EZCare

Policy Wordings

Please read this insurance Policy carefully to ensure that you understand the terms and conditions and that this Policy meets your requirements. If there are any changes that may affect the insurance cover provided, please notify us immediately.

Contents

Introduction

EZCare is an employee benefits starter kit tailored to provide Small and Medium Enterprises (SMEs) a hassle-free and economical experience in covering their employees' health care needs. Its modular structure covers the basic medical needs of most employees with the flexibility to provide more comprehensive cover.

The cover provided shall be determined by the policy wordings contained herein together with any schedule and memoranda. The benefit limits are stated in the Policy schedule and any cover not shown therein is not provided. The base currency for this insurance is Singapore Dollars (S$).

The Insurance is effective only after the applicant has been accepted by the Insurer and remains insured in accordance with the terms, provisions and conditions set out in the Policy.

Insurance shall commence from the date specified on the Policy. The policy is an annual contract which until terminated shall be renewed each year on the Due Date subject to the Policy being in force at the time of each renewal and any variations as may be set out in writing by the Insurer. All premiums will be payable on or before the inception date or Due Date of the Policy. If payment is not made on or before the inception date or Due Date, the insurance will be terminated.

When an Insured Person undergoes medical treatment for Injury or illness he/she can claim for the course of treatment until the exhaustion of the stated limits as shown in the Policy schedule or the expiry of the period of insurance or the termination of this insurance whichever is the earlier event.

Upon receipt of proof of claim the Insurer will pay up to the limits shown in the schedule of Benefits for expenses necessarily incurred as a direct result of the Insured Person suffering bodily Injury, sickness or disease during the period of insurance.

The legal representative of the Insured Person shall have the right to act for an Insured Person who is incapacitated or deceased. Benefits are payable to Insured Person, his/her legal representative or executor, or to the licensed providers of the insured medical treatments and/or services to the Insured Person.

Benefits are limited to the usual Reasonable and Customary charges of Singapore.

General Definitions

The following definitions apply to the plan:

	TERM	MEANING
1.	**Accident**	An event of violent, accidental, external and visible nature which shall independently of any other cause be the sole cause of bodily Injury.
2.	**Actively at Work**	An Employee will be in Actively at Work if he/she is performing in the customary manner all the regular duties of his/her employment. If an employee has not been performing his or her duties for six continuous months, the Employee shall be considered to have ceased being Actively at Work at the expiry of such six-month period.
3.	**Community Hospital**	Intermediate care facilities that cater to patients who are fit for discharge from acute hospitals but require Inpatient convalescent and rehabilitative care.
4.	**Compulsory Plan**	A plan where all eligible Employees must be included.
5.	**Congenital Conditions**	Congenital abnormalities as well as neo-natal physical abnormalities.
6.	**Co-Insurance**	The portion of costs for which the Insured Person is liable.
7.	**Dentist**	A properly qualified practitioner other than the Insured Member or a member of his/her immediate family, who is licensed by the competent authorities of the country in which treatment is provided to render dental treatment, and who in rendering such treatment is practicing within the scope of his/her licensing and training.
8.	**Dependants**	The legal spouse of the Insured Person (but excluding those legally separated) and/or unmarried children and legally adopted children who are dependent on the Insured Person for support. Provided always that such children are not less than 15 days and not more than 18 years old at the date of enrolment in the plan (or 25 years if the child is in continuous full-time education and is not in full-time national service).
9.	**Disability**	All medical conditions resulting from an illness arising from the same cause, including any and all complications arising therefrom or closely related thereto, except that after fourteen (14) days following the latest discharge from Hospital or Surgery, any subsequent Disability from the same cause shall be considered as a new Disability.
10.	**Due Date**	The renewal date of cover as shown on the Schedule or the date on which any subsequent instalment of premium falls due.
11.	**Emergency/Emergency Treatment/Procedures**	Urgent remedial treatment to avoid death or impairment to the Insured Person's immediate or long-term health prospects and

