

MyShield

Here is Your new Medical Expense Insurance Policy. Please examine it together with the Policy Schedule to make sure that You have the protection You need.

It is important that the Policy, the Policy Schedule and any endorsements are read together to avoid misunderstanding.

How Your Insurance Operates

This Policy is a contract between Us-The Company, and You-the Insured named in the Policy Schedule based on the Application Form, declaration and any information given to The Company by or on behalf of the Insured Persons.

This is a Medisave-Approved Integrated Policy which is an Enhancement Plan on top of the basic MediShield plan ("MediShield") operated by the Central Provident Fund Board ("CPF"). MediShield is governed by the Central Provident Fund Act (Chapter 36) ("Act") and Central Provident Fund (MediShield Scheme) Regulations ("Regulations"). MediShield forms the basic tier of insurance whilst We offer the enhanced benefits, as stated in the Policy, on top of MediShield.

An Insured Person under this Policy will also enjoy all benefits of MediShield as provided under the Act and Regulations such as reimbursement of benefits based on the higher of benefits under the Enhancement Plan or MediShield as well as any premium discount if he/ she satisfies the eligibility criteria.

In consideration of You paying to Us the required premium, We agree to indemnify You in the manner and to the extent described in the Policy and in the Policy Schedule in respect of medical or other covered expenses incurred during the Policy Year, or any subsequent period for which You pay and We accept the required premium.

Our Promise of Service

We wish to provide You with a high standard of one-stop service and to meet any claims covered by this Policy honestly, fairly and promptly.

Free Look

If We are issuing this Policy to You for the first time, We will give You a "Free Look" period of two (2) calendar months from the Policy Commencement Date or fourteen (14) days from the date of receipt of this Policy, whichever is the later. If within this period, You inform Us in writing that You do not want the Policy, We will cancel it from its start date and refund in full the premium You have paid after deducting any expenses incurred in assessing the risk under the Policy, as long as no claim has been admitted under the Policy. Please note that You are assumed to have received the Policy within seven (7) days after We have sent it by post.

Special Note:

You do not need to use cash to pay for the premiums of this Medisave-Approved Integrated Policy. It can be paid from the designated Medisave Account. In the event the annual premium exceeds the maximum Medisave withdrawal amount allowed, You need to only pay in cash the shortfall of premium in excess of the maximum Medisave withdrawal amount. Should there be insufficient funds in the designated Medisave Account on the renewal of this Policy, You will need to make up the outstanding balance in cash within two (2) months from the Renewal Date.

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DEFINITIONS

Certain words have been defined below. These have the same meaning wherever they are used in the Policy, unless otherwise stated. The singular includes the plural and the masculine includes the feminine and neuter gender, and in each case vice versa, unless specifically indicated otherwise.

The Company, We, Our, Us

means Aviva Ltd.

You, Your, Insured

means the owner of the Policy who is named the Insured in the Policy Schedule.

Accident

means bodily Injury caused solely by violent, accidental, external and visible means and not by sickness, disease or gradual physical or mental process.

Alternative Medicine Provider

Includes, but not limited to, a chiropractor, homeopath, osteopath, acupuncturist or Chinese Physician.

Annual Deductible

means the accumulative total amount of medical expenses paid or to be paid by an Insured Person during any one Policy Year in excess of which We will indemnify or compensate the Insured Person for medical expenses covered by the Policy. Any covered expenses incurred under SECTION III-COVERED BENEFITS, 2 (OUTPATIENT CATASTROPHIC TREATMENTS) are not subject to the Annual Deductible.

Application Form

means the forms You signed to apply for this Policy from Us, including any written statement, representation or document given to The Company which contains information We relied on in issuing this Policy.

Benefits Schedule

means the schedule attached to this Policy which sets out the benefits and the amounts payable by Us for each specific benefit under this Policy.

Co-Insurance

means the amount as specified in the Benefits Schedule to be borne by You. It is obtained by multiplying the benefit payable in excess of the Annual Deductible with a fixed percentage as stated in the Benefits Schedule.

Community Hospital

means the medical institutions in Singapore that provide intermediate Inpatient convalescent and rehabilitative healthcare services to patients who do not require the care of Hospitals. This includes, but is not limited to, Ang Mo Kio - Thye Hua Kwan Hospital, Bright Vision Hospital, Kwong Wai Shiu Hospital, Ren Ci Community Hospital, St Andrew's Community Hospital, St Luke's Hospital and West Point Hospital.

Critical Illness

means any of the following Critical Illnesses:

Heart Attack

Death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. This diagnosis must be supported by three or more of the following five criteria which are consistent with a new heart attack:

- (a) History of typical chest pain;
- (b) New electrocardiogram (ECG) changes proving infarction;
- (c) Diagnostic elevation of cardiac enzyme CK-MB;
- (d) Diagnostic elevation of Troponin (T or I); or
- (e) Left ventricular ejection fraction less than 50% measured 3 months or more after the event.

End Stage Liver Failure

End stage liver failure as evidenced by all of the following:

- (a) Permanent jaundice;
- (b) Ascites; and
- (c) Hepatic encephalopathy.

Liver disease secondary to alcohol or drug misuse is excluded.

End Stage Lung Disease

End stage lung disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

- (a) FEV₁ test results which are consistently less than 1 litre;
- (b) Permanent supplementary oxygen therapy for hypoxemia;
- (c) Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less (PaO₂ 55mmHg); and
- (d) Dyspnea at rest.

The diagnosis must be confirmed by a respiratory Physician.

Major Cancer

A malignant tumour characterised by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. This diagnosis must be supported by histological evidence of malignancy and confirmed by an oncologist or pathologist.

The following are excluded:

- (a) Tumours showing the malignant changes of carcinoma-in-situ and tumours which are histologically described as pre-malignant or non-invasive, including, but not limited to: Carcinoma-in-Situ of the Breasts, Cervical Dysplasia CIN-1, CIN-2 and CIN-3;
- (b) Hyperkeratoses, basal cell and squamous skin cancers, and melanomas of less than 1.5mm Breslow thickness, or less than Clark Level 3, unless there is evidence of metastases;
- (c) Prostate cancers histologically described as TNM Classification T1a or T1b or Prostate cancers of another equivalent or lesser classification, T₁ N₀ M₀ Papillary micro-carcinoma of the Thyroid less than 1 cm in diameter, Papillary micro-carcinoma of the Bladder, and Chronic Lymphocytic Leukaemia less than RAI Stage 3; and
- (d) All tumours in the presence of HIV infection.

