SPGI – Singapore FAQs for 2025

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GROUP MEDICAL INSURANCE

1. **Q: What is Medical Insurance?**
   A: Medical Insurance covers medically necessary treatment which includes doctor's consult fees, medications and diagnostic tests prescribed by a doctor related to Inpatient, Day-care, Outpatient, Dental and Maternity.

2. **Q: What are the Core Benefits under Medical Insurance?**
   A: Core benefit under Medical Insurance includes benefits such as inpatient, outpatient, maternity, dental, wellness and repatriation subject to a maximum annual overall limit of SGD500,000 per member per policy year.

3. **Q: What are the Voluntary options available under the Medical Insurance Plan?**
   A: The voluntary option under Medical Insurance includes the same plan benefits as per Core with higher plan benefits on some benefits and a higher maximum annual overall limit of SGD1,000,000 per member per policy year.

4. **Q: Who is the service provider for Medical Insurance Policy?**
   A: The service provider for Medical Insurance for insurance period from 1 March 2025 to 28 Feb 2026 is Allianz Global Corporate & Specialty SE Singapore Branch.

5. **Q: How does the new 10% co-payment work for inpatient benefits and when it is implemented?**
   A: The 10% co-payment applies to the inpatient and day-care treatment incurred at the 4 high-cost medical providers listed below with effect from 1 March 2025.
   - Gleneagles Hospital
   - Mount Elizabeth Hospital
   - Mount Elizabeth Novena Hospital
   - Parkway East Hospital

6. **Q: In case of a subsequent follow-up visits post inpatient treatments, would I be subject to 10% co-payment?**
   A: 10% co-payment shall apply to post hospitalization, rehabilitation and other outpatient benefits listed under the inpatient plan following an admission or day care treatment at one of the listed high-cost providers.

7. **Q: I have been seeing a specialist under one of the high-cost medical providers and I'm suggested to do a surgery, will subsequent visits to that specialist be subjected to 10% co-payment?**
   A: Yes, 10% co-payment shall apply to post hospitalization, rehabilitation and other outpatient benefits listed under the inpatient plan following an admission or day care treatment at one of the listed high-cost providers.

8. **Q: What is OPD and what are the coverages under OPD Plan?**
   A: Please refer to your Table of Benefits (TOB) on the coverage, an excerpt is provided as below:

Out-patient Plan benefits
Pre-hospitalisation tests (covered when they are needed in the 72 hours before in-patient or day-care treatment)
Video consultation services
Medical practitioner fees
Prescribed drugs and dressings
Specialist fees
Diagnostic tests
MRI scans
Emergency out-patient treatment
PET and CT-PET scans[2]
CT scans
Oncology[2] (out-patient treatment only)
Kidney dialysis[2] (out-patient treatment only)
Post-hospitalisation physiotherapy (covered when required in the 90 days following in-patient or day-care discharge)
Prescribed physiotherapy (referral from doctor required) (initially limited to 12 sessions per condition)
Prescribed speech therapy[2]
Chiropractic treatment, osteopathy, and podiatry (max. 12 sessions per condition for chiropractic treatment and max. 12 sessions per condition for osteopathic treatment, subject to the benefit limit)
Homeopathy, Chinese herbal medicine and acupuncture
Prescribed medical aids
Psychiatry and psychotherapy (referral from doctor required for psychotherapy and initially limited to 10 sessions per condition)

9. Q: What are the *Exclusions* under the Health Plan?

A: Please refer to your Employee Benefits Guide (EBG) for the full list of exclusions.

10. Q: What is In-patient and what are the coverages under IPD Plan?

A: Please refer to your Table of Benefits (TOB) on the inpatient plan benefits, excerpt is provided as below

Co-payment on Premium Private Providers	10%
In-patient benefits[1]	
Hospital accommodation[1]	Private room
Intensive care[1]	Full refund
Prescribed drugs and materials[1] (in-patient and day-care treatment only)	Full refund
Surgical fees, including anaesthesia and theatre charges[1]	Full refund
Physician and therapist fees[1] (in-patient and day-care treatment only)	Full refund
Surgical appliances and materials[1]	SGD 10,000
Diagnostic tests[1] (in-patient and day-care treatment only)	Full refund
Organ transplant[1] (in-patient treatment only)	SGD50,000
Psychiatry and psychotherapy[1] (in-patient and day-care treatment only)	SGD10,000
Accommodation costs for one parent staying in hospital with an insured child under 18[1]	Full refund
CT and MRI scans[1] (in-patient and day-care treatment only)	Full refund
PET and CT-PET scans[1] (in-patient and day-care treatment only)	Full refund
Emergency in-patient dental treatment	Full refund
Other benefits - please refer to notes for more information on Treatment Guarantee	
Day-care treatment[2]	Full refund
Kidney dialysis[2] (in-patient and day-care treatment only)	Full refund
Out-patient surgery[2]	Full refund
Nursing at home or in a convalescent home[2] (immediately after or instead of hospitalisation)	Full refund up to max 180 days
Rehabilitation treatment[2] (in-patient, day-care and out-patient treatment; must commence within 14 days of discharge after the acute medical and/or surgical treatment ceases) (covered only if you've received in-patient treatment for three or more consecutive days/nights for the same medical condition)	Max. 90 days per discharge
Local ambulance	Full refund
Post-hospitalisation treatment (covered when it is needed in the 100 days following discharge from in-patient or day-care treatment for the same acute medical condition)	Full refund