	TERM	MEANING
		defined by an A&E triage status of P2 and above. P1: Critically ill and in need of resuscitation or immediate medical attention. These cases include multiple major injuries, head injury with loss of consciousness, severe shortness of breath, severe chest pain and unconsciousness from any cause. P2: Major emergencies, where patients are unable to walk and are in various forms of distress. Although patients appear stable during the initial examination and are not in danger of imminent collapse, the severity of their symptoms needs early attention, failing which their medical status may deteriorate. These include limb fractures and joint dislocation, persistent vomiting, severe back pain and renal colic (pain caused by kidney stones).
12.	**Employee**	An Insured Person who is in full-time Actively at Work with the Policyholder. It includes contract employees and does not include temporary employees. The definition may include sole-proprietor partner or director of the Policyholder.
13.	**General Practitioner**	A general medical practitioner (other than an Insured Person or a member of the Insured Person's immediate family) qualified by a medical degree and duly licensed or registered to practice western medicine and who, in rendering treatment, is practicing within the scope of his/her licensing and training in the geographical area of practice.
14.	**Home Country**	The country of citizenship declared on the Insured's passport. For greater than one passport, Home Country is the place of birth.
15.	**Hospital**	An establishment duly constituted and registered subject to the applicable national laws and regulations as a hospital for the care and treatment of sick and injured persons as bed-paying patients and which **a)** has facilities for diagnosis, treatment and major surgery **b)** provides 24 hours a day nursing services by registered graduate nurses **c)** is under the supervision of a Physician; and **d)** is not primarily a nature cure clinic, a place for alcoholics or drugs addicts, a Community Hospital, a nursing rehabilitation or convalescent home or similar establishment or home for the aged
16.	**Hospitalization**	Confinement in a Hospital for a period of 8 hours or more including Short-Stay wards.
17.	**Illness**	A physical condition marked by a pathological deviation from

	TERM	MEANING
		the normal healthy state.
18.	**Injury**	Bodily injury caused by violent, Accidental, external and visible means.
19.	**Inpatient**	A patient admitted into a Hospital for treatment, for which the Hospital leaves a daily room and board charge.
20.	**Insured Person (Insured)**	An individual whose application for the Policy has been approved and confirmed in writing by the Insurer and refers to the person covered under the Policy.
21.	**Medically Necessary**	Healthcare services or supplies ordered by a Physician and which are: a) Provided for the diagnosis or direct treatment of a disability b) Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the insured person's disability c) Provided in accordance with generally accepted medical practices on a national basis d) The most appropriate supply or level of service which can be provided on a cost effective basis e) Not of an experimental or investigative nature, or research purposes The fact that the insured person's Physician prescribes a service or supply does not automatically mean that such service or supply is medically necessary.
22.	**Period of Insurance**	The period of cover shown in the Policy Schedule and for any following period, for which cover is extended by mutual agreement.
23.	**Physician or Surgeon**	A person qualified by degree in Western medicine and legally licensed and duly qualified to practice medicine and surgery authorized in the geographical area of his/her practice.
24	**Policyholder**	Employer of the Insured Person.
25.	**Pre-Authorization**	Process to submit a completed Pre-authorization/Financial Counselling form to Liberty Insurance Pte Ltd at least five (5) days prior to Inpatient Admission. This does not apply to Emergency Procedures.
26.	**Pre-Existing**	Any condition which existed or have developed symptoms or there exist manifestation of Illness or medical treatment has been sought or drugs and medicine have been prescribed before the effective date of cover in respect of any Insured Person of which the Insured Person was aware or should reasonably have been aware based on normal medically accepted physical or pathological development of the Illness or Illnesses.

	TERM	MEANING
		The following diseases if existing prior to Policy inception, are permanently excluded from cover under this Policy for employee group sizes less than 10: **a)** Any condition relating to Heart Disease including: **i)** Heart Attack **ii)** Coronary Artery Disease **iii)** Heart Valve or Aorta Surgery **iv)** Stroke **b)** Renal Failure (any condition which requires kidney dialysis) **c)** Cancer (including pre-cancerous Stage 0 Cancer) **d)** Diabetes (Type 1 and Type 2 Diabetes) The following diseases if existing prior to Policy inception are permanently excluded from cover under this Policy for employee group sizes 10 or more: **a)** Renal Failure (any condition which requires kidney dialysis) **b)** Cancer (including pre-cancerous stage 0 cancer)
27.	**Prescribed Drugs**	Pharmaceuticals, drugs, and medications, the sale and use of which are legally restricted to prescription by a Physician not including items that may be purchased without a Physician's prescription.
28.	**Proration Factor**	The percentage that will be used to pro-rate the hospital bills before the claims payout is computed if the Insured Person is admitted to a ward/hospital higher than what he is entitled to under the policy. The percentage is applied on all actual charges incurred and covered under the policy, including any additional benefits and charges of pre-hospital and post-hospital treatment received in connection with the hospitalization.
29.	**Reasonable and Customary**	Charges for medical care that do not exceed the general level of charges being made by others of similar standing when giving like or comparable treatment services or supplies to individuals of the same sex and of comparable age for a similar disease or Injury in Singapore. Singapore Ministry of Health published data on procedures at the 75% percentile of the respective class ward may be used to establish the upper range of reasonable charges for specific procedures.
30.	**Short-Stay Ward**	A ward where emergency department patients stay up to 24 hours for observation.
31.	**Surgery**	Any invasive surgical intervention.

