Important: This is a sample of the policy document. To determine the precise terms, conditions and exclusions of your cover, please refer to the actual policy and any endorsement issued to you.

Schedule of benefits

Benefits	Plan P	Plan A	Plan B	Plan C
Inpatient hospital treatment	**Limits of compensation**			
Daily ward and treatment charges (each day)				
- Normal ward	$2,000	$1,200	$1,000	$700
- MIC@Home	$2,000	$1,200	$1,000	$700
- Intensive care unit ward	$2,600	$1,700	$1,400	$1,200
Surgical benefits (including day surgery) (each procedure)				
Surgical limits table - limits for various categories of surgery, as classified by the Ministry of Health in its latest surgical operation fees tables				
- Table 1 (less complex procedures)	$1,050	$600	$500	$400
- Table 2	$2,275	$1,300	$1,100	$750
- Table 3	$4,025	$2,300	$2,000	$1,300
- Table 4	$5,425	$3,100	$3,000	$2,000
- Table 5	$8,100	$5,400	$4,300	$3,000
- Table 6	$10,800	$7,200	$5,400	$4,200
- Table 7 (more complex procedures)	$14,100	$9,400	$8,200	$6,800
Surgical implants (each admission)	$14,000	$11,000	$9,000	$7,000
Radiosurgery, including proton beam therapy – Category 4 (each treatment course) #	$15,600	$12,600	$9,600	$9,600
Pre-hospitalisation treatment and post-hospitalisation treatment (up to 90 days before being admitted to or after being discharged from hospital, respectively)	Limited to unused balance amount of daily ward and treatment charges and community hospital.			
Community hospital (Rehabilitative) (each day, up to 45 days for each admission)	$2,000	$1,200	$1,000	$550
Community hospital (Sub-acute) (each day, up to 45 days for each admission)				
Outpatient hospital treatment	**Limits of compensation**			
Radiotherapy for cancer (each treatment)				
- External	$600	$400	$300	$250
- Brachytherapy	$600	$500	$500	$500
- Stereotactic	$5,000	$3000	$2,500	$2,000
- Proton beam therapy – Category 1 #	$600	$400	$300	$250
- Proton beam therapy – Category 2 #	$600	$500	$500	$500
- Proton beam therapy – Category 3 #	$5,000	$3000	$2,500	$2,000
Kidney dialysis (each month)	$3,500	$3,000	$2,500	$2,000
Erythropoietin for chronic kidney failure (each month)	$1,000	$700	$600	$400
Immunosuppressants for organ transplant (each month)	$1,000	$700	$600	$400

Benefits	Plan P	Plan A	Plan B	Plan C
Insured receiving treatment for one primary cancer				
Cancer drug treatment (each month) *	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		3x MSHL Limit for one primary cancer	
Insured receiving treatment for multiple primary cancers ***				
Cancer drug treatment (each month) *	The total of the highest limits among the covered cancer drug treatments received for each primary cancer			
Cancer drug services (each policy year) **	5x MSHL Limit for multiple primary cancers		3x MSHL Limit for multiple primary cancers	
Special benefits	**Limits on special benefits**			
Congenital abnormalities benefit (each policy year) (with 24 months' waiting period)	$10,000	$7,500	$5,000	Covered up to MediShield Life benefits only
Pregnancy complications benefit (each policy year) (with 10 months' waiting period)	$7,000	$5,000	$3,500	Covered up to MediShield Life benefits only
Inpatient psychiatric treatment benefit (each policy year)	$10,000		$7,000	
Prosthesis benefit (each policy year)	$10,000	$6,000	$6,000	$3,000
Final expenses benefit	$5,000		$3,000	$1,500
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

Benefits	Plan P	Plan A	Plan B	Plan C
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
Day surgery or short-stay ward				
- Subsidised	$3,000	$3,000	$3,000	$3,000
- Non-subsidised	$5,250	$5,250	$3,750	$3,000
Co-insurance	10%			
Limit in each policy year	$300,000	$200,000	$150,000	$100,000
Limit in each lifetime	Unlimited			
Last entry age (age next birthday)	75			
Maximum coverage age	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 IncomeShield

Your policy

This is **your** 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, occupation 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. 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**.

IncomeShield is a medical insurance plan which covers **you** for costs associated with a **stay 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**. 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** during a **stay in hospital**.

