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GENERAL PROVISIONS

This Policy is issued under a joint insurance arrangement with the Central Provident Fund (CPF) Board, whereby we provide an enhancement scheme in this Policy.

Provided the Insured meets the eligibility conditions as specified in the CPF Act and its regulations, the Insured is jointly also insured under the MediShield Life Scheme operated by the CPF Board. The Insured shall enjoy all benefits of the MediShield Life Scheme as provided under the CPF Act and the MediShield Life Scheme Act 2015 and their associated regulations as amended from time to time.

This Policy sets out the benefits, terms and conditions applying to the enhancement scheme. For information on the MediShield Life Scheme, you should refer to the CPF Act, the MediShield Life Scheme Act and the CPF Board.

Notwithstanding any other provision to the contrary, any mandatory revision of the minimum deductibles, maximum co-insurance or new guidelines and conditions that may be introduced by the Ministry of Health of Singapore, CPF Board or other relevant government authorities on the MediShield Life Scheme or the said joint insurance agreement from time to time, shall be deemed to apply to this Policy (where applicable).

OUR AGREEMENT

Your Policy is a legally enforceable agreement between you and us. We agree to pay the benefits set out in your Policy in exchange for the premiums paid by you.

We shall rely on the information you and the Insured gave us in your application in deciding whether or not to accept your application. All statements made in your application are, in the absence of fraud, regarded as representations and not warranties. In other words, both you and the Insured must answer all the questions in your application accurately and reveal all the facts both of you know, or ought to know. Otherwise, we can void your Policy, deny a claim under your Policy or impose additional terms and conditions on your Policy.

Your Policy is governed by and interpreted according to the laws of the Republic of Singapore.

MODIFICATIONS

Your Policy's provisions cannot be changed or varied by any of our employees, independent contractors or agents unless such change is contained in an endorsement signed by our duly authorised officer.

NON-ADMISSION

Neither the Insured nor you shall make any admission, offer promise or payment to any third party without our prior written consent. We may at our discretion take over and conduct in the Insured's or your name the defence of any claim or commence any claim for indemnity or damages against any third party, and shall have full discretion in the conduct of any proceeding in the settlement of any claim and both the Insured and you shall give all such information and assistance as we may require.

SUBROGATION

If we shall make any payment or otherwise make good any loss applying under this Policy, we shall be subrogated to all of the Insured's and your rights of recovery against any other person or persons and you shall complete, sign and deliver any document necessary to secure such rights. Both the Insured and you shall not take any action following a loss to prejudice such rights of subrogation.

OWN INSURER

If at the time of any loss or damage, the policy limit of any benefit is less than the total amount of claim, you and/or the Insured shall be considered his own insurer for the difference.

AGE

If the age of the Insured indicated on your application is incorrectly stated, we shall, subject to the satisfaction of our terms and conditions, adjust the premiums payable according to the correct age. We shall accept the correct age if we are satisfied with the evidence produced.

If the adjusted premiums are higher, you shall be required to pay the underpaid premiums. If the adjusted premiums are lower, we shall refund the overpaid premiums without interest. Any refund shall be made to your MediSave account or to you directly, as the case may be.

We may require proof of age at the time of processing any claim under your Policy.

CURRENCY OF PAYMENT

The amounts to be paid by us or to us shall be in the currency shown on the Policy Schedule.

FREE-LOOK PERIOD

We shall give you 21 days from the date of receipt of the Policy to decide whether you want to continue with your Policy. If you do not want to continue, you may cancel this Policy in writing to us and we shall refund the premiums paid for this Policy without interest. Any refund shall be made to your MediSave account or to you directly, as the case may be.

If you opted for an electronic copy of your Policy, the 21-day free-look period will start when you receive our SMS or email notification, informing you that the policy contract documents are available for your viewing on our customer portal (My AIA SG or such other name as we may choose for our customer portal from time to time).

If we have posted the Policy to you, the 21 day free-look period shall start seven (7) days after we have posted the Policy to you.

If the Policy was delivered to you by hand, the 21-day free-look period will start seven (7) days from the date on which the Policy was given to the postal/courier company or your insurance representative.

ELECTRONIC NOTICES / CORRESPONDENCE

If you had opted to receive electronic correspondence for your Policy (such as premium notices and policy statements) or give instructions to us electronically, we may at our discretion send such notices and correspondence to your account at our customer portal (My AIA SG or such other name as we may choose for our customer portal from time to time) or accept such instructions and correspond with you in such manner as we determine appropriate. All electronic communications are entirely at your own

risk and you agree to release us from all liability arising from or in connection with such electronic communications.

CANCELLATION

You may cancel your Policy by giving us 30 days' notice after the Free-Look Period. Cancellation shall be without prejudice to any claim arising prior to the effective date of cancellation.

We shall refund to you the portion of the premiums paid in respect of the period from the effective date of cancellation up to the next policy anniversary. The refund shall exclude the MediShield Life Scheme portion of the premiums. After such refund of premiums, we shall not be liable for any reimbursement of any claim incurred for the remaining period of the Policy Year immediately following the effective date of cancellation.

RIGHTS OF THIRD PARTIES

The Contracts (Rights of Third Parties) Act 2001 and any subsequent changes or replacement of its provisions shall not apply to your Policy.

NON-PARTICIPATING

This Policy shall be Non-Participating.

AVOIDANCE OF POLICY

Your Policy shall be void if any declaration or any written statement provided to us is untrue in any respect or if any material fact affecting the risk is incorrectly represented, stated or if you or the Insured have omitted such written statement.

Your Policy is treated as void:

(a) on the Policy Date if the misrepresentation, omission, or fraudulent statement was made to us on a proposal of insurance; or
(b) on the last Reinstatement Date (if any) or the effective date of change of plan (if any) if the misrepresentation, omission, or fraudulent statement was made to us on an application for reinstatement of insurance or change of plan.

Except in the case of fraud, when this Policy is treated as void pursuant to the above:

(a) If there are no claims made under this Policy, all premiums paid for insurance which became effective on or after the date on which this Policy is treated as void will be refunded.
(b) If there were claims made under this Policy, only the premiums paid for the Policy Year(s) following the Policy Year in which the last claim was made will be refunded.

Your Policy shall be void if any claim is fraudulent or exaggerated or if any false declaration or statement in support of any such claim is made. In this case, the Policy will be void immediately and there will be no refund of premiums. We reserve the right to recover such fraudulent or exaggerated claims that we have paid under this Policy.

CHANGE OF POLICY TERMS AND CONDITIONS

We may vary the premiums, benefits and/or cover or amend any privilege, term or condition of this Policy by giving you 31 days prior written notice, provided that such changes apply to all policies within the same class of insurance.