	TERM	MEANING
32.	**We (Our/Us/Insurer/ Company)**	Liberty Insurance Pte Ltd.
33.	**You (Your)**	The party named in the Schedule as the policyholder.

General Conditions

1. **Cancelation**

This Policy may be cancelled by either the Insurer or the Insured giving 30 days in notice in writing. No premium will be refunded if claims have already been made by the Insured.

Pro-rata refund of premium will be made to the Insured if the Policy is cancelled by the Company during its currency.

Cover for an Insured shall terminate automatically if the Insured Person is living or intending to live in USA/Canada/Japan for a period in excess of three (3) consecutive months.

Cancelation shall be without prejudice to any claim originating prior to the effective date of cancelation.

If the Insured terminates the Policy, the premium charged will be based on the following:

Period of Cover	Premium Charged
1 month	3 months rate
2 months	4 months rate
3 months	6 months rate
4 & 5 months	7 months rate
6 & 7 months	9 months rate
8 months	1 full year premium

2. **Contracts (Rights of Third Parties) Act 2001**

It is hereby noted and agreed that a person who is not a party to this Policy contract shall have no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of its items.

3. **Non-Guaranteed Premium**

Premiums payable for this coverage are not guaranteed and may be revised at policy renewal at the full discretion of the Company.

4. **Right to Return Policy/Free Look**

In the event that the Insured is not satisfied with the Policy for any reason, it may be returned to the Company for cancelation within fourteen days of receipt, deemed as the free look period.

a) Any premium paid or billed will be refunded in full

b) This Policy is deem to be voided from inception

c) The Company shall not be liable for any claims occurring prior to the return of the Policy

This condition shall however only apply to Policies issued in the name of the Insured Person. The Policy document is deemed to have been received by the Insured 3 days after the Company has dispatched it.

5. **Premium Payment Warranty (Corporate)**

a) Notwithstanding anything herein contained but subject to clause b) hereof, it is hereby agreed and declared that if the Period of Insurance is sixty (60) days or more, any premium due must be paid and actually received in full by the Company (Or the intermediary through whom the Policy was effected) within sixty (60) days of the:

i) Inception date of the coverage under the Policy, Renewal Certificate or Cover Note

ii) Effective date of each Endorsement, if any, issued under the Policy, Renewal Certificate or Cover Note

b) In the event that any premium due is not paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) within the sixty (60) day period referred to above, then:

i) The cover under the Policy, Renewal Certificate, Cover Note or Endorsement is automatically terminated immediately after the expiry of the said sixty (60) day period

ii) The automatic termination of the cover shall be without prejudice to any liability incurred within the said sixty (60) day period

iii) The Company shall be entitled to a pro-rata time or risk premium subject to a minimum of S$25.00

c) If the Period of Insurance is less than sixty (60) days, any premium due must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) within the Period of Insurance.

6. Breach of premium warranty

It is a condition precedent that this insurance Policy is issued on the basis that the named Insured has never had any insurance (for the risk insured) cancelled due solely or in part to a breach of premium payment warranty in the last 12 months.

7. Indemnity clause

Where Letters of Guarantee are issued to the Policyholder, the following terms and conditions apply:

a) The Letters of Guarantee shall be used only for hospital admission by members insured under EZCare.

b) For medical costs which are in excess of the limits of benefits and/or which are not reimbursable under the contract of insurance, the Policyholder shall undertake to repay the Company within 30 days from the receipt of all expenses that are not claimable under the policy. An interest charge of 6% will be levied on any amounts outstanding after 30 days.

c) The Policyholder undertakes to furnish the Company details of the insured event for which the claim is made. Failure to furnish proof of claim will render the Policyholder responsible for all interest charges, if any, imposed by the Hospital for delayed settlement of hospital bills.

d) The Policyholder agrees to return all unused Letters of Guarantee to the Company when the Policyholder terminates the contract of insurance with the Company or after the expiry of the validity period.

e) The Policyholder agrees to inform all insured members to sign the Medisave Authorization Form and MediShield Authorization Form at the Admission Room of the hospital notwithstanding the production of the Letter of Guarantee.

f) The Policyholder will be responsible on behalf of its subsidiary companies who are covered under the insurance policy for all the above-mentioned terms.

g) The Policyholder will be responsible for any outstanding amount due to the Company in the event it is not recoverable from the Insured Employee due to the resignation of the said Employee.

