choose to receive treatment. You can select your area of cover at time of application. Your chosen area of cover has an impact on your premium.	**Options:** 1. Worldwide, or 2. Worldwide excluding USA, or 3. Asia	
Outside area of cover This benefit pays for emergency treatment, or treatment of a medical condition which arises suddenly whilst outside the selected area of cover.	Emergency treatment only up to S$250,000	Annual Deductible
In-patient and Daycare Treatment		
Daily accommodation charges While admitted as an in-patient or day-patient, we will pay for the costs of your accommodation in the type of room shown in your benefits table. Wherever a member receives treatment, if the hospital offers several classes for the room type he is entitled for, we will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that hospital for that type of room. If a member stays in a room which is more expensive than the standard room, the member may have to pay for the difference in room charges. The member may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with us prior to admission to avoid unnecessary out of pocket expenses.	Standard single room	Annual Deductible
Hospital charges This benefit pays for hospital charges given between admission and discharge including: a) Diagnostic procedures b) Surgical procedures c) Operating theatre charges d) Nursing care, drugs and dressings e) Surgeons' and anaesthetists' charges f) Intensive care unit charges g) Consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it h) Radiotherapy and chemotherapy i) Kidney dialysis j) Computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques k) Special nursing in hospital	Included	Annual Deductible
Organ transplant This benefit pays for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an eligible medical condition and provided these organ(s) have come from a relative or a certified and verified source of donation. The policy does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor or if the organ(s) is not from a relative or a certified and verified source of donation.	Included	Annual Deductible
Living organ donor This benefit pays up to the annual limits shown in the benefit schedule for reasonable and customary charges incurred for a live member to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung or bone marrow) of this policy, provided : a) the operation and transplant is for the member's family member (parent, sibling, child, spouse or partner) ; b) the transplant is in line with appropriate regulatory guidelines; c) the recipient of the organ was first diagnosed by a doctor or have symptoms which first appeared after a waiting period of twenty-four (24) months from the the policy commencement date or the date after this Living Organ Donor (member) Transplant benefit first became effective under this policy or the last reinstatement date (if any) whichever is the latest; and Shall include eligible expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalization treatment. Both pre- and post-hospitalisation benefit are limited to ninety (90) days prior or after treatment respectively. This benefit requires pre-authorization from us. This benefit does not pay for the cost of collecting donor organs or tissue, administration costs, its complications, and illegal organ transplants.	up to S$60,000 Available only after 24 consecutive months membership	Annual Deductible

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
In-patient and Daycare Treatment		
Reconstructive Surgery This benefit pays for the initial reconstructive surgery and only when it is medically necessary and carried out to restore function after an accident or following surgery for an eligible medical condition, and provided that the member has been continuously covered under the policy since before the accident or surgery happened. Benefit for reconstructive surgery is subject to our pre-authorization and must be done at a medically appropriate stage after the accident or surgery.	Included	Annual Deductible
Surgical implants This benefit pays for medical device surgically implanted into the body as part of the treatment (excluding any dental implants).	Included	Annual Deductible
Companion accommodation We will pay for companion accommodation when the member is receiving eligible in-patient treatment within the area of cover.	up to S$190 per night	Annual Deductible
New Born accommodation This benefit pays for the child who is less than 16 weeks to stay in the hospital while the insured mother is receiving eligible in-patient treatment.	Included	Annual Deductible
Cash benefit Payable for eligible in-patient treatment only when the member receives treatment within area of cover and provided no cost for that treatment is claimed under this plan.	S$300 per night	Annual Deductible
In-patient Rehabilitation This benefit pays for in-patient rehabilitation when: a) it is carried out by a medical practitioner specialising in rehabilitation; and b) it is carried out in a rehabilitation hospital or unit which is recognised by us; and c) the treatment could not be carried out on an out-patient basis, and d) the costs have been agreed, in writing by us before the rehabilitation begins. We will not pay for in-patient rehabilitation for more than twenty-eight (28) days except in cases such as in severe central nervous system damage caused by external trauma. For cases such as in severe central nervous system damage caused by external trauma, we will not pay for in-patient rehabilitation for more than one hundred eighty (180) days.	Included	Annual Deductible
Pre-hospitalisation treatment (up to 90 days before admission) We will pay for consultation, prescribed investigations and essential medications received as an out-patient within 90 days prior to a hospitalisation, where such hospitalisation is eligible for cover under member's plan and where the need for such hospitalisation has arisen as a direct result of the medical examination and investigation findings drawn from that consultation.	Included	Annual Deductible
Post hospitalisation treatment (within 90 days after discharge) This benefit pays for follow-up out-patient consultation and treatment following an eligible in-patient or daycare surgery when such consultation is carried out by the in-patient treating medical practitioner or a referred medical practitioner and provided such consultation or treatment occurs within 90 days following the discharge from hospital or the date of the daycare surgery.	Included	Annual Deductible
Out-patient Treatment		
Primary and Specialist care This benefit pays for consultation, diagnostic procedures, prescribed drugs and dressings received as part of an out-patient treatment. Diagnostic tests include and are limited to laboratory, X-Rays and Ultrasound.	Included	20% co-insurance
Surgical procedures We will pay for any eligible surgical procedures received as an out-patient for an eligible medical condition.	Included	20% co-insurance
Emergency treatment due to accident This benefit pays for out-patient treatment due to accident required immediately (within 24 hours) following bodily injury arising from an accident, provided the member has been continuously covered under the policy since before the accident happened. Follow-up treatment for the same bodily injury will be covered up to 30 days from the date of the accident.	Included	20% co-insurance
Radiotherapy and chemotherapy We will pay for radiotherapy and chemotherapy received as an out-patient for an eligible medical condition at a registered medical facility recognised by us.	Included	Annual Deductible
Kidney dialysis We will pay for kidney dialysis received as an out-patient for an eligible medical condition at registered medical facility recognised by us.	Included	Annual Deductible