Stroke

A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis. This diagnosis must be supported by all of the following conditions:

- (a) Evidence of permanent neurological damage confirmed by a neurologist at least 6 weeks after the event; and
- (b) Findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke.

The following are excluded:

- (i) Transient Ischaemic Attacks;
- (ii) Brain damage due to an Accident or Injury, infection, vasculitis, and inflammatory disease;
- (iii) Vascular disease affecting the eye or optic nerve; and
- (iv) Ischaemic disorders of the vestibular system.

Dependant

means the Insured's legal spouse, parents, grandparents who are 75 years old or below at age next birthday at the Policy Commencement Date and/or biological or legally adopted children who are at least fifteen (15) days old.

Effective Date

means the date expressly stated by Us as the date on which the Insured Person's coverage under this Policy shall commence.

Full Medical Underwriting Option

means the underwriting option chosen by You where You elect to complete a medical history declaration giving details of the Insured Person's medical history which existed before the date of application for this Policy, including any Pre-Existing Conditions.

Hospital

means an institution which is legally licensed as a medical or surgical hospital in Singapore or the country in which it is located. It must be under the constant supervision of a Physician. This does not include any entity which is primarily a place for alcoholics or drug addicts, a nursing, rest or convalescent home or a home for the aged or any other similar establishment.

Illness

means a physical condition marked by pathological deviation from the normal healthy state.

Injury

means bodily injury caused solely and directly by an Accident.

Inpatient

means a person admitted to a Hospital for treatment for at least 6 consecutive hours and for which the Hospital makes a daily room and board charge. It also includes admission of any duration for the purpose of surgery and any preparation and procedure in connection with the surgery without incurring any room and board charge.

Insured Person

means the Insured and/or covered Dependant(s) whose name is included in the Application Form for this Policy and in respect of whom commencement of cover has been confirmed in writing by Us.

Medical Complaint

means a medical condition that requires immediate medical attention by a Physician within 24 hours of an occurrence of an Accident or Illness.

Medically Necessary

means those services and supplies provided by a Physician to identify or treat an Injury or Illness which has been diagnosed or is reasonably suspected to be, and are:

- (a) consistent with the diagnosis and treatment of the Insured Person's condition;
- (b) according to standards of good medical practice;
- (c) required for reasons other than for the convenience of the Insured Person or Physician; and
- (d) the most appropriate supply or level of service which can be safely provided to the Insured Person.

Any Goods and Services Tax (GST) paid in Singapore on a Medically Necessary service or supply is covered under this Policy.

Moratorium

means a waiting period of five (5) years from the Policy Commencement Date, or the date of Upgrade, or the date of the last reinstatement for an Insured Person, whichever is later, after which a particular Pre-Existing Condition will be covered subject to the terms and conditions of the Policy.

Moratorium Underwriting Option

means the underwriting option chosen by You where no medical declaration is required.

Period of Insurance

means each term of cover under this Policy, which is for twelve (12) months and starts on the Policy Commencement Date or the Renewal Date, whichever is applicable.

Physician

means a person who is legally qualified in medical practice following attendance at a recognised medical school, to provide medical treatment and licensed by the competent medical authorities of the country in which treatment is provided but who should not be the Insured Person or the relative, sibling, spouse, child, parent of the Insured Person.

Policy Commencement Date

means the date which the cover under the Policy commences for the Insured Person and as provided in the General Conditions, Clause 22.

Policy Schedule

means the schedule to this Policy which sets out key terms like the name of the Insured, the Insured Persons and the respective plan selected.

Policy Year

means a period of twelve (12) months starting from the Policy Commencement Date and each consecutive 12-month period for which this Policy is renewed.

Pre-Existing Condition

means any Injury, Illness, condition or symptom that existed prior to the Effective Date, the date of Upgrade or the date of the last reinstatement, whichever is later,;

- (a) for which treatment, medication, advice, or diagnosis has been sought or received or was foreseeable by You or the Insured Person;
- (b) for which an ordinary and prudent person with such Injury, Illness, condition or symptom would have sought advice or treatment in connection with his/her health; or
- (c) which You or the Insured Person knew existed, whether or not treatment, medication, advice, or diagnosis was sought or received.

Pro-ration Factor

means the percentage as expressed in the Benefits Schedule which is used in the event that the Insured Person is admitted to a ward higher than what the Insured Person is entitled to under this Policy. The percentage is applied on the actual charges incurred and covered under the Policy, including charges in respect of Pre-Hospital and Post-Hospital Treatment received in connection with hospitalisation, or the Reasonable and Customary Charges for equivalent medical treatment in any Singapore private Hospital or at the Singapore General Hospital, depending on the Plan covered, whichever is lower. The benefit payable is therefore reduced to take into account the difference in government subsidies applicable to the ward type of Your selected plan.

If, during hospitalisation, there is a change of ward, We will base on the ward immediately before the discharge to determine whether the Pro-ration Factor should be applied to the hospital bills.

The Pro-ration Factor is applicable to all expenses other than Outpatient Catastrophic Treatments received and day surgery carried out in a Singapore Restructured Hospital.

Reasonable and Customary Charges

means charges for medical care which We or Our medical advisers consider to be reasonable and customary if they are within the general level of charges being made by other care providers of similar standing in Singapore where the charges are incurred when giving like or comparable treatment, services or supplies to individuals of the same gender and of comparable age for a similar disease or Injury.

Renewal Date

means the date on which the Policy is renewed for a further Period of Insurance.

Singapore Restructured Hospital

means the corporatised Singapore Government Hospitals and medical centres which include, but are not limited to, Singapore General Hospital, Changi General Hospital, KK Women's & Children's Hospital, Alexandra Hospital, Tan Tock Seng Hospital, National University Hospital, National Heart Centre, National Cancer Centre, Singapore National Eye Centre, National Skin Centre, Institute of Mental Health, National Neuroscience Institute, National Dental Centre, The Cancer Institute, The Eye Institute, The Heart Institute, Care Management Centre, Jurong Medical Centre and Singapore Footcare Centre.

