RafflesHealthinsurance
Your Specialist Health Insurer

RAFFLES SHIELD POLICY CONDITIONS

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1. TERMS USED IN THIS POLICY

We, Us and **Our** mean Raffles Health Insurance Pte. Ltd.

You and **Your** mean the Policyholder named in the Policy Certificate.

Accident means an unexpected and unforeseen incident.

Act means the MediShield Life Scheme Act (Act No. 4 of 2015) and related regulations as amended or re-enacted from time to time.

Attending Physician means the key Physician coordinating the medical services and treatment provided to the Insured for an Inpatient Episode.

Benefits refers to the insurance coverage set out in these Policy Conditions and which are also indicated in Your Benefit Schedule.

Benefit Limit means the maximum amount We will cover per Benefit, as set out in Your Benefit Schedule.

Citizenship Factor means the percentage of the Reasonable and Customary Expenses We will pay, as set out in Your Benefit Schedule. We will apply a Citizenship Factor if the Insured is a Singapore Permanent Resident, as stated in the Benefit Schedule.

Co-Insurance means the amount which You have to co-pay after the Deductible has been applied to the Reasonable and Customary Expenses.

Community Hospital refers to an approved government-funded or private community hospital listed as such in the Participating Medical Institution List.

CPF Act means the Central Provident Fund Act (Cap. 36) and its related regulations, as amended or re-enacted from time to time.

CPF Board (CPFB) means the Central Provident Fund Board established under the CPF Act.

Death refers to natural or accidental death and does not include death as a result of voluntary acts or reasons.

Deductible means the amount which You have to pay before We pay any claim under Your Policy.

Eligible Valid Pass refers to a pass issued to a foreigner or non-Singaporean for staying in Singapore, which is recognized by the Singapore Immigration & Checkpoints Authority and the Ministry of Manpower.

Endorsement refers to an authorised amendment to Your Policy made by Us.

Extra Premium means the additional premium that is payable to take into account the higher potential costs of providing coverage to You, due to higher health risks. The amount of Extra Premium is specified in the Policy Certificate.

Family Member refers to a relative, who is either related to You or the Insured by blood, marriage or adoption, and includes an Immediate Family Member.

Government Restructured Hospital (GRH) refers to a public hospital or medical clinic which is listed as such in the Participating Medical Institution List.

Grace Period means the additional 60 days from the Premium Due Date that We give You to pay Your Premium in full.

HSA means the Health Sciences Authority, Singapore.

Hospital refers to an establishment which is a GRH, Private Hospital or Community Hospital. In the case of an establishment which is outside Singapore, it must be recognized by Us as being equivalent in status as these institutions.

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

Immediate Family Member refers to a spouse, child, sibling, or parent, who is either related to You or the Insured by blood, legal marriage or adoption.

Injury refers to an involuntary bodily injury caused directly by an Accident and not resulting from Illness.

Inpatient Episode refers to when an Insured is confined in or admitted to a Hospital and where the Insured is charged for room and board. For the MediShield Life coverage component, a minimum of 8 consecutive hours applies. For the private insurance coverage component, a minimum of 12 consecutive hours applies.

Insured refers to the person who is insured under this Policy and named as such in the Policy Certificate.

Lifetime Limit means the maximum amount, if any, shown in Your Benefit Schedule which we will pay under Your Policy during the lifetime of the Insured.

Medically Necessary refers to medical services or treatments provided by a Physician which are:

(a) consistent with the diagnosis and recommended treatment of the Insured's Illness or Injury;
(b) in accordance with standards of good medical practice;
(c) not administered solely for the convenience of the Insured or the Registered Medical Practitioner; and

(d) the most appropriate service or treatment which can be safely provided to the Insured.

Miscellaneous Medical Charges means charges for items which are not critical for and are ancillary to the Insured's treatment, including dressings, splints and plaster casts, intravenous infusions and blood infusions.

MOH means the Ministry of Health, Singapore.

Panel Specialist refers to a Specialist who is on the list of Raffles Shield Panel of specialists. The list is regularly updated at http://www.raffleshealthinsurance.com.

Parent(s) refer to biological parents and legal guardians.

Participating Medical Institution List means the list of the medical institutions participating in the MediShield Life Scheme, as set out and as may be amended or updated from to time to time at https://www.cpf.gov.sg/Assets/members/Documents/MSH_MedicalInstitutions.pdf

Physician means a person properly qualified by a degree in medicine and is licensed to practice western medicine in Singapore, or is legally licensed to practice medicine in the country in which treatment is provided. This excludes You, the Insured, and Family Members, business partners, colleagues, employees or employers of either party.

Policy Anniversary means the same day and month as the Policy Start Date in each subsequent calendar year that this Policy remains in force.

Policyholder means the person to whom the Policy is issued and to whom claims are paid.

Policy Start Date means the day Your Policy comes into effect.

Policy Year means the period of 12 months following the effective date or subsequent renewal date of insurance cover under Your Policy.

Policy Year Limit means the maximum amount shown in Your Benefit Schedule which we will pay under Your Policy within a Policy Year.

Pre-Existing Illness refers to:
(a) any Illness which the Insured was suffering from; or
(b) for which there were signs or symptoms which –
    (i) the Insured sought or received treatment, medication, consultation, advice or diagnosis for, or
    (ii) would be reasonably expected of a person to seek or receive treatment, medication, consultation, advice or diagnosis for,

prior to the Policy Start Date or the last Reinstatement Date, whichever is the later.

Premium means the amount You pay to Us in consideration for the coverage provided under Your Policy. This is specified in the Policy Certificate.

Premium Due Date means the date by which We should receive payment for Your outstanding Premium in full. In the case of renewal, this is the renewal date of Your Policy.

Private Hospital means a private Hospital or medical clinic which is listed as such on the Participating Medical Institution List.

Pro-ration Factor means the percentage of the Reasonable and Customary Expenses We will pay, as set out in Your Benefit Schedule. We will apply the Pro-ration Factor if the Insured is admitted to a ward or Hospital that is higher than his or her ward entitlement.

Psychiatric Treatment refers to treatment for mental illness, problems, or disorders provided to the Insured by a Specialist who has received training in the relevant field of medicine.

Reasonable and Customary Expenses refers to expenses incurred for services or treatment for the Benefits and which in Our opinion do not exceed the general level of charges for comparable treatment, supplies or services provided by others of similar medical standing in Singapore; but do not include fees or charges that would not have been incurred in the absence of insurance coverage.

Reinstatement Date means the date on which We approve Your application to continue Your Policy after it has been terminated.

Rider refers to the additional insurance coverage that is attached to this Policy, as specified in the Benefit Schedule.

Short Stay Ward refers to a ward in an accident and emergency department of a GRH for patients who need a short period of inpatient monitoring and treatment.

Special Options refers to the Raffles Hospital and the High Deductible options as detailed at clause 3.5 and in Your Benefit Schedule.

Specialist refers to a Physician who is accredited by the Specialists Accreditation Board and registered as a specialist with the Registry of Specialists maintained by the Singapore Medical Council or is legally registered or accredited or recognized to practice in a specific field of medicine in the country in which treatment is provided. This excludes You, the Insured, and Family Members, business partners, colleagues, employees or employers of either party.

Standard Basis refers to the circumstance under which You are enrolled onto Your Policy without any additional terms and conditions, and without imposing Extra Premium.

Surgical Procedures refer to the surgical operations listed in Table 1A to Table 7C of the "Table of Surgical Procedures" published by the MOH, as may be amended and updated from time to time and any other surgical operations which may be approved by Us in writing before such operations are carried out or performed.

Total and Permanent Disability is defined as one of the following which must be confirmed and certified by a Physician:

1) Disability which is total and permanent and persists continuously for at least six (6) months and to the extent that the Insured is incapable of performing any work or engaging in any occupation or profession to earn or obtain wages, compensation or profit, from the time when the disability started.

