**ENDORSEMENT E2409 TO BE ATTACHED TO AND FORMING PART OF THE POLICY**

With effect from the renewal date stated in the letter, and subject to full payment of the premium for **your policy** as set out in the **renewal certificate**, the following terms and conditions shall apply to **your policy** unless **your policy** has ended**.**

Unless the terms and conditions of **your policy** are changed by this endorsement:

a. All other terms and conditions of **your policy** will not change and will apply to this endorsement, if they are applicable; and
b. Words defined in the definitions sections of the conditions of **your policy**, if used in this endorsement, will have the same meanings.

If there is any inconsistency between the terms and conditions of this endorsement and **your policy**, the terms and conditions of this endorsement will apply.

---

Authorised officer

**Schedule of benefits**

| Benefits | Enhanced Preferred | Enhanced Advantage | Enhanced Basic | Enhanced C |
|---|---|---|---|---|
| **Ward entitlement** | **Standard room in private hospital or private medical institution** | **Restructured hospital for ward class A and below** | **Restructured hospital for ward class B1 and below** | **Restructured hospital for ward class B2 and below** |
| **Inpatient hospital treatment** | **Limits of compensation** | | | |
| Daily ward and treatment charges (each day)<br>- Normal ward<br>- Intensive care unit ward | As charged | As charged | As charged | As charged |
| Surgical benefits (including day surgery) | | | | |
| Organ transplant benefit (including stem-cell transplant) | | | | |
| Surgical implants | | | | |
| Radiosurgery | | | | |
| Accident inpatient dental treatment | | | | |
| Pre-hospitalisation treatment | As charged<br><br>Not provided by our Panel: up to 100 days before admission<br><br>Provided by our Panel: up to 180 days before admission | As charged<br><br>Up to 100 days before admission | | |
| Post-hospitalisation treatment | As charged<br><br>Not provided by our Panel: up to 100 days after discharge<br><br>Provided by our Panel: up to 365 days after discharge | As charged<br><br>Up to 100 days after discharge | | |
| Community hospital (Rehabilitative) | As charged (up to 90 days for each admission) | As charged (up to 90 days for each admission) | As charged (up to 90 days for each admission) | As charged (up to 45 days for each admission) |
| Community hospital (Sub-acute) | | | | |
| Inpatient palliative care service (General) | As charged | As charged | As charged | As charged |
| Inpatient palliative care service (Specialised) | | | | |
| **Outpatient hospital treatment** | **Limits of compensation** | | | |
| Radiotherapy for cancer<br>- External (except Hemi-body)<br>- Brachytherapy<br>- Hemi-body<br>- Stereotactic | As charged | As charged | As charged | As charged |
| Kidney dialysis | | | | |
| Erythropoietin for chronic kidney failure | | | | |
| Immunosuppressants for organ transplant | | | | |
| Long-term parenteral nutrition | As charged | As charged | As charged | As charged |

| Benefits | Enhanced Preferred | Enhanced Advantage | Enhanced Basic | Enhanced C |
|---|---|---|---|---|
| Insured receiving treatment for one primary cancer | | | | |
| Cancer drug treatment (each month) * | 5x MSHL Limit for one primary cancer | 5x MSHL Limit for one primary cancer | 5x MSHL Limit for one primary cancer | 3x MSHL Limit for one primary cancer |
| Cancer drug services (each policy year) ** | 5x MSHL Limit for one primary cancer | 5x MSHL Limit for one primary cancer | 5x MSHL Limit for one primary cancer | 3x MSHL Limit for one primary cancer |
| Insured receiving treatment for multiple primary cancers *** | | | | |
| Cancer drug treatment (each month) * | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer |
| Cancer drug services (each policy year) ** | 5x MSHL Limit for multiple primary cancers | 5x MSHL Limit for multiple primary cancers | 5x MSHL Limit for multiple primary cancers | 3x MSHL Limit for multiple primary cancers |
| | | | | |
| **Special benefits** | **Limits on special benefits** | | | |
| Breast reconstruction after mastectomy | As charged | As charged | As charged | As charged |
| Congenital abnormalities benefit (with 12 months' waiting period) | As charged | As charged | As charged | Not covered |
| Pregnancy and delivery-related complications benefit (with 10 months' waiting period) | | | | |
| Living organ donor (insured) transplant benefit – insured as the living donor donating an organ (each transplant with 24 months' waiting period for the person receiving the organ) | As charged, up to $60,000 | As charged, up to $40,000 | As charged, up to $20,000 | |
| Living organ donor (non-insured) transplant benefit (each transplant) – insured as the recipient of organ | As charged, up to $60,000 | Not covered | Not covered | |
| Cell, tissue and gene therapy benefit (each policy year) | As charged, up to $250,000 | As charged, up to $250,000 | As charged, up to $150,000 | As charged, up to $150,000 |
| Proton beam therapy (each policy year) # | As charged up to $100,000 | As charged, up to $100,000 | As charged, up to $70,000 | As charged, up to $70,000 |
| Continuation of autologous bone marrow transplant treatment for multiple myeloma (each policy year) | As charged, up to $25,000 | As charged, up to $25,000 | As charged, up to $10,000 | As charged, up to $10,000 |
| Inpatient psychiatric treatment benefit (each policy year) | As charged, up to $20,000 | As charged, up to $10,000 | As charged, up to $7,000 | As charged, up to $7,000 |
| Prosthesis benefit (each policy year) | As charged, up to $10,000 | As charged, up to $6,000 | As charged, up to $6,000 | As charged, up to $3,000 |
| Emergency overseas treatment | As charged but limited to costs of Singapore private hospitals | As charged but limited to costs of ward class A in Singapore restructured hospitals | As charged but limited to costs of ward class B1 in Singapore restructured hospitals | As charged but limited to costs of ward class B2 in Singapore restructured hospitals |
| Waiver of pro-ration factor for outpatient kidney dialysis | Does not apply | Waive pro-ration factor for applicable treatment provided by our preferred partner | | |
| Final expenses benefit (waiver of co-insurance and deductible) | $5,000 | $5,000 | $3,000 | $1,500 |

| Benefits | Enhanced Preferred | Enhanced Advantage | Enhanced Basic | Enhanced C |
|---|---|---|---|---|
| **Pro-ration factor** | | | | |
| Inpatient | | | | |
| - Restructured hospital | | | | |
| - Ward class C, B2 or B2+ | | Does not apply | Does not apply | Does not apply |
| - Ward class B1 | | Does not apply | Does not apply | 40% |
| - Ward class A | | Does not apply | 85% | 20% |
| - Private hospital or private medical institution or emergency overseas treatment | Does not apply | 65% | 50% | 15% |
| - Community hospital | | | | |
| - Ward class C or B2 | | Does not apply | Does not apply | Does not apply |
| - Ward class B2+ or B1 | | Does not apply | Does not apply | 40% |
| - Ward class A | | Does not apply | 85% | 20% |
| Day surgery or short-stay ward | | | | |
| - Restructured hospital subsidised | | Does not apply | Does not apply | Does not apply |
| - Restructured hospital non-subsidised | Does not apply | Does not apply | Does not apply | 20% |
| - Private hospital or private medical institution or emergency overseas treatment | | 65% | 50% | 15% |
| Outpatient hospital treatment | | | | |
| - Restructured hospital subsidised | | Does not apply | Does not apply | Does not apply |
| - Restructured hospital non-subsidised | Does not apply | Does not apply | Does not apply | Does not apply |
| - Private hospital or private medical institution | | 65% | 50% | 15% |
| **Deductible for each policy year for an insured aged 80 years or below next birthday** | | | | |
| Inpatient | | | | |
| - Restructured hospital | | | | |
| - Ward class C | $1,500 | $1,500 | $1,500 | $1,500 |
| - Ward class B2 or B2+ | $2,000 | $2,000 | $2,000 | $2,000 |
| - Ward class B1 | $2,500 | $2,500 | $2,500 | $2,000 |
| - Ward class A | $3,500 | $3,500 | $2,500 | $2,000 |
| - Private hospital or private medical institution or emergency overseas treatment | $3,500 | $3,500 | $2,500 | $2,000 |
| - Community hospital | | | | |
| - Ward class C | $1,500 | $1,500 | $1,500 | $1,500 |
| - Ward B2 or B2+ | $2,000 | $2,000 | $2,000 | $2,000 |
| - Ward class B1 | $2,500 | $2,500 | $2,500 | $2,000 |
| - Ward class A | $3,500 | $3,500 | $2,500 | $2,000 |
| Day surgery or short-stay ward | | | | |
| - Subsidised | $2,000 | $2,000 | $2,000 | $2,000 |
| - Non-subsidised | $3,500 | $3,500 | $2,500 | $2,000 |
| **Deductible for each policy year for an insured aged over 80 years at next birthday** | | | | |
| Inpatient | | | | |
| - Restructured hospital | | | | |
| - Ward class C | $2,250 | $2,250 | $2,250 | $2,250 |
| - Ward class B2 or B2+ | $3,000 | $3,000 | $3,000 | $3,000 |
| - Ward class B1 | $3,750 | $3,750 | $3,750 | $3,000 |
| - Ward class A | $5,250 | $5,250 | $3,750 | $3,000 |
| - Private hospital or private medical institution or emergency overseas treatment | $5,250 | $5,250 | $3,750 | $3,000 |
| - Community hospital | | | | |
| - Ward class C | $2,250 | $2,250 | $2,250 | $2,250 |
| - Ward B2 or B2+ | $3,000 | $3,000 | $3,000 | $3,000 |
| - Ward class B1 | $3,750 | $3,750 | $3,750 | $3,000 |
| - Ward class A | $5,250 | $5,250 | $3,750 | $3,000 |

| Benefits | Enhanced Preferred | Enhanced Advantage | Enhanced Basic | Enhanced C |
|---|---|---|---|---|
| Day surgery or short-stay ward<br>- Subsidised<br>- Non-subsidised | <br>$3,000<br>$5,250 | <br>$3,000<br>$5,250 | <br>$3,000<br>$3,750 | <br>$3,000<br>$3,000 |
| **Co-insurance** | 10% | 10% | 10% | 10% |
| **Limit in each policy year** | $1,500,000 | $500,000 | $250,000 | $150,000 |
| **Limit in each lifetime** | Unlimited | Unlimited | Unlimited | Unlimited |
| **Last entry age (age next birthday)** | 75 | 75 | 75 | 75 |
| **Maximum coverage age** | Lifetime | Lifetime | Lifetime | Lifetime |

[#] The MOH-approved proton beam therapy indications and eligibility criteria are set out on MOH's website (go.gov.sg/pbt-approved-indications). MOH may update these from time to time.

[*] The cancer drug treatment on the Cancer Drug List (CDL) benefit limit is based on a multiple of the MSHL Limit for the specific cancer drug treatment. For the latest MSHL Limit, refer to the CDL on MOH's website under "MediShield Life Claim Limit per month" (go.gov.sg/moh-cancerdruglist). MOH may update this from time to time. The revised list will be applicable to the cancer drug treatment which occurred on and from the effective date of the revised list.

[**] The cancer drug services benefit limit is based on a multiple of the MSHL Limit for cancer drug services. For the latest MSHL Limit for cancer drug services, refer to "Cancer Drug Services" under the MSHL benefits on MOH's website (go.gov.sg/mshlbenefits). MOH may update this from time to time. The revised limit will be applicable to the cancer drug services incurred within the Policy Year of the revised limit.

[***] Defined as two or more cancers arising from different sites and are of a different histology or morphology group. The claim limits for patients receiving treatment for multiple primary cancers are accorded on an application basis; doctors are to send the application form to MOH and Income Insurance for assessment of MSHL and Integrated Shield Plan coverage respectively.

# Conditions for Enhanced IncomeShield

## Your policy

This is **your** Enhanced IncomeShield policy. It contains:

- these conditions;
- the **policy certificate**;
- the **schedule of benefits**; and
- the riders and endorsements (if this applies).

The full agreement between **us** and **you** is made up of these documents and:

- all statements to medical officers;
- declarations and questionnaires relating to **your** and the **insured**'s lifestyle, occupational or medical condition which **you** or the **insured** provided to **us** for **our** underwriting purposes; and
- written correspondence relating to **your policy** which **we** intend to be legally binding between **you** and **us**.

**We** refer to them all together as '**Your policy**'. Please examine them to make sure **you** have the protection **you** need. It is important that **you** read them together to avoid misunderstanding.

Words defined in the definitions section of these conditions have the meanings given to them in the definitions section and the same definitions apply if the defined words are used in any of the documents in **your policy** or any correspondence between **you** and **us**.

Enhanced IncomeShield is a medical insurance plan which covers **you** for costs associated with **staying in hospital** and having surgery. If **your policy** is integrated with **MediShield Life**, it adds to the **MediShield Life** tier operated by the **CPF Board** and provides extra **benefits** to meet the needs of those who would like more cover and medical insurance protection. **You** will find details of what **we** will cover set out in **your policy**.

## 1 What your policy covers

**Your policy** covers the following **benefits**.

The **benefits** only pay for **reasonable expenses** for **necessary medical treatment** for the **insured** in the **policy year**. This treatment must be provided by a **hospital** or a licensed medical centre or clinic, all of which must be accredited by **MOH** to take part in the **MediShield Life** scheme.

All **benefits** are paid as a reimbursement for treatment received and paid by the **insured** due to illness or injury, and depend on the terms, conditions and limits set out in the **schedule of benefits** and **your policy**.

### 1.1 Inpatient hospital treatment

The inpatient hospital treatment benefit pays for the types of costs set out below, and depends on the limits in the **schedule of benefits** under the heading 'Inpatient hospital treatment'. The inpatient hospital treatment must be recommended by a **registered medical practitioner**. Except for pre-hospitalisation treatment and post-hospitalisation treatment, these costs must be for treatment received by the **insured** while **staying in a hospital**.

Inpatient hospital treatment benefit is made up of the following sub-benefits.

## a Daily ward and treatment charges (normal ward)

Ward charges the **insured** has to pay for each day in a **hospital** including:

- meals;
- prescriptions;
- medical consultations;
- miscellaneous medical charges;
- **specialist** consultations;
- examinations;
- laboratory tests; and
- being admitted to a high-dependency ward or **short-stay ward**.

If the **insured** is in a luxury or deluxe suite or any other special room of a **hospital**, **we** will only pay the equivalent of daily ward and treatment charges for a standard room in the **hospital**. **We** will also apply the **pro-ration factor** if the **insured** is admitted to a ward or **hospital** that is higher than their **ward entitlement.**

## b Daily ward and treatment charges (intensive care unit (ICU) ward)

**ICU** charges the **insured** has to pay for each day in an **ICU** including:

- meals;
- prescriptions;
- medical consultations;
- miscellaneous medical charges;
- **specialist** consultations;
- examinations; and
- laboratory tests.

## c Surgical benefit

Charges the **insured** has to pay for surgery (including day surgery) in a **hospital** by a surgeon including:

- surgeon's fees;
- fees and charges for anaesthesia and oxygen and for them to be administered; and
- using the **hospital**'s operating theatre and facilities.

Any surgery not listed in **MOH**'s surgical operation fees table 1 to 7 as at the date of the surgery is not covered.

## d Organ transplant benefit

The organ transplant benefit pays for medical treatment of the **insured** who is receiving any organ (including **stem-cell transplant**).

**We** will not pay this benefit if the organ transplant is illegal or arises from any illegal transaction or practice.

## e Surgical implants

Charges the **insured** has to pay for implants in their body during surgery. These implants must stay in the **insured**'s body after the surgery. The charges for the following approved medical items are also covered.

- Intravascular electrodes used for electrophysiological procedures
- Percutaneous transluminal coronary angioplasty (PTCA) balloons
- Intra-aortic balloons (or balloon catheters)

## f Radiosurgery

Covers radiosurgery carried out on the **insured**.

## g Accident inpatient dental treatment

The benefit for accident inpatient dental treatment covers the **insured**'s **stay in a hospital** to remove, restore or replace sound natural teeth which have been lost or damaged in an **accident**.

**We** do not cover pre-hospitalisation treatment which is given before and post-hospitalisation treatment which is given after accident inpatient dental treatment.

To avoid doubt, **we** do not cover dental treatment not related to the **accident**, such as extraction (removal) of teeth due to tooth decay, polishing or scaling.

## h Pre-hospitalisation treatment

The cost of medical treatment received by the **insured** in the **policy year** for up to 100 days before the date they went into **hospital**.

