

This policy document covers the terms and conditions of the following plan.

Part One: **PRUShield Premier** and **PRUShield Plus** plans

Part Two: **PRUShield Standard Plan**

You may wish to refer to your policy certificate for the plan that you have bought.

PART ONE

PRUSHIELD PREMIER PRUSHIELD PLUS

	Contents	Page
1.1	Our agreement	2
1.2	What type of benefit?	3
1.3	Payment of premiums	5
1.4	What type of plan?	6
1.5	Can I change my plan?	23
1.6	How to make a claim?	23
1.7	Who do we pay?	25
1.8	What is not covered?	25
1.9	General conditions	27
1.10	Definitions	30
1.11	Illustration of benefits	36
Part Two	PRUShield Standard Plan	37

Your policy is only complete if you have this policy document and a policy certificate

1.1 Our agreement

1.1.1 This policy document and the following documents, will form the entire agreement between you and us and replaces all previous agreements.

- your policy certificate,
- your proposal form (and your supplementary proposal form, if any),
- your PRUPlanner or financial needs analysis,
- the questionnaires relating to your lifestyle, occupational and medical condition that you had submitted to us for our underwriting purposes (if any),
- our offer of conditional acceptance (if any), and
- all written correspondence between yourself and us relating to your policy (if any).

Your policy is a legal contract between you* and us. We* agree to give you the benefits set out in your policy certificate as explained in this policy document for the premium paid by you.

In case of any dispute, the policy document and other documents forming your agreement with us, will apply. These documents can be found in our secure online portal on our website. This portal allows you to access important information about your policy and carry out certain policy transactions.

The information you gave us in the proposal form, supplementary proposal form and any correspondence for this policy was relied on by us in deciding whether or not to insure you.

Your policy may be void if any information you give us is incomplete or inaccurate or you do not comply with the conditions of your policy.

Your policy is only for the cover and the period shown on your policy certificate. It is also subject to the terms and conditions contained in this policy document (as may be changed or updated from time to time).

We give you a new policy certificate when there are changes to your benefits. It becomes your current policy certificate.

A person who is not a party to this policy has no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of the terms and conditions of this policy.

The life assured is also insured under MediShield Life operated by the Central Provident Fund (**CPF**) Board which is governed by the Central Provident Fund Act 1953 and MediShield Life Scheme Act 2015 (**Act**) and the respective subsidiary legislation made thereunder (**Regulations**), provided the life assured meets the eligibility conditions as specified in the Act and Regulations. The life assured, if insured under MediShield Life, shall enjoy all benefits of MediShield Life as provided under the Act and Regulations.

***you** – means the policyowner shown on your policy certificate

***we** – means Prudential Assurance Company Singapore (Pte) Limited

1.1.2 Review period

We give you a period of 21 days from the date of receipt of this policy document, to review your policy.

If you decide this policy is not suitable for your needs, simply write to us within the 21-day review period. We will refund any premium you have paid (without interest), less medical fees, other expenses we have had to pay and any amounts you owe us in connection with the policy.

If we make your policy document and all other documents from us available via our secure online portal, we consider them delivered and received when we send the relevant SMS or email informing you that the documents are accessible on the secure online portal.

Otherwise, your policy and all other documents from us are considered delivered and received in the ordinary course of the post, 7 days from the date of posting to the last known address notified to us.

This review period will not apply if you have done a change of plan (refer to clause 1.5).

1.2 What type of benefit?

PRUShield is the enhancement plan that is offered on top of the MediShield Life tier operated by the CPF Board. It provides additional benefits to meet the needs of Singaporeans and Singapore Permanent Residents who would like more coverage and insurance protection against hospitalisation in B2 or C wards and above of restructured hospitals or private hospitals.

We will pay the claims according to the benefits under this enhancement plan or MediShield Life, whichever is higher.

Benefits under this policy are only payable when the life assured suffers from an injury or illness, which is covered under this policy and the life assured is hospitalised as an inpatient, or undergoes day surgery or selected outpatient treatment, as defined in this policy.

We do not pay under the following benefits if the medical expenses are incurred at non-MediShield Life accredited hospitals or treatment centres:

- Inpatient and Day Surgery benefits (refer to clause 1.4.3)
- Outpatient Hospital benefits (refer to clause 1.4.5)

If the life assured is a foreigner who is not a Singapore Permanent Resident, then your PRUShield plan does not cover the MediShield Life tier operated by the CPF Board. We will pay the claims according to the benefits under this PRUShield plan.

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

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the General Insurance Association (GIA) /Life Insurance Association (LIA) or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

1.2.1 Basic benefits offered

We provide you with 4 basic benefits that pay for medically necessary treatment and reimburses reasonable and customary expenses incurred. They are:

1) **Inpatient and Day Surgery benefits** – comprising 4 sub-benefits:

a) **Daily Ward and Treatment Charges:**

- i) **Normal Ward** – pays for ward and treatment charges for hospital confinement and eligible Mobile Inpatient Care @ Home (MIC@Home) stays, as set out in the Benefits Schedule.
- ii) **Intensive Care Unit Ward** – pays the Intensive Care Unit (ICU) charges, as set out in the Benefits Schedule.
- iii) **Miscellaneous Hospital Services** – pays for medically necessary services or materials supplied by the hospital to the life assured while hospitalised.
- iv) **Daily Inpatient Physician Visit** – pays for charges incurred when a Physician who is a registered medical practitioner attends and treats the life assured while hospitalised.
- v) **Community Hospital** – pays for ward and treatment charges when hospitalised in a community hospital.
- vi) **Accidental Inpatient Dental Treatment** – pays for dental procedures on the life assured's natural teeth lost or damaged through an accident.
- vii) **Inpatient Palliative Care Service (General)** – pays for medical expenses incurred for general inpatient palliative care services.
- viii) **Inpatient Palliative Care Service (Specialised)** – pays for medical expenses incurred for specialised inpatient palliative care services.

b) **Surgical benefit:**

- i) **Surgical Procedure** – pays all medically necessary surgical procedures, as set out in the Benefits Schedule.
- ii) **Organ Transplant** – pays when the life assured is hospitalised for a surgical transplant of the following organs due to a covered disability: kidney(s), heart, liver, cornea(s), bone marrow, skin and musculoskeletal tissue.

- iii) **Stem Cell Transplant Treatment** – pays medical expenses incurred for a life assured to undergo stem cell transplant treatment due to Leukaemia, Lymphoid Malignancies and Haematological Disorders.
 - iv) **Implants** – pays, as set out in the Benefits Schedule, for medically necessary implant(s) inserted into the body of the life assured during surgery and remains in the body of the life assured on completion of the surgery.
 - v) **Radiosurgery** – pays expenses incurred when the life assured undergoes Radiosurgery. Radiosurgery can be performed as an Inpatient or day surgery procedure.
- c) **Living Organ Donor Transplant benefit:**
- i) **When the life assured is the organ donor** – we pay the hospitalisation expenses, as set out in the Benefits Schedule, incurred in a Singapore hospital, when the life assured donates specific organs.
 - ii) **When the life assured is the organ recipient** – we pay the hospitalisation expenses, as set out in the Benefits Schedule, incurred by the organ donor, provided the donor does not have any insurance coverage for such expenses or receive any reimbursement for expenses incurred, from another source.
- d) **Overseas Medical Treatment benefit:**
- i) **Emergency Medical Treatment outside Singapore** – pays the hospitalisation expenses as a result of emergency medical treatment while overseas.
 - ii) **Planned Overseas Medical Treatment** – pays the hospitalisation and day surgery expenses incurred in selected hospitals overseas.
- 2) **Pre- and Post-hospitalisation benefits:**
- a) **Pre-hospitalisation Consultation and Services** – pays pre-hospitalisation expenses incurred for general practitioner consultation (including outpatient telemedicine consultation) resulting in a referral to a specialist, specialist consultation fees and outpatient telemedicine consultation fees, including the cost of medications and diagnostic and laboratory tests service fees, incurred within 180 days before the life assured's hospital confinement (including Psychiatric Treatment), confinement in a community hospital, short stay ward, day surgery or Mobile Inpatient Care @ Home (**MIC@Home**) for treatment of the same injury or illness.
 - b) **Post-hospitalisation Follow-up Treatment and Services** – pays post-hospitalisation treatment for dressings, consultations (including outpatient telemedicine consultation), physiotherapy performed at a hospital or specialist clinic and diagnostic and laboratory tests services and medicines consumed within 365 days after the discharge from hospital (including Psychiatric Treatment), community hospital, short stay ward, day surgery or Mobile Inpatient Care @ Home (**MIC@Home**) for the same injury or illness.

The above benefits under point 1) and 2) are subject to the deductible, co-insurance and pro-ration as set out in the Benefits Schedule.

- 3) **Outpatient Hospital benefits** – comprising 4 sub-benefits:
- a) **Outpatient Cancer Treatment** – reimburses, as set out in the Benefits Schedule, the reasonable and customary expenses incurred for approved outpatient cancer treatment at MediSave/MediShield Life accredited cancer treatment centres.
 - b) **Outpatient Kidney Failure Treatment** – reimburses, as set out in the Benefits Schedule, the reasonable and customary expenses incurred for approved outpatient kidney dialysis treatment at MediSave/MediShield Life accredited dialysis treatment centres and the cost of the medically necessary prescribed erythropoietin for chronic kidney failure.
 - c) **Immunosuppressants for Organ Transplant** – reimburses, as set out in the Benefits Schedule, the cost of the medically necessary prescribed Immunosuppressants. **Long-Term Parenteral Nutrition** - reimburses, as set out in the Benefits Schedule, the cost of Parenteral nutrition bags and consumables necessary for administering Long-Term Parenteral Nutrition that meets the MediShield Life criteria.

The above benefits under point 3) are subject to co-insurance and pro-ration as set out in the Benefits Schedule.

- 4) **Other benefits**
- a) **Final Expense Provision benefit** – waives the deductible and co-insurance amounts up to the Final Expense limits as set out in the Benefits Schedule if the life assured dies during hospitalisation or within 30 days of discharge from the hospital as a result of the cause of the hospitalisation.
 - b) **Serious Pregnancy and Delivery-related Complications** – reimburses the medical expenses incurred when any one of the listed conditions (refer to clause 1.4.6.2) is first diagnosed by an obstetrician after 10 months from the cover start date of the policy or the date of reinstatement (if any), whichever is later.
 - c) **Congenital Abnormalities** for:
 - i) **a life assured** – pays for hospitalisation expenses incurred for medically necessary treatment relating to birth defects, including hereditary conditions and congenital sickness or abnormalities of the life assured, up to the limit as set out in the Benefits Schedule.
 - ii) **a female life assured's biological child** – pays for hospitalisation expenses incurred for medically necessary treatment relating to birth defects, including hereditary conditions and congenital sickness or abnormalities of a female life assured's biological child during the first 24 months from the birth of the child up to the limit as set out in the Benefits Schedule.
 - d) **Psychiatric** – pays the medical expenses incurred, up to the limit as set out in the Benefits Schedule, if the life assured receives inpatient psychiatric treatments. Also includes pre- and post-hospitalisation expenses incurred for Psychiatric Treatment
 - e) **Short Stay Ward** – pays for charges incurred in the short stay ward even if it does not result in the hospitalisation of the life assured. Also includes pre- and post-hospitalisation expenses incurred in the short stay ward.
 - f) **Future Insurance Option at life events** – allows the life assured to buy another policy at certain life events.
 - g) **Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma** – reimburses the medical expenses incurred, up to the limit as set out in the Benefits Schedule, if the life assured undergoes Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma.
 - h) **Inpatient and Outpatient Proton Beam Therapy** – reimburses the medical expenses incurred, up to the limit as set out in the Benefits Schedule, if the life assured undergoes Proton Beam Therapy treatment as an inpatient, outpatient or day surgery procedure
 - i) **Cell Tissue and Gene Therapy Treatment** – reimburses the medical expenses incurred, up to the limit as set out in the Benefits Schedule, if the life assured undergoes inpatient hospital treatment (including day surgery) for Cell Tissue and Gene Therapy Treatment that is on MOH's Cell, Tissue and Gene Therapy Product List.
 - j) **High-Cost Drugs (non-cancer)** - reimburses the medical expenses incurred, up to the limit as set out in the Benefits Schedule, if the life assured undergoes inpatient hospital treatment (including day surgery) for High-Cost Drugs (non-cancer) listed on MediShield Life's benefit schedule.
 - k) **Refresh benefit** – resets the benefit limit for inpatient hospitalisation expenses as set out in the Benefits Schedule if the life assured has exceeded the policy year limit and is subsequently hospitalised for a different medical condition.

For a detailed explanation of the above benefits, please refer to clause 1.4 of this policy document.

1.3 Payment of premiums

1.3.1 Your obligations

Your policy certificate shows the date your first premium is due and the premium amount. Your premium for each subsequent policy year is due on each anniversary of the cover start date (**Premium**

Due Date). You must pay your premium within 90 days from each premium due date (**the Grace Period**). We will send you a notice when your premium is due.

If you fail to pay your premium within the grace period, your policy automatically ends. In this instance, as long as your premiums are not paid, claims submitted for an illness or injury incurred within the grace period will not be considered.

1.3.2 Premium payment from MediSave

If you pay your premium with funds from a MediSave account, we will deduct premiums annually from this MediSave account up to a maximum withdrawal limit per life assured per policy year as stipulated by the CPF Board. If the premium due is more than the maximum withdrawal limit or there are insufficient funds in the MediSave account to pay the premium due, the balance premium due can be paid by cash within the grace period.

1.3.3 Premium payment by other payment methods

If you pay your premiums by credit card or GIRO, we will send you a notice when your premium is due. You must ensure that your premiums are paid on time even if you do not receive the notice.

If you are a foreigner with an eligible valid pass, you must pay your premiums via credit card or GIRO. We will renew your policy only if your premiums are paid by either of these methods.

1.3.4 Renewal premium rate

On the premium due date for each policy year, the required renewal premium rate for the life assured will be determined based on:

- the type of plan of your policy; and
- the age next birthday of the life assured.

1.4 What type of plan?

1.4.1 Types of plan offered

The table below (**Benefits Schedule**) shows the maximum benefits offered for the various plans.

Benefits Schedule (please refer to clauses 1.4.3 to 1.4.6 for the details of these benefits)

	PRUShield Premier	PRUShield Plus
	Singapore Private Hospital	Singapore Restructured Hospital (Class A Ward)
<p><u>Inpatient and Day Surgery Benefits</u> Daily Ward and Treatment Charges: Normal Ward (including eligible MIC@Home stays) Intensive Care Unit Ward Miscellaneous Hospital Services Daily Inpatient Physician Visit Community Hospital (Rehabilitative) Community Hospital (Sub-acute) Accidental Inpatient Dental Treatment Inpatient Palliative Care Service (General) Inpatient Palliative Care Service (Specialised)</p>	As charged	As charged
<p>Surgical benefits: (including Day Surgery) Surgical Procedure Organ Transplant Stem Cell Transplant Treatment</p>	As charged	As charged

	PRUShield Premier	PRUShield Plus
	Singapore Private Hospital	Singapore Restructured Hospital (Class A Ward)
Implants Radiosurgery	As charged	As charged
Living Organ Donor Transplant Benefit Life assured is the organ donor Life assured is the organ recipient	\$60,000 per policy year	\$40,000 per policy year
Overseas Medical Treatment Emergency Medical Treatment outside Singapore Planned Overseas Medical Treatment	As charged (paying the lower of: - the overseas charges; or - in accordance with a Singapore Private Hospital's charges)	As charged (paying the lower of: - the overseas charges; or - in accordance with a Singapore Restructured Hospital's charges)
<u>Pre- & Post-Hospitalisation benefit:</u> Pre-hospitalisation Consultation and Diagnostic Laboratory Services - incurred within 180 days before confinement or day surgery	As charged	As charged
Post-hospitalisation Follow-up Treatment and Diagnostic / Laboratory Services - incurred within 365 days after confinement or day surgery	As charged	As charged
<u>Outpatient Hospital benefits:</u> Outpatient Cancer Treatment - Radiotherapy for Cancer - External (except Hemi-Body) - Brachytherapy - Hemi-Body - Stereotactic - Chemotherapy and Immunotherapy <i>Patients receiving treatment for one primary cancer</i> - Cancer Drug Treatment on MOH's Cancer Drug List - Cancer Drug Services <i>Patients receiving treatment for Multiple Primary Cancers</i> - Cancer Drug Treatment on MOH's Cancer Drug List	As charged 5 x (MediShield Life limit for one primary cancer per month) 5 x (MediShield Life limit for one primary cancer per policy year) Sum of the highest cancer drug treatment limit among the claimable treatments received for each primary cancer per month	As charged 5 x (MediShield Life limit for one primary cancer per month) 5 x (MediShield Life limit for one primary cancer per policy year) Sum of the highest cancer drug treatment limit among the claimable treatments received for each primary cancer per month

	PRUShield Premier	PRUShield Plus
	Singapore Private Hospital	Singapore Restructured Hospital (Class A Ward)
- Cancer Drug Services	5 x (MediShield Life limit for Multiple Primary Cancers per policy year)	5 x (MediShield Life limit for Multiple Primary Cancers per policy year)
Outpatient Kidney Failure Treatment - Kidney Dialysis - Erythropoietin for Chronic Kidney Failure	As charged	As charged
Immunosuppressants for Organ Transplant	As charged	As charged
Long-Term Parenteral Nutrition	As charged	As charged
<u>Other benefits:</u>		
Final Expense Provision	\$5,000	\$3,000
Serious Pregnancy and Delivery-related Complications	As charged	As charged
Congenital Abnormalities of the life assured	As charged	As charged
Congenital Abnormalities of a female life assured's biological child - First diagnosed or symptoms first appear within 24 months from the date of birth of the child	\$20,000 per lifetime (limited to \$5,000 per child)	\$16,000 per lifetime (limited to \$4,000 per child)
Psychiatric (including pre- and post-hospitalisation expenses incurred)	\$8,000 per policy year	\$7,000 per policy year
Short Stay Ward (including pre- and post-hospitalisation expenses incurred in a short stay ward in a Singapore restructured hospital)	As charged	As charged
Future Insurance Option at life events	\$100,000	\$100,000
Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma	\$25,000 per policy year	\$25,000 per policy year
Inpatient and Outpatient Proton Beam Therapy	\$100,000 per policy year	\$100,000 per policy year
Cell Tissue and Gene Therapy Treatment on MOH's Cell, Tissue and Gene Therapy Product (CTGTP) List		
Kymriah	\$250,000 for one treatment per clinical indication per lifetime, subject to the indication requirements as listed within the MOH CTGTP List	\$250,000 for one treatment per clinical indication per lifetime, subject to the indication requirements as listed within the MOH CTGTP List
Yescarta	\$250,000 for one treatment per clinical indication per lifetime, subject to the indication requirements as listed within the MOH CTGTP List	\$250,000 for one treatment per clinical indication per lifetime, subject to the indication requirements as listed within the MOH CTGTP List

