

**AIA HEALTHSHIELD GOLD MAX
Policy contract (version 202510)**



General conditions.....	2
Benefits conditions.....	6
General exclusions.....	20
Premium conditions.....	22
Claim conditions.....	23
Definitions.....	25
Appendix 1 – Schedule of benefits.....	30
Appendix 2 – List of clinical situations.....	39
Appendix 3 – Definitions of 30 critical illnesses.....	40

SAMPLE

General conditions

When any word or term appears in bold in this policy contract, it has the meaning shown in the definitions section towards the end of the document.

We have issued **your policy** under a joint insurance arrangement with the **CPF Board**. Under that arrangement, the **insured** also has cover under the MediShield Life Scheme Act 2015.

This policy contract sets out the benefits, terms and conditions that apply to the AIA HealthShield Gold Max private medical insurance (not the **MediShield Life** cover).

Any changes **MOH**, the **CPF Board** or any other relevant government authority makes to **MediShield Life**, or to the joint insurance agreement with the **CPF Board**, will apply to **your policy** (where appropriate).

If the **insured** stops being a Singapore citizen or Singapore permanent resident, **you** must tell **us** in writing.

Our agreement

Your policy is a legally binding agreement between **you** and **us**. In exchange for the premiums **you** pay, **we** agree to pay the benefits set out in the documents that make up **your policy**.

When deciding whether or not to accept **your** application for **your policy**, **we** relied on the information **you** and the **insured** gave **us** in **your** application. If any of the information **you** or the **insured** gave **us** was incorrect or incomplete (or if **you** or the **insured** give **us** incorrect or incomplete information in the future), **we** can:

- void **your policy** (that is, treat it as if it had never existed);
- refuse to accept any claim under **your policy**; or
- apply additional terms and conditions to **your policy**.

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

Changes to your policy

We may change the premiums, benefits and cover provided by **your policy**, or change any of the terms or conditions set out in this policy contract, by giving **you** 31 days' notice in writing.

The terms and conditions of **your** specific **policy** can only be changed by **us** issuing an endorsement signed by **our** duly authorised officer.

If **we** need to change any of the terms and conditions of **your policy** to meet legal or regulatory requirements (such as the Insurance Act 1966), **we** will tell **you** when the changes will apply from.

Handling proceedings

You and the **insured** must not admit any liability, or give any offer, promise or payment to any third party, without **our** permission in writing. **We** can start, take over and conduct all proceedings relating to claims in **your** or the **insured's** name, and can agree the settlement of any claim. **You** and the **insured** must give **us** all the information and help **we** may need in connection with any proceedings.

Taking over your rights of recovery

If **we** pay a claim under **your policy**, **we** will have all rights to recover the amount **we** paid from any person, company or organisation liable for the event that gave rise to the claim. **You** must provide **us** with any document **we** need to exercise those rights, and **you** and the **insured** must not take any action that would affect those rights.

Claim amount above the limits of compensation

If, at the time any claim arises, the **limits of compensation** for the relevant benefit are less than the total amount of the claim, **you** or the **insured** must pay the excess amount over the **limits of compensation**.

Declared age of the insured

If the **insured's** age given in **your** application was not correct, **we** will adjust **your** premium to reflect their correct age.

If **we** increase the premium, **you** must pay the amount **you** have underpaid from the **policy date**. If **we** reduce the premium, **we** will refund the amount **you** have overpaid from the **policy date**, without interest. **We** will refund the overpaid premiums to **your MediSave** account, or directly to **you**, depending on how **your premiums** were paid.

If **we** would not have accepted **your** application if the age given in it had been correct, **we** will cancel **your policy** and will not pay any benefits.

We may need proof of the **insured's** age to process any claim under **your policy**.

Currency

All amounts to be paid by **us** or to **us** will be in the currency shown in **your policy schedule**.

Free-look period

Your policy has a 'free-look' provision, which allows **you** to cancel **your policy** within a specific number of days (the free-look period) and get a full refund (without interest), less any premium for **MediShield Life**, as long as no claim has been made under **your policy**.

The free-look period is 21 days from the date **you** receive the policy documents.

- If **you** chose to receive electronic copies of the policy documents, the 21-day free-look period will start when **you** receive **our** SMS text message or email telling **you** that the policy documents are available for **you** to view by logging in to the customer portal on **our** website.
- If **you** chose to receive the policy documents by post, the 21-day free-look period will start seven days after **we** post them.
- If **you** chose to have the policy documents delivered to **you** by hand, the 21-day free-look period will start seven days from the date **we** give the policy documents to the postal or courier company, or **your** insurance representative.

During the free-look period, **you** can cancel **your policy** by writing to **us** and **we** will refund any premium **you** have paid, without interest, as long as no claim has been made under **your policy**. **We** will refund the premium to **your MediSave** account, or directly to **you**, depending on how **your premiums** were paid.

Cancelling your policy after the free-look period

After the free-look period, **you** can cancel **your policy** by giving **us** 30 days' notice in writing. This would not affect any claim that arose before **you** gave notice to cancel **your policy**.

If no claim has arisen, **we** will refund an amount of premium that relates to the period from the date **your policy** ends, less any amount for **MediShield Life**. **We** will refund the premium to **your MediSave** account, or directly to **you**, depending on how **your premiums** were paid.

If a claim has arisen, **we** will not make any refund.

We will not be liable for any claim that arises after the date **your policy** ends.

Electronic communications

If **you** have chosen to receive electronic communications for **your policy** (such as premium notices and policy statements), or to give **us** instructions electronically, **we** may send communications for **you** to view online by logging in to the customer portal on **our** website. **We** will send and receive electronic communications in any way **we** consider appropriate. **We** will not be liable for the security of electronic communications.

Rights of third parties under the Contracts (Rights of Third Parties) Act 2001

The terms and conditions of **your policy** cannot be enforced by anybody other than **you** (or **your** estate after **your** death) or **us**.

Non-participating

Your policy is 'non-participating', meaning that it does not receive a share of profits in the form of bonuses from **our** participating life fund.

Voiding your policy

We will void **your policy** (treat it as if it had never existed) if **we** find that any information or document **you** or the **insured** provided was incorrect in any way, or if **you** or the **insured** failed to provide any information or document that would have affected **our** decision to provide cover or the terms and conditions of the cover.

Your policy will be void from:

- the **policy date** (if **you** or the **insured** provided the incorrect information or document, or failed to provide the relevant information or document, when **you** applied for **your policy**);
- the last **reinstatement date** (if **you** or the **insured** provided the incorrect information or document, or failed to provide the relevant information or document, when **you** applied to reinstate **your policy**); or
- the date a change to **your policy** came into effect (if **you** or the **insured** provided the incorrect information or document, or failed to provide the relevant information or document, when requesting a change to **your policy**).

Except in the case of fraud, if **we** void **your policy**, the following will apply.

- a) If no claims have been made, **we** will refund the premium that relates to the period after the date **your policy** becomes void, less any amount for **MediShield Life**.
- b) If any claim has been made, **we** will refund only the premiums paid for **policy years** following the **policy year** in which the last claim was made, less any amount for **MediShield Life**.

We will refund the premiums to **your MediSave** account, or directly to **you**, depending on how **your** premiums were paid.

If **we** discover that **you** have made a claim that is fraudulent or exaggerated, **your policy** will become void immediately and **we** will not refund any premium. **We** can recover any payment **we** have made for fraudulent or exaggerated claims.

Changing the type of plan

You may ask to change the type of plan **you** have (to upgrade, downgrade or convert it) by writing to **us**.

If **we** agree to the change, the following will apply.

- a) The plan type will change on the date **we** tell **you**.
- b) Any claim that arises before the **policy date** for the new plan type will be settled in line with the plan type **you** had before the change.
- c) If **you** upgrade **your** plan, **we** will assess and settle any claim that arises on or after the **policy date** of the upgraded plan in line with that plan type. However, **we** will assess and settle any claim for a **pre-existing condition** that was present before the upgrade in line with the terms and conditions of the plan type **you** had before the upgrade, unless **you** told **us** about the **pre-existing condition** in the application for the upgraded plan and **we** agreed to cover it under that plan. Any **pre-existing condition** that was specifically not covered under the plan type **you** had before the upgrade will not be covered under the upgraded plan.

When your policy ends

Your policy will automatically end when:

- any premium remains unpaid at the end of the **grace period**;
- a **MediSave**-approved **integrated shield plan** with another insurer starts to cover the **insured**;
- the **insured** dies;
- the **insured** stops being a Singapore citizen or Singapore permanent resident; or
- **your policy** is cancelled;

whichever happens first.

If **your policy** ends, this will not automatically end the **MediShield Life** cover, or affect any claim that arose before the date **your policy** ended. **We** will not, under any circumstance, pay benefit for any expense that arose on or after the date **your policy** ended, whether or not:

- the expense is a direct result of a condition the **insured** had before **your policy** ended or was cancelled; or
- **we** accepted any premium paid after **your policy** ends.

If **your policy** ends for a reason other than a premium remaining unpaid after the **grace period**, **we** will refund the premium that relates to the period after **your policy** ended, less any amount for **MediShield Life**. **We** will refund the premium to **your MediSave** account, or directly to **you**, depending on how **your** premiums were paid.

SAMPLE

Benefit conditions

While **your policy** is in force, **we** will pay up to the relevant **limits of compensation** shown in the schedule of benefits (appendix 1) to cover **your eligible expenses**, less any **deductible** and **co-insurance** shown in the schedule of benefits, as long as **you** have kept to all the terms and conditions of **your policy**.

We will only pay **eligible expenses** for **hospitalisation**, medical treatments or services provided by a **MediShield Life**-accredited medical institution (such as a **hospital**, licensed medical centre or clinic) or through **Mobile Inpatient Care @ Home**, except for **eligible expenses** covered under part H (Medical treatment outside Singapore benefit).

Except for benefits under part L (Waiver of one year's premium benefit) and part M (Extra cover for 30 critical illnesses benefit), all benefits are paid as a reimbursement of **eligible expenses** paid by the **insured**, and depend on the terms, conditions and limits set out in the schedule of benefits (appendix 1) and **your policy**.

We will pay up to the relevant **limits of compensation** shown in the schedule of benefits (appendix 1) for the following benefits, after first deducting any **deductible** and **co-insurance**.

- Congenital abnormalities of the **insured's** biological child (covered under part F)
- The **insured** donating an organ or a non-insured donating an organ to the **insured** (covered under part G)
- In-hospital psychiatric treatment and post-hospitalisation psychiatric treatment (covered under part I)

The amount **we** pay for **eligible expenses** will be either the benefits covered by **your policy** or the amount covered by **MediShield Life**, whichever is higher. When **we** calculate the payment, **we** will:

- decide whether any particular charge is **reasonable and customary** (by, for example, referring to information **we** have on other claims, relevant publications or information on fees set by the government, relevant authorities and appropriate medical associations); and
- adjust any amounts relating to a charge that is not, in **our** opinion or the opinion of **our** medical advisor, **reasonable and customary**.

If a claim relates to a medical condition or procedure for which **MOH**, or an official medical body such as the Agency for Care Effectiveness (ACE), has published official guidelines on fees and the most appropriate course of care or treatment, **we** will take account of those guidelines when assessing and paying claims.

All claims will be assessed and paid in line with the terms and conditions of **your policy** and the **MediShield Life** Claims Rules (as shown in the **MOH** website (www.moh.gov.sg)). In the case of a conflict, the terms and conditions of **your policy** will apply over and above the **MediShield Life** Claims Rules (or any terms and conditions stated in the **MOH** website).