Specialist

means a qualified and licensed Physician, possessing the necessary additional qualifications and expertise to practise as a recognised specialist of diagnostic techniques, treatment and prevention, in a particular field of medicine like psychiatry, neurology, pediatrics, endocrinology, obstetrics, gynaecology and dermatology.

Waiting Period

means the period of time applicable to specific benefits under the Policy as set out under the relevant benefit provisions, starting from:

- (i) the date which the benefit first becomes effective under the Policy;
- (ii) the Policy Commencement Date of the Policy;
- (iii) the date of last reinstatement; or
- (iv) the date of Upgrade (applicable to any increased or additional benefit(s))

whichever is the latest, during which this Policy will not provide for those specific benefits regardless of treatment made necessary by any cause.

Upgrade

means a change in plan under the Policy whereby the Insured Person's plan is changed to a new plan offering higher benefits, under the same Policy.

GENERAL CONDITIONS

It is an important part of Our contract that You observe the following General Conditions:

1. Eligibility

To be eligible as an Insured under this Policy, You must be:

- (a) a Singapore Citizen or Singapore Permanent Resident;
- (b) 75 years old or below at age next birthday as at the Policy Commencement Date; and
- (c) a member of Central Provident Fund Board with a CPF Medisave Account from which You can withdraw money to pay for Your premiums for this Policy.

If You are confined in a Hospital on the date when Your cover would otherwise become effective, Your cover will not become effective until the date following Your discharge from the Hospital.

Once You are covered under this Policy, Your Dependants are also eligible for cover. A newly born child is eligible for cover fifteen (15) days after the date of birth or after discharge from the Hospital, whichever is later.

2. Geographical Scope

The Insured Person shall seek treatment in Singapore. Any treatment provided to the Insured Person outside Singapore is limited to benefits covered under SECTION III-COVERED BENEFITS, 3(d) (Inpatient Medical Complaint outside Singapore).

3. Last Payer Status

If the Insured Person has other medical insurance, including medical benefits under any employment contract, which makes provision for reimbursement of medical expenses, We shall be the last payer reimbursing the claim. If benefits payable under this Policy has been made to You first before a claim is made under such other medical insurance policies or employee benefits, the other medical insurers or employer will need to reimburse Us their share. You shall provide Us with the full details of such other insurance policies or employee benefits and all relevant documentary proof necessary to make a claim.

For every claim, the total reimbursement to be made should not exceed the expenses actually incurred.

4. Co-operation

We will not be liable under this Policy unless You, the Insured Person or his/her representatives

- (a) co-operate fully with Us and Our medical advisers;
- (b) fully and faithfully disclose all material facts and matters which the Insured Person knows or ought to know; and
- (c) on Our request sign any document to empower the Company to obtain relevant information, at the Insured Person's expense, from any doctor or Hospital or other sources.

5. Renewal

Your cover is automatically renewed for a further Period of Insurance by payment of the renewal premium before the Renewal Date.

We will request for deduction of the premium from the designated CPF Medisave Account subject to the withdrawal limit set by CPF. Any excess of premium over the withdrawal limit or any shortfall in premium due to insufficient funds in the designated CPF Medisave Account must be paid before the Policy can be renewed.

On the Renewal Date, We may vary the benefits, cover and/or premium or amend the clauses and conditions of this insurance cover (provided that the changes apply to all policies under the same class of insurance) by giving thirty (30) days' advance notice in writing to You but We will not cancel any individual policy.

6. Cancellation

You may cancel the Policy with effect from any Renewal Date by giving thirty (30) days' notice in writing of Your intention not to renew the Policy. The cover on all Insured Persons under the Enhancement Plan will cease on the Renewal Date. However, cover for each Insured Person under the MediShield (if they are covered) will continue to remain in force provided they still satisfy the eligibility criteria as specified in the Act and Regulations.

Should You cancel the Policy during the Policy Year after the Free Look period, You will be entitled to a pro-rated refund of the annual premium paid to Us for the unexpired period of coverage.

7. Change of Plan

You may change the plan of an Insured Person, subject to Our approval in writing, by giving Us a written notice at least thirty (30) days prior to the Renewal Date of this Policy. This is subject to satisfactory evidence of insurability for each Insured Person at Your Expense for any upgrading of plan before the change can be effected on the Renewal Date.

In the event of an Upgrade whereby the Insured Person fails to satisfy the Moratorium of the upgraded plan, any claim arising from a Pre-Existing Condition after the Upgrade will be assessed under the terms and conditions of the plan prior to the Upgrade. If such a claim is admissible after having satisfied the Moratorium of the plan prior to the Upgrade, any benefit payout would be limited to the benefits under the plan prior to the Upgrade.

Any Pre-Existing Condition which has been permanently excluded under the Policy as provided in General Conditions clause 13(b) will remain permanently excluded under the upgraded plan.

8. Termination of Insurance

An Insured Person's cover under this Policy will terminate automatically on the date any one of the following events first occurs:

- (a) upon death of an Insured Person;
- (b) on the expiry of the 30-day notice following a request for Cancellation by the Insured;
- (c) non-payment of required renewal premium after the Grace Period;
- (d) refusal or failure by the Insured or Insured Person to refund Us any sum of money due and owing to Us, and arising out of any prior payment by Us on behalf of the Insured Person for any hospitalisation and/or medical expenses (if applicable); or
- (e) upon commencement of another Medisave-approved Integrated Shield Plan issued by another insurance company covering the Insured Person.

9. Grace Period

A grace period of two (2) months is allowed for payment of the required renewal premium. If the required renewal premium is not paid on or before the last day of the grace period, the cover under the Policy will be treated as terminated on the Renewal Date and may only be reinstated with Our consent.

10. Reinstatement

If the Policy terminates due to non-payment of premium, You may apply to reinstate this Policy within thirty (30) days of the date of notice of Termination by providing Us with satisfactory evidence of insurability for each Insured Person at Your expense, provided the Insured Person for whom reinstatement is requested is not older than age 75 at next birthday on the date of reinstatement. All outstanding premiums must be received by Us before the Policy can be reinstated.

Treatment provided to the Insured Person after the date of Termination and within thirty (30) days of the date of notice of reinstatement will not be covered unless the treatment received as an Inpatient is for Injuries caused by an Accident occurring after the date of notice of reinstatement.