If **you** do not use the maximum benefit each day for daily ward and treatment charges (normal ward), daily ward and treatment charges (intensive care unit (ICU) ward) and **staying in a community hospital**, **you** can use the rest to cover pre-hospitalisation treatment and post-hospitalisation treatment. However, **you** cannot use it for outpatient hospital treatment.

If the **insured** is in **hospital** for only part of a day, **we** will halve the **limits of compensation** for the daily ward and treatment charges (normal ward) benefit, daily ward and treatment charges (intensive care unit (ICU) ward) benefit, and staying in a community hospital benefit, for that part-day. Whether **we** class the **stay in hospital** as a full day or part of a day will depend on whether the **hospital** charges the room rate for a full day or for half a day, for the day in question.

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

b Daily ward and treatment charges (Mobile Inpatient Care @ Home)

Charges the **insured** has to pay for each day of inpatient care provided through **Mobile Inpatient Care @ Home (MIC@Home)**, including for:
- prescriptions;
- medical consultations;
- miscellaneous medical charges;
- **specialist** consultations;
- examinations;
- laboratory tests;
- equipment loan or rental;
- nursing charges;
- home care; and
- transport-related services.

We will cover pre-hospitalisation treatment benefit and post-hospitalisation treatment benefit for the inpatient care provided through **MIC@Home**.

c Daily ward and treatment charges (intensive care unit (ICU) ward)

ICU charges the **insured** has to pay for each day in an **ICU**, including for:
- meals;
- prescriptions;
- medical consultations;
- miscellaneous medical charges;
- **specialist** consultations;
- examinations; and
- laboratory tests.

d Surgical benefit

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

- 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.

Surgical benefit depends on the **surgical limits table**.

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

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. 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, including proton beam therapy (category 4)

Covers radiosurgery, including proton beam therapy (category 4), carried out on 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.

g 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**. It does not include inpatient hospital treatment or day surgery.

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 which is given before inpatient psychiatric treatment, **accident inpatient dental treatment** or emergency overseas treatment.

h Post-hospitalisation treatment

The cost of medical treatment received by the **insured** in the **policy year**, for up to 90 days after the date they leave **hospital**.

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.

It does not include inpatient hospital treatment or day surgery.

Any physiotherapy, occupational therapy or speech therapy must be provided by an Allied Health Professional registered under **MOH.** The Allied Health Professional cannot be **you**, the **insured** or **your** or the **insured**'s parent, brother or sister, husband or wife, child or relative.

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, **accident inpatient dental treatment** or emergency overseas treatment.

i 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 45 days for each stay in the **community hospital**.

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**.
- 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 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**.
- The treatment must arise from the same injury, illness or disease that resulted in the inpatient hospital treatment.

1.2 Outpatient hospital treatment

The outpatient hospital treatment benefit pays for the **insured**'s medical treatment 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, brachytherapy, stereotactic radiotherapy and proton beam therapy categories 1, 2 and 3.

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.

b Outpatient kidney dialysis.

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

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

e Cancer drug treatments listed on the **Cancer Drug List** (**CDL**) and used according to the indications for the cancer drugs, as specified in the **CDL** on **MOH**'s website (go.gov.sg/moh-cancerdruglist).

For each primary cancer, if the cancer drug treatment on the **CDL** involves more than one drug, **we** allow a particular drug to be removed from the treatment or replaced with another drug on the **CDL** that has the indication 'for cancer treatment', only if this is due to intolerance or contraindications (for example, allergic reactions). In such cases, the claim limit of the original cancer drug treatment on the **CDL** will apply.

For each primary cancer, if more than one cancer drug treatment is administered in a month, the following will apply.

- If any of the cancer drug treatments that are on the **CDL** has an indication that states 'monotherapy', only the treatments on the **CDL** that have the indication 'for cancer treatment' will be covered in that month.
- If none of the cancer drug treatments that are on the **CDL** has an indication that states 'monotherapy':
    - if more than one of the cancer drug treatments administered in a month has an indication other than 'for cancer treatment', only cancer drug treatments that are on the **CDL** and have the indication 'for cancer treatment' will be covered 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 cancer drug treatments that are on the **CDL** will be covered in that month.