CHANGE OF PLAN

You may request for a change of plan which includes plan upgrade, plan downgrade or plan conversion in accordance with our terms and conditions for a change of plan by writing to us. The change of plan is subject to our approval and if approved, shall take effect on such date as notified by us to you.

For change of plan, any claim for expenses incurred before the effective date of the change of plan shall be payable in accordance with the benefit limits of the plan in-force prior to the change of plan.

In relation to a plan upgrade, claims that arise on or after the effective date of plan upgrade from a pre-existing condition (physical impairment, illness or disease) developed during the period of insurance of the prior plan will be assessed and payable based on the terms and conditions and benefits limits of the plan in-force prior to the effective date of the plan upgrade, unless the Insured makes a declaration of such pre-existing condition in the application for the plan upgrade and such application is specifically accepted by us. For the avoidance of doubt, any Pre-existing Condition that was not covered under the plan in-force prior to the effective date of plan upgrade will continue to be excluded under the upgraded plan.

TERMINATION

Your Policy shall automatically terminate on the earliest occurrence of the following:

(a) if any premium of your Policy remains unpaid at the end of the Grace Period;
(b) on the commencement date of another MediSave-approved integrated medical insurance plan that is jointly insured by the Central Provident Fund Board for the MediShield Life Scheme component and an insurer in Singapore for the medical enhancement scheme covering the Insured;
(c) on the death of the Insured; or
(d) on the date the Insured ceases to be a Singapore Citizen or Singapore Permanent Resident.

Termination of this Policy shall not (i) affect your cover under the MediShield Life Scheme or (ii) affect any claim arising prior to such termination of this Policy. In no instance shall any benefit be payable for expenses incurred on or after the date of termination, regardless of whether the incurred expense is a direct result of a covered condition which occurred before the termination of this Policy. Our acceptance of any premium after termination shall not create a liability for us.

If the Policy is terminated due to occurrence of (b), (c) or (d), we shall refund to you the portion of the premiums paid for the Policy Year in respect of the period from the date of termination up to the next policy anniversary.

BENEFITS PROVISIONS

LIMITS ON ELIGIBLE EXPENSES

Eligible Expenses are:

(a) limited to Reasonable and Customary charges for medical expenses or fees incurred; and
(b) subject to the Limit of Compensation under each respective benefit stated in the Schedule of Benefits of this Policy.

BENEFITS

While this Policy is in-force, we shall pay up to the Limits of Compensation for each respective benefit under this Policy for any Eligible Expenses incurred, less any Deductible and/or Co-insurance as stated in the Schedule of Benefits and subject to the terms and conditions of this Policy.

The reimbursement for the Eligible Expenses incurred under this Policy shall be on the basis of the higher of the benefits computed under this Policy and the MediShield Life Scheme. For such purposes, we reserve the right to:

(a) determine whether any particular Hospital or medical charge is a Reasonable and Customary charge with reference (but not limited) to relevant publications or information on schedule of fees prescribed by the government, relevant authorities and recognised medical associations in the locality; and
(b) adjust any and all sums payable in relation to any Hospital or medical charge, which is in the opinion of our medical director not a Reasonable and Customary charge.

In no instance shall any benefit be payable for any expense which is incurred before the Policy Date or occurs after the termination or cancellation of the Policy, regardless of whether the incurred expense is a direct result of a covered condition which occurred before the termination or cancellation of the Policy.

(A) Inpatient/Day Surgery Benefits

(i) Normal Ward Benefit

This benefit shall be equal to the Eligible Expenses incurred for room and board charges for a Standard Room including high dependency ward charges, and includes meals, prescriptions, professional charges, investigations and miscellaneous medical charges incurred per day during the period for which the Insured requires Confinement due to an Illness or Injury.

For the avoidance of doubt, an Insured requiring Confinement due to an Illness or Injury in any suite or luxury/deluxe/VIP room or any other special room of a Hospital shall be entitled to this benefit up to the Eligible Expenses incurred for room and board charges for a Standard Room subject to the Pro-ration Factor.

(ii) Intensive Care Unit (ICU) Ward Benefit

This benefit shall be equal to the Eligible Expenses incurred for ICU charges, including meals, prescriptions, professional charges, investigations and miscellaneous medical charges incurred per day during the period for which the Insured requires Confinement at the ICU of a Hospital due to an Illness or Injury.

(iii) Community Hospital Benefit

This benefit shall be equal to the Eligible Expenses incurred for room and board charges for a Standard Room and includes meals, prescriptions, professional charges, investigations and miscellaneous medical charges incurred per day during the period the Insured requires to be treated as an inpatient in a Community Hospital due to an Illness or Injury and provided such hospitalisation is immediately preceded by:

(a) Confinement in a Hospital; or
(b) Treatment from a Restructured Hospital's Accident and Emergency Unit in Singapore

and is referred by a Physician or Specialist of the Hospital or recommended by the Restructured Hospital's Accident and Emergency Unit in Singapore, to continue the treatment for the Illness or Injury.

Such hospitalisation must be for a continuous period of not less than six (6) hours.

(iv) Surgical Benefit

This benefit shall be equal to the Eligible Expenses incurred for Surgical Procedures, surgical implants, Approved Medical Consumables and radiosurgery (including proton beam therapy (category 4)), including operation theatre and anaesthesia fees as required by the Physician or Specialist during Confinement due to an Illness or Injury.

We will only cover proton beam therapy (category 4) if it is administered for an MOH-approved proton beam therapy indication and if the Insured meets the patient eligibility criteria for proton beam therapy under MediShield Life. The MOH-approved proton beam therapy indications and patient eligibility criteria are specified on Ministry of Health of Singapore's website (https://go.gov.sg/pbt-approved-indications).The Ministry of Health of Singapore may update this from time to time.

Any surgical procedure not listed in the "Table of Surgical Procedures" under the MediSave Scheme operated by the Ministry of Health of Singapore (Table 1 to Table 7) is not covered.

(v) Inpatient Palliative Care Service Benefit

This benefit shall be equal to the Eligible Expenses incurred for inpatient palliative care services in a Hospice if the Insured is suffering from a Terminal Illness.

The Insured must be admitted for inpatient palliative care service (general / specialised) by a Physician according to the relevant guidelines from the Ministry of Health of Singapore.

Such inpatient stay in the Hospice must be for a continuous period of not less than six (6) hours.