2) Total and irrecoverable:
    a. Loss of sight of both eyes;
    b. Loss of sight of one (1) eye and loss by loss or severance or loss of use of one (1) limb at or above the ankle or wrist; or
    c. Loss or severance or loss of use of:
        i. Both hands at or above the wrists;
        ii. Both feet at or above the ankles;
        iii. One (1) hand at or above the wrist and one (1) foot at or below the ankle

3) As a result of Illness or Injury the Insured becomes totally and permanently unable to perform at least three (3) of the following activities even with the aid of special equipment for at least six (6) continuous months.
    a. Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa
    b. Mobility: the ability to move indoors from room to room on level surfaces
    c. Toileting: the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene
    d. Dressing: the ability to put on, take off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical appliances
    e. Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by any other means
    f. Feeding: the ability to feed oneself once food has been prepared and made available

In the case of an Insured who is of 66 years old or above, Total and Permanent Disability is only defined as 2) or 3).

Waiting Period refers to the period of time that applies to specific Benefits before a claim can be made. This period commences from the Policy Start Date or the last Reinstatement Date, whichever is the later.

2. YOUR POLICY

2.1. This is Your Raffles Shield Policy ("Your Policy"). It contains the following documents:

- These Policy Conditions;
- The Policy Certificate;
- The Benefit Schedule;
- The Proposal Form; and
- Endorsements, if any.

2.2. Your Policy is a legally enforceable agreement between Us and You.

2.3. The full agreement between Us and You also comprises:

- all statements to Physicians;
- declarations and questionnaires containing information on You or the Insured which You or the Insured provide to Us; and
- all written correspondence relating to Your Policy with Us.

2.4. You and the Insured warrant that the information (including medical information evidence) provided to us, regardless of whether such information is provided in the proposal form or in other forms or correspondence or documents submitted, is true. We will rely on such information in deciding whether or not to accept Your application. You and the Insured must answer all the questions accurately and truthfully. Otherwise, We can void Your Policy, deny a claim under Your Policy or impose additional terms and conditions on Your Policy.

3. WHAT YOUR POLICY COVERS

3.1. OVERVIEW OF BENEFITS

3.1.1. Your Policy only covers the Benefits (i.e. those Benefits explained below which are also listed in the Benefit Schedule), and are subject to the Policy Year Limit as shown in the Benefit Schedule. The benefits explained in this section may not all apply to Your Policy.

3.1.2. To enjoy the Benefits, You must comply with the terms and conditions of Your Policy and pay the Premiums when they are due.

3.1.3. We will only pay for Reasonable and Customary Expenses for Medically Necessary treatment received by the Insured due to Illness or Injury, provided that such treatment is provided by a medical institution listed in the Participating Medical Institution List.

3.1.4. We will deduct any amounts due to Us under Your Policy (including the Deductible) before paying You any Benefits.

3.2. INPATIENT TREATMENT

The following Benefits are subject to the Citizenship Factor, Pro-ration Factor, Deductible, Co-Insurance, and Benefit Limits.

3.2.1. Daily Room and Board and Medical-related Services

We will pay for ward charges the Insured incurs for an Inpatient Episode and for each day's stay in a Hospital including:

- prescriptions;
- medical consultations;
- Miscellaneous Medical Charges;
- consultations with Specialists;
- diagnostic tests and examinations;
- laboratory tests;
- admission into a high-dependency ward; and
- admission into a Short Stay Ward for observation.

If the Insured is admitted into a Hospital or a ward (including any suite or other special room of a Hospital), charges for which are higher than the Insured's ward entitlement stated in the Benefit Schedule, We will only pay for the charges incurred for room and board and medical-related services up to the amount equivalent to the charges which would have been incurred had the Insured been admitted into a Hospital or ward of the same ward entitlement stated in the Benefit Schedule.

If an Inpatient Episode flows over to the next Policy Year, the Benefits will be processed based on the previous Policy Year's Benefit Schedule which was applicable when the Insured was first admitted.

We will also pay for ward charges the Insured incurs for admission to a Short Stay Ward, but will not pay for charges incurred for treatments carried out prior to or after admission to a Short Stay Ward, which is not otherwise covered under Your Policy.

For the avoidance of doubt, accommodation of Immediate Family Members is not included under this Benefit.

3.2.2. Intensive Care Unit (ICU) and Medical-related Services

We will pay for charges the Insured incurs for each day's stay in an ICU including:

- prescriptions;
- medical consultations;
- Miscellaneous Medical Charges;
- consultations with Specialists;
- diagnostic tests and examinations; and
- laboratory tests.

3.2.3. Surgical Benefits

We will pay for charges the Insured incurs for Surgical Procedures (regardless of whether the Surgical Procedure results in an Inpatient Episode) performed by a Physician as a result of Injury or Illness, including:

- surgeon's fees;
- anaesthetist's fees; and
- fees for use of the hospital's operating theatre and facilities.

This benefit excludes Surgical Procedures which may be covered under other benefits in Your Policy, including Gamma Knife and Novalis Radiosurgery, Major Organ Transplant, Stem Cell Transplant, Living Donor Organ Transplant, Pregnancy Complications Benefit, Breast Reconstruction after Mastectomy, Emergency Overseas Medical Treatment and Congenital Abnormalities Benefit for Insured.

3.2.4. Surgical Implants and Approved Medical Consumables

We will pay for charges for surgical implants and approved medical consumables (as defined below) in relation to Surgical Procedures which are covered under Your Policy.

Surgical implants refer to implants that are inserted into the body of the Insured during a Surgical Procedure and remain in the Insured's body after the Surgical Procedure.

Approved medical consumables include:

- intravascular electrodes for electrophysiological procedures;
- percutaneous transluminal coronary angioplasty ("PTCA") balloons;
- intra-aortic balloons (or balloon catheters).

Surgical implants and approved medical consumables used must be Medically Necessary and We will only pay Reasonable and Customary Expenses.

3.2.5. Gamma Knife and Novalis Radiosurgery

We will pay for charges incurred when the Insured undergoes Gamma Knife and Novalis Radiosurgery, regardless of whether it is performed as an inpatient or a day surgery procedure.

The applicable Deductible, Co-Insurance, Citizenship Factor, Pro-ration Factor and Benefit Limits for Gamma Knife and Novalis Radiosurgery procedure will depend on whether it was performed as an inpatient or a day surgery procedure.

3.2.6. Community Hospital Stay

We will pay for daily normal ward charges and treatment charges incurred by the Insured for an Inpatient Episode in a Community Hospital including:

- prescriptions;
- medical consultations;
- Miscellaneous Medical Charges;
- diagnostic tests and examinations; and
- laboratory tests.

For the above charges to be covered under Your Policy, the following conditions must be met:

- A referral must have been made in writing by the Insured's Attending Physician from a GRH or Private Hospital where the Insured was hospitalised;
- Hospitalisation in a Community Hospital must immediately follow discharge from the GRH or Private Hospital; and
- Hospitalisation in a Community Hospital must be for continued treatment for the same Injury or Illness that resulted in the Insured's hospitalisation in the GRH or Private Hospital.

This benefit is capped at 45 days per hospitalisation.

For the avoidance of doubt, We do not cover charges incurred prior to and after admission into the Community Hospital which are not otherwise covered under Your Policy.

3.2.7. Inpatient Psychiatric Treatment

We will pay for charges for Psychiatric Treatment provided by a psychiatrist to the Insured while admitted to Hospital.

3.2.8. Accidental Inpatient Dental Treatment

We will pay for charges for treatment received by the Insured while admitted to Hospital to remove, restore or replace sound natural teeth that were lost or damaged as a result of an Accident.

Coverage does not extend to charges incurred for treatments related to such accidental inpatient dental treatment prior to and after hospitalisation, unless otherwise covered under Your Policy.

3.3. OUTPATIENT TREATMENT

3.3.1. Kidney Dialysis

We will pay for charges for outpatient kidney dialysis treatment received by the Insured for chronic kidney disease or renal failure which has been diagnosed by a Physician, including:

- prescriptions;
- Physician's consultation fees;
- drugs and medicines;
- diagnostic examinations and laboratory tests ordered by a Physician that are directly related to outpatient Kidney Dialysis treatment, provided that the charges of such examinations and tests are incurred within 30 days before the outpatient kidney dialysis treatment; and
- formulated solution prescribed by a Physician and purchased for peritoneal dialysis. Although the peritoneal dialysis does not need to be performed at a Hospital, We will only cover formulated solutions prescribed by a Physician.