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

For insured receiving treatment for one primary cancer

- **We** will pay up to the highest limit among the covered cancer drug treatments on the **CDL** that are administered in that month.

For insured receiving treatment for multiple primary cancers

- The **registered medical practitioner** can apply for higher claim limits for the **insured** receiving treatment for **multiple primary cancers** by sending an application to **us** (for assessment against **your policy**) and **MOH** (for assessment against the cover provided by **MediShield Life**). In this case, **we** will pay up to the total of the highest limits among the covered cancer drug treatments on the **CDL** that are administered for each primary cancer in that month.

f 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.

The **registered medical practitioner** can apply for higher claim limits for the **insured** receiving treatment for **multiple primary cancers** by sending an application to **us** (for assessment against **your policy**) and

MOH (for assessment against the cover provided by **MediShield Life**). In this case, **we** will pay up to the limit set out in the **schedule of benefits**.

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.

The **deductible** does not apply to the outpatient hospital treatment benefit.

1.3 Special benefits

We limit **benefits we** will pay in relation to certain medical conditions or circumstances. **We** call these 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 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 either:
- be first diagnosed by a **registered medical practitioner**; or
- have symptoms which first appeared after 24 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.

b 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, laparoscopic surgery or 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**.

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.

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

c 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 given before, and post-hospitalisation treatment given after, inpatient psychiatric treatment.

d 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 as a result of an injury or illness that the **insured** has to stay in **hospital** for.
- The **prosthesis** is ordered by a **registered medical practitioner**.
- The **prosthesis** is bought within 180 days after the date the **insured** leaves **hospital**.

When **we** work out whether the limit for this benefit (set out in the **schedule of benefits**) has been used up for the **policy year** in which 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 as a result of another injury or illness that the **insured** has to stay in **hospital** again for, **we** will pay for the **prosthesis**.

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

The **deductible** does not apply to this benefit.

e 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**.

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 a **stay in hospital** was necessary.

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

1.4 Emergency overseas treatment

Emergency overseas treatment benefit pays for inpatient hospital treatment resulting from an **emergency** while overseas.

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 given before, and post-hospitalisation treatment given after, emergency overseas treatment.

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

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 The **limits of compensation**
c The **deductible**
d The **co-insurance**
e The **limits on special benefits**
f 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 the **insured** leaves **hospital**. Claims for pre-hospitalisation treatment and post-hospitalisation treatment must be sent to **us** within 90 days from the date of the relevant treatment. **You** must give **us** any 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, **we** will pay the **hospital** direct. Otherwise, **we** will pay **you** direct.

If **we** need to investigate a claim after it has been paid, **we** may recover the claim payment (depending on the outcome of the investigation).

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 to be **reasonable expenses** for **necessary medical treatment**. **We** can reduce **your** claim to reflect what would have been reasonable, based on **our** opinion or the professional opinion of **our** medical advisor.

If there is a dispute in the amount of claim paid by **us**, 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 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** continues for, **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 **limit in each policy year**.

For each **stay in 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 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, 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 hospital** continues 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 Plan B staying in a **private hospital**.

Expenses	Limits of compensation	Bill	Amount you can claim
Daily ward and treatment charges (normal ward) (5 days)	$5,000 ($1,000 a day x 5 days)	$3,000	$3,000
Surgical benefit (table 7)	$8,200	$10,000	$8,200
Total		$13,000	$11,200
Less **deductible**			$2,500
Less **co-insurance**: 10% x ($11,200 - $2,500)			$870
IncomeShield (including **MediShield Life**) pays (This depends on the **limits on special benefits** and the **limit in each policy year**.)			$7,830
Insured pays			$5,170

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 Plan B staying in a **private hospital**.

Expenses	Limits of compensation	Bill	Amount you can claim
Daily ward and treatment charges (normal ward) (367 days)	$367,000 ($1,000/day x 367 days)	$220,200	$220,200
Surgical benefit (table 7)	$8,200	$10,000	$8,200
Total		$230,200	$228,400
Less **deductible:** ($2,500 x 2 years)			$5,000
Less **co-insurance**: 10% x ($228,400 - $5,000)			$22,340
IncomeShield (including **MediShield Life**) pays (Two times the **limits on special benefits** and two times the **limit in each policy year**)			$201,060
Insured pays			$29,140

2.4 Citizenship factor

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

Plan type	Plan B	Plan 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 upgrade to the IncomeShield Standard Plan or Enhanced IncomeShield Plan that corresponds with the **insured**'s citizenship or residency status.

