## Schedule of benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Enhanced Preferred</th>
<th>Enhanced Advantage</th>
<th>Enhanced Basic</th>
<th>Enhanced C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ward entitlement</strong></td>
<td>Standard room in private hospital or private medical institution</td>
<td>Restructured hospital for ward class A and below</td>
<td>Restructured hospital for ward class B1 and below</td>
<td>Restructured hospital for ward class B2 and below</td>
</tr>
<tr>
<td><strong>Inpatient hospital treatment</strong></td>
<td>Limits of compensation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room, board and medical-related services</td>
<td></td>
<td></td>
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<tr>
<td>Intensive care unit (ICU) and medical-related services</td>
<td></td>
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<tr>
<td>Surgical benefits (including day surgery)</td>
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<tr>
<td>Organ transplant benefit (including stem-cell transplant)</td>
<td></td>
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</tr>
<tr>
<td>Surgical implants</td>
<td>As charged</td>
<td>As charged</td>
<td>As charged</td>
<td>As charged</td>
</tr>
<tr>
<td>Gamma knife and novalis radiosurgery</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Accident inpatient dental treatment</td>
<td></td>
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</tr>
<tr>
<td>Pre-hospitalisation treatment (up to 90 days before admission)</td>
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<tr>
<td>Post-hospitalisation treatment (up to 90 days after discharge)</td>
<td></td>
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<tr>
<td>Staying in a community hospital</td>
<td>As charged (up to 90 days for each admission)</td>
<td>As charged (up to 90 days for each admission)</td>
<td>As charged (up to 90 days for each admission)</td>
<td>As charged (up to 45 days for each admission)</td>
</tr>
<tr>
<td><strong>Outpatient hospital treatment</strong></td>
<td>Limits of compensation</td>
<td></td>
<td></td>
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<tr>
<td>Stereotactic radiotherapy for cancer</td>
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<tr>
<td>Radiotherapy for cancer</td>
<td></td>
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<tr>
<td>Chemotherapy for cancer</td>
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</tr>
<tr>
<td>Immunotherapy for cancer</td>
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<td></td>
</tr>
<tr>
<td>Renal dialysis</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Erythropoietin and other drugs approved under MediShield Life for chronic renal failure</td>
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<tr>
<td>Cyclosporin or tacrolimus and other drugs approved under MediShield Life for organ transplant</td>
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<tr>
<td><strong>Special benefits</strong></td>
<td>Limits on special benefits</td>
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<tr>
<td>Breast reconstruction after mastectomy</td>
<td>As charged</td>
<td>As charged</td>
<td>As charged</td>
<td>As charged</td>
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<tr>
<td>Congenital abnormalities benefit (with 12 months’ waiting period)</td>
<td>As charged</td>
<td>As charged</td>
<td>As charged</td>
<td></td>
</tr>
<tr>
<td>Pregnancy complications benefit (with 10 months’ waiting period)</td>
<td>As charged</td>
<td>As charged</td>
<td>As charged</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td>As charged, up to $60,000</td>
<td>As charged, up to $40,000</td>
<td>As charged, up to $20,000</td>
<td>Not covered</td>
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<tr>
<td>Living organ donor (non-insured) transplant benefit (each transplant) – insured as the recipient of organ</td>
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<td>Not covered</td>
<td>Not covered</td>
<td></td>
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<tr>
<td>Inpatient psychiatric treatment benefit (each policy year)</td>
<td>As charged, up to $7,000</td>
<td>As charged, up to $7,000</td>
<td>As charged, up to $5,000</td>
<td>As charged, up to $5,000</td>
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<tr>
<td>Prosthesis benefit (each policy year)</td>
<td>As charged, up to $10,000</td>
<td>As charged, up to $6,000</td>
<td>As charged, up to $6,000</td>
<td>As charged, up to $3,000</td>
</tr>
<tr>
<td>Benefits</td>
<td>Enhanced Preferred</td>
<td>Enhanced Advantage</td>
<td>Enhanced Basic</td>
<td>Enhanced C</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Emergency overseas treatment</td>
<td>As charged but</td>
<td>As charged but</td>
<td>As charged but</td>
<td>As charged but</td>
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<tr>
<td></td>
<td>limited to costs</td>
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<td>limited to costs</td>
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<tr>
<td></td>
<td>of Singapore</td>
<td>of ward class A</td>
<td>of ward class B1</td>
<td>of ward class B2</td>
</tr>
<tr>
<td></td>
<td>private hospitals</td>
<td>in Singapore</td>
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<td>in Singapore</td>
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<tr>
<td></td>
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<td>restructured</td>
<td>restructured</td>
<td>restructured</td>
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<tr>
<td></td>
<td></td>
<td>hospitals</td>
<td>hospitals</td>
<td>hospitals</td>
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<tr>
<td>Final expenses benefit</td>
<td>$5,000</td>
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**Pro-rata factor**