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
Out-patient Treatment		
Computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans We will pay for computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an eligible out-patient treatment.	Included	20% co-insurance
Hormone replacement therapy (HRT) We will pay for the consultations and the cost of the implants, injections, patches or tablets when it is medically necessary and resulting from a medical intervention rather than for the relief of physiological symptoms. Where hormone replacement therapy is only required for the relief of menopausal symptoms,we will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the benefit table applicable to member's plan.	Included (Hormone replacement therapy for relief of menopausal symptoms - up to S$200)	20% co-insurance
Physiotherapy, occupational therapy and speech therapy Treatment given by any of these practitioners must be referred by the medical practitioner who has defined a diagnosis. Benefit is payable only following in-patient treatment for an eligible medical condition, provided that the member has been continuously covered under the policy since before the in-patient treatment commenced. Treatment given by any of these practitioners must be under the medical supervision of a medical practitioner. Medical supervision means that the reason for referral, where applicable, has been initiated by the medical practitioner who has defined a diagnosis. There must be a clear treatment plan from the practitioner with an end point and expected outcome.	Included	20% co-insurance
Alternative and Well-being Medicine		
Consultation and treatment provided and prescribed by a qualified and registered chiropractor, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, homeopath, osteopath, physiotherapist and Traditional Chinese medicine practitioner This benefit pays for the specified complementary and alternative therapist and practitioners.	up to S$2,000	20% co-insurance
Vaccination This benefit pays for necessary vaccinations. Consultation charge made in conjunction with vaccination can be claimed from this benefit where applicable.	up to S$2,000 Available only after 90 consecutive days membership in the first policy year"	20% co-insurance
Health screen This benefit includes the cost of any eligible consultation needed as part of the screening process.	up to S$1,350	20% co-insurance
Dental Treatment		
Accidental damage to natural teeth This benefit pays for dental treatment required within 30 days following accidental damage to natural teeth caused by extra-oral impact. Benefit is not payable if: a) the damage was caused by normal wear and tear b) the injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn c) the damage was caused by tooth brushing or any other oral hygiene procedure d) the damage is not apparent within seven days of the impact which caused the injury This benefit is available only if the member has been continuously covered under the policy since before the accident happened.	Included	20% co-insurance
Oral and maxillofacial surgery This benefit pays only for the following procedures performed by an oral and maxillofacial surgeon: a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms b) Surgical removal of complicated buried roots which are diseased or causing symptoms c) Enucleation (removal) of cysts of the jaw d) Treatment of cancers (For lesion or lump in the mouth) Pre-existing condition limitations apply to this benefit.	Included	20% co-insurance
Routine dental care This benefit pays for routine dental examination, extraction, fillings, scaling/polishing, x-ray, sealant, fluoride treatment, root canal treatment, implants, bridgework, crowns, treatment of gum disease, dentures, inlays and onlays. Pre-existing condition limitations are not applicable to this benefit.	up to S$2,500	20% co-insurance

<table>
<tr><th>Benefits Table</th><th>Plan A</th><th>Only applicable when Annual Deductible/ Co-insurance option is chosen</th></tr>
<tr><td colspan="3">Optical Benefit</td></tr>
<tr><td>Routine optical care
This benefit pays for corrective spectacle lenses, contact lenses and associated spectacle frames prescribed by an ophthalmologist or optometrist. Ophthalmologist or optometrist eye examination is claimable from this benefit.
Lasik/laser surgery and tinted lenses are not covered under this benefit.</td><td>up to S$380</td><td>20% co-insurance</td></tr>
<tr><td colspan="3">Emergency Evacuation and Repatriation</td></tr>
<tr><td>International Emergency Medical Assistance (IEMA)
This benefit pays for the following services:
a) Evacuation where the local medical facilities are not adequate according to our appointed doctor
b) Evacuation will be to the nearest medical facility where treatment is adequate
c) Transportation for returning to the principal country of residence following the evacuation
d) Cost of one accompanying person while the covered person is being evacuated
e) Hotel accommodation of one accompanying person up to 10 days
f) Bringing the body or ashes back to a port or airport in the principal country of residence or home country if the covered person dies abroad as a result of an eligible medical condition.</td><td>Included</td><td>Not Applicable</td></tr>
<tr><td colspan="3">New Born Cover</td></tr>
<tr><td>Acute medical condition (excluding congenital conditions)
This benefit pays for the treatment of acute medical condition, providing there is no underlying congenital condition, developed in a new born baby including nursing of pre-mature baby (i.e. where birth is prior to 37 weeks gestation) in Neonatal Intensive Care Unit (NICU). Common acute medical conditions for new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection.
This benefit is only available if:
a) the parent of the new born baby has been covered under InternationalExclusive for 365 consecutive days or more when the baby is born; and
b) the new born baby is added into the insured parent's policy within 30 days from birth; and
c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received.
This benefit is paid from the insured baby's plan.
This benefit covers treatment received by a new born baby during the first 30 days after birth. After 30 days, treatment can be covered under the main benefits of the insured baby's plan.</td><td>Included</td><td>Annual Deductible</td></tr>
<tr><td>Treatment of congenital conditions
This benefit pays for treatment of congenital conditions.
The benefit becomes available if:
a) the parent of the new born baby has been covered under InternationalExclusive Plan A for 365 days or more when the baby is born; and
b) the new born baby is added into the insured parent's policy within 30 days from birth; and
c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received.
This benefit is paid from the insured baby's plan.
Please note:
1) Treatment for congenital conditions which do not fulfill all above criteria will be paid from 'Pre-existing Condition/Congenital Conditions' benefit.
2) Once the limit for this benefit is reached, no other benefit (including 'Pre-existing Conditions/ Congenital Conditions' benefit) will be payable for the congenital condition(s) which was (were) claimed from this benefit for the remaining policy year.</td><td>up to S$65,000</td><td>Annual Deductible</td></tr>
<tr><td colspan="3">Other Benefits</td></tr>
<tr><td>Home nursing
This benefit pays for charges incurred by an attending registered and qualified nurse for a member and only when the following conditions are met:
a) after his discharge from hospital which the member has been warded in the intensive care unit for an eligible medical condition or undergone for an eligible daycare surgery, and
b) agreed in writing by us beforehand that it is medically necessary and appropriate, and
c) it is prescribed by the treating medical practitioner for the continued treatment for the eligible medical condition which the member was hospitalised for, and
d) when such services are essential for medical as distinct from domestic reasons.
For avoidance of doubt, the charges refer to the fees for the service of the nurse incurred for nursing at home.
For terminal medical condition, this benefit is payable under 'Hospice and Palliative Care' and subject to the limitations applicable to that benefit.</td><td>Included</td><td>20% co-insurance</td></tr>
</table>