Administration

1. **Eligibility**
The maximum age for enrolment is 65 years. Renewals are available between ages 65 to 80 on yearly review basis. Employees of all nationalities and their Dependants (other than new born children) are eligible to join provided they at all times meet such eligibility criteria as may be agreed in writing with the Insurer. Insureds must be domiciled in Singapore, meaning Singapore Citizens, Singapore Permanent Residents (holders of re-entry permits), holders of Employment Passes, Personalized Employment Passes, EntrePasses, Work Permits, student passes or dependant passes. Newborn children shall be eligible 15 days after the date of birth or 15 days after discharge from Hospital where birth took place, whichever is the later. A newborn child's eligibility for cover is subject to him/her being free from Injury or Illness. Dependent children are covered up to age 18 (dependent children can be covered up to age 25 if the child is enrolled in an educational institution on full-time higher education and is not in full-time national service).

2. **Overseas deployment**
For Employees deployed overseas for a period in excess of one hundred and eighty (180) consecutive days, his cover will cease automatically. The Employer of Insured Person should notify the Insurer of the date of his overseas deployment within thirty days of the date of departure. The Insurer will then refund a portion of the premium paid from the date of return up to the next Due Date.

3. **Change of Occupation/Designation/ Country of Residence**
In the event of a change in occupation/ designation/country of residence of the Insured, the Policyholder shall notify the Company in writing of the new occupation/ designation/country of residence. The Company shall increase or reduce the premium rates according to the risk classification for the new occupation/ designation and remove cover if country of residence is changed. Any increase in the cover to be provided to an Employee already included in the group plan which is due to his/her promotion shall become effective on the date of his/her promotion (unless the Employee is absent from work on that date due to Illness or Injury, in which case the increase in cover will take effect from the date of the Employee returns to work). Such increase in Cover will only be effective when We have received written notification from the Policyholder.

4. **Age of Insured**
Age of Insured shall be taken as the insured's age as at next birthday.

5. **Stay in Ward Class above benefit limit**
Where the Insured chooses to be admitted in a ward class above his/her benefit limit, a Proration Factor of 60% applies where Our liability is limited to 60% of the eligible medical expenses subject to the maximum amount stipulated in the Policy schedule.

6. **Minimum Group Size**
Minimum group size is 2 employees subject to fulfilment of a minimum premium. If both employees are below 45 years old, there will be no minimum premium.

7. **Territorial Scope**
Geographic cover for Hospitalisation and Surgical benefits is limited to 60 days from the date of the Insured's travelling overseas. There will be full cover for Emergency Treatments. For non-emergency treatments, there will be a 50% Co-Insurance for USA, Canada and Japan, 30% Co-Insurance for

other countries and no Co-insurance for Malaysia.

8. **Pre-Authorization**
   The Pre-authorization form is to be completed and approval by the Company sought prior to hospitalisation except in the case of Emergency admissions or admissions to B1 to C class wards in Restructure/Government hospitals. Failing which, 20% Co-Insurance will apply.

Conditions for obtaining Cover

1. **Employees**
   a) EZCare is a Compulsory Plan. All cover is effected on a 100% premium payment basis by the Policyholder, and all eligible employees must be included in the Scheme within 90 days from the date of eligibility.

   b) Where an employee is not at work on the date when he/she would otherwise be eligible to join the Scheme, the effective date of such employee's insurance shall be the date of his/her return to work.

   c) All employees in the same employee category must be enrolled under the same plan and have the same Rider covers.

2. **Dependents**
   a) Dependents' cover (if covered) is to be the same as Employees' cover with the applicable premium rate based on age of the Dependent. If Dependent's coverage is taken up, it will apply to all the Dependents of all Employees within the same employee category.

   b) The Dependent's cover shall become effective on any of the following eligibility dates, provided they are included within 31 days:
      i) Upon the date the Employee becomes eligible

      ii) The spouse of a newly-married Employee becomes eligible on the date of his/her marriage to the Employee already covered

      iii) The new-born child becomes eligible on the fifteenth day following the date of birth

   If the Dependant is confined in a hospital on the date when his/her cover otherwise becomes effective, such cover would not become effective until the Dependant is no longer confined and is medically certified to have fully recovered from the Illness/Injury for which the confinement is made.

Benefits – Hospitalization & Surgery Plan

Please refer to the Schedule to determine the coverage of Benefits enrolled.

1. **Annual Overall Limit**
   The total aggregate benefits that may be claimed in any one insurance period by an Insured Person as listed in the Schedule of Benefits.

2. **Room and Board Charges**
For room accommodation, meals and general nursing services.

3. **Intensive Care Unit**
Charges incurred during confinement as an Inpatient in the Intensive Care Unit.

4. **In Hospital Physician's Visit Fees**
Charged by the attending Physician for daily bedside visits.

5. **Day Surgery (include minor surgical procedure in a clinic)**
A surgery carried out by a Surgeon on an out-of-hospital basis. Surgical procedure performed in a clinic is subject to the same interpretation.

