## Schedule of benefits

| Benefits | IncomeShield Standard Plan |
|---|---|
| **Ward entitlement** | **Restructured hospital for ward class B1 and below** |
| **Inpatient hospital treatment** | **Limits of compensation** |
| Room, board and medical-related services (each day) | $1,700 |
| Intensive care unit (ICU) and medical-related services (each day) | $2,900 |
| Surgical benefit (including day surgery)<br>Surgical limits table - limits for various categories of surgery, as classified by the Ministry of Health in its latest surgical operation fees tables<br>- Table 1 (less complex procedures)<br>- Table 2<br>- Table 3<br>- Table 4<br>- Table 5<br>- Table 6<br>- Table 7 (more complex procedures) | <br><br><br><br>$590<br>$1,670<br>$3,290<br>$4,990<br>$8,760<br>$11,670<br>$16,720 |
| Surgical implants (for each admission) | $9,800 |
| Gamma knife and novalis radiosurgery (for each procedure) | $9,600 |
| Staying in a community hospital (each day) | $650 |
| Inpatient psychiatric treatment (each day, up to 35 days for each policy year) | $500 |
| | |
| **Outpatient hospital treatment** | **Limits of compensation** |
| Stereotactic radiotherapy for cancer (for each session) | $1,800 |
| Radiotherapy for cancer (for each session)<br>- External or superficial<br>- Brachytherapy with or without external | <br>$550<br>$1,100 |
| Chemotherapy for cancer (each month) | $5,200 |
| Renal dialysis (each month) | $2,750 |
| Erythropoietin and other drugs approved under MediShield Life for chronic renal failure (each month) | $450 |
| Cyclosporin or tacrolimus and other drugs approved under MediShield Life for organ transplant (each month) | $1,200 |

| **Benefits** | **IncomeShield Standard Plan** | | |
|---|---|---|---|
| **Pro-ration factor** | **Singapore Citizen** | **Singapore Permanent Resident** | **Foreigner** |
| Inpatient | | | |
| - Restructured hospital | | | |
| - Ward class C, B2 or B2+ | Does not apply | Does not apply | Does not apply |
| - Ward class B1 | Does not apply | 90% | 80% |
| - Ward class A | 80% | 80% | 80% |
| - Private hospital or private medical institution | 50% | 50% | 50% |
| - Community hospital | | | |
| - Ward class C, B2 or B2+ | Does not apply | Does not apply | Does not apply |
| - Ward class B1 | Does not apply | 90% | 80% |
| - Ward class A | 80% | 80% | 80% |
| Day surgery or short-stay ward | | | |
| - Restructured hospital subsidised | Does not apply | Does not apply | Does not apply |
| - Restructured hospital non-subsidised | Does not apply | Does not apply | Does not apply |
| - Private hospital or private medical institution | 65% | 65% | 65% |
| Outpatient hospital treatment | | | |
| - Restructured hospital subsidised | Does not apply | Does not apply | Does not apply |
| - Restructured hospital non-subsidised | Does not apply | Does not apply | Does not apply |
| - Private hospital or private medical institution | 65% | 65% | 65% |
| **Deductible for each policy year for an insured aged 80 years or below next birthday** | | | |
| Inpatient | | | |
| - Restructured hospital | | | |
| - Ward class C | $1,500 | | |
| - Ward class B2 or B2+ | $2,000 | | |
| - Ward class B1 | $2,500 | | |
| - Ward class A | $2,500 | | |
| - Private hospital or private medical institution | $2,500 | | |
| - Community hospital | | | |
| - Ward class C | $1,500 | | |
| - Ward class B2 or B2+ | $2,000 | | |
| - Ward class B1 | $2,500 | | |
| - Ward class A | $2,500 | | |
| Day surgery or short-stay ward | | | |
| - Subsidised | $1,500 | | |
| - Non-subsidised | $2,000 | | |

| Benefits | IncomeShield Standard Plan |
|---|---|
| **Deductible for each policy year for an insured aged over 80 years at next birthday** | |
| Inpatient | |
| - Restructured hospital | |
| - Ward class C | $2,000 |
| - Ward class B2 or B2+ | $3,000 |
| - Ward class B1 | $3,000 |
| - Ward class A | $3,000 |
| - Private hospital or private medical institution | $3,000 |
| - Community hospital | |
| - Ward class C | $2,000 |
| - Ward class B2 or B2+ | $3,000 |
| - Ward class B1 | $3,000 |
| - Ward class A | $3,000 |
| Day surgery or short-stay ward | |
| - Subsidised | $3,000 |
| - Non-subsidised | $3,000 |
| | |
| **Co-insurance** | 10% |
| **Limit in each policy year** | $150,000 |
| **Limit in each lifetime** | Unlimited |
| **Last entry age (age next birthday)** | Does not apply |
| **Maximum coverage age** | Lifetime |

# Conditions for IncomeShield Standard Plan

## Your policy

This is **your** IncomeShield Standard Plan policy. It contains:

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

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

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

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

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

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

## 1 What your policy covers

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

The **benefits** only pay for **reasonable expenses** for **necessary medical treatment** for the **insured**. 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'. These costs must be for treatment received by the **insured** while **staying in a hospital**.