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
Other Benefits		
Local road ambulance transport This benefit pays for medically necessary emergency road ambulance transport to or between hospitals.	Included	20% co-insurance
Psychiatric treatment This benefit pays for in-patient, daycare and out-patient treatment (subject to availability of out-patient benefit for your plan) of psychiatric illnesses in aggregate. All treatments given by psychologists, psychotherapists or any individuals other than a registered psychiatrist must be pre-authorised by us.	up to S$11,000	20% co-insurance
Pre-existing conditions and congenital conditions This benefit pays for: a) treatment of congenital conditions (whether existing before or after the commencement of cover), and/or b) all other declared and accepted eligible conditions that existed or for which there were symptoms before the commencement of cover, or reinstatement date, or the introduction of this benefit, whichever is later.	Years 1 & 2 : up to S$3,000 Available only after 270 consecutive days membership Subsequent years: up to S$6,000	Whether it is co-insurance or annual deductible will depend on the treatment received and what is stated on each benefit.
Treatment for HIV/AIDS as a result of occupational accident or blood transfusion This benefit becomes available when signs or symptoms are present for the first time after 36 months of continuous membership.	up to S$13,000 Available after 36 consecutive months membership	20% co-insurance
Artificial limbs This benefit pays for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or surgical procedures. Benefit is only payable following a surgery or an accident for an eligible medical condition provided that the member has been continuously covered under the policy since before the accident or surgery happened.	up to S$3,800 every 3 years	20% co-insurance
Medical aids and durable medical equipments This benefit pays for instruments or devices or durable medical equipments which are prescribed by the medical practitioner as a medically necessary aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint and orthopaedic supports.	up to S$600	20% co-insurance
Hospice and palliative care This benefit becomes available when the member is admitted to a specialist palliative care centre or hospice, recognised by us, following diagnosis, written confirmation (including medical evidence) by a medical practitioner that the member is suffering from an eligible terminal medical condition or conditions.	up to S$52,000 in a member's lifetime Available only after 365 consecutive days membership	Annual deductible
Investigation into infertility This benefit pays for investigation and treatment of the cause of infertility.	up to S$2,500 in a member's lifetime Available only after 18 consecutive months membership	20% co-insurance
Pre and post-natal complications This benefit pays for treatment of an eligible medical condition which is due to and occurs during the pregnancy prior to or after the childbirth for female member over the age of 18 years. Under post-natal complications, we will only pay for treatment received within 90 days following the childbirth. This benefit does not cover: a) the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or b) any complication arising from non-medically necessary caesarean section birth. c) treatment of any medical condition which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted conception. Whilst we recognize that caesarean section may sometimes be a medical necessity, caesarean section is only payable if the **member** insured has paid for the Optional add-on 'Normal (Routine) Pregnancy and childbirth benefit', available for Plan A only, subject to compulsory co-insurance 20% per claim. For avoidance of doubt, this benefit shall not be payable if the: • childbirth is through non-medically necessary caesarean birth, and/or • conception of the child is conceived by artificial means or any form of assisted conception. Please note: If we are not able to determine that a caesarean section is medically necessary we will consider it as not medically necessary.	Included Available only after 365 consecutive days membership	20% co-insurance

Benefits Table (Plan A) (Continued)

Benefits Table	Plan A	Only applicable when Annual Deductible/ Co-insurance option is chosen
Optional Add-On Benefits		
The following Optional add-on benefit is subject to your payment of additional premium and will be indicated in your membership statement / policy schedule if you have applied for this add-on benefit. **Normal (Routine) Pregnancy and childbirth** (Plan A only and subject to compulsory co-insurance) Please refer to the Summary on revised policy terms and conditions: This benefit pays for routine pre-natal care, inpatient childbirth and routine post-natal care up to forty-two (42) days following birth. This benefit is applicable for female member over the age of 18 years. The limit shown is the maximum benefit for each policy year (even if there is more than one pregnancy) or each pregnancy (even if an eligible pregnancy falls across the policy anniversary) provided the policy with this benefit has been renewed. The limit shown applies in aggregate for pre-natal, childbirth and post-natal care. For birth through vaginal childbirth and medically necessary caesarean section, we will pay for the reasonable and customary childbirth costs of a standard single room, up to the limit shown for this benefit in the benefits table. Any complications of pregnancy will be paid from 'Pre- & post-natal complications' benefit. For birth through non-medically necessary caesarean section, we will pay for the inpatient childbirth costs up to the reasonable and customary costs of a natural childbirth in a standard single room. If we are not able to determine that a caesarean section is medically necessary, we will consider it is not medically necessary. The complications arising from such childbirth will be paid up to the remainder of the Normal (Routine) Pregnancy and childbirth limit. Please take note: This benefit is payable when 365 consecutive days membership is achieved by the member under this plan / cover from the date this cover is attached to the member's plan.	up to S$22,000 Available only after 365 consecutive days membership Compulsory 20% co-insurance	Not Applicable