If the inpatient hospital treatment is provided by **our panel** and paid for under the Enhanced IncomeShield Preferred plan, **we** will cover the cost of medical treatment the **insured** received in the **policy year** for up to 180 days before the date they went into **hospital**. To avoid doubt, if the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for the **insured**'s **stay in a hospital**, **we** will cover up to 180 days of pre-hospitalisation treatment only when the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel**.

Pre-hospitalisation treatment includes **specialist** outpatient medical services and consultations, diagnostic and laboratory services, examinations and investigations ordered by a **registered medical practitioner**.

Pre-hospitalisation treatment must lead to the **insured** being admitted to a **hospital** for the same illness or injury for which they received medical treatment before their **stay in hospital**.

**We** do not cover pre-hospitalisation treatment if, under **your policy**, **we** do not pay for the inpatient hospital treatment received during the **stay in hospital**.

**We** do not cover pre-hospitalisation treatment which is given before inpatient psychiatric treatment benefit, accident inpatient dental treatment or emergency overseas treatment.

To avoid doubt, pre-hospitalisation treatment does not include inpatient hospital treatment and day surgery.

## i Post-hospitalisation treatment

The cost of medical treatment received by the **insured** in the **policy year** for up to 100 days after the date they leave **hospital**.

If the inpatient hospital treatment is provided by **our panel** and paid for under the Enhanced IncomeShield Preferred plan, **we** will cover the cost of medical treatment the **insured** received in the **policy year** for up to 365 days after the date they left **hospital**.

To avoid doubt, if the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for the **insured**'s **stay in a hospital**, **we** will cover up to 365 days of post-hospitalisation treatment only when the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel**.

Post-hospitalisation treatment includes **specialist** outpatient medical services and consultations, medication, physiotherapy, occupational therapy, speech therapy, diagnostic and laboratory services, examinations and investigations that are:

- ordered by a **registered medical practitioner**; and
- carried out within the period that **we** cover post-hospitalisation treatment for.

Any physiotherapy, occupational therapy or speech therapy must be provided by an Allied Health Professional registered under **MOH**.

Post-hospitalisation treatment must:

- have resulted directly from the condition for which the **stay in hospital** was needed; and
- be recommended by the **registered medical practitioner** who treated the **insured** during the period they were in **hospital**.

**We** do not cover post-hospitalisation treatment if, under **your policy**, **we** do not pay for the inpatient hospital treatment received during the **stay in hospital**.

**We** do not cover post-hospitalisation treatment such as medication bought during a period of post-hospitalisation treatment but not used during that period.

**We** do not cover post-hospitalisation treatment which is given after inpatient psychiatric treatment benefit, accident inpatient dental treatment or emergency overseas treatment.

To avoid doubt, post-hospitalisation treatment does not include inpatient hospital treatment and day surgery.

## j Staying in a community hospital (for rehabilitative care or sub-acute care)

Charges the **insured** has to pay while **staying in a community hospital**, but only up to the maximum number of days for each stay as stated in the **schedule of benefits**.

To claim the inpatient hospital treatment benefit for a stay in a **community hospital**, the following conditions must all be met.

- The **insured** must have first had inpatient hospital treatment in a **restructured hospital** or **private hospital** or been referred from the emergency department of a **restructured hospital**.
- The attending **registered medical practitioner** in the **restructured hospital** or **private hospital** must have recommended in writing that the **insured** needs to be admitted to a **community hospital** for **necessary medical treatment**.
- After the **insured** is discharged from the **restructured hospital** or **private hospital**, they must be immediately admitted to a **community hospital** for a continuous period of time.
- The treatment must arise from the same injury, illness or disease that resulted in the inpatient hospital treatment.

## k Inpatient palliative care service (general or specialised)

Charges the **insured** has to pay for **general inpatient palliative care** or **specialised inpatient palliative care** from an **inpatient palliative care provider**.

To claim this benefit, the following conditions must all be met.

- The **insured** must have been admitted for inpatient palliative care (general or specialised) by a **registered medical practitioner**, according to the relevant guidelines from **MOH**.

## 1.2 Outpatient hospital treatment

The outpatient hospital treatment benefit pays for medical treatment of the **insured** set out below and depends on the limits in the **schedule of benefits** under the heading 'Outpatient hospital treatment'.

This benefit covers the following main outpatient hospital treatments received by the **insured** from a **hospital** or a licensed medical centre or clinic.

a Radiotherapy for cancer – external radiotherapy (except hemi-body), brachytherapy, stereotactic radiotherapy, and hemi-body radiotherapy.

b Outpatient kidney dialysis.

c Approved immunosuppressant drugs, including, cyclosporin and tacrolimus for organ transplant, and other drugs approved under **MediShield Life**.

d Erythropoietin and other drugs approved under **MediShield life** for chronic kidney failure.

e Parenteral bags (bags containing nutrients to be administered through tubing attached to a needle or catheter) and consumables (non-durable medical supplies) necessary for administering long-term parenteral nutrition that meets the **MediShield Life claimable criteria**. **We** will treat these claims as part of the outpatient hospital treatment under **your policy** and the same **limits of compensation** will apply.

f Cancer drug treatments listed on the **Cancer Drug List (CDL)** and used according to the indications on the **CDL**. To avoid doubt, for **CDL** treatments, the indications refer to the clinical indications of the drug as specified in the **CDL** on **MOH**'s website go.gov.sg/moh-cancerdruglist. For each primary cancer, if the **CDL** treatment involves more than one drug, **we** allow drug omission or replacement with another **CDL** drug with the indication "for cancer treatment", only if such omission or replacement is due to intolerance or contraindications. In such cases, the claim limit of the original **CDL** treatment will apply. For each primary cancer, where multiple cancer drug treatments are administered in a month:

- if any of the **CDL** treatments has an indication that states "monotherapy", only **CDL** treatments with the indication "for cancer treatment" will be claimable in that month.
- if none of the **CDL** treatments has an indication that states "monotherapy", the following will apply:
    - If more than one of the cancer drug treatments administered in a month has an indication other than "for cancer treatment", only **CDL** treatments with the indication "for cancer treatment" will be claimable in that month.
    - If one or none of the cancer drug treatments administered in a month has an indication other than "for cancer treatment", all **CDL** treatments will be claimable in that month.

Cancer drug treatments not on the **CDL** will be considered as having an indication other than "for cancer treatment".

This benefit pays for cancer drug treatment set out below and depends on the limits in the **schedule of benefits**.

- For **insured** with only one primary cancer, **we** will pay up to the highest limit among the claimable **CDL** treatments received in that month.
- For **insured** receiving treatment for **multiple primary cancers**, **we** will pay up to the sum of the highest limit among the claimable **CDL** treatments received for each primary cancer in that month. An application form for higher claim limits for **insured** receiving treatment for **multiple primary cancers** are to be sent to **us** and **MOH** by their **registered medical practitioner** for assessment of **your policy** and **MediShield Life** Plan coverage respectively.

g Cancer drug services that are part of any outpatient cancer drug treatment. This includes consultations, scans, lab investigations, preparing and administering the cancer drug, supportive-care drugs and blood transfusions. It does not cover services provided before the **insured** is diagnosed with cancer or after the

cancer drug treatment has ended. An application form for higher claim limits for **insured** receiving treatment for **multiple primary cancers** are to be sent to **us** and **MOH** by their **registered medical practitioner** for assessment of the Integrated Shield Plan and **MediShield Life** Plan coverage respectively. **We** will pay up to the limit as set out in the **schedule of benefits** if the **insured** had received treatment for **multiple primary cancers** at any point in time within the **policy year**.

Clauses a, b, c and d above include consultation fees, medicines, examinations and tests that are directly related to the outpatient hospital treatment and ordered by the **registered medical practitioner. We** will pay these claims if the treatment is provided within 30 days (before and after) of the main outpatient hospital treatment, and the same **limits of compensation** will apply.

## 1.3 Special benefits

**We** limit **benefits we** will pay in relation to certain specified medical conditions or in certain circumstances (which **we** call special benefits). The **limits on special benefits** are set out in the **schedule of benefits** under the heading 'Special benefits'. These special benefits are shown below.

### a Breast reconstruction after mastectomy

This benefit pays for inpatient hospital treatment for reconstructive surgery of the breast on which a mastectomy has been performed as a result of breast cancer. The breast reconstruction must be performed by a **registered medical practitioner** during a **stay in hospital** within 365 days from the date the **insured** leaves the **hospital** when the mastectomy was done. The breast cancer must be first diagnosed on or after the **start date** of **your policy**, or the last **reinstatement date**, whichever is later. Any surgery or reconstruction of the other breast to produce a symmetrical appearance will not be covered. To avoid doubt, any further breast reconstruction after mastectomy shall not be payable 365 days after the date the **insured** leaves the **hospital** when the mastectomy was done, even if **we** have paid for the re-construction in an earlier claim.

### b Congenital abnormalities benefit

This benefit pays for inpatient hospital treatment for birth defects including hereditary conditions and congenital sickness or abnormalities.

These birth defects must:

- be first diagnosed by a **registered medical practitioner**; and
- have symptoms which first appeared,

after 12 months from:

- 1 September 2008, which is the date on which this congenital abnormalities benefit first became effective;
- the **start date**; or
- the last **reinstatement date** (if any);

whichever is later.

### c Pregnancy and delivery-related complications benefit

Pregnancy and delivery-related complications benefit pays for inpatient hospital treatment for the following complications in pregnancy.

- Ectopic pregnancy – the condition in which a fertilised ovum implants outside the womb. The ectopic pregnancy must have been terminated by laparotomy, laparoscopic surgery or ultrasound-guided methotrexate injection.
- Pre-eclampsia or eclampsia.
- Disseminated intravascular coagulation (DIC).

- Miscarriage – when the fetus of the **insured** dies as a result of a sudden unexpected and involuntary event which must not be due to a voluntary or malicious act.
- Ending a pregnancy if an obstetrician considers it necessary to save the life of the **insured**.
- Acute fatty liver diagnosed during pregnancy.
- Postpartum haemorrhage (haemorrhage after delivery) with hysterectomy done.
- Amniotic fluid embolism.
- Abruptio placentae (placenta abruption).
- Choriocarcinoma and Hydatidiform mole – a histologically confirmed choriocarcinoma or molar pregnancy.
- Placenta previa.
- Antepartum haemorrhage (haemorrhage before delivery).

These pregnancy and delivery-related complications must have been first diagnosed by an obstetrician after 10 months from the **start date** or the last **reinstatement date** (if any), whichever is later.

Pregnancy and delivery-related complications benefit pays for inpatient hospital treatment for the following complications if treatment is provided by **our preferred partner** in the areas of obstetrics and gynaecology.

To avoid doubt, if the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for the complications, **we** will cover the complications only when the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our preferred partner** in the areas of obstetrics and gynaecology.

- Intrapartum haemorrhage (haemorrhage during delivery)
- Postpartum haemorrhage (haemorrhage after delivery)
- Cervical incompetency (weakness or insufficiency)
- Accreta placenta (placenta attaches too deeply to the uterine wall)
- Placental insufficiency (failure of placenta to deliver an adequate supply of nutrients and oxygen to the fetus) and intrauterine growth restriction (unborn baby is smaller than expected for the gestational age)
- Gestational diabetes mellitus
- Obstetric cholestasis (liver disorder during pregnancy resulting in a build-up of bile)
- Twin to twin transfusion syndrome (disease of the placenta that affects identical twins, resulting in intrauterine blood transfusion from one twin to another)
- Infection of the amniotic sac and membranes
- Fourth-degree perineal laceration (tears that extend into the rectum)
- Uterine rupture
- Postpartum inversion of uterus (when the uterus turns inside out after childbirth)
- Obstetric injury or damage to pelvic organs
- Complications resulting from a hysterectomy carried out at the time of a caesarean section
- Retained placenta and membranes
- Abscess of the breast
- Stillbirth
- Death of the mother

The complications listed above must have been first diagnosed by an obstetrician or gynaecologist after 10 months from:

- 1 May 2020, which is the date on which this pregnancy and delivery-related complications benefit first became effective;
- the **start date**; or
- the last **reinstatement date** (if any);

whichever is latest.

Under this pregnancy and delivery-related complications benefit, **we** do not cover delivery charges except in the event of pre-eclampsia or eclampsia, stillbirth or death of the mother.

## d Inpatient psychiatric treatment benefit

Inpatient psychiatric treatment benefit pays for psychiatric treatment provided to the **insured** while in **hospital** by a **registered medical practitioner** qualified to provide that psychiatric treatment.

**We** do not cover pre-hospitalisation treatment which is given before and post-hospitalisation treatment which is given after inpatient psychiatric treatment.

## e Living organ donor (insured) transplant benefit

The living organ donor transplant benefit pays for inpatient hospital treatment for the **insured** if they are a **living organ donor** of any **specified organ** and the following conditions are met.

- The transplant is approved under **HOTA** and carried out in a **hospital** in Singapore.
- The person receiving the **specified organ** must have been first diagnosed with organ failure by a **registered medical practitioner** after 24 months from:
  - the **start date**; or
  - the last **reinstatement date** (if any);

  whichever is later.
- The **reasonable expenses** are to treat the **insured** for the transplant and the treatment is, in the opinion of a **registered medical practitioner** or a **specialist** in that field of medicine, appropriate and necessary for the transplant.

When **we** pay for each transplant, **we** add together all **reasonable expenses** for the treatment (including pre-hospitalisation treatment, post-hospitalisation treatment and any post-surgery complications) and pay up to the limit for this benefit as set out in the **schedule of benefits**.

**We** will not pay for this benefit if the transplant is illegal or arises from any illegal transaction or practice.

## f Living organ donor (non-insured) transplant benefit

The living organ donor (non-insured) transplant benefit pays for inpatient hospital treatment for someone who is not insured if they are a **living organ donor** providing any **specified organ** for transplant into an **insured.** This applies as long as the following conditions are met.

- The transplant is approved under **HOTA** and carried out in a **hospital** in Singapore.
- **You** and the **living organ donor** agree that **you** pay for the **living organ donor**'s inpatient hospital treatment and claim under **your policy**.
- **We** will pay the organ transplant benefit for the **insured** to have a transplant from the **living organ donor**.
- The inpatient hospital treatment must be necessary for removing the organ from the **living organ donor**'s body to be transplanted into the **insured'**s body. **We** will not pay more than the costs of:
  - the **living organ donor**'s **stay in a hospital** that is needed for them to donate their organ;
  - surgical operations to remove the organ from the **living organ donor**'s body; and
  - storing and transporting the organ after it is removed from the **living organ donor**'s body.

To avoid doubt, **we** will not pay for the costs of:

- pre-hospitalisation treatment received by the **living organ donor** including specialist outpatient medical services and consultations, diagnostic and laboratory services, examinations and investigations such as pre-harvesting laboratory services and investigations;
- post-hospitalisation treatment received by the **living organ donor** including specialist outpatient medical services and consultations, diagnostic and laboratory services, examinations and investigations such as post-transplant treatment arising from complications from the surgery; and
- counselling provided to the **living organ donor**'s family before or after an organ has been donated.

**We** will not pay for this benefit if the transplant is illegal or arises from any illegal transaction or practice.

## g Prosthesis benefit

The prosthesis benefit pays for buying any **prosthesis** for the **insured** to use. This applies if the following conditions are met.

- The **insured** needs the **prosthesis** because they have lost a limb or eye resulting from an injury or illness that the **insured** has to **stay in a hospital** for.
- The **prosthesis** is ordered by a **registered medical practitioner**.
- The **prosthesis** must be bought within 180 days after the date the **insured** leaves **hospital**.
- When **we** work out if the limit for this benefit (set out in the **schedule of benefits**) has been used up for the **policy year** that the **insured** is admitted to **hospital** for the injury or illness that results in them losing a limb or eye, **we** will take account of any amount already paid under this benefit.
- **We** will only pay for one **prosthesis** for each limb or eye. However, if the **insured** has to buy a **prosthesis** again for the same limb or eye resulting from another injury or illness that the **insured** has to **stay in hospital** for again, **we** will pay for the **prosthesis**.

To avoid doubt, **we** will not pay for replacing, repairing or maintaining the **prosthesis**.

## h Emergency overseas treatment

If the **insured** needs inpatient hospital treatment resulting from an **emergency** while overseas, the emergency overseas treatment benefit pays either the actual **hospital** expenses involved or **reasonable expenses** that would have been paid for equivalent medical treatment in a Singapore **hospital** (according to **your plan**), whichever is lower.

**We** do not cover emergency overseas treatment if the **insured** is a foreigner who does not have an **eligible valid pass** at the time of the treatment.