11. Misstatement of Age

If the age of any Insured Person has been misstated in the Application Form, the premium shall be adjusted based on the correct age of the Insured Person. Any excess premium shall be refunded and any shortfall in premium made up. Our liability for excess premium shall be limited to the refund of the total premium paid without interest.

12. Age

For the purpose of determining premiums payable, an Insured Person's age shall be based on his age next birthday.

13. Pre-Existing Conditions

All Pre-Existing Conditions are excluded under this Policy unless

- (a) if You have chosen the Full Medical Underwriting Option, the Pre-Existing Condition has been declared by You and specifically accepted by Us, in writing, to be covered under this Policy;

Or

- (b) if You have chosen the Moratorium Underwriting Option, and during the 5-year Moratorium in which the Insured Person remains in continuous cover under this Policy, the Insured Person has not, in relation to a Pre-Existing Condition:
- (i) experienced symptoms;
 - (ii) sought advice or tests from a Physician, Specialist or Alternative Medicine Provider (including checkups for that Pre-Existing Condition);
 - (iii) required treatment or medication; or
 - (iv) received treatment or medication

in which case, We will cover that Pre-Existing Condition under this Policy. However, if at any time, during the 5-year Moratorium, the Insured Person undergoes any of the above, then that particular Pre-Existing Condition shall be permanently excluded under this Policy.

If You have already been insured under this Policy but do not fall within (a) or (b) above and We had previously excluded a Pre-Existing Condition, then the Moratorium Underwriting Option shall apply. The 5-year Moratorium will be deemed to have commenced from the Policy Commencement Date.

For the avoidance of doubt, the Moratorium will not apply to the following list of Pre-Existing Conditions and these Pre-Existing Conditions shall be permanently excluded under the Policy if You have chosen the Moratorium Underwriting Option:

- Heart Attack, heart bypass, angioplasty
- Chronic obstructive lung disease, chronic cor pulmonale, pulmonary hypertension
- Stroke
- Liver cirrhosis
- Paralysis
- Osteoporosis
- AIDS or HIV infection
- Thalassaemia Intermediate/ major
- Diabetes with complications such as protein in urine or eye problem
- Kidney failure
- Organ transplantation
- Systemic lupus erythematosus (SLE)
- Muscular dystrophy
- Multiple sclerosis
- Alzheimer's disease
- Dementia
- Any form of Cancer (other than skin cancer)
- Autism

14. Payment of Premiums

The premiums for this Policy are payable annually. They will be deducted in full from the designated Medisave Account.

In the event the annual premium exceeds the maximum Medisave withdrawal amount allowed for a Medisave-Approved medical insurance scheme, or the balance in the designated Medisave Account is insufficient to pay the full annual premium, the shortfall in premium shall be paid in cash.

15. Payment of Benefits

For any claim of benefits after the Policy Commencement Date but before We receive the full payment of premium, We reserve the right to pay the covered expenses only on receipt of all the premiums due to Us.

No benefit shall be payable if the confinement due to Illness or disability occurs after the Termination or Cancellation of this Policy. This is regardless of whether or not the confinement is a direct result of Illness occurring before the Termination or Cancellation of this Policy.

16. Full Disclosure

You are required to disclose fully and truthfully all material facts and circumstances to The Company up to the date full cover is provided in respect of any Insured Person.

Any non-disclosure or misrepresentation shall entitle the Company to declare this Policy void and avoid all liabilities existing under this Policy in respect of that Insured Person right from the Policy Commencement Date or date of reinstatement.

If You were covered previously with MediShield or a Medisave-Approved Plan offered by another insurer, only Your cover under MediShield will be reinstated. This Policy will be void right effective from the Policy Commencement Date or date of reinstatement.

We will refund You all premiums paid to Us provided You have not made any claim under this Policy.

17. Fraud

If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Insured Person or any Dependant or anyone acting on their behalf to obtain any benefit under this Policy, the Policy will be cancelled immediately and all benefits and premiums will be forfeited.

18. Trust

We will not recognise or be affected by any notice of trust, charge or assignment relating to this Policy.

19. Applicable Law

The terms and conditions of this Policy will be governed by and construed, determined and enforced according to the laws of Singapore.

20. Currency

Payment of all claims and benefits will be made in Singapore currency. Charges incurred in any other currency outside Singapore shall be payable in Singapore Dollars on the basis of the exchange rate used by Us on the date the claims were processed.

21. Exclusion of the Contracts (Rights of Third Parties) Act

The Contracts (Rights of Third Parties) Act 2001 and any subsequent amendments or replacements of that Act shall not apply to this Policy. A person who is not a party to this Policy shall have no right under the Act to enforce any of its terms.

22. Policy Commencement Date

The Policy Commencement Date is the date cover under this Policy commences for the Insured Person(s) PROVIDED We receive the full premium within fifteen (15) days of the Policy Commencement Date. Otherwise, We may change the Policy Commencement Date to a later date pending receipt of the full premium. If this happens, an endorsement will be issued to confirm the new Policy Commencement Date. We will not be liable for any claim arising before the new Policy Commencement Date.

SECTION I - EXTENT OF COVER

The Policy will pay up to the Limits as stated in the Benefits Schedule for medical or other covered expenses as a direct result of the Insured Person suffering an Accident, Illness, death or any other covered event.

We will pay any benefits due under this Policy either to You, the Insured Person or to the providers of covered medical or other services which payment of that benefit will discharge Us from the liability We have under the Policy.

A satisfactory proof of claim must be submitted in all cases. We reserve the right to appoint independent administrators to settle claims on Our behalf.

SECTION II - LIMITS OF LIABILITY

The Company's liability is limited in amount to the Limits as stated in the Benefits Schedule for each item or type of cover provided under this Policy.

If an Insured Person under Plan 2 or 3 is hospitalised in a ward higher than what he is entitled to, the benefit payable will be reduced by first applying the applicable Pro-ration Factor as specified in the Benefits Schedule to the original final bills.

As long as the Insured Person is admitted to the ward (or below) of the plan chosen, no Pro-ration Factor will be imposed on the hospital bills. The Pro-ration factor is not applicable for Plan 1.