Benefits Table (Plan B)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
Please note: Benefit values are per member each year unless otherwise specified and are reduced each time the member claims only by the net amount (less any annual deductible or co-insurance) we have actually paid. Please refer to the policy wordings on full terms applying to these benefits.		
Overall Annual Limit		
Yearly maximum limit This is the maximum we will pay for each member each policy year. All benefits paid during the policy period will count against the yearly maximum.	S$3,500,000	
Area of cover		
Area of cover This is the geographical area where you can choose to receive treatment. You can select your area of cover at time of application. Your chosen area of cover has an impact on your premium.	**Options:** 1. Worldwide, or 2. Worldwide excluding USA, or 3. Asia	
Outside area of cover This benefit pays for emergency treatment, or treatment of a medical condition which arises suddenly whilst outside the selected area of cover.	Emergency treatment only up to S$250,000	Annual Deductible
In-patient and Daycare Treatment		
Daily accommodation charges While admitted as an in-patient or day-patient, we will pay for the costs of your accommodation in the type of room shown in your benefits table. Wherever a member receives treatment, if the hospital offers several classes for the room type he is entitled for, we will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that hospital for that type of room. If a member stays in a room which is more expensive than the standard room, the member may have to pay for the difference in room charges. The member may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with us prior to admission to avoid unnecessary out of pocket expenses.	Standard single room	Annual Deductible
Hospital charges This benefit pays for hospital charges given between admission and discharge including: a) Diagnostic procedures b) Surgical procedures c) Operating theatre charges d) Nursing care, drugs and dressings e) Surgeons' and anaesthetists' charges f) Intensive care unit charges g) Consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it h) Radiotherapy and chemotherapy i) Kidney dialysis j) Computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques k) Special nursing in hospital	Included	Annual Deductible
Organ transplant This benefit pays for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an eligible medical condition and provided these organ(s) have come from a relative or a certified and verified source of donation. The policy does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor or if the organ(s) is not from a relative or a certified and verified source of donation.	Included	Annual Deductible
Living organ donor This benefit pays up to the annual limits shown in the benefit schedule for reasonable and customary charges incurred for a live member to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung or bone marrow) of this policy, provided : a) the operation and transplant is for the member's family member (parent, sibling, child, spouse or partner) ; b) the transplant is in line with appropriate regulatory guidelines; c) the recipient of the organ was first diagnosed by a doctor or have symptoms which first appeared after a waiting period of twenty-four (24) months from the the policy commencement date or the date after this Living Organ Donor (member) Transplant benefit first became effective under this policy or the last reinstatement date (if any) whichever is the latest; and Shall include eligible expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalization treatment. Both pre- and post-hospitalisation benefit are limited to ninety (90) days prior or after treatment respectively. This benefit requires pre-authorization from us. This benefit does not pay for the cost of collecting donor organs or tissue, administration costs, its complications, and illegal organ transplants.	up to S$60,000 Available only after 24 consecutive months membership	Annual Deductible

Benefits Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
In-patient and Daycare Treatment		
Reconstructive Surgery This benefit pays for the initial reconstructive surgery and only when it is medically necessary and carried out to restore function after an accident or following surgery for an eligible medical condition, and provided that the member has been continuously covered under the policy since before the accident or surgery happened. Benefit for reconstructive surgery is subject to our pre-authorization and must be done at a medically appropriate stage after the accident or surgery.	Included	Annual Deductible
Surgical implants This benefit pays for medical device surgically implanted into the body as part of the treatment (excluding any dental implants).	Included	Annual Deductible
Companion accommodation We will pay for companion accommodation when the member is receiving eligible in-patient treatment within the area of cover.	up to S$190 per night	Annual Deductible
New Born accommodation This benefit pays for the child who is less than 16 weeks to stay in the hospital while the insured mother is receiving eligible in-patient treatment.	Included	Annual Deductible
Cash benefit Payable for eligible in-patient treatment only when the member receives treatment within area of cover and provided no cost for that treatment is claimed under this plan.	S$200 per night	Annual Deductible
In-patient Rehabilitation This benefit pays for in-patient rehabilitation when: a) it is carried out by a medical practitioner specialising in rehabilitation; and b) it is carried out in a rehabilitation hospital or unit which is recognised by us; and c) the treatment could not be carried out on an out-patient basis, and d) the costs have been agreed, in writing by us before the rehabilitation begins. We will not pay for in-patient rehabilitation for more than twenty-eight (28) days except in cases such as in severe central nervous system damage caused by external trauma. For cases such as in severe central nervous system damage caused by external trauma, we will not pay for in-patient rehabilitation for more than one hundred eighty (180) days.	Included	Annual Deductible
Pre-hospitalisation treatment (up to 90 days before admission) We will pay for consultation, prescribed investigations and essential medications received as an out-patient within 90 days prior to a hospitalisation, where such hospitalisation is eligible for cover under member's plan and where the need for such hospitalisation has arisen as a direct result of the medical examination and investigation findings drawn from that consultation.	Included	Annual Deductible
Post hospitalisation treatment (within 90 days after discharge) This benefit pays for follow-up out-patient consultation and treatment following an eligible in-patient or daycare surgery when such consultation is carried out by the in-patient treating medical practitioner or a referred medical practitioner and provided such consultation or treatment occurs within 90 days following the discharge from hospital or the date of the daycare surgery.	Included	Annual Deductible
Out-patient Treatment		
Primary and Specialist care This benefit pays for consultation, diagnostic procedures, prescribed drugs and dressings received as part of an out-patient treatment. Diagnostic tests include and are limited to laboratory, X-Rays and Ultrasound.	Included	20% co-insurance
Surgical procedures We will pay for any eligible surgical procedures received as an out-patient for an eligible medical condition.	Included	20% co-insurance
Emergency treatment due to accident This benefit pays for out-patient treatment due to accident required immediately (within 24 hours) following bodily injury arising from an accident, provided the member has been continuously covered under the policy since before the accident happened. Follow-up treatment for the same bodily injury will be covered up to 30 days from the date of the accident.	Included	20% co-insurance
Radiotherapy and chemotherapy We will pay for radiotherapy and chemotherapy received as an out-patient for an eligible medical condition at a registered medical facility recognised by us.	Included	Annual Deductible
Kidney dialysis We will pay for kidney dialysis received as an out-patient for an eligible medical condition at registered medical facility recognised by us.	Included	Annual Deductible
Computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans We will pay for computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an eligible out-patient treatment.	Included	20% co-insurance