Emergency treatment outside area of cover (for trips of a maximum period of six weeks)	Full refund max. 30 days
Medical evacuation[2] (in the event of **emergency** treatment) · Where necessary treatment is not available locally, we will evacuate the insured person to the nearest appropriate medical centre[2] · Where ongoing treatment is required, we will cover hotel accommodation costs[2] · Evacuation in the event of unavailability of adequately screened blood[2] · If medical necessity prevents an immediate return trip following discharge from an in-patient episode of care, we will cover hotel accommodation costs[2]	Full refund max. 14 days
Expenses for one person accompanying an evacuated person[2]	Full refund
Repatriation of mortal remains or burial expenses[2]	Full refund
Oncology[2] (in-patient and day-care treatment only) • Purchase of a wig, prosthetic bra or other external prosthetic device for cosmetic purposes	Full refund SGD 350
In-patient cash benefit at Singapore Government Restructured Hospitals (per night)	SGD 175 max. 30 nights
Congenital conditions[2] (in-patient and day-care treatment only)	SGD5,000
Out-patient dental treatment (required as follow-up to an in-patient stay for accidental damage to natural teeth) (covered when required in the 90 days following discharge from in-patient treatment)	SGD2,000
Emergency out-patient dental treatment	SGD 2,000
Long term care[2] (in-patient, day-care and out-patient treatment)	Max. 90 days per lifetime
Additional Core Plan Services	
Employee Assistance Programme Offers access to a range of 24/7 multilingual support services as follows: • Confidential, professional counselling (in-person, phone and video) • Legal and financial support services • Wellness website access	Services available
Travel Security Services Offers 24/7 access to personal security information and advice for all your travel safety queries. This includes: • Emergency Security Assistance Hotline (not a free phone number) • Country intelligence and security advice • Daily security news updates and travel safety alerts	Services available
MyHealth Digital Services • Manage your cover online with our app or portal anytime, anywhere. • Submit and track progress of claims. • Access your policy documents, health services, payment details and more.	Services available
Olive Our Health & Wellness support program includes, for example: • Fitness app • Access to wellness resources	Services available
Second Medical Opinion Service Offers access to expert help on the best treatment options available if you have been diagnosed with a serious illness or had surgery recommended	Services available

11. Q: Does OPD cover routine diagnostics tests?

A: Routine diagnostics tests forms part of the Wellness plan benefits and includes screening for the early detection of illness or disease and cancer screening.

12. Q: How can we claim OPD/In-patient? Is it via re-imbursement or cashless process?

A: For inpatient and high-cost outpatient treatment, Treatment Guarantee (TG) /Pre-authorization facilities is available for cashless access, with added advantage of having your treatment pre-approved by Allianz team of medical professionals. Visits to panel outpatient GP/SP clinics are rendered cashless facility with the presentation of your Allianz membership card.

13. Q: What is the turnaround time of claims processing of inpatient and OPD claims?

A: Inpatient is 5 to 10 working days and Outpatient is 48 hours to 5 working days upon receipt of complete claims document.

14. **Q: Does OPD cover vaccination and testing equipment?**
    A: Vaccination is not covered under Outpatient benefit but Wellness benefit instead.
    Prescribed medical aids on any device that is prescribed and medically necessary to enable you to carry out everyday activities are covered under Outpatient benefit.
    Examples include:
    - Biochemical aids such as insulin pumps, glucose meters and peritoneal dialysis machines
    - Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses
    - Hearing and speaking aids such as an electronic larynx
    - Medically graduated compression stockings
    - Long-term wound aids such as dressings and stoma supplies

    Allianz does not cover costs for medical aids that form part of palliative care or long-term care.

15. **Q: Can a single member of the family utilize the total sum insured?**
    A: The Medical Insurance maximum annual overall limit of SGD500,000 (Core) or SGD1,000,000 (Voluntary) is on per insured member basis.

16. **Q: Which are the benefits subject to co-payment? Is it applicable to all insured members?**
    A: 10% co-payment applies to all colleagues and the enrolled dependents for inpatient admission or day care treatment at 4 high-cost medical providers listed above with effect from 1 March 2025.

    While a **20%** co-payment applies to all colleagues and the enrolled dependents to all under Dental treatment.

17. **Q: Does policy cover Lasik surgery?**
    A: No, this falls under the exclusions.

18. **Q: Does policy cover knee replacement surgeries?**
    A: Yes, under medically necessary surgeries, subject to benefits limits and policy terms and conditions.

19. **Q: Does pre-existing diseases covered for all the members who are enrolled in the policy?**
    A: Yes, pre-existing diseases are covered subject to the benefit limits and policy terms and conditions.

20. **Q: Are pre and post-natal expenses covered? If yes, is it covered under In-patient or OPD benefit?**
    A: Pre and Post natal expenses are covered under Maternity benefit up to the benefit limit and/or per pregnancy and applicable annual limits and terms and conditions.

21. **Q: Is pre and post-natal expenses covered in case of abortion/miscarriage due to medical reasons?**
    A: Yes, this is covered. However, please note that abortion/termination of pregnancy is excluded except where the life of the pregnant woman is in danger.

22. **Q: If the limit of the maternity benefit is exhausted, can I claim the medical expenses from OPD benefit?**
    A: No, maternity related expenses do not form part of the Outpatient benefits.

23. **Q: What is covered under Infertility benefit?**
    A: All invasive investigative procedures necessary to establish the cause of infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. It also covers treatment such as InVitro Fertilization (IVF), for diagnosed cases of infertility. The insurer will cover the cost of treatment for the insured member who receives it, up to the benefit limit indicated in the Table of Benefits. You can't claim under an insured spouse/partner's cover for costs that exceed your benefit limit.

24. **Q: Are pre and post hospitalization expenses covered under Infertility benefit?**
    A: Yes, if it's related to infertility treatment.

25. **Q: What is covered in Postnatal coverage for the Maternity coverage?**
    A: Routine post-partum medical care received up to the benefit limit per pregnancy, subject to policy terms and conditions.

26. **Q: I'm currently pregnant. Am I eligible to upgrade to a higher medical plan during annual enrolment period to be eligible for the higher Maternity benefit under the upgraded plan?**
    A: Yes. There is no waiting period imposed under the maternity cover of the Medical Insurance.

27. **Q: Is sleep apnea covered?**
    A: No, the current medical benefit does not cover treatment of sleep disorders, including insomnia, obstructive sleep apnea, narcolepsy, snoring and bruxism.

28. **Q: Are throat gargles for sore throat covered?**
    A: No. Commercial gargles or antiseptic mouthwashes are excluded as this helps to relieve the symptoms of sore throat but not medication to treat sore throat.

29. **Q: How do you define experimental?**
    A: Any form of treatment or drug therapy that in reasonable opinion is experimental or unproven, based on generally accepted medical practice is excluded. Experimental treatment is a course of treatment, procedure, device or other medical intervention that is not yet recognized by the professional medical community as an effective, safe and proven treatment for the condition for which it is being used.

30. **Q: Do our benefits cover Hormone Replacement Treatment (HRT)?**
    A: For the relief of symptoms resulting from the cessation of ovarian function, cover is provided for medical practitioner fees, specialists fees as well as prescription drug expenses.