We will further deduct the following amounts as specified in the Benefits Schedule from the benefits payable:

- (a) the Annual Deductible which shall be borne by You;
- (b) the Co-Insurance up to the maximum amount stated in the Benefits Schedule (if the aggregate medical expenses covered under this Policy exceeds the Annual Deductible) which shall be borne by You; and
- (c) any sums due or owing to Us under this Policy.

The final computed benefits payout shall not exceed the Policy Year Limit as stated in the Benefits Schedule based on the Plan selected for each Insured Person. As the Insured Person is also covered under MediShield, he shall enjoy reimbursement of benefits based on the higher of benefits under this Enhancement Plan or MediShield.

The Policy Year Limit per Insured Person stated in the Benefits Schedule is the maximum amount recoverable under the Policy as a whole in respect of any one Insured Person during any one Policy Year.

If the Insured Person has reached the Lifetime Limit of MediShield, an endorsement will be passed to reflect the termination of MediShield cover. We will continue to cover You under the plan You have chosen.

In the event the Insured Person reaches the age limit of MediShield, the cover under MediShield will be terminated. We will provide him cover under the Enhancement Plan beyond this age limit. An endorsement will be passed to reflect the termination of MediShield cover.

SECTION III - COVERED BENEFITS

The following benefits are available. Not all of them may apply in respect of Your Policy.

Please refer to the Policy Schedule to determine the plan that applies to the Insured Person concerned and the Benefits Schedule for details of the cover provided.

1. HOSPITAL AND RELATED SERVICES

The following charges which are Medically Necessary for the treatment of an Insured Person for Illness or Injury, at a Hospital as an Inpatient:

(a) Daily Room and Board

Charges for standard room accommodation, meals and general nursing services. Standard room shall mean the class of hospital ward which is categorised as standard (including the High Dependency Ward) by the Hospital in which the Insured Person is confined as an Inpatient and shall not include luxury suites or other special rooms that are available at the Hospital in addition to the standard room.

For Plan 2, the daily room and board entitled is any standard ward of any Singapore Restructured Hospital subject to the limits specified in the Benefits Schedule.

For Plan 3, the daily room and board entitled is a 4-bed standard ward of any Singapore Restructured Hospital subject to the limits specified in the Benefits Schedule.

(b) Intensive Care Unit

Charges incurred during confinement in the Intensive Care Unit of the Hospital. This shall not include charges incurred in the High Dependency Ward.

(c) Hospital Miscellaneous Services

Services or materials supplied by the Hospital to the Insured Person during a Hospital confinement and provided they are Medically Necessary and rendered or supplied at Reasonable and Customary Charges. These include operating theatre charges; anaesthetist fees; oxygen and their administration; drugs, dressings or medicines prescribed by the attending Physician for in-Hospital use; diagnostic procedures and laboratory tests; theatre consumables or implants and other ancillary charges. The costs of non-Medically Necessary goods or services including items such as telephone, television and newspapers are not covered.

(d) Surgical Benefits

Fees for surgery by a surgeon, including the surgeon's visits while in Hospital. Charges for day surgery, Gamma Knife and Novalis radiosurgery are also payable.

(e) Surgical Benefits for Major Organ Transplant

Fees for Major Organ Transplant operations of the kidneys, heart, liver, lung or bone marrow where the Insured Person is the recipient. This includes the costs of acquiring the organ from a cadaveric (deceased) donor but not a living donor and only if the transplantation is Medically Necessary and rendered at Reasonable and Customary Charges. We will not pay for any costs if the transplantation is illegal or arises from any illegal transaction or practice.

(f) Accident Inpatient Dental Treatment

Charges for Inpatient treatment required to restore or replace sound natural teeth lost or damaged in an Accident and for which treatment was received within fourteen (14) days following the Accident.

(g) Daily In-Hospital Doctor's Visit

Fees charged by the attending Physician for daily bedside visits.

(h) Pre-Hospital Specialist's Consultation

Charges for Medically Necessary consultation with a Specialist, if recommended in writing by a Physician, within ninety (90) days prior to an Inpatient treatment for the same injury or illness covered by the Policy.

(i) Pre-Hospital Diagnostic and Laboratory Services

Charges for Medically Necessary diagnostic procedures and laboratory examinations, which are recommended in writing by a Physician, and incurred within ninety (90) days prior to an Inpatient treatment for the same injury or illness covered by the Policy.

(j) Post-Hospital Follow-up Treatment

Charges for Medically Necessary follow-up treatment with the same attending Physician as an outpatient, incurred within ninety (90) days immediately following discharge from a Hospital as an Inpatient.

(k) Confinement in Community Hospital

Charges incurred at a Community Hospital for accommodation, meals and general nursing services that are Medically Necessary, subject to the limits specified in the Benefits Schedule. The benefit payable will be reduced by applying the Pro-ration Factor, if applicable, as specified in the Benefits Schedule.

The following conditions must be met:

- (i) A referral from the Insured Person's attending physician from the Hospital where the Insured Person had received Inpatient treatment is required; and
- (ii) Admission to a Community Hospital must be immediately following discharge from the Hospital where the Insured Person had received Inpatient treatment; and
- (iii) Such admission to the Community Hospital arises from the same Injury or Illness that resulted in the Insured Person's Inpatient treatment at the Hospital.

(l) Inpatient Congenital Anomalies

Charges for Medically Necessary Inpatient treatment of the Insured Person due to any congenital anomalies, including hereditary conditions, provided such condition is first diagnosed by a Physician, or the symptoms first appeared, after a Waiting Period of twenty-four (24) months.

(m) Inpatient Pregnancy Complications

Charges for Medically Necessary Inpatient treatment of an Insured Person for pregnancy complications. For purposes of this benefit, the pregnancy complications must fall within one of the following categories, namely:

- (i) Ectopic pregnancy;
- (ii) Pre-Eclampsia or Eclampsia;
- (iii) Disseminated intravascular coagulation; or
- (iv) Miscarriage after the first trimester (not due to voluntary or malicious act)

and must first be diagnosed by a qualified obstetrician after a Waiting Period of ten (10) months.

(n) Living Donor Organ Transplant

Charges for Major Organ Transplant operations of the kidneys or liver, subject to the limits specified in the Benefits Schedule, excluding any post-surgery complications, where the Insured Person is a living donor, provided the transplantation is carried out at a Hospital in Singapore. The recipient of the kidney or liver must be the Insured Person's family member, where the recipient's kidney or liver failure is first diagnosed by a Physician, or the symptoms of which first appeared, after a Waiting Period of twenty-four (24) months.