(vi) Continuation of Autologous Bone Marrow Transplant for Multiple Myeloma

This benefit shall be equal to the Eligible Expenses incurred for outpatient treatment for continuation of autologous bone marrow transplant for multiple myeloma as required by the Physician or Specialist, which includes consultation, clinical lab and investigations, consumables and drugs needed for continuation of autologous bone marrow transplant for multiple myeloma.

The treatments for continuation of autologous bone marrow transplant for multiple myeloma eligible for reimbursement are:
(a) Stem-cell mobilisation
(b) Harvesting of healthy stem cells
(c) Pre-transplant workup
(d) Use of high dosage chemotherapeutic drugs to destroy cancerous cells
(e) Engraftment of healthy stem cells
(f) Post-transplant monitoring

For the avoidance of doubt, the coverage under this benefit is only applicable for treatment in the outpatient setting. If the Insured requires the above treatments in the inpatient setting, refer to terms under Part A(i) – Normal Ward &/or Part A(ii) - Intensive Care Unit (ICU) Ward Benefit.

(vii) Serious Pregnancy and Delivery-Related Complications Benefit

We shall reimburse the Eligible Expenses incurred if the Insured requires Confinement in a Hospital to undergo medical or surgical treatment due to one of the following serious pregnancy and delivery-related complications:

(a) Eclampsia and pre-eclampsia
(b) Cervical incompetency
(c) Accreta placenta
(d) Placental abruption
(e) Placenta praevia
(f) Antepartum, intrapartum and postpartum haemorrhage
(g) Placental insufficiency and intrauterine growth restriction
(h) Gestational diabetes mellitus
(i) Acute fatty liver of pregnancy
(j) Obstetric cholestasis
(k) Twin to twin transfusion syndrome
(l) Infection of amniotic sac and membranes
(m) Amniotic fluid embolism
(n) Fourth degree perineal laceration
(o) Uterine rupture
(p) Postpartum inversion of uterus
(q) Obstetric injury or damage to pelvic organs
(r) Complications resulting in a caesarean hysterectomy
(s) Retained placenta and membranes
(t) Abscess of breast
(u) Ectopic pregnancy, hydatidiform mole and subsequent complications
(v) Medically necessary abortions
(w) Still-birth
(x) Maternal death

These serious pregnancy and delivery-related complications must have been first Diagnosed after the Insured has been insured under this Policy for a continuous period of 10 months from the Policy Date, the last Reinstatement Date (if any) or the effective date of plan upgrade (if any) of this Policy, whichever is latest.

For the avoidance of doubt:
(i) Eligible Expenses incurred in respect of and in connection with the Serious Pregnancy and Delivery-Related Complications Benefit are eligible to be reimbursed under Part (A)(i) – Normal Ward Benefit, Part A(ii) - Intensive Care Unit (ICU) Ward Benefit, Part A(iii) – Community Hospital Benefit and Part A(iv) – Surgical Benefit under the Benefits Provisions of this Policy; and
(ii) Delivery charges are excluded except in the event of caesarean section with hysterectomy

(viii) Psychiatric Benefit

We shall reimburse the Eligible Expenses incurred for medical or surgical treatment including room and board charges for a Standard Room, meals, prescriptions, professional charges, investigations and miscellaneous medical charges incurred per day, up to 60 days per Policy Year, during the period the Insured is Confined in a Hospital to receive psychiatric treatment provided by a Psychiatrist. Such hospitalisation and psychiatric treatment must be advised in writing for the Insured by a Psychiatrist and administered to the Insured under the direct supervision of a Psychiatrist.

(B) Outpatient Benefit

This benefit shall be equal to the Eligible Expenses incurred during the following course of treatment, including consultations and laboratory tests performed by a Physician, that the Insured is required to undergo upon the written recommendation or approval of a Physician or Specialist if these are done in connection with that treatment and within 30 days prior to such treatment:

(i) cancer drug treatment on the Cancer Drug List (CDL)
(ii) Cancer Drug Services
(iii) radiotherapy for cancer
    a. external (except hemi-body)
    b. brachytherapy
    c. hemi-body
    d. stereotactic
    e. proton beam therapy (category 1, 2 and 3)
(iv) kidney dialysis
(v) immunosuppressant for organ transplant – provided such drug is approved by Health Sciences Authority which are prescribed to the Insured following an organ transplant
(vi) erythropoietin for chronic kidney failure
(vii) long-term parenteral nutrition

In relation to cancer drug treatment on the CDL, we will only cover cancer drug treatments listed on the CDL published on the Ministry of Health of Singapore's website (https://go.gov.sg/moh-cancerdruglist). For avoidance of doubt, for CDL treatments, the indications refer to the clinical indications of the drug as specified in the CDL on the Ministry of Health of Singapore's website. Any drug that is on the CDL but used for a different indication than what is specified on the CDL, will not be claimable.

For each primary cancer, if the CDL treatment involves more than one drug, we allow drug omission or replacement with another CDL drug with the indication "for cancer treatment", only if they are due to intolerance or contraindications. In such cases, the claim limit of the original CDL treatment will apply.

For each primary cancer, where multiple cancer drug treatments are administered in a month, if any of the CDL treatments have an indication that states "monotherapy", only CDL treatments with the indication "for cancer treatment" will be claimable in that month. Otherwise, the following will apply:
(a) If more than one of the cancer drug treatments administered in a month have an indication other than "for cancer treatment", only CDL treatments with the indication "for cancer treatment" will be claimable in that month.
(b) If one or none of the cancer drug treatments administered in a month has an indication other than "for cancer treatment", all CDL treatments will be claimable in that month.

Non-CDL treatments will be considered as having an indication other than "for cancer treatment".

For patients with only one primary cancer, we will pay up to the highest limit among the claimable CDL treatments received in that month.

For patients receiving treatment for Multiple Primary Cancers, we will pay up to the sum of the highest limit among the claimable CDL treatments received for each primary cancer in that month.

Cancer Drug Services include consultations, scans, lab investigations, treatment preparation and administration fees, supportive care drugs and blood transfusions that are part of any outpatient cancer drug treatment. It does not cover services incurred before the Insured is diagnosed with cancer and/or after the cancer drug treatment has ended.

We will double the claim limit for Cancer Drug Services if the patient had received treatment for Multiple Primary Cancers at any point in time within the Policy Year.

Higher claim limits for patients receiving treatment for Multiple Primary Cancers are accorded on an application basis; doctors are to send the application form to the Ministry of Health of Singapore and us for assessment of MediShield Life and Integrated Shield Plan coverage respectively, prior to the commencement of treatment for Multiple Primary Cancers. We will only provide coverage after the treatment regimen has been assessed and approved by us. Please refer to our website for further information.