	PRUShield Premier	PRUShield Plus
	Singapore Private Hospital	Singapore Restructured Hospital (Class A Ward)
High-Cost Drugs (non-cancer) listed on MediShield Life's benefit schedule		
- Drug treatment and Prophylaxis for Haemophilia A	\$2,800 per month	\$2,800 per month
- Drug treatment and Prophylaxis for Haemophilia B	\$9,600 per month	\$9,600 per month
- Drug Treatment for Immune Thrombocytopenia and Refractory Severe Aplastic Anaemia	\$3,600 per month	\$3,600 per month
- Drug Treatment of Thalassaemia	\$1,600 per month	\$1,600 per month
- Drug Treatment of Children with Short Stature due to Conditions Associated with Growth Failure	\$1,600 per month	\$1,600 per month
- Drug Treatment for Spinal Muscular Atrophy	\$14,800 per month	\$14,800 per month
- Drug Treatment for Fabry Disease	\$8,800 per month	\$8,800 per month
- Drug Treatment for X-Linked Hypophosphataemia	\$13,600 per month	\$13,600 per month
<u>Outpatient and Home Based Treatment benefit:</u>		
Home Ventilation and Respiratory Support Service	\$1,680 per month	\$1,680 per month
- Paediatric Home Care	\$840 per month	\$840 per month
- Negative Pressure Wound Therapy	\$240 per day	\$240 per day
- Repetitive Transcranial Magnetic Stimulation	\$240 per treatment session	\$240 per treatment session
- Pasteurised Donated Human Milk	\$170 per day	\$170 per day
- Hyperbaric Oxygen Therapy	\$1,560 per treatment session	\$1,560 per treatment session
- Outpatient Parenteral Antibiotic Therapy	\$180 per day	\$180 per day
<u>Deductible per policy year:</u> ¹		
Restructured C Ward	\$1,500	\$1,500
Restructured B2 Ward	\$2,000	\$2,000
Restructured B1 Ward	\$2,500	\$2,500
Restructured A Ward	\$3,500	\$3,500
Private Hospital	\$3,500	\$3,500
Day Surgery – Subsidised	\$1,500	\$1,500
Day Surgery – Non-Subsidised	\$2,000	\$2,000
Short Stay Ward – Subsidised	\$1,500	\$1,500
Short Stay Ward – Non-Subsidised	\$2,000	\$2,000
¹ Deductibles will be increased by 50% depending on ward class when life assured is above age 85.		
<u>Co-Insurance</u>	10%	10%

	PRUShield Premier	PRUShield Plus
	Singapore Private Hospital	Singapore Restructured Hospital (Class A Ward)
<p>Pro-Ration: ²</p> <p>Private Hospital Higher-class wards Private clinics or medical institutions</p> <p>² Pro-ration factors are applied to reduce expenses in higher-class wards, private hospitals, private clinics or treatment centres in the claims computation to suit the lower plan's coverage. Overseas Government hospitals are considered private hospitals and pro-ration will apply.</p>	N.A.	65%
<p>Limits of Cover:</p> <p>Policy Year Limit</p> <p>Lifetime Limit</p> <p>Refresh Benefit (resets the policy year limit when it is reached)</p>	<p>\$1,200,000 or \$2,000,000 (if admitted to and treated by our panel providers)</p> <p>Unlimited</p> <p>\$1,200,000</p>	<p>\$1,000,000</p> <p>Unlimited</p> <p>\$1,000,000</p>
<p>Age Limits:</p> <p>Maximum Entry Age</p> <p>Maximum Renewal Age</p>	<p>75</p> <p>Lifetime</p>	<p>75</p> <p>Lifetime</p>

1.4.2 What plan do you have?

Your policy certificate shows the type of plan you have.

1.4.3 Inpatient and Day Surgery benefits

These benefits below are subject to the deductible, co-insurance and pro-ration.

1.4.3.1 What do we pay for Normal Ward?

If the life assured is hospitalised in a standard room of a hospital as a result of injury or illness, we pay the normal ward charges for each day of hospital confinement that are reasonable and customary expenses. This may include meals, inpatient prescriptions, professional charges, investigations, laboratory tests, high dependency ward stay and charges for other medical services.

In addition, we also cover services at home that are the same as hospital inpatient services, cost of medical equipment used and nursing care at home as part of Mobile Inpatient Care @ Home (MIC@Home).

For PRUShield Plus, the normal ward entitlement is any standard room of a Singapore restructured hospital.

If a hospital confinement flows over to the next policy year, the benefits will be processed based on the previous policy year's benefits, limits and deductible when the life assured was first admitted for hospitalisation.

If the life assured changes ward of stay during hospital confinement, the deductible applicable to the claim will be based on the highest ward class the life assured had stayed in.

1.4.3.2 What do we pay for Intensive Care Unit (ICU) Ward?

We pay the ICU ward charges if the life assured is confined in the ICU ward because of injury or illness. Charges may include meals and other medical services.

1.4.3.3 What do we pay for Miscellaneous Hospital Services?

We pay for the services or materials supplied by the hospital to the life assured during his hospitalisation, provided they are medically necessary and deemed to be reasonable and customary expenses.

The services and materials include inpatient drugs, dressing or medicines prescribed for treatment, diagnostic and investigative procedures, laboratory tests and other miscellaneous medical charges during the life assured's hospitalisation.

1.4.3.4 What do we pay for Daily Inpatient Physician Visit?

We pay for the professional charges and consultation fees when a Physician who is a registered medical practitioner attends to and treats the life assured during his hospitalisation.

1.4.3.5 What do we pay for Community Hospital?

Upon discharge from the hospital or upon a referral from a Singapore restructured hospital's emergency department, if the life assured is immediately hospitalised in a standard room of a community hospital to continue treatment for Rehabilitative care or for Sub-acute care, we pay the actual normal ward charges including meals, inpatient prescriptions, professional charges, investigations, laboratory tests, charges for high dependency wards and other medical services.

Hospice, convalescent centres/hospitals/homes and transitional care facilities are not covered.

1.4.3.6 What do we pay for Accidental Inpatient Dental Treatment?

We pay for dental procedures performed by a duly qualified dental surgeon during hospital confinement to remove, replace or restore natural teeth lost or damaged because of an accident.

We pay if the treatment is within one year from the date of accident.

1.4.3.7 What do we pay for Inpatient Hospice Palliative Care Service?

We pay for reasonable and customary expenses incurred for inpatient palliative care services in a Hospice if the life assured is suffering from a terminal illness. This inpatient stay in a hospice must be referred by a registered medical practitioner or specialist and must be for a continuous period of at least six hours.

1.4.3.7.1 What do we pay for Inpatient Palliative Care Service (General)?

We pay for the medical expenses incurred if the life assured receives General Inpatient Palliative Care, up to the limits as set out in the Benefits Schedule.

The life assured must be admitted for General Inpatient Palliative Care by a registered medical practitioner, according to the relevant guidelines from MOH.

1.4.3.7.2 What do we pay for Inpatient Palliative Care Service (Specialised)?

We pay for the medical expenses incurred if the life assured receives Specialised Inpatient Palliative Care, up to the limits as set out in the Benefits Schedule.

The life assured must be admitted for Specialised Inpatient Palliative Care by a registered medical practitioner, according to the relevant guidelines from MOH.

1.4.3.8 What do we pay for Surgical Procedure?

We pay if the life assured undergoes a medically necessary surgical procedure during his hospital confinement. Charges may include operating theatre and anaesthesia fees.

If the life assured undergoes day surgery where normal ward charges may not be applicable, we will still pay the Surgical Procedure benefit.

1.4.3.8.1 What do we pay for Organ Transplant?

We pay if the life assured is hospitalised for an injury or illness and undergoes a surgical transplant of the following organs – kidney(s), heart, liver, 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 but only if the transplantation is medically necessary.

However, we will not pay:

- for the expense of acquiring the organ from a living donor; or
- if the transplantation is illegal or arises from any illegal transaction or practice.

This benefit does not cover organ transplant surgery if the life assured is the donor of the organ.

1.4.3.8.2 What do we pay for Stem Cell Transplant Treatment?

We pay for the medical expenses incurred if the life assured undergoes stem cell transplant treatment because of Leukaemia, Lymphoid Malignancies and Haematological Disorders.

We do not pay for the expenses in relation to stem cell transplant treatment, incurred by or is connected to a donor who is not the life assured. Expenses include all costs that are directly or indirectly a result of the stem cell transplant and may include donor searches, harvesting and laboratory tests, investigations, storage, transportation and cell culture.

Outpatient therapy such as injection or extraction where there is no surgery or hospitalisation involved for the life assured and/or donor who is not the life assured will not be covered under this expense item.

We do not pay for Inpatient and Outpatient Proton Beam Therapy and Cell Tissue & Gene Therapy Treatment under this benefit.

1.4.3.8.3 What do we pay for Implants?

We pay if the life assured undergoes surgery and an implant is inserted into the body of the life assured and remains in the body on completion of the surgery.

We pay for approved medical consumables which may include intravascular electrodes used for electrophysiological procedures, Percutaneous Transluminal Coronary Angioplasty (**PTCA**) and intra-aortic balloons (or balloon catheters).

The implants and approved medical consumables must be medically necessary and deemed to be reasonable and customary expenses.

1.4.3.8.4 What do we pay for Radiosurgery?

We pay for the expenses incurred when the life assured undergoes Radiosurgery. Radiosurgery can be performed as an inpatient or day surgery procedure.

The applicable deductible and pro-ration factor for Radiosurgery procedure will depend on its classification as an inpatient or day surgery procedure.

We do not pay for Inpatient and Outpatient Proton Beam Therapy and Cell Tissue & Gene Therapy Treatment under this benefit.

1.4.3.9 What do we pay for the Living Organ Donor Transplant benefit?

The benefits below are subject to the deductible, co-insurance limits and pro-ration.

1.4.3.9.1 When the life assured is the organ donor

We pay for the hospitalisation expenses, as set out in the Benefits Schedule, if the life assured donates his organ(s) – kidney and/or liver, provided the transplantation is carried out in a hospital in Singapore.

The recipient must have been first diagnosed by a registered medical practitioner, or the symptoms of the organ failure must have first appeared after 24 months from the:

- cover start date of this policy; or
- date of reinstatement (if any),

whichever is later.

We will pay for the following:

- charges for any pre-hospitalisation expenses as covered under clause 1.4.4, provided the claim on the Living Organ Donor Transplant benefit is payable. We pay specialist consultations, medications, diagnostic and laboratory tests, pre-harvesting laboratory tests and investigations;
- charges for the life assured's hospital confinement in a standard room or Intensive Care Unit (ICU);
- charges for the surgical procedure to remove the specified organ from the life assured's body;
- charges for the storage and transportation of the specified organ after the organ is removed from the life assured's body; and
- charges for any post-hospitalisation expenses, as covered under clause 1.4.4, including any post-transplant complications that may arise following the organ transplantation surgery of the life assured, provided the claim on the Living Organ Donor Transplant benefit is payable.

We will not pay for charges incurred for any counselling service done.

Payment for all eligible expenses incurred under the Living Organ Donor Transplant benefit shall be accumulated and paid up to the respective limit as set out in the Benefits Schedule.

1.4.3.9.2 When the life assured is the organ recipient

If the life assured undergoes a transplant of the following organs – kidney and/or liver, we pay the hospitalisation expenses, as set out in the Benefits Schedule, incurred by the organ donor, provided the donor does not have any insurance coverage for such expenses or receive any reimbursement for expenses incurred, from another source.

The organ transplant must be carried out in a hospital in Singapore.

The life assured's organ failure must have been first diagnosed by a registered medical practitioner, or the symptoms of the organ failure must have first appeared after 24 months from the:

- cover start date of the policy; or
- date of reinstatement (if any),

whichever is later.

We will assess this benefit together with the life assured's inpatient hospitalisation claims. This benefit is payable only if the inpatient hospitalisation claim for the same illness or injury is payable.

We will pay for the following:

- charges for the organ donor's hospital confinement in a standard room or Intensive Care Unit (ICU);
- charges for the surgical procedure to remove the specified organ from the organ donor's body; and
- charges for the storage and transportation of the specified organ after the organ is removed from the organ donor's body.

We will not pay for any pre- or post-hospitalisation and any counselling service expenses incurred by the organ donor.

Payment for all eligible expenses incurred under the Living Organ Donor Transplant benefit shall be accumulated and paid up to the respective limit as set out in the Benefits Schedule.

1.4.3.10 What do we pay for the Overseas Medical Treatment benefit?

The benefits below are subject to the deductible, co-insurance and pro-ration.

All claims for Planned Overseas Medical Treatment or Emergency Medical Treatment done outside of Singapore are not considered as claims under our panel providers.

1.4.3.10.1 Emergency Medical Treatment outside Singapore

We pay for the hospitalisation expenses at a registered hospital, incurred by the life assured as a result of emergency medical treatment while overseas.

Emergency Medical Treatment means urgent remedial treatment to avoid death, or serious impairment to the life assured's health as a result of a Serious Illness or the onset of a serious condition.

The Pre- and Post-hospitalisation benefit, incurred in Singapore or overseas, covered under clause 1.4.4 is payable only if the overseas hospitalisation claim for Emergency Medical Treatment is payable.

We do not pay for the following:

- Day surgery;
- Outpatient Hospital benefits;
- Stem Cell Transplant treatment;
- Organ Transplant;
- Living Organ Donor Transplant;
- Psychiatric Treatment;
- Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma;
- Inpatient and Outpatient Proton Beam Therapy; and
- Cell Tissue and Gene Therapy Treatment;

We will reimburse the lower of the actual medically necessary expenses incurred, or such amount that would be deemed reasonable and customary expenses charged by a hospital in Singapore for the same treatment.

We will convert bills for hospital confinement denominated in a foreign currency to our Singapore currency at our banker's exchange rate as at the date of such bills.

This clause 1.4.3.10.1 is subject to the exclusions stated in clause 1.8.

1.4.3.10.2 Planned Overseas Medical Treatment

We pay for the hospitalisation or surgical (including day surgery) expenses at a registered hospital, incurred by the life assured for a planned medical treatment overseas in a standard room that is deemed to be reasonable and customary expenses.

The life assured must obtain referrals for each hospitalisation or surgical procedure (including day surgery) from a MediSave-accredited institution/referral centre in Singapore for approved overseas hospitalisation as covered by MediSave. The list of MediSave-accredited institutions/referral centres can be found on our website <www.prudential.com.sg> and the overseas hospitals must have an approved working arrangement with the MediSave-accredited institution / referral centre in Singapore. To confirm the countries and respective hospitals where treatment would be allowed, please contact an approved MediSave-accredited institution/referral centre in Singapore.

We reserve the right to review and change the approved institution/referral centre as required, from time to time.

The pre- and post-hospitalisation expenses incurred in Singapore that are covered under clause 1.4.4 is payable only if the overseas hospitalisation or day surgery claim for Planned Overseas Medical Treatment is payable.

We do not pay for the following:

- Outpatient Hospital benefits;
- Living Organ Donor Transplant;
- Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma;
- Inpatient and Outpatient Proton Beam Therapy;
- Cell Tissue and Gene Therapy Treatment;
- Serious Pregnancy and Delivery-related Complications; and
- Stem Cell Transplant Treatment except for Stem Cell Transplant Treatment in relation to Leukaemia, Lymphoid Malignancies and Haematological Disorders.

We will reimburse the lower of the actual medically necessary expenses incurred, or such amount that would be deemed reasonable and customary expenses charged by a hospital in Singapore for the same treatment.

We will convert bills for hospital confinement or day surgery, denominated in a foreign currency to our Singapore currency at our banker's exchange rate as at the date of such bills.

1.4.4 Pre and Post-Hospitalisation Benefits

These benefits below are subject to the deductible, co-insurance and pro-ration.

We will assess these benefits together with the related inpatient hospitalisation or day surgery claim submitted. These benefits are payable only if the inpatient hospitalisation or day surgery claim for the same injury or illness is payable.

1.4.4.1 What do we pay for Pre-hospitalisation Consultation and Diagnostic and Laboratory Services?

We pay pre-hospitalisation expenses:

- incurred for general practitioner consultation (including outpatient telemedicine consultation*) resulting in a referral to a specialist, specialist consultation fees and outpatient telemedicine consultation fees*, including the cost of medications and diagnostic and laboratory tests service fees; and
- incurred within 180 days before the life assured's hospital confinement (including Psychiatric Treatment), confinement in a community hospital, short stay ward*, day surgery or MIC@Home for treatment of the same injury or illness that resulted in the hospitalisation or day surgery.

If there is more than one referral from one or more general practitioners, we will only pay one medical bill and this would be the last one before the hospital confinement (including Psychiatric Treatment), confinement in a community hospital, short stay ward*, day surgery or MIC@Home for treatment of the same injury or illness.

We do not pay pre-hospitalisation expenses incurred prior to the diagnosis of Serious Pregnancy and Delivery-related Complications.

*We will only reimburse outpatient telemedicine consultation fees conducted by telemedicine consultation providers (i) that are approved as active MOH sandbox providers under the MOH Licensing Experimentation and Adaptation Programme or (ii) from Singapore restructured hospitals. We will not pay for the cost of delivery or courier of medication.

*We pay for pre-hospitalisation expenses incurred only if the short stay ward is under a Singapore restructured hospital and the stay is a continuous period of at least 6 hours.

1.4.4.2 What do we pay for Post-hospitalisation Follow-up Treatment and Services?

We pay for the post-hospitalisation expenses:

- incurred for dressing, consultations (including outpatient telemedicine consultation*), physiotherapy performed at a hospital or specialist clinic by an Allied Health Professional registered under MOH, diagnostic and laboratory test services and medications consumed; and
- incurred within 365 days after the life assured's hospital confinement (including Psychiatric Treatment), confinement in a community hospital, short stay ward*, day surgery or MIC@Home for treatment of the same injury or illness that resulted in the hospitalisation or day surgery.

All alternative and traditional treatments are excluded. Examples of alternative and traditional treatments are, but not limited to, Traditional Chinese Medicine treatment, Chiropractic treatment and Osteopathic treatment.

*We will only reimburse outpatient telemedicine consultation fees conducted by telemedicine consultation providers (i) that are approved as active MOH sandbox providers under the MOH Licensing Experimentation and Adaptation Programme or (ii) from Singapore restructured hospitals. We will not pay for the cost of delivery or courier of medication.

*We pay for post-hospitalisation expenses incurred only if the short stay ward is under a Singapore restructured hospital and the stay is a continuous period of at least 6 hours.

1.4.5 Outpatient Hospital benefits

These benefits cater to outpatient treatments (which do not require hospital confinement) as specified in the Benefits Schedule.

The deductible is not applicable to this benefit, but it is still subject to co-insurance and pro-ration.