We will not pay for any costs if the transplantation is illegal or arises from any illegal transaction or practice.

For the purposes of this benefit, the Insured Person's family members are deemed to be his parents, siblings, children and spouse.

2. OUTPATIENT CATASTROPHIC TREATMENTS

(a) Outpatient Kidney Dialysis

Charges for treatment of an Insured Person requiring machines or apparatus for providing kidney dialysis at a legally registered dialysis centre. Cover includes examination and tests ordered by the attending Physician during the course of treatment. It extends to cover Erythropoietin as part of the treatment for Chronic Renal Failure and ambulatory peritoneal dialysis ordered by a Physician.

(b) Outpatient Cancer Treatment

Charges for Chemotherapy, Radiotherapy, Immunotherapy and/or Stereotactic Radiotherapy treatment (or any other cancer treatment approved by Us) provided by a Hospital or at a legally registered cancer treatment centre, including examinations and tests ordered by a Physician and conducted on the same day of treatment. Charges for consultation by the attending Physician are not covered.

(c) Major Organ Transplant - Approved immunosuppressant drugs

Charges for immunosuppressant drugs approved by Ministry of Health and which are Medically Necessary as part of the outpatient treatment after a Major Organ Transplant to reduce the rate of rejection episodes. Such Major Organ Transplant operation must first be approved under the MyShield Policy. This benefit will cover drugs including, but not limited to:

- (i) Cyclosporin;
- (ii) Tacrolimus;
- (iii) Azathioprine;
- (iv) Prednisolone; and/or
- (v) Other approved immunosuppressant drugs for Major Organ Transplant.

3. SPECIAL BENEFITS

(a) Extra Inpatient Coverage for 5 Critical Illnesses

If an Insured Person is diagnosed with any of the 5 Critical Illnesses as defined, We will offer Extra Inpatient Coverage in addition to the Insured Person's Per Policy Year Limit with the additional amounts as stated under the Benefits Schedule of the chosen Plan.

Any payment of Inpatient benefit relating to any of the Critical Illnesses will first be made from this Extra Coverage Benefit. When the limits under this Extra Inpatient Coverage are exhausted, the excess payment will then be made from the Per Policy Year Limit as stated in the Benefits Schedule of the chosen Plan.

(b) In-Hospital Psychiatric Treatment

If this benefit is specifically stated as covered under the Benefits Schedule, We will pay for the costs of psychiatric treatment which is received as an Inpatient in a psychiatric unit of a Hospital after You have been insured under this Policy for a continuous period of 10 months. All treatment must be administered under the direct control of a registered psychiatrist.

(c) Free Coverage for Child(ren)

Any eligible Insured Person up to 20 years old at age next birthday will be covered for free under Plan 2 provided that both parents are covered under Plan 1 or 2 of this Policy. This is subject to satisfactory evidence of insurability for the child to be provided at the Insured's expense at the point of application for cover.

(d) Inpatient Medical Complaint outside Singapore

Insured Persons shall be covered for any Inpatient treatment due to a Medical Complaint outside Singapore.

This Policy will reimburse the cost of such covered treatment subject to the following conditions:

- (i) If You are covered under Plan 2 or 3, We will pay the actual incurred charges or the Reasonable and Customary Charges for equivalent medical treatment in the Singapore General Hospital according to the plan coverage, whichever is lower. The benefit payable will be reduced by applying the Pro-ration Factor, if applicable, as specified in the Benefits Schedule; and
- (ii) If You are covered under Plan 1, We will pay the actual incurred charges or the Reasonable and Customary Charges for equivalent medical treatment in any Singapore private Hospital, whichever is lower.

Any Pre- and Post-hospitalisation treatment following such Inpatient Medical Complaint outside Singapore will not be covered under the Policy, regardless of where the Pre- and Post-hospitalisation treatment is received.

4. FINAL EXPENSES BENEFIT

In the event the Insured Person dies during hospitalisation or within 30 days of discharge of hospitalisation, provided in both cases the death is a result of the cause of the hospitalisation, a Final Expenses Benefit which is a waiver of the Annual Deductible and Co-Insurance amounts up to the amount stipulated in the Benefits Schedule, will be given.

CLAIMS CONDITIONS

We will act in good faith in all Our dealings with You. In return, You must ensure that the following are observed:

1. Making a Claim

Upon Your admission or surgery at any Hospital, medical clinic or institution accredited by MOH to submit Integrated Shield Plan claims via the online claim system, You are required to complete a common claim form for the Medisave-Approved Integrated Plan. The claim will be submitted to Us on Your behalf by the Hospital, medical clinic or institution through the online claim system. It is important that You complete all the questions in the form to the best of Your knowledge, give Your consent to the Hospital, medical clinic or institution under Section 1 to verify Your insurance membership information and release of medical information.

The Hospitals, medical clinics or institutions, CPF Board and all private insurers of the Medisave-Approved Integrated Plan have agreed on the following order of preference for signatories in the claim form:

- (a) Insured Person who is admitted as an Inpatient;
- (b) Insured Person or Insured (if different from Insured Person and the Insured Person is not able to sign the form); and
- (c) Next-of-kin (in the absence of Insured Person or Insured or under certain circumstances that both Insured Person and Insured are not able to sign the claim form)

The next-of-kin of the Insured Person is not a party to this Policy and will not acquire any rights under this Policy by being a signatory to the claim form but by virtue of the above arrangement, the next-of-kin shall be given the authority to give consent and sign on the claim form. The order of preference for signatories is to facilitate the process of making a claim on behalf of the Insured Person under this Medisave-Approved Integrated Plan.

If You intend to make a claim under Inpatient Medical Complaint outside Singapore or the Insured Person making a claim is not a Singapore Citizen or Singapore Permanent Resident, You must complete our Claim Form and submit it to Us as soon as possible after an Insured Person seeks covered treatment. In respect of Our Claim Form:

- the Insured Person or the Insured Person's legal personal representative(s) must complete all the questions in Section A and sign it;
- the treating Physician must complete all questions in Section B, affix his rubber stamp on the Claim Form and sign it; and
- give Us all supporting medical information (including originals of all relevant documents and bills) within three (3) months after the treatment begins or as soon as possible after such information is reasonably available, whichever is earlier. We will not accept photocopies of the relevant documents.