Benefits Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
Out-patient Treatment		
Hormone replacement therapy (HRT) We will pay for the consultations and the cost of the implants, injections, patches or tablets when it is medically necessary and resulting from a medical intervention rather than for the relief of physiological symptoms. Where hormone replacement therapy is only required for the relief of menopausal symptoms, we will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the benefit table applicable to member's plan.	Included (Hormone replacement therapy for relief of menopausal symptoms - up to S$200)	20% co-insurance
Physiotherapy, occupational therapy and speech therapy Treatment given by any of these practitioners must be referred by the medical practitioner who has defined a diagnosis. Benefit is payable only following in-patient treatment for an eligible medical condition, provided that the member has been continuously covered under the policy since before the in-patient treatment commenced. Treatment given by any of these practitioners must be under the medical supervision of a medical practitioner. Medical supervision means that the reason for referral, where applicable, has been initiated by the medical practitioner who has defined a diagnosis. There must be a clear treatment plan from the practitioner with an end point and expected outcome.	Included	20% co-insurance
Alternative and Well-being Medicine		
Consultation and treatment provided and prescribed by a qualified and registered chiropractor, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, homeopath, osteopath, physiotherapist and Traditional Chinese medicine practitioner This benefit pays for the specified complementary and alternative therapist and practitioners.	up to S$2,000	20% co-insurance
Vaccination This benefit pays for necessary vaccinations. Consultation charge made in conjunction with vaccination can be claimed from this benefit where applicable.	up to S$500 Available only after 90 consecutive days membership in the first policy year	20% co-insurance
Health screen This benefit includes the cost of any eligible consultation needed as part of the screening process.	up to S$250	20% co-insurance
Dental Treatment		
Accidental damage to natural teeth This benefit pays for dental treatment required within 30 days following accidental damage to natural teeth caused by extra-oral impact. Benefit is not payable if: a) the damage was caused by normal wear and tear b) the injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn c) the damage was caused by tooth brushing or any other oral hygiene procedure d) the damage is not apparent within seven days of the impact which caused the injury This benefit is available only if the member has been continuously covered under the policy since before the accident happened.	Included	20% co-insurance
Oral and maxillofacial surgery This benefit pays only for the following procedures performed by an oral and maxillofacial surgeon: a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms b) Surgical removal of complicated buried roots which are diseased or causing symptoms c) Enucleation (removal) of cysts of the jaw d) Treatment of cancers (For lesion or lump in the mouth) Pre-existing condition limitations apply to this benefit.	Included	20% co-insurance
Routine dental care This benefit pays for routine dental examination, extraction, fillings, scaling/polishing, x-ray, sealant, fluoride treatment, root canal treatment, implants, bridgework, crowns, treatment of gum disease, dentures, inlays and onlays. Pre-existing condition limitations are not applicable to this benefit.	up to S$250	20% co-insurance
Optical Benefit		
Routine optical care This benefit pays for corrective spectacle lenses, contact lenses and associated spectacle frames prescribed by an ophthalmologist or optometrist. Ophthalmologist or optometrist eye examination is claimable from this benefit. Lasik/laser surgery and tinted lenses are not covered under this benefit.	No benefit	20% co-insurance

Benefits Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
Emergency Evacuation and Repatriation		
International Emergency Medical Assistance (IEMA) This benefit pays for the following services: a) Evacuation where the local medical facilities are not adequate according to our appointed doctor b) Evacuation will be to the nearest medical facility where treatment is adequate c) Transportation for returning to the principal country of residence following the evacuation d) Cost of one accompanying person while the covered person is being evacuated e) Hotel accommodation of one accompanying person up to 10 days f) Bringing the body or ashes back to a port or airport in the principal country of residence or home country if the covered person dies abroad as a result of an eligible medical condition.	Included	Not Applicable
New Born Cover		
Acute medical condition (excluding congenital conditions) This benefit pays for the treatment of acute medical condition, providing there is no underlying congenital condition, developed in a new born baby including nursing of pre-mature baby (i.e. where birth is prior to 37 weeks gestation) in Neonatal Intensive Care Unit (NICU). Common acute medical conditions for new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: a) the parent of the new born baby has been covered under **International**Exclusive for 365 consecutive days or more when the baby is born; and b) the new born baby is added into the insured parent's policy within 30 days from birth; and c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received. This benefit is paid from the insured baby's plan. This benefit covers treatment received by a new born baby during the first 30 days after birth. After 30 days, treatment can be covered under the main benefits of the insured baby's plan.	Included	Annual Deductible
Treatment of congenital conditions This benefit pays for treatment of congenital conditions. The benefit becomes available if: a) the parent of the new born baby has been covered under **International**Exclusive Plan A for 365 days or more when the baby is born; and b) the new born baby is added into the insured parent's policy within 30 days from birth; and c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received. This benefit is paid from the insured baby's plan. Please note: 1) Treatment for congenital conditions which do not fulfill all above criteria will be paid from 'Pre-existing Condition/Congenital Conditions' benefit. 2) Once the limit for this benefit is reached, no other benefit (including 'Pre-existing Conditions/ Congenital Conditions' benefit) will be payable for the congenital condition(s) which was (were) claimed from this benefit for the remaining policy year.	No benefit	Annual Deductible
Other Benefits		
Home nursing This benefit pays for charges incurred by an attending registered and qualified nurse for a member and only when the following conditions are met: a) after his discharge from hospital which the member has been warded in the intensive care unit for an eligible medical condition or undergone for an eligible daycare surgery, and b) agreed in writing by us beforehand that it is medically necessary and appropriate, and c) it is prescribed by the treating medical practitioner for the continued treatment for the eligible medical condition which the member was hospitalised for, and d) when such services are essential for medical as distinct from domestic reasons. For avoidance of doubt, the charges refer to the fees for the service of the nurse incurred for nursing at home. For terminal medical condition, this benefit is payable under 'Hospice and Palliative Care' and subject to the limitations applicable to that benefit.	Included	20% co-insurance
Local road ambulance transport This benefit pays for medically necessary emergency road ambulance transport to or between hospitals.	Included	20% co-insurance

Benefits Table (Plan B) (Continued)