We will only cover proton beam therapy (category 1, 2 and 3) if it is administered as an-approved proton beam therapy indication, and if the Insured meets the patient eligibility criteria for proton beam therapy under MediShield Life. The approved proton beam therapy indications and patient eligibility criteria are specified on the Ministry of Health of Singapore's website (https://go.gov.sg/pbt-approved-indications), as may be amended from time to time.

In relation to immunosuppressant drugs, we shall not reimburse the immunosuppressant drugs if the organ transplant is illegal or arises from any illegal transaction or practice.

Confinement is not required for this benefit to be payable. The Eligible Expenses incurred under the Outpatient Benefit are not subject to Deductible but are subject to Co-insurance.

PRO-RATION FACTOR

If the Insured:

(a) incurs Eligible Expenses in a private Hospital/any other private medical institution in Singapore; or
(b) incurs Eligible Expenses (excluding such expenses under the Outpatient Benefit) in a Class A ward of a Government/Restructured Hospital in Singapore; or
(c) incurs Eligible Expenses (excluding such expenses under the Outpatient Benefit) in a Class B1 ward of a Government/Restructured Hospital in Singapore if he/she is a Singapore Permanent Resident,

any such charges payable will first be reduced by multiplying such Eligible Expenses with the Pro-ration Factor (as specified under the Schedule of Benefits). Thereafter, we shall pay up to the Limits of Compensation for each respective benefit under this Policy, less any Deductible and/or Co-insurance as set out in the Schedule of Benefits.

LIMIT PER POLICY YEAR

The Limit Per Policy Year in this Policy is inclusive of the MediShield Life Scheme's policy year limit.

In the event of any benefit payment by us for a loss insured under this Policy, such amount paid shall be accumulated towards the Maximum Limit Per Policy Year (for the applicable Policy Year).

The remaining balance of the Maximum Limit Per Policy Year for a particular Policy Year is computed by deducting all accumulated benefit payments in that same Policy Year from the Maximum Limit Per Policy Year.

In the event that the Insured is admitted into a Hospital in a Policy Year and the Confinement in a Hospital or outpatient consultations and treatments (if any) arising from the Confinement in a Hospital extends into the following Policy Year, the Eligible Expenses payable will be subject to the Policy Year Limit of the Policy Year in which the Confinement commenced.

In the event there is no Confinement, the claim amount payable for outpatient consultations and treatments will be determined based on the Policy Year Limit applicable on the date the medical expenses are incurred regardless of the actual date of usage of such medical services.

Deductibles shall be applied in each Policy Year before any benefit becomes payable under this Policy.

GENERAL EXCLUSIONS

Any Pre-existing Condition from which the Insured is suffering prior to the Policy Date or Reinstatement Date, whichever is later, shall not be covered unless the Insured makes a declaration in the application for this Policy or on reinstatement and such application is specifically accepted by us.
For the avoidance of doubts, any Pre-existing Condition that is excluded under this Policy but covered under MediShield Life will be covered up to the benefit limits, subject to the terms and conditions, of MediShield Life.

This Policy also does not cover any claims incurred directly or indirectly in connection with any of the following, whether or not a declaration has been submitted and accepted by us:

(a) Entire stay in a Hospital or a medical institution if such Confinement commences before the Policy Date;

(b) Non-approved experimental or pioneering medical or surgical techniques and medical devices by the Health Sciences Authority;

(c) Congenital abnormalities including hereditary conditions and physical defects from childbirth;

(d) Pregnancy, miscarriages, abortion, childbirth, sterilisation, contraception (except where expressly covered by Part A(vii) – Serious Pregnancy and Delivery-Related Complications under the Benefits Provisions of this Policy);

(e) Infertility, sub-fertility, assisted conception, erectile dysfunction, impotence or any contraceptive operation and sex change operations;

(f) Any injury or illness caused directly or indirectly, by:

(i) self-destruction, or intentional self-inflicted injury, or attempted suicide, with a Hospital admission date before 1 April 2023,
(ii) abuse or misuse of drugs or alcohol, or the Insured being under the influence of drugs or alcohol, with a Hospital admission date before 1 April 2023,
(iii) addiction to any controlled drug that is specified in the First Schedule to the Misuse of Drugs Act 1973 or the Insured being under the influence of any such controlled drug,
(iv) injuries sustained as a result of the Insured's criminal act,

whether the Insured is sane or insane;

(g) Injury or illness resulting from, hazardous activities or sports, engaged in a professional capacity or where remuneration or income could or would be earned;

(h) Any sexually transmitted disease, including Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related complications. For the purpose of this Policy:

(i) The definition of AIDS shall be that used by the World Health Organisation in 1987, or any subsequent revision by the World Health Organisation of that definition;
(ii) Infection shall be deemed to have occurred where blood or other relevant tests indicate in our opinion either the presence of any Human Immunodeficiency Virus or antibodies to such a virus;

(i) Treatment for mental illnesses and psychiatric disorders (except where expressly covered by the In-hospital Psychiatric Treatment benefit under the Benefits Provisions of this Policy);

(j) Treatment for obesity, weight reduction or weight improvement;

(k) Injuries sustained directly or indirectly during wars (whether war be declared or not), civil commotion, riots, revolutions, strikes, nuclear reaction, terrorist activities or any war-like operations;

(l) Buying or renting, for use at home or as an outpatient, of special medical appliances (including location, transport and administrative costs, of such appliances) which are not necessary for the completion of a surgical operation, braces, prostheses, durable medical equipment or machines, corrective devices, wheelchairs, walking aids, home aids, kidney dialysis machines, iron lungs, oxygen machines, hospital beds or any hospital equipment;

(m) Any form of Surgical Procedure that is elective such as dental, cosmetic or plastic surgery (except when such surgery is necessary for the repair of Injuries sustained within 365 days of an Accident or breast reconstruction within 365 days of a mastectomy), and correction for refractive errors of the eye;

(n) Costs for routine eye and ear examinations, including costs of spectacles, contact lenses and hearing aids;

(o) Private nursing charges and nursing home services;

(p) Rest cures, hospice or palliative care (except where expressly covered by Part (A) (v) – Inpatient Palliative Care Service Benefit under the Benefits Provisions of this Policy) , home or outpatient nursing, convalescent care in convalescent or nursing homes, sanatoriums or similar establishments or outpatient rehabilitation services such as counselling and physical rehabilitation;

(q) Transport-related services including ambulance fee, emergency evacuation, repatriation assistance and repatriation of mortal remains;

(r) Outpatient cancer drug treatments not on the Cancer Drug List (CDL), outpatient consultations, including medical or health screening, diagnostic and laboratory tests and treatments except where expressly covered by the Outpatient Benefit under the Benefits Provisions of this Policy;

(s) Vaccination;

(t) Overseas (outside Singapore) medical treatment or hospitalisation;

(u) Non-medical items such as, but not limited to, parking fees, Hospital administration and registration fees and, laundry, rental of television, newspaper and, medical report fees;

(v) Alternative or complementary treatments, including but not limited to, Traditional Chinese Medicine, Podiatric, Chiropractic or Osteopathic treatment or a stay in any health-care establishment for social or non-medical reasons;

(w) Confinement in a hospital, primarily for diagnosis, preventive purpose, X-ray examinations, general physical or medical check-up; or

(x) Violation or attempted violation of law, resistance to lawful arrest or any resultant imprisonment.