**We** do not cover pre-hospitalisation treatment which is given before and post-hospitalisation treatment which is given after emergency overseas treatment.

**We** will convert bills for this treatment which are shown in a foreign currency to Singapore currency at the exchange rate **we** decide to use on the date the **insured** leaves **hospital**.

## i Final expenses benefit

**We** will waive (not enforce) the **co-insurance** and **deductible** due for a claim for the inpatient hospital treatment, pre-hospitalisation treatment and post-hospitalisation treatment if the **insured** dies:

- while in **hospital**; or
- within 30 days of leaving **hospital**.

However, if the **insured** dies within 30 days of leaving the **hospital**, **we** will also waive the **co-insurance** due for a claim of outpatient hospital treatment if the treatment was received by the **insured** within 30 days of leaving **hospital**.

Both the death and the claim for inpatient hospital treatment, pre-hospitalisation treatment, post-hospitalisation treatment, or outpatient hospital treatment must be related to the injury or illness for which the **stay in the hospital** was necessary.

The waiver of **co-insurance** and **deductible** will be up to the limit of compensation set out in the **schedule of benefits**.

## j Cell, tissue and gene therapy benefit

This benefit pays for inpatient hospital treatment (including day surgery), and outpatient hospital treatment, for cell, tissue and gene therapy provided to the **insured**, as long as the following conditions are met.

- The cell, tissue and gene therapy is approved by **MOH** and Health Science Authority (HSA).
- The **registered medical practitioner** recommends in writing that the **insured** needs the cell, tissue and gene therapy for **necessary medical treatment**, according to the relevant guidelines from **MOH.**

This benefit also pays for outpatient hospital treatment for cell, tissue and gene therapy, including consultation fees, medicines, examinations and tests that are directly ordered by the **registered medical practitioner**. **We** will pay these claims if the treatment is provided within 30 days (before and after) of the outpatient hospital treatment.

When **we** pay the cell, tissue and gene therapy benefit, **we** add together all **reasonable expenses** for the cell, tissue and gene therapy treatment (including pre-hospitalisation treatment, post-hospitalisation treatment and outpatient hospital treatment), and pay up to the limit for this benefit, as set out in the **schedule of benefits**.

## k Continuation of autologous bone marrow transplant treatment for multiple myeloma

This benefit pays for autologous bone marrow transplant treatment for multiple myeloma (a form of white blood cell cancer) to continue to be provided to the **insured**, in an outpatient setting, for the following stages of the treatment.

- Stem-cell mobilization (a process where drugs are used to move the stem cells into the bloodstream)
- Harvesting healthy stem cells
- Pre-transplant workup (Pre-transplant preparation)
- Use of high dosage chemotherapeutic drugs to destroy cancerous cells
- Engraftment (Transplant) of healthy stem cells
- Post-transplant monitoring

To avoid doubt, **we** do not cover pre-hospitalisation treatment and post-hospitalisation treatment provided before or after autologous bone marrow transplant treatment for multiple myeloma.

This benefit also pays for consultation fees, medicines, examinations and tests that are directly ordered by the **registered medical practitioner** for autologous bone marrow transplant treatment for multiple myeloma to continue in an outpatient setting, and were provided within 30 days (before or after) of the treatment.

When **we** pay the continuation of autologous bone marrow transplant treatment for multiple myeloma benefit, **we** add together all **reasonable expenses** for the autologous bone marrow transplant treatment for multiple myeloma and pay up to the limit for this benefit, as set out in the **schedule of benefits**.

To avoid doubt, the **pro-ration factor** for the continuation of autologous bone marrow transplant treatment for multiple myeloma will be the **pro-ration factor** for outpatient hospital treatment (see clause 2.5b).

## l Proton beam therapy benefit

This benefit pays for inpatient hospital treatment (including day surgery), and outpatient hospital treatment, for proton beam therapy provided to the **insured. We** will only cover the proton beam therapy if it is administered for an **MOH**-approved proton beam therapy indication (that is, **MOH** has approved the therapy for the **insured's** condition) and the **insured** meets the eligibility criteria for proton beam therapy under **MediShield Life**. The proton beam therapy indications and the eligibility criteria are set out on **MOH**'s website (go.gov.sg/pbt-approved-indications). **MOH** may update these from time to time.

This benefit also pays for outpatient hospital treatment for proton beam therapy, including consultation fees, medicines, examinations and tests that are directly ordered by the **registered medical practitioner**. **We** will pay these claims if the treatment is provided within 30 days (before and after) of the outpatient hospital treatment.

When **we** pay the proton beam therapy benefit, **we** add together all **reasonable expenses** for the proton beam therapy treatment (including pre-hospitalisation treatment, post-hospitalisation treatment and outpatient hospital treatment), and pay up to the limit for this benefit, as set out in the **schedule of benefits**.

### m Waiver of pro-ration factor for outpatient kidney dialysis

**We** will not use a **pro-ration factor** for outpatient kidney dialysis, or erythropoietin and other drugs approved under **MediShield Life** for chronic kidney failure, if the treatment the **insured** received was provided by **our preferred partner** in the area of kidney dialysis.

## 2 Our responsibilities to you

**We** are only responsible to **you** for the cover and period shown in **your policy certificate** or **renewal certificate** (as the case may be). The policy is governed by the terms, conditions and limits of the **schedule of benefits** and **your policy**.

### 2.1 Claims

Depending on the terms, conditions and limits in the **schedule of benefits** and **your policy**, **we** use the following limits in the following order on the **benefits** covered (if it applies).

a **Citizenship factor**
b **Pro-ration factor**
c The **limits of compensation**
d The **deductible**
e **Co-insurance**
f The **limits on special benefits**
g The **limit in each policy year**

As long as **you** have paid the **premium** or any amount **you** owe **us** under **your policy**, **we** will pay **you** the **benefits**.

All claims (except pre-hospitalisation treatment and post-hospitalisation treatment) must be made and sent to **us** through the system set up by **MOH** (electronic filing) and according to the **act** and **regulations** within 90 days from the date of billing or the date the **insured** leaves **hospital**, whichever is later. Claims for pre-hospitalisation treatment and post-hospitalisation treatment must be sent to **us** within 120 days from the date the **insured** leaves **hospital**. **You** must give **us** any other documents, authorisations or information **we** need for assessing the claim. **You** must also pay any costs involved.

For claims which are not eligible for electronic filing (for example, claims under plans which are not integrated with **MediShield Life** or claims for pre-hospitalisation treatment, post-hospitalisation treatment or emergency overseas treatment), **you** must send the claim to **us** by post or online, or deliver it to **us** by hand. For claims which are electronically filed to **us**, **we** will pay the **hospital** direct. Otherwise, **we** will pay **you**. If a claim must be investigated again after payment had been made, depending on the outcome of the investigation, **we** have a right to recover the payment made for the claim.

**You**, or if **you** die **your** legal representative, must give **us** all documents, authorisations or information **we** need to assess the claim. **You** must also pay any costs involved in doing so. If **you**, **your** legal representative or the **insured** fails to co-operate with **us** in dealing with the claim, the assessment of the claim may be delayed or **we** can reject the claim.

**We** will pay claims according to **your policy** or **MediShield Life**, whichever is higher.

If **your plan** is not integrated with **MediShield Life**, **your plan** does not cover the **MediShield Life** tier operated by the **CPF Board**. **We** will pay claims according to **your policy**.

If **your** claim includes expenses that are not reasonable, **we** will pay only the amount of **your** claim that **we** believe is **reasonable expenses** for **necessary medical treatment**. **We** can reduce **your** claim to reflect what would have been reasonable, based on the professional opinion of **our registered medical practitioner** or the **insured**'s entitlement to **benefits** under **your policy**. If there is a difference in opinion between **our registered medical practitioner** and **your registered medical practitioner**, the matter will be referred to an independent person for adjudication under clause 4.14 of these conditions.

## 2.2 Deductible and co-insurance

**You** must pay the **deductible** and **co-insurance** before **we** pay any benefit. **We** will apply the **deductible** followed by the **co-insurance**.

For each period of 12 months or less that the **insured stays in hospital**, **you** must pay the **deductible** for one **policy year** (even if the **stay in a hospital** runs into the next **policy year**). If the stay is for a continuous period of more than 12 months but less than 24 months, **you** must also pay the **deductible** for the next **policy year**. And, for each further period of 12 months or less that the **stay in hospital** extends, **you** must pay a further **deductible** for one extra **policy year**.

## 2.3 Limits of compensation, limits on special benefits and limit in each policy year

If it applies, **you** must pay any amount over the **limits of compensation**, **limits on special benefits** or the **limit in each policy year**.

For each **stay in a hospital** of 12 months or less, **we** will apply the **limits on special benefits** and **limit in each policy year** for one **policy year** (even if the **stay in a hospital** runs into the next **policy year**). If the **stay in a hospital** is for a continuous period of more than 12 months but less than 24 months, the **limits on special benefits** and **limit in each policy year** for two **policy years** will apply. And, for each further period of 12 months or less that the **stay in a hospital** extends for, the **limits on special benefits** and **limit in each policy year** for one extra **policy year** will apply.

**How we apply the deductible, limits on special benefits and limit in each policy year**
(Figures are for illustration purposes only.)

**Example 1**

If **your policy** began on 1 January in year X, the **policy year** will run from 1 January to 31 December in year X and will renew from 1 January to 31 December in year X+1. If the **insured**'s **stay in hospital** is from 28 December in year X to 1 January in year X+1 (runs into the next **policy year** but for a continuous period of less than 12 months), **we** will work out the claim as follows for an **insured** covered under Enhanced IncomeShield Preferred plan staying in a **private hospital**:

| Expenses | Limits of compensation | Bill | Amount you can claim |
|---|---|---|---|
| Daily ward and treatment charges (normal ward) (5 days) | As charged | $ 3,000 | $ 3,000 |
| Surgical benefit (table 7) | As charged | $10,000 | $10,000 |
| Total | | $13,000 | $13,000 |
| Less **deductible** | | | $ 3,500 |
| Less **co-insurance**: 10% x ($13,000 - $3,500) | | | $ 950 |
| Enhanced IncomeShield (including **MediShield Life**) pays (this depends on the **limits on special benefits** and the **limit in each policy year**) | | | $ 8,550 |
| **Insured** pays | | | $ 4,450 |

**Example 2**

If **your policy** began on 1 January in year X, the **policy year** will run from 1 January to 31 December in year X and will renew from 1 January to 31 December in year X+1. If the **insured**'s **stay in hospital** is from 28 December in year X to 29 December in year X+1 (runs into the next **policy year** and for a continuous period of more than 12 months but less than 24 months), **we** will work out the claim as follows for an **insured** covered under Enhanced IncomeShield Preferred plan staying in a **private hospital**:

| Expenses | Limits of compensation | Bill | Amount you can claim |
|---|---|---|---|
| Daily ward and treatment charges (normal ward) (367 days) | As charged | $ 220,200 | $ 220,200 |
| Surgical benefit (table 7) | As charged | $10,000 | $10,000 |
| Total | | $230,200 | $230,200 |
| Less **deductible** ($3,500 x 2 years) | | | $ 7,000 |
| Less **co-insurance**: 10% x ($230,200 - $7,000) | | | $ 22,320 |
| Enhanced IncomeShield (including **MediShield Life**) pays (depending on two times the **limits on special benefits** and two times the **limit in each policy year**) | | | $ 200,880 |
| **Insured** pays | | | $ 29,320 |

## 2.4 Citizenship factor

If the **insured** is not a Singapore citizen or Singapore permanent resident (is a foreigner) but is covered under the **plan** for a Singapore Citizen, **we** will reduce the amount of each benefit **we** will pay to the percentages (**citizenship factors**) in the following table.

| Plan type | Enhanced Basic | Enhanced C |
|---|---|---|
| Percentage of **benefit we** will pay | 80% | 28% |

The **citizenship factor** applies to any claim under **your policy**.

**You** must tell **us** about the citizenship status or any change to the citizenship status of the **insured**.

If **you** do not want **us** to apply any **citizenship factor** to **your** claim, **you** must apply to change **your plan** to a foreigner plan, to correspond with the **insured**'s citizenship or residency status.

**We** will not apply a **citizenship factor** for an **insured** who is covered under Enhanced IncomeShield Preferred plan or Advantage plan.

## 2.5 Pro-ration factor

### a Ward entitlement and pro-ration factor for inpatient hospital treatment

The **ward entitlement** means the class of ward and medical institution covered by **your policy** and depends on the **plan**. The **ward entitlement** is shown in the **schedule of benefits**.

The class of ward covered refers to a standard room, and does not include luxury suites, luxury rooms or any other special room in the **hospital**.

If the **insured** is admitted into a ward and medical institution that is the same as or lower than their **ward entitlement**, **we** pay **reasonable expenses** for the **necessary medical treatment** according to the **plan. We** will pay up to the **limits of compensation**.

If the **insured** is admitted into a ward and medical institution that is higher than what they are entitled to, **we** will only pay the percentage of the **reasonable expenses** for **necessary medical treatment** of the **insured** as shown using the **pro-ration factor** which applies to the **plan.** This is set out in the **schedule of benefits**. **We** will work out the **benefits we** will pay by multiplying the relevant **pro-ration factor** by the **insured**'s medical expenses which **you** can claim under **your policy**.

If the **insured**'s **stay in a hospital** is in a ward that is the same as or lower than their **ward entitlement** but their pre-hospitalisation treatment or post-hospitalisation treatment is in a **hospital** or clinic higher than they are entitled to, **we** will use the **pro-ration factor** on the **reasonable expenses** relating to the pre-hospitalisation treatment or post-hospitalisation treatment, as the case may be.

**We** will not use a **pro-ration factor** for:

- an **insured** who is covered under the Enhanced IncomeShield Preferred plan; or
- pre-hospitalisation or post-hospitalisation treatment in general practitioner (GP) clinics and specialist outpatient clinics (SOC) in **restructured hospitals**.

**b Pro-ration factor for outpatient hospital treatment**

If the **insured** receives outpatient hospital treatment from a **restructured hospital**, **we** pay **reasonable expenses** for their **necessary medical treatment** according to the **plan. We** will pay up to the **limit of compensation**.

If the **insured** receives outpatient hospital treatment from a **private hospital** or **private medical institution**, **we** will only pay the percentage of the **reasonable expenses** for the **necessary medical treatment** of the **insured,** depending on the **pro-ration factor** which applies to the **plan**, as set out in the **schedule of benefits**. **We** will work out the **benefits we** will pay by multiplying the **pro-ration factor** by the **insured**'s medical expenses which they can claim under **your policy**.

**We** will not use a **pro-ration factor** for:

- an **insured** who is covered under the Enhanced IncomeShield Preferred **plan**; or
- outpatient hospital treatment received by the **insured** from a **restructured hospital**.
- outpatient kidney dialysis, or erythropoietin and other drugs approved under **MediShield Life** for chronic kidney failure, if the treatment the **insured** received was provided by our **preferred partner** in the area of kidney dialysis.

# 3 Your responsibilities

## 3.1 Premium

**Your policy certificate** or the **renewal certificate** (as the case may be) shows the **premium** which **you** have to pay to **us** to receive the **benefits**. **You** must pay the **premium** every year.

**We** give **you** 60 days' grace from the **renewal date** to pay the **premium** for **your policy**. During this **period of grace**, **your policy** will stay in force. **You** must first pay any **premium** or other amounts **you** owe **us** before **we** pay any claim under **your policy**.

If **you** still have not paid the **premium** after the **period of grace**, **your policy** will be cancelled. This cancellation will apply from the **renewal date**.

**You** are responsible for making sure that **your premium** is paid up to date.

**We** may take **your premium** from **your** Medisave account according to the **act** and **regulations**.

**You** will need to pay the **premium**, or any part of it, by cash if:

a the **premium you** owe is more than the maximum withdrawal limit set by the **CPF Board**;
b there are not enough funds in **your** Medisave account to pay the **premium** due; or
c the **premium,** or part of it, is not taken from **your** Medisave account for any reason.

## 3.2 Refunding your premium when the policy ends

When **your policy** ends, **we** will refund the unused part of the **premium** (based on **our** scale of refund as shown below):

a to **your** Medisave account (if **your premium** was paid using deductions from **your** Medisave account); or
b in cash (if **your premium** was paid in cash).