There are specific clinical situations for which **you** must meet additional criteria in order for **us** to accept a claim. Those clinical situations are set out in appendix 2.

We will not pay benefit for any expense which arose before the **policy date** or after **your policy** ended or was cancelled, whether or not the expense is a direct result of a condition the **insured** had before **your policy** ended or was cancelled.

Part A – Hospitalisation and surgical benefits

a) Daily room and board charges

This benefit is equal to the **eligible expenses** for room and board charges for a **standard room** (including on a high-dependency ward), or equivalent charges for inpatient care provided through **Mobile Inpatient Care @ Home**, for each day of the **insured's hospitalisation** due to an **illness** or **injury**. For this benefit, room and board charges include costs for meals, prescriptions and investigations, professional fees, and miscellaneous medical charges.

b) Daily intensive care unit charges

This benefit is equal to the **eligible expenses** for **intensive care unit** charges (including costs for meals, prescriptions and investigations, professional fees, and miscellaneous medical charges) for each day of the **insured's hospitalisation** in the **intensive care unit** of a **hospital** due to an **illness** or **injury**.

c) Community hospital charges

This benefit is equal to the **eligible expenses** for room and board charges for a **standard room** for each day the **insured** needs inpatient treatment in a **community hospital** following:

- a period of **hospitalisation** in a **hospital**; or
- treatment in a **public hospital's** accident and emergency department.

The inpatient treatment in the **community hospital** must:

- have been recommended by a **physician** at the **hospital** or the accident and emergency department; and
- be for a continuous period of at least six hours.

For this benefit, room and board charges include costs for meals, inpatient prescriptions, investigations, laboratory tests and rehabilitation services, professional fees, and miscellaneous medical charges.

d) Surgical charges

This benefit is equal to the **eligible expenses** for **surgical procedures**, surgical implants, approved medical consumables and **stereotactic radiosurgery**, including operating theatre and anaesthesia fees, that are required by the **physician** during **hospitalisation** due to an **illness** or **injury**.

For the purpose of this cover, approved medical consumables are:

- intravascular electrodes (devices placed inside blood vessels or arteries) for electrophysiological procedures (tests doctors use to evaluate the electrical activity of **your** heart);
- percutaneous transluminal coronary angioplasty balloons (balloon catheters inflated in an artery to widen it); and
- intra-aortic balloons (balloons that are inflated in the aorta to control the flow of blood).

Any surgical procedure that is not listed in table 1 to table 7 of the 'Table of Surgical Procedures' on the **MOH** website (www.moh.gov.sg) is not covered.

e) Organ transplant

If the **insured** has a human organ transplant of all of, or tissue from, a kidney, heart, liver, lung, pancreas, cornea or skin (skin grafted from another person), or has a bone marrow transplant, **we** will pay the **eligible expenses** for the surgery, including operating theatre and anaesthesia fees, that is required by the **physician** during the **hospitalisation**.

We will also pay the **eligible expenses** for the costs arising from or in connection with harvesting (removing) the organ or bone marrow, or related parts approved from time to time under **MediShield Life**, from a non-living donor. Those costs will be limited to the charges for:

- the donor's body staying in a **hospital** for the necessary period after their death;
- surgery to remove the organ or bone marrow from the donor's body;
- any laboratory tests and investigations needed before the organ or bone marrow is removed;
- any counselling that medical social workers provide to the donor's family in connection with the organ or bone marrow being donated; and
- storing and transporting the organ or bone marrow after it has been removed from the donor's body.

The costs of removing the organ or bone marrow from the donor cannot be claimed until the **insured** has had the transplant surgery in a **hospital** in Singapore.

We will not pay for other costs relating to harvesting all or any part of an organ (or related parts approved from time to time under the MediShield Life Scheme Act 2015) other than kidney, heart, liver, lung, pancreas, cornea, skin or bone marrow.

We will not pay any costs if the organ or bone marrow transplant is illegal or arises from any illegal practice.

f) Stem cell transplant

If the **insured** has a stem cell transplant, **we** will pay the **eligible expenses** for the surgery, including operating theatre and anaesthesia fees, that is required by the **physician** during the **hospitalisation**.

Outpatient treatments relating to stem cell transplants are not covered.

g) Hospice inpatient palliative care

This benefit is equal to the **eligible expenses** for inpatient palliative care (care to improve quality of life, rather than to cure) provided in a **hospice** if the **insured** has a terminal illness (a disease or condition which is expected to result in death within 12 months of a **diagnosis** made by a relevant **specialist**).

For this benefit to apply, a **physician** or **specialist** must have referred the **insured** to the **hospice** for palliative care, and they must stay in the **hospice** for a continuous period of at least six hours.

h) Continuation of autologous bone marrow transplant for multiple myeloma

This benefit is equal to the **eligible expenses** for outpatient treatment for autologous bone marrow transplant treatment for multiple myeloma (a type of bone marrow cancer).

Autologous bone marrow transplant is a procedure in which a patient's healthy stem cells (blood-forming cells) that were collected before radiotherapy or chemotherapy are then transplanted back to the patient after the treatment, to replace the stem cells that were destroyed.

For this benefit to apply, the autologous bone marrow transplant must be required by the **physician** or **specialist**. The costs covered include consultation fees and the cost of necessary laboratory tests, investigations, approved medical consumables and drugs needed for:

- stem cell mobilisation (a procedure which stimulates stem cells out of the bone marrow and into the bloodstream);
- harvesting (collecting) healthy stem cells from the blood;
- pre-transplant work-up (procedures, such as blood tests, before the transplant);
- high-dosage chemotherapy to destroy cancer cells;
- transplanting the healthy stem cells; and
- monitoring the **insured** after the transplant.

This benefit only applies if the **insured** receives the treatment as an outpatient. If the **insured** needs to receive the treatment as an inpatient, they may be covered for daily room and board charges or daily **intensive care unit** charges (or both).

We will not pay for cell, tissue and gene therapy and proton beam therapy under this benefit. These may be covered under part N or P.

Part B – Pre-hospitalisation benefit

If the **insured** needs **hospitalisation** for medical or surgical treatment due to an **illness** or **injury**, **we** will pay the **eligible expenses** for pre-hospitalisation treatment (outpatient treatment needed before **hospitalisation** for the same **illness** or **injury** the **hospitalisation** is for) that is recommended or approved in writing by the **physician** treating the **illness** or **injury**, and is provided within the relevant period set out in the table below.

Plan type	A	B	B Lite
Pre-hospitalisation benefit	Within either: <ul style="list-style-type: none"> • 100 days before hospitalisation; or • 13 months before hospitalisation under an AIA preferred provider 	Within either: <ul style="list-style-type: none"> • 100 days before hospitalisation under a private hospital; or • 12 months before hospitalisation under a public hospital 	Within 100 days before hospitalisation

When there is more than one **physician** treating the **insured** for the same **hospitalisation**, the main treating **physician** must be an **AIA preferred provider**.

The costs covered for pre-hospitalisation treatment include the costs of:

- medicines (prescribed by a licensed **physician**) and consultations (including **outpatient telemedicine consultations**);
- tests;
- diagnostic and laboratory services; and
- examinations and investigations;

recommended or approved in writing by the **physician** treating the same **illness** or **injury** the **hospitalisation** will be for.

We will not pay for outpatient treatments, cell, tissue and gene therapy, proton beam therapy or outpatient and home-based treatments under this benefit. These may be covered under parts J, N, O or P.

We will not pay the delivery cost for medication prescribed or recommended by the provider of the **outpatient telemedicine consultation**, or any additional costs in connection with the **outpatient telemedicine consultation**.

Part C – Post-hospitalisation benefits

If the **insured** is **hospitalised** due to an **illness** or **injury**, **we** will pay the **eligible expenses** for post-hospitalisation treatment (outpatient treatment needed after the **hospitalisation** for the same **illness** or **injury** treated during the **hospitalisation**).

The costs covered for post-hospitalisation treatment include the costs of:

- medicines (prescribed by a licensed **physician**) and consultations (including **outpatient telemedicine consultations**);
- tests;
- diagnostic and laboratory services;
- examinations and investigations;
- rehabilitation services provided by an Allied Health Professional registered by the Allied Health Professions Council board in line with the Allied Health Professions Act 2011); and
- nursing and dressing services provided in a specialist clinic;

recommended or approved in writing by the **physician** treating the same **illness** or **injury** the **hospitalisation** was for.

Any **hospitalisation** that is needed for the same **illness** or **injury** that causes the initial **hospitalisation** is not covered under this part C (Post-hospitalisation benefits).

We will not pay for outpatient treatments, cell, tissue and gene therapy, proton beam therapy or outpatient and home-based treatments under this benefit. These may be covered under parts J, N, O or P.

We will not pay the delivery cost for medication prescribed or recommended by the provider of the **outpatient telemedicine consultation**, or any additional costs in connection with the **outpatient telemedicine consultation**.

We will not pay the cost of any routine medical check-up which is not part of the post-hospitalisation treatment recommended by the **physician** and is not related to the **hospitalisation**. **We** will also not pay for treatments, medical services, supplies or medication bought within the relevant period specified in the table below but not used within the same period.

(a) Post-hospitalisation treatment

We will pay the **eligible expenses** for any consultations (including **outpatient telemedicine consultations**), medicines, diagnostic and laboratory services, examinations and investigations that the **insured** needs as part of post-hospitalisation treatment recommended or approved in writing by the **physician** or **specialist**, as long as they are for the same **illness** or **injury** the **hospitalisation** was for and are provided within the relevant period set out in the table below.

Plan type	A	B	B Lite
Post-hospitalisation benefit	Within either: <ul style="list-style-type: none"> • 100 days after hospitalisation; or • 13 months after hospitalisation under an AIA preferred provider 	Within either: <ul style="list-style-type: none"> • 100 days after hospitalisation under a private hospital; or • 12 months after hospitalisation under a public hospital 	Within 100 days after hospitalisation

When there is more than one **physician** treating the **insured** for the same **hospitalisation**, the main treating **physician** must be an **AIA preferred provider**.

(b) Extended post-hospitalisation treatment for 30 critical illnesses

We will continue to pay the **eligible expenses** for consultations, medicines, diagnostic and laboratory services, examinations and investigations that the **insured** needs after **hospitalisation** as a direct result of one of the 30 critical illnesses listed in part M (Extra cover for 30 critical illnesses benefit) for an additional 100 days after **hospitalisation**.

The extended period of cover will start after the post-hospitalisation benefit under part C(a) ends and must be recommended or approved in writing, by a **physician**, for the same critical illness the **hospitalisation** was needed for.

This cover for extended post-hospitalisation treatment will end once the post-hospitalisation treatment has been claimed for a total of 200 days following the day the **hospitalisation** ended.

Part D – Accidental inpatient dental treatment benefit

We will pay the **eligible expenses** that arise if the **insured** needs **hospitalisation** to repair their natural teeth (not dentures, dental implants and dental crowns) due to an **injury** caused by an **accident**.

Eligible expenses for inpatient dental treatment are covered under part A (Hospitalisation and surgical benefits), part B (Pre-hospitalisation benefit) and part C (Post-hospitalisation benefits), as appropriate.

Part E – Pregnancy complications benefit

We will pay the **eligible expenses** that arise if the **insured** needs **hospitalisation** in a **hospital** to undergo medical or surgical treatment due to one of the following complications of pregnancy, according to an obstetrician's **diagnosis**.