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</thead>
<tbody>
<tr>
<td>- Restructured hospital</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Ward class C, B2 or B2+</td>
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</tr>
<tr>
<td>- Ward class B1</td>
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<tr>
<td>- Ward class A</td>
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<td></td>
</tr>
<tr>
<td>- Private hospital or private medical institution or emergency overseas treatment</td>
<td></td>
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<tr>
<td>- Community hospital</td>
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<tr>
<td>- Ward class C, B2 or B2+</td>
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<tr>
<td>- Ward class B1</td>
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<tr>
<td>- Ward class A</td>
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</tr>
<tr>
<td>Day surgery or short-stay ward</td>
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<td>Does not apply</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
<tr>
<td>- Restructured hospital subsidised</td>
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<td></td>
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<tr>
<td>- Restructured hospital non-subsidised</td>
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<tr>
<td>- Private hospital or private medical institution or emergency overseas treatment</td>
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<td>Outpatient hospital treatment</td>
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<td>Does not apply</td>
<td>Does not apply</td>
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<tr>
<td>- Restructured hospital subsidised</td>
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<tr>
<td>- Restructured hospital non-subsidised</td>
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<td>- Private hospital or private medical institution</td>
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</table>

**Deductible for each policy year for an insured aged 80 years or below next birthday**

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>$1,500</th>
<th>$1,500</th>
<th>$1,500</th>
<th>$1,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Restructured hospital</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Ward class C</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>- Ward class B2 or B2+</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
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</tr>
<tr>
<td>- Ward class B1</td>
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</tr>
<tr>
<td>- Ward class A</td>
<td>$3,500</td>
<td>$3,500</td>
<td>$2,500</td>
<td>$2,000</td>
</tr>
<tr>
<td>- Private hospital or private medical institution or emergency overseas treatment</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Community hospital</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
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</tr>
<tr>
<td>- Ward class C</td>
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<td></td>
</tr>
<tr>
<td>- Ward B2 or B2+</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
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</tr>
<tr>
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<td>- Ward class A</td>
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<td>$3,500</td>
<td>$2,500</td>
<td>$2,000</td>
</tr>
<tr>
<td>Day surgery or short-stay ward</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>- Subsidised</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non-subsidised</td>
<td>$3,500</td>
<td>$3,500</td>
<td>$2,500</td>
<td>$2,000</td>
</tr>
<tr>
<td>Benefits</td>
<td>Enhanced Preferred</td>
<td>Enhanced Advantage</td>
<td>Enhanced Basic</td>
<td>Enhanced C</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Benefits</strong></td>
<td></td>
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</tr>
<tr>
<td><strong>Deductible for each policy year for an insured aged over 80 years at next birthday</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Restructured hospital</td>
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<td></td>
</tr>
<tr>
<td>- Ward class C</td>
<td>$2,250</td>
<td>$2,250</td>
<td>$2,250</td>
<td>$2,250</td>
</tr>
<tr>
<td>- Ward class B2 or B2+</td>
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<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>- Ward class B1</td>
<td>$3,750</td>
<td>$3,750</td>
<td>$3,750</td>
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</tr>
<tr>
<td>- Ward class A</td>
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<td>$5,250</td>
<td>$3,750</td>
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<tr>
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</tr>
<tr>
<td>- Community hospital</td>
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</tr>
<tr>
<td>- Ward class C</td>
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<td>$2,250</td>
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<td>- Ward class A</td>
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<td>$3,750</td>
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</tr>
<tr>
<td><strong>Day surgery or short-stay ward</strong></td>
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<tr>
<td>- Subsidised</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>- Non-subsidised</td>
<td>$5,250</td>
<td>$5,250</td>
<td>$3,750</td>
<td>$3,000</td>
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<tr>
<td><strong>Co-insurance</strong></td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
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<tr>
<td><strong>Limit in each policy year</strong></td>
<td>$1,000,000</td>
<td>$500,000</td>
<td>$250,000</td>
<td>$150,000</td>
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<tr>
<td><strong>Limit in each lifetime</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
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<tr>
<td><strong>Last entry age (age next birthday)</strong></td>
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<td>75</td>
<td>75</td>
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<tr>
<td><strong>Maximum coverage age</strong></td>
<td>Lifetime</td>
<td>Lifetime</td>
<td>Lifetime</td>
<td>Lifetime</td>
</tr>
</tbody>
</table>
Conditions for Enhanced IncomeShield