We will not apply a **citizenship factor** for an **insured** who is covered under IncomeShield Plan P or Plan A.

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 your 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
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 from **your** MediSave account and partly by cash, **we** will refund the **premium** in line with the percentages of the **premium** paid from **your** MediSave account and by 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 **your 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** has received a reimbursement from any other source.

If **you** or the **insured** has 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** 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** shown in the **application form** is wrong, **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 **your policy** has not ended in accordance with clause 4.6.

4.4 Cancelling your 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 your 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 The **insured** is covered under another MediSave-approved Integrated Shield Plan.
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 what date **your policy** will end on.

When **your 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, this will not affect the **insured**'s cover under **your policy**.

4.7 Reinstating your 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 and any amount **you** owe **us** under **your policy** before **we** will reinstate **your policy**.

b **We** will not pay for any expenses which happen between the date **your 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 make **us** liable for 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, if 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 **your** 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 **your** existing **plan** to a foreigner plan, provided the **insured** is holding an **eligible valid pass**.

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

a convert **your plan** to one that corresponds to the **insured**'s citizenship and residency status, which helps to avoid the amount of each benefit **we** will pay being reduced 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 **your plan** was converted.

4.9 Changing the policy terms or conditions

We may change the **premiums**, **benefits**, 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 they apply to all policies within the same class.

If **MOH**, the **CPF Board** or any other regulatory authority relating to **MediShield Life** introduces any mandatory changes to the benefits, features, guidelines or conditions of **your policy**, **we** may immediately apply those mandatory changes without giving **you** written notice.

4.10 Changing your plan

You may ask in writing to change **your plan**. If **we** 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 **you** 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 **your policy**. **You** will have to repay to **us** all amounts **we** have paid out under **your 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 **your policy**. **You** will have to repay to **us** all amounts **we** have paid out under **your 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 (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 **your 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, **your policy** will continue without any integration with **MediShield Life**.

4.17 Giving notice

We will assume any notice or communication under **your 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 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 this was 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 or any medical treatment claimed to generally prevent illness, promote health or improve bodily function or appearance.
d General outpatient medical expenses (unless 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 covered under congenital abnormalities benefit).
f Overseas medical treatment (unless covered 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 covered under inpatient psychiatric treatment benefit).
h Pregnancy, childbirth, miscarriage, abortion or termination of pregnancy, lactation complications, or any related **stay in hospital** or treatment (unless covered 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 A **stay in hospital** before 1 April 2023 for injuries or illness resulting from attempted suicide or 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.

p Dental treatment (unless covered under **accident inpatient dental treatment**), regardless of whether it is a direct or indirect result of an illness or injury.

q Transport-related services, including ambulance fees, emergency evacuation, and sending home a body or ashes (unless covered under **MIC@Home**).

r Sex-change operations.

s The costs of 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), including, but 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 covered under prosthesis benefit or **MIC@Home**).

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 (unless covered under **MIC@Home**).

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 a convalescent home or nursing home, care provided in a sanatorium or similar establishment, or outpatient rehabilitation services such as counselling and physical rehabilitation (unless covered under **MIC@Home**).

aa Alternative or complementary treatments, including those provided by a traditional Chinese medicine practitioner, chiropractor, naturopath, acupuncturist, homeopath, osteopath or 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 A **stay in 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, charges for laundry, television rental, personal-care and hygiene products or newspapers, or fees for medical reports (including test results).

af Genetic testing that is carried out for health screening, risk evaluation or assessing prognosis, unless the genetic testing is ordered by a **registered medical practitioner** 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 aids.

ah Outpatient cancer drug treatments that are not on the **CDL**, unless covered under a rider benefit (if applicable).

ai Cell, tissue and gene therapy products.

aj High-cost drugs (HCDs) that are used for the medical conditions covered by **MediShield Life**. This includes HCDs listed and not listed on **MediShield Life**'s benefit schedule (go.gov.sg/mshlbenefits).

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

5 Definitions

Accident means an unexpected incident 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 injuries caused specifically by drowning, food poisoning, choking on food, or suffocation by smoke, fumes or gas.