We will not pay for the following charges:

- Any expenses incurred after the last Outpatient Kidney Dialysis Treatment;
- Costs of purchase or rental of the machine and apparatus for peritoneal dialysis; and
- Costs for prescribed drugs and medicines apart from erythropoietin (as specifically provided for under clause 3.3.4.).

3.3.2. Outpatient Cancer Treatment

We will pay for charges incurred for Outpatient Cancer Treatments received by the Insured if the Insured is diagnosed with cancer by a Physician, including:

- prescriptions;
- Physician's consultation fees;
- drugs and medicines; and

- diagnostic examinations and laboratory tests ordered by a Physician that are directly related to cancer which results in Outpatient Cancer Treatments, provided that the charges of such examinations and tests are incurred within 30 days before the outpatient cancer treatment.

We will only pay for the following outpatient cancer treatments:
- Radiotherapy
    - External or Superficial
    - Brachytherapy;
- Chemotherapy;
- Immunotherapy; and
- Stereotactic Radiotherapy.

We will not pay for any expenses incurred after the last outpatient cancer treatment.

3.3.3. Immunosuppressants for Organ Transplant

We will pay for charges incurred for Immunosuppressants prescribed to the Insured for an organ transplant which is covered under Your Policy, provided that such immunosuppressants are approved by MOH for organ transplant, as well as approved by the HSA.

We will only pay for charges incurred for immunosuppressants after We have paid for the charges for the organ transplant for which such Immunosuppressants were prescribed.

3.3.4. Erythropoietin

We will pay for charges incurred for erythropoietin that the Insured received for treatments of chronic kidney disease or chronic renal failure as diagnosed by a Physician including:
- prescriptions;
- Physician's consultation fees;
- drugs and medicines; and
- diagnostic examinations and laboratory tests ordered by the Physician that are directly related to the prescription of erythropoietin for the chronic kidney disease or chronic renal failure treatment, provided that the charges of such examinations and tests are incurred within 30 days before the prescription of erythropoietin.

We will not pay for any charges incurred after the last session of erythropoietin for chronic kidney disease or chronic renal failure treatment.

3.4. ADDITIONAL BENEFITS

The following Benefits are also subject to Citizenship Factor, Pro-Ration Factor, Deductible, Co-Insurance, and Benefit Limits as set out in the Benefit Schedule. For pre- and post-hospitalisation

treatment, the Citizenship Factor, Pro-ration Factor and Deductible will be tied to the Insured's Inpatient Episode.

3.4.1. Pre-Hospitalisation Treatment

We will pay for charges the Insured incurs for pre-hospitalisation treatment including:

- consultations with Specialists;
- consultations with Physicians resulting in referral to a Specialist;
- medications;
- diagnostic tests and examinations; and
- laboratory tests.

We will assess pre-hospitalisation treatment claims together with the related inpatient hospitalisation claim submitted. We will only pay the Benefits for pre-hospitalisation treatment for the same Injury or Illness which results in the subsequent hospitalisation which is covered under Your Policy.

We will only pay for charges for treatment administered within the number of days before admission into a Hospital as stated in the Benefit Schedule.

If there is more than one referral from more than one Physician, We will only pay for charges for consultations of one Physician and this would be the last Physician consulted before admission into the Hospital. We will not pay for second opinions unless considered by Us to be reasonable at the point of consultation, and pursued with Our prior written approval.

3.4.2. Post-Hospitalisation Treatment

We will pay for charges the Insured incurs for post-hospitalisation treatment including:

- consultations with Specialists;
- outpatient medical services including physiotherapy;
- diagnostic tests and examinations; and
- laboratory tests.

We will assess post-hospitalisation treatment claims together with the related inpatient hospitalisation claim submitted. We will only pay the benefits for post-hospitalisation treatment for the same Injury or Illness which had resulted in hospitalisation that is covered under Your Policy.

Post-hospitalisation treatment must:

- have resulted directly from an Injury or Illness for which hospitalisation was needed; and
- be recommended by the Attending Physician who treated the Insured during his or her period of stay in Hospital.

We will only pay for charges for treatment administered to the Insured within the number of days after admission to Hospital as stated in Your Benefit Schedule.

3.4.3. Post-Hospitalisation Psychiatric Treatment

We will pay for post-hospitalisation psychiatric treatment up to 90 days after discharge from the Hospital. Any charges for such treatment are subject to and form part of the same Benefit Limit as Inpatient Psychiatric Treatment.

For the avoidance of doubt, We do not cover charges incurred prior to hospitalisation for Psychiatric Treatment which are not otherwise covered under Your Policy.

3.4.4. Major Organ Transplant

We will pay for charges incurred when the Insured is hospitalized for an Injury or Illness, and undergoes a surgical transplant of any of the following organs – kidney(s), heart, liver, lung, cornea(s), bone marrow, skin and musculoskeletal tissue.

We will also pay for the Reasonable and Customary Expenses of acquiring any one of the above listed organs from a deceased donor, provided that the transplantation is Medically Necessary and is not illegal and does not result from illegal transactions or practices.

This Benefit does not cover organ transplant surgeries where the Insured is a living donor of the organ or the expenses of acquiring the organ from a living donor.

3.4.5. Stem Cell Transplant

We will pay for charges incurred if the Insured undergoes stem cell transplant treatment because of leukaemia, thalassemia major and lymphoma and the Insured does not respond to other treatments such as chemotherapy, radiotherapy or surgery.

We will not pay for charges arising from, or in relation to or incidental to the stem cell transplant, including costs of harvesting, laboratory tests, investigations, cell cultures, storage and transportation. The charges for any outpatient therapy related to stem cell transplant and which does not require hospitalisation are also excluded.

3.4.6. Living Donor Organ Transplant

Any transplant covered under this benefit must be approved under the Human Organ Transplant Act (Cap 131A) and carried out in a Hospital in Singapore and must not be illegal or result from illegal transactions or practices.

3.4.6.1. Insured as the Living Donor donating an organ

We will pay for charges for treatment provided to the Insured for the transplant that is covered under this benefit, including

- Room and board charges;
- Expenses for the surgery to remove the organ from the Insured;
- Pre-hospitalisation treatment;
- Post-hospitalisation treatment; and
- Treatment for post-surgery complications.

We will only pay for such charges if the Insured is a living donor of an organ for an organ transplant that meets the following criteria:

- The person receiving the organ donated by the Insured is diagnosed with organ failure by a Physician and has symptoms of organ failure appearing after the Waiting Period of 24 months from the Policy Start Date or last Reinstatement Date, whichever is the later; and
- The person receiving the organ must be an Immediate Family Member.

3.4.6.2. Non-Insured donating an organ to Insured

We will pay for charges for inpatient hospital treatment for an individual who is not the Insured, if he or she is a living donor of an organ for transplant into the Insured, provided that the donor does not have insurance coverage that covers such expenses, and does not receive reimbursement for expenses incurred from any other source. Such charges include:

- Room and board charges;
- Expenses for the surgery to remove the organ to be transplanted into the Insured's body; and
- Storing and transporting the organ after it is removed from the living donor's body.

We will not pay for the following charges incurred by the donor:

- Pre-hospitalisation treatment;
- Post-hospitalisation treatment;
- Costs of any counselling provided to the living donor and his or her family; and
- Treatment for post-surgery complications.

3.4.7. Pregnancy Complications

We will pay for charges incurred if the Insured requires hospitalisation to undergo medical or surgical treatment due to one of the following:

- Choriocarcinoma and hydatidiform mole – occurrence of a histologically confirmed choriocarcinoma and/or molar pregnancy;
- Disseminated intravascular coagulation – diagnosis of disseminated intravascular coagulation by an obstetrician;

- Ectopic pregnancy – diagnosis by an obstetrician of a condition in which implantation of a fertilised ovum occurs outside the uterine cavity;
- Miscarriage – diagnosis by an obstetrician of the death of the foetus of the Insured after 13 weeks of pregnancy as a result of a sudden unforeseen and involuntary event and must not be due to a voluntary or malicious act;
- Pre-eclampsia or eclampsia – diagnosis of pre-eclampsia or eclampsia by an obstetrician;
- Postpartum haemorrhage requiring hysterectomy – the ongoing bleeding secondary to an unresponsive and atonic uterus, a ruptured uterus, or a large cervical laceration extending into the uterus requiring hysterectomy. Proof of actual undergoing of hysterectomy is required.