**How we use our scale of refund**
(Figures are for illustration purposes only.)

**Example**

| | |
|---|---|
| **Policy year** | : 1 January to 31 December in year X |
| Enhanced IncomeShield yearly **premium** | : $100 |
| **MediShield Life** yearly premium (for the relevant age next birthday) | : $50 |

If the policy ends on 30 November in year X, the number of days unused left for the **policy year** will be 31 days.

If the policy is integrated with **MediShield Life**, the refund amount will be:

$$\frac{31 \text{ days}}{365 \text{ days}} \times (\$100 - \$50) = \$4.25$$

If the policy is not integrated with **MediShield Life**, or if the policy ends because **you** have switched insurer or died, the refund amount will be:

$$\frac{31 \text{ days}}{365 \text{ days}} \times \$100 = \$8.49$$

If **you** had paid the **premium** partly by CPF and partly by cash, **we** will refund the **premium** as a percentage to the amount of the **premium** paid by CPF or cash.

**Example**
If **you** pay 70% of your **premium** from **your** Medisave account and the other 30% in cash, the refund of unused **premium** will be in the same percentage – meaning 70% returned to **your** Medisave account and 30% paid in cash to **you**.

### 3.3 Change in premium

The **premium** that **you** pay for this policy can change from time to time. If **we** change the **premium** for **your policy**, **we** will write to **you** at **your** last known address, at least 30 days before the change is to take place, to tell **you** what **your** new **premium** is. **We** will change the **premium** for **your policy** only if the change applies to all policies within the same class.

## 4 What you need to be aware of

### 4.1 Other insurance

**We** do not pay for claims if the medical expenses have been paid by other medical insurance or **you** or the **insured** have received a reimbursement from any other source.

If **you** or the **insured** have other medical insurance, including medical benefits under any employment contract, which allows **you** or them to claim a refund for medical expenses, **you** or the **insured** must first claim from these policies before making any claim under **your policy**. **Our** obligations to pay under **your policy** will only arise after **you** have fully claimed under these policies.

If **we** have paid any benefit to **you** first before a claim is made under the other medical insurance policies or employee benefits, the other medical insurers or employer will have to refund **us** their share. **You** must give **us** all information and evidence **we** need to help **us** get back any other medical insurer's share of the claim **we** have paid. For every claim, the total reimbursement **we** will make will not be more than the actual expenses paid.

## 4.2 Declaring the insured's age

The **premium** is based on the age of the **insured** on his or her next birthday. If the age or date of birth of the **insured** is shown wrongly in the **application form**, **we** will adjust the **premium you** must pay. **We** will refund any extra **premium** paid or ask for any shortfall in **premium you** need to pay.

## 4.3 Guaranteed renewal

**We** will renew **your policy** automatically every year. **We** guarantee to do this for life as long as:

a the **premium** is paid at the current rate which applies; and
b the cover for the **insured** under **your policy** has not been ended.

## 4.4 Cancelling the policy

**You** may cancel **your policy** by giving **us** at least 30 days' notice in writing. **We** will tell **you** the date it will end.

## 4.5 Not enforcing a condition

If **we** do not enforce any of the conditions of **your policy** at any time, it does not mean **we** cannot enforce it in the future.

## 4.6 Ending the policy

All **benefits** will end when one of the following events happens, and **we** will not be legally responsible for any further payment under **your policy**.

a **You** cancel **your policy** under clause 4.4.
b **We** do not receive **your premium** after the **period of grace**.
c The **insured** dies.
d **You** fail or refuse to pay or refund any amount **you** owe **us**.
e Fraud as shown in clause 4.12 is identified.
f Relevant information as shown in clause 4.11 is not revealed or is misrepresented.
g **You** take out another Medisave-approved Integrated Shield Plan covering the **insured**.
h The **insured** is no longer a Singapore citizen or Singapore permanent resident.
i The **insured**, who is a foreigner, no longer has an **eligible valid pass.**

**We** or the **CPF Board** (as the case may be) will decide on what date **your policy** will end.

When the policy ends, **you** have no further claims or rights against **us** under **your policy**.

Ending **your policy** will not affect **your** insurance cover under **MediShield Life**. **You** will continue to be insured under **MediShield Life** as long as **you** are eligible under the **act** and **regulations**.

If **you** are not the **insured**, as long as **you** have paid all the **premiums** and **your policy** is not cancelled or ended, if **you** die, it will not affect the cover of the **insured** under **your policy**.

## 4.7 Reinstating the policy

If **your policy** is cancelled because **you** have not paid the **premiums**, **you** may apply to reinstate **your policy**.

**You** can do this if **we** agree and **you** meet all of the following conditions.

a **You** must pay all **premiums you** owe before **we** will reinstate **your policy**.

b **We** will not pay for any expenses which happen between the date the policy ends and the date immediately before the **reinstatement date** of **your policy**.

c If there is any change in the **insured**'s medical or physical condition, **we** may add exclusions or charge an extra **premium** from the **reinstatement date**.

To avoid doubt, if **we** accept any **premium** after **your policy** has ended, it does not mean **we** will not enforce **our** rights under **your policy** or create any liability for **us** in terms of any claim. **Our** responsibility to pay will only arise after **we** have reinstated **your policy**.

## 4.8 Change of citizenship and residency status

**You** must tell **us**, as soon as possible, when the **insured**'s citizenship or residency status changes in any way.

If the **insured** is, or becomes, a Singapore citizen or permanent resident, **we** can convert the existing **plan** to a MediSave-approved Integrated Shield Plan.

If, at the time **your policy** is converted to **our** MediSave-approved Integrated Shield Plan, **you** have an existing MediSave-approved Integrated Shield Plan with another insurer, the policy with that insurer will end automatically as **you** can only be insured under one Integrated Shield Plan.

If the **insured** is no longer a Singapore citizen or permanent resident, **we** can convert the existing **plan** to a foreigner plan.

When **we** convert **your plan** to a MediSave-approved Integrated Shield Plan or foreigner plan, **we** will also:

a convert the **plan** to one that corresponds to the **insured**'s citizenship and residency status which helps to avoid the reduction in the amount of each benefit **we** will pay as a result of the **citizenship factor** (see clause 2.4); and

b adjust the **start date** and **renewal date** of **your** new policy accordingly.

Any claim arising before the **start date** of **your** new **plan** will be paid in line with the limits and other terms and conditions that applied before the **plan** was converted.

## 4.9 Changing policy terms or conditions

**We** may change the **premiums**, **benefits** or cover or these conditions at any time. **We** will write to **you** at **your** last-known address at least 30 days before doing so. **We** will apply the changes only if the changes apply to all policies within the same class. **We** may apply mandatory changes to the policy benefits, features, guidelines and/or conditions as may be introduced by **MOH**, the Central Provident Fund Board or any other regulatory authority on **MediShield Life** immediately without written notice given to **you**.

## 4.10 Changing the plan

**You** may write and ask to change the **plan** if **we** approve. If **we** do approve **your** request, **we** will tell **you** when the change in **plan** will take place.

## 4.11 Giving us all information

**You** and the **insured** must give **us** all significant information about the **insured** (as at the **start date** or the last **reinstatement date**, whichever is later) that may influence **our** decision whether to provide cover or to impose any terms under **your policy**.

If **you** fail to give **us** this information or misrepresent any information, **we** may do any of the following.

a Declare **your policy** as 'void' from the **start date**, if no claim has been paid. **We** will refund **you** all the **premiums** paid to **us**, and **we** will not pay any **benefits**.

b End **your policy**, if any claim has been paid. **We** will refund the **premiums** paid for the renewal of **your policy** after the date of the last claim, and **we** will not pay any **benefits**.

c Add extra terms and conditions to **your policy**.

## 4.12 Fraud

If a claim or any part of a claim is false or fraudulent, or if **you** use fraudulent methods or devices to gain any **benefit**, **we** can do any or all of the following.

- **We** may declare **your policy** invalid and **you** will lose all **benefits** under this policy. **You** will have to repay to **us** all amounts **we** have paid out under the policy and **we** will not refund your **premiums**.
- **We** may end **your policy.**
- **We** may refuse to renew **your policy**.
- **We** may add extra terms and conditions. If **you** disagree with the addition of extra terms and conditions, **you** can write to **us** to cancel this policy. **You** will have to repay to **us** all amounts **we** have paid out under the policy and **we** will refund all **premiums** to **you**.

## 4.13 Currency

All **premium** and **benefits** will be paid in Singapore dollars.

## 4.14 Dealing with disputes

Any dispute or matter arising under, out of or in connection with **your policy** must be referred to the Financial Industry Disputes Resolution Centre Ltd (FIDReC) to be dealt with. (This applies if it is a dispute that can be brought before FIDReC.)

If the dispute cannot be referred to or dealt with by FIDReC, the dispute must be referred to and decided using arbitration in Singapore in line with the Arbitration Rules of the Singapore International Arbitration Centre which apply at that point of time. **We** will not be legally responsible under **your policy** unless **you** have first received an award under arbitration.

## 4.15 Excluding the rights of others

A person who is not directly involved in **your policy** will have no right, under the Contracts (Rights of Third Parties) Act 2001, to enforce any of its terms.

## 4.16 Integration with MediShield Life

The **MediShield Life** scheme is run by the **CPF Board** under the **act** and **regulations**.

**Your policy** is integrated with **MediShield Life** if the **insured** meets the eligibility conditions shown in the **act** and **regulations**.

If **your policy** is integrated with **MediShield Life** to form a Medisave-approved Integrated Shield Plan, the following will apply.

a The **insured** will enjoy all **benefits** under **MediShield Life** provided in the **act** and **regulations**.
b If the cover for the **insured** under this policy ends, the cover for the **insured** under **MediShield Life** will continue as long as the **insured** meets the eligibility conditions shown in the **act** and **regulations**.
c If the **MediShield Life** cover ends or is not renewed, this policy will continue without any integration with **MediShield Life**.

## 4.17 Notice of communication

**We** will assume any notice or communication under this policy has been given and received if sent:

a personally – on the day it is delivered;
b by prepaid mail – within seven days after the mail is sent;
c by fax – immediately, as long as a transmission report is produced by the machine from which the fax was sent which shows that the fax was sent to the fax number of the recipient; or
d by email, SMS or other electronic means – as soon as it is sent.

## 4.18 Exclusions

The following treatment items, procedures, conditions, activities and their related complications are not covered under **your policy**.

a A **stay in hospital** if the **insured** was admitted to the **hospital** before the **start date**.
b Any **pre-existing illness, disease or condition** from which the **insured** was suffering, unless declared in the **application form** and **we** accepted the application without any exclusions. However, **we** will exclude any **pre-existing illness, disease or condition** which is specifically excluded in **your policy**, whether a declaration was made in the **application form** or not. To avoid doubt, any **pre-existing illness, disease or condition** will be covered under **MediShield Life** according to the **act** and **regulations**, as long as the **insured** satisfies the eligibility criteria for **MediShield Life** at the time the claim is made under **your policy**.
c Cosmetic surgery (unless this is covered under breast reconstruction after mastectomy benefit or **cosmetic surgery due to accident)** or any medical treatment claimed to generally prevent illness, promote health or improve bodily function or appearance.
d General outpatient medical expenses (unless this is covered under outpatient hospital treatment, pre-hospitalisation treatment or post-hospitalisation treatment).
e Treatment for birth defects, hereditary conditions and disorders, and congenital sickness or abnormalities (unless **we** do cover it under congenital abnormalities benefit).
f Overseas medical treatment (unless **we** cover it under emergency overseas treatment).
g Psychological disorders, personality disorders, mental conditions or behavioural disorders, including any addiction or dependence arising from these disorders such as gambling or gaming addiction (unless **we** cover it under inpatient psychiatric treatment benefit).

h Pregnancy, childbirth, miscarriage, abortion or termination of pregnancy, lactation complications, or any form of related **stay in hospital** or treatment (unless **we** cover this under pregnancy and delivery-related complications benefit).

i Infertility, sub-fertility, assisted conception, erectile dysfunction, impotence or any contraceptive treatment.

j Treatment of sexually-transmitted diseases.

k Acquired immunodeficiency syndrome (AIDS), AIDS-related complex or infection by human immunodeficiency virus (HIV) (except **HIV due to blood transfusion** and **occupationally acquired HIV**).

l A **stay in hospital** before 1 April 2023 for injuries or illness resulting from attempted suicide and for self-inflicted injuries, whether the **insured** is sane or insane.

m A **stay in hospital** before 1 April 2023 for drug or alcohol abuse or misuse, or any injury, illness or disease caused directly or indirectly by the abuse or misuse of alcohol, drugs or substance.

n Injuries or illness resulting directly or indirectly from addiction to or the influence of any controlled drug that is specified in the First Schedule in the Misuse of Drugs Act 1973.

o Expenses of getting an organ or body part for a transplant from a **living organ donor** for the **insured** and all expenses the **living organ donor** has to pay (unless this is covered under living organ donor (insured) transplant benefit or living organ donor (non-insured) transplant benefit).

p Dental treatment regardless of whether it is caused directly or indirectly by an illness or injury (unless this is covered under accident inpatient dental treatment).

q Transport-related services including ambulance fees, emergency evacuation, sending home a body or ashes.

r Sex-change operations.

s Buying or renting special braces, appliances, equipment, machines and other devices, such as wheelchairs, walking or home aids, dialysis machines, iron lungs, oxygen machines and any other hospital-type equipment to use at home or as an outpatient. To avoid doubt, this includes but is not limited to all associated fees such as general or specialist medical services and consultations, diagnostic and laboratory services, examinations and investigations.

t Optional items which are outside the scope of treatment, prostheses and corrective devices, and medical appliances which are not needed surgically (unless this is covered under prosthesis benefit).

u Experimental or pioneering medical or surgical techniques and 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 these trials have a clinical trial certificate issued by the Health Sciences Authority of Singapore.

v Private nursing charges and home-based nursing services.

w Vaccinations.

x Treatment of injuries arising from being directly or indirectly involved in civil commotion, riot, strike, terrorist activities, breaking or attempting to break the law, resisting arrest or any imprisonment.

y The consequences arising, whether directly or indirectly, from nuclear fallout, radioactivity, any nuclear fuel, material or waste, war and related risks.

z Rest cures, hospice care, home or outpatient nursing, home visits or treatments, home rehabilitation or palliative care, convalescent care in convalescent or nursing homes, sanatoriums or similar establishments, outpatient rehabilitation services such as counselling and physical rehabilitation (unless **we** cover it under inpatient palliative care service (general or specialised)).

aa Alternative or complementary treatments, including traditional Chinese medicine (TCM), chiropractor, naturopath, acupuncturist, homeopath, osteopath, dietician or a stay in any health-care establishment for social or non-medical reasons.

ab Treatment for any illness or injury resulting from the **insured** taking part in a dangerous activity or sport whether as a professional or when an income could or would be earned from the activity or sport.

ac Treatment arising from or related to obesity, weight reduction or weight management (regardless of whether it is for medical or psychological reasons), including but not limited to gastric band or stapling, or removing fat or surplus tissue from any part of the body.

ad **Staying in a hospital** for the main purpose of an X-ray, CT scan or MRI scan, a medical check-up, health screening or **primary prevention** (except for surveillance screening that is related to the **insured's** history of cancer and is ordered by a **registered medical practitioner**)

ae Non-medical items such as parking fees, hospital administration and registration fees, laundry, television rental, personal-care and hygiene products, newspapers or fees for medical reports (including test results).

af Genetic testing that is carried out for health screening, risk evaluation or assessing prognosis. To avoid doubt, genetic testing is only covered when it is ordered by the **registered medical practitioner** because the result of the genetic testing is needed to determine the medical treatment for the diagnosed condition.

ag Routine eye and ear examinations, correction for refractive errors of the eye (conditions such as nearsightedness, farsightedness, presbyopia (gradual loss of the eye's ability to focus on nearby objects) and astigmatism), lasik treatments, costs of spectacles, costs of contact lenses and costs of hearing aid.

ah Outpatient cancer drug treatments that are not on the **CDL**.

To avoid doubt, **your policy** does not cover any item or exclusion that is set out in the **act** and its **regulations** or not allowed by **MediShield Life Claims Rules**, unless **we** issue an endorsement to **your policy**.

## 5 Definitions

**Accident** means an unexpected incident that happens on or after the **start date** of **your policy**, or the last **reinstatement date**, whichever is later, that results in an injury. The injury must be caused entirely by being hit by an external object that produces a bruise or wound, except for injury caused specifically by drowning, food poisoning, choking on food, or suffocation by smoke, fumes, or gas.

**Act** means the Central Provident Fund Act 1953 and the MediShield Life Scheme Act 2015, as amended, extended or re-enacted from time to time.