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'. 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 Room, board and medical-related services

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.
If the insured is in a short-stay ward, we will pay for the ward charges. We do not cover pre-hospitalisation treatment which is given before and post-hospitalisation treatment which is given after the stay in a 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 room, board and medical-related services 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 Intensive care unit (ICU) and medical-related services
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 Gamma knife and novalis radiosurgery
Covers gamma knife and novalis 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.

h Pre-hospitalisation treatment
The cost of medical treatment received by the insured in the policy year for up to 90 days before the date they went into hospital.

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, emergency overseas treatment or stay in a short-stay ward.
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’.

Outpatient hospital treatment covers the following received by the insured from a hospital or a licensed medical centre or clinic.

a. Stereotactic radiotherapy, radiotherapy, chemotherapy and immunotherapy for cancer.

b. Outpatient renal dialysis.

c. Approved immunosuppressant drugs including erythropoietin for chronic renal failure, cyclosporin and tacrolimus for organ transplant and other drugs approved under MediShield Life.

d. Consultation fees, medicines, and examinations and tests carried out by the attending registered medical practitioner as part of, the stereotactic radiotherapy, radiotherapy, chemotherapy, immunotherapy or outpatient renal dialysis medical treatment. We will treat these claims as part of the outpatient hospital treatment, and it will depend on the same limits of compensation.

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.
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 complications benefit

Pregnancy 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 or laparoscopic surgery.
- Pre-eclampsia or eclampsia.
- Disseminated intravascular coagulation (DIC).
- Miscarriage - when the foetus 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 with hysterectomy done.
- Amniotic fluid embolism.
- Abruptio placenta (placenta abruption).
- Choriocarcinoma and Hydatidiform mole – a histologically confirmed choriocarcinoma or molar pregnancy.
- Placenta previa.
- Antepartum haemorrhage.

Pregnancy complications must have been first diagnosed by an obstetrician after 10 months from:

- 1 September 2008, which is the date on which this pregnancy complications benefit first became effective;
- the start date; or
- the last reinstatement date (if any); whichever is later.

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 by a registered medical practitioner, and the symptoms of their organ failure must first appear, after 24 months from:
  - 1 September 2010, which is the date on which this living organ donor transplant benefit first became effective under your policy;
  - the start date; or
  - the last reinstatement date (if any); whichever is later; and
- 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.

For the purpose of working out the limit of benefit we will 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).
We will not pay for this benefit if the transplant is illegal or arises from any illegal transaction or practice.

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.

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.

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.

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 Medisave Life or claims for pre-hospitalisation treatment, post-hospitalisation treatment or emergency overseas treatment), you must send the claim to us by post or by hand. For claims which are electronically filed to us, we will pay the hospital direct. Otherwise, we will pay you.

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 MediSave Life, whichever is higher.

If your plan is not integrated with MediSave Life, your plan does not cover the MediSave 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. 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 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
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:

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Limits of compensation</th>
<th>Bill</th>
<th>Amount you can claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room, board and medical-related services (5 days)</td>
<td>As charged</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Surgical benefit (table 7)</td>
<td>As charged</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$13,000</td>
<td>$13,000</td>
</tr>
<tr>
<td>Less deductible</td>
<td></td>
<td></td>
<td>$3,500</td>
</tr>
<tr>
<td>Less co-insurance: 10% x ($13,000 - $3,500)</td>
<td></td>
<td></td>
<td>$950</td>
</tr>
<tr>
<td>Enhanced IncomeShield (including MediShield Life) pays (this depends on the limits on special benefits and the limit in each policy year)</td>
<td></td>
<td></td>
<td>$8,550</td>
</tr>
<tr>
<td>Insured pays</td>
<td></td>
<td></td>
<td>$4,450</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Limits of compensation</th>
<th>Bill</th>
<th>Amount you can claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room, board and medical-related services (367 days)</td>
<td>As charged</td>
<td>$220,200</td>
<td>$220,200</td>
</tr>
<tr>
<td>Surgical benefit (table 7)</td>
<td>As charged</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$230,200</td>
<td>$230,200</td>
</tr>
<tr>
<td>Less deductible ($3,500 x 2 years)</td>
<td></td>
<td></td>
<td>$7,000</td>
</tr>
<tr>
<td>Less co-insurance: 10% x ($230,200 - $7,000)</td>
<td></td>
<td></td>
<td>$22,320</td>
</tr>
<tr>
<td>Enhanced IncomeShield (including MediShield Life) pays (depending on two times the limits on special benefits and two times the limit in each policy year)</td>
<td></td>
<td></td>
<td>$200,880</td>
</tr>
<tr>
<td>Insured pays</td>
<td></td>
<td></td>
<td>$29,320</td>
</tr>
</tbody>
</table>
2.4 Citizenship factor