31. **Q: Is there a cap of Accident & Emergency (A&E) visit?**
    A: This is covered up to annual benefit limit, subject to policy terms and conditions.

32. **Q: What about doctor-prescribed probiotics for digestion issues?**
    A: No, costs incurred as a result of nutritional or dietary consultations are excluded.

SUBSTANCES, PERSONAL PRODUCTS AND DIETARY SUPPLEMENTS

Substances, personal products and dietary supplements including vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes), mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, cosmetic products, sanitiser, gloves, masks, visors, thermometers, children's food, baby supplies and infant formula given orally. These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

33. **Q: Is body cream and moisturizer covered for eczema and itchy skin?**
    A: No, body cream and moisturizer are excluded as these helps to relieve the symptoms but not medication to treat the skin condition.

34. **Q: Is shingles vaccination covered for adults?**
    A: No. Only all basic immunizations and booster injections required by Law of Singapore in which they are administered are covered up to the benefit limit of Wellness Plan. Please refer to the link: https://www.moh.gov.sg/seeking-healthcare/overview-of-diseases/communicable-diseases/nationally-recommended-vaccines.

35. **Q: What is covered under Mental Health Care and who is eligible for this benefit?**
A: Treatment of mental, behavioral and personality disorders, including autism spectrum and eating disorder. Treatment must be carried out by a psychiatrist, clinical psychologist or licensed psychotherapist. The condition must be clinically significant and the treatment medically necessary.

All day-care or in-patient admissions must include prescription medication related to the condition.

Out-patient psychotherapy treatment (where covered) requires referral by a doctor and is limited to 10 sessions per condition initially. After every 10 sessions, a psychiatrist must review the treatment. If you need more sessions, you must send us a progress report that indicates the diagnosis and the medical necessity for further treatment.

Colleague and enrolled dependents are eligible for this benefit.

36. **Q: Is Outpatient physiotherapy covered? Is there a need for referral letter?**
A: Outpatient physiotherapy is covered for first 12 sessions with a referral letter. Please provide further progress report to Allianz for assessment if more sessions are needed. The benefit is extended under a combined limit up to maximum 20 sessions (with speech therapy, chiropractor, osteopathy and podiatry treatments) at SGD150 per visit. If the Colleague and enrolled dependents have an existing referral with validity within 6 months, he/she can use it for the first 12 sessions. After that, a new progress report is needed.

37. **Q: Is Rolfing covered?**
A: No, rolfing is not covered.

38. **Q: Is speech therapy covered?**
A: Yes, it is covered for first 12 sessions with a referral letter is required. It is a combined limit up to maximum 20 sessions (with chiropractor, osteopathy and podiatry treatments) at SGD150 per visit.

39. **Q: Where can I refer to the list of panel GP, Specialist and Dental clinics?**
A: Please refer to MyHeath under Allianz for the latest panel listing the full list of Allianz network.
Upon successful login to MyHealth, please click on “Provider Finder” and click on the provider type (AllianzCare or Fullerton).

40. **Q: What is the timeline for Guarantee of Payment (GOP)’s letter?**
A: For schedule treatment, please send the request to Allianz Helpdesk at least 5 working days before the date of treatment and 24 hours for urgent GOP.

41. **Q: How can I request a GOP letter from the new medical provider?**
A: For admission from 1 March 2025 onwards, please follow the steps:
- Download a Treatment Guarantee Form from our website: https://commercial.allianz.com/global-offices/singapore/partnership-allianz-care.html
- Complete the form and send it to us at least 5 working days before treatment.
- You can send it by email, fax or post to the address shown on the form.
- Allianz to contact the hospital to organise payment of your bill directly, where possible.

Note: If you intend to change your medical plan selection for PY2025-26, please hold on to any claims submission for reimbursement and Guarantee of Payment (GOP) requests from 1 March 2025 till welcome email with the new policy number is triggered by Allianz based on your new selected plan following the final selection data provided to Allianz. Otherwise, the effective date of your new selected plan will be 1 day after your claims incurred date instead of 1 March 2025.

42. **Q: Do I need a GP referral letter to make an appointment with a panel Specialist?**
A: Waiver of GP referral letter to visit a Specialist with exception to below:
- PET & CT-PET scans
- Prescribed physiotherapy
- Prescribed speech therapy

43. **Q: Is antiseptic lozenges prescribed by doctor covered? Why do panel clinics collect payment from me for prescribed antiseptic lozenges?**
    A: By exceptional request, Allianz has agreed to cover antiseptic lozenges on a pay and claim basis. Please submit your antiseptic lozenges expenses with a copy of the medical invoice via the Allianz portal for reimbursement.

    Please note that non-prescribed and non-antiseptic lozenges remain excluded under the policy.

44. **Q: My wife is more comfortable speaking to Korean doctors due to the language barrier. Could we claim reimbursement for travel and stay under any circumstance?**
    A: No, travel and accommodation expenses are excluded under the policy.

45. **Q: What is the medical claims submission timeline?**
    A: Member should submit their claim no later than 6 months after the date that the cover ended. After this time, Allianz is not obliged to admit the claim. For example, claims incurred on 1 March 2024, the employee is allowed to submit to Allianz for assessment within 6 months from current policy expiry date of 28 Feb 25.

MEDICAL ENROLMENT

1. **Q: How are we going to receive our new membership details and e-cards and when can we expect this to happen?**
   A: Welcome email with account creation details to MyHealth under Allianz will be sent from client.services.gmc@allianzworldwidecare.com to your corporate email address. Please contact Allianz Helpline: asia.helpline@e.allianz.com or 1800 670 9766 (from inside Singapore) if you require assistance.

2. **Q: How do I retrieve a copy of Employee Benefits Guide and Table of Benefits of my selected medical plan?**
   A: Please login to MyHealth and follow the below steps:
   - Go to "MyHealth" login page
   - Upon successful login goto "MyPolicy" tab.
   - Click on "View Policy" to see a summary of cover, including details of any dependants covered and the option to download insurance documents.
   - Within this section, you'll find your "Table of Benefits," which outlines all covered benefits and their limits and along with your "Benefit Guide," which includes detailed information on how to access your cover and all the available services to you, along with definitions and exclusions.