**Application form** means the application to cover the **insured** under this policy **you** make to **us**.

**Benefits** means the benefits set out in the **schedule of benefits** and **your policy**.

**Cancer Drug List (CDL)** means the list of clinically proven and more cost-effective cancer drug treatments on the **MOH** website (go.gov.sg/moh-cancerdruglist). **MOH** may update the **CDL** from time to time.

**Citizenship factor** means the percentage given in clause 2.4 of these conditions. The citizenship factor does not apply to the prosthesis benefit.

**Co-insurance** means the amount that **you** need to pay after the **deductible**. The **co-insurance** percentages for the **benefits** are shown in the **schedule of benefits**. **Co-insurance** applies to all claims made under **your policy** except for final expenses benefit.

**Community hospital** means any approved community hospital under the **act** and **regulations** that provides an intermediate level of care for individuals who have simple illnesses which do not need **specialist** medical treatment and nursing care.

**Cosmetic surgery due to accident** means inpatient hospital treatment for **necessary medical treatment** done to repair damage for the injury caused only by an **accident**. This surgery must be recommended by the **registered medical practitioner** who treated the **insured** for the injury and must be performed during a **stay in hospital** within 365 days of the **accident**.

**CPF Board** means the Central Provident Fund Board of Singapore.

**Deductible** means the part of the **benefit you** are claiming that the **insured** must pay before **we** will pay any benefit. The **deductible** is shown in the **schedule of benefits**. The **deductible** does not apply to claims for **benefits** covered under section 1.2 (Outpatient hospital treatment) or section 1.3g (Prosthesis benefit).

**Eligible valid pass** means a valid pass with a foreign identification number (FIN) recognised by the Immigration and Checkpoints Authority of Singapore (ICA).

**Emergency** means a sudden or unexpected serious medical condition or injury which needs immediate surgery or medical treatment in a **hospital** to prevent death or serious damage to the **insured's** immediate or long-term health. **We** have the right to determine if the medical condition or injury is classed as an **emergency**.

**Expiry date** means the date the insurance cover under **your policy** ends and is shown in the **policy certificate** or **renewal certificate** (as the case may be).

**General inpatient palliative care** means general palliative care to improve the quality of life of patients with terminal illnesses who need to be treated as inpatients (for example, relieving symptoms such as pain and breathlessness through oral and subcutaneous medication), as well as support for patients and caregivers.

**HIV due to blood transfusion** means infection with the human immunodeficiency virus (HIV) as a result of a blood transfusion as long as all of the following conditions are met.

- The blood transfusion is **necessary medical treatment**.
- The blood transfusion was received in Singapore on or after the **start date** or last **reinstatement date** (if any), whichever is later.
- The source of infection is from the **hospital** that gave the blood transfusion.
- The cause of HIV is the blood provided by the **hospital** that gave the blood transfusion.
- The **insured** does not suffer from thalassaemia major or haemophilia.

**We** do not cover HIV infection resulting from any other means, including sexual activity and using intravenous drugs.

**Hospital** means:

- a **restructured hospital**;
- a **private hospital**;
- a **community hospital**; or
- any other hospital **we** accept.

**HOTA** means the Human Organ Transplant Act 1987, as amended, extended or re-enacted from time to time.

**Inpatient palliative care provider** means any **MOH**-approved inpatient palliative care provider. **You** can find the details at www.moh.gov.sg. **MOH** may update this list from time to time.

**Insured** means the person named as the insured in the **policy certificate** or **renewal certificate** (as the case may be).

**Intensive care unit (ICU)** means the intensive care unit of a **hospital**.

**Limit in each lifetime** means the maximum amount (if any) shown in the **schedule of benefits** which **we** will pay under **your policy** during the lifetime of the **insured**.

**Limit in each policy year** means the maximum amount set out in the **schedule of benefits** which **we** will pay under **your policy** for the relevant **policy year**.

**Limits of compensation** means the limits of compensation set out in the **schedule of benefits** and is the most **we** will pay in **benefits**.

**Limits on special benefits** means the limits on **benefits we** will pay as set out in the **schedule of benefits** and is the most **we** will pay in **benefits**.

**Living organ donor** means a living person from whom a **specified organ** is removed and transplanted into another living person.

**MOH** means the Ministry of Health, Singapore.

**Medical institution** means a licensed:
- private clinic;
- medical centre;
- diagnostic centre; or
- dialysis centre

in Singapore.

**MediShield Life (MSHL)** means the basic tier of insurance protection scheme run by the **CPF Board** and governed by the **act** and **regulations**.

**MediShield Life claimable criteria** means the list of criteria that long-term and home parenteral-nutrition patients must meet in order to qualify for **MediShield Life** cover. **You** can find the details at www.moh.gov.sg. **MOH** may update this list from time to time.

**MediShield Life Claims Rules** means rules which guide whether a claim is appropriate for **MediShield Life** (see **MOH** website).

**Multiple primary cancers** means two or more cancers arising from different sites and are of a different histology or morphology group.

**Necessary medical treatment** means reasonable and common treatment which, in the professional opinion of a **registered medical practitioner** or a **specialist** in the relevant field of medicine, is appropriate and consistent with the symptoms, findings, diagnosis and other relevant clinical circumstances of the illness or injury and reduces the negative effect of the illness or injury on the **insured**'s health.

The treatment:
- must be provided in line with generally accepted standards of good medical practice in Singapore, be consistent with current standards of professional medical care, have proven medical benefits, and also be cost-effective and supported by the guidelines of **MOH** (such as the **MediShield Life Claims Rules**) or official bodies such as Health Science Authority, the Allied Health Professions Council or the Agency for Care Effectiveness;
- must not be for the convenience of the **insured** or **registered medical practitioner** or **specialist** (for example, treatment that can reasonably be provided out of a hospital, but is provided as an inpatient treatment);
- must not be for medical trials and/or experimental, investigational or research in nature. This includes but is not limited to experimental therapy, pioneering or new medical techniques, surgical techniques, physiotherapy, medical devices, medicinal products, whether or not these have been approved and/or issued with a clinical trial certificate by **MOH** or the Health Sciences Authority or other regulatory bodies in Singapore; and
- must not be for **primary prevention**, or preventive treatments unrelated to the current diagnosis, or for health screening or promoting good health (such as dietary replacement or supplement), or if the outcome of the examination or test has no medical indication. To avoid doubt, **we** do not cover dietary replacement or supplements whether or not medically proven, if they are not evaluated for its quality, safety and efficacy by Health Sciences Authority (HSA).

**We** reserve the right to determine whether a treatment, service or expense is **necessary medical treatment**.

**Occupationally acquired HIV** means infection with the human immunodeficiency virus (HIV) which resulted from an incident which happened on or after the **start date** or the last **reinstatement date** (if any), whichever is later, while the **insured** was carrying out their job. However, **you** must give **us** satisfactory proof of all of the following.

- **You** must report the incident giving rise to the HIV infection to **us** within 30 days of the incident.
- **We** need proof that the incident was the cause of the HIV infection.
- **We** also need proof that the **insured** has changed from HIV negative to HIV positive during the 180 days after the reported incident. This proof must include a negative HIV antibody test carried out within five days of the incident.
- The incident happened while the **insured** was carrying out their normal professional duties in Singapore as a medical practitioner, houseman, medical student, state registered nurse, medical laboratory technician, dentist, dental surgeon, dental nurse or paramedical worker working in a **hospital** or in a licensed medical centre or clinic in Singapore.

**We** will not cover HIV infection resulting from any other means, including sexual activity and using intravenous drugs.

**Panel** or **preferred partner** means a:

- **registered medical practitioner**;
- **specialist**;
- **hospital**; or
- **medical institution**;

approved by **us**. The lists of approved **panels** and **preferred partners,** which **we** may update from time to time, can be found at www.income.com.sg/specialist-panel. **Our** list of approved **panels** also includes all **restructured hospitals**, **community hospitals** and **voluntary welfare organisations (VWO)** dialysis centres.

**Period of grace** means the period shown in clause 3.1.

**Plan** means the type of plan that **you** have chosen under **your policy** and which is shown in the **policy certificate** or the **renewal certificate** (as the case may be).

**Policy certificate** means the policy certificate which **we** issue to **you**.

**Policy year** means one year starting from:

- the **start date**; or
- if **your policy** is renewed, the **renewal date**.

**Pre-existing illness, disease or condition** means any illness, disease or condition:

- for which the **insured** asked for or received treatment, medication, advice or diagnosis (or which they ought to have asked for or received) before the **start date** or the last **reinstatement date** (if any), whichever is later;
- which was known to exist before the **start date** or the last **reinstatement date** (if any), whichever is later, whether or not the **insured** asked for treatment, medication, advice or diagnosis; or
- the conditions or symptoms of which existed before the **start date** or the last **reinstatement date** (if any), whichever is later, and would have led a reasonable and sensible person to get medical advice or treatment.

**Premium** means the premium as shown in clause 3.1.

**Private hospital** means any licensed private hospital in Singapore that is not a **restructured hospital**.

**Primary prevention** means medical services for generally healthy people, which are carried out in the absence of signs or symptoms that would indicate the need for treatment, in order to prevent a disease from occurring, including (but not limited to) general medical or health screening, general physical check-ups, vaccinations, and medical certificates and examinations for employment or travel.

**Private medical institution** means a licensed private:

- clinic;
- medical centre;
- diagnostic centre; or
- dialysis centre;

in Singapore.

**Pro-ration factor** means the pro-ration factor as shown in clause 2.5. The pro-ration factor does not apply to the prosthesis benefit.

**Prosthesis** means an artificial device extension that replaces any limb or eye of the **insured**.

**Reasonable expenses** means expenses which are appropriate and consistent with the diagnosis and according to accepted medical standards, and which could not have reasonably been avoided without negatively affecting the **insured**'s medical condition.

The expenses:

- must not be more than the general level of charges made by other medical service suppliers of similar standing in Singapore for the services and supplies;
- must not include fees or charges that would not have been made if no insurance had existed; and
- must be within the current range of fee guidelines published by the Singapore government, **MOH** or official bodies such as the Health Sciences Authority and the Allied Health Professions Council.

**Registered medical practitioner** means a doctor who:

- is registered with the Singapore Medical Council (SMC);
- has a valid Practising Certificate (PC); and
- holds an MBBS/MD degree awarded by a recognized medical school in the first schedule and second schedule of the Medical Registration Act 1997.

This cannot be **you**, the **insured** or **your** or the **insured**'s parent, brother or sister, husband or wife, child or relative.

**Regulations** means any subsidiary legislation made under the **Act** and, as amended, extended or re-enacted from time to time.

**Rehabilitative care** means therapy to improve the **insured**'s disability and functional impairment after an illness.

**Reinstatement date** means the date when **we** approve **your** application for reinstatement or when **we** receive the reinstatement **premium**, whichever is later.

**Renewal certificate** means (in cases where **your policy** is renewed) the renewal certificate issued for **your policy**.

**Renewal date** means the start date of the relevant renewed **policy year** covered by **your policy** and shown in the **renewal certificate**.

**Restructured hospital** means a hospital in Singapore that:

- is run as a private company owned by the Singapore Government;
- is governed by broad policy guidance from the Singapore Government through **MOH**; and
- receives a yearly government subsidy to provide subsidised medical services to its patients.

**Schedule of benefits** means the schedule of benefits attached to these conditions (or any revised schedule of benefits which **we** may issue in an endorsement to **your policy**, or when renewing **your policy**).

**Short-stay ward** means a ward in the emergency department of a **hospital** for patients who need a short period of inpatient monitoring and treatment.

**Specialist** means a **registered medical practitioner** who is:

- on the Register of Medical Practitioners;
- accredited by the Specialists Accreditation Board (SAB); and
- registered by the Singapore Medical Council (SMC) with recognized specialties and subspecialties.

**Specialised inpatient palliative care** means specialised palliative care to improve the quality of life of patients with terminal illnesses who have complex needs and require higher levels of care (compared with general palliative care). Examples include administering intravenous medication and specialised wound care for complex wounds.

**Specified organ** means a specified organ as defined in **HOTA**.

**Start date** means the date **your policy** starts and is shown in the **policy certificate**.

**Staying in a community hospital** is defined in line with the conditions in clause 1.1(j).

**Staying in a hospital** means a continuous period of time, during which the **insured** is admitted to and stays in a **hospital** for **necessary medical treatment**, in line with the terms of **your policy** and where room and board charges are made. This includes day surgery for which no overnight stay is needed (as long as the surgery is listed in the **surgical limits table**).

**Stem-cell transplant** means the infusion of healthy stem cells into the body of the **insured**.

**Sub-acute care** means care for complicated medical conditions that require additional medical and nursing care that is less intensive compared to **hospitals** with acute care inpatient facilities.

**Surgical limits table** means the latest surgical operation fee tables 1 to 7 (in 'Table of Surgical Procedure') set by **MOH** from time to time.

**Voluntary Welfare Organisations (VWO)** means a non-profit organisation that provides welfare services or services that benefit the whole community.

**Ward entitlement** means the ward entitlement shown in clause 2.5(a).

**We, us** or **our** means Income Insurance Limited.

**You** or **your** means the person named in the **policy certificate** as the policyholder.

# Conditions for Deluxe Care Rider

## 1 What your rider covers

This rider covers the following **benefits**.

This rider applies as well as **your policy**. **We** will only pay the **benefits** under this rider if **you** are eligible to make a claim under **your policy**.

Paying the **benefits** under this rider depends on the **limits of compensation**, **limits on special benefits** (if it applies), **limit for each policy year** of **your policy** and all other limits listed in the **schedule of benefits**, where it applies.

### 1.1 Deductible and co-insurance

While this rider is in force, there is no **deductible** or **co-insurance** due under **your policy**. However, **you** will have to make a co-payment and an extended panel and non-panel payment (if it applies) for each claim, as set out below.

#### a Co-payment

For each claim under **your policy**, **you** will have to make a co-payment, as shown in the table below. If the treatment is provided by **our panel** or **extended panel**, **we** will apply a co-payment limit as shown in the table.

| Treatment provided by | Our panel | Extended panel | Others |
|---|---|---|---|
| Co-payment and limit | 5% co-payment of the **benefits** due under **your policy** | | |
| | Up to $3,000 limit (each **policy year**) | | No limit |

If **you** are claiming for pre-hospitalisation treatment, post-hospitalisation treatment or special benefits (if it applies), **we** will not apply the co-payment limit if the treatment during the **insured**'s **stay in hospital** is not provided by **our panel** or **extended panel**.

If **you** are claiming for consultation fees, medicines, examinations or tests for the main outpatient hospital treatment that is covered under **your policy**, **we** will apply the co-payment limit only if the main outpatient hospital treatment is provided by **our panel** or **extended panel**.

For each claim that meets the **limits on special benefits** (if it applies) or the **limit for each policy year** of **your policy,** the co-payment for that claim will not be added towards the co-payment limit of $3,000 for each **policy year**.

When the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for their **stay in hospital** or the main outpatient hospital treatment under **your policy**, **we** will apply the co-payment limit as long as the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel** or **extended panel**.

For each **stay in hospital** of 12 months or less, where the treatment is provided by **our panel** or **extended panel**, **you** must pay the co-payment (up to a maximum of $3,000) for one **policy year** (even if the **stay in hospital** runs into the next **policy year**). If the **stay in hospital** is for a continuous period of more than 12 months but less than 24 months, **you** must also pay up to the maximum co-payment for the next **policy year**. And, for each further period of 12 months or less that the **stay in hospital** extends for, **you** must pay the co-payment for one extra **policy year**.

### b Extended panel and non-panel payment (ENP)

If the treatment during the **insured**'s **stay in hospital** is provided by a **registered medical practitioner** or **specialist** who is not from **our panel** or is from the **extended panel, you** will have to make an extended panel and non-panel payment (ENP) of up to $2,000 in each **policy year** for **your** claims for inpatient hospital treatment, pre-hospitalisation treatment, post-hospitalisation treatment or special benefits (if it applies). **You** must pay the co-payment followed by the ENP. **We** will only pay the amount of **your** claim which is more than the total of the co-payment and the ENP. To avoid doubt, ENP is also applicable for claim paid under emergency overseas treatment benefit of **your policy**.

When there is more than one treating **registered medical practitioner** or **specialist** for the **insured**'s **stay in hospital, we** will apply the ENP as long as the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is not from **our panel** or is from the **extended panel**.