6. **Surgeon's Fee**
Fees for surgery by a Surgeon, including the Surgeon's visits while in Hospital. Charges for Day Surgery are also payable.

7. **Theatre Fee**
Costs associated with the use of an Operating Theatre for the purpose of Surgery.

8. **Anaesthetist's Fee**
Charges for anaesthesia fees and oxygen and the administration.

9. **Hospital Miscellaneous Services**
   a) Medical services rendered to the Insured Person for Medically Necessary treatment procedures and when admitted as a registered in-patient to a hospital.

   b) Reasonable and customary charges in the area where treatment is provided for hospital services and surgery including: hospital medical facilities, medical treatments, and medical services prescribed by a Physician.

10. **Local Ambulance Services**
The Medically Necessary road transportation provided by a recognized ambulance service provider to a local hospital. Charges are covered only if there had been an Inpatient admission of the Insured.

11. **Medical Report Fee**
The fee charged by the hospital for retrieval of medical records and provision of a Medical Report (if claim is payable).

12. **Cashless Inpatient Treatment**
Inpatient Treatment benefits rendered on a cashless basis. Treatment must be Pre-authorized through Liberty Insurance Pte Ltd's medical concierge services prior to admission to Inpatient facility.

13. **Pre Hospitalization Consultation, Diagnostic Services and Treatment**
If the Insured had received medical treatment by a Specialist on a Physician's recommendation prior to the Hospitalization, the Reasonable and Customary charges incurred for the Pre-Hospitalization Specialist consultation, diagnostic procedures and laboratory examinations will be paid in respect of outpatient Specialist consultations and medication prescribed by the Specialist up to the maximum number of days preceding the Inpatient treatment or Day Surgery as set out in the schedule of benefits. The amount payable shall not exceed the maximum benefit amount set out in the Insurance schedule for any one Disability. Pre-Hospitalization Treatment given before Hospitalization in a Short-Stay Ward is not covered.

14. **Post-Hospitalization Treatment**
Charges incurred in follow-up treatment, after Inpatient treatment or Day Surgery, by the same attending Physician, will be paid up to the maximum number of days following the Inpatient treatment or Day Surgery as set

out in the schedule of benefits. Post-Hospitalization treatment which is given after Hospitalization in a Short-Stay Ward is not covered.

15. **Emergency Outpatient Accidental Treatment**
Charges for services and medical supplies provided by the hospital or clinic for Emergency Treatment of an Injury as a result of an Accident and received as an outpatient within 24 hours after the Accident. Eligible expenses incurred thereafter for follow-up treatment of the same condition will be reimbursed up to 31 days from the date of Accident.

16. **Emergency Dental Treatment**
Charges for dental procedures necessary to restore or replace sound natural teeth lost or damaged in an Accident and received as an outpatient within 24 hours after the Accident. Eligible expenses incurred thereafter for follow-up treatment of the same condition will be reimbursed up to 31 days from the date of Accident.

17. **Surgical Implants**
Charges incurred by an Insured Person for any surgically implanted lens, prosthesis, braces (excluding braces for teeth), heart implant, artificial limbs or similar orthopaedic appliances and implants certified to be Medically Necessary and not implanted for cosmetic reasons.

18. **Nursing at Home**
The services of a government licensed nurse in the Insured Person's abode when prescribed by a Physician for continued treatment of the specific medical condition for which the Insured Person was hospitalized and only when such services are essential for medical as distinct from domestic reasons. Cover will be limited to a maximum of 26 consecutive weeks in any one insurance period.

19. **Lodger Benefit**
If on account of an ailment or medical condition an Insured child who is not more than 12 years old is hospitalized the Insurer will pay the expenses incurred for one accompanying adult during such hospitalization as charged by the Hospital up to the daily limit as per policy schedule.

20. **Special Grant**
Payable if an Insured Person dies from an Injury or an Illness during or after treatment for such Illnesses at a Hospital or in Day Surgery within the policy period. This will be paid to the Policyholder who will be responsible for disbursing the payment to the Insured's next-of-kin.

21. **Hospital Cash Benefit**
If an Insured is confined to a Hospital as a result of Illness or Injury and chooses to stay in a ward class below his/her Room & Board eligibility and benefit limit, he/she will receive the daily hospital cash benefit as per the tiers indicated in the Policy Schedule.

22. **Accidental Miscarriage**
Charges incurred for necessary emergency treatment by a Physician for miscarriage suffered by an Insured Person as a result of an Accident.

23. **Outpatient Kidney Treatment**
The Insurer shall pay the amount actually charged for kidney dialysis performed at a legally registered dialysis centre or unit but this benefit shall not exceed the maximum limit per year as stated in the Schedule.