3. **Q: How long do I have to wait before my newly enrolled dependents are added to see their details in the insurance app/portal?**
   A: The annual enrolment period for PY2025/2026 is from 3 to 14 March 2025. The newly enrolled dependents during this enrolment window will only be reported to Allianz post annual enrolment. The insurer will update your new dependents, and trigger welcome email to your corporate email address within 18 days from the annual enrolment closure date.

4. **Q: Are dependents be automatically enrolled under the medical provider?**
   A: Existing dependents enrolled under Allianz for PY2024/2025 will be automatically enrolled under PY2025/2026.

5. **Q: How can new dependents be enrolled?**
   A: Please enroll your dependents via Darwin system. Your dependents data will be provided to Allianz after the end of the enrolment window. The processing time is within 18 days from the annual enrolment closure date during annual enrolment period and 5-7 working days for mid-year enrolment to trigger welcome email upon receipt of complete data.

5. **Q: Is baby covered in the policy from Day 1?**
   A: Newborn infants (including multiple birth babies, babies born by surrogacy, adopted and fostered children) will be accepted for cover from birth, if Allianz is notified within 4 weeks of the date of birth. No exceptions will be agreed beyond this.

6. **Q: Is mid-term enrollment of dependents allowed? If yes, in which all cases are allowed?**
   A: This is allowed if enrolment is within 30 days after any of the following life events only. No exceptions will be agreed beyond this.
   - date of employment with SPGI / IHSM for newly joined colleagues;
   - date of marriage;
   - date of birth of a newborn.

7. **Q: What is the Enrollment process for New Joiner?**
   A: Eligible colleagues and dependents will be given a 30 days of enrollment window (dates to be determined) or within 30 days after any of the following life events noted above.

   Notes on voluntary plan:
   - When the colleague enrolls to the top-up plan, all of his/her eligible dependents must be enrolled under the same plan with the colleague.

- When the colleague terminates his/her policy, all of his/her enrolled dependents will also be terminated on the same effective date.
- Termination mid-term during the policy year is not allowed unless due to divorce, death, non-compliant with age eligibility and criteria or termination of employment. Termination will apply to the entire family.
- The member is not allowed to re-enroll again in the future after she/he is terminated from the top-up plan, unless there is a change in the criteria of life events defined above.

8. **Q: What is the age limit for enrolling spouse/parents in the policy?**
   A: For spouse, the maximum entry age is 75 and no maximum renewable age. Parents are not eligible for the medical insurance.

9. **Q: In case a colleague fails/miss out to enroll themselves during the current Enrollment period, under which plan will they be added in the current Policy Period?**
   A: For existing colleague, he/she will be covered under the last selected medical plan of PY2024/2025. For new hires, he/she will be covered under the default Core medical plan if he/she misses the enrolment period.

10. **Q: If I had upgraded my core medical plan to a higher medical plan, will my dependents be enrolled under the same medical plan?**
    A: Yes, your dependents will be covered under the same medical plan as you.

11. **Q: My spouse/partner is working in the same company. How is our medical insurance arrangement and our eligible child(ren)?**
    A: For spouse/partner is working at S&P Global (including entities of S&P Group), Allianz would not allow duplication in coverage under the same employer (S&P Group). Spouse/partner to be insured as individual colleague and the eligible child(ren) are to be enrolled under only one of the colleagues. Please update in Darwin accordingly to ensure that the data is flow to Allianz for the insurance arrangement is accurate according to the terms and conditions noted above.

12. **Q: I'm making a change to my medical plan for PY2025/2026 during annual enrolment period, what do I need to take note of my claims submission from 1 March 2025 onwards?**
    A: For employees who intend to change their medical plan selection for PY2025/2026, please hold on to any claims submission for reimbursement and Guarantee of Payment (GOP) requests from 1 March 2025 till a welcome email with the new policy number is triggered by Allianz based on your new selected plan following the final selection data provided to Allianz.

13. **`Q: Where can I find the information on my medical plan?**
    A: You may refer to the membership pack in the welcome email triggered by Allianz to your corporate email address.

    If there is a change in your medical plan in PY2025/26, a welcome email with new policy number will be triggered to you by Allianz based on your new selected plan following the final selection data provided to Allianz by 20 March 25.

    Please contact Allianz Helpline: asia.helpline@e.allianz.com or 1800 670 9766 (from inside Singapore) if you require assistance.

GROUP PERSONAL ACCIDENT

1. **Q: What is Group Personal Accident plan?**
   A: Pays Sum Insured as per schedule of benefits against Death or Total Permanent Disablement (TPD) which was sudden and unforeseen identifiable event that happens unexpectedly and causes Bodily Injury to the colleague.

2. **Q: What are the voluntary options given under Group Personal Accident cover to the Colleagues?**
   A: The voluntary option is additional 12 times last drawn monthly salary.

3. **Q: What is Accidental Temporary Total Disablement, Accidental Permanent Total Disablement and Accidental Permanent Partial Disablement?**
   A: **Temporary Total Disablement** means disablement that results solely and independently of all other causes from Bodily Injury and which occurs within three hundred and sixty-five (365) consecutive days of the Accident in which Bodily Injury was sustained, and entirely disables and entirely prevents the Insured Person from attending to any portion of his ordinary business, profession or occupation for a continuous and uninterrupted period of time.

   Permanent Total Disablement means disablement that results solely and independently of all other causes from Bodily Injury, and which occurs within three hundred and sixty-five (365) consecutive days, will in all probability entirely prevent the Insured Person from engaging in employment of any and every kind for the remainder of his life and from which there is no hope of improvement.

   Temporary Partial Disablement means disablement that results solely and independently of all other causes from Bodily Injury, and which occurs within three hundred and sixty-five (365) consecutive days of the Accident in which Bodily Injury was sustained, and renders the Insured Person incapable of attending to a substantial portion of his ordinary business, profession or occupation for a continuous and uninterrupted period of time.

4. **Q: What is the coverage under Group Personal Accident?**
   A: The coverage is 36 times last drawn monthly salary against Death or Total Permanent Disablement (TPD) which was a sudden and unforeseen identifiable event that happens unexpectedly and causes Bodily Injury.