If the **insured** is in **hospital** for only part of a day, **we** will halve the **limits of compensation** for the room, board and medical-related services benefit and the intensive care unit (ICU) and medical-related services 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 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.

If the **insured** is in a luxury or deluxe suite or any other special room of a **hospital**, **we** will pay only 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 **hospita**l 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.

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

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 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)

**e Gamma knife and novalis radiosurgery**

Covers gamma knife and novalis radiosurgery carried out on the **insured**.

**f Staying in a community hospital**

Charges the **insured** has to pay for each day while **staying in a 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.

### g 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, for each day up to 35 days for each **policy year**.

### 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 and chemotherapy for cancer.
**b** Renal dialysis.
**c** Approved immunosuppressant drugs including erythropoietin for chronic renal failure, cyclosporin and tacrolimus for organ transplant (to avoid doubt, this does not include stem-cell or bone marrow transplant) and other drugs approved by the Health Science Authority of Singapore.
**d** Outpatient consultation fees, medicines, examinations and tests ordered by the attending **registered medical practitioner** which take place within 30 days before the outpatient hospital treatment. The consultation fees, medicines, examinations and tests must be needed as a result of the same injury, illness or disease that resulted in the outpatient hospital treatment, and the medicines must be used within 30 days before the outpatient hospital treatment. **We** will treat these claims as part of the outpatient hospital treatment, and pay **benefits** depending on any balance under the **limits of compensation** for the outpatient hospital treatment that the **insured** receives within the next 30 days. To avoid doubt, follow-up consultation fees, medicines, examinations and tests after the outpatient hospital treatment are not covered.

## 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** **Pro-ration factor**
**b** The **limits of compensation**
**c** The **deductible**
**d** **Co-insurance**
**e** 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 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. **We** will only accept claims that are electronically filed and **we** will pay the **hospital** direct. **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 integrated with **MediShield Life**, **you** must send the claim to **us** by post or by hand. These claims must be sent to **us** within 90 days from the date of billing or

the date the **insured** leaves **hospital**, whichever is later.

To make a claim for the benefit under clause 1.2(d), the claim for outpatient hospital treatment under clause 1.2(a), (b) or (c) must have already been filed and approved.

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

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

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

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

## 2.2 Deductible and co-insurance

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

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

If the **insured** stays in different **hospitals** over a continuous period of time, **we** will treat the expenses for the stay in each **hospital** as a separate claim and apply the **deductible** and **co-insurance** for each claim.

## 2.3 Limits of compensation and limit in each policy year

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

For each **stay in a hospital** of 12 months or less, **we** will apply the **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 **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 **limit in each policy year** for one extra **policy year** will apply.

**How we apply the deductible 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** who is a Singapore Citizen, covered under IncomeShield Standard Plan staying in ward class B1 of a **restructured hospital**.

| Expenses | Limits of compensation | Bill | Amount you can claim |
|---|---|---|---|
| Room, board and medical-related services (5 days) | $8,500 ($1,700 a day x 5 days) | $3,000 | $3,000 |
| Surgical benefit (table 7) | $16,720 | $10,000 | $10,000 |
| Total | | $13,000 | $13,000 |
| Less **deductible** | | | $2,500 |
| Less **co-insurance:** 10% x ($13,000 - $2,500) | | | $1,050 |
| IncomeShield Standard Plan (including **MediShield Life**) pays (this depends on the **limit in each policy year**) | | | $9,450 |
| **Insured** pays | | | $3,550 |

**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** who is a Singapore Citizen, covered under IncomeShield Standard Plan staying in a ward class B1 of a **restructured hospital**.

| Expenses | Limits of compensation | Bill | Amount you can claim |
|---|---|---|---|
| Room, board and medical-related services (367 days) | $623,900 ($1,700 a day x 367 days) | $220,200 | $220,200 |
| Surgical benefit (table 7) | $16,720 | $10,000 | $10,000 |
| Total | | $230,200 | $230,200 |
| Less **deductible:** ($2,500 x 2 years) | | | $5,000 |
| Less **co-insurance:** 10% x ($230,200 - $5,000) | | | $22,520 |
| IncomeShield Standard Plan (including **MediShield Life**) pays (this depending on two times the **limit in each policy year**) | | | $202,680 |
| **Insured** pays | | | $27,520 |