24. **Outpatient Cancer Treatment**
Cancer means a disease manifested by the presence of a malignant tumour characterized by the uncontrolled growth and

spread of malignant cells and the invasion of tissue. The term cancer also includes leukaemia and malignant disease of the lymphatic system such as Hodgkin's disease. Any non-invasive cancer in situ and all skin cancers except invasive melanoma are excluded.

The Insurer shall pay the amount actually charged for outpatient cancer treatment provided by the outpatient department of a hospital or a registered cancer treatment centre including examinations and tests ordered by a medical practitioner but this benefit shall not exceed the maximum limit per year as stated in the Schedule.

25. **Best Doctors**
Best Doctors service allows Insureds to consult with world leading Specialists and General Practitioners on any medical condition You may have.

26. **Diagnostic Tests**
Medically Necessary diagnostic procedures excluding routine health checks. Cover includes CT Scans, PET Scans, MRIs, Ultrasounds, X-Rays, laboratory tests and Mammograms.

27. **Day of Hospital Confinement**
A day of Hospital Confinement refers to a full 24 hours during a period of hospital confinement. The first day of confinement will commence 24 hours after the commencement of the previous day of confinement, and the day of discharge will also be regarded as a day of confinement.

Insureds can claim under the Hospitalization and Surgery benefit cover if they have been Hospitalized or underwent a Surgery.

Emergency Medical Evacuation

If You sustain an Injury or an Illness occurs while You are Overseas during the Period of Insurance, We must be contacted at the Liberty Helpline to provide the following assistance and services, subject to the Benefit Limit in the Policy Schedule and the following terms and conditions:

Emergency Medical Evacuation
If the event of a Serious Medical Condition whilst You are Overseas, We will organize and pay for the Medically Necessary expense of air and/or surface transportation, medical care during transportation, communications and all usual ancillary charges incurred in moving You to the nearest Hospital where appropriate medical care is available (and which may not necessarily be in Singapore).

“Serious Medical Condition” means a condition which, in our opinion, constitutes a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to Your immediate or long-term health prospects. The seriousness of the medical condition will be judged within the context of Your geographical location, the nature of the medical emergency and the local availability of appropriate medical care or facility.

Repatriation
We will arrange and pay for the Medically Necessary expenses unavoidably incurred in returning You to Singapore or Your Overseas Residence following an emergency medical evacuation where You are evacuated to a place outside Your Home Country and/or Overseas Residence for in-Hospital treatment.

Please note that We reserve the right to decide:

1. whether Your Injury or Illness is sufficiently serious to warrant emergency medical evacuation

2. the place to which You will be evacuated; and

3. the means or method by which such evacuation and/or repatriation will be carried out having regard to all the assessed facts and circumstances which We are aware of at the relevant time

Benefits - Riders

Benefits in this section are only applicable if selected at the Group level for all covered Employees.

1. **Outpatient Services**
   Medical treatment provided to the Insured Person who is not a registered in-patient in a Hospital or in any other facility for medical care.

2. **Outpatient General Practitioner Services**
   Outpatient Services ordered, prescribed or performed by a Physician who is licensed as a General Practitioner.
   a) Excludes Paediatric consultations and services

   b) Diagnostic services covered are limited to x-rays and laboratory tests up to the amount specified in the Policy Schedule. Dental X-rays are excluded

   c) Overseas outpatient cover is applicable only for first 60 days of Insured Person's travelling overseas

   d) TCM cover is limited to panel TCM services only up to the amount specified in the Policy Schedule

   e) A&E cover is limited to A&E visits at Restructure Hospitals

   f) Exclusions: Charges in respect of the following:
      i) More than one outpatient visit per day

      ii) Visits at home or in office

      iii) Prescription drugs obtained without consultation

      iv) Kidney dialysis and cancer treatment

3. **Outpatient Specialist Services**
   Outpatient Services prescribed and provided by a Specialist or consultant to whom the Insured Person has been referred to by a General Practitioner.
   a) A referral letter from a General Practitioner is required for panel and non-panel Specialist visits. This referral letter is valid for 1 year for the first appointment with the Specialist (i.e. The Insured needs to have his first appointment with the Specialist within 1 year from the date of the referral letter for the claim to be payable)

   b) For Paediatric visits, this referral letter requirement is waived for the first 18 months from birth

   c) Diagnostic services are defined as Medically Necessary diagnostic procedures excluding routine health checks. Diagnostic services include CT Scans, PET Scans, MRIs, Ultrasounds, X-Rays, laboratory tests and Mammograms

d) A referral letter from a Specialist is required for outpatient Physiotherapy treatment and treatment must be conducted by a qualified physiotherapist licensed under the Allied Health Professions Act 2011 of Singapore and registered with the Allied Health Professions Council (AHPC) in Singapore.