   Additional benefits include:
   - Funeral Expenses – Pays up to S$2,000
   - Child Education Fund – Pays up to S$5,000 per child
   - Accidental Death Benefit due to Natural Catastrophe – Pays up to 15% of Sum Insured up to S$75,000 per Insured Person whichever is lower
   - Accidental Hospital Recuperation Benefit (at least 24 hours as resident patient) – Pays up to S$250
   - Ambulance Costs – Pays up to S$500
   - Comatose State Benefit – Pays 10% of Sum Insured up to S$50,000 per Insured Person whichever is lower
   - HIV due to Blood Transfusion – Pays up to 10% of Sum Insured up to S$20,000 per Insured Person whichever is lower
   - Mobility Aid Extension – Pays up to 10% of Sum Insured up to S$20,000 per Insured Person whichever is lower
   - Major Head Trauma – Pays 10% of Sum Insured up to S$20,000 per Insured Person whichever is lower
   - Fractures (% depending on severity) – Pays up to S$5,000
   - Terrorism Benefit (additional payout) – Pays up to 15% of the capital sum insured or up to S$75,000 or its equivalent, whichever is lesser

- Accidental Death due to Common Carrier – Pays up to 10% of the capital sum insured or up to S$10,000 or its equivalent, whichever is lesser

5. **Q: How can I purchase the voluntary plan?**
   A: Please make your selection via Darwin during the enrolment window advised.

6. **Q: Any medical underwiring required for Group Personal Accident?**
   A: No, there is no medical underwriting.

7. **Q: I have salary change during mid-year of policy, is my sum assured change accordingly?**
   A: Yes, the insurer will consider mid-year salary changes to increase the sum assured, allowing the employee to claim up to the increased sum assured.

8. **Q: When can I make the claim in Group Personal Accident policy?**
   A: Written notice of potential claim must be given to Zurich within thirty (30) days after the date of the Accident causing an injury. Please contact your HR or Aon for assistance.

9. **Q: Will there be changes to colleague coverage for Group Personal Accident?**
   A: There is no change in the basis of cover and provider for PY2025/2026.

10. **Q: What are the exclusions?**
    A: This Policy does not cover death, disablement, injury, loss or expense, directly or indirectly, related to the following:
    - War, declared or undeclared, unless otherwise agreed and endorsed by the insurer; or
    - Engaging in duty with any armed force of any country or international authority (except peace time reservist training or operationally ready national service under Section 14 of Enlistment Act, Cap. 93 of the Republic of Singapore); or
    - Self-inflicted injury, suicide or any attempt thereat, whilst sane or insane, reckless misconduct or any illegal or criminal act committed by Insured Person(s); or
    - Professional competitive sports or racing on wheels.

GROUP TERM LIFE

1. **Q: What is Group Term Life insurance benefit plan?**
   A: Pays Sum Insured as per schedule of benefits against Death or Total Permanent Disablement (TPD) due to all causes.

2. **Q: What are the various coverages under Group Term Life Cover?**
   A: The cover includes
   - Death Benefit: Pays 100% sum assured
   - Total Permanent Disablement (TPD) Benefit
   - Terminal Illness: Pays 100% of sum assured if certified the probability of death within 12 months.
   - Extended Benefit period if the colleague's employment with policyholder is terminated on medical grounds, his cover will be extended for a period of 12 months from date of termination, subject to policy terms and conditions.

3. **Q: What is the default benefit under the Group Term Life Cover?**
   A: The default is 36 times last drawn monthly salary.

4. **Q: What are the voluntary options available under the Group Term Life cover?**
   A: The voluntary option is Additional 12 times last drawn monthly salary.

5. **Q: How can I purchase the voluntary plan?**
   A: Please make your selection via Darwin during the enrolment window advised.

6. **Q: I have received the medical underwriting requirements via email from HSBC Life. Why am I subject to medical underwriting?**
   A: Your Group Term Life benefit is subject to medical underwriting due to your age or entitled sum assured above the non-medical limit granted by the insurer:

Cover	Non-Medical Limit
GTL & GCI	S$1,610,000 up to age 65 (combined GTL and GCI)

   If you do not exceed the age or the sum assured, you will be covered at entitled sum assured without health declaration to the insurer. Otherwise, any sum assured from your last accepted sum assured above S$1.61 million (GTL + GCI combined) will only be accepted upon successful underwriting.

   If you do not fulfil the medical underwriting requirements, you will only be covered at the last accepted sum assured or Non-Medical Limit, whichever is lower.

7. **Q: What are the some of the medical underwriting requirements required from the insurer?**
   A: Medical underwriting requirements are dependent on the sum assured and age of the insured employee. Some of the requirements include completion of health declaration form, undergo medical examination at panel clinic, completion of health questionnaire pertaining of a specific medical condition etc.

8. **Q: What is the timeline to complete the medical requirements as requested by the insurer?**
   A: The timeline is indicated in the medical underwriting letter by the insurer. If you wish to extend the timeline, please email to cc.h@mail.life.hsbc.com.sg

9. **Q: I have query on my medical underwriting requirements or underwriting decision. What is the contact point?**
   A: Please send the completed underwriting request to HSBC Employee Benefits Underwriting Department at eb.uw@mail.life.hsbc.com.sg

   If you have any questions regarding underwriting matters, please contact :
   HSBC Employee Benefits Department
   Email : cc.h@mail.life.hsbc.com.sg
   Tel : +65 6880 4888 (HSBC Customer Care Officers)

   If you do not complete or fulfil the medical underwriting requirements, you will only be covered at the last accepted sum assured or Non-Medical Limit, whichever is lower.

10. **Q: I was asked to provide additional medical information from a specialist at my own cost. Why this is at my own expense?**
    A: The insurer will bear the costs for the initial medical underwriting requirement sent to you e.g. attend medical examination at the insurer's panel clinics.

    It is the duty of the employee to submit the medical information as proof of insurability for a higher coverage/sum assured. Thus, any additional medical expenses to provide the proof to the insurer will be at the cost of the insured employee.

    If you do not complete or fulfil the medical underwriting requirements, you will only be covered at the last accepted sum assured or Non-Medical Limit, whichever is lower.

11. **Q: I have salary change during mid-year of policy, is my sum assured change accordingly?**
    A: Yes, the insurer will consider mid-year salary changes to increase the sum assured, allowing the employee to claim up to the increased sum assured subject to completion of any medical underwriting guidelines and requirements of HSBC Life if sum assured or age is above GTL's Non-Medical Limit.