- Ectopic pregnancy
- Pre-eclampsia or eclampsia
- Disseminated intravascular coagulation
- Miscarriage after 13 weeks of pregnancy
For the cover to apply, the death of the foetus must be as a result of an unforeseen and involuntary event.
- Acute fatty liver during pregnancy
The obstetrician's **diagnosis** must specify at least three of the following criteria.
 - Imaging studies are consistent with fatty liver.
 - Bilirubin is persistently above 150 umol/L (10 mg/dL) for a at least five days.
 - There is kidney damage.
 - Coagulopathy is present.
 Liver damage caused by eclampsia, pre-eclampsia or viral hepatitis is not covered.
- Choriocarcinoma and hydatidiform mole (molar pregnancy)
For the cover to apply, the **diagnosis** must be based on histological evidence.
- Postpartum haemorrhage requiring hysterectomy
This is where a hysterectomy is **medically necessary** after childbirth as a result of excessive, uncontrolled bleeding from the uterus.
- Stillbirth after 24 weeks of pregnancy
For the cover to apply, the death of the foetus must be due to an unforeseen and involuntary event and the **diagnosis** must meet the definition of stillbirth in the Registration of Births and Death Act 2021 (or any revision to it).
- Cervical incompetency
For the cover to apply, a cervix cerclage (treatment that involves temporarily sewing the cervix closed with stitches) must be carried out.
- Accreta placenta
This is covered if a hysterectomy and a caesarean section were performed.

- Placental abruption after 20 weeks or more of pregnancy and before childbirth
- Placenta praevia
This is covered if a caesarean section is required.
- Antepartum, intrapartum and postpartum haemorrhage
This is severe bleeding from the female genital tract before, during or after childbirth, as diagnosed by an obstetrician. For the cover to apply, this must occur at or after 20 weeks of pregnancy.
- Placental insufficiency which leads to intrauterine growth restriction
- Gestational diabetes mellitus
The **diagnosis** must have been made after a 75g oral glucose tolerance test (a blood test to measure **your** body's ability to maintain a normal blood sugar level after ingesting a glucose drink).
- Obstetric cholestasis
- Twin-to-twin transfusion syndrome
There should be evidence from an ultrasound scan to support the **diagnosis**.
- Infection of amniotic sac and membranes
- Amniotic fluid embolism
- Fourth-degree perineal laceration following a vaginal delivery
- Uterine rupture
For the cover to apply, there must be a tear affecting all layers of the uterus.
- Postpartum inversion of uterus
- Obstetric injury or damage to pelvic organs following a vaginal delivery
- Complications resulting in a caesarean hysterectomy
This is where the uterus is removed during a caesarean section due to complications that have arisen during the pregnancy or delivery.
- Retained placenta and membranes after delivery, or after miscarriage that happens after 13 weeks of pregnancy as a result of an unforeseen and involuntary event
- Abscess of the breast, associated with childbirth and breastfeeding
- **Medically necessary** abortion
This includes abortions carried out to save the mother's life or those performed due to a congenital abnormality where the foetus would not be able to survive.
- Maternal death (death of the mother as a consequence of pregnancy or childbirth)

The pregnancy complication must have been first diagnosed after the **insured** has been covered by **your policy** for a continuous period of 10 months or more after:

- the **policy date** of **your policy**;
- the last **reinstatement date** (if any) of **your policy**; or
- the date of a plan upgrade (if any);

whichever is latest.

Eligible expenses arising in connection with pregnancy complications are covered under part A (Hospitalisation and surgical benefits), part B (Pre-hospitalisation benefit) and part C (Post-hospitalisation benefits), as appropriate.

Part F – Congenital abnormalities benefits
(a) Congenital abnormalities of the insured's biological child

We will pay the **eligible expenses** arising if the **insured's** biological child needs **hospitalisation** in a **hospital** for medical or surgical treatment due to a congenital abnormality that developed while the foetus was in the uterus, as diagnosed by a **specialist**, whether or not it was present or diagnosed before, at or after birth.

The cover only applies to treatment provided during the first 24 months after the child's birth.

Cover for this benefit will only apply to congenital abnormalities that are first diagnosed by a **physician** after the **insured** has been covered by **your policy** for 10 months or more after:

- the **policy date** of **your policy**;
- the last **reinstatement date** (if any) of **your policy**; or
- the date of a plan upgrade (if any);

whichever is latest.

This benefit applies only if the **insured** is a female.

(b) Congenital abnormalities of the insured

We will pay the **eligible expenses** arising if the **insured** needs **hospitalisation** in a **hospital** for medical or surgical treatment due to a congenital abnormality that developed while the foetus was in the uterus, as diagnosed by a **specialist**, whether or not it was present or diagnosed before, at or after birth.

The exclusion relating to **pre-existing conditions**, as set out in the general exclusions, applies to this benefit. This means that **your policy** does not cover any congenital abnormality of the **insured** that:

- was diagnosed or treated;
- a **physician** was consulted about; or
- there were any signs or symptoms of;

at any time before the **policy date**, the last **reinstatement date** (if any) or the date of a plan upgrade (if any), whichever is later.

Eligible expenses arising in connection with congenital abnormalities of the **insured** or the **insured's** biological child are covered under part A (Hospitalisation and surgical benefits), part B (Pre-hospitalisation benefit) and part C (Post-hospitalisation benefits), as appropriate.

Part G – Living donor organ transplant benefits
(a) Insured (as a living donor) donating an organ

We will pay the **eligible expenses** arising in connection with removing one of the **insured's** kidneys, or part of their liver, so it can be transplanted into another living person, as long as the following requirements are met.

- (i) The surgery to remove the organ is approved under the MediShield Life Scheme Act 2015, is regulated under the Human Organ Transplant Act 1987 (as amended), and was performed in a **hospital** in Singapore.
- (ii) The person receiving the **insured's** organ was first diagnosed with organ failure 24 months or more after the **policy date**, the last **reinstatement date** (if any), or the date of a plan upgrade (if any), whichever is latest.
- (iii) The **eligible expenses** being claimed arose directly from the **insured's** surgery to have the organ removed, and are limited to the charges for:
 - any pre-hospitalisation treatment the **insured** needed, including pre-harvesting laboratory tests and investigations needed before the organ or bone marrow is removed;
 - the **insured's hospitalisation** in a **hospital**, when necessary for the surgery to donate their organ;
 - the **surgical procedure** to remove the **insured's** organ;
 - storing and transporting the **insured's** organ after it is removed; and
 - any post-hospitalisation treatment the **insured** needed after their surgery for any complication that arose from the surgery.

We will not pay any cost relating to the organ-donation surgery if the organ transplant is illegal or arises from any illegal practice. **We** also will not pay costs for any counselling that medical social workers provide to the **insured's** family in connection with the organ donation.

(b) Non-insured (as a living donor) donating an organ to the insured

We will pay the **eligible expenses** arising in connection with a living donor having one of their kidneys, or part of their liver, removed so it can be transplanted into the **insured's** body, as long as the following requirements are met.

- (i) The surgery to remove the organ from the living donor is approved under the MediShield Life Scheme Act 2015, is regulated under the Human Organ Transplant Act 1987 (as amended), and was performed in a **hospital** in Singapore.
- (ii) The living donor cannot claim expenses for their organ-donation surgery from **MediShield Life**, a **MediSave**-approved integrated shield plan, or any other insurance plan.
- (iii) The **insured** and the living donor agree to make a claim under **your policy** for the organ-donation surgery, and the **insured's MediShield Life** covers the living donor's expenses.
- (iv) The **eligible expenses** being claimed arose directly from the organ-donation surgery, and are limited to the charges for:
 - the living donor's **hospitalisation** in a **hospital** as necessary for the organ donation;
 - **surgical procedures** to remove the living donor's organ; and
 - storing and transporting the living donor's organ after it is removed.

We will not pay any expenses for:

- pre-hospitalisation treatment the living donor needed, including 'pre-harvesting' laboratory tests and investigations the living donor needs before the organ or bone marrow is removed;
- post-hospitalisation treatment the living donor needed, including any complications resulting from the organ-donation surgery; or
- counselling that medical social workers provided to the living donor's family in connection with the organ donation.

We will not pay any cost relating to the organ-donation surgery if the organ transplant is illegal or arises from any illegal practice.

Part H – Medical treatment outside Singapore benefits

(a) Emergency medical treatment outside Singapore

We will pay the **eligible expenses** for medical or surgical treatment that needs to be provided in a **hospital** outside Singapore as a result of an emergency. The amount **we** will pay is limited to the **reasonable and customary** charges which would have arisen for similar medical treatment or surgery carried out in a private **hospital** in Singapore.

For the purpose of this benefit, an emergency is a sudden or unexpected serious medical condition or **injury** which happens outside Singapore and which urgent medical treatment is needed for (in **our** opinion or in the opinion of **our** medical advisor) to avoid death or serious risk to the **insured's** health. **We** can determine whether the claim is considered to be an emergency.

Eligible expenses for emergency medical treatment outside Singapore are covered under:

- part A - Hospitalisation and surgical benefits; and
- part C - Post-hospitalisation benefits (if the post-hospitalisation treatment is provided in Singapore).

If **we** accept a claim for this benefit, **we** will convert all bills to Singapore dollar using the exchange rate, as determined by **us**, that applied on the date the **insured** was discharged.

The **deductible** applied to the **eligible expenses** for this benefit will be equivalent to that for treatment on an A-class ward of a **public hospital** in Singapore or in a private **hospital** in Singapore.

(b) Planned medical treatment outside Singapore

We will pay the **eligible expenses** for planned medical or surgical treatment carried out in a **hospital** outside Singapore. The amount **we** will pay is limited to the **reasonable and customary** charges which would have arisen for similar medical treatment or surgery carried out in Singapore, as long as:

- a **MediSave**-accredited institution or referral centre in Singapore referred the **insured** for the treatment overseas; and
- the overseas **hospital** has an approved working arrangement with the **MediSave**-accredited institution or referral centre in Singapore.

The **reasonable and customary** charges for this benefit are limited to:

- those charged for treatment in a private **hospital** in Singapore (for AIA HealthShield Gold Max A); or
- those charged for an A-class ward of a **public hospital** in Singapore (for AIA HealthShield Gold Max B).

There is a list of **MediSave**-accredited institutions and referral centres on **our** website at www.aia.com.sg.

Eligible expenses that arise in connection with planned medical treatment outside Singapore are covered under:

- part A - Hospitalisation and surgical benefits;
- part B - Pre-hospitalisation benefit (if the pre-hospitalisation treatment is provided in Singapore); and
- part C - Post-hospitalisation benefits (if the post-hospitalisation treatment is provided in Singapore).

If **we** accept a claim for this benefit, **we** will convert all bills to Singapore dollar using the exchange rate, as determined by **us**, that applied on the date the **insured** was discharged.

The **deductible** applied to the **eligible expenses** for this benefit will be equivalent to that for treatment on an A-class ward of a **public hospital** in Singapore or in a private **hospital** in Singapore.

Part I – Psychiatric treatment benefits**(a) In-hospital psychiatric treatment**

We will pay the **eligible expenses** for medical or surgical treatment, including daily room and board charges (including costs for meals, prescriptions and investigations, professional fees, and miscellaneous medical charges) for a **standard room**, during the period the **insured** is **hospitalised** in a **hospital** to receive inpatient psychiatric treatment or undergo relevant investigations. The **hospitalisation**, investigations and psychiatric treatment must be recommended or approved in writing by a **psychiatrist**.