e) Exclusions: Charges in respect of the following:
   i) More than one outpatient visit per day
   ii) Visits at home or in office
   iii) Prescription drugs obtained without consultation
   iv) Kidney dialysis and cancer treatment

4. **Outpatient Dental Services**
   Charges incurred for dental treatment of an Insured Member by a Dentist. We shall not reimburse for Pre-Existing dental conditions, dental implants, gold crowns, caps or inlays or onlays, orthodontic treatment and temporary dentures, retainers, braces or treatment consisting of cosmetic or plastic surgery or for beautification not necessitated by Injury or Illness. Overseas outpatient Dental cover is not applicable.

Exclusions

The following treatments, conditions, activities, items and their related expenses and any complications relating thereto are excluded from this insurance (Hospitalization and Surgery plan as well as Riders) and the Insurer shall not be liable for:

1. Expenses relating to Pre-Existing conditions or Injuries for the first year (12 months) an individual is covered under the Policy. Pre-Existing conditions in the specified conditions list (For employee group size of less than 10: Heart Disease, Kidney Failure, Cancer and Diabetes. For employee group size 10 and above: Kidney Failure and Cancer) will be permanently excluded. If the Insured has suffered from any of these conditions, that condition will never be covered. Any condition related to an excluded condition will also be excluded from cover. This applies only to Hospitalization and Surgery Base Plan and does not apply to Riders.

2. Charges which are not for actual, necessary and Reasonable and Customary expenses incurred for the treatment of the Illness or Injury.

3. Outpatient treatment costs not related to Inpatient treatment or Day Surgery except as a result of an Accident under Emergency Outpatient Accidental Treatment or unless Optional Outpatient Services rider(s) has/have been undertaken.

4. Costs resulting from abuse of drugs or alcohol, self-inflicted Injuries, criminal acts of the Insured Person and sexually transmitted diseases or treatment which in anyway arises from, is attributable to, or is consequential upon Acquired Immune Deficiency Syndrome (AIDS) AIDS related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive and any communicable diseases requiring isolation or quarantine by law.

5. Treatment for Injuries or diseases arising from or consequent upon war (whether declared or undeclared), riot, civil commotion, civil war, invasion, acts of foreign enemies, hostilities, rebellion, mutiny revolution,

insurrection or military or usurped power, confiscation or nationalization by or under the order of any government or public or local authority, nuclear energy (nuclear reactions radiation contamination), illegal act, regular imprisonment and full-time service or reservist in any of the uniform groups.

6. Routine medical examinations where there is no objective indication of impairment (including the issue of medical certificates and attestations).

7. Gender reassignment surgery or therapy.

8. Cosmetic (Aesthetic) or plastic surgery or treatment (including for skin or hair related treatments), or any treatment which relates to or is needed because of previous cosmetic treatment, provided that this exclusion does not apply to reconstructive surgery if:
   a) It is carried out to restore function or appearance after an Accident or following Surgery for a medical condition, (provided that the Accident or Surgery occurred while the Insured Person was covered under this Policy); and

   b) it is done at a medically appropriate stage after the Accident or Surgery; and

   c) the cost of the treatment is approved by Us in writing before it is done

9. Refractive defects of the eye.

10. Confinement in Hospital to facilitate the taking of x-ray or conduct of routine tests, eye examinations, refractive errors of the eyes (including spectacles & lenses), or tests of the ear (including hearing/conduction tests).

11. Medical appliances which are not surgically required e.g. prostheses, corrective devices, special braces, hearing aids and wheelchairs).

12. Dental care and treatment (including oral surgeries) except emergency treatment to sound natural teeth damaged during an Accident or unless the Dental rider has been undertaken.

13. Pregnancy including but not restricted to normal and complicated childbirth, miscarriage unless due to Accident, complications of pregnancy, ectopic pregnancy, pre and post-natal care, caesarean section. Abortion (and its consequences), hydatidiform mole, infertility, sterilization and contraception are not covered under any Plan.

14. Organ Transplantation and all related costs are excluded from this Plan if the Insured is the organ donor. If the Insured is the recipient of the organ, cover will be as per the Plan limits for an Inpatient admission.

15. Treatment relating to birth defects, Congenital conditions and hereditary conditions.

16. Charges for private nursing.

17. Sleep disorders (including sleep apnoea).

18. Behavioral or developmental disorders.

19. Psychotic, mental or nervous disorders.

20. Vaccinations.

21. Services or treatments by any institution that is mainly a long term care facility like convalescent and nursing homes nature, care clinics, spa, hydro-clinic, rehabilitation centre or sanatorium and that provides incidental or limited hospital services.