For each **stay in hospital** of 12 months or less that is provided by a **registered medical practitioner** or **specialist** who is not from **our panel** or is from the **extended panel**, **you** must pay the ENP of up to $2,000 for one **policy year** (even if the **stay in hospital** runs into the next **policy year**). If the **stay in hospital** is for a continuous period of more than 12 months but less than 24 months, **you** must also pay the ENP of up to $2,000 for the next **policy year**. And, for each further period of 12 months or less that the **stay in hospital** extends for, **you** must pay the ENP of up to $2,000 for one extra **policy year.**

## 1.2 Additional cancer drug treatment benefit

This benefit pays for outpatient cancer drug treatments that are listed on the **CDL**, and selected cancer drug treatments that are not listed on the **CDL** (non-**CDL** treatments), up to the limits shown in tables 1a and 1b. This benefit will be paid on top of the **benefits** covered under **your policy**.

For claims under this rider for outpatient cancer drug treatments on the **CDL**, the following apply.

- **We** cover outpatient cancer drug treatments on the **CDL** in accordance with the conditions set out in **your policy**.
- For **insured** receiving treatment for **multiple primary cancers**, **we** will pay up to the limits shown in tables 1c and 1d for the cancer drugs administered in that month.
- The cancer drug treatment on the **CDL** benefit limit is based on a multiple of the **MSHL** Limit for the specific cancer drug treatment. For the latest **MSHL** Limit, refer to the **CDL** on **MOH**'s website under "MediShield Life Claim Limit per month" (go.gov.sg/moh-cancerdruglist). **MOH** may update this from time to time. The revised list will be applicable to the cancer drug treatment which occurred on and from the effective date of the revised list.

For outpatient cancer drug treatments not on the **CDL**, **we** cover only treatments with drug classes A to E (according to the Life Insurance Association, Singapore's (LIA's) Non-**CDL** Classification Framework). **You** can find the details at www.lia.org.sg. LIA may update the list from time to time.

Table 1a

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits | | | |
|---|---|---|---|---|
| | Enhanced IncomeShield | | | |
| | **Preferred** | **Advantage** | **Basic** | **Enhanced C** |
| Treatment on **CDL** (each month) | 18x **MSHL** limit | 18x **MSHL** limit | 10x **MSHL** limit | 6x **MSHL** limit |
| Non-**CDL** treatment (each month) | $15,000 | $7,000 | $6,000 | $4,000 |

Table 1b

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits | | | | |
|---|---|---|---|---|---|
| | IncomeShield Standard Plan | IncomeShield Plans | | | |
| | | **Plan P** | **Plan A** | **Plan B** | **Plan C** |
| Treatment on **CDL** (each month) | 6x **MSHL** limit | 10x **MSHL** limit | 10x **MSHL** limit | 6x **MSHL** limit | 6x **MSHL** limit |
| Non-**CDL** treatment (each month) | $5,200 | $4,000 | $3,800 | $3,500 | $3,200 |

Table 1c

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits for multiple primary cancers | | | |
|---|---|---|---|---|
| | Enhanced IncomeShield | | | |
| | **Preferred** | **Advantage** | **Basic** | **Enhanced C** |
| Treatment on **CDL** (each month) | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer | | | |
| Non-**CDL** treatment (each month) | $15,000 x number of primary cancers | $7,000 x number of primary cancers | $6,000 x number of primary cancers | $4,000 x number of primary cancers |

Table 1d

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits for multiple primary cancers | | | | |
|---|---|---|---|---|---|
| | IncomeShield Standard Plan | IncomeShield Plans | | | |
| | | **Plan P** | **Plan A** | **Plan B** | **Plan C** |
| Treatment on **CDL** (each month) | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer | | | | |
| Non-**CDL** treatment (each month) | $5,200 x number of primary cancers | $4,000 x number of primary cancers | $3,800 x number of primary cancers | $3,500 x number of primary cancers | $3,200 x number of primary cancers |

For each outpatient cancer drug treatment claim under **your** rider, **you** will have to make a co-payment as shown in table 2.

If the **insured** receives cancer drug treatment on the **CDL** that is provided by **our panel** or **extended panel**, the co-payment for that claim will be counted towards the co-payment limit of $3,000 in clause 1.1a. To avoid doubt, **we** will not apply the co-payment limit for all non-**CDL** treatments, including non-**CDL** treatments provided by **our panel** or **extended panel**.

Table 2

| Types of Treatment | Co-payment |
|---|---|
| Treatment on **CDL**, not provided by **our panel** or **extended panel** | 5% of the benefits due under the rider |
| Treatment on **CDL**, provided by **our panel** or **extended panel** | 5% of the benefits due under the rider, up to a co-payment limit of $3,000 for each **policy year** |
| Non-**CDL** treatment | 10% of the benefits due under the rider |

### 1.3 Extra-bed benefit

If during the **insured**'s **stay in hospital** their parent or guardian stays and shares the same room, **we** will reimburse up to $80 for each day the parent or guardian stays. This applies as long as the following conditions are met.

- The **insured** is a child aged 18 or younger during their **stay in hospital**.
- **We** will pay up to 10 days for each **stay in hospital.**
- If the **insured** is in **hospital** for only part of a day, **we** will pay half of this benefit for that day.

The co-payment under clause 1.1 (a) and ENP under clause 1.1 (b) of this rider does not apply to any claim for this benefit.

## 2 Our responsibilities to you

**Our** responsibilities to **you** are only for the cover and period shown in this endorsement or **renewal certificate** (as the case may be) and depend on the terms, conditions and limits of this rider.

### 2.1 Co-payment and extended panel and non-panel payment

**You** must make the co-payment and extended panel and non-panel payment (ENP) (if it applies) before **we** pay any benefit. **We** will only pay the amount of **your** claim which is more than the co-payment and ENP.

**We** will apply the co-payment followed by the ENP (if it applies).

## 3 Your responsibilities

### 3.1 Premium

The **premium you** have to pay **us** for this rider so that **you** can receive the **benefits** in clause 1 is set out above. If **you** add this rider to **your policy** during a **policy year**, the **premium** for this rider for that **policy year** will be pro-rated. **You** must pay the **premium** for this rider every year.

**We** give **you** 60 days' grace from the **renewal date** of this rider to pay the **premium** for this rider. During this **period of grace**, this rider will stay in force. **You** must first pay any outstanding **premium** for this rider, **premium** for **your policy** or amounts **you** owe **us** before **we** pay any claim under this rider.

If **you** still have not paid the **premium** for this rider after the **period of grace**, this rider will be cancelled. This cancellation will apply from the **renewal date** of this rider.

**You** are responsible for making sure that the **premium** for this rider is paid up to date.

### 3.2 Refunding the premium when this rider ends

**We** will refund the unused pro-rated portion of the **premium** for this rider to **you** in cash when this rider ends.

### 3.3 Change in premium

The **premium** for this rider can change. If **we** change the **premium** for this rider, **we** will write to **you** at **your** last-known address, at least 30 days before the change is to take place, to tell **you** what **your** new **premium** for this rider is. **We** will change the **premium** for this rider only if the change applies to all policies within the same class.

## 4 What you need to be aware of

### 4.1 Cancelling this rider

**You** may cancel this rider by giving **us** at least 30 days' notice in writing. **We** will tell **you** the date it will end. Cancelling this rider will not affect the validity of **your policy**.

### 4.2 Ending this rider

If **your policy** is cancelled, ends, or has lapsed for any reason, this rider will automatically end immediately even if the **period of grace** has not come to an end.

### 4.3 Reinstating this rider

If this rider is cancelled because **you** have not paid the **premiums**, **you** may apply to reinstate this rider.

**You** can do this if **we** agree and **you** meet all of the following conditions.

a **You** must pay all **premiums** for this rider **you** owe before **we** will reinstate this rider.

b **We** will not pay for any expenses which happen between the date this rider ends and the date immediately before the **reinstatement date** of this rider.
c If there is any change in the **insured**'s medical or physical condition, **we** may add exclusions or charge an extra **premium** for this rider from the **reinstatement date**.

To avoid doubt, if **we** accept any **premium** for this rider after this rider has ended, it does not mean **we** create any liability for **us** in terms of any claim or will not enforce **our** rights under this rider. **Our** responsibility to pay will only arise after **we** have reinstated this rider.

### 4.4 The terms and conditions of your policy

**We** may change the **premiums**, **benefits** or cover or these conditions at any time. However, **we** will write to **you** at **your** last-known address at least 30 days before doing so. **We** will apply the changes only if the changes apply to all policies within the same class.

Unless they are changed by this rider:
a all other terms and conditions of **your policy** will not change and will apply to this rider, if it applies; and
b words defined in the definitions section of the conditions of **your policy**, if used in this rider, will have the same meanings.

If there is any inconsistency between the terms and conditions of this rider and **your policy**, the terms and conditions of this rider will apply.

### 4.5 Exclusions

All exclusions under **your policy** will apply to this rider.

## 5 Definitions

For the purposes of this rider, **we** have added the following definitions.

**Panel** or **preferred partner** means a:
- **registered medical practitioner**;
- **specialist**;
- **hospital**; or
- **medical institution;**

approved by **us**. The lists of approved **panels** and **preferred partners**, which **we** may update from time to time, can be found at www.income.com.sg/specialist-panel. **Our** list of approved **panels** also includes all **restructured hospitals**, **community hospitals** and **voluntary welfare organisations (VWO)** dialysis centres.

**Extended panel** means a **registered medical practitioner** or **specialist** approved by **us** to provide coverage on the benefits in Section 1.1. The **registered medical practitioner** or **specialist** must not be on **our panel** or **preferred partners** lists and must meet other criteria including being on another Integrated Shield Plan provider's panel listing. The approved **extended panel** list, which **we** may update from time to time, can be found at www.income.com.sg/specialist-panel.

**————————————————————End of policy conditions————————————————————**

**Summarised changes to Enhanced IncomeShield (For renewal from 1 Sep 2024)**

| | Enhancement | New Benefits |
|---|---|---|
| **1. Benefits under Outpatient hospital treatment** | | |
| a. Cancer drug treatment | ✓ | |
| b. Cancer drug services | ✓ | |
| **2. Benefits under Special benefits** | | |
| a. Inpatient psychiatric treatment benefit | ✓ | |

**Changes in clauses and definitions**

Note: The words in bold are defined in the definitions section of your policy.

| Clause heading | Existing clause | Revised clause |
|---|---|---|
| 1.1 (h) Pre-hospitalisation treatment | The cost of medical treatment received by the **insured** in the **policy year** for up to 100 days before the date they went into **hospital**.<br><br>If the inpatient hospital treatment is provided by **our panel** and paid for under the Enhanced IncomeShield Preferred plan, **we** will cover the cost of medical treatment the **insured** received in the **policy year** for up to 180 days before the date they went into **hospital**. To avoid doubt, if the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for the **insured**'s **stay in a hospital**, **we** will cover up to 180 days of pre-hospitalisation treatment only when the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel**.<br><br>Pre-hospitalisation treatment includes **specialist** outpatient medical services and consultations, diagnostic and laboratory services, examinations and investigations ordered by a **registered medical practitioner**.<br><br>Pre-hospitalisation treatment must lead to the **insured** being admitted to a **hospital** for the same illness or injury for which they received medical treatment before their **stay in hospital**.<br><br>**We** do not cover pre-hospitalisation treatment if, under **your policy**, **we** do not pay for the inpatient hospital treatment received during the **stay in hospital**. | The cost of medical treatment received by the **insured** in the **policy year** for up to 100 days before the date they went into **hospital**.<br><br>If the inpatient hospital treatment is provided by **our panel** and paid for under the Enhanced IncomeShield Preferred plan, **we** will cover the cost of medical treatment the **insured** received in the **policy year** for up to 180 days before the date they went into **hospital**. To avoid doubt, if the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for the **insured**'s **stay in a hospital**, **we** will cover up to 180 days of pre-hospitalisation treatment only when the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel**.<br><br>Pre-hospitalisation treatment includes **specialist** outpatient medical services and consultations, diagnostic and laboratory services, examinations and investigations ordered by a **registered medical practitioner**.<br><br>Pre-hospitalisation treatment must lead to the **insured** being admitted to a **hospital** for the same illness or injury for which they received medical treatment before their **stay in hospital**.<br><br>**We** do not cover pre-hospitalisation treatment if, under **your policy**, **we** do not pay for the inpatient hospital treatment received during the **stay in hospital**. |

| | | |
|---|---|---|
| | **We** do not cover pre-hospitalisation treatment which is given before inpatient psychiatric treatment benefit, accident inpatient dental treatment or emergency overseas treatment. | **We** do not cover pre-hospitalisation treatment which is given before inpatient psychiatric treatment benefit, accident inpatient dental treatment or emergency overseas treatment.<br><br>To avoid doubt, pre-hospitalisation treatment does not include inpatient hospital treatment and day surgery. |
| 1.1(i) Post-hospitalisation treatment | The cost of medical treatment received by the **insured** in the **policy year** for up to 100 days after the date they leave **hospital**.<br><br>If the inpatient hospital treatment is provided by **our panel** and paid for under the Enhanced IncomeShield Preferred plan, **we** will cover the cost of medical treatment the **insured** received in the **policy year** for up to 365 days after the date they left **hospital**.<br><br>To avoid doubt, if the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for the **insured**'s **stay in a hospital**, **we** will cover up to 365 days of post-hospitalisation treatment only when the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel**.<br><br>Post-hospitalisation treatment includes **specialist** outpatient medical services and consultations, medication, physiotherapy, occupational therapy, speech therapy, diagnostic and laboratory services, examinations and investigations that are:<br>• ordered by a **registered medical practitioner**; and<br>• carried out within the period that **we** cover post-hospitalisation treatment for.<br><br>Any physiotherapy, occupational therapy or speech therapy must be provided by an Allied Health Professional registered under **MOH**.<br><br>Post-hospitalisation treatment must: | The cost of medical treatment received by the **insured** in the **policy year** for up to 100 days after the date they leave **hospital**.<br><br>If the inpatient hospital treatment is provided by **our panel** and paid for under the Enhanced IncomeShield Preferred plan, **we** will cover the cost of medical treatment the **insured** received in the **policy year** for up to 365 days after the date they left **hospital**.<br><br>To avoid doubt, if the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for the **insured**'s **stay in a hospital**, **we** will cover up to 365 days of post-hospitalisation treatment only when the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel**.<br><br>Post-hospitalisation treatment includes **specialist** outpatient medical services and consultations, medication, physiotherapy, occupational therapy, speech therapy, diagnostic and laboratory services, examinations and investigations that are:<br>• ordered by a **registered medical practitioner**; and<br>• carried out within the period that **we** cover post-hospitalisation treatment for.<br><br>Any physiotherapy, occupational therapy or speech therapy must be provided by an Allied Health Professional registered under **MOH**.<br><br>Post-hospitalisation treatment must: |

| | | |
|---|---|---|
| | • have resulted directly from the condition for which the **stay in hospital** was needed; and<br>• be recommended by the **registered medical practitioner** who treated the **insured** during the period they were in **hospital**.<br><br>**We** do not cover post-hospitalisation treatment if, under **your policy**, **we** do not pay for the inpatient hospital treatment received during the **stay in hospital**.<br><br>**We** do not cover post-hospitalisation treatment such as medication bought during a period of post-hospitalisation treatment but not used during that period.<br><br>**We** do not cover post-hospitalisation treatment which is given after inpatient psychiatric treatment benefit, accident inpatient dental treatment or emergency overseas treatment. | • have resulted directly from the condition for which the **stay in hospital** was needed; and<br>• be recommended by the **registered medical practitioner** who treated the **insured** during the period they were in **hospital**.<br><br>**We** do not cover post-hospitalisation treatment if, under **your policy**, **we** do not pay for the inpatient hospital treatment received during the **stay in hospital**.<br><br>**We** do not cover post-hospitalisation treatment such as medication bought during a period of post-hospitalisation treatment but not used during that period.<br><br>**We** do not cover post-hospitalisation treatment which is given after inpatient psychiatric treatment benefit, accident inpatient dental treatment or emergency overseas treatment.<br><br>To avoid doubt, post-hospitalisation treatment does not include inpatient hospital treatment and day surgery. |
| 1.2(f) Outpatient hospital treatment | Cancer drug treatments listed on the **Cancer Drug List (CDL)** and used according to the indications on the **CDL**. If the **insured** is claiming for more than one cancer drug treatment, **we** will pay a total amount of up to the highest limit for the cancer drugs administered in that month, as long as they are used according to the indications on the **CDL**. If any of the cancer drug treatments provided are not used according to the indications on the **CDL**, **we** will not cover any of the cancer drug treatments used, even individual treatments that are listed on the **CDL**, except where a particular drug being removed from the indicated treatment, or replaced with another drug indicated 'for cancer treatment' on the **CDL**, is a **necessary medical treatment** due to intolerance or contraindications (for example, allergic reactions). | Cancer drug treatments listed on the **Cancer Drug List (CDL)** and used according to the indications on the **CDL**. To avoid doubt, for **CDL** treatments, the indications refer to the clinical indications of the drug as specified in the **CDL** on **MOH**'s website go.gov.sg/moh-cancerdruglist. For each primary cancer, if the **CDL** treatment involves more than one drug, **we** allow drug omission or replacement with another **CDL** drug with the indication "for cancer treatment", only if such omission or replacement is due to intolerance or contraindications. In such cases, the claim limit of the original **CDL** treatment will apply. For each primary cancer, where multiple cancer drug treatments are administered in a month:<br>• if any of the **CDL** treatments has an indication that states "monotherapy", only **CDL** treatments with the indication "for |