    Please note that notification on salary changes to be provided by S&P Group to the insurer. The insurer will take about 7 working days to update upon receipt of data, and the medical underwriting letter will be auto triggered from the insurer's system to you.

12. **Q: How can I claim for this plan?**
    A: For death, written notice and proof of the claim must be given to HSBC Life immediately.

    For Total and Permanent Disability or has been diagnosed with a Terminal Illness, written notice and proof of the claim must be given to us within thirty (30) days from the date:
    • the Total and Permanent Disability is certified and confirmed by a Physician; or
    • the date of diagnosis of the Terminal Illness, whichever is applicable.

13. **Q: Will there be changes to colleague coverage for Group Term Life?**
    A: There is no change in the basis of cover and provider for PY2025/2026.

GROUP CRITICAL ILLNESS

1. **Q: What is Group Critical Illness benefit plan?**
   A: Benefit will be payable if a colleague is diagnosed with one of the 37 critical illnesses as per the insurer's definitions. The GTL Sum Insured will be reduced by the amount of the advance payment made under this policy.

   Note: This benefit is payable only once, even if more than one critical illness is diagnosed.

2. **Q: What are the various coverages under Group Critical Illness Cover?**
   A: 37 covered critical illnesses:

1. Major Cancer *	20. Fulminant Hepatitis
2. Heart Attack of Specified Severity *	21. Motor Neurone Disease
3. Stroke with Permanent Neurological Deficit	22. Primary Pulmonary Hypertension
4. Coronary Artery By-pass Surgery *	23. HIV Due to Blood Transfusion and Occupationally Acquired HIV
5. End Stage Kidney Failure	24. Benign Brain Tumour
6. Irreversible Aplastic Anaemia	25. Severe Encephalitis
7. End Stage Lung Disease	26. Severe Bacterial Meningitis
8. End Stage Liver Failure	27. Angioplasty & Other Invasive Treatment for Coronary Artery *
9. Coma	28. Blindness (Irreversible Loss of Sight)
10. Deafness (Irreversible Loss of Hearing)	29. Major Head Trauma
11. Open Chest Heart Valve Surgery	30. Paralysis (Irreversible Loss of Use of Limbs)
12. Irreversible Loss of Speech	31. Terminal Illness
13. Major Burns	32. Progressive Scleroderma
14. Major Organ / Bone Marrow Transplantation	33. Persistent Vegetative State (Apallic Syndrome)
15. Multiple Sclerosis	34. Systemic Lupus Erythematosus with Lupus Nephritis
16. Muscular Dystrophy	35. Other Serious Coronary Artery Disease *
17. Idiopathic Parkinson's Disease	36. Poliomyelitis
18. Open Chest Surgery to Aorta	37. Loss of Independent Existence
19. Alzheimer's Disease / Severe Dementia	

   The Life Insurance Associate Singapore (LIA) has standard definition for 37 sever-stage Critical Illnesses (Version 2019). You may refer to www.lia.org.sg for the standard definitions.

   * Note: 90 days waiting period applies to Heart Attack of Specified Severity, Major Cancer, Coronary Artery By-pass Surgery, Angioplasty and Other Invasive Treatment for Coronary Artery and Other Serious Coronary Artery Disease.

3. **Q: What is the default benefit under the Group Critical Illness cover?**
   A: The default benefit is 18 times last drawn monthly salary.

4. **Q: Is there a voluntary option available under the Group Critical Illness cover?**
   A: No, there is no voluntary option available.

5. **Q: Are pre-existing diseases covered for Group Critical Illness cover?**
   A: No, pre-existing condition(s) which have existed at any time prior to the commencement or reinstatement of insurance coverage whether known or unknown to the colleague in so far as the cause and pathology of the conditions have already existed is excluded.

6. **Q: What is waiting period?**
   A: 90 days waiting period applies to Heart Attack of Specified Severity, Major Cancer, Coronary Artery By-pass Surgery, Angioplasty and Other Invasive Treatment for Coronary Artery and Other Serious Coronary Artery Disease.

7. **Q: Is there any prior medical test required to avail this benefit?**
   A: Medical underwriting is required if your GTL and GCI (Combined sum assured) is above S$1,610,000 or age above 65 next birthday.

   For claims submission, you would require your attending doctor to complete the Group Critical Illness cover claim form. Any cost involved is borne by you.

8. **Q: I have received the medical underwriting requirements via email from HSBC Life. Why am I subject to medical underwriting?**
   A: Your Group Critical Illness benefit is subject to medical underwriting due to your age or entitled sum assured above the non-medical limit granted by the insurer:

Cover	Non-Medical Limit
GTL & GCI	S$1,610,000 up to age 65 (combined GTL and GCI)

   If you do not exceed the age or the sum assured, you will be covered at entitled sum assured without health declaration to the insurer. Otherwise, any sum assured from your last accepted sum assured above S$1.61 million (GTL + GCI combined) will only be accepted upon successful underwriting.

   If you do not fulfil the medical underwriting requirements, you will only be covered at the last accepted sum assured or Non-Medical Limit, whichever is lower.

9. **Q: How can I claim for this plan?**
   A: Written notice of potential claim must be given to HSBC Life within thirty (90) days from the date of diagnosis of the Critical Illness by a Physician. The diagnosis of the Critical Illness must be supported by acceptable clinical, radiological, histological and laboratory evidence. Please contact your HR or Aon for assistance.

10. **Q: Will there be changes to colleague coverage for Group Critical Illness?**
    A: There is no change in the basis of cover and provider for PY2025/2026.

11. **Q: What are the exclusions?**
    A: No Benefit will be payable regardless of whether the Insured Member is accepted within the Free Cover Limit or under other terms of acceptance in writing for any critical illness caused directly or indirectly, wholly or partly, by any one of the following occurrences:

    - Pre-existing Condition(s) which have existed at any time prior to the commencement or reinstatement of insurance coverage whether known or unknown to the Policyholder and/or Insured Member in so far as the cause and pathology of the conditions have already existed;
    - Suicide, attempted suicide or self-inflicted injuries, regardless of the Insured Member's mental condition;
    - Under the influence of narcotics or drugs which are not prescribed by a Physician.
    - Acquired Immune Deficiency Syndrome (AIDS), or any AIDS-related condition or infection by any Human Immunodeficiency Virus (HIV),
    - Participation in a riot or civil commotion, violation or attempted violation of law, or resistance to lawful arrest or imprisonment.
    - Engaging in or taking part in acts of terrorism, nuclear contamination, biological contamination or chemical contamination.
    - Engaging or taking part in war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons, or any event similar to the one listed.