1.4.5.1 What do we pay for Outpatient Cancer Treatment?

We reimburse you for the reasonable and customary expenses incurred for approved outpatient cancer treatment at MediSave/MediShield Life accredited cancer treatment centres up to the maximum limit set out in the Benefits Schedule for your plan. Treatment refers to chemotherapy, immunotherapy and radiotherapy for external (except hemi-body), brachytherapy, hemi-body and stereotactic. We will also pay consultation fees, diagnostic and laboratory tests if it is ordered by the registered medical practitioner before such treatment.

We do not pay for Inpatient and Outpatient Proton Beam Therapy and Cell Tissue & Gene Therapy Treatment under this benefit.

1.4.5.1.1 What do we pay for Cancer Drug Treatment?

We pay for cancer drug treatments that are on the Cancer Drug List (CDL), up to the treatment-specific claim limits. Cancer drug treatments not listed or not administered exactly as described in the CDL, are considered non-CDL and will not be claimable under PRUShield, unless otherwise stated in this policy.

The CDL currently covers most cancer drug treatments approved by the Health Sciences Authority (HSA). The cancer drug treatment claim limit is based on a multiple of the MediShield Life limit for the specific cancer drug treatment. For the latest CDL and MediShield Life limits, refer to the CDL on MOH's website. MOH may update this from time to time. The revised list will be applicable to the Cancer Drug Treatment which occurred on and from the effective date of the revised list.

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

For each primary cancer, where multiple cancer drug treatments are administered in a month, if any of the CDL treatments have an indication that states "monotherapy", only CDL treatments with the indication "for cancer treatment" will be claimable in that month. Otherwise, the following will apply:

- (a) If more than one of the cancer drug treatments administered in a month have an indication other than "for cancer treatment", only CDL treatments with the indication "for cancer treatment" will be claimable in that month.
- (b) If one or none of the cancer drug treatments administered in a month has an indication other than "for cancer treatment", all CDL treatments will be claimable in that month.

To avoid any doubt, for CDL treatments, the indications refer to the clinical indications of the drug as specified in the CDL on MOH's website. Non-CDL treatments will be considered as having an indication other than "for cancer treatment".

For patients receiving treatment for only one primary cancer, we will pay up to the highest limit among the claimable CDL treatments received in that month. Multiple Primary Cancers are two or more cancers arising from different sites and/or are of a different histology or morphology group. A patient with cancer that has spread (metastasised) from the place where it first started to another part of the body will be considered as having a single primary cancer as the cancer in the other part of the body started from the original cancer. For example, cancer cells may spread from the breast (primary cancer) to form new tumours in the lung (secondary cancer / metastatic cancer). The new tumour in the lung will not be considered as another primary cancer.

Higher claim limits for patients receiving treatment for Multiple Primary Cancers are given on an application basis; doctors are to send the application form to MOH and to us for assessment of MediShield Life and PRUShield coverage respectively.

For patients receiving treatment for Multiple Primary Cancers, the maximum claim payable from a PRUShield plan for that month will be up to the sum of the highest claim limits among the claimable CDL treatments received for each primary cancer in that month.

1.4.5.1.2 What do we pay for Cancer Drug Services?

We pay for cancer drug services that are part of a cancer drug treatment (including treatments not on the CDL), such as consultations, scans, laboratory investigations, treatment preparation and administration, supportive care drugs and blood transfusions, up to specified claim limits. Cancer drug

services incurred before the cancer is diagnosed, after the cancer has gone into remission, or once the course of treatment has ceased, will not be covered.

The Cancer Drug Services claim limit is based on a multiple of the MediShield Life limit for Cancer Drug Services. You can find the latest MediShield Life limit for Cancer Drug Services on MOH's website. The Ministry of Health of Singapore may update this from time to time. The revised limit will be applicable to the Cancer Drug Services incurred within the policy year of the revised limit.

This limit does not only apply to services related to cancer drug treatments on the CDL, meaning we will also pay even if the service was for a non-CDL cancer drug treatment. Supportive drugs must be claimed under this limit.

Higher claim limits for patients receiving treatment for Multiple Primary Cancers are given on an application basis; doctors are to send the application form to MOH and to us for assessment of MediShield Life and PRUShield coverage respectively.

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

1.4.5.2 What do we pay for Outpatient Kidney Failure Treatment?

We reimburse you for the reasonable and customary expenses incurred for approved outpatient kidney dialysis treatment at MediSave/MediShield Life accredited dialysis treatment centres and the cost of the medically necessary prescribed erythropoietin for chronic kidney failure.

We will not apply a pro-ratio factor for outpatient kidney dialysis, if the treatment received by the life assured was administered at any of the dialysis centres under the list as shown on our website <www.prudential.com.sg>

1.4.5.3 What do we pay for Immunosuppressants for Organ Transplant?

We reimburse you for the cost of the medically necessary Immunosuppressants prescribed as a result of an organ transplant and as part of the outpatient treatment to reduce the rate of rejection episodes.

The Immunosuppressants refer to those approved under the MediShield Life Scheme and by MOH as the immunosuppressants for organ transplant.

1.4.5.4 What do we pay for Long-Term Parenteral Nutrition?

We reimburse the reasonable and customary expenses incurred for Long-Term Parenteral Nutrition. This includes the cost of parenteral nutrition bags and consumables necessary for administering Long-Term Parenteral Nutrition and that meets the claimable criteria under the MediShield Life Scheme.

1.4.6 Other benefits

1.4.6.1 What do we pay for Final Expense Provision?

If the life assured dies during hospitalisation or within 30 days of discharge from the hospital as a result of the cause of the hospitalisation, we will waive the deductible and co-insurance amounts up to maximum limits of the Final Expense Provision benefit for your type of plan as set out in the Benefits Schedule above.

1.4.6.2 What do we pay for Serious Pregnancy and Delivery-related Complications?

We will reimburse expenses incurred if the life assured is hospitalised as a result of the pregnancy complication conditions listed below. These pregnancy complications must have been first diagnosed after 10 months from the:

- cover start date of the policy; or
- date of reinstatement (if any),

whichever is later.

1) Abruptio Placentae

This is the separation of the normally implanted placenta after the 20th week of gestation and prior to the birth of the foetus, resulting in life threatening foetal distress and/or maternal shock. The diagnoses of Abruptio Placentae must be confirmed by a medical specialist and supported with medical evidence of Class 2 or Class 3 abruptio necessitating an emergency caesarean section.

2) Abscess of breast

The diagnosis, by an obstetrician, of an abscess of breast associated with childbirth.

- 3) **Accreta placenta**
The diagnosis of accreta placenta by an obstetrician of abnormal trophoblast invasion into the myometrium of the uterine wall, requiring caesarean hysterectomy during delivery.
- 4) **Amniotic Fluid Embolism**
This is a condition in which, following the infusion of amniotic fluid into the maternal circulation, there is the sudden development of acute respiratory distress and shock. The diagnosis must be confirmed by a registered medical practitioner and supported with medical evidence of any combination of respiratory distress, cardiovascular collapse, disseminated intravascular coagulation, coma and lung scans showing embolization.
- 5) **Antepartum, intrapartum and postpartum haemorrhage**
The diagnosis, by an obstetrician, of severe abnormal bleeding from the female genital tract at or after 24 weeks of pregnancy or during or after childbirth.
- 6) **Cervical incompetency**
The diagnosis of cervical incompetency by an obstetrician and requires cervical cerclage.
- 7) **Complications resulting in a caesarean hysterectomy**
The diagnosis of complications resulting in a caesarean hysterectomy by an obstetrician where the uterus is removed during a caesarean section delivery in cases where removal of the uterus is solely due to complications that has arisen during the pregnancy or delivery.
- 8) **Disseminated Intravascular Coagulation (DIC)**
The diagnosis of disseminated intravascular coagulation by an obstetrician where DIC is due to the result of pregnancy complications.
- 9) **Ectopic pregnancy**
This is a condition in which implantation of a fertilised ovum occurs outside the uterine cavity. The ectopic pregnancy must have been terminated by laparotomy or laparoscopic surgery.
- 10) **Fatty Liver during Pregnancy**
This is the condition of a severe acute fatty liver occurring during pregnancy and associated with acute liver failure where all of the following diagnostic conditions must be met:
 - bilirubin is persistently elevated above 150 umol/L (10 mg/dL) for a period of at least 5 days; and
 - there is associated hepatic encephalopathy.
- 11) **Fourth degree perineal laceration**
The diagnosis of fourth degree perineal laceration by an obstetrician. To avoid any doubt, perineal laceration less than fourth degree or without identified degree are excluded.
- 12) **Gestational diabetes mellitus**
The diagnosis of gestational diabetes mellitus by an obstetrician. The diagnosis was made through a 75g oral glucose tolerance test.
- 13) **Hydatidiform mole and subsequent complications (including Choriocarcinoma)**
The diagnosis, by an obstetrician, of hydatidiform mole and subsequent complications (including choriocarcinoma)
- 14) **Infection of amniotic sac and membranes**
The diagnosis of an infection of the amniotic sac and membranes by an obstetrician.
- 15) **Maternal death**
The diagnosis of maternal death by an obstetrician.
- 16) **Medically necessary abortions**
The diagnosis of medically necessary abortions by an obstetrician. However, medically necessary abortions due to a miscarriage that does not meet the definition of miscarriage under sub-benefit 17 below will not be covered under this sub-benefit.
- 17) **Miscarriage**
Death of the foetus of the life assured 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.
- 18) **Obstetric cholestasis**
The diagnosis of obstetric cholestasis by an obstetrician.
- 19) **Obstetric injury or damage to pelvic organs**
The diagnosis of obstetric injury or damage to the pelvic organs by an obstetrician where the injury or damage is a consequence of vaginal delivery.
- 20) **Placenta praevia**
The diagnosis, by an obstetrician, of the presence of placental tissue extending over the internal cervical, resulting in a caesarean delivery.
- 21) **Placental insufficiency and Intrauterine growth restriction**
The diagnosis, by an obstetrician, of placental insufficiency leading to intrauterine growth restriction.

22) Postpartum Haemorrhage requiring Hysterectomy

This is the condition of ongoing bleeding secondary to an unresponsive and atonic uterus, a ruptured uterus or a large cervical laceration extending into the uterus requiring surgical intervention in the form of a hysterectomy.

23) Postpartum inversion of uterus

The diagnosis of postpartum inversion of the uterus by an obstetrician where the uterine fundus collapses into the endometrial cavity, turning the uterus partially or completely inside out.

24) Pre-eclampsia and eclampsia

The diagnosis of pre-eclampsia or eclampsia by an obstetrician.

25) Retained placenta and membranes

The diagnosis of retained placenta and membranes by an obstetrician.

26) Still-birth

The diagnosis by an obstetrician, of the death of the foetus of the life assured after 22 weeks of pregnancy which meets the definition of still birth in the Registration of Births and Deaths Act 2021 (or any subsequent revision of the definition by the Act).

27) Twin to twin transfusion syndrome

The diagnosis of twin to twin transfusion syndrome by an obstetrician and supported with ultrasonic evidence of a single monochorionic placenta with twin oligohydramnios / polyhydramnios sequence.

28) Uterine rupture

The diagnosis of uterine rupture by an obstetrician where there is complete disruption of all uterine layers, including the serosa and surgery is performed to correct the abnormality.

We will pay for the conditions listed above, only if they are diagnosed by a registered medical practitioner or obstetrician.

This benefit is subject to the deductible, co-insurance and pro-ration.

We do not pay for

- delivery charges, except in the event of a caesarean section arising from one of the Serious Pregnancy and Delivery-related Complications listed above; and
- assisted conception pregnancy and/or its procedures/complications, including the listed Serious Pregnancy and Delivery-related Complications.

1.4.6.3 What do we pay for Congenital Abnormalities benefit?

For a life assured with congenital abnormalities, we pay for hospitalisation expenses incurred, up to the limit as set out in the Benefits Schedule, for medically necessary treatment relating to birth defects, including hereditary conditions and congenital sickness or abnormalities of the life assured. We will also pay for any pre- or post-hospitalisation expenses incurred in relation to the Congenital Abnormalities benefit.

To avoid any doubt, under this benefit, we do not pay expenses incurred for Cell Tissue and Gene Therapy Treatment relating to congenital abnormalities of the life assured.

These conditions must be first diagnosed by a registered medical practitioner.

This benefit is subject to the deductible, co-insurance and pro-ration.

For a female life assured's biological child

For a female life assured's biological child with congenital abnormalities, we pay for hospitalisation expenses incurred, up to the limit as set out in the Benefits Schedule, for medically necessary treatment relating to birth defects, including hereditary conditions and congenital sickness or abnormalities of the female life assured's biological child during the first 24 months from the date of birth of the child. We will also pay for any pre- or post-hospitalisation expenses incurred in relation to the Congenital Abnormalities benefit.

These conditions must be first diagnosed by a registered medical practitioner or symptoms first appear after 10 months from the cover start date or date of reinstatement (if any).

This benefit only applies to a life assured who is female.

We pay the hospitalisation expenses, as set out in the Benefits Schedule, provided the female life assured's biological child does not have any insurance coverage for such expenses or receive any reimbursement for expenses incurred, from another source.

This benefit is subject to the deductible, co-insurance and pro-ration.

1.4.6.4 What do we pay for Psychiatric Treatment?

We pay for the medical expenses incurred, up to the limit as set out in the Benefits Schedule, if the life assured receives inpatient psychiatric treatments.

Payment for all eligible expenses incurred under the Psychiatric Treatment, including short stay ward, shall be accumulated and paid up to the respective limit as set out in the Benefits Schedule.

This benefit is subject to the deductible, co-insurance and pro-ration.

We will also pay for any pre- or post-hospitalisation expenses incurred in relation to inpatient psychiatric treatments.

1.4.6.5 What do we pay for Short Stay Ward?

We pay for the cost of short stay ward even if it does not result in hospital confinement of the life assured.

If the life assured is hospitalised and is confined to more than one ward type during his hospitalisation, the deductible applied is based on the highest ward class the life assured had stayed in.

This benefit is subject to the deductible, co-insurance and pro-ration.

We will also pay for any pre- or post-hospitalisation expenses incurred in relation to a short stay ward only under a Singapore restructured hospital and the stay is a continuous period of at least six hours.

1.4.6.6 What is the Future Insurance Option at life events?

If this policy was purchased on standard terms, (i.e. you were not given our offer of conditional acceptance where the life assured was offered special terms and conditions for acceptance of the proposal) then you can buy another policy on the life assured (or if you are the life assured then you can buy another policy on your own life), without evidence of good health, when the life assured experiences any of the following life events:

- marriage;
- becoming a parent;
- adoption of a child through legal means;
- death of a spouse;
- divorce;
- marriage of his/her child;
- his/her child entering primary school; or
- his/her child entering secondary school.

The new policy can be an endowment, whole life or term policy providing death, accelerated terminal illness and disability benefits without any Future Insurance Option benefit within. The new policy's sum assured cannot be more than the amount set out in the Benefits Schedule.

The life assured can exercise this Future Insurance Option twice, i.e. on two separate life events, provided:

- all premiums due under this policy are paid;
- the life assured is under 45 years old;
- this policy has not ended, for any reason;
- no claim has been made under this policy or PRUExtra policy (if any);
- the total sum assured of the new policies does not exceed the amount set out in the Benefits Schedule; and
- the new policy is purchased within 3 months from the date of the relevant life event.

1.4.6.7 What do we pay for Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma?

We reimburse for the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, if the life assured undergoes medically necessary Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma for the following stages of the treatment:

- Stem-cell mobilisation
- Harvesting healthy stem cells
- Pre-transplant workup
- Use of high dosage chemotherapeutic drugs to destroy cancerous cells
- Engraftment of healthy stem cells
- Post-transplant monitoring

We will pay for all treatment costs, including consultation, clinical and lab investigations, consumables and drugs needed for the Continuation of Autologous Bone Marrow Transplant Treatment for Multiple Myeloma in the outpatient setting.

This applies strictly to treatment in the outpatient setting only. If the life assured requires certain phases of bone marrow transplant in the inpatient setting, these treatments will be covered under the prevailing inpatient limits.

This benefit is subject to the deductible, co-insurance and pro-ration.

We will not pay for any pre or post-hospitalisation expenses incurred in relation to the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma.

1.4.6.8 What do we pay for Inpatient and Outpatient Proton Beam Therapy?

We reimburse for the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, when the life assured undergoes Proton Beam Therapy treatment as an inpatient, day surgery or outpatient procedure, treated by a registered medical practitioner in a hospital or MediSave/MediShield Life accredited cancer treatment centres.

This benefit is subject to the deductible, co-insurance and pro-ration.

We will only cover proton beam therapy treatment if it is administered as an approved proton beam therapy indication as stated on MOH's website, as may be amended from time to time.

We will also reimburse consultation fees, diagnostic and laboratory tests if it is ordered by the registered medical practitioner before the life assured undergoes this treatment.

We will not pay for any pre- or post-hospitalisation expenses incurred in relation to Outpatient Proton Beam Therapy.

1.4.6.9 What do we pay for Cell Tissue and Gene Therapy Treatment?

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule for one treatment per clinical indication per lifetime, when the life assured undergoes Cell Tissue and Gene Therapy Treatment as an inpatient or day surgery procedure, as long as the following conditions are met:

- the Cell Tissue and Gene Therapy Treatment must be approved by MOH and the HSA and must satisfy all other guidelines of the Cell Tissue and Gene Therapy Treatment regulations, as issued by MOH;
- the attending registered medical practitioner must recommend in writing that the Cell Tissue and Gene Therapy Treatment is medically necessary; and
- the Cell Tissue and Gene Therapy Treatment that is on MOH's Cell, Tissue and Gene Therapy Product List which has been assessed by MOH to be clinically- and cost-effective.

Any Cell Tissue and Gene Therapy Product-indication pairs not listed on the Cell, Tissue and Gene Therapy Product List will not be covered.

Please refer to MOH's website <go.gov.sg/ctgtp-list> for the latest Cell, Tissue and Gene Therapy Product List and each product's clinical indication(s). MOH may update this list from time to time. The revised Cell, Tissue and Gene Therapy Product List will apply to any Cell Tissue and Gene Therapy Treatment which occurred on and from the effective date of the revised list.

This benefit is subject to the deductible, co-insurance and pro-ration.

When we work out the benefit limit that we will pay for the Cell Tissue and Gene Therapy Treatment, we will include all reasonable and customary expenses incurred for the treatment, including but not limited to, the cost of drug(s), room & board, diagnostic test(s), laboratory charges, doctor attendance fee, medical consumables, etc. (including pre- and post-hospitalisation treatment) under this benefit, up to the benefit sub-limit.

All Cell, Tissue and Gene Therapy Treatment claims must be filed under the Cell Tissue and Gene Therapy Treatment benefit. They cannot be filed under the inpatient and day surgery benefit or any other benefit, regardless of setting.

