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No. S 622

MEDISHIELD LIFE SCHEME ACT 2015
(ACT 4 OF 2015)

MEDISHIELD LIFE SCHEME REGULATIONS 2015

ARRANGEMENT OF REGULATIONS

In exercise of the powers conferred by section 34 of the MediShield Life Scheme Act 2015, the Minister for Health makes the following Regulations:

PART 1

PRELIMINARY

Citation and commencement

1. These Regulations may be cited as the MediShield Life Scheme Regulations 2015 and come into operation on 1 November 2015.

Definitions

2.—(1) In these Regulations, unless the context otherwise requires —

"additional private insurance coverage" means any private insurance cover provided under an integrated shield plan that is additional to the insurance cover provided by the MediShield Life Component of that integrated shield plan;

"admission date", in relation to a claim for any approved medical treatment or services, means the admission date assigned to the approved medical treatment or services claimed in accordance with guidelines issued by the Minister, and "admission" and "admitted" have corresponding meanings;

"approved cancer drug" means any active ingredient (or combination of active ingredients) in the dosage form and strength listed in the CDL and administered for the corresponding clinical indication listed in the CDL;

[S 711/2022 wef 01/09/2022]

"approved community hospital" means an approved medical institution that provides an intermediate level of care for outpatients and in-patients who have simple ailments that do not require specialist medical and nursing care;

[S 231/2025 wef 01/04/2025]

"approved day surgery centre" —

(*a*) means an approved medical institution that provides day surgical treatment; but

(*b*) does not include an approved medical institution which is a private hospital or restructured hospital;

[S 403/2023 wef 26/06/2023]

"approved dental treatment" means dental work or dental treatment —

(*a*) owing to accidental injuries;

(*b*) certified in writing, by an approved medical practitioner, to be necessary in relation to a separate surgical treatment (excluding any surgical treatment specified in the Third Schedule); or

(*c*) certified in writing, by an approved medical practitioner, to be necessary in relation to any approved medical treatment or services (excluding any medical treatment or services specified in the Third Schedule), and assessed by the Council to be appropriate;

"approved in-patient palliative care" means any of the following approved medical treatment or services received as an in-patient of any approved in-patient palliative care institution:

(*a*) general palliative care;

(*b*) specialised palliative care;

[S 224/2020 wef 01/04/2020]

" approved in-patient palliative care institution" means any of the following approved medical institutions that provides in-patient palliative care:

(*a*) an approved community hospital;

(*b*) a nursing home;

[S 231/2025 wef 01/04/2025]

"Approved Indications for PBT" means Approved Indications for Use of Proton Beam Therapy in Treatment published on the website of the Ministry of Health at https://www.moh.gov.sg;

[S 769/2022 wef 01/10/2022]

"approved medical practitioner" means a medical practitioner who is approved by the Minister for the purposes of these Regulations;

"approved OS", "OS application", "OS scheme" and "relevant amount" have the meanings given by the MediShield Life Scheme (Scheme for Overseas Singapore Citizens) Regulations 2016 (G.N. No. S 535/2016);

[S 300/2018 wef 14/05/2018]

"approved outpatient treatment" means any of the following approved medical treatment or services that is a claimable medical treatment or services received as an outpatient of any approved medical institution:

(*a*) renal dialysis;

(*b*) cancer drug treatment;

[S 711/2022 wef 01/09/2022]

(*c*) radiotherapy treatment;

[S 731/2018 wef 01/11/2018]

(*d*) administration of immunosuppressants for organ transplant;

(*e*) administration of erythropoietin for dialysis and chronic renal failure;

(*f*) long term parenteral nutrition provided on or after 1 November 2018;

[S 731/2018 wef 01/11/2018]

[S 231/2025 wef 01/04/2025]

"approved permanent premises", in relation to an approved medical institution, has the meaning given by section 2(1) of the Healthcare Services Act 2020;

[S 231/2025 wef 01/04/2025]

"approved private hospital" means an approved medical institution which is a private hospital;

[S 135/2021 wef 26/02/2021]

"approved proton beam therapy" means any radiotherapy treatment or radiosurgery treatment using proton beam therapy for a clinical indication listed in the Approved Indications for PBT;

[S 769/2022 wef 01/10/2022]

"approved public healthcare institution" means an approved medical institution that is —

(*a*) a restructured hospital;

(*b*) any of the following:

(i) National Cancer Centre of Singapore Pte Ltd;