### 2.4 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**.

**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**.

## 3 Your responsibilities

### 3.1 Premium

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

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

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

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

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

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

**a** the **premium you** owe is more than the maximum withdrawal limit set by the **CPF Board**;

**b** there are not enough funds in **your** Medisave account to pay the **premium** due; or

**c** the **premium,** or part of it, is not taken from **your** Medisave account for any reason.

### 3.2 Refunding your premium when the policy ends

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

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

**b** in cash (if **your premium** was paid in cash).

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

**Example**

| | |
|---|---|
| **Policy year** | : 1 January to 31 December in year X |
| IncomeShield Standard Plan 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:
31 days/365 days x ($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:
31 days/365 days x $100 = $8.49

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

**Example**

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

### 3.3 Change in premium

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

## 4 What you need to be aware of

### 4.1 Other insurance, benefit, incentive or subsidy scheme

**We** do not pay for claims if the medical expenses have been paid, or **you** or the **insured** have received a refund or similar benefits from other sources, whether under any insurance, incentive (including discounts) or subsidy scheme.

If **you** or the **insured** have other medical insurance, or 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 or employee benefits 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 or employee benefits.

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 or employer'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**.

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

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

### 4.8 Change of citizenship and residency status

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

### 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**, or the last **reinstatement date** of **your policy** (if any), whichever is later, that may influence **our** decision whether to provide cover or to impose any terms under **your policy**.

If **you** fail to give **us** this information or misrepresent any information, **we** may:

**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 or change the terms and conditions for **your** cover.

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

### 4.14 Dealing with disputes

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

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

### 4.15 Excluding the rights of others

A person who is not directly involved in **your policy** will have no right, under the Contracts (Rights of Third Parties) Act (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** or, if it applies, between the date the policy ends and the date immediately before the **reinstatement date** of **your policy**.

**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, any **pre-existing illness, disease or condition** which falls under any other exclusion under this clause 4.18 is not covered under **your policy**, whether a declaration was made in the **application form** or not. To avoid doubt, any **pre-existing illness, disease or condition** (including birth defects and congenital sickness or abnormalities) 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 **cosmetic surgery due to accident** or **breast reconstruction after mastectomy**) or any medical treatment claimed to generally prevent illness, promote health or improve bodily function or appearance.

**d** General outpatient medical expenses or retail items or treatment before or after the inpatient hospital treatment or outpatient hospital treatment, even when the treatment arises from the same injury, illness or disease that resulted in the inpatient or outpatient hospital treatment (unless this is covered under outpatient hospital treatment).

**e** Treatment for birth defects, including hereditary conditions and disorders and congenital sickness or abnormalities.

**f** Overseas medical 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.

**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 suicide or attempted suicide, whether the **insured** is sane or insane.

**m** 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** Expenses of getting an organ or body part for a transplant from a living donor for the

**insured** and all expenses the living donor has to pay.

**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 the following, including parts attached to them, for use at home or as an outpatient.
- Braces
- Prostheses
- Medical appliances including storage, transport and associated administrative costs of those appliances and which are not necessary to complete a surgical operation.
- Medical equipment or machines
- Corrective devices
- Wheelchairs
- Walking aids
- Home aids
- Renal-dialysis machines
- Iron lungs
- Oxygen machines
- Hospital beds
- Replacement organs
- Any other hospital-type equipment

**s** Optional items which are outside the scope of treatment or prostheses.

**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 or indirectly involved in civil commotion, riot, strike or terrorist activities, breaking or attempting to break the law, resisting arrest or any imprisonment.

**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, home visits or treatments, home rehabilitation or palliative care, convalescent care in convalescent or nursing homes, sanatoriums or similar establishments, outpatient rehabilitation services such as counselling and physical rehabilitation.

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

**aa** Treatment for illness or injury resulting from the **insured** taking part in any dangerous activities or sports, when they are performed in a professional capacity or when income could or would be earned from those activities or sports.

**ab** Treatment for obesity, losing weight, increasing weight, or any procedures relating to managing weight.

**ac** **Staying in a hospital** mainly for general physical or medical check-ups or screenings.

**ad** Non-medical items such as parking fees, hospital administration and registration fees, laundry, television rental, newspaper or medical report (including test results) fees.

**ae** Genetic testing and preventive treatment or procedures.

Some of the exclusions shown above may be covered under **MediShield Life**.

## 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.

**Accident inpatient dental treatment** means inpatient treatment to remove, restore or replace sound natural teeth which have been lost or damaged in an **accident**.

**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**.

**Breast reconstruction after mastectomy** means 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.

**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**.

**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 a **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 covered by **your policy**.

**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.

**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**.

**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 **restructured 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 2.4.

**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.

**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(f).

**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**).

**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 2.4(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).