Benefits Table	Plan B	Only applicable when Annual Deductible/ Co-insurance option is chosen
Other Benefits		
Psychiatric treatment This benefit pays for in-patient, daycare and out-patient treatment (subject to availability of out-patient benefit for your plan) of psychiatric illnesses in aggregate. All treatments given by psychologists, psychotherapists or any individuals other than a registered psychiatrist must be pre-authorised by us.	up to S$7,000	20% co-insurance
Pre-existing conditions and congenital conditions This benefit pays: a) treatment of congenital conditions (whether existing before or after the commencement of cover), and/or b) all other declared and accepted eligible conditions that existed or for which there were symptoms before the commencement of cover, or reinstatement date, or the introduction of this benefit, whichever is later.	Years 1 & 2 : up to S$3,000 Available only after 270 consecutive days membership Subsequent years: up to S$6,000	Whether it is co-insurance or annual deductible will depend on the treatment received and what is stated on each benefit.
Treatment for HIV/AIDS as a result of occupational accident or blood transfusion This benefit becomes available when signs or symptoms are present for the first time after 36 months of continuous membership.	No benefit	20% co-insurance
Artificial limbs This benefit pays for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or surgical procedures. Benefit is only payable following a surgery or an accident for an eligible medical condition provided that the member has been continuously covered under the policy since before the accident or surgery happened.	up to S$1,300 every 3 years	20% co-insurance
Medical aids and durable medical equipments This benefit pays for instruments or devices or durable medical equipments which are prescribed by the medical practitioner as a medically necessary aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint and orthopaedic supports.	up to S$300	20% co-insurance
Hospice and palliative care This benefit becomes available when the member is admitted to a specialist palliative care centre or hospice, recognised by us, following diagnosis, written confirmation (including medical evidence) by a medical practitioner that the member is suffering from an eligible terminal medical condition or conditions.	up to S$40,000 in a member's lifetime Available only after 365 consecutive days membership	Annual deductible
Investigation into infertility This benefit pays for investigation and treatment of the cause of infertility.	No benefit	20% co-insurance
Pre and post-natal complications This benefit pays for treatment of an eligible medical condition which is due to and occurs during the pregnancy prior to or after the childbirth for female member over the age of 18 years. Under post-natal complications, we will only pay for treatment received within 90 days following the childbirth. This benefit does not cover: a) the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or b) any complication arising from non-medically necessary caesarean section birth. c) treatment of any medical condition which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted conception. Whilst we recognize that caesarean section may sometimes be a medical necessity, caesarean section is only payable if the **member** insured has paid for the Optional add-on 'Normal (Routine) Pregnancy and childbirth benefit', available for Plan A only, subject to compulsory co-insurance 20% per claim. No upgrade of plan is allowed without prior approval from us and subject to the terms and conditions of the policy. For avoidance of doubt, this benefit shall not be payable if the: • childbirth is through non-medically necessary caesarean birth, and/or • conception of the child is conceived by artificial means or any form of assisted conception. Please note: If we are not able to determine that a caesarean section is medically necessary we will consider it as not medically necessary.	S$5,000 Available only after 365 consecutive days membership	20% co-insurance

Benefits Table (Plan C)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
Please note: Benefit values are per member each year unless otherwise specified and are reduced each time the member claims only by the net amount (less any annual deductible or co-insurance) we have actually paid. Please refer to the policy wordings on full terms applying to these benefits.		
Overall Annual Limit		
Yearly maximum limit This is the maximum we will pay for each member each policy year. All benefits paid during the policy period will count against the yearly maximum.	S$2,500,000	
Area of cover		
Area of cover This is the geographical area where you can choose to receive treatment. You can select your area of cover at time of application. Your chosen area of cover has an impact on your premium.	**Options:** 1. Worldwide, or 2. Worldwide excluding USA, or 3. Asia	
Outside area of cover This benefit pays for emergency treatment, or treatment of a medical condition which arises suddenly whilst outside the selected area of cover.	Emergency treatment only up to S$250,000	Annual Deductible
In-patient and Daycare Treatment		
Daily accommodation charges While admitted as an in-patient or day-patient, we will pay for the costs of your accommodation in the type of room shown in your benefits table. Wherever a member receives treatment, if the hospital offers several classes for the room type he is entitled for, we will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that hospital for that type of room. If a member stays in a room which is more expensive than the standard room, the member may have to pay for the difference in room charges. The member may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with us prior to admission to avoid unnecessary out of pocket expenses.	Standard single room	Annual Deductible
Hospital charges This benefit pays for hospital charges given between admission and discharge including: a) Diagnostic procedures b) Surgical procedures c) Operating theatre charges d) Nursing care, drugs and dressings e) Surgeons' and anaesthetists' charges f) Intensive care unit charges g) Consultations and physiotherapy while admitted for treatment of an eligible medical condition and when such treatment directly relates to it h) Radiotherapy and chemotherapy i) Kidney dialysis j) Computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques k) Special nursing in hospital	Included	Annual Deductible
Organ transplant This benefit pays for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an eligible medical condition and provided these organ(s) have come from a relative or a certified and verified source of donation. The policy does not cover the costs of collecting donor organs (including but not limited to, transportation and administration costs) or any expenses incurred by the donor or if the organ(s) is not from a relative or a certified and verified source of donation.	Included	Annual Deductible
Living organ donor This benefit pays up to the annual limits shown in the benefit schedule for reasonable and customary charges incurred for a live member to donate an organ or tissue specified in the Organ Transplant benefit (limited to kidney, heart, liver, lung or bone marrow) of this policy, provided : a) the operation and transplant is for the member's family member (parent, sibling, child, spouse or partner) ; b) the transplant is in line with appropriate regulatory guidelines; c) the recipient of the organ was first diagnosed by a doctor or have symptoms which first appeared after a waiting period of twenty-four (24) months from the the policy commencement date or the date after this Living Organ Donor (member) Transplant benefit first became effective under this policy or the last reinstatement date (if any) whichever is the latest; and Shall include eligible expenses relating to pre-hospital specialist consultation, related examination and laboratory tests and post-hospitalization treatment. Both pre- and post-hospitalisation benefit are limited to ninety (90) days prior or after treatment respectively. This benefit requires pre-authorization from us. This benefit does not pay for the cost of collecting donor organs or tissue, administration costs, its complications, and illegal organ transplants.	up to S$60,000 Available only after 24 consecutive months membership	Annual Deductible