(b) Post-hospitalisation psychiatric treatment

If the **insured** has received in-hospital psychiatric treatment in line with (a) above, **we** will reimburse the **eligible expenses** for post-hospitalisation psychiatric treatment and tests within 200 days of the day after the **hospitalisation** ends. The post-hospitalisation psychiatric treatment must be for the same condition the in-hospital psychiatric treatment was for.

We will not pay the cost of any routine medical check-up which is not part of the post-hospitalisation psychiatric treatment. **We** will also not pay for treatments, medical services, supplies or medication bought within the period specified in the schedule of benefits (appendix 1) but not used within the same period.

We will not pay for outpatient and home-based treatments under this benefit. These may be covered under part P.

Part J – Outpatient benefits

This benefit will be equal to the **eligible expenses** that arise during or for:

- radiotherapy for cancer;
- stereotactic radiotherapy for cancer;
- cancer drug treatment on the **Cancer Drug List** (see (a) below);
- **cancer drug services** (see (b) below);
- kidney dialysis;
- treatment with erythropoietin (a growth factor that stimulates the bone marrow to make red blood cells);
- treatment with immunosuppressant drugs that are approved by the Health Sciences Authority and were prescribed for the **insured** following an organ transplant (see (c) below); and
- long-term parenteral nutrition (see (d) below).

For all outpatient treatments, except cancer drug treatments on the **Cancer Drug List** and **cancer drug services**, **we** will pay for consultation fees, medicines, examinations and tests that are provided during the outpatient treatment. These treatments must be directly related to the outpatient treatment and ordered by the **physician**, and the same **limits of compensation** for the respective outpatient treatment as shown in the schedule of benefit (appendix 1) will apply.

- (a) For cancer drug treatments listed on the **Cancer Drug List** (CDL treatments), the treatment must be provided in line with the indications specified on the **Cancer Drug List**. **We** will not cover any cancer drug treatment that is listed on the **Cancer Drug List** but not used in line with the specified indications.

Insured receiving treatment for only one primary cancer

If the CDL treatment involves more than one drug, **we** allow a drug to be removed from the treatment, or replaced with another drug indicated 'for cancer treatment' on the **Cancer Drug List**, if this is necessary due to intolerance or contraindications (for example, allergic reactions). In such cases, the **limits of compensation** for the unaltered CDL treatment will apply.

If more than one CDL treatment is given in a particular month, and any of them have an indication that states 'monotherapy', only CDL treatments with the indication 'for cancer treatment' will be covered in that month.

If more than one CDL treatment is given in a particular month and none of them has an indication that states 'monotherapy', the following will apply.

- If more than one of the CDL treatments have an indication that is not 'for cancer treatment', only CDL treatments with the indication 'for cancer treatment' will be covered in that month.
- If one or none of the CDL treatments has an indication that is not 'for cancer treatment', all the CDL treatments will be covered in that month.

Cancer drug treatments that are not listed on the **Cancer Drug List** will be considered to have an indication that is not 'for cancer treatment'.

We will pay up to the highest limit from among the covered CDL treatments in that month.

Insured receiving treatment for multiple primary cancers

We will pay up to the total of the highest limits from among the covered CDL treatments given for each primary cancer in that month, as long as **we** assessed and approved the course of treatment for **multiple primary cancers**. More information can be found on **our** website at www.aia.com.sg.

- (b) **We** will double the **limits of compensation** for **cancer drug services** if the **insured** has received treatment for **multiple primary cancers** at any time during the **policy year**, as long as **we** assessed and approved the course of treatment for **multiple primary cancers**. More information can be found on **our** website at www.aia.com.sg.
- (c) For treatment involving immunosuppressant drugs after an organ transplant, **we** will not pay the costs for the immunosuppressant drugs if the organ transplant was illegal or arose from any illegal practice.
- (d) For treatment involving long-term parenteral nutrition (that is, providing nutrition directly into the veins):
- **we** will cover the costs for the parenteral nutrition bags and replaceable parts necessary for administering the parenteral nutrition; and
 - the **insured** must meet all **MediShield Life's** criteria for long-term parenteral nutrition.

The **insured** does not need **hospitalisation** for benefit to be paid under this part J (Outpatient benefits). No **deductible** applies to the **eligible expenses** covered for outpatient benefit, but **you** do have to pay **co-insurance**.

We will not pay for cell, tissue and gene therapy, proton beam therapy or outpatient and home-based treatments under this benefit. These may be covered under parts N, O or P.

Part K – Final expense benefit

If the **insured** dies:

- during a period of **hospitalisation** in a **hospital**; or
- within 30 days from the date they were discharged from **hospital**;

we will pay an amount equal to the **deductible** and **co-insurance** that **you** paid or became liable for in that **policy year**, as long the death is a result of an **illness** or **injury** that led to the **hospitalisation**.

The total amount **we** will pay is limited to the **limits of compensation** shown in the schedule of benefits (appendix 1).

No **deductible** or **co-insurance** applies to claims for this benefit.

Part L – Waiver of one year’s premium benefit (upon total and permanent disability)

If, while **your policy** is in force but before the policy anniversary immediately after (or on) the **insured’s** 70th birthday, the **insured** suffers a total and permanent disability classed as TPD 1, TPD 2 or TPD 3 (see below), **we** will waive the premium (meaning **you** will not have to pay it) for one year (12 months), starting on the next **policy date** after the date the total and permanent disability started.

TPD 1 – disability arising before the policy anniversary immediately after (or on) the **insured’s** 65th birthday, which prevents the **insured** from doing any paid work, occupation or profession, as long as the total and permanent disability and inability to work:

- is diagnosed and certified by a **physician**;
- continues uninterrupted for at least six months; and
- is not likely to improve in the future.

TPD 2 – disability arising after (or on) the policy anniversary immediately after (or on) the **insured’s** 65th birthday, which prevents the **insured** from performing at least two of the activities of daily living shown in the table below without physical help from another person throughout the entire activity, even with the use of special equipment, as long as the total and permanent disability and inability to perform the activities of daily living:

- is diagnosed and certified by a **physician**; and
- continues uninterrupted for at least six months.

Activities of daily living	
Washing	Washing in the bath or shower (including getting into and out of the bath or shower), or washing satisfactorily by any other method
Dressing	Putting on, taking off, fastening and unfastening all garments and, if appropriate, any braces, artificial limbs or other surgical appliances
Transferring	Moving from a bed to an upright chair or wheelchair, and vice versa
Mobility	Moving from room to room on level surfaces indoors
Toileting	Using the toilet or otherwise managing bowel and bladder functions in a way that maintains a satisfactory level of personal hygiene
Feeding	Feeding oneself after food has been prepared and made available

TPD 3 – this is:

- total and irrecoverable loss of sight of both eyes; or
- complete loss of, or total and irrecoverable loss of use of, two limbs at or above the wrist or ankle; or
- total and irrecoverable loss of sight of one eye and complete loss of, or loss of use of, one limb at or above the wrist or ankle.

If the **insured** is a juvenile, **we** will only accept a claim for total and permanent disability classed as TPD 3. An **insured** is considered to be a juvenile until he or she:

- is in paid employment or self-employment from the age of 16; or
- reaches the age of 21;

whichever is earlier.

No **deductible** or **co-insurance** applies to claims for this benefit.

Part M – Extra cover for 30 critical illnesses benefit

If the **insured** needs medical or surgical treatment as a direct result of one of the 30 critical illnesses listed below, the **limit per policy year** and **limit per lifetime** shown in the schedule of benefits (appendix 1) will be increased by the additional limit per policy year and additional limit per lifetime shown for part M in the schedule of benefits. The **eligible expenses** will first be taken off the additional limit per policy year for this benefit, and any amount over that will be taken off the **limit per policy year**.

However, for AIA HealthShield Gold Max A this extra cover for 30 critical illnesses will not increase the overall **limit per policy year** to more than S\$2,000,000.

List of 30 critical illnesses (defined in appendix 3)

1. Heart attack of specified severity
2. Stroke
3. Coronary artery bypass surgery
4. HIV due to blood transfusion, or occupationally acquired HIV
5. Angioplasty or other invasive treatment for coronary artery
6. Major cancers
7. Fulminant hepatitis
8. Primary pulmonary hypertension
9. Kidney failure
10. Major organ transplant or bone marrow transplant
11. Multiple sclerosis
12. Blindness (loss of sight)
13. Paralysis (loss of use of limbs)
14. Muscular dystrophy
15. Alzheimer's disease or severe dementia
16. Coma
17. Deafness (loss of hearing)
18. Heart valve surgery
19. Loss of speech
20. Major burns
21. Surgery to aorta
22. Terminal illness
23. End-stage lung disease
24. End-stage liver failure
25. Motor neurone disease
26. Parkinson's disease
27. Aplastic anaemia
28. Benign brain tumour
29. Bacterial meningitis
30. Viral encephalitis

No **deductible** or **co-insurance** applies to claims for this benefit.

Part N – Cell, tissue and gene therapy benefit

We will pay the **eligible expenses** that arise if the **insured** needs cell, tissue and gene therapy as an inpatient, outpatient or day-surgery patient. **We** will only cover cell, tissue and gene therapy treatments listed on the **Cell, Tissue and Gene Therapy Product List** (CTGTP treatments), as shown in the schedule of benefits (appendix 1), and the treatment must be provided in line with the indications requirements specified on the **Cell, Tissue and Gene Therapy Product List**.

We will only pay for one treatment per indication per lifetime, subject to indication requirements as listed within the **Cell, Tissue and Gene Therapy Product List**, for each CTGTP treatment under this benefit.

We will not cover any cell, tissue and gene therapy treatments that are listed on the **Cell, Tissue and Gene Therapy Product List** but not shown in the schedule of benefits (appendix 1) or used in line with the specified indications.

For outpatient cell, tissue and gene therapy treatments (including cell, tissue and gene therapy treatments not on the **Cell, Tissue and Gene Therapy Product List**), **we** will pay for consultation fees, medicines, examinations and tests that are provided during the outpatient cell, tissue and gene therapy treatment. These treatments must be directly related to the outpatient cell, tissue and gene therapy treatment and ordered by the **physician**, and the same **limits of compensation** for this benefit will apply.

We will not pay for inpatient, outpatient and day-surgery cell, tissue and gene therapy treatments under any other benefits.

Part O – Proton beam therapy benefit

We will pay the **eligible expenses** that arise if the **insured** needs proton beam therapy as an inpatient, outpatient or day-surgery patient. We will only cover proton beam therapy if it is an approved proton beam therapy shown on the **MOH** website (<https://go.gov.sg/pbt-approved-indications>), which may change from time to time.

For outpatient proton beam therapy treatment, we will pay for consultation fees, medicines, examinations and tests that are provided during the outpatient proton beam treatment. These treatments must be directly related to the outpatient proton beam therapy treatment and ordered by the **physician**, and the same **limits of compensation** this benefit will apply.

Part P – Outpatient and home-based treatments benefit

This benefit will be equal to the **eligible expenses** that arise during or for:

- home ventilation and respiratory support service (HVRSS);
- negative pressure wound therapy (NPWT);
- repetitive transcranial magnetic stimulation (rTMS) (see (a) below);
- pasteurised donated human milk (PDHM) (see (b) below);
- hyperbaric oxygen therapy (HBOT) (see (c) below); and
- outpatient parenteral antibiotic therapy (OPAT) (see (d) below).