Pregnancy complications must have been first diagnosed after the Insured has been insured under Your Policy for a continuous period of 10 months from the Policy Start Date or last Reinstatement Date, whichever is the later.

3.4.8. Breast Reconstruction after Mastectomy

We will pay for charges for Medically Necessary breast reconstruction after a mastectomy, provided that:

- The mastectomy must be due to breast cancer;
- The breast reconstruction must be done within 12 months from the original mastectomy;

A breast implant will be covered, up to the Medically Necessary requirement.

We will not pay for any surgery or reconstruction of the other breast to produce a symmetrical appearance.

3.4.9. Emergency Overseas Medical Treatment

We will pay for charges incurred by the Insured for inpatient hospital treatment as a result of emergency medical treatment while overseas.

We will not pay for charges for the following:

- Day surgery;
- Outpatient Benefits;
- Stem Cell Transplant treatment;
- Organ Transplant;
- Living Organ Donor Transplant;
- Inpatient Psychiatric Treatment;
- Pre-hospitalisation treatment; and
- Post-hospitalisation treatment.

Emergency medical treatment means a serious injury or illness which requires immediate medical attention by a Physician within 24 hours to avoid death or serious impairment to the health of the Insured.

We will only pay the actual charges incurred by the Insured or the Reasonable and Customary Expenses that would have been incurred for equivalent medical treatment in a Hospital in Singapore, whichever is lower.

3.4.10. Congenital Abnormalities Benefit for Insured

We will pay for charges incurred by the Insured for treatment relating to birth defects, hereditary conditions and congenital sickness or abnormalities of the Insured, provided that these conditions must be first diagnosed by a Physician or symptoms must have first appeared after 24 months from the Policy Start Date, or last Reinstatement Date, whichever is the later.

3.4.11. Human Immunodeficiency Virus ("HIV") Due to Blood Transfusion and Occupationally Acquired HIV

3.4.11.1. Infection with HIV through a blood transfusion

We will only pay charges for treatment of the Insured for such infection provided that:

- The blood transfusion which caused the infection was Medically Necessary and received in Singapore;
- The blood transfusion which caused the infection was received after the Policy Start Date or last Reinstatement Date, whichever is the later;
- The source of infection is from the hospital that provided the transfusion and was the cause of the HIV infection; and
- The Insured does not suffer from thalassaemia major or haemophilia.

3.4.11.2. Occupationally Acquired HIV

We will only pay for charges for treatment of the Insured for such infection provided that:

- The Insured was infected with HIV as a result of an Accident which occurred while the Insured was carrying out the normal professional duties of his or her occupation and the date of the Accident is after the Policy Start Date or last Reinstatement Date, whichever is the later;
- The Accident must be reported to Us within 30 days of the Accident taking place;
- There is proof that the HIV infection was caused by the Accident;
- There is proof that the Insured has changed from HIV negative to HIV positive during the 180 days after the Accident. Such proof must include a negative HIV antibody test carried out within 5 days of the Accident; and

- The occupation of the Insured is 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.

3.4.12. Waiver of Premium for Insured

In the event of Death or Total and Permanent Disability of the payor of this Policy, the Base Premium (as explained at clause 5.3 of Your Policy), excluding any amount payable to the CPF Board for Your MediShield Life coverage, will be waived until the Insured reaches 21 years of age if:

- the payor is the Parent of the Insured;
- the Policy has been in force for a continuous period of at least 2 years; and
- the Insured has not, at the time of the Death or Total and Permanent Disability of the payor, reached 21 years of age.

For the avoidance of doubt, in the case where the payor is the Parent of the Insured, the Parent need not be enrolled on a Raffles Shield policy.

This clause does not apply to You if You are paying Extra Premium (as explained at clause 5.4 of Your Policy) for Your Policy, or if the Insured is the payor of the Policy.

3.4.13. Final Expense Benefit

We will waive the Co-Insurance and Deductible, up to the limit of this Benefit as stated in the Benefit Schedule, for a claim for any inpatient hospital treatment, pre-hospitalisation treatment and post-hospitalisation treatment if the Insured dies during hospitalisation or within 30 days after discharge from Hospital as result of the Injury or Illness which the Insured was hospitalized for.

3.5. SPECIAL OPTIONS

These are variations to Your Raffles Shield plan. These Special Options can be applied with effect from Your Policy Start Date or upon renewal at the end of each Policy Year. These Special Options can only be removed upon renewal.

For the avoidance of doubt, the addition or removal of Special Options to Your Policy will not result in the termination of the existing Policy and will not restart the Waiting Period under Your Policy.

3.5.1. Raffles Hospital Option

If You choose to add this option to the Raffles Shield A plan, the Pro-ration Factor for hospitalization, day surgery, short stay wards and outpatient treatment in Raffles Hospital will be increased from 70% to 100% under the Raffles Shield A plan.

Addition of this option to Your Raffles Shield plan is subject to additional underwriting for the enhanced benefits, except under the Guaranteed Plan Upgrade Feature.

Removal of this option from Your Raffles Shield plan is not subject to additional underwriting.

For the avoidance of doubt, this option cannot be added to Raffles Shield Private, Raffles Shield B and Raffles Shield Standard plans.

3.5.2. High Deductible Option

This option increases the Deductible applicable to the amount stated in the Benefit Schedule to $10,000 for each policy for all wards types and ages.

Addition or removal of this option is not subject to additional underwriting. However, once this option is removed, it can no longer be added to Your plan, even if you upgrade or downgrade Your plan in the future. In addition, a Waiting Period of 3 months upon the removal of this option applies before the lowered Deductible takes effect.

For the avoidance of doubt, this option cannot be added to Raffles Shield Standard plan and plans with the Key Rider added.

3.6. RAFFLES SHIELD PANEL

Some benefits in Your Benefit Schedule may differ, depending on whether the Attending Physician is a Panel Specialist or from a GRH, or is a non-Panel or non-GRH Specialist.

A lower Policy Year Limit applies as long as there is one Inpatient Episode in which the Attending Physician is not a Panel Specialist or is not from a GRH. This lower limit shall apply with effect from the date of admission into Hospital for that Inpatient Episode and will continue to apply for the rest of the Policy Year.

A shorter pre-hospitalisation and post-hospitalisation period for each Inpatient Episode would apply if the Attending Physician for the Inpatient Episode is not a Panel Specialist or is not from a GRH. The period refreshes for subsequent Inpatient Episodes, even if these are within the same Policy Year.

For post-hospitalisation visits to Specialists, visits to Specialists which are not Panel Specialists will be treated in the same way as though the Insured visited Panel Specialists and would enjoy the same Benefits under Your Policy, provided that Our prior written approval is obtained prior to such visits and the approval is sought in accordance with the approval process at http://www.raffleshealthinsurance.com.

4. WHAT YOUR POLICY DOES NOT COVER

Your Policy does not cover the Insured for the charges incurred directly or indirectly for the following, regardless of whether a declaration has been submitted and accepted by Us.

However, some of these charges may be covered under MediShield Life, in which case the coverage provided is subject to MediShield Life terms, conditions and applicable Benefit Limits.

The following are excluded unless expressly covered under the Benefits.

- **Treatment before Policy Start Date.** Expenses associated with hospitalisation or day surgery, and the associated pre-hospitalisation and post-hospitalisation expenses, provided that the Insured was admitted to the hospital or the surgery started before the Policy Start Date.

- **Pre-existing illness.** Any Pre-Existing Illnesses from which the Insured is suffering from prior to the Policy Start Date, unless they were declared to Us in the proposal and specifically accepted by Us.