1.4.6.10 What do we pay for High-Cost Drugs (non-cancer) Treatment?

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, when the life assured undergoes High-Cost Drugs (non-cancer) treatment as an inpatient or day surgery procedure, as long as the High-Cost Drugs (non-cancer) is listed on MediShield Life's benefit schedule <go.gov.sg/mshlbenefits> which has been assessed by MOH to be clinically- and cost-effective.

We will not cover any High-Cost Drugs (non-cancer) not listed on MediShield Life's benefit schedule, used for the conditions covered by MediShield Life. Please refer to MOH's website for the latest MediShield Life's benefit schedule. MOH may update this list from time to time. The updated High-Cost Drugs (non-cancer) coverage will apply on and from the effective date of the revised list.

This benefit is subject to the deductible, co-insurance and pro-ration.

All High-Cost Drugs (non-cancer) treatment claims must be filed under the High-Cost Drugs (non-cancer) Treatment benefit. They cannot be filed under the inpatient and day surgery benefit or any other benefit, regardless of setting.

1.4.6.11 What do we pay for Outpatient and Home-Based Treatment?

a) **Home Ventilation and Respiratory Support Service**

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, by the life assured who receives home ventilation and respiratory support services that meet the claimable criteria under MediShield Life.

b) **Paediatric Home Care**

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, by the life assured who receives paediatric home care that meets the claimable criteria under MediShield Life.

c) **Negative Pressure Wound Therapy**

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, by the life assured who receives outpatient negative pressure wound therapy that meets the claimable criteria under MediShield Life.

d) **Repetitive Transcranial Magnetic Stimulation**

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, by the life assured who receives outpatient repetitive transcranial magnetic stimulation treatment, if the treatment is administered according to the guidance recommendation by the Agency for Care Effectiveness (ACE), the national health technology assessment and clinical guidelines agency established by the MOH (<https://www.ace-hta.gov.sg/healthcare-professionals/ace-technology-guidances/medical-technology-guidance/repetitive-transcranial-magnetic-stimulation-for-adults-with-treatment-resistant-major-depressive-disorder/>).

Repetitive transcranial magnetic stimulation treatment for patients who did not respond to the initial treatment or for maintenance, will not be covered.

e) **Pasteurised Donated Human Milk**

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, by the life assured who receives pasteurised donated human milk as part of a medical treatment provided by an MOH registered milk bank in Singapore.

f) **Hyperbaric Oxygen Therapy**

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, by the life assured who receives outpatient hyperbaric oxygen therapy that meets the clinical and claimable criteria under MediShield Life.

g) **Outpatient Parenteral Antibiotic Therapy**

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, when the life assured receives outpatient parenteral antibiotic therapy where the antibiotic administered is listed on MOH's list of subsidised drugs (<https://www.moh.gov.sg/managing-expenses/schemes-and-subsidies/list-of-subsidised-drugs/>).

The deductible is not applicable to this Outpatient and Home-Based Treatment benefit, but it is subject to co-insurance and pro-ration.

1.4.6.12 What is the Refresh benefit?

If the life assured has exceeded the policy year limit and is hospitalised subsequently for an illness or injury that is not directly or indirectly related to any existing or past illnesses or injuries within the same policy year, we will reset the policy year limit and any benefit sub-limit (if applicable) for that policy year. The Refresh benefit will not apply if there is any available balance in the existing policy year limit at the time of an inpatient hospitalisation.

The policy year limit will be refreshed only once in the same policy year.

If the refreshed policy year limit is not used within the policy year, it cannot be carried forward to the next policy year.

The Refresh benefit cannot exceed the policy year limit and any benefit sub-limit (if applicable).

The Refresh benefit is only applicable for inpatient hospitalisation. We will not pay for any outpatient, day surgery, pre- or post-hospitalisation expenses or for any other inpatient treatment related to a previously known condition under the Refresh benefit.

Claims submitted under Refresh benefit will be on a reimbursement basis only (if applicable).

We have the right to determine whether or not the illness or injury is directly or indirectly related to an existing or past illness or injury.

1.5 Can I change my plan?

You can apply to change to a higher or lower plan (where applicable) by giving us written notification.

When you apply to change to a higher plan, the life assured must give us satisfactory evidence of a health condition that is acceptable to us.

Once we have changed your plan to the new plan, medical expenses incurred from the cover 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 policy/benefit limits which will apply from the cover start date of the new plan.

When you change to a higher plan, some of the policy benefits require the life assured to wait out a period of time before such benefits will be covered (**Waiting Period**). This Waiting Period commences from the cover start date of the new plan. If the life assured claims for hospitalisation or medical treatment that occurred within this Waiting Period, we will assess such claims according to the terms and conditions of the immediate preceding plan instead of the new plan.

For any claim payable, we will determine the claim amount based on the policy year limit and pro-ration (if applicable) of the plan that is applicable on the date of the hospital admission and/or medical expense bill.

If the plan you have applied to change to is withdrawn, we reserve the right to change your plan to a similar medical product that is available at the time of renewal.

You must use our appropriate application form and meet the conditions on it. We will notify you if we accept your application.

1.6 How to make a claim?

You must authorise the MediSave/MediShield Life accredited hospitals or treatment centres to submit all eligible medical bills relating to the following benefits, electronically to us:

- Inpatient and Day Surgery benefits (refer to clause 1.4.3)
- Outpatient Hospital benefits (refer to clause 1.4.5)

For the Overseas Treatment benefit (refer to clause 1.4.3.10) and the non-insured living organ donor covered under the Living Organ Donor Transplant benefit (refer to clause 1.4.3.9), we require the following to be submitted:

- a completed PRUShield claim form;

- original final hospital bills and payment receipts;
- medical report from the life assured's registered medical practitioner;
- a completed Clinical Abstract Application form;
- death certificate issued by the relevant authority, if applicable;
- a certified true copy of the identification documents of the claimant, if applicable;
- evidence that the person is entitled to receive the payment (e.g. birth certificate, marriage certificate, the deceased's last will, Letter of Administration or Probate, Trust Deed, etc.), if applicable; and
- any documentary proof as required by us.

If the life assured is a foreigner who is not a Singapore Permanent Resident, you have to submit the following in addition to the above documents to us:

- a certified true copy of the life assured's:
 - Eligible Valid Pass; and
 - travel documents or passport.
- any documentary proof as required by us.

Eligible Valid Pass is a pass recognised by the Immigration & Checkpoints Authority (ICA) and the Ministry of Manpower (MOM). The list of eligible valid passes, acceptable by us, is listed in clause 1.10.

To make a claim for the life assured's pre- and post-hospitalisation expenses, here are the requirements:

- the PRUShield inpatient or day surgery claim must have already been filed and approved;
- a completed PRUShield pre- and post-hospitalisation claim form;
- medical report from the life assured's registered medical practitioner;
- laboratory reports;
- general practitioner's referral letter;
- a completed Clinical Abstract Application form;
- original hospital bill, tax invoice and payment receipts for the same injury or illness; and
- other medical information as required by us.

We will consider pre- and post-hospitalisation expenses claims only if PRUShield inpatient hospitalisation and day surgery claims are payable for the same injury or illness.

You must file your claims within 180 days from the date of the medical bills.

We reserve the right to ask you or your legal representative to provide, at your own expense, more documents or evidence to our satisfaction to help us assess your claim and to appoint a registered medical practitioner to re-examine the life assured.

If you make a claim for treatment of any injury or illness as a result of hazardous activities or sports, you must provide the name of the licensed organisation carrying out these hazardous activities or sports for our verification.

We also reserve the right to adjust any duration of hospital confinement or surgical procedure or hospitalisation expenses which, in the opinion of our medical advisers, is considered as excessive. The duration of hospital confinement and surgical procedure should not exceed the general level by hospitals of similar standing in the same locality where the charges are incurred, taking into consideration similar or comparable treatment, services or supplies to individuals of the same sex and of comparable age, for similar illness or injury.

For medical treatment received outside of Singapore, we assess the benefits on the basis of similar treatment that is reasonably and customarily charged by a hospital in Singapore.

You must co-operate fully with us and our medical advisers. You must disclose fully and faithfully all material facts and matters which the life assured knows or ought to know and if required, on our request, sign any document to allow us to obtain relevant information, at your expense, from any registered medical practitioner, hospital or other sources.

All documents submitted that are not in English must be translated to English by an accredited translator at your own or the claimant's expense.

1.6.1 Recovery of claims paid

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

If any claim has been found to be fraudulent, exaggerated or if there is any false declaration or statements in support of any claim, we reserve the right to terminate or void this policy, or recover any benefits paid under the policy.

1.7 Who do we pay?

Claims processed electronically will be paid to the hospital. Otherwise, we pay you, the policyowner or the MediSave account that is used to pay the bill, provided we receive to our satisfaction, evidence of your entitlement.

The claims amount will be paid out provided:

- your claim amount has not exceeded the policy year limit or benefit limit as set out in the Benefits Schedule; and
- your current premium has been paid.

If you have used MediSave funds to pay the medical bill, we will first reimburse any cash payment you made in the medical bill, then to the MediSave account that was used.

1.8 What is not covered?

We do not pay for any benefits under this policy which are directly or indirectly related to any of the following conditions, including outcomes from these conditions and their related complications, except otherwise expressly allowed by MediShield Life Claims Rules specified on MOH's website. However, (MediShield Life may cover some of the following conditions, up to the respective terms and conditions of MediShield Life):

- All expenses incurred by a life assured for the period of hospital confinement if admission into a hospital is before the cover start date of the policy;
- Treatment or diagnosis of any Serious Illness for which the life assured received medical treatment (including follow-up and consultations) during the period of 12 months prior to the cover start date of the policy;
- Any pre-existing illnesses, diseases or impairments from which the life assured is suffering from prior to the cover start date of the policy, unless they were declared in the proposal and specifically accepted by us. A pre-existing condition is the existence of any signs or symptoms for which treatment, medication, consultation, advice or diagnosis has been sought or received by the life assured or would have caused an ordinary prudent person to seek treatment, diagnosis or cure, prior to the cover start date of this benefit or the date of reinstatement (if any), whichever is later;
- Treatment relating to birth defects, including hereditary conditions and congenital sickness or abnormalities except when it is covered under clause 1.4.6.3;
- Overseas medical treatment (except in the event that a life assured requires inpatient hospital treatment as a result of Emergency Medical Treatment outside Singapore or under the Planned Overseas Medical Treatment benefit (refer to clause 1.4.3.10). This exception is, however, still subject to all the other exclusions stated in this clause 1.8);
- Mental illness and personality disorders except when it is covered under the "Psychiatric Treatment benefit" as set out in clause 1.4.6.4;
- Pregnancy, childbirth and any complications as a result of pregnancy and childbirth except complications covered under clause 1.4.6.2;
- Elective abortion; threatened abortion; miscarriage occurring within 13 weeks of pregnancy; birth control*, sterilisation*, infertility*, sub-fertility*, impotence treatment, assisted conception or any contraceptive treatment; (* for males and females);
- Treatment of sexually transmitted diseases;
- Acquired Immunodeficiency Syndrome (**AIDS**), AIDS-related complex or infection by Human Immunodeficiency Virus (**HIV**) except HIV Due to Blood Transfusion and Occupationally Acquired HIV as set out in clause 1.10.12;
- Treatment of self-inflicted injuries, or injuries resulting from attempted suicide;
- Treatment directly or indirectly arising from drug or alcohol misuse;
- Cosmetic or Plastic Surgery except:
 - Cosmetic or Plastic Surgery due to an accident; or
 - Breast Reconstruction after a Mastectomy;

- All dental treatment except those covered under clause 1.4.3.6;
- Correction for refractive errors of the eye (including the use of artificial lens implants and Lasik), routine eye and ear examinations, costs of spectacles, costs of contact lenses and costs of hearing aids;
- All other types of lenses for cataract, except monofocal non-toric lenses;
- Ambulance fee;
- Sex change operations;
- Purchase of kidney dialysis machine, replacement organ, iron-lung, prosthesis and other special appliances including the location, transport and associated administration costs of such special appliances (except when it is covered by us, as part of MIC@Home);
- Optional items which are outside the scope of treatment;
- Rest cures, hospice care, home or outpatient nursing or palliative care (except when it is covered by us), convalescent care in convalescent or nursing homes, sanatoriums, transitional care facilities or similar establishments, outpatient rehabilitation services such as counselling and physical rehabilitation (except when it is covered by us, as part of MIC@Home);
- Vaccination, other than inpatient hospital treatment due to the adverse effects caused by vaccinations which are authorised by the Singapore Health Sciences Authority and provided that such vaccinations have been administered on the recommendation of a medical practitioner duly licensed by Singapore Medical Council;
- Treatment of injuries arising from direct participation in civil commotion, riots or strikes;
- Treatment of injuries arising directly or indirectly from nuclear fallout, terrorism, war and related risks;
- Treatment for which the life assured had received work injury compensation under the Work Injury Compensation Act 2019 and other forms of insurance coverage;
- Hospitalisation primarily for medical services such as but not limited to X-ray, CT or MRI scans, medical check-up or health screening or other investigations which can routinely be conducted on an outpatient basis (unless otherwise covered under the terms and conditions of the PRUShield plan, as listed in the Benefits Schedule set out in clause 1.4.1);
- Treatment of illness or injury resulting from the life assured engaging in any hazardous activities or sports in a professional capacity; or where the life assured would or could earn or earns income or remuneration in these hazardous activities or sports;
- Treatment of illness or injury caused by any hazardous activities or sports unless carried out legally under the supervision of licensed organisations. (This exception is however still subject to all the other exclusions stated in this clause 1.8);
- Treatment for weight reduction, weight improvement, or obesity or any injury or illness which arises from, or is related to, or a consequence of weight reduction, weight improvement, or obesity in any way, such as, but not limited to, the use of gastric banding or stapling, the removal of fat or surplus tissue from any part of the body, whether or not needed for medical or psychological reasons;
- Violation or attempted violation of law, resistance to lawful arrest or any resultant imprisonment;
- Non-medical items such as, but not limited to, parking fees, hospital Administration and Registration fees, laundry, rental of television, newspaper, medical report fees;
- Experimental or pioneering medical or surgical techniques, clinical trials for drugs or medical devices and appliances (such as, but not limited to, ergonomic tables and chairs) not approved by MOH;
- Any genetic testing and any procedure done as a result of genetic testing, prophylactic measures that are not therapeutic in nature, primary prevention (refers to medical services for generally healthy individuals to prevent a disease from ever occurring, in the absence of medical indications, eg. general medical / health screening packages, general physical checkups, vaccinations, etc.), surveillance screening, diagnostic, investigation tests or checks, except:
 - Cell Tissue and Gene Therapy Treatment as set out in clause 1.4.6.9;
 - any genetic testing that is medically necessary and has justification for prognostication and treatment selection as a result of a confirmed diagnosis; or
 - the expenses incurred for medically necessary treatment relating to the removal of cysts, polyps and/or lumps (even if they are benign in nature);
- Outpatient treatment and medical services except when it is covered under the "Outpatient Hospital benefits" as listed in the Benefits Schedule set out in clause 1.4.1;
- Dietary supplements and substances that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances unless prescribed by a registered medical practitioner as part of the hospitalisation (including Post-hospitalisation Follow-up Treatment and Services);
- Cell, Tissue and Gene Therapy Products that are not on the Cell, Tissue and Gene Therapy Product List;

- High-Cost Drugs that are not on MediShield Life's benefit schedule but used for the medical conditions covered by MediShield Life;
- Alternative or complementary treatments, including Traditional Chinese Medicine (TCM), naturopathic, homeopathic, podiatric, chiropractic or osteopathic treatment or a stay in any healthcare establishment for social or non-medical reasons; or
- All other exclusions that apply to the MediShield Life Scheme as set out in the relevant legislation, regulations and guidelines, unless we say otherwise under this policy.

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

We do not pay for any expenses for any treatment, service or item incurred for the hospital confinement of a life assured, received on or after 27 March 2020 but before 20 October 2020 for COVID-19 infection or otherwise, if the life assured is an at-risk traveller while being treated for COVID-19 infection.

We also do not pay for any expenses for any treatment, service or item incurred for the hospital confinement of a life assured received on or after 27 March 2020 but before 20 October 2020, if the life assured is an at-risk traveller who is:

- (i) admitted to the hospital to test for suspected COVID-19 infection;
- (ii) whose test results for COVID-19 infection is negative; and
- (iii) does not need inpatient treatment for any other medical condition.

We do not pay for any treatment, service or item that is required for any other medical condition occurring over the same period as the COVID-19 treatment for an at-risk traveller.

An "at-risk traveller" means a life assured who

- (i) Travelled out of Singapore on or after 27 March 2020 and travelled against any travel advisory concerning the risk of COVID-19 infection issued by MOH and published on its website (which may be changed, added or otherwise modified from time to time); and
- (ii) Began to show symptoms consistent with the COVID-19 infection within the possible incubation period. The possible incubation period refers to the period starting from when the life assured leaves Singapore, at the start of his overseas trip, and ending on and including the 14th day after his arrival in Singapore, at the end of his overseas trip.

"COVID-19" means the infectious disease known as Coronavirus Disease 2019.

1.9 General Conditions

1.9.1 Territorial cover

We will pay for all hospitalisation claims paid in Singapore, subject to the terms and conditions of this policy document.

Subject to clause 1.8, for hospitalisation claims incurred overseas, we will pay, provided the hospitalisation expenses are payable under the Emergency Medical Treatment outside Singapore or Planned Overseas Medical Treatment benefits.

We will reimburse you the lower of the actual medically necessary expenses paid, or the amount that would be reasonably and customarily charged by a hospital in Singapore for the treatment that is necessary for the illness or injury.

We will convert bills for hospital confinement or day surgery that are in a foreign currency to Singapore currency at our banker's exchange rate as at the date of the bills.

1.9.2 Payer of last resort

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

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

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

1.9.3 Declaration of age

If the age of the life assured is stated wrongly in your proposal form, we will adjust the premium that you have to pay. We will refund any excess premium amount that you paid or we will ask you to pay for any shortage in the premium amount.

1.9.4 Renewal of your policy

We guarantee that this policy is renewable yearly for as long as you live, only if you pay the premiums within the grace period and your policy has not ended (as set out in clause 1.9.7) and subject to the terms as set out in clause 1.9.9, 1.9.10 & 1.9.13.

This automatic renewal will happen only if you pay the premium based on the age next birthday of the life assured at the time of renewal.

1.9.5 Right to change the premium

We can change the premium at any time. However, we will give you 30 days' written notice before we do so.

1.9.6 No Waiver

If we do not enforce any of the conditions of this policy document at any time, the policy document will remain valid. We will still have the right to enforce each condition in future even if we have not done so in the past.

1.9.7 When does the policy end?

The policy ends when:

- you cancel your policy, after the expiry of the Review Period, by giving us 30 days' written notice;
- your MediSave-approved integrated shield plan with another insurer starts;
- the life assured renounces his/her Singapore citizenship or Singapore Permanent Residence status;
- your premium is not received after the grace period; or
- the life assured dies.