We will only pay for the **eligible expenses** for the above listed outpatient and home-based treatments if:

- the **insured** meets all the **MediShield Life's** criteria as shown on the **MOH** website (<https://go.gov.sg/mshlbenefits>);
- the treatments and services are provided in line with the **MediShield Life's** terms and conditions as shown on the **MOH** website (<https://go.gov.sg/mshlbenefits>); and
- the treatment is recommended in writing by a **physician**.

The treatment received under this benefit needs to be provided in a medical institution in Singapore or the **insured's** home.

We will pay for consultation fees, medicines, examinations and tests that are provided during the outpatient and home-based treatment. These treatments must be directly related to the outpatient and home-based treatment and ordered by the **physician**, and the same **limits of compensation** for the respective outpatient and home-based treatment as shown in the schedule of benefits (appendix 1) will apply.

The **insured** does not need **hospitalisation** for the benefit to be paid. No **deductible** applies to the **eligible expenses** covered for this benefit, but **you** do have to pay **co-insurance**.

- (a) For the treatment involving rTMS, we will only pay if the treatment is administered according to the guidance recommendation published on the **MOH's** Medical Technology Advisory Committee's website (<https://www.ace-hta.gov.sg/healthcare-professionals/ace-technology-guidances/medical-technology-guidance/>).
- (b) For the treatment involving PDHM, we will only pay if the **insured** is a recipient of the PDHM treatment, and the treatment is provided by a **MOH** registered milk bank in Singapore. We will not pay for any consumables related to the PDHM treatment.
- (c) For the treatment involving HBOT, we will only pay if the treatment is administered for the clinical indications that can be claimed for under **MediShield Life**.
- (d) For the treatment involving OPAT, we will only pay for subsidised antibiotics (for infusions or injections) listed on the **MOH's** website (<https://www.moh.gov.sg/managing-expenses/schemes-and-subsidies/list-of-subsidised-drugs>)

For points (a) to (d), please refer to the clinical situations which are set out in appendix 2.

Pro-ration factor

If covered under AIA HealthShield Gold Max B

If eligible expenses arise:

- in a private **hospital** or private medical institution in Singapore (except for any **eligible expenses** for outpatient benefit covered under part J); or
- for medical treatment in a **hospital** outside Singapore;

the amount of **eligible expenses** we will pay will be reduced by multiplying the **eligible expenses** by the pro-ration factor shown in the schedule of benefits (appendix 1) before we apply any **deductible** and **co-insurance** set out in the schedule of benefits.

If **eligible expenses** arise for outpatient treatment covered under part J (except for 'Cancer drug treatment on the **Cancer Drug List**' and '**Cancer drug services**') in a private **hospital** or private medical institution in Singapore, the following will apply.

- If the **eligible expenses** are less than or equal to the **limits of compensation** for the relevant treatment, as shown in the schedule of benefits (appendix 1), we will pay up to the **limits of compensation** for the relevant treatment, less the **co-insurance** (as set out in the schedule of benefits). No pro-ration factor will apply.
- If the **eligible expenses** are more than the **limits of compensation** for the relevant treatment, as shown in the schedule of benefits (appendix 1), the following will apply.
 - For the amount of **eligible expenses** up to and including the **limits of compensation**, we will pay up to the **limits of compensation** less the **co-insurance** (as set out in the schedule of benefits) and no pro-ration factor will apply; and
 - For the remaining amount of **eligible expenses** above the **limits of compensation**, we will multiply that amount by the pro-ration factor (as shown in the schedule of benefits) before we apply the **co-insurance**.

If **eligible expenses** covered under part J (Outpatient benefits) arise for cancer drug treatment on the **Cancer Drug List** or **cancer drug services**, the amount of **eligible expenses** we will pay will be reduced by multiplying the **eligible expenses** by the pro-ration factor, as shown in the schedule of benefits, before we apply the **co-insurance** set out in the schedule of benefits (appendix 1).

If covered under AIA HealthShield Gold Max B Lite

If eligible expenses arise:

- for care or treatment provided on an A-class ward of a **public hospital**, or in a private **hospital** or private medical institution in Singapore; or
- for medical treatment in a **hospital** outside Singapore;

the amount of **eligible expenses** we will pay will be reduced by multiplying the **eligible expenses** by the pro-ration factor as shown in the schedule of benefits (appendix 1) before we apply any **deductible** and **co-insurance**.

If the **insured** is a Singapore permanent resident, and **eligible expenses** arise for care or treatment provided on a B1-class ward in a **public hospital**, the amount of **eligible expenses** we will pay will be reduced by multiplying the **eligible expenses** by the pro-ration factor shown in the schedule of benefits (appendix 1) before we apply any **deductible** or **co-insurance**.

Limit per policy year and limit per lifetime

If we accept any claim covered by **your policy**, the amount we pay will be taken off the **limit per policy year** for the appropriate **policy year**.

If the **insured** is admitted to a **hospital**, and the **hospitalisation** (or any outpatient consultations and treatments arising from it) extends into the following **policy year**, the **limit per policy year** for the claim will be that for the **policy year** the **hospitalisation** started in.

For any re-admission within 24 hours after a discharge from the same **hospital** for the same **diagnosis**, the **limit per policy year** and **deductible** for the claim will be that for the **policy year** the previous **hospitalisation** started in.

If a claim covered by **your policy** does not involve **hospitalisation**, the **eligible expenses** that we will pay for outpatient consultations and treatments will be based on the **limit per policy year** that applies on the date the medical expenses become due, regardless of the actual date the medical services are used.

Deductibles will be applied to each **policy year** before we pay any benefit under **your policy**.

You must pay any amount over the limits of compensation, limit per policy year and limit per lifetime.

General exclusions

We will not cover any **pre-existing condition** unless it was declared in the application for **your policy** or any application to reinstate **your policy**, and **we** specifically agreed to cover it.

Your policy also does not cover any claims resulting directly or indirectly from or in connection with any of the following.

- (1) Any medical treatment which starts before the **policy date**.
- (2) Medication and medical devices that are not registered under the Health Products Act 2007 and listed on the Health Sciences Authority of Singapore's website (www.hsa.gov.sg).
- (3) Experimental or investigational medical or surgical techniques, as decided by **our** medical advisor. This includes medical devices not approved by the Institutional Review Board and the Centre of Medical Device Regulation and medical trials for medicinal products, whether or not the trials have a clinical trial certificate from the Health Sciences Authority of Singapore (HSA).
- (4) Congenital abnormality, except where covered under part F (Congenital abnormalities benefits).
- (5) Pregnancy, miscarriage, abortion, childbirth, sterilisation or contraception, except where covered under part E (Pregnancy complications benefit).
- (6) Infertility, sub-fertility (lower than normal fertility), assisted conception, any contraceptive operation or any sex change operation.
- (7) Any injury or illness directly or indirectly caused by intentional self-neglect, intentional self-inflicted injury, misuse or abuse of drugs or alcohol, drug overdose (whether intentional, accidental or otherwise), or injuries caused as a direct result of a criminal act or attempted suicide, whether the **insured** was sane or insane.
- (8) Any sexually transmitted disease, including AIDS (Acquired Immune Deficiency Syndrome) and AIDS-related complications, except for HIV due to blood transfusion and occupationally acquired HIV if covered by part M (Extra cover for 30 critical illnesses benefit). For the purpose of considering whether this general exclusion applies, **we** will:
 - use the definition of AIDS published by the World Health Organization in 1987, or any subsequent revision of that definition; and
 - consider whether blood tests or other relevant tests indicate, in **our** opinion or in the opinion of **our** medical advisor, the presence of HIV or antibodies to it.
- (9) Treatment for mental illnesses or psychiatric disorders, except where covered under part I (Psychiatric treatment benefits).
- (10) Treatment for, arising from or related to obesity, weight loss, weight improvement or weight management, regardless of whether it is for medical or psychological reasons.
- (11) Injuries caused during war (whether or not war has been declared), civil commotion, riot, revolution, strike, nuclear incident or any war-like event.
- (12) Buying or renting medical devices or appliances, equipment or machines, braces or corrective devices, prostheses, wheelchairs, walking aids, home aids, kidney dialysis machines, iron lungs, oxygen machines, hospital beds or any hospital equipment for use at home or as an outpatient, unless this is covered by **MediShield Life** for inpatient care provided through **Mobile Inpatient Care @ Home** or covered under part P (Outpatient and home-based treatments benefit).
- (13) Cosmetic or plastic surgery, unless it is:
 - to correct a defect in the function of the relevant organ; or
 - breast reconstruction after mastectomy (surgery to remove all or part of the breast) following a **diagnosis** of breast cancer, and is performed within 365 days of the mastectomy.

Any surgery or reconstruction of the breast (or breasts) to produce a symmetrical appearance after a mastectomy or to alter the breast size or shape will not be covered.

- (14) Dental treatment, except where covered under part D (Accidental inpatient dental treatment benefit).
- (15) Correcting refractive errors (imperfections of the eye that prevent it from focusing light properly), such as short-sightedness.
- (16) Routine eye and ear examinations, and the costs of glasses, contact lenses and hearing aids.

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- (17) Care provided in a **hospice**, unless covered under part A (g) (Hospice inpatient palliative care), rest cures (periods of rest or leisure intended to improve physical or mental health), nursing at home or as an outpatient, or care in a convalescent home, nursing home or similar establishment, unless this is covered by **MediShield Life** for inpatient care provided through **Mobile Inpatient Care @ Home** or covered under part P (Outpatient and home-based treatments benefit).
 - (18) Transport-related services, including ambulance fees and transport used for emergency evacuation and repatriation (returning a person or their remains to their home country), unless this is covered by **MediShield Life** for inpatient care provided through **Mobile Inpatient Care @ Home**.
 - (19) Any treatments, medical services or supplies which are for primary prevention (medical services for generally healthy people when there are no signs or symptoms that would indicate the need for the medical services, or to prevent an **illness** from occurring), for health screening or for improving general health, including genetic tests, vitamins, health supplements, dietary replacements and non-prescribed drugs.
 - (20) Acne, pigmentation, keloids, skin tags, moles, alopecia and circumcision (unless it is **medically necessary**).
 - (21) Vaccinations.
 - (22) Costs relating to getting an organ or parts of an organ from a living donor for an organ transplant, including the living donor's expenses, except where covered under part G (Living donor organ transplant benefits).
 - (23) Medical treatment or **hospitalisation** outside Singapore, except where covered under part H (Medical treatment outside Singapore benefits).
 - (24) All exclusions for **MediShield Life**, as listed on the **MOH** website (www.moh.gov.sg), except where **your policy** says otherwise.
 - (25) Non-medical items such as parking fees, **hospital** administration and registration fees, fees for laundry, television rental and newspapers, and the cost of medical reports.
 - (26) Alternative or complementary treatments, including traditional Chinese medicine, podiatric, chiropractic or osteopathic treatment, or a stay in any healthcare establishment for social or non-medical reasons.
 - (27) X-rays, general check-ups and medical services (including those provided to inpatients in a **hospital**) carried out mainly for primary prevention (medical services for generally healthy people when there are no signs or symptoms that would indicate the need for the medical services, or to prevent an **illness** from occurring).
 - (28) Breaking (or intending to break) the law, resisting arrest, or any detention or imprisonment.
 - (29) Medication and medical devices being used in a way that is not registered with the Health Sciences Authority of Singapore, unless the medical device or product:
 - is registered under the Health Products Act 2007 and listed on the Health Sciences Authority of Singapore website (www.hsa.gov.sg); and
 - has been approved for the particular use by an overseas agency listed as a reference agency in the 'Reference drug regulatory agencies' area of the Health Sciences Authority of Singapore's website (www.hsa.gov.sg).
 - (30) Medical services and prescriptions that are not directly for the treatment of an **illness** or **injury** that has led to **hospitalisation**, except where covered under part B (Pre-hospitalisation benefit) or part C (Post-hospitalisation benefits).
 - (31) **Hospitalisation**, medical treatment or services at a medical institution that is not accredited by **MediShield Life**, except where covered under part H (Medical treatment outside Singapore benefits).
 - (32) **Hospitalisation**, medical treatment or services that are not **medically necessary**.
 - (33) Medical fees or expenses which are over **reasonable and customary** charges.
 - (34) Outpatient cancer drug treatments not on the **Cancer Drug List**.
 - (35) Cell, tissue and gene therapy treatments not on the **Cell, Tissue and Gene Therapy Product List**.
 - (36) High-cost drugs treatments used for the medical conditions indicated under **MediShield Life**, which are not listed on the **MediShield Life's** benefit schedule (<https://go.gov.sg/mshlbenefits>). This website may be updated from time to time.
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Premium conditions

Paying the premium

Your premium includes **GST**.