- **Serious illness.** Treatment or diagnosis of any serious illness for which the Insured received medical treatment (including follow-up and consultations) during the period of twelve months prior to the Policy Start Date, including:
  a) Ischaemic heart disease / coronary heart disease, heart valves disorders or arrhythmia (irregular heartbeats);
  b) Cancer;
  c) Stroke/Cerebrovascular disorders, tumour of the brain or Arteriovenous Malformation;
  d) Renal failure or renal dialysis;
  e) Diabetes with complications;
  f) Chronic liver disorders, liver cirrhosis, hepatic encephalopathy or liver failure;
  g) Acquired Immune Deficiency Syndrome (AIDS) / HIV infection;
  h) Dementia / Alzheimer's Disease;
  i) Severe psychiatric or mental illness;
  j) Motor neuron disease;
  k) Muscular dystrophy;
  l) Paralysis (Hemiplegia / Paraplegia / Quadriplegia);
  m) Chronic lung disease;
  n) Rheumatoid arthritis with complications;
  o) Multiple sclerosis or any other degenerative disease;
  p) Systemic lupus erythematosus;
  q) Parkinson's disease with complications;
  r) Pulmonary hypertension;
  s) Aplastic anaemia, thalassaemia major or severe blood disorders;

t) Any Illness, excluding those mentioned from (a) to (s), which is likely to lead to a limb / spinal / eye / mental condition; or
u) Any other Illness, excluding those mentioned from (a) to (t), which is certified by a medical practitioner registered under the Medical Registration Act (Cap 174) to be a serious, life-threatening, or terminal illness.

- **Cosmetic or Plastic Surgery**, except for:
  a) Breast reconstruction after a mastectomy due to breast cancer, except as covered under clause 3.4.8;
  b) Cosmetic or plastic surgery due to an accident resulting in permanent debilitating scarring or loss of functional use of any body parts.

- **Congenital disease.** Treatment for birth defects, including hereditary conditions and disorders and congenital sickness or abnormalities or conditions arising therefrom, except as covered under clause 3.4.10.

- **Developmental conditions.** Consultation or treatment for developmental conditions, including developmental delay and/or learning disabilities in children.

- **Organ transplant.** Costs incurred from the acquisition of an organ or related parts of an organ from a living donor for an organ transplant and expenses incurred by the living donor of such organ or related parts, except as covered under clauses 3.4.4 and 3.4.6.

- **Dental treatment or surgery**, except as covered under clause 3.2.8.

- **Eye / ear examination, correction, aids**. Correction for refractive errors of the eye including Lasik treatments, as well as routine eye and ear examinations, including costs of spectacles, contact lenses and hearing aids.

- **Overseas treatment.** Overseas (outside Singapore) medical treatment or Hospitalisation, except as covered under clause 3.4.9;

- **Psychological disorders, personality disorders, mental conditions, etc.** Treatment for mental, emotional, personality, nervous, physical, psychological, learning, educational, behavioral and psychiatric problems, disorders and developments, except where covered under clause 3.2.7 and 3.4.3;

- **Pregnancy and fertility treatments.** Treatment arising from pregnancy, childbirth, abortion or miscarriage and any complications arising therefrom; investigations and treatment relating to birth control, assisted reproduction, sterilisation (or its reversal), infertility and erectile dysfunction; consultation, treatment or surgical procedures done at fertility clinics, in-vitro

fertilisation clinics, reproductive assistance clinics or centres and reproductive medicine clinics or centres (except where covered under clause 3.4.7).

- **Treatments for menopause.** Consultation or treatment for natural/physiological menopause and/or medical conditions arising directly from it (such as osteoporosis) except where the menopause was induced by the surgical removal of both ovaries deemed medically necessary.

- **Sexually Transmitted Diseases (STDs), HIV, AIDS**. Any investigation, test or treatment arising directly or indirectly from STDs, AIDS, any AIDS-related condition or infection by HIV, except as covered under clauses 3.4.11.1 and 3.4.11.2. Investigations and treatment of sexually transmitted diseases resulting from Human Papilloma Virus are specifically excluded.

- **Sex reassignment surgery**.

- **Self-inflicted injuries or suicide or attempted suicide**, whether the Insured is sane or insane, including treatment for self-inflicted injuries from an attempted suicide;

- **Drug, alcohol abuse and related injuries.** Drug or alcohol abuse or misuse, or any Injury or Illness or disease caused directly or indirectly by the abuse or misuse of alcohol, drugs or substance.

- **Items purchased or rented for outpatient uses**. Purchase or rental of such items (unless such item satisfies the definition of surgical implants and approved medical consumables under clause 3.2.4) for use at home or as an outpatient: braces, prostheses, corrective devices, durable medical equipment/machines, hospital beds, iron lungs, kidney dialysis machines, oxygen machines, walking or home aids, wheelchairs, special/medical appliances including location, transport, and associated administrative costs of such appliances and which are not necessary for the completion of a Surgical Procedure; any other hospital-type equipment;

- **Non-hospitalisation care.** Ambulatory care services, rest cures and services or treatment in any home, hospice care, outpatient nursing or palliative care, convalescent care in convalescent or nursing homes, stays in any healthcare establishment for health, social or non-medical reasons, spa, hydroclinic, sanatorium or long-term care facility that is not a Hospital.

- **Private nursing charges and nursing home services**;

- **Occupational and Speech Therapy**. Requirement for occupational and speech therapy resulting from congenital medical conditions. Speech therapy will only be covered for post stroke rehabilitation treatment for speech and swallowing. Occupational therapy will only be covered for rehabilitation post hand surgeries.

- **Alternative or complementary treatments**, including Traditional Chinese Medicine, chiropractor, acupuncturist, podiatrist, reflexologist, naturopath, homeopath, osteopath,

dietitian / nutritional therapy or a stay in any health-care establishment for social or non-medical reasons.

- **Weight management.** Treatment for obesity, weight reduction or weight improvement. All bariatric surgeries/surgeries to achieve weight loss are specifically excluded, regardless of the reason for which the bariatric surgery is being done.

- **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 HSA;

- **Off-label use of medicine.** Drugs or medicines not registered with the HSA or the MOH are specifically excluded. Drugs that are registered with the HSA or MOH but used for purposes other than those approved by the HSA are also specifically excluded.

- **Elective / optional medications, investigations, treatment**. All medications, investigations or treatment requested by the Insured and are not Medically Necessary, as well as optional items which are outside the scope of treatment or normal standards of practice.

- **Vaccination**(s).

- **Preventive, screening, health-enhancing treatments.** Any treatments, medical services and / or supplies which are preventive, screening or health-enhancing in purpose, including but not limited to vitamins, health supplements, dietary replacements and non-prescribed drugs unless medically required as a result of vitamin deficiency; treatment of acne, pigmentation, keloids, skin tags, moles, alopecia, circumcision (except where it is Medically Necessary) or treatment relating to the same, and genetic testing.

- **Medical check-ups**. Hospitalisation for the primary purpose of diagnosis, x-ray examinations, including CT Scans and MRI Scans, medical check-up or health screening, unless the eventual treatment requires hospitalisation or surgery as covered under Your Policy.

- **Examinations and services for educational purposes**. Diagnostic examinations or services for educational purposes, such as, but not limited to, investigations and/or treatment as part of clinical trials. Blood tests for food allergies are specifically excluded.

- **Transport related services** including but not limited to charges for trips made for the purposes of obtaining medical treatment, including ambulance services, emergency evacuation and repatriation or assistance in the transport or repatriation of mortal remains.

- **Non-medical items** such as, parking fees, hospital administration and registration fees, laundry, rental of television, newspaper, medical report fees, personal care and hygiene products, extra bed, regardless of whether it is Medically Necessary.

- **Illnesses / injuries resulting from sports risks.** Injury or illness arising directly or indirectly from or in connection with engagement or involvement in:
  a) any sports where remuneration or income could or would be earned or in a professional or competitive pursuit full-time, part-time, contractual or ad hoc basis other than for leisure or as a hobby; and/or
  b) hazardous sports, such as racing of any kind, scuba diving, aerial sports, and any other hazardous activities or sports unless agreed by us.