PREMIUM PROVISIONS

PAYMENT

All premiums are inclusive of the prevailing GST and shall be payable to us on or before the Premium Due Date. Premiums are payable annually and may be deducted from your MediSave account maintained with the CPF Board.

In the case where the annual premium exceeds the maximum MediSave withdrawal amount allowed for any MediSave-approved integrated medical insurance plan, or the balance in your MediSave account is insufficient to pay in full the annual premium due on renewal for this Policy, the shortfall in the annual premium shall be paid in cash within the Grace Period, failing which this Policy shall automatically terminate.

We shall inform you of the premiums payable under this Policy, based on such rates as may be determined by us from time to time.

You have to notify us in writing once the Insured ceases to be a Singapore Citizen or Singapore Permanent Resident.

PREMIUM RATE

Premium rates payable for this Policy are not guaranteed and are expected to be adjusted from time to time in line with our claims experience, medical inflation and general cost of treatments, supplies or medical services in Singapore.

We have the right to change the premium rate, provided that we send you a written notification at least 31 days in advance of such change in premium rate.

RENEWAL

Subject to the Cancellation Clause set out in this Policy, your Policy is guaranteed yearly renewable on the policy anniversary date by payment of the premiums in advance, before the end of the Grace Period, subject to our acceptance and the following:

(a) your Policy is in-force on the date of renewal; and
(b) we receive and accept payment of your Policy's premium in accordance with the premium rates then applicable to the Insured's attained age at next birthday on the date of renewal.

REINSTATEMENT

If your Policy lapses due to non-payment of premium, you may reinstate this Policy within two (2) years from the date this Policy lapses subject to underwriting (including producing evidence of insurability) and such other requirements we may have to our satisfaction. Additional terms, including exclusions, may be imposed and are subject to our review at the time of reinstatement. Such reinstatement, if approved by us, shall only cover hospitalisation, surgery and treatment occurring on or after the Reinstatement Date.

CLAIMS PROCEDURES

HOSPITALISATION

Claims must be submitted to us through the system set up by the Ministry of Health of Singapore in accordance with the terms and conditions under the CPF Act and the MediShield Life Scheme Act 2015 (where applicable), as amended from time to time. If the claims for consultations and laboratory tests covered by the Outpatient Benefit under the Benefits Provisions of this Policy cannot be submitted to us through the system set up by the Ministry of Health of Singapore, we must be notified through ClaimEz – an online claim submission portal at our customer portal (My AIA SG or such other name as we may choose for our customer portal from time to time). Such claim submission must be filed with us within 60 days from the date of the Insured receiving treatment as an out-patient, and there must be sufficient particulars to enable us to identify the Insured and the occurrence, nature and extent of the loss.

The occurrence of a claim must be proven to our satisfaction at your own expense, and any such proof shall include the following:

(a) proof of treatment or surgery; and
(b) the Hospital's original and final statement of accounts, bills and receipts; and
(c) such other documents as we may require.

In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, we shall have the right to call for an examination of the Insured and the evidence used in arriving at such opinion. An independent acknowledged medical specialist in the relevant field concerned shall conduct this examination and we shall select this medical specialist.

PAYMENT OF BENEFITS

All benefits under this Policy are payable to you, your legal representative, the Hospital, the Community Hospital or such other authorised parties (as the case may be) and such payment shall be a valid discharge of our liability under this Policy.

LAST PAYER STATUS

If you have any other medical insurance which allows you to claim for the reimbursement of the Insured's medical expenses, you must first seek reimbursement from these policies before making any claim under this Policy. If you have received payment under this Policy, you must file a claim with your other medical insurer who will reimburse us.

The total reimbursement made to you must not exceed the actual expenses incurred.

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

DEFINITIONS

In your Policy, the following definitions shall apply (where applicable):

Accident refers to an unforeseen and involuntary event.

Approved Medical Consumables refers to:
(a) Intravascular electrodes used for electrophysiological procedures.
(b) Percutaneous Transluminal Coronary Angioplasty (PTCA) Balloons.
(c) Intra-aortic balloons (or Balloon Catheters).

Cancer Drug List (CDL) refers to a list of clinically proven and more cost-effective cancer drug treatments developed by the Ministry of Health of Singapore. Outpatient cancer drug treatments are only claimable under your Policy if used according to the clinical indications specified in the Cancer Drug List (CDL), unless otherwise stated in this Policy. The list is updated periodically and can be found on the website of the Ministry of Health of Singapore (https://go.gov.sg/moh-cancerdruglist).

Cancer Drug Services refers to services that are part of any outpatient cancer drug treatment, such as consultations, scans, lab investigations, treatment preparation and administration fees, supportive care drugs and blood transfusions, which are Medically Necessary. It does not cover services incurred before the Diagnosis and/or after the cancer drug treatment has ended.

Co-insurance refers to the amount you need to co-pay on the Eligible Expenses which is a fixed percentage (as specified in the Schedule of Benefits) of the Eligible Expenses in excess of the Deductible (if any).

Community Hospital refers to a community hospital approved by the Ministry of Health of Singapore to provide an intermediate level of care for individuals who have simple ailments and do not require Specialist medical treatment and nursing care. For the avoidance of doubt, hospices, convalescent centres, Hospitals and homes are not Community Hospitals.

Confined or **Confinement** refers to:
(a) any continuous period of hospitalisation in a Hospital for which a daily room and board charge is incurred for medical treatment as an inpatient (for a period of not less than six (6) hours); or
(b) admission into a short stay ward for medical treatment, examination or observation at the Accident and Emergency Department in a Hospital (for a period of not less than six (6) hours); or
(c) admission of any duration in a Hospital or medical institution which is lawfully operated in Singapore, approved under the MediShield Life Scheme and accredited by the Ministry of Health of Singapore, for the purpose of a Surgical Procedure.