You must pay **your** premium on or before the **premium due date** each year. **We** may deduct it from **your MediSave** account. If the premium is more than the **MediSave** maximum withdrawal limit, or the balance in **your MediSave** account is not enough to pay the full premium due, **you** must pay the shortfall, in cash, within the **grace period**. If **you** don't, **your policy** will automatically end.

We will tell **you** the premium **you** must pay under **your policy**, based on premium rates decided by **us**.

Premium rates

The premium rates **we** use are not guaranteed and **we** will change them from time to time to reflect **our** claims experience, medical inflation (medical trends and developments, and the increase in cost to support them) and the general cost of treatments, supplies and medical services in Singapore.

We must send **you** a written notice at least 31 days before any change in premium rate comes into force.

Automatic renewal

Your policy is guaranteed to renew each year, on the policy anniversary, if:

- **your policy** is in force on the policy anniversary; and
- **you** pay, and **we** receive, the renewal premium before the end of the **grace period**.

The renewal premium will be in line with the premium rate for the **insured's** age next birthday on the date of renewal.

Reinstating your policy

If **your policy** automatically ends because a premium remains unpaid after the **grace period**, **we** may agree to reinstate it within two years from the date it ended, as long as **you** meet the criteria and requirements that apply at the time. **We** may apply additional terms, including exclusions, to **your** reinstated **policy**. **Your** reinstated **policy** will only cover **hospitalisation**, surgery and treatment that arises after the **reinstatement date**.

Claim conditions

Claims for hospitalisation

All claims must be submitted to **us** by the **hospital** or medical institution through the system set up by **MOH**, in line with the terms and conditions that apply under the Central Provident Fund Act 1953 and the MediShield Life Scheme Act 2015 (where appropriate).

This does not apply to claims:

- under part B (Pre-hospitalisation benefit);
- under part C (Post-hospitalisation benefits);
- for 'Congenital abnormalities of the **insured's** biological child' under part F (a);
- for 'Non-insured (as a living donor) donating an organ to the **insured**' under part G (b);
- under part H (Medical treatment outside Singapore benefits); or
- for 'In-hospital psychiatric treatment' under part I (a).

You must make these claims online through the 'Claims EZ' portal on **our** website.

All claims must be made within 60 days from the date the **insured** is discharged from the **hospital** or the date they receive outpatient treatment. **You** must provide all the details **we** ask for about the **insured** and the claim.

You must provide, at **your** own expense, any supporting documents and proof **we** ask for, including:

- proof of the treatment or surgery; and
- the **hospital's** original final bills, receipts and statements.

If **we** do not believe the **diagnosis** is appropriate or correct, **we** can:

- require the **insured** to have a medical examination; and
- analyse the evidence used for the **diagnosis**.

We will appoint an independent **specialist** in the relevant field to carry out this examination and analysis.

Claims for total and permanent disability

You must make **your** claim by filling in the disability form found on the 'Claims EZ' portal on **our** website and providing any supporting documents and proof **we** ask for. **You** must make the claim within 60 days from the date that the **insured** suffers a total and permanent disability classed as TPD 1, TPD 2 or TPD 3 (as described in part L), and **you** must provide all the details **we** ask for about the **insured** and the claim.

You must provide, at **your** expense, any supporting documents and proof **we** ask for, including:

- evidence provided by the appropriate **physician**;
- the findings of appropriate medical investigations, such as clinical, radiological, histological and laboratory evidence.

We may require the **insured** to have a medical examination, and analyse the evidence used for the **diagnosis** of the total and permanent disability. **We** will appoint an independent **specialist** in the relevant field to carry out the examination and analysis, which will be at **your** expense. The **specialist's** opinion will be binding on **you** and **us**.

We will only pay the benefit if all of the following apply.

- (a) **We** are satisfied that the **diagnosis** of total and permanent disability meets the definition of TPD 1, TPD 2 or TPD 3.
- (b) **We** are satisfied with:
 - the findings of any medical examination (or re-examination) the **insured** undergoes;
 - the analysis (or further analysis) of the evidence used for the **diagnosis** of the total and permanent disability; and
 - any supporting documents and evidence **we** ask for and receive.

Paying benefits

All benefits due under **your policy**, except for 'Waiver of one year's premium benefit' under part L, will be paid to **you, your** legal representative, the **hospital** or **community hospital**, or any other relevant party **we** choose.

Last-payer status

If **you** have any other medical insurance which covers the **insured's** medical expenses, **you** must first claim payment from that insurance before making any claim under **your policy**. If **you** have received payment under **your policy**, **you** must make a claim with **your** other medical insurers for them to reimburse **us**.

The total payment **you** receive under all policies must not be more than the actual expenses.

We do not pay claims where the medical expenses have been paid by other medical insurance or from any other source.

SAMPLE

Definitions

In this policy contract, the words and terms below have the meanings shown whenever they appear in bold.

Accident

An unexpected and involuntary event.

AIA preferred provider

Any **public hospital** and any private medical service provider listed on **our** website at www.aia.com.sg/qualityhealthcare (**we** may change **our** list of medical service providers at any time).

Cancer Drug List

A list of clinically proven and cost-effective cancer drug treatments developed by **MOH**. The list is on the **MOH** website (<https://go.gov.sg/moh-cancerdruglist>) and may be updated from time to time.

Cancer drug services

Services that are part of any outpatient cancer drug treatment, including outpatient cancer drug treatments not on the **Cancer Drug List**, (such as consultations, scans, lab investigations, preparing and administering the treatment, supportive-care drugs and blood transfusions) which are **medically necessary**. It does not include services provided before a **diagnosis** or after the cancer drug treatment has ended.

Cell, Tissue and Gene Therapy Product List

A list of clinically proven and cost-effective cell, tissue and gene therapy products developed by **MOH**. The list is on the **MOH** website (<https://go.gov.sg/ctgtp-list>) and may be updated from time to time.

Co-insurance

The amount **you** need to pay after the **deductible** (if any). The co-insurance amounts for the benefits are shown in the schedule of benefits (appendix 1).

Community hospital

A public health institution that provides medical services and short-term care for patients who have just been discharged from **hospital**, and is classified as a community hospital by **MOH**.

CPF Board

The body that administers the Central Provident Fund, which is a social security savings scheme funded by contributions from employers and employees. The Central Provident Fund was established under the Central Provident Fund Act 1953.

Day surgery

Scheduled surgery that is performed as outpatient treatment by a **physician** at a **hospital** or clinic.

Deductible

The part of the **eligible expenses** per **policy year** which **you** must pay before **you** can claim any benefit under **your policy**. The different deductibles are shown in the schedule of benefits (appendix 1).

Diagnosis

A **physician's** definitive conclusion of the nature of an **illness**, based on radiological, clinical, histological or laboratory evidence acceptable to **us**.

A diagnosis must be supported by **our** medical advisor, who may base his or her opinion on evidence provided by **you** or the **insured**, or any other evidence he or she receives.

Eligible expenses

The expenses for **medically necessary** treatment, supplies or medical services. The expenses are limited to:

- **reasonable and customary** charges for the relevant treatment, supplies or medical services; and
- the **limits of compensation** for the particular benefit, as shown in the schedule of benefits (appendix 1), at the time the expenses arise.

Eligible expenses can be reduced by a pro-ration factor, as shown in the schedule of benefits (appendix 1), for a higher class of ward.

Grace period

The 60-day period **we** give **you** to pay **your** premiums. The grace period starts on the **premium due date**.

GST

Goods and services tax, which is applied in line with the GST Act 1993.

Hospice

A medical facility approved by **MOH** to provide medical and care services that aim to improve the quality of life of patients with terminal illnesses. This does not include convalescent centres, **hospitals, community hospitals**, or nursing or care homes.

Hospital

An institution that is lawfully run to care for and treat injured or ill patients, and which has facilities for diagnosing conditions, performing major surgery and providing full-time nursing care. This does not include **community hospitals**, convalescent centres, any institution used mainly as a nursing or care home, similar establishments, or facilities used mainly for the treatment of alcohol or drug addiction.

Institutions in Singapore must be registered as a hospital and accredited by **MOH** in line with the MediShield Life Scheme Act 2015. Institutions outside Singapore must be recognised by **our** medical advisor as a facility that is equivalent to an institution in Singapore.

Hospitalisation (also hospitalised)

This is any of the following.

- (a) Being in a **hospital**, as an inpatient, for a period during which daily room and board charges become due
- (b) Being on a short-stay ward in the accident and emergency department of a **hospital** for eight hours or more for medical treatment, examination or observation
- (c) Being in a **hospital** or medical institution accredited by **MOH** under the MediShield Life Scheme Act 2015, for any period, for a **surgical procedure**
- (d) Receiving inpatient treatment at home under the **Mobile Inpatient Care @ Home** programme (only for **public hospitals**).

Illness

A disease or period of sickness affecting the body or mind.

Injury

A bodily injury caused directly as a result of an **accident**.

Insured

The person named as the insured in **your policy schedule**.

Intensive care unit

A unit within a **hospital** which:

- provides 24-hour care and treatment for patients in a critical medical condition; and
- is equipped to provide specialist nursing and medical services not available elsewhere in the **hospital**;

including a coronary care unit, cardiac care unit or critical care unit in a **hospital**.

Limits of compensation

The limits of compensation shown in the schedule of benefits (appendix 1), which **we** will pay for each benefit depending on the plan type and hospital ward entitlement.

Limit per lifetime

The maximum amount **we** will pay in total over the life of **your policy**. The limit per lifetime is shown in the schedule of benefits (appendix 1). It may be increased by an additional amount under part M (see the 'Additional limit per lifetime' shown for part M in the schedule of benefits). The limit per lifetime includes the **MediShield's Life** lifetime limit (if any).

Limit per policy year

The maximum amount **we** will pay in total under **your policy** in one **policy year**, as shown in the schedule of benefits (appendix 1). It may be increased by an additional amount under part M (see the 'Additional limit per policy year' shown for part M in the schedule of benefits). The limit per policy year includes the **MediShield Life's** limit.

Medically necessary

A medical treatment, service or supply is medically necessary if all of the following apply.