Failure to observe these conditions for making a claim, without any reasonable explanation, may invalidate a claim.

2. Settlement of Claim

We shall make payment of the claim once We are satisfied that all requirements are fully complied with. Payment advice will be despatched to the Insured or Insured Person as the case may be and payment will be made to the Hospital, medical clinic or institution for claims processed electronically, otherwise We will reimburse the Insured or the Insured Person as the case may be.

Any payment made under this clause shall wholly discharge Us from any further liability in respect of the claim.

In the event that the amount paid by Us to a Hospital(s) pursuant to the Letter(s) of Guarantee issued to the Hospital(s) is not payable under this Policy for any reason whatsoever, You shall fully indemnify and reimburse Us for any such amount within 30 days from the date of notice given by Us requesting for reimbursement.

3. Examinations

The Company shall have the right and opportunity through its medical representatives to examine the Insured Person whenever and as often as it may reasonably require during the duration of any claim. In addition, The Company shall have the right to require a post-mortem examination, where this is not forbidden by law.

4. Legal Proceedings

No action in law or equity shall be brought under the Policy until after the expiration of sixty (60) days from the date a satisfactory proof of claim has been furnished to The Company according to the terms and conditions of this Policy.

5. Arbitration

Any difference of medical opinion in connection with the results of any Accident, Illness, death or expense will be settled between two medical experts appointed respectively in writing by the two parties to the dispute. Any difference of opinion between the two medical experts shall be referred to an umpire, who shall have been appointed in writing by the two medical experts at the outset.

GENERAL EXCLUSIONS

The following treatment items, conditions, activities and their related or consequential expenses are excluded from the Policy and The Company will not be liable for them. If We say that because of an Exclusion and/or any other term and condition of this Policy, any loss, damage, cost or expense is not covered by this Policy, the burden is on You to prove otherwise.

1. All expenses incurred by an Insured Person for the period of hospitalisation if admission in a hospital is before the Policy Commencement Date.
2. Pre-Existing Conditions (except as provided in clause 13, General Conditions).
3. Overseas medical treatment (except as specified in SECTION III-COVERED BENEFITS, 3(d) (Inpatient Medical Complaint outside Singapore)).
4. Transport for trips made for the purpose of obtaining medical treatment such as ambulance fee, emergency evacuation, assistance and repatriation of mortal remains.
5. Private Nursing charges and nursing home services.
6. Hospitalisation primarily for diagnosis, X-ray examinations, general physical or medical check-up; routine medical examinations or check-ups; vaccinations, medical certificates, examinations for employment or travel, routine eye or ear examinations, hearing aids, spectacles, contact lenses and correction for refractive errors of the eye.
7. Elective cosmetic treatments and plastic surgery; all dental treatment or oral surgery related to teeth other than those Inpatient treatment due to Accident; rest cures and services or treatment in any home, spa, hydro-clinic, sanatorium or long-term care facility that is not a Hospital as defined.
8. Tests or treatment relating to infertility, contraception, sterilisation, impotence, sexual dysfunction, sex change operations; treatment or surgical procedures done at fertility clinics, in-vitro fertilisation clinics, reproductive assistance clinics or centres and reproductive medicine clinics or centres; treatment resulting from pregnancy, childbirth, miscarriage, abortion and all related complications (except as provided for and defined under SECTION III-COVERED BENEFITS, 1(m) (Inpatient Pregnancy Complications)).
9. Treatment for obesity, weight reduction or weight improvement; congenital anomalies, birth defects or hereditary conditions (except as provided for and defined under SECTION III-COVERED BENEFITS, 1(l) (Inpatient Congenital Anomalies)).

10. Prosthesis, corrective devices and medical appliances which are not surgically required; all treatment that is not scientifically recognised by western European or North American standards.
11. All costs relating to cornea, muscular, skeletal or human organ or tissue transplant from a donor to a recipient (except as provided for and defined under SECTION III-COVERED BENEFITS, 1(n) (Living Donor Organ Transplant)) and all expenses directly or indirectly related to organ transplantation (except as provided for and defined under SECTION III-COVERED BENEFITS, 1(e) (Surgical Benefits for Major Organ Transplant) and 2(c) (Major Organ Transplant - Approved immunosuppressant drugs).
12. Treatment for self-inflicted Injury, suicide, abuse of alcohol, drug addiction or abuse, psychological, emotional or mental problems or conditions (except as provided for and defined under SECTION III-COVERED BENEFITS, 3(b) (In-Hospital Psychiatric Treatment)).
13. Experimental or pioneering medical, surgical techniques or clinical trial for drugs or medical device not commonly available or not approved by Ministry of Health which the Insured Person chooses to receive even though treatment usually and customarily provided for the medical condition concerned is available.
14. Second opinions in respect of medical conditions which have already been diagnosed and/or treated at the date such second opinions are obtained unless considered by Our medical advisers to be reasonable and necessary having regard to the medical facts and circumstances.
15. Additional Fees billed by a referring Physician for treatment given after the date on which an Insured Person has been referred to another Physician or Specialist.
16. Injury or Illness arising out of or in connection with
 - (a) active military, police or civil defence training, duties or operations, including maintenance of civil order, engagement in hostilities, participation in war (whether war be declared or not) and whether or not compensation or reimbursement of hospitalisation or medical expenses in part or full has been made by the Government or the relevant authorities. For the avoidance of doubt, this shall not include operationally ready national service duty under Section 14 of the Enlistment Act Cap 93 of the Republic of Singapore; or
 - (b) any illegal act including resultant imprisonment.
17. Rock climbing, mountaineering, pot-holing, skydiving, parachuting, hang-gliding, para-sailing, ballooning, all diving; racing of any kind other than on foot and all professional or inherently dangerous sports.
18. Air travel, other than as a fare-paying passenger on a duly licensed aircraft on a regular scheduled route operated by a recognised airline.
19. Costs arising out of any litigation or dispute between the Insured Person and any medical person 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 the Policy.
20. Any loss or damage, cost or expense of whatever nature directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at the same time or in any other sequence to the loss:
 - (a) ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;
 - (b) the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component; or
 - (c) any weapon of wars employing atomic or nuclear fission and/or fusion or other like reaction of radioactive force or matter.