In addition to the above, for a life assured who is a foreigner and is not a Singapore Permanent Resident, the policy will also end when:

- the life assured 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 your premiums via credit card or GIRO.

To avoid any doubt, if the life assured is without an eligible valid pass for more than 60 days after the eligible valid pass has expired or is terminated, the end date of this policy will be the date of expiry or termination of the eligible valid pass. Any claims incurred after this expiry or termination date will not be valid. This includes any claims incurred during the 60-day period.

We will refund the pro-rated premiums, regardless of any payout during the policy year.

Except in the situation where the life assured dies, if your policy ends before the next premium due date, and no claim has been paid during that policy year, we will refund the pro-rated premium based on the number of unused days for the rest of that policy year, to the MediSave account.

If you pay part of your premium in cash, then the amounts we refund will be proportionate to the amount we deduct from the MediSave account and the amount we collect from you in cash.

Example

If your premium is made up of 80% from the MediSave account and you pay the remainder of 20% in cash, then the refund of unused premium will be in the same proportion – meaning 80% returned to the MediSave account and 20% paid to you.

We or the CPF Board (as the case may be) will determine the effective date of termination of your policy.

When your policy ends in this way, you have no further claims or rights against us under your policy, except if it is specifically stated otherwise in this policy document.

To avoid any doubt, the termination of your policy by you or us shall not affect the insurance coverage under MediShield Life. The life assured will continue to be insured under the MediShield Life Scheme with the CPF Board as long as the life assured is eligible for the scheme.

1.9.8 Reinstatement of your policy

You can apply to reinstate your policy if:

- you apply within 12 months from the end date of your policy;
- you pay all the premiums you owe us; and
- you give us satisfactory evidence of the health of the life assured. You must pay for the costs involved in this.

We will not cover any claim incurred before the effective date of the reinstatement of the policy, unless the claim was declared in the reinstatement form and specifically accepted by us.

To apply you must use our appropriate application form and meet the conditions on it. We will notify you if we accept your application.

1.9.9 Change of citizenship, residency status or occupation for foreigners

You must inform us as soon as possible when the life assured's citizenship or residency status changes in any way. You must submit documentary proof of your change.

If the life assured 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 expired or was terminated, this policy will end. So, you must inform us as soon as possible when the eligible valid pass expires or is terminated.

To avoid any doubt, if the life assured is without an eligible valid pass for more than 60 days after the eligible valid pass has expired or was terminated, the end date of this policy will be the date of expiry or termination of the eligible valid pass. Any claims incurred after this expiry or termination date will not be valid. This includes any claims incurred during the 60-day period.

If the life assured is a Work Permit holder and if they change their occupation to one that is not within the acceptable occupation classes listed by us, the policy will end. You must inform us as soon as possible when the life assured changes occupation.

1.9.10 Changes to policy benefits, conditions or plan

We can change the policy benefits, features, conditions and/or name at any time. This includes compulsory changes to the policy benefits, features, guidelines and/or conditions that may be introduced by the Ministry of Health (MOH), the Central Provident Fund Board or any other regulatory authority on MediShield Life.

Also, if PRUShield is not available when your policy is due for renewal, we can renew your policy to a similar medical product that is available at the time of renewal.

We will give you 30 days' written notice before doing so. However, these compulsory changes to the policy benefits, features, guidelines and/or conditions set out by the relevant regulatory authority will immediately apply to your policy without written notice given to you.

Any such changes will be subject to compliance with the conditions for MediSave-approved medical insurance plan issued by MOH.

1.9.11 Special terms and conditions

If we have accepted your proposal for this policy with special terms and conditions, we give you a copy of our offer of conditional acceptance which contains the special terms and conditions. The special terms and conditions shown on our offer of conditional acceptance become part of your policy.

This offer of conditional acceptance with the special terms and conditions will continue to be part of your policy at each renewal unless we inform you in writing or through your preferred means of communication.

1.9.12 Currency in use

Unless we say otherwise, all premiums and benefits are payable in Singapore dollars.

We will convert hospital bills that are in a foreign currency to Singapore currency at the prevailing exchange rate we decide, effective on the issue date of the hospital bill.

1.9.13 Policy becomes void

We may declare your policy void if:

- the information or any written statement you give us before the cover start date of the policy (or at any application for reinstatement) is untrue in any way ; or
- any material fact affecting the risk is stated or represented to us wrongly or is left out from any of the documents you gave us.

If no claim has been paid, we will refund the total premium paid to you and/or the MediSave account with the Central Provident Fund Board.

If we have paid any claim previously, we will only refund the premium paid for the renewal of your policy after the date of the last claim.

1.9.14 Governing Law

Your policy is governed by the laws of the Republic of Singapore, and the Singapore courts alone will deal with any dispute arising from your policy.

1.10 Definitions

1.10.1 Accident

An event caused by violent, external and visible means and caused solely and independently of any other means.

1.10.2 Benefit Limit in the Benefits Schedule

If a supplementary plan (like PRUExtra) is also purchased, the Benefit Limit is applied to both the main plan (PRUShield) and supplementary plan (PRUExtra).

1.10.3 Breast Reconstruction after a Mastectomy

Breast Reconstruction after a Mastectomy refers to medically necessary breast reconstruction after a mastectomy, subject to the following conditions:

- The mastectomy must be due to breast cancer;
- The breast reconstruction or any subsequent follow-up reconstruction surgery on the same breast must be done within 365 days from the original mastectomy;
- A breast implant will be covered, up to the medically necessary requirement.

Any surgery or reconstruction of the other breast to produce a symmetrical appearance will not be covered.

1.10.4 Co-insurance

Co-insurance is the amount that you need to co-pay after the deductible is met. The co-insurance percentages for the various benefits under this policy are stated in the Benefits Schedule. Co-insurance is applicable to all the benefits under this policy except for Final Expense Benefits.

1.10.5 Community Hospitals

A community hospital is one that is registered and classified under the category of community hospitals with MOH, Singapore.

1.10.6 Cover Start Date

The cover start date is the date of commencement of insurance coverage of your policy and is shown on your policy certificate.

1.10.7 Deductible

This is the part of the claimable amount that you are liable for before any benefits are payable under this policy. The deductible amounts for the various benefits under this policy are stated in the Benefits Schedule.

1.10.8 Eligible Valid Pass

An Eligible Valid Pass is a pass recognised by the Immigration & Checkpoints Authority (ICA) and the Ministry of Manpower (MOM). The valid passes, acceptable by us, are:

- Personalised Employment Pass (PEP)
- Employment Pass
- S Pass
- Student Pass
- EntrePass
- Long Term Visit Pass (LTVP) ¹
- Dependant's Pass (DP) ²
- Overseas Networks and Expertise Pass
- Work Permit (those from Occupation Class 1 to 3)

¹ We will accept a Long Term Visit Pass that is valid as well as linked to a current Singapore Citizen, Singapore Permanent Resident, Personalised Employment Pass (PEP) holder, Employment Pass holder or EntrePass holder.

We will also accept a Long Term Visit Pass applied under the "Visitor Seeking Long Term Stay" criteria that is granted by the Immigration and Checkpoints Authority (ICA) of Singapore. The applicant's family, comprising spouse and unmarried children (both minor and adult) will also be eligible to apply for a Long Term Visit Pass for the purpose of long term stay. For such applications, the issuance of the Long Term Visit Pass to the family members is tied to the grant of the Long Term Visit Pass to the main applicant. The cancellation of the main applicant's Long Term Visit Pass will result in the cancellation of the Long Term Visit Passes of all their accompanying family members.

² We will only accept a Dependant's Pass that is valid as well as linked to a current Personalised Employment Pass (PEP) holder, Employment Pass holder, S Pass holder or EntrePass holder.

1.10.9 Emergency

Emergency is when urgent remedial treatment is needed and is medically necessary to avoid death or serious impairment to the life assured's health as a result of a Serious Illness or the onset of a serious condition.

1.10.10 Extended Panel (EP) Specialists

An Extended Panel (EP) Specialist is a registered medical practitioner who:

- is on another Integrated Shield Plan insurer's approved panel list;
- has obtained pre-authorisation approval from us;
- follows our fees schedule; and
- meets pre-authorisation terms and conditions.

1.10.11 Grace Period

You have 90 days from the premium due date to pay your premiums. This is the grace period.

1.10.12 HIV Due to Blood Transfusion and Occupationally Acquired HIV

A) Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

- The blood transfusion was medically necessary or given as part of a medical treatment;
- The blood transfusion was received in Singapore after the cover start date of the policy or the date of reinstatement (if any), whichever is the later; and
- The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood.

B) Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the Issue Date, cover start date of the policy or the date of reinstatement (if any), whichever is the later whilst the Insured was carrying out the normal professional duties of his or her occupation in Singapore, provided that all of the following are proven to the Company's satisfaction:

- Proof that the accident involved a definite source of the HIV infected fluids;

- Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident. This proof must include a negative HIV antibody test conducted within 5 days of the accident; and
- HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

Reimbursement of medical expenses under this benefit is only payable when the occupation of the life assured is a medical practitioner, housemen in a hospital, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in a medical centre or clinic (in Singapore).

1.10.13 Hospital

Hospital means a facility which satisfies all of the following:

- a) is a licensed, lawfully operating institution duly constituted and registered as a hospital with the MOH or in the case of a hospital overseas, registered with its local health authority;
- b) is open at all times;
- c) is operated mainly to diagnose and treat disabilities on an inpatient basis and at the patient's expense;
- d) has organised facilities for major surgery;
- e) has a staff of one or more doctors on call at all times;
- f) has 24-hour nursing services by or under the supervision of registered nurses;
- g) is not a skilled nursing facility, clinic, place for treatment of alcoholism or drug abuse, nursing home, rest home, convalescent home, community hospital, hospice, home for the aged, place for the treatment of mental disorders or a similar establishment; and
- h) maintains a daily medical report for each patient, which is accessible to our medical advisers.

The lists of Singapore Restructured and Private hospitals can be found on our website < www.prudential.com.sg.>

1.10.14 Hospital Confinement

Hospital confinement means a continuous period of time, lasting at least 6 hours, where normal ward is charged, during which it is medically necessary for the life assured to be confined to a hospital.

1.10.15 (a) Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological functions and requires medical treatment.

(b) Injury

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a registered medical practitioner.

1.10.16 Inpatient

An inpatient is a person who is under hospital confinement.

1.10.17 Medical Adviser

A Medical Adviser is someone who gives advice relating to the science or practice of medicine and surgery.

1.10.18 Medically Necessary

Medically necessary means treatments, services or expenses incurred which are:

- in the opinion of a specialist is appropriate and consistent with the symptoms, findings, diagnosis and other relevant clinical circumstances of the illness. The treatment must be provided in accordance with generally accepted medical practice in Singapore;
- in accordance with the standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
- approved by the Institutional Review Board, the Centre of Medical Device Regulation, HSA or other relevant authority in Singapore;
- not for the convenience of the life assured or registered medical practitioner, and unable to be reasonably rendered out of a hospital, community hospital or similar establishments;
- not of an experimental, investigational or research nature (including but not limited to experimental, pioneering medical or surgical techniques and medical devices, and medical trials

- for medicinal products, whether or not these trials have a clinical trial certificate issued by the Health Sciences Authority or other relevant authority in Singapore); and
- not for preventive or screening nature or for health enhancement (including but not limited to dietary replacement or supplement) in purpose.

We have the right to determine whether or not a treatment, service or expense is medically necessary.

1.10.19 MediShield Life

MediShield Life is mandatory for all Singapore Citizens and Permanent residents. It is the basic tier of insurance protection scheme operated by the CPF Board which helps Singaporeans and Singapore Permanent Residents to meet their hospitalisation costs in the class B2 or C wards of a hospital.

1.10.20 Mobile Inpatient Care @ Home (MIC@Home)

A care-delivery model, covered under MediShield Life, that allows patients who a physician assesses as being clinically suitable to receive the same hospital inpatient services in their own homes, instead of in a Singapore restructured hospital.

1.10.21 MOH

MOH means the Ministry of Health in Singapore.

1.10.22 Multiple Primary Cancers

Multiple Primary Cancers mean two or more cancers arising from different sites and/or are of a different histology or morphology group.

1.10.23 Panel Providers

Our panel providers consist of participating specialists on the PRUPanel Connect programme who provide inpatient or day surgery treatment at Panel Healthcare Institutions.

Panel Healthcare Institutions (Panel HI) refer to:

- all restructured hospitals and treatment centres in Singapore;
 - participating private hospitals in Singapore; and
 - participating private treatment centres in Singapore,
- that appear on PRUPanel Connect on our website

Participating specialists refer to Registered Medical Practitioners and Specialists that appear on PRUPanel Connect on our website, as well as all specialists in restructured hospitals and treatment centres.

1.10.24 Policy Year

Policy year means a period of 12 months from the cover start date or renewal of the life assured's insurance cover under PRUShield. Subject to the terms and conditions of this policy document, the life assured's insurance cover under this policy shall, be renewed yearly on the premium due date.

1.10.25 Policy Year Limit

The policy year limit is the maximum claimable amount that the life assured can claim in one policy year from all the benefits in this plan. If you have a PRUShield Premier plan, the policy year limit is \$2,000,000 provided all claims within the same policy year are incurred at panel providers.

Any claim that you make under your MediShield Life plan will also be added to the claims for the year and reduce the remaining amount on your PRUShield's policy year limit.

If hospital confinement or non-inpatient medical expenses flow over to the next policy year, the claim for a given medical bill will be processed subject to the policy year limit of the previous year. This means that for medical expenses due to hospital confinement, the claim amount will be determined based on the policy year limit applicable at the date of hospital admission. If the policy year limit is reached, we do not pay the claim utilising the policy year limit of the next policy year even if the hospital confinement period flows over to the next policy year.

For non-inpatient medical expenses, the claim amount will be determined based on the policy year limit applicable on the date the medical expenses were incurred regardless of the actual date of usage of such medical services.

1.10.26 Pro-ration

Pro-ration factors are applied to reduce inpatient, outpatient, day surgery hospital bills and pre- and post-hospitalisation expenses in higher-class wards, private hospitals (as classified by MOH) or private clinics/medical institutions in the claims computation to suit the lower plan.

Pro-ration for overseas Government Hospitals

Overseas Government hospitals are considered private hospitals. If you have a PRUShield Plus policy we will apply the pro-ration factor to your medical expenses incurred in all overseas hospitals.

1.10.27 Reasonable and Customary Expenses

This refers to expenses incurred for medical service or treatment provided which are appropriate and consistent with the diagnosis and which according to accepted medical standards, could not have been omitted without adversely affecting the life assured's medical condition. Such charges shall not exceed the general level of charges made by others of similar standing in Singapore for such services and supplies.

1.10.28 Registered Medical Practitioner

Any person properly qualified by degree in western medicine to practice medicine, and is licensed by the appropriate medical authority of his country of residence to practice medicine within the scope of his licensing and training and excludes the policyowner, the life assured or a family member of either.

1.10.29 Review Period

Review Period is the period stated in clause 1.1.2 above.

1.10.30 Serious Illnesses

- Blood Disorder
- Cancer
- Ischaemic heart disease
- Coronary artery disease
- Rheumatic heart disease
- Chronic obstructive lung disease
- Chronic renal disease, including renal failure
- Cerebrovascular accidents
- Chronic Liver Cirrhosis
- Systemic Lupus Erythematosus
- Degenerative diseases

1.10.31 Short Stay Ward

A short stay ward is a ward where emergency department patients stay for up to 24 hours for observation to allow the doctors to decide whether the patient is fit for discharge or should be admitted to a standard room of a hospital as an inpatient.

1.10.32 Specialist

Specialist refers to a registered medical practitioner registered as a specialist with the Singapore Medical Council.

1.10.33 Standard Room

It is a room equipped with minimum standards, like the following:

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

It shall exclude deluxe rooms, luxury suites, superior rooms, super rooms or other special rooms that may also be available at the hospital.

For a single room in a private hospital, we pay normal ward rates up to the rates charged for a standard single room.

1.10.34 Surgical Procedure

Any operative procedure listed under MOH's Table of Surgical Procedure (TOSP) 1-7, including day surgery, performed by a registered medical practitioner involving general or local anaesthesia for the correction of deformities or defects, repair of injuries, and the diagnosis or cure of illnesses.

Surgery excludes Minor Surgical Procedures (MSP) as may be determined by MOH. To avoid any doubt, any surgery not listed in Table 1 to 7 of MOH's TOSP list as at the date of the surgery is not covered.

SAMPLE

1.11 Illustration of benefits

PRUShield Claim

PRUShield Premier policyholder - Male, Age 52

Diagnosis: Ischaemic Heart Disease
Surgery: Coronary Artery Bypass Graft
Hospital: Private hospital - 2-bedded ward
Hospitalisation: 9 days

<u>Benefits</u>	<u>Incurred</u>	<u>No. of Days</u>	<u>Payable</u>
<u>Daily Ward and Treatment Charges</u>			
Normal Ward	\$ 5,870.00	7 days	\$ 5,870.00
Intensive Care Unit Ward	\$ 1,630.00	2 days	\$ 1,630.00
<u>Surgical Benefits</u>			
Surgical Procedure	\$ 9,000.00		\$ 9,000.00
Implants	\$ 2,400.00		\$ 2,400.00
	\$ 18,900.00		\$ 18,900.00
Less: Deductible (Private hospital)			\$ 3,500.00
Balance After deductible			\$ 15,400.00
Less: Co-insurance (10% of \$15,400)			\$ 1,540.00
PRUShield Premier Pays (inclusive of MediShield Life payout, if any)			\$ 13,860.00

This policy document covers the terms and conditions of the following plan.

Part One: **PRUShield Premier** and **PRUShield Plus** plans

Part Two: **PRUShield Standard Plan**

You may wish to refer to your policy certificate for the plan that you have bought.

PART TWO

PRUSHIELD STANDARD PLAN

	Contents	Page
2.1	Our agreement	38
2.2	What type of benefit?	39
2.3	Payment of premiums	40
2.4	What type of plan?	40
2.5	Can I change my plan?	48
2.6	How to make a claim?	49
2.7	Who do we pay?	50
2.8	What is not covered?	50
2.9	General conditions	52
2.10	Definitions	55

Your policy is only complete if you have this policy document and a policy certificate

2.1 Our agreement

2.1.1 This policy document and the following documents, will form the entire agreement between you and us and replaces all previous agreements.

- your policy certificate,
- your proposal form (and your supplementary proposal form, if any),
- your PRUPlanner or financial needs analysis,
- the questionnaires relating to your lifestyle, occupational and medical condition that you had submitted to us for our underwriting purposes (if any),
- our offer of conditional acceptance (if any), and
- all written correspondence between yourself and us relating to your policy (if any).

Your policy is a legal contract between you* and us. We* agree to give you the benefits set out in your policy certificate as explained in this policy document for the premium paid by you.

In case of any dispute, the policy document and other documents forming your agreement with us, will apply. These documents can be found in our secure online portal on our website. This portal allows you to access important information about your policy and carry out certain policy transactions.