GROUP DISABILITY INCOME

1. **Q: What is Group Disability Income insurance benefit plan?**
   A: Pays Sum Insured as per schedule of benefits against Total and complete incapacity of a colleague, as a result of injury or sickness to engage in his own occupation or any other occupation for which he is suited by reason of training, education or experience and is not following any other occupation.

2. **Q: What is the default benefit under the Group Disability Income cover?**
   A: The default is 60% of the Insured's annual salary subject to the maximum amount of S$250,000. Benefit period is 5 years with deferred period of 6 months. Coverage up to age 70.

3. **Q: Is there a voluntary option available under the Group Disability Income cover?**
   A: No, there is no voluntary option available.

4. **Q: I have received the medical underwriting requirements via email from HSBC Life. Why am I subject to medical underwriting?**
   A: Your Group Disability Income benefit is subject to medical underwriting due to your age or entitled sum assured above the non-medical limit granted by the insurer:

Cover	Non-Medical Limit
GDI	S$120,750 up to age 60

   If you do not exceed the age or the sum assured, you will be covered at entitled sum assured without health declaration to the insurer. Otherwise, any sum assured from your last accepted sum assured above S$120,750 will only be accepted upon successful underwriting.

   If you do not fulfil the medical underwriting requirements, you will only be covered at the last accepted sum assured or Non-Medical Limit, whichever is lower.

5. **Q: How can I claim for this plan?**
   A: Written notice and proof of the claim must be given to HSBC Life within thirty (30) days from the date which the Disability is certified and confirmed by a Physician. Please contact your HR or Aon for assistance.

6. **Q: Will there be changes to colleague coverage for Group Disability Income cover?**
   A: There is no change in the basis of cover and provider for PY2025/2026.

7. **Q: What are the exclusions?**
   A: The Benefits will not be paid if the Insured Member's Disability was in any way caused or contributed by:
   - Pregnancy, childbirth, abortion, miscarriage, infertility, pre and post-natal care and all complications arising therefrom; birth control measures, assisted reproduction, sterilisation (or its reversal) or any events arising out of or in connection thereto;
   - Acquired Immune Deficiency Syndrome (AIDS), or any AIDS-related condition or infection by any Human Immunodeficiency Virus (HIV) except where it is occupationally acquired or through blood transfusion;
   - The influence of alcohol, narcotics or drugs unless administered by a Physician;
   - Suicide, attempted suicide or self-inflicted injuries, regardless of the Insured Member's mental condition;
   - Any consequence (whether direct or indirect) of war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons, or any event similar to one of those listed;

- Pre-existing Condition(s) which have existed at any time prior to the commencement or reinstatement of insurance coverage whether known or unknown to the Policyholder and/or Insured Member in so far as the cause and pathology of the conditions have already existed;
- Air travel, other than as a fare-paying passenger on a licensed commercial aircraft.

CONTACT POINTS

1. Q: Who can I contact if I have further questions?

A:

For general queries, Guarantee of Payment and claims with effect from 1 March 204 onwards	**Allianz** • Membership packs. Addition/Deletions of members / welcome emails/ e-card: Group.admin@allianzworldwidecare.com • For members 24/7 hotline, Guarantee of Payment, any enquiries related to their policy (member portal, benefits, network etc): 1800 670 9766 (inside Singapore) +60 (0)3 92127818 (outside Singapore) asia.helpline@e.allianz.com
For Risk benefits related queries	• **Risk Claims:** Syed Qabir Jaffar syed.qabir.jaffar@aon.com / +65 6239 8742 • **Medical Underwriting:** cc.h@mail.life.hsbc.com.sg / +65 6880 4888
General queries on flex enrolment and use of portal	(65) 6383 1700 or email SPGIflex@mercermarshbenefits.com from Mondays to Fridays, 8.30 am to 6.00 pm (Closed on Singapore Public Holidays)

MEDICAL INSUARNCE – EXCLUSIONS

Although we cover most medically necessary treatment, we do not cover the following expenses unless indicated otherwise in the Table of Benefits or in any written policy endorsement.

ACQUISITION OF AN ORGAN
Expenses for the acquisition of an organ such as, but not limited to donor search, typing, harvesting, transport and administration costs.

CHEMICAL CONTAMINATION AND RADIOACTIVITY
Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material, including the combustion of nuclear fuel.

COMPLEMENTARY TREATMENT
Complementary treatment, with the exception of those treatments shown in the Table of Benefits.

COMPLICATIONS CAUSED BY CONDITIONS NOT COVERED UNDER YOUR PLAN
Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

CONSULTATIONS PERFORMED BY YOU OR A FAMILY MEMBER
Consultations performed and any drugs or treatments prescribed by you, your spouse, parents or children.

COSMETIC TREATMENT
Any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. This includes treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes. The following exceptions apply:
• Reconstructive surgery necessary to restore function or appearance after a disfiguring accident or as a result of surgery for cancer, if the accident or initial surgery was also covered by this policy.
• Gender reassignment surgery, if you meet the criteria for gender dysphoria services.

DENTAL VENEERS
Dental veneers and related procedures.

DEVELOPMENTAL DELAY
Delay in cognitive or physical development, unless a child has not achieved the developmental milestones expected for a child of that age. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified medical professionals and documented as a delay in development of at least 12 months.

DRUG ADDICTION OR ALCOHOLISM
Care and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments to stop smoking), death associated with drug addiction or alcoholism, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).

EXPERIMENTAL OR UNPROVEN TREATMENT OR DRUG THERAPY
Any form of treatment or drug therapy that in our reasonable opinion is experimental or unproven, based on generally accepted medical practice.

FAILURE TO SEEK OR FOLLOW MEDICAL ADVICE
Treatment required as a result of failure to seek or follow medical advice.

FAMILY THERAPY AND COUNSELLING
Costs in respect of a family therapist or counsellor for out-patient psychotherapy treatment.