| | | |
|---|---|---|
| | | cancer treatment" will be claimable in that month.<br>• if none of the **CDL** treatments has an indication that states "monotherapy", the following will apply:<br>  • If more than one of the cancer drug treatments administered in a month has an indication other than "for cancer treatment", only **CDL** treatments with the indication "for cancer treatment" will be claimable in that month.<br>  • If one or none of the cancer drug treatments administered in a month has an indication other than "for cancer treatment", all **CDL** treatments will be claimable in that month.<br><br>Cancer drug treatments not on the **CDL** will be considered as having an indication other than "for cancer treatment".<br><br>This benefit pays for cancer drug treatment set out below and depends on the limits in the **schedule of benefits**.<br>• For **insured** with only one primary cancer, **we** will pay up to the highest limit among the claimable **CDL** treatments received in that month.<br>• For **insured** receiving treatment for **multiple primary cancers**, **we** will pay up to the sum of the highest limit among the claimable **CDL** treatments received for each primary cancer in that month. An application form for higher claim limits for **insured** receiving treatment for **multiple primary cancers** are to be sent to **us** and **MOH** by their **registered medical practitioner** for assessment of **your policy** and **MediShield Life** Plan coverage respectively. |
| 1.2(g) Outpatient hospital treatment | Cancer drug services that are part of any outpatient cancer drug treatment. This includes consultations, scans, lab investigations, preparing and administering the cancer drugs, supportive-care drugs and blood | Cancer drug services that are part of any outpatient cancer drug treatment. This includes consultations, scans, lab investigations, preparing and administering the cancer drug, supportive-care drugs and blood |

| | | |
|---|---|---|
| | transfusions. It does not cover services provided before the **insured** is diagnosed with cancer or after the cancer drug treatment has ended. | transfusions. It does not cover services provided before the **insured** is diagnosed with cancer or after the cancer drug treatment has ended. An application form for higher claim limits for **insured** receiving treatment for **multiple primary cancers** are to be sent to **us** and **MOH** by their **registered medical practitioner** for assessment of the Integrated Shield Plan and **MediShield Life** Plan coverage respectively. **We** will pay up to the limit as set out in the **schedule of benefits** if the **insured** had received treatment for **multiple primary cancers** at any point in time within the **policy year**. |
| 1.3(a) Breast reconstruction after mastectomy | This benefit pays for inpatient hospital treatment for reconstructive surgery of the breast on which a mastectomy has been performed as a result of breast cancer. The breast reconstruction must be performed by a **registered medical practitioner** during a **stay in hospital** within 365 days from the date the **insured** leaves the **hospital** when the mastectomy was done. The breast cancer must be first diagnosed on or after the **start date** of **your policy**, or the last **reinstatement date**, whichever is later. Any surgery or reconstruction of the other breast to produce a symmetrical appearance will not be covered. | This benefit pays for inpatient hospital treatment for reconstructive surgery of the breast on which a mastectomy has been performed as a result of breast cancer. The breast reconstruction must be performed by a **registered medical practitioner** during a **stay in hospital** within 365 days from the date the **insured** leaves the **hospital** when the mastectomy was done. The breast cancer must be first diagnosed on or after the **start date** of **your policy**, or the last **reinstatement date**, whichever is later. Any surgery or reconstruction of the other breast to produce a symmetrical appearance will not be covered. To avoid doubt, any further breast reconstruction after mastectomy shall not be payable 365 days after the date the **insured** leaves the **hospital** when the mastectomy was done, even if **we** have paid for the re-construction in an earlier claim. |
| 2.1 Claims | Depending on the terms, conditions and limits in the **schedule of benefits** and **your policy**, **we** use the following limits in the following order on the **benefits** covered (if it applies).<br><br>a **Citizenship factor**<br>b **Pro-ration factor**<br>c The **limits of compensation**<br>d The **deductible**<br>e **Co-insurance**<br>f The **limits on special benefits**<br>g The **limit in each policy year** | Depending on the terms, conditions and limits in the **schedule of benefits** and **your policy**, **we** use the following limits in the following order on the **benefits** covered (if it applies).<br><br>a **Citizenship factor**<br>b **Pro-ration factor**<br>c The **limits of compensation**<br>d The **deductible**<br>e **Co-insurance**<br>f The **limits on special benefits**<br>g The **limit in each policy year** |

| | | |
|---|---|---|
| | As long as **you** have paid the **premium** or any amount **you** owe **us** under **your policy**, **we** will pay **you** the **benefits**.<br><br>All claims (except pre-hospitalisation treatment and post-hospitalisation treatment) must be made and sent to **us** through the system set up by **MOH** (electronic filing) and according to the **act** and **regulations** within 90 days from the date of billing or the date the **insured** leaves **hospital**, whichever is later. Claims for pre-hospitalisation treatment and post-hospitalisation treatment must be sent to **us** within 120 days from the date the **insured** leaves **hospital**. **You** must give **us** any other documents, authorisations or information **we** need for assessing the claim. **You** must also pay any costs involved.<br><br>For claims which are not eligible for electronic filing (for example, claims under plans which are not integrated with **MediShield Life** or claims for pre-hospitalisation treatment, post-hospitalisation treatment or emergency overseas treatment), **you** must send the claim to **us** by post or online, or deliver it to **us** by hand. For claims which are electronically filed to **us**, **we** will pay the **hospital** direct. Otherwise, **we** will pay **you**.<br><br>**You**, or if **you** die **your** legal representative, must give **us** all documents, authorisations or information **we** need to assess the claim. **You** must also pay any costs involved in doing so. If **you**, **your** legal representative or the **insured** fails to co-operate with **us** in dealing with the claim, the assessment of the claim may be delayed or **we** can reject the claim.<br><br>**We** will pay claims according to **your policy** or **MediShield Life**, whichever is higher.<br><br>If **your plan** is not integrated with **MediShield Life**, **your plan** does not cover the **MediShield Life** tier operated by the **CPF Board**. **We** will pay claims according to **your policy**. | As long as **you** have paid the **premium** or any amount **you** owe **us** under **your policy**, **we** will pay **you** the **benefits**.<br><br>All claims (except pre-hospitalisation treatment and post-hospitalisation treatment) must be made and sent to **us** through the system set up by **MOH** (electronic filing) and according to the **act** and **regulations** within 90 days from the date of billing or the date the **insured** leaves **hospital**, whichever is later. Claims for pre-hospitalisation treatment and post-hospitalisation treatment must be sent to **us** within 120 days from the date the **insured** leaves **hospital**. **You** must give **us** any other documents, authorisations or information **we** need for assessing the claim. **You** must also pay any costs involved.<br><br>For claims which are not eligible for electronic filing (for example, claims under plans which are not integrated with **MediShield Life** or claims for pre-hospitalisation treatment, post-hospitalisation treatment or emergency overseas treatment), **you** must send the claim to **us** by post or online, or deliver it to **us** by hand. For claims which are electronically filed to **us**, **we** will pay the **hospital** direct. Otherwise, **we** will pay **you**. If a claim must be investigated again after payment had been made, depending on the outcome of the investigation, **we** have a right to recover the payment made for the claim.<br><br>**You**, or if **you** die **your** legal representative, must give **us** all documents, authorisations or information **we** need to assess the claim. **You** must also pay any costs involved in doing so. If **you**, **your** legal representative or the **insured** fails to co-operate with **us** in dealing with the claim, the assessment of the claim may be delayed or **we** can reject the claim.<br><br>**We** will pay claims according to **your policy** or **MediShield Life**, whichever is higher. |

| | | |
|---|---|---|
| | If **your** claim includes expenses that are not reasonable, **we** will pay only the amount of **your** claim that **we** believe is **reasonable expenses** for **necessary medical treatment**. **We** can reduce **your** claim to reflect what would have been reasonable, based on the professional opinion of **our registered medical practitioner** or the **insured**'s entitlement to **benefits** under **your policy**. If there is a difference in opinion between **our registered medical practitioner** and **your registered medical practitioner**, the matter will be referred to an independent person for adjudication under clause 4.14 of these conditions. | If **your plan** is not integrated with **MediShield Life**, **your plan** does not cover the **MediShield Life** tier operated by the **CPF Board**. **We** will pay claims according to **your policy**.<br><br>If **your** claim includes expenses that are not reasonable, **we** will pay only the amount of **your** claim that **we** believe is **reasonable expenses** for **necessary medical treatment**. **We** can reduce **your** claim to reflect what would have been reasonable, based on the professional opinion of **our registered medical practitioner** or the **insured**'s entitlement to **benefits** under **your policy**. If there is a difference in opinion between **our registered medical practitioner** and **your registered medical practitioner**, the matter will be referred to an independent person for adjudication under clause 4.14 of these conditions. |
| 4.9 Changing policy terms or conditions | **We** may change the **premiums**, **benefits** or cover or these conditions at any time. However, **we** will write to **you** at **your** last-known address at least 30 days before doing so. **We** will apply the changes only if the changes apply to all policies within the same class. | **We** may change the **premiums**, **benefits** or cover or these conditions at any time. **We** will write to **you** at **your** last-known address at least 30 days before doing so. **We** will apply the changes only if the changes apply to all policies within the same class. **We** may apply mandatory changes to the policy benefits, features, guidelines and/or conditions as may be introduced by **MOH**, the Central Provident Fund Board or any other regulatory authority on **MediShield Life** immediately without written notice given to **you**. |
| 4.18(p) Exclusion | Dental treatment (unless this is covered under accident inpatient dental treatment). | Dental treatment regardless of whether it is caused directly or indirectly by an illness or injury (unless this is covered under accident inpatient dental treatment). |
| 4.18(s) Exclusion | Buying or renting special braces, appliances, equipment, machines and other devices, such as wheelchairs, walking or home aids, dialysis machines, iron lungs, oxygen machines and any other hospital-type equipment to use at home or as an outpatient. | Buying or renting special braces, appliances, equipment, machines and other devices, such as wheelchairs, walking or home aids, dialysis machines, iron lungs, oxygen machines and any other hospital-type equipment to use at home or as an outpatient. To avoid doubt, this includes but is not limited to all associated fees such as general or specialist medical services and consultations, diagnostic and |

| | | |
|---|---|---|
| | | laboratory services, examinations and investigations. |
| 4.18 Exclusion | To avoid doubt, **your policy** does not cover any item or exclusion that is set out in the **act** and its **regulations**, unless **we** issue an endorsement to **your policy**. | To avoid doubt, **your policy** does not cover any item or exclusion that is set out in the **act** and its **regulations** or not allowed by **MediShield Life Claims Rules**, unless **we** issue an endorsement to **your policy**. |
| 5 Definition | **Necessary medical treatment** means reasonable and common treatment which, in the professional opinion of a **registered medical practitioner** or a **specialist** in the relevant field of medicine, is appropriate and consistent with the symptoms, findings, diagnosis and other relevant clinical circumstances of the illness or injury and reduces the negative effect of the illness or injury on the **insured**'s health.<br><br>The treatment:<br>• must be provided in line with generally accepted standards of good medical practice in Singapore, be consistent with current standards of professional medical care, have proven medical benefits, and also be cost-effective and supported by the guidelines of **MOH** (where available) or official bodies such as Health Science Authority, the Allied Health Professions Council or the Agency for Care Effectiveness;<br>• must not be for the convenience of the **insured** or **registered medical practitioner** or **specialist** (for example, treatment that can reasonably be provided out of a hospital, but is provided as an inpatient treatment);<br>• must not be for investigation or research (for example, experimental or new physiotherapy, medical techniques or surgical techniques, medical devices not approved by the Institutional Review Board and the Health Sciences Authority, and medical trials for medicinal products, whether or not these trials have a clinical trial certificate issued by the Health Sciences Authority or similar bodies); and | **Necessary medical treatment** means reasonable and common treatment which, in the professional opinion of a **registered medical practitioner** or a **specialist** in the relevant field of medicine, is appropriate and consistent with the symptoms, findings, diagnosis and other relevant clinical circumstances of the illness or injury and reduces the negative effect of the illness or injury on the **insured**'s health.<br><br>The treatment:<br>• must be provided in line with generally accepted standards of good medical practice in Singapore, be consistent with current standards of professional medical care, have proven medical benefits, and also be cost-effective and supported by the guidelines of **MOH** (such as the **MediShield Life Claims Rules**) or official bodies such as Health Science Authority, the Allied Health Professions Council or the Agency for Care Effectiveness;<br>• must not be for the convenience of the **insured** or **registered medical practitioner** or **specialist** (for example, treatment that can reasonably be provided out of a hospital, but is provided as an inpatient treatment);<br>• must not be for medical trials and/or experimental, investigational or research in nature. This includes but is not limited to experimental therapy, pioneering or new medical techniques, surgical techniques, physiotherapy, medical devices, medicinal products, whether or not these have been approved and/or issued with a clinical trial certificate by **MOH** or the Health Sciences |

| | | |
|---|---|---|
| | • must not be preventive, or for health screening or promoting good health (such as dietary replacement or supplement). | Authority or other regulatory bodies in Singapore; and<br>• must not be for **primary prevention**, or preventive treatments unrelated to the current diagnosis, or for health screening or promoting good health (such as dietary replacement or supplement), or if the outcome of the examination or test has no medical indication. To avoid doubt, **we** do not cover dietary replacement or supplements whether or not medically proven, if they are not evaluated for its quality, safety and efficacy by Health Sciences Authority (HSA).<br><br>**We** reserve the right to determine whether a treatment, service or expense is **necessary medical treatment**. |

**New clauses and definitions**

Note: The words in bold are defined in the definitions section of your policy.

| Clause heading | New |
|---|---|
| 5 Definition | **MediShield Life Claims Rules** means rules which guide whether a claim is appropriate for **MediShield Life** (see **MOH** website). |
| 5 Definition | **Multiple primary cancers** means two or more cancers arising from different sites and are of a different histology or morphology group. |

**Disclaimer**

This document on summarised changes does not form a part of the contract of insurance. The contents of this document may be different from the terms of cover we eventually issue. Please read the policy contract for the precise terms, conditions and exclusions. Only the terms, conditions and exclusions in the policy contract will be enforceable by you and us.

**Summarised changes to Deluxe Care Rider (For renewal from 1 Sep 2024)**

| **Changes to Benefits** |
|---|
| • Additional cancer drug treatment benefit<br>• Renamed 'Additional Non-Panel Payment' to 'Extended Panel and Non-panel Payment (ENP)' |

**Changes in clauses and definitions**

Note: The words in bold are defined in the definitions section of your policy.