(ii) National Dental Centre of Singapore Pte. Ltd.;

(iii) National Neuroscience Institute of Singapore Pte Ltd;

(iv) National Skin Centre (Singapore) Pte Ltd;

(v) Singapore National Eye Centre Pte Ltd; or

(*c*) any of the following, in relation to the approved medical institution's provision of an outpatient

medical service within the meaning of the Healthcare Services Act 2020:

(i) Alexandra Health Pte. Ltd.;

(ii) National University Health Services Group Pte. Ltd.;

(iii) National University Hospital (Singapore) Pte Ltd;

[S 231/2025 wef 01/04/2025]

"approved restructured hospital" means an approved medical institution which is a restructured hospital;

"approved voluntary welfare organisation" means an approved medical institution that is —

(*a*) an organisation that is granted membership of the National Council of Social Service under section 15 of the National Council of Social Service Act 1992;

(*b*) an institution that is registered as a charity under section 7 of the Charities Act 1994; or

(*c*) an institution of a public character as defined in section 40 of the Charities Act 1994;

[S 231/2025 wef 01/04/2025]

"cancer drug" means any drug, including any approved cancer drug, used for the treatment of neoplasms;

[S 711/2022 wef 01/09/2022]

"cancer drug treatment" means —

(*a*) the administration of any cancer drug for the treatment of neoplasms; or

(*b*) any other medical treatment or services ancillary to the administration of any cancer drug for the treatment of neoplasms;

[S 711/2022 wef 01/09/2022]

"CDL" means the Cancer Drug List published on the website of the Ministry of Health at https://www.moh.gov.sg;

[S 711/2022 wef 01/09/2022]

"claim bar date", in relation to an insured person who is an in-patient of an approved medical institution, means the 7th calendar day after the earliest day when the insured person is both —

(*a*) certified, by a medical practitioner employed or engaged by the approved medical institution, to be medically fit for discharge from in-patient treatment provided by that approved medical institution; and

(*b*) assessed by that medical practitioner to have a feasible discharge option;

[S 231/2025 wef 01/04/2025]

"commencement date" —

(*a*) in relation to an insured person's MediShield Life cover, means the date determined under regulation 4 from which the insured person's MediShield Life cover has been continuously in force; or

(*b*) in relation to an insured person's pre-existing MediShield cover, means the date from which the insured person's pre-existing MediShield cover has been continuously in force;

"CPF member" includes a CPF member who is an undischarged bankrupt;

"cross implementation claim" means a claim under an insured person's pre-existing MediShield cover, in respect of approved medical treatment or services received by an insured person as an in-patient, with —

(*a*) an admission date before 1 November 2015; and

(*b*) a date of discharge on or after 1 November 2015;

"cross insurance period claim" means a claim under an insured person's MediShield Life cover, in respect of approved medical treatment or services received by the insured person as an in-patient (other than a day treatment patient) of an

approved medical institution, with an admission date and a date of discharge in different insurance periods;

[S 286/2019 wef 01/04/2019]

[S 231/2025 wef 01/04/2025]

"day surgical treatment" means any surgical treatment (including any radiosurgery treatment) received by a person who is admitted and discharged on the same day, and includes any ancillary medical treatment received by that person between such admission and discharge;

"day treatment patient" means a patient who —

(*a*) receives any approved medical treatment or service specified in the Eleventh Schedule from an approved medical institution; but

[S 231/2025 wef 01/04/2025]

(*b*) is not required to be hospitalised for the purpose of receiving that treatment or service;

[S 286/2019 wef 01/04/2019]

"dependant", in relation to a CPF member, means —

(*a*) a CPF member's spouse, child, parent, grandparent or sibling; or

[S 933/2020 wef 03/11/2020]

(*b*) any other person whom the Board approves as a dependant for the purpose of these Regulations;

"in-patient" means —

(*a*) a patient who —

(i) is admitted for a stay at any approved permanent premises of an approved medical institution, for any treatment other than day surgical treatment, for a period of not less than 8 hours; or

[S 231/2025 wef 01/04/2025]

(ii) has died within 8 hours after being admitted for any treatment other than day surgical treatment; or

[S 231/2025 wef 01/04/2025]

(*b*) a day treatment patient;

[S 286/2019 wef 01/04/2019]