- **Illnesses / injuries resulting from civil commotions, illegal activities etc.** Treatment of Injury 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.

- **Illnesses / injuries resulting from nuclear events, terrorism, war.** Treatment for Illness or Injury sustained directly or indirectly during wars or any war like operations, terrorism, civil commotions, insurrections, overthrow of a legally constituted government, riots, rebellions, revolutions, strikes, act of foreign enemy, invasions, ionising radiation, contamination by radioactivity from any nuclear fuels, nuclear wastes or nuclear reactions from process of nuclear fission or from any nuclear weapons materials.

- **Other costs not directly related to the medical treatment.** Costs arising out of any litigation or dispute between the Insured and any medical personnel or establishment from whom treatment has been sought or given, or any other costs not directly and specifically related to the payment of the medical expenses covered by Your Policy.

5. PREMIUM

5.1. BASIS OF PREMIUM

The Premium is based on the age of the Insured on his or her next birthday, and will increase when the Insured reaches the next age band.

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 excess Premium paid or ask for any shortfall in Premium You need to pay.

5.2. PAYMENT OF PREMIUM

Your Policy Certificate shows the Policy Start Date and the Premium paid by You.

Your Premium for each subsequent Policy Year is due on the Premium Due Date and is determined based on Your plan type and the Insured's age on his or her next birthday on the Premium Due Date. We will send You a notice when Your Premium is due.

All Premiums are inclusive of the prevailing Goods and Services Tax (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 plan, or the balance in Your Medisave account is insufficient to pay in full the annual Premium due on the renewal for Your Policy, the shortfall in the annual Premium shall be paid in cash to Us within the Grace Period. We may also deduct your Premiums from any claim amount payable to You.

5.3. PREMIUM RATE

If the Insured is a Singapore Citizen or a Permanent Resident, the Premium comprises the MediShield Life premium payable to the CPF Board, as well as the additional private insurance premium payable to Us. The additional private insurance premium comprises the Base Premium as well the Extra Premium, where the Base Premium refers to the Premium which applies to an Insured who is approved for coverage on a Standard Basis, and the Extra Premium applies only to some policies and is as defined in clause 5.4.

If the Insured is a Foreigner, the MediShield Life premium does not apply ie. the entire premium is comprised of private insurance premium payable to Us.

Base Premium rates payable for this Policy are not guaranteed and may be adjusted from time to time. We have the right to change the Base Premium rates, provided that We send You a written notification

at least 30 days in advance of such change in Premium rate, and that the change applies to all policies within the same class.

5.4. EXTRA PREMIUM

Extra Premium applies only to Insureds with selected chronic conditions, as reflected in Your Endorsement(s). Extra Premium is calculated as a percentage of the Base Premium, and can be reduced based on the conditions listed in Your Endorsement(s).

In instances where Extra Premium applies, You will also be offered the option of a policy without Extra Premium, but with exclusions for specific medical conditions as listed in the Endorsement(s).

Extra Premium rates are not guaranteed and may be changed upon renewal of Your Policy.

6. CHANGES TO YOUR POLICY

6.1. CHANGE OF PLAN

You can apply to change to a plan with a higher or lower ward entitlement (where applicable) by giving Us written notification.

When You apply to change to a higher ward entitlement plan, the approval is subject to additional underwriting for the enhanced benefits (except under the Guaranteed Plan Upgrade Feature at clause 6.2)., depending on which we may:

- Decline Your application for upgrading of your Raffles Shield plan;
- Not provide You with certain enhanced Benefits under the upgraded Raffles Shield plan; or
- Require You to pay Extra Premiums in order to provide You with certain enhanced Benefits, subject to the conditions stated in Your Endorsement(s).

For changes of plan that do not fall under the Guaranteed Plan Upgrade Feature (described at clause 6.2), You can change the cover at any time, without having to wait for the next renewal date. However, there will be a 40-day period from the start date of the new IP or downgraded/upgraded plan, during which You will not be allowed to downgrade or upgrade.

The Policy Year for Your existing plan will end on the day immediately before the day on which Your new plan takes effect. The period of coverage for the new plan will be a 12-month term from the date on which the new plan takes effect and the limits shown in the benefits schedule for the new plan will apply from the date on which the new plan takes effect. The benefits which We pay on a per lifetime basis will not be paid again in the new Policy Year if You have made a claim on these benefits and We have paid 100% of the limits shown in the benefits schedule for these benefits before Your change of plan.

When You change to a higher ward entitlement plan:

- Charges incurred from the Policy Start Date shown in the new policy certificate will be processed according to the terms and conditions of the new plan, including the Deductible and Benefit Limits which will apply from the Policy Start Date of the new plan.
- Charges incurred before the change in plan will follow the previous plan's benefits (i.e. benefits that applies when the claim is first made).
- For any claim payable, We will determine the claim amount based on the Benefit Limit for the Policy Year and Pro-ration Factor (if applicable) of the plan that is applicable on the date of the admission into hospital and/or medical expense bill.
- The Waiting Period for certain Benefits will commence from the Policy Start Date of the new plan. Any claims made during this Waiting Period shall be assessed and paid according to the terms and conditions of the immediate preceding plan instead of the new plan.

6.2. GUARANTEED PLAN UPGRADE FEATURE

This feature applies for Insureds of Raffles Shield B and Raffles Shield A plans accepted on a Standard Basis, up to age 60 at next birthday. When this feature is valid, You are allowed to upgrade to a higher ward entitlement plan and to add Special Options without additional underwriting.

Such upgrades are allowed upon renewal of Your Policy every year, so long as You exercise this feature within 5 years beginning from the Policy Start Date or from the date of the most recent plan upgrade. A Waiting Period of 3 months applies before the upgraded Benefits take effect. This Waiting Period will commence from the date You exercise the option to upgrade Your Policy or add Special Options. Any treatment for diagnoses made before or during this Waiting Period shall be assessed and paid according to the terms and conditions of the immediate preceding plan instead of the new plan.

Plan upgrades are allowed as follows:

- *For Raffles Shield B*: Upgrade to Raffles Shield A
- *For Raffles Shield A*: Upgrade to Raffles Shield A with Raffles Hospital Option
- For the avoidance of doubt, the highest plan that the policyholder can upgrade to under this feature is Raffles Shield A with Raffles Hospital Option, ie. no further upgrades to Raffles Shield Private plans will be permitted.

The feature will expire if one of the following occurs:

- The feature has not been exercised within the 5 year period from the Policy Start Date or the date of the most recent plan upgrade;
- You downgrade Your plan; or
- A claim is paid on Your Policy.

While the addition of Special Options is covered under this feature, the addition of Riders is not covered under this feature.

6.3. RENEWAL

Raffles Shield provides lifetime coverage. Your Policy is renewable every year, for as long as the Insured lives. This is provided the Premiums are paid and the Policy has not been terminated.

The following may have implications on Our guarantee to renew Your Policy:

- Misstatement or non-disclosure relating to age, gender, health or personal details; or
- Change of citizenship / residency status.

6.4. GRACE PERIOD

Premiums must be paid in full within the Grace Period for You to be able to enjoy the Benefits under Your plan. Your Policy will lapse at the end of the Premium Due Date if the Premiums are not paid in full during the Grace Period.

If the Insured receives medical treatment for which charges are payable under Your Policy and are incurred during the Grace Period, and a claim is submitted, and there is still an amount of Premium to be paid or the Premium has not been paid yet, We will not pay for any claim(s) submitted (even if the claim is approved) until the Premium is paid in full before the end of the Grace Period.

We will send You a notice when Your Policy lapses. We give You the Grace Period from each Premium Due Date to pay Your Premium, and during this Grace Period, Your Policy will stay in force.

6.5. CANCELLATION

You may also cancel Your Policy during the Policy Year and after the Free Look Period (as stated in clause 8.2) by giving Us at least 30 days' written notice. We will refund You the pro-rated private insurance component of the Premium (the additional private insurance component only for Integrated Shield Plans, and the full premium for non-Integrated Shield Plans) for the unexpired period of cover.