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
In-patient and Daycare Treatment		
Reconstructive Surgery This benefit pays for the initial reconstructive surgery and only when it is medically necessary and carried out to restore function after an accident or following surgery for an eligible medical condition, and provided that the member has been continuously covered under the policy since before the accident or surgery happened. Benefit for reconstructive surgery is subject to our pre-authorization and must be done at a medically appropriate stage after the accident or surgery.	Included	Annual Deductible
Surgical implants This benefit pays for medical device surgically implanted into the body as part of the treatment (excluding any dental implants).	Included	Annual Deductible
Companion accommodation We will pay for companion accommodation when the member is receiving eligible in-patient treatment within the area of cover.	up to S$190 per night	Annual Deductible
New Born accommodation This benefit pays for the child who is less than 16 weeks to stay in the hospital while the insured mother is receiving eligible in-patient treatment.	Included	Annual Deductible
Cash benefit Payable for eligible in-patient treatment only when the member receives treatment within area of cover and provided no cost for that treatment is claimed under this plan.	S$140 per night	Annual Deductible
In-patient Rehabilitation This benefit pays for in-patient rehabilitation when: a) it is carried out by a medical practitioner specialising in rehabilitation; and b) it is carried out in a rehabilitation hospital or unit which is recognised by us; and c) the treatment could not be carried out on an out-patient basis, and d) the costs have been agreed, in writing by us before the rehabilitation begins. We will not pay for in-patient rehabilitation for more than twenty-eight (28) days except in cases such as in severe central nervous system damage caused by external trauma. For cases such as in severe central nervous system damage caused by external trauma, we will not pay for in-patient rehabilitation for more than one hundred eighty (180) days.	Included	Annual Deductible
Pre-hospitalisation treatment (up to 90 days before admission) We will pay for consultation, prescribed investigations and essential medications received as an out-patient within 90 days prior to a hospitalisation, where such hospitalisation is eligible for cover under member's plan and where the need for such hospitalisation has arisen as a direct result of the medical examination and investigation findings drawn from that consultation.	Included	Annual Deductible
Post hospitalisation treatment (within 90 days after discharge) This benefit pays for follow-up out-patient consultation and treatment following an eligible in-patient or daycare surgery when such consultation is carried out by the in-patient treating medical practitioner or a referred medical practitioner and provided such consultation or treatment occurs within 90 days following the discharge from hospital or the date of the daycare surgery.	Included	Annual Deductible
Out-patient Treatment		
Primary and Specialist care This benefit pays for consultation, diagnostic procedures, prescribed drugs and dressings received as part of an out-patient treatment. Diagnostic tests include and are limited to laboratory, X-Rays and Ultrasound.	Included if it is part of pre-hospitalisation treatment or post hospitalisation treatment Subject to the limitations applied for 'Pre-hospitalisation treatment' or 'Post-hospitalisation treatment' benefit	20% co-insurance
Surgical procedures We will pay for any eligible surgical procedures received as an out-patient for an eligible medical condition.	Included This benefit includes one post-surgery consultation within 90 days from the date of the surgical procedure	20% co-insurance
Emergency treatment due to accident This benefit pays for out-patient treatment due to accident required immediately (within 24 hours) following bodily injury arising from an accident, provided the member has been continuously covered under the policy since before the accident happened. Follow-up treatment for the same bodily injury will be covered up to 30 days from the date of the accident.	Included	20% co-insurance
Radiotherapy and chemotherapy We will pay for radiotherapy and chemotherapy received as an out-patient for an eligible medical condition at a registered medical facility recognised by us.	Included	Annual Deductible

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
Out-patient Treatment		
Kidney dialysis We will pay for kidney dialysis received as an out-patient for an eligible medical condition at registered medical facility recognised by us.	Included	Annual Deductible
Computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans We will pay for computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans received as part of an eligible out-patient treatment.	Included	20% co-insurance
Hormone replacement therapy (HRT) We will pay for the consultations and the cost of the implants, injections, patches or tablets when it is medically necessary and resulting from a medical intervention rather than for the relief of physiological symptoms. Where hormone replacement therapy is only required for the relief of menopausal symptoms, we will pay for consultation and prescribed implants, patches or tablets up to the limit shown in the the benefit table applicable to member's plan.	Included if it is part of post-hospitalisation treatment Subject to the limitations applied for 'Post-hospitalisation treatment' benefit	20% co-insurance
Physiotherapy, occupational therapy and speech therapy Treatment given by any of these practitioners must be referred by the medical practitioner who has defined a diagnosis. Benefit is payable only following in-patient treatment for an eligible medical condition, provided that the member has been continuously covered under the policy since before the in-patient treatment commenced. Treatment given by any of these practitioners must be under the medical supervision of a medical practitioner. Medical supervision means that the reason for referral, where applicable, has been initiated by the medical practitioner who has defined a diagnosis. There must be a clear treatment plan from the practitioner with an end point and expected outcome.	Included if it is part of post-hospitalisation treatment Subject to the limitations applied for 'Post-hospitalisation treatment' benefit	20% co-insurance
Alternative and Well-being Medicine		
Consultation and treatment provided and prescribed by a qualified and registered chiropractor, podiatrist, dietitian, nutritionist, naturopath, acupuncturist, homeopath, osteopath, physiotherapist and Traditional Chinese medicine practitioner This benefit pays for the specified complementary and alternative therapist and practitioners.	No benefit	20% co-insurance
Vaccination This benefit pays for necessary vaccinations. Consultation charge made in conjunction with vaccination can be claimed from this benefit where applicable.	No benefit	20% co-insurance
Health screen This benefit includes the cost of any eligible consultation needed as part of the screening process.	No benefit	20% co-insurance
Dental Treatment		
Accidental damage to natural teeth This benefit pays for dental treatment required within 30 days following accidental damage to natural teeth caused by extra-oral impact. Benefit is not payable if: a) the damage was caused by normal wear and tear b) the injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn c) the damage was caused by tooth brushing or any other oral hygiene procedure d) the damage is not apparent within seven days of the impact which caused the injury This benefit is available only if the member has been continuously covered under the policy since before the accident happened.	Included	20% co-insurance
Oral and maxillofacial surgery This benefit pays only for the following procedures performed by an oral and maxillofacial surgeon: a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms b) Surgical removal of complicated buried roots which are diseased or causing symptoms c) Enucleation (removal) of cysts of the jaw d) Treatment of cancers (For lesion or lump in the mouth) Pre-existing condition limitations apply to this benefit.	Included	20% co-insurance
Routine dental care This benefit pays for routine dental examination, extraction, fillings, scaling/polishing, x-ray, sealant, fluoride treatment, root canal treatment, implants, bridgework, crowns, treatment of gum disease, dentures, inlays and onlays. Pre-existing condition limitations are not applicable to this benefit.	No benefit	20% co-insurance
Optical Benefit		
Routine optical care This benefit pays for corrective spectacle lenses, contact lenses and associated spectacle frames prescribed by an ophthalmologist or optometrist. Ophthalmologist or optometrist eye examination is claimable from this benefit. Lasik/laser surgery and tinted lenses are not covered under this benefit.	No benefit	20% co-insurance