CPF refers to the Central Provident Fund established under the Central Provident Fund Act 1953.

Deductible refers to the deductible amount as specified in the Schedule of Benefits, which is the total amount of Eligible Expenses incurred per Policy Year which is borne by you before any benefit becomes payable under this Policy. If the Insured has stayed in more than one ward type during his Confinement, the higher amount of Deductible shall apply. Outpatient Benefit are not subject to a Deductible.

Diagnosed or **Diagnosis** refers to a definitive conclusion made by a Physician or Specialist based upon such specific evidence as referred to in this Policy in the definition of the particular condition, or, in the absence of such specific evidence, based upon radiological, clinical, histological, or laboratory evidence acceptable by us. Such Diagnosis must be supported by our medical director who may base his/her opinion on the medical evidence submitted by you, the Insured, and/or any additional evidence that he/she may require.

Eligible Expenses refers to the expenses incurred for medical or surgical treatment under the Benefits Provisions of this Policy during the period the Policy is in-force.

Family Members refers to your or the Insured's lawful spouse, father, mother, brother, sister and/or legal children.

Government / Restructured Hospital refers to the Singapore government hospitals and Singapore government medical institutions which are approved by the Ministry of Health of Singapore.

Grace Period refers to the extra 60 days that we give you from the Premium Due Date, for you to pay your premiums.

GST refers to the goods and services tax according to the GST Act 1993.

Hospital refers to a lawfully operated institution in Singapore registered as a hospital and approved by the Ministry of Health of Singapore, for the purposes of the MediShield Life Scheme, for the care and treatment of injured or ill persons and which provides facilities for diagnosis, major surgery and full-time nursing service, including Government/Restructured Hospitals and is not primarily a rest or convalescent home, Community Hospital or similar establishment or, other than incidentally, a place for alcoholics or drug addicts.

Hospice refers to a medical facility approved and accredited by the Ministry of Health of Singapore to provide medical and care services that aim to improve the quality of life of patients with life-limiting illnesses. For the avoidance of doubt, convalescent centres, Hospitals, Community Hospitals and homes are not Hospices.

Illness refers to a physical condition marked by a pathological deviation from the normal healthy state.

Injury refers to bodily injury effected directly and independently of all other causes by Accident.

Insured refers to the person as named in the Policy Schedule of your Policy.

Intensive Care Unit or **ICU** refers to a section within a Hospital which is designated as an intensive care unit by such Hospital and which is operating on a 24-hour basis solely for treatment of patients in critical medical condition and which is equipped to provide special nursing and medical services not available elsewhere in such Hospital. For purpose of this definition, Intensive Care Unit or ICU shall also refer to a Coronary Care Unit, Cardiac Care Unit or Critical Care Unit in a Hospital.

Issue Date refers to the date when the Policy was issued to you and is shown on your Policy Schedule or endorsement.

Limits of Compensation refers to the limits of compensation stated in the Schedule of Benefits for which each respective benefit is subject to in accordance to the Plan Type and Hospital Ward Entitlement.

Limit Per Lifetime refers to the maximum total amount of all reimbursements that we shall make for the Eligible Expenses which are accumulated towards the Maximum Limit Per Lifetime under the Maximum Claim Limit during the Insured's lifetime and which are the limits stated in the Schedule of Benefits.

Limit Per Policy Year refers to the maximum reimbursement that we shall make for the Eligible Expenses which are accumulated towards the Maximum Limit Per Policy Year under the Maximum Claim Limit in any one Policy Year and which are the limits stated in the Schedule of Benefits. Eligible Expenses which are incurred in the current Policy Year where the payout is made in the subsequent Policy Year shall be accumulated under the current Policy Year's limit. Such payouts shall not be accumulated towards the Policy Year limit in the subsequent Policy Year.

Medically Necessary refers to a medical service treatment, service and/or supply which is:
(a) consistent with the Diagnosis and customary medical treatment, service and/or supply for an Illness or Injury;
(b) in accordance with standards of good medical practice, consistent with current standard of professional medical care, and proven medical benefits;

(c) not for the convenience of the Insured or the Physician or Specialist, and unable to be reasonably rendered out of a Hospital, an Outpatient Centre or Community Hospital;
(d) not of an experimental, investigational or research nature, preventive or screening nature; and
(e) unable to be omitted without negatively affecting the medical condition which the Insured is Diagnosed for.

MediShield Life Scheme refers to the scheme administered by the CPF Board, and is governed by the MediShield Life Scheme Act 2015 as amended from time to time.

Multiple Primary Cancers refer to two or more cancers arising from different sites and/or 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 the Ministry of Health of Singapore and us for assessment of MediShield Life and Integrated Shield Plan claims respectively.

The occurrence of the Diagnosis of Multiple Primary Cancers must be proven to our satisfaction at your own expense, and any such proof shall include the following:
(a) evidence provided by the appropriate Physician or Specialist as the case may be;
(b) appropriate medical investigations and/or reports including, but not limited to, clinical, radiological, histological and laboratory evidence; and
(c) such other documents as we may require.

Non-Participating refers to a policy that does not share in the divisible surplus of our participating life fund.

Outpatient Centre refers to a MediSave / MediShield accredited centre for treatments covered under Part (B) – Outpatient Benefit.

Physician refers to any person qualified as a medical practitioner by a medical degree in western medicine and who is legally registered with, authorised and/or licensed by the relevant authority in the geographical area of his practice to render medical or surgical treatment and who in rendering treatment is practicing within the scope of his licensing and training in the geographical area of practice, but excluding you, the Insured and, respective spouses and Family Members of such persons.

Policy consists of:
(a) this enhancement scheme (including the Schedule of Benefits);
(b) the Policy Schedule;
(c) the application; and
(d) the endorsements (if any).

Policy Date refers to the date shown on your Policy Schedule for your Policy and is the date from which policy anniversary, policy years and months and Premium Due Dates are determined and is the date from which your insurance coverage starts.

Policy Schedule refers to the schedule that is issued with your Policy that includes the plan name, product and/or code names of your Policy. This includes renewal certificate or endorsement.

Policy Year refers to 12 months starting from the Policy Date of this Policy and in the case of Policy renewal, each consecutive 12 months period following the renewal date of this Policy.

Pro-ration Factor refers to the pro-ration factor as described in the Pro-ration Factor Clause under the Benefits Provisions of this contract.