The information you gave us in the proposal form, supplementary proposal form and any correspondence for this policy was relied on by us in deciding whether or not to insure you.

Your policy may be void if any information you give us is incomplete or inaccurate or you do not comply with the conditions of your policy.

Your policy is only for the cover and the period shown on your policy certificate. It is also subject to the terms and conditions contained in this policy document (as may be changed or updated from time to time).

We give you a new policy certificate when there are changes to your benefits. It becomes your current policy certificate.

A person who is not a party to this policy has no right under the Contracts (Rights of Third Parties) Act to enforce any of the terms and conditions of this policy.

The life assured is also insured under MediShield Life operated by the Central Provident Fund (CPF) Board which is governed by the Central Provident Fund Act 1953 and MediShield Life Scheme Act 2015 (Act) and the respective subsidiary legislation made thereunder (Regulations), provided the life assured meets the eligibility conditions as specified in the Act and Regulations. The life assured, if insured under MediShield Life, shall enjoy all benefits of MediShield Life as provided under the Act and Regulations.

*you – means the policyowner shown on your policy certificate

*we – means Prudential Assurance Company Singapore (Pte) Limited

2.1.2 Review period

We give you a period of 21 days from the date of receipt of this policy document, to review your policy.

If you decide this policy is not suitable for your needs, simply write to us within the 21-day review period. We will refund any premium you have paid (without interest), less medical fees, other expenses we have had to pay and any amounts you owe us in connection with the policy.

If we make your policy document and all other documents from us available via our secure online portal, we consider them delivered and received when we send the relevant SMS or email informing you that the documents are accessible on the secure online portal.

Otherwise, your policy and all other documents from us are considered delivered and received in the ordinary course of the post, 7 days from the date of posting to the last known address notified to us.

This review period will not apply if you have done a change of plan (refer to clause 2.5).

2.2 What type of benefit?

PRUShield Standard Plan is the enhancement plan that is offered on top of the MediShield Life tier operated by the CPF Board. It provides benefits to meet the needs of Singaporeans and Singapore Permanent Residents who would like adequate coverage and insurance protection against hospitalisation in B1 wards and below, of restructured hospitals.

We will pay the claims according to the benefits under this enhancement plan or MediShield Life, whichever is higher.

Benefits under this policy are only payable when the life assured suffers from an injury or illness, which is covered under this policy and the life assured is hospitalised as an inpatient, or undergoes day surgery or selected outpatient treatment, as defined in this policy.

We do not pay under the following benefits if the medical expenses are incurred at non-MediShield Life accredited hospitals or treatment centres:

- Inpatient and Day Surgery benefits (refer to clause 2.2.1)
- Outpatient Treatment benefits (refer to clause 2.2.1)

If the life assured is a foreigner who is not a Singapore Permanent Resident, then your PRUShield plan does not cover the MediShield Life tier operated by the CPF Board. We will pay the claims according to the benefits under this PRUShield plan.

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

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the General Insurance Association (GIA) /Life Insurance Association (LIA) or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

2.2.1 Basic benefits offered

We provide you with the following basic benefits that pay for medically necessary treatment:

a) Inpatient and Day Surgery benefits:

We will reimburse the reasonable and customary expenses incurred for the following treatments up to the respective benefit limits as set out in the Benefits Schedule:

- Normal Ward (including eligible MIC@Home stays)
- Intensive Care Unit Ward
- Psychiatric
- Community Hospital (Rehabilitative)
- Community Hospital (Sub-acute)
- Inpatient Palliative Care Service (General)
- Inpatient Palliative Care Service (Specialised)
- Surgical Procedure
- Implants
- Radiosurgery, including Proton Beam Therapy – Category 4
- Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma
- Serious Pregnancy and Delivery-related Complications
- High-Cost Drugs (non-cancer) listed on MediShield Life's benefit schedule

The above benefits under point a) are subject to the deductible, co-insurance, pro-ration and benefits limits as set out in the Benefits Schedule.

b) Outpatient Treatment benefits:

We will reimburse, as set out in the Benefits Schedule, the reasonable and customary expenses incurred for approved outpatient treatment at MediSave/MediShield Life accredited treatment centres for the following:

- Kidney dialysis
- Cancer Drug Treatment
- Cancer Drug Services
- Radiotherapy for cancer:
 - External (except Hemi-Body)
 - Brachytherapy
 - Hemi-Body
 - Stereotactic

- Proton Beam Therapy:
 - Category 1
 - Category 2
 - Category 3
- Immunosuppressants for Organ Transplant
- Erythropoietin for Chronic Kidney Failure
- Long-term Parenteral Nutrition

The above benefits under point b) are subject to co-insurance, pro-ration and benefits limits as set out in the Benefits Schedule.

For a detailed explanation of the above benefits, please refer to clause 2.4 of this policy document.

2.3 Payment of premiums

2.3.1 Your obligations

Your policy certificate shows the date your first premium is due and the premium amount. Your premium for each subsequent policy year is due on each anniversary of the cover start date (**Premium Due Date**). You must pay your premium within 90 days from each premium due date (**the Grace Period**). We will send you a notice when your premium is due.

If you fail to pay your premium within the grace period, your policy automatically ends. In this instance, as long as your premiums are not paid, claims submitted for an illness or injury incurred within the grace period will not be considered.

2.3.2 Premium payment from MediSave

If you pay your premium with funds from a MediSave account, we will deduct premiums annually from this MediSave account up to a maximum withdrawal limit per life assured per policy year as stipulated by the CPF Board. If the premium due is more than the maximum withdrawal limit or there are insufficient funds in the MediSave account to pay the premium due, the balance premium due can be paid by cash within the grace period.

2.3.3 Premium payment by other payment methods

If you pay your premiums by credit card or GIRO, we will send you a notice when your premium is due. You must ensure that your premiums are paid on time even if you do not receive the notice.

If you are a foreigner with an eligible valid pass, you must pay your premiums via credit card or GIRO. We will renew your policy only if your premiums are paid by either of these methods.

2.3.4 Renewal premium rate

On the premium due date for each policy year, the required renewal premium rate for the life assured will be determined based on the age next birthday of the life assured.

2.4 What type of plan?

2.4.1 Types of benefits offered

The table below (**Benefits Schedule**) shows the maximum benefits offered for the plan.

Benefits Schedule (please refer to clauses 2.4.2 to 2.4.3 for the details of these benefits)

	Singapore Restructured Hospital (Class B1 Ward)
<u>Inpatient and Day Surgery Benefits</u>	
Daily Ward and Treatment Charges:	
Normal Ward (including eligible MIC@Home stays)	\$ 2,250 per day**
Intensive Care Unit Ward	\$ 6,850 per day**

	Singapore Restructured Hospital (Class B1 Ward)
Psychiatric	\$ 680 per day (up to 60 days per policy year)
Community Hospital (Rehabilitative)	\$ 760 per day
Community Hospital (Sub-acute)	\$ 960 per day
Inpatient Palliative Care Service (General)	\$ 560 per day
Inpatient Palliative Care Service (Specialised)	\$ 760 per day
Surgical Procedure based on MOH's Table of Surgical Procedure (per procedure):	
Table 1A	\$ 590
Table 1B	\$ 1,050
Table 1C	\$ 1,050
Table 2A	\$ 1,800
Table 2B	\$ 2,300
Table 2C	\$ 2,370
Table 3A	\$ 3,290
Table 3B	\$ 4,240
Table 3C	\$ 4,760
Table 4A	\$ 5,970
Table 4B	\$ 8,220
Table 4C	\$ 8,220
Table 5A	\$ 8,920
Table 5B	\$ 9,750
Table 5C	\$11,030
Table 6A	\$15,910
Table 6B	\$15,910
Table 6C	\$17,300
Table 7A	\$21,840
Table 7B	\$21,840
Table 7C	\$21,840
Implants	\$ 9,800 (per treatment session)
Radiosurgery including Proton Beam Therapy – Category 4	\$31,300 (per treatment course)
Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma	\$ 14,040 (per treatment session)
Serious Pregnancy and Delivery-related Complications	As covered under the Inpatient and Day Surgery benefits
High-Cost Drugs (non-cancer) listed on MediShield Life's benefit schedule	As covered under the Inpatient and Day Surgery benefits
<u>Outpatient Treatment benefits:</u>	
Kidney Dialysis	\$ 3,740 per calendar month*

	Singapore Restructured Hospital (Class B1 Ward)	
<p>Outpatient Cancer Treatment:</p> <p><i>Patients receiving treatment for one primary cancer.</i></p> <ul style="list-style-type: none"> - Cancer drug treatment on MOH's Cancer Drug List - Cancer drug services <p><i>Patients receiving treatment for Multiple Primary Cancers</i></p> <ul style="list-style-type: none"> - Cancer drug treatment on MOH's Cancer Drug List - Cancer drug services - Radiotherapy for Cancer: <ul style="list-style-type: none"> - External (except Hemi-Body) \$ 880 per treatment session - Brachytherapy \$ 1,100 per treatment session - Hemi-Body \$ 2,510 per treatment session - Stereotactic \$ 6,210 per treatment session - Proton Beam Therapy <ul style="list-style-type: none"> - Category 1 \$ 880 per treatment session - Category 2 \$ 1,100 per treatment session - Category 3 \$ 6,210 per treatment session <p>Immunosuppressants for Organ Transplant \$ 1,480 per calendar month*</p> <p>Erythropoietin for Chronic Kidney Failure \$ 450 per calendar month*</p> <p>Long-term Parenteral Nutrition \$ 3,980 per calendar month*</p>	<p>3 x (MediShield Life limit for one primary cancer per month)</p> <p>2 x (MediShield Life limit for one primary cancer per policy year)</p> <p>Sum of the highest cancer drug treatment limit among the claimable treatments received for each primary cancer per month</p> <p>2 x (MediShield Life limit for Multiple Primary Cancers per policy year)</p>	
<u>Deductible per policy year:</u>	80 years old and below (age next birthday)	81 years old and above (age next birthday)
Singapore Restructured Hospital C Ward	\$1,500	\$2,000
Singapore Restructured Hospital B2/B2+ Ward	\$2,000	\$3,000
Singapore Restructured Hospital B1 Ward	\$2,500	\$3,000
Singapore Restructured Hospital A Ward	\$2,500	\$3,000
Private Hospital	\$2,500	\$3,000
Day Surgery – Subsidised	\$1,500	\$2,000
Day Surgery – Non-Subsidised	\$2,000	\$3,000
Short Stay Ward – Subsidised	\$1,500	\$2,000
Short Stay Ward – Non-Subsidised	\$2,000	\$3,000
<u>Co-Insurance</u>	10%	
<u>Limits of Cover:</u>		
Policy Year Limit	\$200,000	
Lifetime Limit	Unlimited	
<u>Age Limits:</u>		
Maximum Entry Age	N.A.	
Maximum Coverage Age	Lifetime	

	Singapore Restructured Hospital (Class B1 Ward)		
	Singapore Citizens	Singapore Permanent Residents	Foreigners
Pro-Ration:			
Private Hospital / Private Community Hospital / Private Inpatient Palliative Care Service	50%	50%	50%
Singapore Restructured Hospital / Community Hospital / Inpatient Palliative Care Service A Ward	80%	80%	80%
Singapore Restructured Hospital / Community Hospital / Inpatient Palliative Care Service B1 Ward	N.A.	90%	80%
Singapore Restructured Hospital / Community Hospital / Inpatient Palliative Care Service B2/B2+/C Ward	N.A.	N.A.	N.A.
Short Stay Ward (Subsidised / Non-Subsidised)	N.A.	N.A.	N.A.
Day Surgery (Subsidised / Non-Subsidised)	N.A.	N.A.	N.A.
Day Surgery (Private)	65%	65%	65%
Outpatient Treatment (Subsidised / Non-Subsidised)	N.A.	N.A.	N.A.
Outpatient Treatment (Private)	65%	65%	65%

* Refer to clause 2.10.4 for the definition of Claim Limit per Calendar Month

** Limits are higher by \$300 for the first two days of inpatient stay

2.4.2 Inpatient and Day Surgery benefits

These benefits below are subject to the deductible, co-insurance, pro-ration and benefit limits as set out in the Benefits Schedule.

2.4.2.1 What do we pay for Normal Ward?

If the life assured is hospitalised in a standard room of a hospital as a result of injury or illness, we pay the normal ward charges for each day of hospital confinement that are reasonable and customary expenses. This may include meals, inpatient prescriptions, professional charges, investigations, laboratory tests, high dependency ward stay and charges for other medical services.

In addition, we also cover services at home that are the same as hospital inpatient services, cost of medical equipment used, nursing care at home and transport-related services as part of Mobile Inpatient Care @ Home (MIC@Home).

If a hospital confinement flows over to the next policy year, the benefits will be processed based on the previous policy year's benefits limits and deductible when the life assured was first admitted for hospitalisation.

If the life assured changes ward of stay during hospital confinement, the deductible applicable to the claim will be based on the highest ward class the life assured had stayed in.

We will pay for the cost of a short stay ward only if there is a charge for short stay ward in the hospital bill. We will pay such cost even if it does not result in hospital confinement of the life assured.

2.4.2.2 What do we pay for Intensive Care Unit (ICU) Ward?

We pay the ICU ward charges if the life assured is confined in the ICU ward because of injury or illness. Charges may include meals, inpatient prescriptions, professional charges, investigations, laboratory tests and charges for other medical services.

2.4.2.3 What do we pay for Community Hospital?

Upon discharge from the hospital and if the life assured is immediately hospitalised in a standard room of a community hospital to continue treatment for Rehabilitative care or for Sub-acute care, we pay the actual normal ward charges including meals, inpatient prescriptions, professional charges, investigations, laboratory tests, and other medical services. Hospice and convalescent centres/hospitals/homes are not covered.

We also reimburse the reasonable and customary expenses incurred for community hospital if the life assured is referred from emergency department of a restructured acute hospital.

2.4.2.4 What do we pay for Psychiatric Treatment?

We pay for the medical expenses incurred if the life assured receives inpatient psychiatric treatments. All eligible expenses incurred under the Psychiatric Treatment, including short stay ward, shall be accumulated and paid up to the limit as set out in the Benefits Schedule.

2.4.2.5 What do we pay for Surgical Procedure?

We pay if the life assured undergoes a medically necessary surgical procedure during his hospital confinement. Charges may include operating theatre and anaesthesia fees.

If the life assured undergoes day surgery where normal ward charges may not be applicable, we will still pay the Surgical Procedure benefit.

2.4.2.6 What do we pay for Implants?

We pay if the life assured undergoes surgery and an implant is inserted into the body of the life assured and remains in the body on completion of the surgery.

We pay for approved medical consumables which may include intravascular electrodes used for electrophysiological procedures, Percutaneous Transluminal Coronary Angioplasty (PTCA) and intra-aortic balloons (or balloon catheters).

The implants and approved medical consumables must be medically necessary and deemed to be reasonable and customary expenses.

2.4.2.7 What do we pay for the Radiosurgery, including Proton Beam Therapy–Category 4?

We pay for the expenses incurred when the life assured undergoes Radiosurgery or Proton Beam Therapy - Category 4 for an MOH-approved Proton Beam Therapy indication and if the life assured meets the eligibility criteria for Proton Beam Therapy under MediShield Life. The MOH-approved Proton Beam Therapy indications and patient eligibility criteria are specified on MOH's website. MOH may update this from time to time. Radiosurgery, including Proton Beam Therapy – Category 4 can be performed as an inpatient or day surgery procedure.

The applicable deductible and pro-rata factor for Radiosurgery, including Proton Beam Therapy – Category 4 procedure will depend on its classification as an inpatient or day surgery procedure.

2.4.2.8 What do we pay for Inpatient Palliative Care Service (General)?

We pay for the medical expenses incurred if the life assured receives General Inpatient Palliative Care, up to the limits as set out in the Benefits Schedule.

The life assured must be admitted for General Inpatient Palliative Care by a registered medical practitioner, according to the relevant guidelines from MOH.

2.4.2.9 What do we pay for Inpatient Palliative Care Service (Specialised)?

We pay for the medical expenses incurred if the life assured receives Specialised Inpatient Palliative Care, up to the limits as set out in the Benefits Schedule.

The life assured must be admitted for Specialised Inpatient Palliative Care by a registered medical practitioner, according to the relevant guidelines from MOH.

2.4.2.10 What do we pay for Continuation of the Autologous Bone Marrow Transplant Treatment for Multiple Myeloma?

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, if the life assured undergoes medically necessary Autologous Bone Marrow Transplant Treatment for Multiple Myeloma for the following stages of the treatment:

- Stem-cell mobilisation
- Harvesting healthy stem cells
- Pre-transplant workup
- Use of high dosage chemotherapeutic drugs to destroy cancerous cells
- Engraftment of healthy stem cells
- Post-transplant monitoring

We pay for all treatment costs, including consultation, clinical and lab investigations, consumables and drugs needed for the Continuation of Autologous Bone Marrow Transplant Treatment for Multiple Myeloma in the outpatient setting.

This applies strictly to treatment in the outpatient setting only. If the life assured requires certain phases of bone marrow transplant in the inpatient setting, these treatments will be covered under the prevailing inpatient limits.

This benefit is subject to the deductible, co-insurance and pro-ration.

2.4.2.11 What do we pay for Serious Pregnancy and Delivery-related Complications?

We will reimburse expenses incurred if the life assured is hospitalised as a result of the pregnancy complication conditions listed below. These pregnancy complications must have been first diagnosed after 10 months from the:

- cover start date of the policy; or
- date of reinstatement (if any),

whichever is later.

1) Abruptio Placentae

This is the separation of the normally implanted placenta after the 20th week of gestation and prior to the birth of the foetus, resulting in life threatening foetal distress and/or maternal shock. The diagnoses of Abruptio Placentae must be confirmed by a medical specialist and supported with medical evidence of Class 2 or Class 3 abruptio necessitating an emergency caesarean section.

2) Abscess of breast

The diagnosis, by an obstetrician, of an abscess of breast associated with childbirth.

3) Accreta placenta

The diagnosis of accreta placenta by an obstetrician of abnormal trophoblast invasion into the myometrium of the uterine wall, requiring caesarean hysterectomy during delivery.

4) Acute Fatty Liver of Pregnancy

This is the condition of a severe acute fatty liver occurring during pregnancy and associated with acute liver failure where all of the following diagnostic conditions must be met:

- bilirubin is persistently elevated above 150 umol/L (10 mg/dL) for a period of at least 5 days; and
- there is associated hepatic encephalopathy.

5) Amniotic Fluid Embolism

This is a condition in which, following the infusion of amniotic fluid into the maternal circulation, there is the sudden development of acute respiratory distress and shock. The diagnosis must be confirmed by a registered medical practitioner and supported with medical evidence of any combination of respiratory distress, cardiovascular collapse, disseminated intravascular coagulation, coma and lung scans showing embolization

6) Antepartum, intrapartum and postpartum haemorrhage

The diagnosis, by an obstetrician, of severe abnormal bleeding from the female genital tract at or after 24 weeks of pregnancy or during or after childbirth.