You may cancel Your Policy with effect from any renewal date by giving Us at least 30 days' written notice in advance of the renewal date, of Your intention not to renew Your Policy. The cover under Your Policy will end on the last day of the current Policy Year.

For the avoidance of doubt, the cancellation of Your Policy by You shall not affect the insurance coverage under the Act. The Insured will continue to be insured under the MediShield Life scheme with the CPF Board as long as the Insured is eligible for the MediShield Life scheme.

6.6. TERMINATION

All the Benefits shall terminate immediately when one of the following occurs:

- There has been non-disclosure, misrepresentation or fraud as outlined at clause 6.7;
- You cancel Your Policy in accordance with clause 6.5 and 30 days have passed since the date of the notice of Your cancellation;
- You commence a Medisave-approved Integrated Shield Plan with another insurer;
- the Insured renounces his/her Singapore Citizenship or Singapore Permanent Residency status;
- the Premium is not received by the end of the Grace Period; or
- the Insured dies.

In addition to the above, for an Insured who is a foreigner and is not a Singapore Permanent Resident, the policy shall also terminate when:

- the Insured is without an Eligible Valid Pass for more than 60 days after the Eligible Valid Pass has expired or is terminated; or
- You stop paying the Premiums.

We will refund the pro-rated private insurance component of the Premium (the additional private insurance component only for Integrated Shield Plans, and the full premium for non-Integrated Shield Plans) to You upon termination, regardless of whether We have paid any claims during the Policy Year. The pro-rated Premium will be based on the number of unused days for the rest of that Policy Year and such refund will be made to Your Medisave account. If You pay part of Your Premium in cash, then the amount We refund into Your Medisave account and in cash will be proportionate to the amount We deduct from Your Medisave account and the amount We collect from You in cash respectively.

We or the CPF Board will determine the effective date of termination of Your Policy.

In the event of such termination, You shall have no further claims or rights against Us under Your Policy, except as specifically stated otherwise in this Policy Contract.

For the avoidance of doubt, the termination of Your Policy by You or Us shall not affect the insurance coverage under the Act. The Insured will continue to be insured under the MediShield Life scheme with the CPF Board as long as the Insured is eligible for the MediShield Life scheme.

6.7. NON-DISCLOSURE, MISREPRESENTATIONS, FRAUD

In the event of non-disclosure; if any information that You or the Insured provide to Us is inaccurate or misrepresented; if a claim or any part of a claim is false or fraudulent; or if You or the Insured use fraudulent methods or devices to gain any benefit, We can and may do any of the following.

- We may declare Your Policy void and You will lose all Benefits. You will have to repay to Us all amounts We have paid out under the policy and We will refund all paid Premiums to You;
- We may terminate Your Policy;
- We may refuse to renew Your Policy;
- We may add or change the terms and conditions of Your Policy. If You disagree with the additions or changes, You can write to Us to cancel Your Policy. You will have to repay to Us all amounts We have paid out under Your Policy and We will refund all paid Premiums to You.

6.8. REINSTATEMENT

If Your Policy terminates because You have not paid the Premium by the end of the Grace Period, You may apply to Us in writing within 30 days from the date of notice of termination to reinstate Your Policy, if You meet all of the following conditions:

- You have paid all Premiums that You owe Us;
- The Insured is not older than 75 years at his or her next birthday on the Reinstatement Date for all plans except Raffles Shield Standard; and

- You have given Us satisfactory proof of insurability for each Insured at Your expense.

If We agree to reinstate Your Policy, We will issue You a notice of reinstatement. If there is any change in the Insured's health, medical or physical condition, We may add Extra Premiums and exclusions which will apply from the Reinstatement Date.

For the avoidance of doubt, Us accepting payment of any Premium after Your Policy has ended does not mean that Your Policy has been reinstated. The reinstated Policy does not come into effect and We are not obliged to pay for any Benefits under Your Policy until We issue a notice of reinstatement.

6.9. CHANGE OF POLICY TERMS AND CONDITIONS

We may change the Benefits, cover, Premiums or terms and conditions of Your Policy, as long as the changes apply to all policies of the same class. We will give You at least 30 days' written notice before We do so.

7. MAKING CLAIMS UNDER YOUR POLICY

We will make payment of the claim subject to the following conditions:

- All outstanding Premiums have been paid; and
- The payout for the claim does not exceed the Benefit Limits and the Policy Year Limit as stated in the Benefit Schedule; and
- The claim is approved by Us.

If the Insured's policy is integrated with MediShield Life, We will pay claims according to the terms of Your Policy or MediShield Life, whichever is higher.

If the Insured is a foreigner who is not a Singapore Permanent Resident, he or she is not covered under MediShield Life. We will pay claims according to the Benefits under Your Policy.

7.1. COMPUTATION OF CLAIM

We will compute Your claim in the following order on the Benefits You are eligible for, where applicable:

- Reasonable and Customary Expenses;
- Citizenship Factor;
- Pro-ration Factor;
- Benefit Limit;
- Deductible;
- Co-Insurance; and
- Policy Year Limit.

7.2. METHOD OF SUBMISSION

All claims (except pre-hospitalisation treatment, post-hospitalisation treatment, post-hospitalisation psychiatric treatment, emergency overseas treatment, claims under plans which are not integrated with MediShield Life) must be made and sent to Us through the electronic filing system set up by MOH and according to the Act and CPF Act. You must complete the Medical Claims Authorisation Form (Single or Multiple version) to give Your consent to the CPF Board, medical clinic or institution to verify Your insurance membership and release of medical information, and give Us any other documents, authorisations or information We need to assess the claim.

If Your claim is not eligible for electronic filing by the Participating Medical Institution (such as claims for pre-hospitalisation treatment and post-hospitalisation treatment, post-hospitalisation psychiatric treatment and claims under plans which are not integrated with MediShield Life, You need to complete a claim form and submit this to Us by post or by hand, together with the original final bill(s) There must be sufficient particulars to enable Us to identify the Insured and the occurrence, nature and extent of the loss.

7.3. SUBMISSION TIMELINE

All claims and supporting documents, whether submitted through the electronic filing system or by post or by hand, should reach Us within 90 days from the incurred date or date of discharge, whichever is the later.

7.4. PROOF, RIGHT TO ASK FOR EXAMINATION

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

- proof of treatment or surgery;
- the hospital's original and final statement of accounts, bills and receipts; and
- other documents that We may require.

To qualify for the Waiver of Premium for Insured benefit, proof of Death or Total and Permanent Disability of the Parent who is the payor for the Insured's policy must be provided to Our satisfaction.

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 the opinion. An independent acknowledged medical specialist in the relevant field concerned shall conduct this examination and We shall select this medical specialist. In addition, We shall have the right to require a post-mortem examination, where this is not forbidden by law.

7.5. CLAIMS FOR OVERSEAS TREATMENT

If You make a claim for emergency overseas treatment or the Insured is not a Singapore citizen or Singapore Permanent Resident, You must complete the claim form as follows and submit it to Us, ensuring that:

- the Insured or the Insured's legal personal representative completes all relevant questions in the claim form and signs it;
- the attending doctor completes all relevant questions in the claim form, affixes his rubber stamp on the claim form and signs it; and
- as soon as possible after the information or document becomes available and in any case, within 90 days after treatment begins, the Insured or the Insured's legal personal representative gives Us the originals of all documents and bills, authorisations or information We need to assess the claim and deal with it. You must pay all costs involved. We do not accept photocopies.

A medical report in English is required to file a claim. If a translation is required, the cost of translating the report shall be borne by You. Both the original report and translated report are required for claim submission.

7.6. RECIPIENT OF PAYMENT

Depending on the hospital, the Insured's Hospital bill(s) may have to be paid in full or partially first during the Insured's hospitalisation. For claims which are electronically filed to Us by the Hospital, We will pay the Hospital directly. If You had paid Your bill(s) in full or partially, the Hospital will then make the necessary refund(s) to You.

Otherwise, We will reimburse You by paying You, the Medisave account that was used to pay the bill(s), or in the event of Your Death or mental incapacity, Your legal representative.