Pre-existing Condition refers to any physical condition, impairment or the existence of any illness or disease that was diagnosed, treated, or for which a Physician or Specialist was consulted at any time prior to the Policy Date or last Reinstatement Date of this Policy (if any), whichever is later. For this purpose, an illness or disease has occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested which would cause an ordinary prudent person to seek Diagnosis, care or treatment.

Premium Due Date refers to the date when your premium payment is due.

Psychiatrist refers to any person qualified as a medical practitioner by a medical degree in psychiatric treatment who is legally registered with, authorised and/or licensed by the relevant authority in the geographical area of his practice to render psychiatric treatment, and who in rendering treatment is practicing within the scope of his licensing and training, but excluding you, the Insured and, respective spouses and Family Members of such persons.

Reasonable and Customary refers to any fee or expense which is charged for treatment, supplies or medical service that is Medically Necessary to treat the condition and which is in accordance with the standards of good medical practice for the care of an injured or ill person under the supervision or order of a Physician or Specialist and which does not in our opinion or in the opinion of our medical advisor:

(a) exceed the usual level of charges for similar treatment, supplies or medical services in Singapore;
(b) include fees or charges that would not have been made if no insurance had existed;
(c) exceed the upper bound of the fee benchmarks recommended by the Singapore government, the Ministry of Health of Singapore or official bodies such as the Health Sciences Authority and the Allied Health Professions Council, including the Ministry of Health of Singapore Fee Benchmarks for Private Sector Surgeon Fees; or
(d) exceed our internal benchmarks for episodes of care with similar diagnoses or procedures performed.

Reinstatement Date refers to the date shown on an endorsement when your Policy is reinstated.

Specialist refers to a qualified and licensed Physician, possessing the necessary additional qualifications and expertise to practice as a recognised specialist of diagnostic techniques, treatment and prevention by the Ministry of Health of Singapore, but excluding you, the Insured and, respective spouses and Family Members of such persons.

Standard Room refers to room equipped with a minimum standard, like the following:.

(a) suitable bed, mattress, pillow, a chair and locker facility;
(b) bed screening facilities;
(c) adequate lighting and ventilation;
(d) an effective nurse-to-patient call bell system; and
(e) adequate toilet facilities / wash basin.

It shall exclude deluxe rooms, luxury suites, superior room, super rooms and other special rooms that may also be available at the Hospital (or at a Community Hospital, with regards to Part A (iii) – Community Hospital Benefit).

For a single room in a Private Hospital, we shall only pay the room and board rates up to the rates charged for a standard single room.

Surgical Procedures refer to the types of surgical operations listed in the "Table of Surgical Procedures" under the MediSave Scheme operated by the Ministry of Health of Singapore (Table 1 to Table 7).

We, **us** or **our** refers to the AIA Singapore Private Limited (Reg. No. 201106386R) (“AIA Singapore”)

You or **your** refers to the Policy Owner as shown in the Policy Schedule of your Policy.

Wherever the context requires, masculine form shall apply to the feminine and singular term shall include the plural and vice versa.

<table>
<tr><th colspan="2">Schedule of Benefits</th></tr>
<tr><td></td><td>Limits of Compensation
(inclusive of MediShield Life Scheme's limits)</td></tr>
<tr><td></td><td>(figures are in Singapore Dollars and inclusive of GST)</td></tr>
<tr><td>Plan Type</td><td>AIA HealthShield Gold Max Standard Plan</td></tr>
<tr><td>Hospital Ward Entitlement</td><td>B1 Class Ward and Below in Government/Restructured Hospital</td></tr>
<tr><td colspan="2">(A) Inpatient/Day Surgery Benefits</td></tr>
<tr><td>(i) Normal Ward Benefit[1]</td><td>2,250 per day[6]</td></tr>
<tr><td>(ii) Intensive Care Unit (ICU) Ward Benefit[1]</td><td>6,850 per day[6]</td></tr>
<tr><td>(iii) Community Hospital Benefit[1]</td><td></td></tr>
<tr><td>• Community Hospital (Rehabilitative)</td><td>760 per day</td></tr>
<tr><td>• Community Hospital (Sub-acute)</td><td>960 per day</td></tr>
<tr><td>(iv) Surgical Benefit</td><td></td></tr>
<tr><td>• Surgical Procedures[2]</td><td>
<table>
<tr><th>Surgery</th><th>Claim Limit</th></tr>
<tr><td>Table 1A</td><td>590</td></tr>
<tr><td>Table 1B</td><td>1,050</td></tr>
<tr><td>Table 1C</td><td>1,050</td></tr>
<tr><td>Table 2A</td><td>1,800</td></tr>
<tr><td>Table 2B</td><td>2,300</td></tr>
<tr><td>Table 2C</td><td>2,370</td></tr>
<tr><td>Table 3A</td><td>3,290</td></tr>
<tr><td>Table 3B</td><td>4,240</td></tr>
<tr><td>Table 3C</td><td>4,760</td></tr>
<tr><td>Table 4A</td><td>5,970</td></tr>
<tr><td>Table 4B</td><td>8,220</td></tr>
<tr><td>Table 4C</td><td>8,220</td></tr>
<tr><td>Table 5A</td><td>8,920</td></tr>
<tr><td>Table 5B</td><td>9,750</td></tr>
<tr><td>Table 5C</td><td>11,030</td></tr>
<tr><td>Table 6A</td><td>15,910</td></tr>
<tr><td>Table 6B</td><td>15,910</td></tr>
<tr><td>Table 6C</td><td>17,300</td></tr>
<tr><td>Table 7A</td><td>21,840</td></tr>
<tr><td>Table 7B</td><td>21,840</td></tr>
<tr><td>Table 7C</td><td>21,840</td></tr>
</table>
</td></tr>
<tr><td>• Surgical Implants and Approved Medical Consumables</td><td>9,800 per admission</td></tr>
<tr><td>• Radiosurgery, including Proton Beam Therapy – Category 4[3]</td><td>31,300 per treatment course</td></tr>
<tr><td>(v) Inpatient Palliative Care Service Benefit</td><td></td></tr>
<tr><td>• Inpatient Palliative Care Service (General)</td><td>560 per day</td></tr>
<tr><td>• Inpatient Palliative Care Service (Specialised)</td><td>760 per day</td></tr>
<tr><td>(vi) Continuation of Autologous Bone Marrow Transplant for Multiple Myeloma</td><td>14,040 per treatment</td></tr>
<tr><td>(vii) Serious Pregnancy and Delivery-Related Complications Benefit</td><td>Subject to the respective Limits of Compensation applicable to Benefits under Parts (A)(i), A(ii), A(iii) and A(iv)</td></tr>
<tr><td>(viii) Psychiatric Benefit[1]</td><td>680 per day (up to 60 days per Policy Year)</td></tr>
</table>