- The **physician's** or **specialist's** opinion on medical treatment, service or supply is appropriate and consistent with the symptoms, findings, **diagnosis** and relevant clinical circumstances of the **illness** or **injury**.
- It is a customary treatment, service or supply for the **illness** or **injury**.
- It is in line with standards of good medical practice and consistent with current standards of professional medical care.
- It has proven medical benefits.
- It is not for the convenience of the **insured**, the **physician** or the **specialist** (for example, if treatment that could be provided out of a **hospital** is being provided as inpatient treatment in a **hospital**).
- It is not experimental or for investigation or research.
- It is not preventive or for health screening.
- Not providing it would have a negative effect on the **insured's** medical condition.

MediSave

A national medical-savings scheme that helps people set aside part of their income to pay for their or eligible dependants' inpatient care and treatment, **day surgery** and certain outpatient expenses, as well as their healthcare needs in old age.

MediShield Life

Basic health insurance that is administered by the **CPF Board** and governed by the MediShield Life Scheme Act 2015 (as amended from time to time). There is more information on MediShield Life on the **MOH** website (www.moh.gov.sg).

Mobile Inpatient Care @ Home

A care-delivery model, covered under **MediShield Life**, that allows patients who a **physician** assesses as being clinically suitable to receive inpatient treatment in their own homes, instead of a **public hospital**. This type of care has to be recommended by a **physician**.

MOH

The Ministry of Health of Singapore.

Multiple primary cancers

Two or more cancers that arise from different sites of the body or are of different histology or morphology groups (that have a different microscopic structure, form or shape), which are diagnosed by an oncologist.

The higher claim limits for patients receiving treatment for **multiple primary cancers** are granted on the basis of an application, which the **physician** would need to send to **MOH** (for **MediShield Life** claims) and **us** (for **MediSave**-approved integrated shield plan claims) for review and approval. More information can be found on **our** website at www.aia.com.sg.

The **diagnosis** of **multiple primary cancers** must be proven to **our** satisfaction and at **your** own expense. The proof **we** must receive includes:

- evidence provided by the appropriate **physician** or **specialist**, as the case may be;
- appropriate medical investigations or reports, or both, including (but not limited to) clinical, radiological, histological and laboratory evidence; and
- any other documents **we** ask for.

Outpatient telemedicine consultation

Consultations **you** have over the phone, online, digitally or by another telecommunication method. The service must be provided by:

- a provider approved under the **MOH** Licensing Experimentation and Adaption Programme (see the **MOH** website); or
- a **public hospital**.

Physician

Any person who is registered and legally qualified as a medical practitioner, has a medical degree in Western medicine, is authorised or licensed by the relevant authority in the country they work in, and is not:

- **you** or the **insured**;
- **your** or the **insured's** husband, wife, unmarried partner, father, mother, brother, sister, or biological or legally adopted child, or a child **you** or the **insured** is legally responsible for; or
- any other person related to **you** or the **insured** in any way, including by marriage or adoption.

Policy

Your AIA HealthShield Gold Max policy, made up of the following documents (the policy documents).

- This policy contract
- **Your policy schedule**
- **Your** application
- Any endorsements
- Any supplementary agreements **we** issue

Policy date

The policy date shown in **your policy schedule** or endorsements (if any). The policy date is the date **your** insurance cover started or was renewed. It determines the policy anniversaries, **policy years** and months for **your policy**.

Policy schedule

This is:

- the schedule that was issued when **you** first took out **your policy**; or
 - the policy schedule issued when **your policy** was last renewed;
- as appropriate.

It shows details of **your policy**, benefits and premiums.

Policy year

Each 12-month period starting from the **policy date** shown in **your policy schedule** or an endorsement (if any).

Pre-existing condition

Any **illness**, disease or condition that the **insured**:

- was diagnosed with; or
- received (or should have received) treatment, medication, or advice from a **physician** for; or
- had symptoms or signs of (and which would have led a reasonable and sensible person to get medical advice or treatment from a **physician**),

before the **policy date** or the last **reinstatement date**, whichever is later.

Premium due date

The date **your** premium becomes due, as shown in **your policy schedule** or an endorsement (if any).

Psychiatrist

A medical practitioner who has a medical degree in psychiatric treatment, is legally registered with, authorised by or licensed by the relevant authority for the area they provide psychiatric treatment in, is working within the scope of their registration, licence or authorisation, and is not:

- **you** or the **insured**;
- **your** or the **insured's** husband, wife, unmarried partner, father, mother, brother, sister, or biological or legally adopted child, or a child **you** or the **insured** is legally responsible for; or
- any other person related to **you** or the **insured** in any way, including by marriage or adoption.

Public hospital

A Singapore government **hospital** or Singapore government medical institution which is approved by **MOH** under the MediShield Life Scheme Act 2015.

Reasonable and customary

A charge is reasonable and customary if it:

- is charged for medical treatment, supplies or services that are **medically necessary** to treat an **illness** or **injury** in a way that is in line with acceptable standards of good medical practice;
- does not include fees or charges that would not have been made if no insurance had existed; and
- is not (in **our** opinion or the opinion of **our** medical advisor) more than:
 - the usual level of charges for similar medical treatment, supplies or services in Singapore;
 - the relevant fee benchmark (recommended charge for doctors and hospital fees in the private sector) published by the Singapore Government, **MOH**, or official bodies such as the Health Sciences Authority and the Allied Health Professions Council; or
 - **our** limits for similar diagnoses or procedures.

Reinstatement date

The date **your policy** was reinstated, as shown in an endorsement.

Specialist

A **physician** who has been accredited as a medical specialist by the Specialist Accreditation Board, is registered as a specialist with the Singapore Medical Council (or, for a specialist outside Singapore, registered with the relevant specialist board and medical councils), and is not:

- **you** or the **insured**;
- **your** or the **insured's** husband, wife, unmarried partner, father, mother, brother, sister, or biological or legally adopted child, or a child **you** or the **insured** is legally responsible for; or
- any other person related to **you** or the **insured** in any way, including by marriage or adoption.

Standard room

A room equipped to the minimum standard, with:

- a suitable bed, mattress, pillow, chair and locker;
- screens around the bed;
- adequate lighting and ventilation;
- an effective nurse-call system; and
- adequate toilet facilities and washbasin.

This does not include deluxe rooms, luxury suites, superior rooms, super rooms and other special rooms that may also be available at a **hospital** (or at a **community hospital**, for the purposes of community hospital charges benefit).

For a single room in a private **hospital**, **we** will only pay up to the room and board rates charged for a standard single room.

Stereotactic radiosurgery

Non-surgical radiotherapy used to treat abnormalities and small tumours of the brain. It delivers precisely targeted radiation in fewer high-dose treatments than traditional radiotherapy. The types of stereotactic radiosurgery covered are 'gamma knife' and 'novalis shaped beam'.

Surgical procedures

The types of surgical operations listed in table 1 to table 7 of the 'Table of Surgical Procedures' for **MediSave** and **MediShield Life** (see the **MOH** website (www.moh.gov.sg)).

We, us or our

AIA Singapore Private Limited (registration number 201106386R).

You or your

The policy owner named in **your policy schedule**.

Where appropriate, words that are singular also mean the plural.

Appendix 1 – Schedule of benefits

Part A – Hospitalisation and surgical benefits

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
(a) Daily room and board charges (or equivalent charges for inpatient care provided through Mobile Inpatient Care @ Home)	As charged	As charged	As charged
(b) Daily intensive care unit charges	As charged	As charged	As charged
(c) Community hospital charges	As charged	As charged	As charged
(d) Surgical charges <ul style="list-style-type: none"> • Surgical procedures • Surgical implants and approved medical consumables • Stereotactic radiosurgery 	As charged	As charged	As charged
(e) Organ transplant	As charged	As charged	As charged
(f) Stem cell transplant	As charged	As charged	As charged
(g) Hospice inpatient palliative care	As charged	As charged	As charged
(h) Continuation of autologous bone marrow transplant for multiple myeloma (available as an outpatient treatment)	As charged	As charged	As charged

Part B – Pre-hospitalisation benefit

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
	As charged	As charged	As charged

Part C – Post-hospitalisation benefits

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
(a) Post-hospitalisation treatment	As charged	As charged	As charged
(b) Extended post-hospitalisation treatment for 30 critical illnesses	As charged	As charged	As charged

Part D – Accidental inpatient dental treatment benefit

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
	As covered for benefits under part A (Hospitalisation and surgical benefits), part B (Pre-hospitalisation benefit) and part C (Post-hospitalisation benefits)		

Part E – Pregnancy complications benefit

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
	As covered for benefits under part A (Hospitalisation and surgical benefits), part B (Pre-hospitalisation benefit) and part C (Post-hospitalisation benefits)		

Part F – Congenital abnormalities benefits

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
(a) Congenital abnormalities of the insured's biological child	Up to S\$20,000 per lifetime and S\$5,000 per child	Up to S\$16,000 per lifetime and S\$4,000 per child	Up to S\$12,000 per lifetime and S\$3,000 per child
(b) Congenital abnormalities of the insured	As covered for benefits under part A (Hospitalisation and surgical benefits), part B (Pre-hospitalisation benefit) and part C (Post-hospitalisation benefits)		

Part G – Living donor organ transplant benefits

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
(a) Insured (as a living donor) donating an organ	S\$60,000 per organ transplant	S\$40,000 per organ transplant	S\$20,000 per organ transplant
(b) Non-insured (as a living donor) donating an organ to the insured	S\$60,000 per organ transplant	S\$40,000 per organ transplant	S\$20,000 per organ transplant

Part H – Medical treatment outside Singapore benefits

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
(a) Emergency medical treatment outside Singapore	As covered for benefits under part A (Hospitalisation and surgical benefits) and part C (Post-hospitalisation benefits)		
(b) Planned medical treatment outside Singapore	As covered for benefits under part A (Hospitalisation and surgical benefits), part B (Pre-hospitalisation benefit) and part C (Post-hospitalisation benefits)		Not covered

Part I – Psychiatric treatment benefits

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
(a) In-hospital psychiatric treatment	S\$5,000 per policy year	S\$4,000 per policy year	S\$3,500 per policy year
(b) Post-hospitalisation psychiatric treatment	S\$5,000 per policy year	S\$2,500 per policy year	S\$1,000 per policy year

**Part J – Outpatient benefits
(No deductible, but co-insurance applies)**

Limits of compensation (Figures include GST.)					
Plan type	A	B		B Lite	
Type of hospital	Private or public hospital	Private hospital	Public hospital	Public hospital	
Radiotherapy for cancer	As charged	S\$500 per treatment session (see note 1 below)	As charged	As charged	
Stereotactic radiotherapy for cancer	As charged	S\$4,000 per treatment session (see note 1 below)	As charged	As charged	
Patients receiving treatment for one primary cancer					
Cancer drug treatments on the Cancer Drug List	5 x the 'MediShield Life limit per month' for one primary cancer per month (see note 2 below)	5 x the 'MediShield Life limit per month' for one primary cancer per month (see note 2 below)		5 x the 'MediShield Life limit per month' for one primary cancer per month (see note 2 below)	
	Patients receiving treatment for multiple primary cancers				
	The total of the highest limits from among the covered CDL treatments for each primary cancer in that month (see note 2 below)	The total of the highest limits from among the covered CDL treatments for each primary cancer in that month (see note 2 below)		The total of the highest limits from among the covered CDL treatments for each primary cancer in that month (see note 2 below)	
Cancer drug services	Patients receiving treatment for one primary cancer				
	5 x the 'MediShield Life limit for cancer drug services' for one primary cancer per policy year (see note 3 below)	5 x the 'MediShield Life limit for cancer drug services' for one primary cancer per policy year (see note 3 below)		5 x the 'MediShield Life limit for cancer drug services' for one primary cancer per policy year (see note 3 below)	