21. Death, disability, loss, damage, destruction, any legal liabilities, cost or expense including consequential loss of every type which is, directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at the same time or in any other sequence to the loss:
- (a) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war is declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power; or
 - (b) any act of terrorism including but not limited to
 - (i) the use or threat of force, violence;
 - (ii) harm or damage to life or to property (or the threat of such harm or damage) including, but not limited to, nuclear radiation and/or contamination by chemical and/or biological agents or by any person(s) or group(s) of persons, committed for political, religious, ideological or similar purposes, express or otherwise, and/or to put the public or any section of the public in fear; or
 - (iii) any action taken in controlling, preventing, suppressing or in any way relating to (a) or (b) above.
22. Sexually transmitted diseases and any treatment or test in connection with Human Immunodeficiency Virus (HIV) Infection and all HIV infection-related conditions or diseases, except
- (a) HIV infection acquired through blood transfusion in Singapore or
 - (b) HIV acquired while performing regular professional duties in a medical profession in Singapore.

IMPORTANT:

The Insured is requested to read this Policy. If any error or mis-description is found, the Policy should be returned to the issuing office for correction.

	MyShield		
	Plan 1	Plan 2	Plan 3 ¹
Hospital Ward Type	Any Private Ward	Any Government/ Restructured Ward	B1 Government/ Restructured Ward
Inpatient Benefits			
Daily Room & Board	As charged		
Intensive Care Unit			
Hospital Miscellaneous Services (including surgical implants and approved medical consummables)			
Surgical Benefits (including Radiosurgery ² & day surgery)			
Surgical Benefits for Major Organ Transplant (including cost of procuring organs from cadaveric donor)			
Accident Inpatient Dental Treatment (within 14 days following Accident)			
Daily In-Hospital Doctor's Visit			
Pre-Hospital Specialist's Consultation (within 90 days prior to admission)			
Pre-Hospital Diagnostic & Laboratory Services (within 90 days prior to admission)			
Post-Hospital Follow-up Treatment (within 90 days after discharge)			
Confinement in Community Hospital (Up to 45 days per Policy Year)			
Inpatient Congenital Anomalies (after waiting period of 24 months)			
Inpatient Pregnancy Complications (after waiting period of 10 months)			
Living Donor Organ Transplant (per Lifetime) (after waiting period of 24 months)	\$50,000	\$30,000	\$20,000
Outpatient Catastrophic Treatments			
Outpatient Kidney Dialysis (including Erythropoietin drug as part of the treatment for chronic renal failure)	As charged		
Outpatient Cancer Treatment: Radiotherapy/ Chemotherapy, Immunotherapy			
Major Organ Transplant - Approved Immunosuppressant Drugs (including Cyclosporin and Tacrolimus)			
Final Expenses Benefit³	\$1,000		
Special Benefits			
Extra Inpatient Coverage for Heart Attack, Major Cancer, Stroke, End Stage Lung Disease and End Stage Liver Disease (per Policy Year)	\$150,000	\$100,000	\$50,000
Inpatient Psychiatric Treatment (after 10 months of continuous coverage) (per Policy Year)	As charged up to 60 days	As charged up to 45 days	N.A.
Free Coverage for Child(ren) (under Plan 2 up to 20 years old at age next birthday provided both parents take up either Plan 1 or 2)	Yes	Yes	N.A.
Inpatient Medical Complaint outside Singapore	As charged (pegged to costs of Singapore Private Hospitals)	As charged (pegged to costs of Singapore Restructured Hospitals)	As charged (pegged to costs of B1 ward of Singapore Restructured Hospitals)
Pro-ration Factor			
Private Hospital/ Medical Institutions and Hospitals outside Singapore	N.A.	65% ⁴	50% ⁵
Restructured Hospitals - Class A	N.A.	N.A.	85% ⁵
Unsubsidised wards in Community Hospitals	N.A.	N.A.	85% ⁶
Annual Deductible⁷ for Insured Persons 80 years old and below at age next birthday			
Inpatient			
C Class Ward	\$1,000	\$1,000	\$1,000
B2 Class Ward	\$1,500	\$1,500	\$1,500
B1 Class Ward	\$2,000	\$2,000	\$2,000
A1 Class Ward/Private Hospital and Hospitals outside Singapore	\$3,000	\$3,000	\$3,000
Day Surgery	\$3,000	\$3,000	\$2,000
Co-Insurance (applicable to claimable amount after deductible)	10% Maximum \$25,500 per Policy Year		
Maximum Claim Limits :			
Policy Year Limit	\$500,000	\$300,000	\$150,000
Lifetime Limit	Unlimited	Unlimited	Unlimited
Age Limits (Age Next Birthday)			
Last Entry Age	75 years old	75 years old	75 years old
Maximum Coverage Age	Lifetime	Lifetime	Lifetime
<p>¹ For Singapore Citizens only.</p> <p>² Radiosurgery includes Gamma Knife & Novalis Treatment which can be performed as an Inpatient or day surgery procedure. The applicable Annual Deductible and Pro-ration Factor for Radiosurgery will depend on its classification as an Inpatient or day surgery procedure.</p> <p>³ Final Expenses Benefit is a waiver of Annual Deductible and Co-Insurance amounts, up to the limit stated, upon death occurring during hospitalisation or within 30 days of discharge of the hospitalisation and provided death occurs as a result of the cause of the hospitalisation.</p> <p>⁴ Pro-ration Factor is applied to reduce overseas/ higher class wards/ private hospital bills to Singapore Restructured Hospital equivalent in the claims computation of Plan 2. This is not applicable to Outpatient Catastrophic Treatments.</p> <p>⁵ Pro-ration Factor is applied to reduce overseas/ higher class wards/ private hospital bills to B1 Restructured Hospital equivalent in the claims computation of Plan 3. This is not applicable to Outpatient Catastrophic Treatments and day surgery carried out in a Singapore Restructured Hospital.</p> <p>⁶ Pro-ration Factor is applied to reduce the unsubsidised hospital charges to equivalent subsidised charges in a Community Hospital.</p> <p>⁷ Annual deductible will be increased by 50% for any Insured Person above 80 years old at age next birthday.</p>			