FEES FOR THE COMPLETION OF A CLAIM FORM
Doctor's fees for the completion of a Claim Form or other administration charges.

GENETIC TESTING
Genetic testing, except:
- where specific genetic tests are included within your plan.
- where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over.
- where testing for genetic receptor of tumours is covered.

HOME VISITS
Home visits, unless they are necessary after the sudden onset of an acute illness that leaves you incapable of visiting your doctor or therapist.

INJURIES CAUSED BY PROFESSIONAL SPORTS
Treatment or diagnostic procedures for injuries arising from taking part in professional sports.

INTENTIONALLY CAUSED DISEASES OR SELF-INFLICTED INJURIES
Care and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.

LOSS OF HAIR AND HAIR REPLACEMENT
Investigations into and treatment for loss of hair, including hair replacement unless the loss of hair is due to cancer treatment.

MEDICAL ERROR
Treatment required as a result of medical error.

MORTAL REMAINS
The purchase of a burial plot, or funeral costs, including, but not limited to, flowers and the funeral director's fees.

OBESITY TREATMENT
Investigations into and treatment for obesity including bariatric surgery, diet pills or supplements, health club memberships, diet programs or residential eating disorder programs.

ORTHOMOLECULAR TREATMENT
Please refer to the definition of 'Orthomolecular treatment'.

PARTICIPATION IN WAR OR CRIMINAL ACTS
Death from or treatment for any illnesses, diseases or injuries resulting from active participation in the following, whether war has been declared or not:
- War
- Riots
- Civil disturbances
- Terrorism
- Criminal acts
- Illegal acts
- Acts against any foreign hostility

PRODUCTS PURCHASED WITHOUT A PRESCRIPTION
Products that are purchased without a doctor's prescription.

SEX CHANGE

Sex change related operations and related treatments such as:

- Blepharoplasty
- Cheek/malar implants
- Chin/nose implants
- Collagen injections
- Face/forehead lift
- Facial bone reduction (osteoplasty)
- Hair removal/hair transplantation
- Jaw reduction
- Laryngoplasty
- Rhinoplasty
- Skin resurfacing (e.g., dermabrasion, chemical peels)
- Thyroid reduction chondroplasty
- Neck tightening
- Lip enhancement
- Botox and filler injections

SLEEP DISORDERS

Treatment of sleep disorders, including insomnia, obstructive sleep apnea, narcolepsy, snoring and bruxism.

SPEECH THERAPY

Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

STAYS IN A CURE CENTRE

Stays in a cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.

STERILISATION, SEXUAL DYSFUNCTION AND CONTRACEPTION

Investigations into, treatment of and complications arising from:

- Sterilisation
- Sexual dysfunction (unless as a result of a total prostatectomy following cancer surgery)
- Contraception (including the insertion and removal of contraceptive devices and all other contraceptives), unless prescribed for medical reasons that are unrelated to birth control

SUBSTANCES, PERSONAL PRODUCTS AND DIETARY SUPPLEMENTS

Substances, personal products and dietary supplements including vitamins and minerals (except during pregnancy or to treat diagnosed vitamin deficiency syndromes), mouthwash, toothpaste, antiseptic lozenges and sprays, shampoo, sunscreen, cosmetic products, sanitiser, gloves, masks, visors, thermometers, children's food, baby supplies and infant formula given orally. These products are excluded even if they are medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are also not covered, unless a specific benefit shows in your Table of Benefits.

SURROGACY

Treatment directly related to surrogacy whether you are acting as a surrogate, or are the intended parent.

TERMINATION OF PREGNANCY

Termination of pregnancy, except where the life of the pregnant woman is in danger.

TRAVEL COSTS

Travel costs to and from medical facilities (including parking costs) for treatment, except when covered under 'Local ambulance', 'Medical evacuation' and 'Medical repatriation' benefits.

TREATMENT IN THE USA IN THE FOLLOWING CASES

Treatment in the USA if we believe that cover was taken out with the purpose of travelling to the USA to get treatment for a condition or symptoms you were aware of:
• before being insured with us.
• before having the USA in your region of cover.
If we paid any claims in these circumstances, we reserve the right to seek reimbursement from you.

TREATMENT OUTSIDE THE GEOGRAPHICAL AREA OF COVER

Treatment outside the geographical area of cover unless for emergencies or authorised by us. Cover for treatment and services in Belarus, Cuba, Iran, North Korea and Russia is always excluded.

TRIPLE/BART'S, QUADRUPLE OR SPINA BIFIDA TESTS

Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

VESSEL AT SEA

Medical evacuation/repatriation from a vessel at sea to a medical facility on land.

BENEFITS THAT ARE NOT IN YOUR TABLE OF BENEFITS

The following benefits or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:
• Complications of pregnancy and childbirth
• Congenital conditions
• Dental treatment, dental surgery, periodontics, orthodontics, dental implants and dental prostheses. The only exception is oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan
• Dietician fees
• Elective circumcision for newborn males
• Emergency dental treatment
• Expenses for one person accompanying an evacuated/repatriated person
• Health and wellbeing checks including screening for the early detection of illness or disease
• HIV/AIDS treatment
• Homeopathy, Chinese herbal medicine, Tui na, cupping, bone setting, acupuncture and ayurvedic treatment
• Hormone replacement therapy
• Infertility treatment
• In-patient psychiatry and psychotherapy treatment
• Laser eye treatment
• Medical evacuation in the event of non-emergency treatment
• Medical repatriation
• Out-patient psychiatry and psychotherapy treatment
• Out-patient treatment
• Palliative care
• Prescribed glasses and contact lenses including eye examination
• Prescribed medical aids
• Preventative surgery
• Preventive treatment
• Repatriation of mortal remains or burial expenses
• Routine maternity
• Travel costs of insured family members in the event of an evacuation/repatriation
• Travel costs of insured family members in the event of the repatriation of mortal remains
• Travel costs of insured members to be with a close relative who is at peril of death or who has died

These materials and the outlines and/or summaries of insurance contained herein are produced solely for brevity and convenience only. In all cases whatsoever of claims, disputes or policy interpretations, the original policy document(s), as issued by the insurer(s), will prevail. Please refer directly to the relevant policy document(s) in each such instance. The information contained herein is of a general or summary nature and is provided for informational purposes only and is not intended to constitute advice.