**Part J – Outpatient benefits
(No deductible, but co-insurance applies)**

Limits of compensation (Figures include GST.)				
Plan type	A	B		B Lite
Type of hospital	Private or public hospital	Private hospital	Public hospital	Public hospital
	Patients receiving treatment for multiple primary cancers			
	5 x the 'MediShield Life limit for cancer drug services' for multiple primary cancers per policy year (see note 3 below)	5 x the 'MediShield Life limit for cancer drug services' for multiple primary cancers per policy year (see note 3 below)		5 x the 'MediShield Life limit for cancer drug services' for multiple primary cancers per policy year (see note 3 below)
Kidney dialysis	As charged	S\$36,000 per policy year (see note 1 below)	As charged	As charged
Erythropoietin	As charged	S\$7,200 per policy year (see note 1 below)	As charged	As charged
Approved immunosuppressant	As charged	S\$7,200 per policy year (see note 1 below)	As charged	As charged
Long-term parenteral nutrition	As charged	As charged		As charged

**Part K – Final expense benefit
(No deductible or co-insurance applies.)**

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
	S\$5,000	S\$3,500	S\$2,500

**Part L – Waiver of one year's premium benefit (upon total and permanent disability)
(No deductible or co-insurance applies.)**

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
	One year's premium (12 months' premiums)		

Part M – Extra cover for 30 critical illnesses benefit

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
Additional limit per policy year	S\$100,000	S\$75,000	S\$50,000
Additional limit per lifetime	Unlimited	Unlimited	Unlimited

Part N – Cell, tissue and gene therapy benefit

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
Kymriah	S\$250,000 per treatment per indication per lifetime (see note 5 below)	S\$250,000 per treatment per indication per lifetime (see note 5 below)	S\$250,000 per treatment per indication per lifetime (see note 5 below)
Yescarta	S\$250,000 per treatment per indication per lifetime (see note 5 below)	S\$250,000 per treatment per indication per lifetime (see note 5 below)	S\$250,000 per treatment per indication per lifetime (see note 5 below)

Part O – Proton beam therapy benefit

Limits of compensation (Figures include GST.)			
Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
	S\$100,000 per policy year	S\$100,000 per policy year	S\$100,000 per policy year

Part P – Outpatient and home-based treatments benefit**Limits of compensation**
(Figures include GST.)

Plan type	A	B	B Lite
Room or ward entitlement	Standard room (or lower) in a private hospital	A-class ward (or lower) in a public hospital	B1-class ward (or lower) in a public hospital
Home ventilation and respiratory support service (HVRSS)	S\$1,680 per month	S\$1,680 per month	S\$1,680 per month
Negative pressure wound therapy (NPWT)	S\$120 per day	S\$120 per day	S\$120 per day
Repetitive transcranial magnetic stimulation (rTMS)	S\$240 per treatment session	S\$240 per treatment session	S\$240 per treatment session
Pasteurised donated human milk (PDHM)	S\$85 per day	S\$85 per day	S\$85 per day
Hyperbaric oxygen therapy (HBOT)	S\$780 per treatment session	S\$780 per treatment session	S\$780 per treatment session
Outpatient parenteral antibiotic therapy (OPAT)	S\$180 per day	S\$180 per day	S\$180 per day

Maximum claim limit			
Plan type	A	B	B Lite
Limit per policy year	S\$1,000,000, or S\$2,000,000 if hospitalised under an AIA preferred provider (see note 4 below)	S\$1,000,000, or S\$1,200,000 if hospitalised under an AIA preferred provider (see note 4 below)	S\$300,000
Limit per lifetime	Unlimited	Unlimited	Unlimited
Pro-ration factor			
Plan type	A	B	B Lite
Private hospital <ul style="list-style-type: none"> • Inpatient • Day surgery • Outpatient 	Does not apply Does not apply Does not apply	70% 70% 70%	50% 65% 65%
Public hospital <ul style="list-style-type: none"> • A-class ward • B1-class ward (for Singapore permanent resident) 	Does not apply Does not apply	Does not apply Does not apply	80% 90%
Deductible per policy year			
	Age 81 next birthday or younger		
<ul style="list-style-type: none"> • Inpatient <ul style="list-style-type: none"> ◦ C-class ward ◦ B2-class ward ◦ B1-class ward ◦ A-class ward ◦ Private hospital (except day surgery and short-stay ward) • Day surgery or short-stay ward 	S\$1,500 S\$2,000 S\$2,500 S\$3,500 S\$3,500	S\$1,500 S\$2,000 S\$2,500 S\$3,500 S\$3,500	S\$1,500 S\$2,000 S\$2,500 S\$3,500 S\$3,500
	Age 82 next birthday or older		
<ul style="list-style-type: none"> • Inpatient <ul style="list-style-type: none"> ◦ C-class ward ◦ B2-class ward ◦ B1-class ward ◦ A-class ward ◦ Private hospital (except day surgery and short-stay ward) • Day surgery or short-stay ward 	S\$1,500 S\$2,250 S\$3,000 S\$4,500 S\$4,500	S\$1,500 S\$2,250 S\$3,000 S\$4,500 S\$4,500	S\$1,500 S\$2,250 S\$3,000 S\$4,500 S\$4,500
Co-insurance			
	10%	10%	10%
Maximum period of cover			
	Lifetime	Lifetime	Lifetime

Notes**Note 1**

If the **eligible expenses** arise in a private **hospital** or a private medical institution, the following will apply.

(a) For the eligible expenses up to or equal to the **limits of compensation**:

- **we** will not apply a **pro-ration factor**; and
- **we** will pay the **eligible expense** less the **co-insurance**.

(b) For the amount of **eligible expenses** over the **limits of compensation**:

- **we** will reduce the **eligible expenses** by multiplying them by the **pro-ration factor**; and
- **we** will take the **co-insurance** off the reduced amount.

Note 2

The latest **MediShield Life** limit per month is shown in the **Cancer Drug List**, under 'MediShield Life Claim Limit per month', on the **MOH** website (<https://go.gov.sg/moh-cancerdruglist>).

MOH may update the list from time to time. The latest limit will apply to cancer drug treatments received on and from the date the list was updated.

Note 3

For the latest **MediShield Life** limit for **cancer drug services**, check 'Cancer Drug Services' under '**MediShield Life** Benefit' on the **MOH** website (<https://go.gov.sg/mshlbenefits>).

MOH may update this from time to time. The latest limit will apply to cancer drug services received within the policy year during which the list was updated.

Note 4

All **hospitalisation** and outpatient treatments (covered under parts J, N, O or P) must be provided by, or under, an **AIA preferred provider** within the same **policy year**. When there is more than one **physician** treating the **insured** for the same **hospitalisation**, the main treating **physician** must be an **AIA preferred provider**.

Note 5

Subject to the indication requirements as listed within the **Cell, Tissue and Gene Therapy Product List**.

Appendix 2 – List of clinical situations

The list of clinical situations referred to in the benefit conditions is as follows.

- Ptosis surgery
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Pasturised donated human milk (PDHM)
- Hyperbaric oxygen therapy (HBOT)
- Outpatient parenteral antibiotic therapy (OPAT)

Details of the additional criteria that apply to the clinical situations above are on **our** website at www.aia.com.sg/clinical-situations.

SAMPLE

Appendix 3 – Definitions of 30 critical illnesses

1. Heart attack of specified severity

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

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

For the above definition, the following are excluded:

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

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

2. Stroke

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

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

The following are excluded:

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

Permanent means expected to last throughout the lifetime of the **insured**.

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

3. Coronary artery bypass surgery

The actual undergoing of open-chest surgery or minimally invasive direct coronary artery by-pass surgery to correct the narrowing or blockage of one (1) or more coronary arteries with bypass grafts. This **diagnosis** must be supported by angiographic evidence of significant coronary artery obstruction and the procedure must be considered **medically necessary** by a consultant cardiologist.

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

4. HIV due to blood transfusion, or occupationally acquired HIV

- (a) Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:
- The blood transfusion was **medically necessary** or given as part of a medical treatment;
 - The blood transfusion was received in Singapore after the **policy date**, endorsement date or **reinstatement date** of this **policy**, whichever is the later;
 - The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood; and
 - The **insured** does not suffer from thalassaemia major or haemophilia.
- (b) Infection with the Human Immunodeficiency Virus (HIV) which resulted from an **accident** occurring after the **policy date**, endorsement date or **reinstatement date** of this **policy**, whichever is the later whilst the **insured** was carrying out the normal professional duties of his or her occupation in Singapore, provided that all of the following are proven to **our** satisfaction:
- Proof of the **accident** giving rise to the infection must be reported to us within 30 days of the **accident** taking place;
 - Proof that the **accident** involved a definite source of the HIV infected fluids;
 - Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented **accident**. This proof must include a negative HIV antibody test conducted within five (5) days of the **accident**; and
 - HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

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

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

5. Angioplasty or other invasive treatment for coronary artery

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

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. The branches of above coronary arteries are excluded.

Diagnostic angiography is excluded.

6. Major cancers

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

The term malignant tumour includes leukemia, lymphoma and sarcoma.

For the above definition, the following are excluded:

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

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

7. Fulminant hepatitis

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

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

8. Primary pulmonary hypertension

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

Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea or anginal pain.

Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.

Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.

Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

9. Kidney failure

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

10. Major organ transplant or bone marrow transplant

The receipt of a transplant of:

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

Other stem cell transplants are excluded.

11. Multiple sclerosis

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

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

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

12. Blindness (loss of sight)

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

13. Paralysis (loss of use of limbs)

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

Self-inflicted injuries are excluded.

14. Muscular dystrophy

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

Activities of Daily Living:

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

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

15. Alzheimer's disease or severe dementia

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

The following are excluded:

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

16. Coma

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

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

Coma resulting directly from alcohol or drug abuse is excluded.

17. Deafness (loss of hearing)

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

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

18. Heart valve surgery

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

19. Loss of speech

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

All psychiatric related causes are excluded.

20. Major burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the **insured's** body.

21. Surgery to aorta

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

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

22. Terminal illness

The conclusive **diagnosis** of an **illness** that is expected to result in the death of the **insured** within 12 months. This **diagnosis** must be supported by a **specialist** and confirmed by **our** appointed **physician**.

Terminal illness in the presence of HIV infection is excluded.

23. End-stage lung disease

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

- (a) FEV₁ test results which are consistently less than one (1) litre;
- (b) Permanent supplementary oxygen therapy for hypoxemia;
- (c) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO₂ = 55mmHg); and
- (d) Dyspnea at rest.

The **diagnosis** must be confirmed by a respiratory **physician** or **specialist**.

24. End-stage liver failure

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

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

Liver disease secondary to alcohol or drug abuse is excluded.

25. Motor neurone disease

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

26. Parkinson's disease

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

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

Activities of Daily Living:

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

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

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

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

27. Aplastic anaemia

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

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

The **diagnosis** must be confirmed by a haematologist.

28. Benign brain tumour

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

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

The following are excluded:

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

29. Bacterial meningitis

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

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

Bacterial meningitis in the presence of HIV infection is excluded.

30. Viral encephalitis

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

Encephalitis caused by HIV infection is excluded.