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
Emergency Evacuation and Repatriation		
International Emergency Medical Assistance (IEMA) This benefit pays for the following services: a) Evacuation where the local medical facilities are not adequate according to our appointed doctor b) Evacuation will be to the nearest medical facility where treatment is adequate c) Transportation for returning to the principal country of residence following the evacuation d) Cost of one accompanying person while the covered person is being evacuated e) Hotel accommodation of one accompanying person up to 10 days f) Bringing the body or ashes back to a port or airport in the principal country of residence or home country if the covered person dies abroad as a result of an eligible medical condition.	Included	Not Applicable
Maternity Benefit		
Investigation into infertility This benefit pays for investigation and treatment of the cause of infertility.	No benefit	20% co-insurance
Pre and post-natal complications This benefit pays for treatment of an eligible medical condition which is due to and occurs during the pregnancy prior to or after the childbirth for female member over the age of 18 years. Under post-natal complications, we will only pay for treatment received within 90 days following the childbirth. This benefit does not cover: a) the costs of any childbirth whether such childbirth is normal, by caesarean section or by any other assisted means, or b) any complication arising from non-medically necessary caesarean section birth. c) treatment of any medical condition which is due to and occurs during the pregnancy prior to or after the childbirth if the pregnancy was a result of any form of assisted conception. Whilst we recognize that caesarean section may sometimes be a medical necessity, caesarean section is only payable if the **member** insured has paid for the Optional add-on 'Normal (Routine) Pregnancy and childbirth benefit', available for Plan A only, subject to compulsory co-insurance 20% per claim. No upgrade of plan is allowed without prior approval from us and subject to the terms and conditions of the policy. For avoidance of doubt, this benefit shall not be payable if the: • childbirth is through non-medically necessary caesarean birth, and/or • conception of the child is conceived by artificial means or any form of assisted conception. Please note: If we are not able to determine that a caesarean section is medically necessary we will consider it as not medically necessary.	S$2,500 Available only after 365 consecutive days membership	20% co-insurance
New Born Cover		
Acute medical condition (excluding congenital conditions) This benefit pays for the treatment of acute medical condition, providing there is no underlying congenital condition, developed in a new born baby including nursing of pre-mature baby (i.e. where birth is prior to 37 weeks gestation) in Neonatal Intensive Care Unit (NICU). Common acute medical conditions for new born babies include neonatal jaundice, colic, diarrhea, constipation, vomiting and ear infection. This benefit is only available if: a) the parent of the new born baby has been covered under **International**Exclusive for 365 consecutive days or more when the baby is born; and b) the new born baby is added into the insured parent's policy within 30 days from birth; and c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received. This benefit is paid from the insured baby's plan. This benefit covers treatment received by a new born baby during the first 30 days after birth. After 30 days, treatment can be covered under the main benefits of the insured baby's plan.	Included	Annual Deductible
Treatment of congenital conditions This benefit pays for treatment of congenital conditions. The benefit becomes available if: a) the parent of the new born baby has been covered under **International**Exclusive Plan A for 365 days or more when the baby is born; and b) the new born baby is added into the insured parent's policy within 30 days from birth; and c) both parent and baby have been continuously covered under the policy and the policy is in force when the treatment is received. This benefit is paid from the insured baby's plan. Please note: 1) Treatment for congenital conditions which do not fulfill all above criteria will be paid from 'Pre-existing Condition/Congenital Conditions' benefit. 2) Once the limit for this benefit is reached, no other benefit (including 'Pre-existing Conditions/ Congenital Conditions' benefit) will be payable for the congenital condition(s) which was (were) claimed from this benefit for the remaining policy year.	No benefit	Annual Deductible

Benefits Table (Plan C) (Continued)

Benefits Table	Plan C	Only applicable when Annual Deductible/ Co-insurance option is chosen
Other Benefits		
Home nursing This benefit pays for charges incurred by an attending registered and qualified nurse for a member and only when the following conditions are met: a) after his discharge from hospital which the member has been warded in the intensive care unit for an eligible medical condition or undergone for an eligible daycare surgery, and b) agreed in writing by us beforehand that it is medically necessary and appropriate, and c) it is prescribed by the treating medical practitioner for the continued treatment for the eligible medical condition which the member was hospitalised for, and d) when such services are essential for medical as distinct from domestic reasons. For avoidance of doubt, the charges refer to the fees for the service of the nurse incurred for nursing at home. For terminal medical condition, this benefit is payable under 'Hospice and Palliative Care' and subject to the limitations applicable to that benefit.	Included	20% co-insurance
Local road ambulance transport This benefit pays for medically necessary emergency road ambulance transport to or between hospitals.	Included	20% co-insurance
Psychiatric treatment This benefit pays for in-patient, daycare and out-patient treatment (subject to availability of out-patient benefit for your plan) of psychiatric illnesses in aggregate. All treatments given by psychologists, psychotherapists or any individuals other than a registered psychiatrist must be pre-authorised by us.	up to S$5,400	20% co-insurance
Pre-existing conditions and congenital conditions This benefit pays: a) treatment of congenital conditions (whether existing before or after the commencement of cover), and/or b) all other declared and accepted eligible conditions that existed or for which there were symptoms before the commencement of cover, or reinstatement date, or the introduction of this benefit, whichever is later.	No benefit	Whether it is co-insurance or annual deductible will depend on the treatment received and what is stated on each benefit.
Treatment for HIV/AIDS as a result of occupational accident or blood transfusion This benefit becomes available when signs or symptoms are present for the first time after 36 months of continuous membership.	No benefit	20% co-insurance
Artificial limbs This benefit pays for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or surgical procedures.	No benefit	20% co-insurance
Medical aids and durable medical equipments This benefit pays for instruments or devices or durable medical equipments which are prescribed by the medical practitioner as a medically necessary aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint and orthopaedic supports.	No benefit	20% co-insurance
Hospice and palliative care This benefit becomes available when the member is admitted to a specialist palliative care centre or hospice, recognised by us, following diagnosis, written confirmation (including medical evidence) by a medical practitioner that the member is suffering from an eligible terminal medical condition or conditions.	up to S$15,000 in a member's lifetime Available only after 365 consecutive days membership	Annual deductible

11. Your AXA office/Important Contact Details

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Please contact AXA Health Customer Care Centre: Tel +65 6880 4944 or email: intlx@axa.com.sg for International Emergency Medical Assistance, Direct Settlement with Hospitals, and other policy enquiries.

Please contact Health at Hand Tel: +44 1892 556753 or email: healthathand.health@axa-ppp.co.uk for information on specific illnesses, treatments and medications as well as details of local and national organizations.

You only pay for the call charge to access the service and the service is entirely confidential.

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