We will pay the claim once We are satisfied that all requirements are completely fulfilled. Any payment made under this clause will entirely release Us from any obligations and any further liability in respect of the claim.

7.7. LAST PAYER STATUS

If You or the Insured have other medical insurance policies (including any medical benefits under any employment contract) which allows You or the Insured to claim a refund for medical expenses, You or the Insured, must first claim from these policies before making any claim under Your Policy. Our obligations to pay under Your Policy will only arise after You have fully claimed up to the applicable limits under the other medical insurance policies.

If We have paid any benefit to You first before You make a claim under the other medical insurance policies, the other medical insurers or Your employer must refund Us their share. You must file Your claim with the other medical insurers or Your employer so that We can get back their share of the claim We have paid. You must give Us all information and evidence We need to help Us get back any other medical insurer's share of the claim We have paid. For every claim, the total reimbursement that You receive will not be more than the expenses actually paid.

7.8. REIMBURSEMENT TO INSURER

If We have settled a claim that is later found not payable for any reason, You must fully indemnify and reimburse Us for the amount within 30 days from the date of Our notice asking for reimbursement.

7.9. EXPIRATION OF LIABILITY

If We first deny liability to You or Your legal personal representative(s) for any claim, We will not be liable to pay that claim after 365 days have passed from the date of denial unless the claim is the subject of dispute filed in accordance with clause 8.13.

8. GENERAL CONDITIONS

8.1. INTEGRATED SHIELD PLAN

For Insureds who are Singapore Citizens or Permanent Residents, this is a Medisave-approved Integrated Shield Plan that provides additional coverage to the MediShield Life tier operated by the CPF Board. All Singapore Citizens and Permanent Residents are covered by and enjoy all Benefits under MediShield Life. Even if the Insured's cover under Your Policy ends, the Insured's cover under MediShield Life will continue if he or she is a Singapore Citizen or Permanent Resident.

8.2. FREE LOOK PERIOD

We give You a period of 21 days from the date of receipt of these Policy Conditions to review Your Policy. The date of receipt will be 7 days from the date of posting, which will be the date of the letter.

If You decide Your Policy is not suitable for Your needs, simply return the documents which comprise Your Policy to Us within the period mentioned above. We will refund in full the private insurance component of the premium to You, as long as no claims have been made. The private insurance component comprises the Base Premium and Extra Premium for Integrated Shield Plans, and the full Premium for non-Integrated Shield Plans.

If any claim(s) was made during the Free Look Period, the Free Look Period will no longer apply and We will give You a pro-rated refund of the private insurance component of the Premium.

8.3. CHANGE OF CITIZENSHIP / RESIDENCY

You must inform Us when the Insured's citizenship or residency status changes in any way. You must submit documentary proof of Yours or the Insured's change of citizenship or residency status within 30 days from the date of change. If the Insured is a foreigner who is not a Singapore permanent resident and is without an Eligible Valid Pass for more than 60 days after the Pass has expired/ terminated, Your Policy will terminate. Failing to inform Us of the citizenship or permanent residency change may result in duplicate coverage and Premium payment for the Insured.

8.4. APPLICATIONS AND NOTICES

Any request, notice, instruction or correspondence required under Your Policy whether to Us or the Policyholder has to be in writing and will be delivered personally or sent by courier, or by post, or electronic mail addressed to the addressee or by any other means as may be approved or adopted or accepted by Us. For the Policyholder, the mailing address is that stated in the proposal or any other address that the Policyholder has informed Us of in writing.

Our notice, request, instruction or communication is presumed to be received:

- In the case of a letter, on the 7th day after posting if posted locally, and on the 14th day after posting if posted overseas;
- In the case of personal delivery or delivery by courier, on the day of delivery;
- In the case of electronic mail, on the business day immediately following the day of dispatch; and
- In the case of other means as approved, adopted or accepted by Us, as and when We decide when it is reasonable to be received.

8.5. 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.

8.6. 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 defense 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.

8.7. SUBROGATION

If We make any payment or otherwise make good any loss applying under Your 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.

8.8. RIGHTS OF THIRD PARTIES

Anyone not a party to Your Policy cannot enforce it under the Contracts (Rights of Third Parties) Act (Cap. 53B).

8.9. CURRENCY OF PAYMENT

Unless otherwise stated, all Premiums and Benefits are payable in Singapore dollars. We will convert bills for hospitalisation denominated in a foreign currency to Our Singapore currency at Our banker's exchange rate as at the date of such bills.

8.10. APPLICABLE LAW

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

8.11. LEGAL PROCEEDINGS

You shall have no right to bring any legal action or commence any legal proceedings under Your Policy until the expiration of 60 days from the date on which a satisfactory proof of claim has been submitted to Us in accordance with clause 7 above.

8.12. NON-WAIVER

Even if We do not insist on the compliance or performance of any of the provisions of Your Policy at any time, this shall not affect the validity of these provisions and You are required to continue to comply or perform them. We will still have the right to enforce each and every provision even if We have not done so in the past.

8.13. DISPUTE RESOLUTION

If We and You agree, all disputes arising out of Your Policy may be submitted to the Financial Industry Disputes Resolution Centre Ltd (FIDREC) for settlement by mediation and / or adjudication in accordance with the mediation and / or adjudication procedure for the time being in force. We and You agree to take part in the mediation and / or adjudication in good faith and undertake to be bound by the terms of any settlement reached.

If any dispute is not referred to FIDREC or if mediation and adjudication fails in FIDREC, the dispute has to be referred to arbitration. Arbitration shall be conducted in accordance with the Arbitration Rules of the Singapore International Arbitration Centre.

The arbitration shall be in English and heard by a single arbitrator to be agreed by the parties within fourteen (14) days from the notice of arbitration failing which the arbitrator shall be appointed in accordance with and subject to the provisions of the Arbitration Rules (as maybe amended from time to time).

Where any dispute is by this condition to be referred to arbitration, the making of an award shall be binding to You and Us.

8.14. SEVERABILITY

If any provision (or part of a provision) of Your Policy is invalid or unenforceable under law, the validity and enforceability of the remaining provisions are not affected. The affected provision (or part of the provision) is deemed to be severed.

8.15. POLICY OWNERS' PROTECTION SCHEME

Your 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 Us or visit the Life Insurance Association Singapore (LIA) or General Insurance Association Of Singapore (GIA) or SDIC websites (www.lia.org.sg, or www.gia.org.sg or www.sdic.org.sg).

8.16. SOURCE OF FUNDS; NO MONEY LAUNDERING; NO TAX EVASION

You represent, warrant and certify to Us that (i) monies for all amounts paid for or invested in Your Policy (including the Premium) have been or will be properly declared to relevant tax authorities in the jurisdiction of Your tax residence and / or any other jurisdictions as necessary or appropriate in accordance with applicable laws and regulations, and (ii) none of the funds derive, directly or indirectly, from illegal activities or sources and / or tax evasion.

In cases where You are not a tax resident of the jurisdiction in which Your Policy is issued, We may disclose to Your home country's tax and / or other governmental authorities Your identity and Your beneficiaries and certain information concerning Your Policy and You hereby consent and agree that We may, in Our discretion, make such disclosure.

In the event of a violation of the above representation and warranty, We shall, to the fullest extent permitted by applicable law and regulation, have the right to:

a) Terminate Your Policy immediately;
b) Impose the appropriate charges as a result of such early termination;
c) Notify relevant governmental authorities and furnish all information deemed necessary or appropriate, in Our entire discretion, concerning You and/or Your Policy; and
d) If deemed appropriate after consultation with governmental authorities and legal counsel, either (a) refund to You Premiums and other amounts paid to Us until the date of such termination less any charges which We may impose for the early termination (Refund Amount), or (b) if requested or required to do so by competent governmental authorities, freeze or pay over to relevant governmental authorities all or a portion of the Refund Amount or take such other actions as competent governmental authorities may request or require.

8.17. SANCTIONS

Under no circumstances shall Your Policy be deemed to provide cover and no liability be incurred to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose Us to any sanction, prohibition, or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, United States of America or Singapore. If a potential breach is discovered, where possible We will advise You in writing as soon as We can.