Accident inpatient dental treatment means inpatient treatment to remove, restore or replace sound natural teeth which have been lost or damaged in an **accident.** The treatment must be performed within 14 days of the **accident**. **We** do not cover pre-hospitalisation treatment which is given before, and post-hospitalisation treatment which is given after, accident inpatient dental treatment.

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 **you** make to **us** to cover the **insured** under **your policy**.

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 **MOH**'s website (go.gov.sg/moh-cancerdruglist). **MOH** may update the Cancer Drug List from time to time.

Citizenship factor means the percentage **we** will reduce the amount of **benefit** to. The percentage is 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.

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**.

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, as shown in the **policy certificate** or **renewal certificate** (as the case may be).

High dependency unit (HDU) means the high dependency unit or high dependency ward of a **hospital**.

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 was **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 was from the **hospital** that gave the blood transfusion.
- The cause of HIV was 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 cause, 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.

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**, which is the most **we** will pay in **benefits**.

Limits on special benefits means the limits on the amounts **we** will pay for the special benefits shown in the **schedule of benefits,** which are 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.

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

Mobile Inpatient Care @ Home (MIC@Home) refers to a care-delivery model, covered under **MediShield Life**, that allows the **insured**, who has been assessed by a **registered medical practitioner** as being clinically suitable, to receive inpatient hospital treatment in the **insured**'s own home, instead of a **restructured hospital**. This type of care has to be recommended by a **registered medical practitioner**.

MOH means the Ministry of Health, Singapore.

Multiple primary cancers means two or more cancers that arise from different sites of the body and are of a different histology or morphology group (that is, that have a different microscopic structure, form or shape).

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
- be cost-effective and supported by the guidelines of **MOH** (such as the **MediShield Life Claims Rules** shown on **MOH**'s website) or official bodies such as Health Sciences Authority, the Allied Health Professions Council or the Agency for Care Effectiveness.

The treatment must not:

- be for the convenience of the **insured** or a **registered medical practitioner** or **specialist** (for example, treatment that can reasonably be provided out of a **hospital**, but is provided as an inpatient treatment);
- be for medical trials, experimental purposes, investigation or research (for example, experimental therapy, or pioneering or new medical techniques or surgical techniques, physiotherapy, medical devices or medicinal products), whether or not these have been approved by, or have a clinical trial certificate that has been issued by, **MOH**, Health Sciences Authority or another regulatory body in Singapore;
- be for **primary prevention**, be preventive treatment unrelated to the current diagnosis, or be an examination or test the outcome of which will not show the cause of or treatment for a medical condition; or
- be for health screening or promoting good health (such as dietary replacements or supplements, unless they are medically proven after being evaluated for their quality, safety and usefulness by Health Sciences Authority).

We have the right to decide 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.

- That **you** reported the incident giving rise to the HIV infection to **us** within 30 days of the incident.
- That the incident was the cause of the HIV infection.

- 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.
- That 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 cause, 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 (or should have asked for or received) treatment, medication, advice or diagnosis 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 described in clause 3.1.

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

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

in Singapore

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

Reasonable expenses means expenses paid for medical treatment or services which are appropriate and consistent with the diagnosis, are in line with accepted medical standards, and 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 providers of similar standing in Singapore for similar medical treatment or services. **We** will determine the general level of charges based on what **we** determine is a medical provider of a similar standing and to be similar medical treatments and services;
- must not include fees or charges that would not have been made if no insurance had existed;
- must be within the current range of fee guidelines published by the Singapore government, **MOH** or official bodies such as Health Sciences Authority and the Allied Health Professions Council; and
- must not exceed **our** internal benchmarks for episodes of care with similar diagnoses or medical treatment or services performed.

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 recognised 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 first **premium** due after **your plan** is reinstated, 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 recognised specialties and subspecialties.

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

Start date means the date **your policy** starts, as shown in the **policy certificate**.

Stay in 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**).

Staying in a community hospital means a stay in a **community hospital** in line with the conditions in clause 1.1(i).

Sub-acute care means care for complicated medical conditions that require additional medical and nursing care that is less intensive compared with **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 Organisation (VWO) means a non-profit organisation that provides welfare services or services that benefit the whole community.

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

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