If the insured is not a Singapore citizen (in other words, the person is either a Singapore permanent resident or a foreigner), we will reduce the amount of each benefit we will pay to the percentages in the following table.

<table>
<thead>
<tr>
<th>Plan type</th>
<th>Permanent resident</th>
<th>Foreigner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enhanced Basic</td>
<td>Enhanced C</td>
</tr>
<tr>
<td>Percentage of benefit</td>
<td>89%</td>
<td>57%</td>
</tr>
</tbody>
</table>

The citizenship factor applies to any claim under your policy unless you have chosen the Singapore permanent resident or foreigner plan and have paid the extra premium for the plan.

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 the corresponding permanent resident or foreigner plan (if this applies).

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.
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.)

<table>
<thead>
<tr>
<th>Policy year</th>
<th>Enhanced IncomeShield yearly premium</th>
<th>MediShield Life yearly premium (for the relevant age next birthday)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 January to 31 December in year X</td>
<td>$100</td>
<td>$50</td>
</tr>
</tbody>
</table>

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.

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.

f Not revealing relevant information or misrepresentation as shown in clause 4.11.

g If another Medisave-approved Integrated Shield Plan is taken out to cover the insured.

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.
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 permanent resident or foreigner, you should switch to the corresponding plan for a Singapore permanent resident or foreigner (whichever applies). This will help avoid the reduction in the claims paid to you as a result of the citizenship factor (under clause 2.4).

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.

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, up to the start date of your policy, 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:

a declare your policy as 'void' from the start date or end the cover for the insured and we will not pay any benefits; or
b 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 refund all premiums to you.
- 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 premiums 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 (Cap 53B), 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 any 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, including 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, or any form of related stay in hospital or treatment (unless we cover this under pregnancy 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 Treatment for self-inflicted injuries or injuries or illnesses resulting from attempted suicide, whether the insured is sane or insane.

m Drug or alcohol misuse.
n 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).

o Dental treatment (unless this is covered under accident inpatient dental treatment).

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

q Sex-change operations.

r 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.

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

t 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.

u Private nursing charges and nursing home services.

v Vaccinations.

w Treatment of injuries arising from being directly involved in civil commotion, riot or strike.

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

y Rest cures, hospice care, home or outpatient nursing or palliative care, convalescent care in convalescent or nursing homes, sanatoriums or similar establishments, outpatient rehabilitation services such as counselling and physical rehabilitation.

z Alternative or complementary treatments, including traditional Chinese medicine (TCM) or a stay in any health-care establishment for social or non-medical reasons.

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 (Cap. 36) and the MediShield Life Scheme Act (Act No. 4 of 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.

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 outpatient hospital treatment and prosthesis benefit covered by your policy.
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 serious injury or the start of a serious condition which needs immediate surgery or medical treatment in a hospital to prevent death or serious damage to the insured's health.

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).

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 (Cap. 131A), as amended, extended or re-enacted 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, insured or non-insured, from whom a specified organ is removed and transplanted into another living person.

MOH means the Ministry of Health, Singapore.

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

Necessary medical treatment means 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 medical practice in Singapore.

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.

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 restricted hospital.

Private medical institution means any licensed private clinic or medical 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 paid for medical services or treatment 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. These 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.

Registered medical practitioner means a doctor qualified in western medicine who is licensed and authorised in the geographical area they are practising in to provide medical or surgical services. This cannot be you, the insured or your or the insured’s parent, brother or sister, husband or wife, child or relative.

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

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 has the extra qualifications and expertise needed to practise as a recognised specialist of diagnostic techniques, treatment and prevention, in a particular field of medicine, like psychiatry, neurology, paediatrics, endocrinology, obstetrics, gynaecology, dermatology and physiotherapy.

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**.

**Surgical limits table** means the latest surgical operation fee tables 1 to 7 set by **MOH** from time to time.

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

**We, us or our** means **NTUC Income Insurance Co-operative Limited**.

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

**Policy Owners’ Protection Scheme**

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