22. Community Hospital charges.

23. Treatment arising from any geriatric, psycho-geriatric, psychiatric conditions.

24. Chiropractic.

25. Treatment by family members.

26. Treatment that is not scientifically recognized.

27. Non-Prescribed drugs.

28. Racing of any form other than on foot and Injury related to participation in professional sports.

29. Expenses recoverable from a third party including Workmen's Compensation insurance or Social Security Organization.

30. Weight management related treatment including obesity, weight reduction and weight improvement.

31. The cost of Second Opinions for medical conditions unless considered by the Insurer's medical advisers to be Reasonable and Customary and Medically Necessary having regard to the medical facts and circumstances. Best Doctors is not considered a Second Opinion for the purposes of this exclusion.

32. Medical tourism (i.e. travelling overseas expressly for the purpose of treatment).

33. All transportation costs incurred for trips specifically made for the purpose of obtaining medical treatment if not part of an Emergency Medical Evacuation and except as defined under Local Ambulance Services.

34. All Emergency Medical Evacuation costs not approved in advance by the appointed Assistance Centre.

35. Claims for treatment costs in respect of medical expenses incurred after the expiry date of the policy arising from miscarriage, Accidental bodily Injury and/or illness occurring during the insurance period unless the insurance has been renewed and the premium paid.

36. Occupations that fall under declined risks include air and shipping crew, professional sportsmen and sportswomen and team, occupations involving diving, working on oil rigs, onboard vessels or offshore, fire-fighting, police or military personnel.

Claims

1. **Arbitration**
   Any difference in respect of medical opinion in connection with the treatment of an Injury or Illness shall be settled between two medical experts appointed in writing by the parties to the dispute. Any difference of opinion between the two medical experts shall be referred to an umpire who shall have been appointed in writing by the two medical experts at the outset. Should the two medical experts fail to agree despite the mediation of the umpire then the decision of the umpire shall be final and binding.

2. **Fraud**
   If any claim shall in any respect be false or fraudulent or if any fraudulent means or devices are used by the Insured or anyone acting on his behalf to obtain benefits hereunder then the Policy shall be cancelled immediately and all benefits and premiums will be forfeited.

3. Payer of Last Resort

If You are entitled to reimbursement for the expenses incurred in respect of any claim from sources other than this Policy, including any contractual agreement provided by any insurer or government or company, We shall be the last payer reimbursing the claim. For every claim, the total actual reimbursement from such insurer/insurance policies, government or company and that under this Policy shall not exceed such expenses actually incurred.

If You have already received payment from Us prior to seeking reimbursement from other policies, the other insurer shall reimburse Us their share. You shall provide Us all information including the full details of such other policies and all relevant documentary proof that We require to make a claim for the expenses that We have paid.

4. Examination

The Insurer shall have the right through his medical representative to examine any Insured Person whenever and as often as may be reasonably required within the duration of any claim. In addition, the Insurer shall have the right to require an autopsy to be done in the case of death where this is not forbidden by law or religious beliefs.

5. Legal Proceedings

No action in law or equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after proof of claim has been furnished in accordance with the requirements of the Policy. Nor shall any such action be brought at all unless commenced within six years from the date of claim.

The parties hereto agree that the Laws of Singapore shall govern and control in the event of any conflict or dispute between the parties with regard to the Plan and that the parties submit themselves to the exclusive venue and jurisdiction of the courts of Singapore for the resolution of any such conflict or dispute.

6. Proof of Claim

Written proof of claim must be submitted to the Insurer within thirty days starting from the first date of treatment of the insured disability for which the claim is made. Failure to claim within the time required by the Policy (thirty days) shall invalidate or reduce the claim unless it can be shown that it was not reasonably possible to furnish such proof within the required time and that it was furnished as soon as reasonably possible.

Original documents (supporting invoices and receipts) must be submitted to IHP (12 Hoy Fatt Road, #05-01A, Singapore 159506) and a scanned copy through the IHP web portal or mobile application. A fully completed claim form (signed by the treating Physician) is to be submitted together with the original bills if pre-authorisation had not been sought. Affirmative proof of Illness or Injury must be submitted at the expense of the Claimant. Photocopies are not admissible.

7. Co-operation

As a condition precedent to the Insurer's liability, the Policyholder or the Insured Person or his representatives shall co-operate fully with the Insurer and its medical advisers and will fully and faithfully disclose all material facts and matters which the Policyholder or the Insured Person knows or ought to know and will upon request execute any document to empower the Insurer to obtain relevant information at the Insured Person's expense from any doctor or Hospital or other source as may from time to time be required.