<table>
<tr><th>Clause heading</th><th>Existing clause</th><th>Revised clause</th></tr>
<tr><td>1.1 Deductible and co-insurance</td><td>While this rider is in force, there is no deductible or co-insurance due under your policy. However, you will have to make a co-payment and an additional non-panel payment (if it applies) for each claim, as set out below.</td><td>While this rider is in force, there is no deductible or co-insurance due under your policy. However, you will have to make a co-payment and an extended panel and non-panel payment (if it applies) for each claim, as set out below.</td></tr>
<tr><td>1.1a Co-payment</td><td>For each claim under your policy, you will have to make a co-payment, as shown in the table below. If the treatment is provided by our panel or extended panel, we will apply a co-payment limit as shown in the table.<br><br><table><tr><th>Types of Treatment</th><th>Co-payment</th></tr><tr><td>Treatment not provided by our panel or extended panel</td><td>5% of the benefits due under your policy</td></tr><tr><td>Treatment provided by our panel or extended panel</td><td>5% of the benefits due under your policy, up to a co-payment limit of $3,000 for each policy year</td></tr></table><br>If you are claiming for pre-hospitalisation treatment, post-hospitalisation treatment or special benefits (if it applies), we will not apply the co-payment limit if the treatment during the insured's stay in hospital is not provided by our panel or extended panel.<br><br>If you are claiming for consultation fees, medicines, examinations or tests for the main outpatient hospital treatment that is covered under your policy, we will apply the co-payment limit only if the main outpatient hospital treatment is provided by our panel or extended panel.</td><td>For each claim under your policy, you will have to make a co-payment, as shown in the table below. If the treatment is provided by our panel or extended panel, we will apply a co-payment limit as shown in the table.<br><br><table><tr><th>Treatment provided by</th><th>Our panel</th><th>Extended panel</th><th>Others</th></tr><tr><td rowspan="2">Co-payment and limit</td><td colspan="3">5% co-payment of the benefits due under your policy</td></tr><tr><td colspan="2">Up to $3,000 limit (each policy year)</td><td>No limit</td></tr></table><br>If you are claiming for pre-hospitalisation treatment, post-hospitalisation treatment or special benefits (if it applies), we will not apply the co-payment limit if the treatment during the insured's stay in hospital is not provided by our panel or extended panel.<br><br>If you are claiming for consultation fees, medicines, examinations or tests for the main outpatient hospital treatment that is covered under your policy, we will apply the co-payment limit only if the main outpatient hospital treatment is provided by our panel or extended panel.<br><br>For each claim that meets the limits on special benefits (if it applies) or the limit for each policy year of your policy, the co-payment for that claim will not be added towards the co-payment limit of $3,000 for each policy year.</td></tr>
</table>

| | | |
|---|---|---|
| | For each claim that meets the **limits on special benefits** (if it applies) or the **limit for each policy year** of **your policy,** the co-payment for that claim will not be added towards the co-payment limit of $3,000 for each **policy year**.<br><br>When the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for their **stay in hospital** or the main outpatient hospital treatment under **your policy**, **we** will apply the co-payment limit as long as the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel** or **extended panel**.<br><br>For each **stay in hospital** of 12 months or less, where the treatment is provided by **our panel** or **extended panel**, **you** must pay the co-payment (up to a maximum of $3,000) for one **policy year** (even if the **stay in hospital** runs into the next **policy year**). If the **stay in hospital** is for a continuous period of more than 12 months but less than 24 months, **you** must also pay up to the maximum co-payment for the next **policy year**. And, for each further period of 12 months or less that the **stay in hospital** extends for, **you** must pay the co-payment for one extra **policy year**. | When the **insured** is under the care of more than one **registered medical practitioner** or **specialist** for their **stay in hospital** or the main outpatient hospital treatment under **your policy**, **we** will apply the co-payment limit as long as the main treating **registered medical practitioner** or **specialist** (shown in the **hospital** records as the principal doctor) is part of **our panel** or **extended panel**.<br><br>For each **stay in hospital** of 12 months or less, where the treatment is provided by **our panel** or **extended panel**, **you** must pay the co-payment (up to a maximum of $3,000) for one **policy year** (even if the **stay in hospital** runs into the next **policy year**). If the **stay in hospital** is for a continuous period of more than 12 months but less than 24 months, **you** must also pay up to the maximum co-payment for the next **policy year**. And, for each further period of 12 months or less that the **stay in hospital** extends for, **you** must pay the co-payment for one extra **policy year**. |
| Clause '1.1b Additional non-panel payment' is revised to Clause '1.1b Extended panel and non-panel payment (ENP)' | If the treatment during the **insured**'s **stay in hospital** is provided by a **registered medical practitioner** or **specialist** who is not from **our panel** or is from the **extended panel, you** will have to make an additional non-panel payment of up to $2,000 in each **policy year** for **your** claims for inpatient hospital treatment, pre-hospitalisation treatment, post-hospitalisation treatment or special benefits (if it applies). **You** must pay the co-payment followed by the additional non-panel payment. **We** will only pay the amount of **your** claim which is more than the total of the co-payment and the additional non-panel payment.<br><br>When there is more than one treating **registered medical practitioner** or **specialist** for the **insured**'s **stay in hospital, we** will apply the additional non-panel payment as long as the main treating **registered medical practitioner** or | If the treatment during the **insured**'s **stay in hospital** is provided by a **registered medical practitioner** or **specialist** who is not from **our panel** or is from the **extended panel, you** will have to make an extended panel and non-panel payment (ENP) of up to $2,000 in each **policy year** for **your** claims for inpatient hospital treatment, pre-hospitalisation treatment, post-hospitalisation treatment or special benefits (if it applies). **You** must pay the co-payment followed by the ENP. **We** will only pay the amount of **your** claim which is more than the total of the co-payment and the ENP. To avoid doubt, ENP is also applicable for claim paid under emergency overseas treatment benefit of **your policy**.<br><br>When there is more than one treating **registered medical practitioner** or **specialist** for the **insured**'s **stay in hospital, we** will apply the ENP as long as the main treating **registered medical practitioner** or **specialist** (shown in |

| | | |
|---|---|---|
| | **specialist** (shown in the **hospital** records as the principal doctor) is not from **our panel** or is from the **extended panel**.<br><br>For each **stay in hospital** of 12 months or less that is provided by a **registered medical practitioner** or **specialist** who is not from **our panel** or is from the **extended panel**, **you** must pay the additional non-panel payment of up to $2,000 for one **policy year** (even if the **stay in hospital** runs into the next **policy year**). If the **stay in hospital** is for a continuous period of more than 12 months but less than 24 months, **you** must also pay the additional non-panel payment of up to $2,000 for the next **policy year**. And, for each further period of 12 months or less that the **stay in hospital** extends for, **you** must pay the additional non-panel payment of up to $2,000 for one extra **policy year.** | the **hospital** records as the principal doctor) is not from **our panel** or is from the **extended panel**.<br><br>For each **stay in hospital** of 12 months or less that is provided by a **registered medical practitioner** or **specialist** who is not from **our panel** or is from the **extended panel**, **you** must pay the ENP of up to $2,000 for one **policy year** (even if the **stay in hospital** runs into the next **policy year**). If the **stay in hospital** is for a continuous period of more than 12 months but less than 24 months, **you** must also pay the ENP of up to $2,000 for the next **policy year**. And, for each further period of 12 months or less that the **stay in hospital** extends for, **you** must pay the ENP of up to $2,000 for one extra **policy year.** |
| 1.3 Extra-bed benefit | If during the **insured**'s **stay in hospital** their parent or guardian stays and shares the same room, **we** will refund up to $80 for each day the parent or guardian stays. This applies as long as the following conditions are met.<br>• The **insured** is a child aged 18 or younger during their **stay in hospital**.<br>• **We** will pay up to 10 days for each **stay in hospital.**<br>• If the **insured** is in **hospital** for only part of a day, **we** will pay half of this benefit for that day.<br><br>The co-payment under clause 1.1 (a) and additional non-panel payment under clause 1.1 (b) of this rider does not apply to any claim for this benefit. | If during the **insured**'s **stay in hospital** their parent or guardian stays and shares the same room, **we** will reimburse up to $80 for each day the parent or guardian stays. This applies as long as the following conditions are met.<br>• The **insured** is a child aged 18 or younger during their **stay in hospital**.<br>• **We** will pay up to 10 days for each **stay in hospital.**<br>• If the **insured** is in **hospital** for only part of a day, **we** will pay half of this benefit for that day.<br><br>The co-payment under clause 1.1 (a) and ENP under clause 1.1 (b) of this rider does not apply to any claim for this benefit. |

| | | |
|---|---|---|
| Clause '2.1 Co-payment and additional non-panel payment' is revised to Clause '2.1 Co-payment and extended panel and non-panel payment' | **You** must make the co-payment and additional non-panel payment (if it applies) before **we** pay any benefit. **We** will only pay the amount of **your** claim which is more than the co-payment and additional non-panel payment.<br><br>**We** will apply the co-payment followed by the additional non-panel payment (if it applies). | **You** must make the co-payment and extended panel and non-panel payment (ENP) (if it applies) before **we** pay any benefit. **We** will only pay the amount of **your** claim which is more than the co-payment and ENP.<br><br>**We** will apply the co-payment followed by the ENP (if it applies). |

**Changes in clause 1.2 Additional cancer drug treatment benefit**

Note: The words in bold are defined in the definitions section of your policy.

**Existing clause**

This benefit pays for outpatient cancer drug treatments that are listed on the **CDL**, and selected cancer drug treatments that are not listed on the **CDL** (non-**CDL** treatments), up to the limits shown in tables 1a, 1b and 1c. This benefit will be paid on top of the **benefits** covered under **your policy**.

For claims under this rider for outpatient cancer drug treatments on the **CDL**, the following apply.

- The benefit limits in tables 1a, 1b and 1c (indicated as a multiple of **MSHL** limits) are equal to 200% of the outpatient cancer drug treatment limits stated in the **schedule of benefits** in **your policy**.
- The **MSHL** limit varies depending on the cancer drug treatment. The latest **MSHL** limits can be found at go.gov.sg/moh-cancerdruglist. **MOH** may update the **CDL** from time to time.
- If the **insured** is claiming for more than one cancer drug treatment, **we** will pay a total amount of up to the highest limit for the cancer drugs administered in that month, as long as they are used according to the indications in the **CDL**. If any of the cancer drug treatments provided are not used according to the indications on the **CDL**, **we** will not cover any of the cancer drug treatments used, even individual treatments that are listed on the **CDL**, except where a particular drug being removed from the indicated treatment, or replaced with another drug indicated 'for cancer treatment' on the **CDL**, is a **necessary medical treatment** due to intolerance or contraindications (for example, allergic reactions).

For outpatient cancer drug treatments not on the **CDL**, **we** cover only treatments with drug classes A to E (according to the Life Insurance Association, Singapore's (LIA's) Non-**CDL** Classification Framework). **You** can find the details at www.lia.org.sg. LIA may update the list from time to time.

Table 1a

| **Type of cancer drug treatment** | **Additional cancer drug treatment benefit limits** | | |
|---|---|---|---|
| | **Enhanced IncomeShield** | | |
| | **Preferred** | **Advantage** | **Basic** |
| Treatment on **CDL** (each month) | 10x **MSHL** limit | 8x **MSHL** limit | 6x **MSHL** limit |
| Non-**CDL** treatment (each month) | $15,000 | $7,000 | $6,000 |

Table 1b

| **Type of cancer drug treatment** | **Additional cancer drug treatment benefit limits** | |
|---|---|---|
| | **Enhanced IncomeShield** **Enhanced C** | **IncomeShield Standard Plan** |
| Treatment on **CDL** (each month) | 4x **MSHL** limit | 6x **MSHL** limit |
| Non-**CDL** treatment (each month) | $4,000 | $5,200 |

Table 1c

| **Type of cancer drug treatment** | **Additional cancer drug treatment benefit limits** | | | |
|---|---|---|---|---|
| | **IncomeShield Plans** | | | |
| | **Plan P** | **Plan A** | **Plan B** | **Plan C** |
| Treatment on **CDL** (each month) | 8x **MSHL** limit | 6x **MSHL** limit | 4x **MSHL** limit | 2x **MSHL** limit |
| Non-**CDL** treatment (each month) | $4,000 | $3,800 | $3,500 | $3,200 |

For each outpatient cancer drug treatment claim under **your** rider, **you** will have to make a co-payment as shown in table 2.

If **you** receive cancer drug treatment on the **CDL** that is provided by **our panel** or **extended panel**, the co-payment for that claim will be counted towards the co-payment limit of $3,000 in clause 1.1a.

Table 2

| **Types of Treatment** | **Co-payment** |
|---|---|
| Treatment on **CDL**, not provided by **our panel** or **extended panel** | 5% of the benefits due under the rider |
| Treatment on **CDL**, provided by **our panel** or **extended panel** | 5% of the benefits due under the rider, up to a co-payment limit of $3,000 for each **policy year** |
| Non-**CDL** treatment | 10% of the benefits due under the rider |

**Revised clause**

This benefit pays for outpatient cancer drug treatments that are listed on the **CDL**, and selected cancer drug treatments that are not listed on the **CDL** (non-**CDL** treatments), up to the limits shown in tables 1a and 1b. This benefit will be paid on top of the **benefits** covered under **your policy**.

For claims under this rider for outpatient cancer drug treatments on the **CDL**, the following apply.

- **We** cover outpatient cancer drug treatments on the **CDL** in accordance with the conditions set out in **your policy**.
- For **insured** receiving treatment for **multiple primary cancers**, **we** will pay up to the limits shown in tables 1c and 1d for the cancer drugs administered in that month.
- The cancer drug treatment on the **CDL** benefit limit is based on a multiple of the **MSHL** Limit for the specific cancer drug treatment. For the latest **MSHL** Limit, refer to the **CDL** on **MOH**'s website under "MediShield Life Claim Limit per month" (go.gov.sg/moh-cancerdruglist). **MOH** may update this from time to time. The revised list will be applicable to the cancer drug treatment which occurred on and from the effective date of the revised list.

For outpatient cancer drug treatments not on the **CDL**, **we** cover only treatments with drug classes A to E (according to the Life Insurance Association, Singapore's (LIA's) Non-**CDL** Classification Framework). **You** can find the details at www.lia.org.sg. LIA may update the list from time to time.

Table 1a

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits | | | |
|---|---|---|---|---|
| | Enhanced IncomeShield | | | |
| | **Preferred** | **Advantage** | **Basic** | **Enhanced C** |
| Treatment on **CDL** (each month) | 18x **MSHL** limit | 18x **MSHL** limit | 10x **MSHL** limit | 6x **MSHL** limit |
| Non-**CDL** treatment (each month) | $15,000 | $7,000 | $6,000 | $4,000 |

Table 1b

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits | | | | |
|---|---|---|---|---|---|
| | IncomeShield Standard Plan | IncomeShield Plans | | | |
| | | **Plan P** | **Plan A** | **Plan B** | **Plan C** |
| Treatment on **CDL** (each month) | 6x **MSHL** limit | 10x **MSHL** limit | 10x **MSHL** limit | 6x **MSHL** limit | 6x **MSHL** limit |
| Non-**CDL** treatment (each month) | $5,200 | $4,000 | $3,800 | $3,500 | $3,200 |

Table 1c

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits for multiple primary cancers | | | |
|---|---|---|---|---|
| | Enhanced IncomeShield | | | |
| | **Preferred** | **Advantage** | **Basic** | **Enhanced C** |
| Treatment on **CDL** (each month) | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer | | | |
| Non-**CDL** treatment (each month) | $15,000 x number of primary cancers | $7,000 x number of primary cancers | $6,000 x number of primary cancers | $4,000 x number of primary cancers |

Table 1d

| Type of cancer drug treatment | Additional cancer drug treatment benefit limits for multiple primary cancers | | | | |
|---|---|---|---|---|---|
| | IncomeShield Standard Plan | IncomeShield Plans | | | |
| | | **Plan P** | **Plan A** | **Plan B** | **Plan C** |
| Treatment on **CDL** (each month) | Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer | | | | |
| Non-**CDL** treatment (each month) | $5,200 x number of primary cancers | $4,000 x number of primary cancers | $3,800 x number of primary cancers | $3,500 x number of primary cancers | $3,200 x number of primary cancers |

For each outpatient cancer drug treatment claim under **your** rider, **you** will have to make a co-payment as shown in table 2.

If the **insured** receives cancer drug treatment on the **CDL** that is provided by **our panel** or **extended panel**, the co-payment for that claim will be counted towards the co-payment limit of $3,000 in clause 1.1a. To avoid doubt, **we** will not apply the co-payment limit for all non-**CDL** treatments, including non-**CDL** treatments provided by **our panel** or **extended panel**.

Table 2

| **Types of Treatment** | **Co-payment** |
|---|---|
| Treatment on **CDL**, not provided by **our panel** or **extended panel** | 5% of the benefits due under the rider |
| Treatment on **CDL**, provided by **our panel** or **extended panel** | 5% of the benefits due under the rider, up to a co-payment limit of $3,000 for each **policy year** |
| Non-**CDL** treatment | 10% of the benefits due under the rider |

**Disclaimer**

This document on summarised changes does not form a part of the contract of insurance. The contents of this document may be different from the terms of cover we eventually issue. Please read the policy contract for the precise terms, conditions and exclusions. Only the terms, conditions and exclusions in the policy contract will be enforceable by you and us.