7) Cervical incompetency

The diagnosis of cervical incompetency by an obstetrician and requires cervical cerclage.

8) Complications resulting in a caesarean hysterectomy

The diagnosis of complications resulting in a caesarean hysterectomy by an obstetrician where the uterus is removed during a caesarean section delivery in cases where removal of the uterus is solely due to complications that has arisen during the pregnancy or delivery.

9) Ectopic pregnancy

This is a condition in which implantation of a fertilised ovum occurs outside the uterine cavity. The ectopic pregnancy must have been terminated by laparotomy or laparoscopic surgery.

10) Fourth degree perineal laceration

The diagnosis of fourth degree perineal laceration by an obstetrician. To avoid any doubt, perineal laceration less than fourth degree or without identified degree are excluded.

11) Gestational diabetes mellitus

The diagnosis of gestational diabetes mellitus by an obstetrician. The diagnosis was made through a 75g oral glucose tolerance test.

12) Hydatidiform mole and subsequent complications (including Choriocarcinoma)

The diagnosis, by an obstetrician, of hydatidiform mole and subsequent complications (including choriocarcinoma) that is supported histologically.

- 13) **Infection of amniotic sac and membranes**
The diagnosis of an infection of the amniotic sac and membranes by an obstetrician.
- 14) **Maternal death**
The diagnosis of maternal death by an obstetrician.
- 15) **Medically necessary abortions**
The diagnosis of medically necessary abortions by an obstetrician. **Obstetric cholestasis**
The diagnosis of obstetric cholestasis by an obstetrician.
- 16) **Obstetric injury or damage to pelvic organs**
The diagnosis of obstetric injury or damage to the pelvic organs by an obstetrician where the injury or damage is a consequence of vaginal delivery
- 17) **Placenta praevia**
The diagnosis, by an obstetrician, of the presence of placental tissue extending over the internal cervical, resulting in a caesarean delivery.
- 18) **Placental insufficiency and Intrauterine growth restriction**
The diagnosis, by an obstetrician, of placental insufficiency leading to intrauterine growth restriction.
- 19) **Postpartum inversion of uterus**
The diagnosis of postpartum inversion of the uterus by an obstetrician where the uterine fundus collapses into the endometrial cavity, turning the uterus partially or completely inside out.
- 20) **Pre-eclampsia and eclampsia**
The diagnosis of pre-eclampsia or eclampsia by an obstetrician.
- 21) **Retained placenta and membranes**
The diagnosis of retained placenta and membranes by an obstetrician.
- 22) **Still-birth**
The diagnosis by an obstetrician, of the death of the foetus of the life assured after 22 weeks of pregnancy which meets the definition of still birth in the Registration of Births and Deaths Act 2021 (or any subsequent revision of the definition by the Act).
- 23) **Twin to twin transfusion syndrome**
The diagnosis of twin to twin transfusion syndrome by an obstetrician and supported with ultrasonic evidence of a single monochorionic placenta with twin oligohydramnios / polyhydramnios sequence.
- 24) **Uterine rupture**
The diagnosis of uterine rupture by an obstetrician where there is complete disruption of all uterine layers, including the serosa and surgery is performed to correct the abnormality.

This benefit is subject to the deductible, co-insurance and pro-ration.

We do not pay for delivery charges, except in the event of a caesarean section with Hysterectomy.

2.4.2.12 What do we pay for High-Cost Drugs (non-cancer)?

We reimburse the reasonable and customary expenses incurred, up to the limits as set out in the Benefits Schedule, when the life assured undergoes High-Cost Drugs (non-cancer) treatment as an inpatient or day surgery procedure, as long as the High-Cost Drugs (non-cancer) is listed on MediShield Life's benefit schedule < go.gov.sg/mshlbenefits> which has been assessed by MOH to be clinically- and cost-effective.

We will not cover any High-Cost Drugs (non-cancer) not listed on MediShield Life's benefit schedule, used for the conditions covered by MediShield Life. Please refer to MOH's website for the latest MediShield Life's benefit schedule. MOH may update this list from time to time. The updated High-Cost Drugs (non-cancer) coverage will apply on and from the effective date of the revised list.

This benefit is subject to the deductible, co-insurance and pro-ration.

When we work out the benefit limit that we will pay for the High-Cost Drugs (non-cancer), we will include all reasonable and customary expenses incurred for the treatment, including but not limited to, the cost of drug(s), room & board, diagnostic test(s), laboratory charges, doctor attendance fee, medical consumables, etc. (including pre- and post-hospitalisation treatment) under this benefit.

2.4.3 Outpatient Treatment benefits

These benefits cater to outpatient treatments (which do not require hospital confinement) as specified in the Benefits Schedule. Treatment must be done at MediSave /MediShield Life accredited treatment centres and we pay for the reasonable and customary expenses incurred up to the limit as set out in the Benefits Schedule.

The deductible is not applicable to this benefit, but it is still subject to co-insurance and pro-ration.

We pay for:

- Kidney dialysis
- Cancer Drug Treatment
- Cancer Drug Services
- Radiotherapy for Cancer:
 - External (except Hemi-Body)
 - Hemi-Body
 - Brachytherapy
 - Stereotactic
 - Proton Beam Therapy:
 - Category 1
 - Category 2
 - Category 3
- Immunosuppressants for organ transplant
- Erythropoietin for Chronic Kidney Failure
- Long-term Parenteral Nutrition

Cancer Drug Treatment

We pay for cancer drug treatments that are on the Cancer Drug List (**CDL**), up to the treatment-specific claim limits. Cancer drug treatments not listed or not administered exactly as described in the CDL, are considered non-CDL and will not be claimable under PRUShield, unless otherwise stated in this policy.

The CDL currently covers most cancer drug treatments approved by the Health Sciences Authority (**HSA**). The cancer drug treatment claim limit is based on a multiple of the MediShield Life limit for the specific cancer drug treatment. For the latest CDL and MediShield Life limits, refer to the CDL on MOH's website. MOH may update this from time to time. The revised list will be applicable to the Cancer Drug Treatment which occurred on and from the effective date of the revised list.

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

For each primary cancer, where multiple cancer drug treatments are administered in a month, if any of the CDL treatments have an indication that states "monotherapy", only CDL treatments with the indication "for cancer treatment" will be claimable in that month. Otherwise, the following will apply:

- (a) If more than one of the cancer drug treatments administered in a month have an indication other than "for cancer treatment", only CDL treatments with the indication "for cancer treatment" will be claimable in that month.
- (b) If one or none of the cancer drug treatments administered in a month has an indication other than "for cancer treatment", all CDL treatments will be claimable in that month.

To avoid any doubt, for CDL treatments, the indications refer to the clinical indications of the drug as specified in the CDL on MOH's website. Non-CDL treatments will be considered as having an indication other than "for cancer treatment".

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

Multiple Primary Cancers are two or more cancers arising from different sites and/or are of a different histology or morphology group. A patient with cancer that has spread (metastasised) from the place where it first started to another part of the body will be considered as having a single primary cancer as the cancer in the other part of the body started from the original cancer. For example, cancer cells may spread from the breast (primary cancer) to form new tumours in the lung (secondary cancer / metastatic cancer). The new tumour in the lung will not be considered as another primary cancer.

Higher claim limits for patients receiving treatment for Multiple Primary Cancers are given on an application basis; doctors are to send the application form to MOH and to us for assessment of MediShield Life and PRUShield coverage respectively.

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

Cancer Drug Services

We pay for cancer drug services that are part of a cancer drug treatment (including treatments not on the CDL), such as consultations, scans, laboratory investigations, treatment preparation and administration, supportive care drugs and blood transfusions, up to specified claim limits. Cancer drug services incurred before the cancer is diagnosed, after the cancer has gone into remission, or once the course of treatment has ceased, will not be covered.

The Cancer Drug Services claim limit is based on a multiple of the MediShield Life limit for Cancer Drug Services. You can find the latest MediShield Life limit for Cancer Drug Services on MOH's website. The Ministry of Health of Singapore may update this from time to time. The revised limit will be applicable to the Cancer Drug Services incurred within the policy year of the revised limit.

This limit does not only apply to services related to cancer drug treatments on the CDL, meaning we will also pay even if the service was for a non-CDL cancer drug treatment. Supportive drugs must be claimed under this limit.

Higher claim limits for patients receiving treatment for Multiple Primary Cancers are given on an application basis; doctors are to send the application form to MOH and to us for assessment of MediShield Life and PRUShield coverage respectively.

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

Proton Beam Therapy

We will only pay for Proton Beam Therapy if it is administered for an MOH-approved Proton Beam Therapy indication and if the life assured meets the eligibility criteria for Proton Beam Therapy under MediShield Life. The MOH-approved Proton Beam Therapy indications and patient eligibility criteria are specified on MOH's website. MOH may update this from time to time.

Immunosuppressants for organ transplant and Erythropoietin for Chronic Kidney Failure

Erythropoietin for chronic kidney failure, Immunosuppressants such as cyclosporin, tacrolimus for organ transplant and other drugs must be approved by the HSA of Singapore.

Long-term Parenteral Nutrition

Long-term Parenteral Nutrition expenses include the cost of parenteral nutrition bags and consumables necessary for administering Long-term Parenteral Nutrition and that meets the claimable criteria under the MediShield Life Scheme.

We will also pay for consultation and laboratory tests that are related to the outpatient treatment, if they are ordered by the treating registered medical practitioner within 30 days before such outpatient treatment. We will not pay for follow-up consultation, laboratory tests and other medical attention after the outpatient treatments.

2.5 Can I change my plan?

You can apply to change to a higher or lower plan (where applicable) by giving us written notification.

When you apply to change to a higher plan, the life assured must give us satisfactory evidence of a health condition that is acceptable to us.

Once we have changed your plan to the new plan, medical expenses incurred from the cover 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 policy/benefit limits which will apply from the cover start date of the new plan.

When you change to a higher plan, some of the policy benefits require the life assured to wait out a period of time before such benefits will be covered (**Waiting Period**). This Waiting Period commences from the cover start date of the new plan. If the life assured claims for hospitalisation or medical treatment that occurred within this Waiting Period, we will assess such claims according to the terms and conditions of the immediate preceding plan instead of the new plan.

For any claim payable, we will determine the claim amount based on the policy year limit and pro-ration (if applicable) of the plan that is applicable on the date of the hospital admission and/or medical expense bill.

If the plan you have applied to change to is withdrawn, we reserve the right to change your plan to a similar medical product that is available at the time of renewal.

You must use our appropriate application form and meet the conditions on it. We will notify you if we accept your application.

2.6 How to make a claim?

You must authorise the MediSave/MediShield Life accredited hospitals or treatment centres to submit all eligible medical bills relating to the following benefits, electronically to us:

- Inpatient and Day Surgery benefits (refer to clause 2.4.2)
- Outpatient Treatment benefits (refer to clause 2.4.3)

If the life assured is a foreigner who is not a Singapore Permanent Resident, you have to submit the following documents to us:

- a completed PRUShield claim form;
- original final hospital bills and payment receipts;
- medical report from the life assured's registered medical practitioner;
- a completed Clinical Abstract Application form;
- death certificate issued by the relevant authority, if applicable;
- a certified true copy of the life assured's:
 - Eligible Valid Pass; and
 - travel documents or passport.
- a certified true copy of the identification documents of the claimant, if applicable;
- evidence that the person is entitled to receive the payment (e.g. birth certificate, marriage certificate, the deceased's last will, Letter of Administration or Probate, Trust Deed, etc.), if applicable; and
- any documentary proof as required by us.

Eligible Valid Pass is a pass recognised by the Immigration & Checkpoints Authority (ICA) and the Ministry of Manpower (MOM). The list of eligible valid passes, acceptable by us, is listed in clause 2.10.

You must file your claims within 180 days from the date of the medical bills.

We reserve the right to ask you or your legal representative to provide, at your own expense, more documents or evidence to our satisfaction to help us assess your claim and to appoint a registered medical practitioner to re-examine the life assured.

We also reserve the right to adjust any duration of hospital confinement or surgical procedure or hospitalisation expenses which, in the opinion of our medical advisers, is considered as excessive. The duration of hospital confinement and surgical procedure should not exceed the general level by hospitals of similar standing in the same locality where the charges are incurred, taking into consideration similar or comparable treatment, services or supplies to individuals of the same sex and of comparable age, for similar illness or injury.

You must co-operate fully with us and our medical advisers. You must disclose fully and faithfully all material facts and matters which the life assured knows or ought to know and if required, on our request, sign any document to allow us to obtain relevant information, at your expense, from any registered medical practitioner, hospital or other sources.

All documents submitted that are not in English must be translated to English by an accredited translator at your own or the claimant's expense.

2.6.1 Recovery of claims paid

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

If any claim has been found to be fraudulent, exaggerated or if there is any false declaration or statements in support of any claim, we reserve the right to terminate or void this policy, or recover any benefits paid under the policy.

2.7 Who do we pay?

Claims processed electronically will be paid to the hospital. Otherwise, we pay you, the policyowner or the MediSave account that is used to pay the bill, provided we receive to our satisfaction, evidence of your entitlement.

The claims amount will be paid out provided:

- your claim amount has not exceeded the policy year limit or benefit limit as set out in the Benefits Schedule; and
- your current premium has been paid.

If you have used MediSave funds to pay the medical bill, we will first reimburse any cash payment you made in the medical bill, then to the MediSave account that was used.

2.8 What is not covered?

We do not pay for any benefits under this policy which are directly or indirectly related to any of the following conditions, including outcomes from these conditions and their related complications, except otherwise expressly allowed by MediShield Life Claims Rules specified on MOH's website. However, (MediShield Life may cover some of the following conditions, up to the respective terms and conditions of MediShield Life):

- All expenses incurred by a life assured for the period of hospital confinement if admission into a hospital is before the cover start date of the policy;
- Any pre-existing illnesses, diseases or impairments from which the life assured is suffering from prior to the cover start date of the policy, unless they were declared in the proposal and specifically accepted by us. A pre-existing condition is the existence of any signs or symptoms for which treatment, medication, consultation, advice or diagnosis has been sought or received by the life assured or would have caused an ordinary prudent person to seek treatment, diagnosis or cure, prior to the cover start date of this benefit or the date of reinstatement (if any), whichever is later;
- Treatment relating to birth defects, including hereditary conditions and congenital sickness or abnormalities;
- Overseas medical treatment;
- Mental illness and personality disorders except when it is covered under the Psychiatric Treatment benefit as set out in clause 2.4.2.4;
- Pregnancy and childbirth and any complications arising from such conditions;
- Elective abortion; threatened abortion; miscarriage; birth control*, sterilisation*, infertility*, sub-fertility*, impotence treatment, assisted conception or any contraceptive treatment; (* for males and females);
- Treatment of sexually transmitted diseases;
- Acquired Immunodeficiency Syndrome (**AIDS**), AIDS-related complex or infection by Human Immunodeficiency Virus (**HIV**) except HIV Due to Blood Transfusion and Occupationally Acquired HIV as set out in clause 2.10.13;
- treatment resulting from drug addiction or under the influence of any controlled drugs listed under the First Schedule to the Misuse of Drugs Act 1973;
- Cosmetic or Plastic Surgery except:
 - Cosmetic or Plastic Surgery due to an accident (refer to clause 2.10.7); or
 - Breast Reconstruction after a Mastectomy (refer to clause 2.10.3);
- Outpatient treatment and medical services except when it is covered under the "Outpatient Treatment benefit";
- All dental treatment except Accidental Inpatient Dental Treatment (refer to clause 2.10.2);
- Correction for refractive errors of the eye (including the use of artificial lens implants and Lasik), routine eye and ear examinations, costs of spectacles, costs of contact lenses and costs of hearing aids;
- All other types of lenses for cataract, except monofocal non-toric lenses;
- Transport-related services including ambulance fees, emergency evacuation and repatriation of mortal remains (except when it is covered by us, as part of MIC@Home);
- Sex change operations;

- Purchase or rental for use at home or as an outpatient (except when it is covered by us, as part of MIC@Home), of:
 - Braces
 - Prostheses
 - Special / Medical appliances including the location, transport and associated administration costs of such appliances and which are not necessary for the completion of a surgical operation
 - Durable medical equipment / machines
 - Corrective devices
 - Wheelchairs
 - Walking aids
 - Home aids
 - Kidney dialysis machines
 - Iron lungs
 - Oxygen machines
 - Hospital beds
 - Any other hospital type equipment; or
 - Replacement organ;
- Experimental or pioneering medical or surgical techniques, clinical trials for drugs or medical devices not approved by MOH;
- Private nursing charges and nursing home services (except when it is covered by us, as part of MIC@Home);
- Vaccination;
- Treatment of injuries arising from direct or indirect participation in civil commotion, riots or strikes;
- Treatment of injuries arising directly or indirectly from nuclear fallout, terrorism, war and related risks;
- Treatment for which the life assured had received work injury compensation under the Work Injury Compensation Act 2019 and other forms of insurance coverage;
- Rest cures, hospice care, home or outpatient nursing or palliative care (except when it is covered by us), convalescent care in convalescent or nursing homes, sanatoriums or similar establishments, outpatient rehabilitation services such as counselling and physical rehabilitation (except when it is covered by us, as part of MIC@Home);
- Alternative or complementary treatments including Traditional Chinese Medicine (**TCM**), or a stay in any healthcare establishment for social or non-medical reasons;
- Hospitalisation primarily for medical services such as but not limited to X-ray, CT or MRI scans, medical check-up or health screening or other investigations which can routinely be conducted on an outpatient basis (unless otherwise covered under the terms and conditions of the PRUShield plan, as listed in the Benefits Schedule set out in clause 2.4.1);
- Treatment of illness or injury resulting from the life assured engaging in any hazardous activities or sports in a professional capacity; or where the life assured would or could earn or earns income or remuneration in these hazardous activities or sports;
- Treatment for weight reduction, weight improvement, or obesity or any injury or illness which arises from, or is related to, or a consequence of weight reduction, weight improvement, or obesity in any way, such as, but not limited to, the use of gastric banding or stapling, the removal of fat or surplus tissue from any part of the body, whether or not needed for medical or psychological reasons;
- Violation or attempted violation of law, resistance to lawful arrest or any resultant imprisonment;
- Non-medical items such as, but not limited to, parking fees, hospital Administration and Registration fees, laundry, rental of television, newspaper, medical report fees;
- Elective hospital confinements, medical treatments or medical services which are not medically necessary;
- Any genetic testing and any procedure done as a result of genetic testing, prophylactic measures that are not therapeutic in nature, primary prevention (refers to medical services for generally healthy individuals to prevent a disease from ever occurring, in the absence of medical indications, eg. general medical / health screening packages, general physical checkups, vaccinations, etc.), surveillance screening, diagnostic, investigation tests or checks, except:
 - any genetic testing that is medically necessary and has justification for prognostication and treatment selection as a result of a confirmed diagnosis; or
 - the expenses incurred for medically necessary treatment relating to the removal of cysts, polyps and/or lumps (even if they are benign in nature);
- High-Cost Drugs that are not on MediShield Life's benefit schedule but used for the medical conditions covered by MediShield Life.