Schedule of Benefits		
	Limits of Compensation (inclusive of MediShield Life Scheme's limits)	
	(figures are in Singapore Dollars and inclusive of GST)	
Plan Type	**AIA HealthShield Gold Max Standard Plan**	
Hospital Ward Entitlement	**B1 Class Ward and Below in Government/Restructured Hospital**	
(B) Outpatient Benefit[4]	Patients receiving treatment for one primary cancer	Patients receiving treatment for multiple primary cancers[7]
(i) Cancer Drug Treatment on the Cancer Drug List (CDL)	3 x (MediShield Life's limit for one primary cancer per month)[8]	Sum of the highest cancer drug treatment limit amongst the claimable treatments received for each primary cancer per month[8]
(ii) Cancer Drug Services	2 x (MediShield Life's limit for one primary cancer per Policy Year)[9]	2 x (MediShield Life's limit for multiple primary cancers per Policy Year)[9]
(iii) Radiotherapy for cancer: (a) External (except Hemi-Body) (b) Brachytherapy (c) Hemi-Body (d) Stereotactic (e) Proton Beam Therapy – Category 1[10] (f) Proton Beam Therapy – Category 2[10] (g) Proton Beam Therapy – Category 3[10]	880 per treatment 1,100 per treatment 2,510 per treatment 6,210 per treatment 880 per treatment 1,100 per treatment 6,210 per treatment	
(iv) Kidney Dialysis	3,740 per month	
(v) Erythropoietin	450 per month	
(vi) Immunosuppressants for organ transplant[5]	1,480 per month	
(vii) Long-term Parenteral Nutrition	3,980 per month	
Maximum Claim Limit		
• Maximum Limit Per Policy Year	200,000	
• Maximum Limit Per Lifetime	Unlimited	

Pro-ration Factor

	Singapore Citizen	**Singapore Permanent Resident**
Class C	100%	100%
Class B2/B2+	100%	100%
Class B1	100%	90%
Class A	80%	80%
Private Hospital	50%	50%
Outpatient Treatment in restructured hospital	100%	100%
Outpatient Treatment in private hospital or private medical institution	65%	65%
Day surgery in restructured hospital	100%	100%
Day surgery in private hospital or private medical institution	65%	65%
Short stay ward in restructured hospital	100%	100%

Deductible

	Age Next Birthday 80 and below	**Age Next Birthday 81 and above**
Class C	1,500	2,000

<table>
<tr><th colspan="4">Schedule of Benefits</th></tr>
<tr><td></td><td colspan="3">Limits of Compensation
(inclusive of MediShield Life Scheme's limits)</td></tr>
<tr><td></td><td colspan="3">(figures are in Singapore Dollars and inclusive of GST)</td></tr>
<tr><td>Plan Type</td><td colspan="3">AIA HealthShield Gold Max Standard Plan</td></tr>
<tr><td>Hospital Ward Entitlement</td><td colspan="3">B1 Class Ward and Below in Government/Restructured Hospital</td></tr>
<tr><td></td><td colspan="3"><table>
<tr><td>Class B2/B2+</td><td>2,000</td><td>3,000</td></tr>
<tr><td>Class B1</td><td>2,500</td><td>3,000</td></tr>
<tr><td>Class A</td><td>2,500</td><td>3,000</td></tr>
<tr><td>Private Hospital</td><td>2,500</td><td>3,000</td></tr>
<tr><td>Subsidised Day Surgery/ Short Stay Ward</td><td>1,500</td><td>2,000</td></tr>
<tr><td>Unsubsidised Day Surgery/Short Stay Ward</td><td>2,000</td><td>3,000</td></tr>
</table></td></tr>
<tr><td>Co-insurance</td><td colspan="3">10%</td></tr>
<tr><td>Maximum Coverage Period</td><td colspan="3">Lifetime</td></tr>
</table>

[1] Inclusive of meals, prescriptions, professional charges, investigations and other miscellaneous medical charges.

[2] Surgical Procedures refer to the types of surgical operations listed in the "Table of Surgical Procedures" under the MediSave Scheme operated by the Ministry of Health of Singapore (Table 1 to Table 7). The costs of any surgical implants, Approved Medical Consumables and/or Radiosurgery procedure are not included in this portion of the benefit.

[3] Radiosurgery means the gamma knife treatment or the Novalis shaped beam treatment of neurosurgical or neurological disorders, or proton beam therapy (Category 4) for the Ministry of Health of Singapore-approved indications and patient eligibility criteria listed on the Ministry of Health of Singapore's website (https://go.gov.sg/pbt-approved-indications). The Ministry of Health of Singapore may update this from time to time.

[4] Eligible Expenses incurred under the Outpatient Benefit are not subject to the Deductible but are subject to Co-insurance. Eligible Expenses incurred under all other benefits are subject to the Deductible and Co-insurance.

[5] In the event of an organ transplant surgery, we shall reimburse the charges for any of the immunosuppressants approved by Health Sciences Authority for organ transplant.

[6] The limits are higher by S$300 for the first two (2) days of inpatient stay.

[7] "Multiple primary cancers" refers to two or more cancers arising from different sites and/or 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 the Ministry of Health of Singapore and us for assessment of MediShield Life and Integrated Shield Plan claims respectively.

[8] The Cancer Drug Treatment on the Cancer Drug List (CDL) benefit limit is based on a multiple of the MediShield Life limit for the specific cancer drug treatment. For the latest MediShield Life limit, refer to the CDL on the Ministry of Health of Singapore's website under "MediShield Life Claim Limit per month" (https://go.gov.sg/moh-cancerdruglist). The Ministry of Health of Singapore 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.

[9] The Cancer Drug Services benefit limit is based on a multiple of the MediShield Life limit for Cancer Drug Services. For the latest MediShield Life limit for Cancer Drug Services, refer to "Cancer Drug Services" under the MediShield Life Benefits on the Ministry of Health of Singapore's website (https://go.gov.sg/mshlbenefits). The Ministry of Health of Singapore 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.

[10] We will only cover proton beam therapy (category 1, 2 and 3) if it is administered as an-approved proton beam therapy indication, and if the Insured meets the patient eligibility criteria for proton beam therapy under MediShield Life. The approved proton beam therapy indications and patient eligibility criteria are specified on the Ministry of Health of Singapore's website (https://go.gov.sg/pbt-approved-indications). The Ministry of Health of Singapore may update this from time to time. The revised approved proton beam therapy indication will be applicable to the proton beam therapy which occurred on and from the effective date of the revised indication.