"insured person" —

(*a*) in relation to an insurance cover under the MediShield Scheme or an integrated medical insurance plan, means a person who was insured under the MediShield Scheme or integrated medical insurance plan, as the case may be, before 1 November 2015; or

(*b*) in relation to an integrated shield plan or a medisave-approved plan, means a person who is insured under the integrated shield plan or medisave-approved plan, as the case may be;

"insurer" means an insurer which is licensed under the Insurance Act 1966;

[S 403/2023 wef 31/12/2021]

"integrated medical insurance plan" means any plan, under which a person was insured before 1 November 2015, under a medical insurance policy approved by the Minister for the purposes of regulation 4(1)(*b*) of the revoked PMIS Regulations, with or without a MediShield Component;

"integrated shield plan" means a medisave-approved plan that comprises a MediShield Life Component and additional private insurance coverage;

"living donor organ transplant" has the same meaning as in the Human Organ Transplant Act 1987;

[S 403/2023 wef 31/12/2021]

"long term parenteral nutrition" means parenteral nutrition provided by an approved medical institution to a patient with a condition specified by the Minister on the website at https://www.moh.gov.sg;

[S 731/2018 wef 01/11/2018]

[*Deleted by S 403/2023 wef 26/06/2023*]

"medical practitioner" means a medical practitioner registered under the Medical Registration Act 1997 or a dentist registered under the Dental Registration Act 1999;

[S 403/2023 wef 31/12/2021]

[*Deleted by S 231/2025 wef 01/04/2025*]

"medisave-approved plan" has the same meaning as in the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015 (G.N. No. S 623/2015);

"MediShield Component", in relation to a person insured under an integrated medical insurance plan, means the person's insurance cover under the MediShield Scheme which formed part of the person's integrated medical insurance plan;

"MediShield Life Component" means insurance cover provided by the Scheme which forms part of an integrated shield plan;

"MediShield Life cover" means insurance cover under the Scheme;

"MIC@Home programme" means a health programme known by that name or known as the Mobile Inpatient Care@Home programme;

[S 231/2025 wef 01/04/2025]

"MIC@Home treatment" means any medical treatment or services received under the MIC@Home programme;

[S 231/2025 wef 01/04/2025]

"multiple neoplasms" means 2 or more neoplasms that —

(*a*) arise from different sites;

(*b*) are of a different histology or morphology group; or

(*c*) arise from different sites and are of a different histology or morphology group;

[S 772/2023 wef 01/12/2023]

"nursing home" means an approved medical institution that holds a valid nursing home service licence under the Healthcare Services Act 2020;

[S 231/2025 wef 01/04/2025]

"organ transplantation costs" means —

(*a*) any costs arising in relation or incidental to the removal of any organ from a non-living organ donor for organ transplant and includes the costs of —

(i) the donor's extended stay, before the donor's death, in a hospital as necessitated by the donation of the organ;

(ii) any surgical operation to remove the organ from the donor's body;

(iii) any pre-harvesting laboratory test and investigation;

(iv) any counselling provided to the donor's family in connection with the donation of the organ;

(v) the storage and transport of the organ; and

(vi) such other procedures as the Minister may approve; or

(*b*) any costs that are reasonably or directly attributable to the removal of any specified organ from a living organ donor for organ transplant and includes the costs of —

(i) the donor's stay in a hospital as necessitated by the donation of the specified organ until the donor is discharged;

(ii) any surgical operation to remove the specified organ from the donor's body;

(iii) the storage and transport of the specified organ; and

(iv) such other procedures as the Minister may approve,

but does not include —

(A) any costs arising in relation or incidental to complications suffered by the donor due to the

donation of the specified organ after the donor's discharge from the hospital under sub-paragraph (i);

(B) any pre-harvesting laboratory test and investigation; and

(C) any counselling provided to the donor's family in connection with the donation of the specified organ;

"outpatient" means a patient other than —

(*a*) an in-patient;

[S 231/2025 wef 01/04/2025]

(*b*) a patient receiving day surgical treatment; or

[S 231/2025 wef 01/04/2025]

(*c*) a patient receiving MIC@Home treatment;

[S 231/2025 wef 01/04/2025]

"policy year" means —

(*a*) in relation to any insurance cover under the MediShield Scheme in Division 2 of Part II of the revoked MediShield Regulations for a period referred to in regulation 9(1)(*ca*)(i), (2)(*a*) or (3)(*a*) of those Regulations, that period;