We do not pay for any expenses for any treatment, service or item incurred for the hospital confinement of a life assured, received on or after 27 March 2020 but before 20 October 2020 for COVID-19 infection or otherwise, if the life assured is an at-risk traveller while being treated for COVID-19 infection.

We also do not pay for any expenses for any treatment, service or item incurred for the hospital confinement of a life assured received on or after 27 March 2020 but before 20 October 2020, if the life assured is an at-risk traveller who is:

- (i) admitted to the hospital to test for suspected COVID-19 infection;
- (ii) whose test results for COVID-19 infection is negative; and
- (iii) does not need inpatient treatment for any other medical condition.

We do not pay for any treatment, service or item that is required for any other medical condition occurring over the same period as the COVID-19 treatment for an at-risk traveller.

An “at-risk traveller” means a life assured who

- (i) Travelled out of Singapore on or after 27 March 2020 and travelled against any travel advisory concerning the risk of COVID-19 infection issued by MOH and published on its website (which may be changed, added or otherwise modified from time to time); and
- (ii) Began to show symptoms consistent with the COVID-19 infection within the possible incubation period. The possible incubation period refers to the period starting from when the life assured leaves Singapore, at the start of his overseas trip, and ending on and including the 14th day after his arrival in Singapore, at the end of his overseas trip.

“COVID-19” means the infectious disease known as Coronavirus Disease 2019

2.9 General Conditions

2.9.1 Territorial cover

We will pay for all hospitalisation claims incurred in Singapore, subject to the terms and conditions of this policy document. No overseas medical treatments are covered.

2.9.2 Payer of last resort

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

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

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

2.9.3 Declaration of age

If the age of the life assured is stated wrongly in your proposal form, we will adjust the premium that you have to pay. We will refund any excess premium amount that you paid or we will ask you to pay for any shortage in the premium amount.

2.9.4 Renewal of your policy

We guarantee that this policy is renewable yearly for as long as you live, only if you pay the premiums within the grace period and your policy has not ended (as set out in clause 2.9.7) and subject to the terms as set out in clause 2.9.9, 2.9.10 & 2.9.13.

This automatic renewal will happen only if you pay the premium based on the age next birthday of the life assured at the time of renewal.

2.9.5 Right to change the premium

We can change the premium at any time. However, we will give you 30 days' written notice before we do so.

2.9.6 No Waiver

If we do not enforce any of the conditions of this policy document at any time, the policy document will remain valid. We will still have the right to enforce each condition in future even if we have not done so in the past.

2.9.7 When does the policy end?

The policy ends when:

- you cancel your policy, after the expiry of the Review Period, by giving us 30 days' written notice;
- your MediSave-approved integrated shield plan with another insurer starts;
- the life assured renounces his/her Singapore citizenship or Singapore Permanent Residence status;
- your premium is not received after the grace period; or
- the life assured dies.

In addition to the above, for a life assured who is a foreigner and is not a Singapore Permanent Resident, the policy will also end when:

- the life assured 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 your premiums via credit card or GIRO.

To avoid any doubt, if the life assured is without an eligible valid pass for more than 60 days after the eligible valid pass has expired or is terminated, the end date of this policy will be the date of expiry or termination of the eligible valid pass. Any claims incurred after this expiry or termination date will not be valid. This includes any claims incurred during the 60-day period.

We will refund the pro-rated premiums, regardless of any payout during the policy year.

Except in the situation where the life assured dies, if your policy ends before the next premium due date, and no claim has been paid during that policy year, we will refund the pro-rated premium based on the number of unused days for the rest of that policy year, to the MediSave account.

If you pay part of your premium in cash, then the amounts we refund will be proportionate to the amount we deduct from the MediSave account and the amount we collect from you in cash.

Example

If your premium is made up of 80% from the MediSave account and you pay the remainder of 20% in cash, then the refund of unused premium will be in the same proportion – meaning 80% returned to the MediSave account and 20% paid to you.

We or the CPF Board (as the case may be) will determine the effective date of termination of your policy.

When your policy ends in this way, you have no further claims or rights against us under your policy, except if it is specifically stated otherwise in this policy document. To avoid any doubt, the termination of your policy by you or us shall not affect the insurance coverage under MediShield Life. The life assured will continue to be insured under the MediShield Life Scheme with the CPF Board as long as the life assured is eligible for the scheme.

2.9.8 Reinstatement of your policy

You can apply to reinstate your policy if:

- you apply within 12 months from the end date of your policy;
- you pay all the premiums you owe us; and
- you give us satisfactory evidence of the health of the life assured. You must pay for the costs involved in this.

We will not cover any claim incurred before the effective date of the reinstatement of the policy, unless the claim was declared in the reinstatement form and specifically accepted by us.

To apply you must use our appropriate application form and meet the conditions on it. We will notify you if we accept your application.

2.9.9 Change of citizenship, residency status or occupation for foreigners

You must inform us as soon as possible when the life assured's citizenship or residency status changes in any way. You must submit documentary proof of your change.

If the life assured 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 expired or was terminated, this policy will end. So, you must inform us as soon as possible when the eligible valid pass expires or is terminated.

To avoid any doubt, if the life assured is without an eligible valid pass for more than 60 days after the eligible valid pass has expired or was terminated, the end date of this policy will be the date of expiry or termination of the eligible valid pass. Any claims incurred after this expiry or termination date will not be valid. This includes any claims incurred during the 60-day period.

If the life assured is a Work Permit holder and if they change their occupation to one that is not within the acceptable occupation classes listed by us, the policy will end. You must inform us as soon as possible when the life assured changes occupation.

2.9.10 Changes to policy benefits, conditions or plan

We can change the policy benefits, features, conditions and/or name at any time. This includes compulsory changes to the policy benefits, features, guidelines and/or conditions that may be introduced by the Ministry of Health (MOH), the Central Provident Fund Board or any other regulatory authority on MediShield Life.

Also, if PRUShield is not available when your policy is due for renewal, we can renew your policy to a similar medical product that is available at the time of renewal.

We will give you 30 days' written notice before doing so. However, these compulsory changes to the policy benefits, features, guidelines and/or conditions set out by the relevant regulatory authority will immediately apply to your policy without written notice given to you.

Any such changes will be subject to compliance with the conditions for MediSave-approved medical insurance plan issued by MOH.

2.9.11 Special terms and conditions

If we have accepted your proposal for this policy with special terms and conditions, we give you a copy of our offer of conditional acceptance which contains the special terms and conditions. The special terms and conditions shown on our offer of conditional acceptance become part of your policy.

This offer of conditional acceptance with the special terms and conditions will continue to be part of your policy at each renewal unless we inform you in writing or through your preferred means of communication.

2.9.12 Currency in use

Unless we say otherwise, all premiums and benefits are payable in Singapore dollars.

We will convert hospital bills that are in a foreign currency to Singapore currency at the prevailing exchange rate we decide, effective on the issue date of the hospital bill.

2.9.13 Policy becomes void

We may declare your policy void if:

- the information or any written statement you give us before the cover start date of the policy (or at any application for reinstatement) is untrue in any way; or
- any material fact affecting the risk is stated or represented to us wrongly or is left out from any of the documents you gave us.

If no claim has been paid, we will refund the total premium paid to you and/or the the MediSave account with the Central Provident Fund Board.

If we have paid any claim previously, we will only refund the premium paid for the renewal of your policy after the date of the last claim.

2.9.14 Governing Law

Your policy is governed by the laws of the Republic of Singapore, and the Singapore courts alone will deal with any dispute arising from your policy.

2.10 Definitions

2.10.1 Accident

An event caused by violent, external and visible means and caused solely and independently of any other means.

2.10.2 Accidental Inpatient Dental Treatment benefit

Accidental Inpatient Dental Treatment refers to dental procedures performed by a duly qualified dental surgeon during hospitalisation, to remove, replace or restore natural teeth lost or damaged because of an accident. The benefit is subject to the respective benefit limits under surgical procedure based on MOH's Table of Surgical Procedure.

2.10.3 Breast Reconstruction after a Mastectomy

Breast Reconstruction after a Mastectomy refers to medically necessary breast reconstruction after a mastectomy, subject to the following conditions:

- The mastectomy must be due to breast cancer;
- The breast reconstruction or any subsequent follow-up reconstruction surgery on the same breast must be done within 365 days from the original mastectomy;
- A breast implant will be covered, up to the medically necessary requirement.

Any surgery or reconstruction of the other breast to produce a symmetrical appearance will not be covered.

2.10.4 Claim Limit per Calendar Month

The Claim Limit per Calendar Month is the maximum claimable amount that the life assured can claim in one calendar month.

This means that the claim amount we pay out is assessed from the start date of the treatment and cannot exceed the claim limit applicable for that calendar month. If the claim limit is reached, we will not pay the claim utilising the benefit amount from the next calendar month even if the treatment period flows over to the next calendar month.

Example

Mr J has to undergo kidney dialysis every two weeks.

5 January – kidney dialysis treatment session 1 = \$3,000

19 January – kidney dialysis treatment session 2 = \$3,500

Cost of treatment for January = \$6,500

Minus 10% co-insurance = - 650

= \$5,850

Claim Limit per Calendar Month for kidney dialysis = \$3,740

We will pay \$3,740.

2.10.5 Co-insurance

Co-insurance is the amount that you need to co-pay after the deductible is met. The co-insurance percentages for the various benefits under this policy are stated in the Benefits Schedule. Co-insurance is applicable to all the benefits under this policy.

2.10.6 Community Hospitals

A community hospital is one that is registered and classified under the category of Community Hospitals with MOH, Singapore.

2.10.7 Cosmetic or Plastic Surgery Due to Accident

Cosmetic or Plastic Surgery Due to Accident refers to medically necessary cosmetic or plastic surgery for the repair of damage caused solely by an accident. The surgery must be done within 365 days from the accident.

2.10.8 Cover Start Date

The cover start date is the date of commencement of insurance coverage of your policy and is shown on your policy certificate.

2.10.9 Deductible

This is the part of the claimable amount that the policyowner is liable for before any benefits are payable under this policy. The deductible amounts for the various benefits under this policy are stated in the Benefits Schedule.

2.10.10 Eligible Valid Pass

An Eligible Valid Pass is a pass recognised by the Immigration & Checkpoints Authority (ICA) and the Ministry of Manpower (MOM). The valid passes, acceptable by us, are:

- Personalised Employment Pass (PEP)
- Employment Pass
- S Pass
- Student Pass
- EntrePass
- Long Term Visit Pass (LTVP) ¹
- Dependant's Pass (DP) ²
- Overseas Networks and Expertise Pass
- Work Permit (those from Occupation Class 1 to 3)

¹ We will accept a Long Term Visit Pass that is valid as well as linked to a current Singapore Citizen, Singapore Permanent Resident, Personalised Employment Pass (PEP) holder, Employment Pass holder or EntrePass holder.

We will also accept a Long Term Visit Pass applied under the "Visitor Seeking Long Term Stay" criteria that is granted by the Immigration and Checkpoints Authority (ICA) of Singapore. The applicant's family, comprising spouse and unmarried children (both minor and adult) will also be eligible to apply for a Long Term Visit Pass for the purpose of long term stay. For such applications, the issuance of the Long Term Visit Pass to the family members is tied to the grant of the Long Term Visit Pass to the main applicant. The cancellation of the main applicant's Long Term Visit Pass will result in the cancellation of the Long Term Visit Passes of all their accompanying family members.

² We will only accept a Dependant's Pass that is valid as well as linked to a current Personalised Employment Pass (PEP) holder, Employment Pass holder, S Pass holder or EntrePass holder.

2.10.11 Emergency

Emergency is when urgent remedial treatment is needed and is medically necessary to avoid death or serious impairment to the life assured's health as a result of a Serious Illness or the onset of a serious condition.

2.10.12 Grace Period

You have 90 days from the premium due date to pay your premiums. This is the grace period.

2.10.13 HIV Due to Blood Transfusion and Occupationally Acquired HIV

- A) Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:
- The blood transfusion was medically necessary or given as part of a medical treatment;
 - The blood transfusion was received in Singapore after the cover start date of the policy or the date of reinstatement (if any), whichever is the later; and
 - The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood.
- B) Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the cover start date of the policy or the date of reinstatement (if any), whichever is the later whilst the Insured was carrying out the normal professional duties of his or her

occupation in Singapore, provided that all of the following are proven to the Company's satisfaction:

- Proof that the accident involved a definite source of the HIV infected fluids;
- Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident. This proof must include a negative HIV antibody test conducted within 5 days of the accident; and
- HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

Reimbursement of medical expenses under this benefit is only payable when the occupation of the life assured is a medical practitioner, housemen in a hospital, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in a medical centre or clinic (in Singapore).

2.10.14 Hospital

Hospital means a facility which satisfies all of the following:

- a) is a licensed, lawfully operating institution duly constituted and registered as a hospital with the MOH;
- b) is open at all times;
- c) is operated mainly to diagnose and treat disabilities on an inpatient basis and at the patient's expense;
- d) has organised facilities for major surgery;
- e) has a staff of one or more doctors on call at all times;
- f) has 24-hour nursing services by or under the supervision of registered nurses;
- g) is not other than incidentally a skilled nursing facility, clinic, place for treatment of alcoholism or drug abuse, nursing home, rest home, convalescent home, community hospital, hospice, home for the aged, place for the treatment of mental disorders or a similar establishment; and
- h) maintains a daily medical report for each patient, which is accessible to our medical advisers.

The lists of Singapore Restructured and Private hospitals can be found on our website < www.prudential.com.sg.>

2.10.15 Hospital Confinement

Hospital confinement means a continuous period of time, lasting at least 8 hours, where normal ward is charged, during which it is medically necessary for the life assured to be confined to a hospital.

2.10.16 (a) Illness

Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.

(b) Injury

Injury means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a registered medical practitioner.

2.10.17 Inpatient

An inpatient is a person who is under hospital confinement.

2.10.18 Medical Adviser

A Medical Adviser is someone who gives advice relating to the science or practice of medicine and surgery.

2.10.19 Medically Necessary

Medically necessary means treatments, services or expenses incurred which are:

- in the opinion of a specialist is appropriate and consistent with the symptoms, findings, diagnosis and other relevant clinical circumstances of the illness. The treatment must be provided in accordance with generally accepted medical practice in Singapore;
- in accordance with the standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
- approved by the Institutional Review Board, the Centre of Medical Device Regulation, HSA or other relevant authority in Singapore;

- not for the convenience of the life assured or registered medical practitioner, and unable to be reasonably rendered out of a hospital, community hospital or similar establishments;
- not of an experimental, investigational or research nature (including but not limited to experimental, pioneering medical or surgical techniques and medical devices, and medical trials for medicinal products, whether or not these trials have a clinical trial certificate issued by the Health Sciences Authority or other relevant authority in Singapore); and
- not for preventive or screening nature or for health enhancement (including but not limited to dietary replacement or supplement) in purpose.

We have the right to determine whether or not a treatment, service or expense is medically necessary.

2.10.20 MediShield Life

MediShield Life is mandatory for all Singapore Citizens and Permanent residents. It is the basic tier of insurance protection scheme operated by the CPF Board which is targeted to cover hospitalisation in the class B2 or C wards of a hospital for Singaporeans and Singapore Permanent Residents.

2.10.21 Mobile Inpatient Care @ Home (MIC@Home)

A care-delivery model, covered under MediShield Life, that allows patients who a physician assesses as being clinically suitable to receive the same hospital inpatient services in their own homes, instead of in a Singapore restructured hospital.

2.10.22 MOH

MOH means the Ministry of Health in Singapore.

2.10.23 Multiple Primary Cancers

Multiple Primary Cancers mean two or more cancers arising from different sites and/or are of a different histology or morphology group.

2.10.24 Policy Year

Policy year means a period of 12 months from the cover start date or renewal of the life assured's insurance cover under PRUShield. Subject to the terms and conditions of this policy document, the life assured's insurance cover under this policy shall, be renewed yearly on the premium due date.

2.10.25 Policy Year Limit

The policy year limit is the maximum claimable amount that the life assured can claim in one policy year from all the benefits in this plan.

If hospital confinement or non-inpatient medical expenses flow over to the next policy year, the claim for a given medical bill will be processed subject to the policy year limit of the previous year. This means that for medical expenses due to hospital confinement, the claim amount will be determined based on the policy year limit applicable at the date of hospital admission. If the policy year limit is reached, we do not pay the claim utilising the policy year limit of the next policy year even if the hospital confinement period flows over to the next policy year.

For non-inpatient medical expenses, the claim amount will be determined based on the policy year limit applicable on the date the medical expenses were incurred regardless of the actual date of usage of such medical services.

2.10.26 Pro-ration

Pro-ration factors are applied to reduce medical bills in higher-class wards, private sector outpatient clinics or private hospitals (as classified by MOH) to the level of the B1 ward class of a hospital in the claims computation.

2.10.27 Reasonable and Customary Expenses

This refers to expenses incurred for medical service or treatment provided which are appropriate and consistent with the diagnosis and which according to accepted medical standards, could not have been omitted without adversely affecting the life assured's medical condition. Such charges shall not exceed the general level of charges made by others of similar standing in Singapore for such services and supplies.

2.10.28 Registered Medical Practitioner

Any person properly qualified by degree in western medicine to practice medicine and is licensed by the appropriate medical authority of his country of residence to practice medicine within the scope of his licensing and training and excludes the policyowner, the life assured or a family member of either.

2.10.29 Review Period

Review Period is the period stated in clause 2.1.2 above.

2.10.30 Short Stay Ward

A short stay ward is a ward where emergency department patients stay for up to 24 hours for observation to allow the doctors to decide whether the patient is fit for discharge or should be admitted to a standard room of a hospital as an inpatient.

2.10.31 Specialist

Specialist refers to a registered medical practitioner registered as a specialist with the Singapore Medical Council.

2.10.32 Standard Room

It is a room equipped with minimum standards, like the following:

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

For any single room (including deluxe rooms, luxury suites, superior rooms, super rooms or other special rooms) in a hospital, we pay normal ward rates up to the rates charged for a standard single room. We will also apply the pro-ration factor according to the type of ward or hospital

2.10.33 Surgical Procedure

Any operative procedure listed under MOH's Table of Surgical Procedure (TOSP) 1-7, including day surgery, performed by a registered medical practitioner involving general or local anaesthesia for the correction of deformities or defects, repair of injuries, and the diagnosis or cure of illnesses.

Surgery excludes Minor Surgical Procedures (MSP) as may be determined by MOH. To avoid any doubt, any surgery not listed in Table 1 to 7 of MOH's TOSP list as at the date of the surgery is not covered.