(*b*) in relation to any other insurance cover under the MediShield Scheme, a period of 12 months from the date of the commencement or renewal of that insurance cover; or

(*c*) in relation to a person's integrated medical insurance plan (including any MediShield Component of that plan), a period of 12 months from the date of the commencement or renewal of that plan;

"pre-existing MediShield cover" means insurance cover under the MediShield Scheme in force immediately before 1 November 2015 which is replaced by MediShield Life cover under regulation 19(1);

"premium payable" excludes any Government subsidies paid towards the amount of premium determined under regulation 8;

"private hospital" means a provider of an acute hospital service within the meaning of the Healthcare Services Act 2020 that —

(*a*) holds a valid acute hospital service licence under that Act; and

(*b*) is not a restructured hospital;

[S 231/2025 wef 01/04/2025]

"radiosurgery treatment" means the treatment of neurosurgical or neurological disorders using any of the following:

(*a*) gamma knife technology;

(*b*) linear accelerator technology;

(*c*) proton beam therapy for a Category 4 clinical indication listed in the Approved Indications for PBT;

(*d*) externally generated ionising radiation delivered using —

(i) a rigidly attached stereotactic guiding device or other immobilisation technology; or

(ii) a stereotactic image-guidance system,

but excludes stereotactic radiotherapy;

[S 769/2022 wef 01/10/2022]

"radiotherapy treatment" means the treatment of any malignant disease or certain benign conditions with ionising radiation delivered externally or internally by sealed or unsealed radionuclides and irradiating apparatus;

[S 731/2018 wef 01/11/2018]

"restructured hospital" means any of the following providers of an acute hospital service within the meaning of the Healthcare Services Act 2020:

(*a*) Alexandra Health Pte. Ltd.;

(*b*) Alexandra Hospital;

(*c*) Changi General Hospital Pte Ltd;

(*d*) Institute of Mental Health;

(*e*) KK Women's and Children's Hospital Pte. Ltd.;

(*f*) National Heart Centre of Singapore Pte Ltd;

(*g*) National University Health Services Group Pte. Ltd.;

(*h*) National University Hospital (Singapore) Pte Ltd;

(*i*) Sengkang General Hospital Pte Ltd;

(*j*) Singapore General Hospital Pte Ltd;

(*k*) Tan Tock Seng Hospital Pte Ltd;

(*l*) WoodlandsHealth Pte. Ltd.;

[S 231/2025 wef 01/04/2025]

"revoked MediShield Regulations" means the Central Provident Fund (MediShield Scheme) Regulations (Cap. 36, Rg 20) as in force immediately before 1 November 2015;

"revoked PMIS Regulations" means the Central Provident Fund (Private Medical Insurance Scheme) Regulations (Cap. 36, Rg 26) as in force immediately before 1 November 2015;

"specified organ" has the same meaning as in the Human Organ Transplant Act 1987;

[S 403/2023 wef 31/12/2021]

"treatment of neoplasms" means the treatment of malignant neoplasms, certain benign neoplasms and neoplasms of uncertain behaviour.

[S 711/2022 wef 01/09/2022]

(2) For the purposes of these Regulations —

(*a*) if the day on which a person was born cannot be ascertained but the month of the person's birth can be ascertained, the person is taken to be born on the first day of the month in which the person was born;

[S 231/2025 wef 01/04/2025]

(*b*) if the month in which the person was born cannot be ascertained, the person is taken to be born in January.

(3) For the purposes of paragraphs 19 and 20 of the Third Schedule —

(*a*) "at-risk traveller" means an insured person who —

(i) makes a relevant journey; and

(ii) begins to show symptoms consistent with COVID-19 infection before the end of the at-risk traveller's possible incubation period in relation to that relevant journey;

(*b*) "COVID-19" means the infectious disease known as Coronavirus Disease 2019;

(*c*) "possible incubation period", in relation to each relevant journey of an at-risk traveller, means a period starting upon the arrival in Singapore of the at-risk traveller at the end of that relevant journey and ending on and including the 14th day after that day of arrival in Singapore;

(*d*) subject to sub-paragraph (*e*), an insured person makes a relevant journey if —

(i) the insured person leaves Singapore on or after 27 March 2020; and

(ii) that insured person's journey is against any travel advisory concerning the risk of COVID-19 infection, issued by the Ministry of Health and published on the website of that Ministry, that is applicable to that journey; and

(*e*) an insured person does not make a relevant journey if that insured person satisfies the Minister that the insured person had a compelling reason for undertaking the journey mentioned in sub-paragraph (*d*) despite the travel advisory.

[S 192/2020 wef 27/03/2020]

(4) In these Regulations, in relation to admissions before 1 October 2022, "radiosurgery treatment" means the gamma knife treatment or

the Novalis shaped beam treatment of neurosurgical or neurological disorders.

[S 769/2022 wef 01/10/2022]

(5) For the purposes of these Regulations, a patient is taken to have been transferred —

(*a*) from any approved permanent premises of an approved restructured hospital to receiving MIC@Home treatment provided by that approved restructured hospital;

(*b*) from receiving MIC@Home treatment provided by an approved restructured hospital to any approved permanent premises of that approved restructured hospital (except where the patient is treated by the emergency department of the approved restructured hospital immediately after the patient ceases to receive MIC@Home treatment); or

(*c*) between an approved permanent premises of an approved restructured hospital and an approved permanent premises of an approved community hospital,

if the medical treatment or services at the approved permanent premises of the approved restructured hospital and the MIC@Home treatment, or at the different approved permanent premises of the approved restructured hospital and approved community hospital respectively, are provided consecutively (in any order) and without any break in treatment, and the transfer is not taken to be a new admission.

[S 231/2025 wef 01/04/2025]

Applications and notices

3. An application made or a notice given to the Board under these Regulations must be made or given in such form and supported by such evidence as the Board may require.

PART 2

INSURANCE COVER

Commencement of insurance cover

4.—(1) A person's MediShield Life cover commences —

(*a*) on 1 November 2015, if the person is a citizen or permanent resident of Singapore on that date and was not insured under the MediShield Scheme immediately before that date;

(*b*) on the date of birth of the person, if the person is born on or after 1 November 2015 and is a citizen of Singapore by birth or descent; or

(*c*) on the date the person becomes a citizen or permanent resident of Singapore after 1 November 2015, if the person is not already insured under the Scheme.

(1A) Despite paragraph (1)(*c*), a person's MediShield Life cover is deemed to commence on the date of birth of the person if the person is born on or after 3 November 2020 and, before the first anniversary of the date of the person's birth —

(*a*) the person becomes a citizen or permanent resident of Singapore; and

(*b*) the person's parent or guardian applies to the Board, in the form and manner specified by the Board, for the person's MediShield Life cover to commence on the person's date of birth.

[S 933/2020 wef 03/11/2020]

(2) If the Board considers it appropriate when an event referred to in paragraph (1)(*a*) or (*c*) occurs, the person's MediShield Life cover may instead be commenced on a later date determined by the Board, not more than 12 months after that event occurs.

Termination or cancellation of insurance cover on death

5.—(1) Subject to paragraph (2), a person's MediShield Life cover is terminated and ceases immediately after the day on which the person dies.

(2) The Board may cancel a person's MediShield Life cover if —

(*a*) the person dies before the premium for the first insurance period of that person's MediShield Life cover has been paid, or the Board is notified of the person's death after the premium for the first insurance period has been paid; and

(*b*) no claim has been made under the person's MediShield Life cover.

(3) On the cancellation of a person's insurance cover under paragraph (2), the person is deemed never to have been insured under the Scheme.

[S 933/2020 wef 03/11/2020]

Termination and reinstatement of insurance cover in relation to changes in citizenship or permanent residency status

6.—(1) Subject to paragraph (3), a person's MediShield Life cover is terminated and ceases at the time specified in paragraph (2) if the person —

(*a*) ceases to be a citizen of Singapore and does not immediately become a permanent resident of Singapore; or

(*b*) ceases to be a permanent resident of Singapore and does not immediately become a citizen of Singapore.

(2) Subject to paragraph (3), a person's MediShield Life cover is terminated and ceases under paragraph (1) —

(*a*) immediately after the person ceases to be a citizen or permanent resident of Singapore, as the case may be; or

(*b*) on a later date (before or immediately after the end of the insurance period in which the person ceases to be a citizen or permanent resident of Singapore, as the case may be) specified by the Board.

(3) Where a person becomes a permanent resident of Singapore within 12 months after ceasing (on or after 3 November 2020) to be a permanent resident of Singapore, the person's MediShield Life cover is reinstated and is deemed not to have been terminated or ceased under paragraph (1).

[S 933/2020 wef 03/11/2020]

PART 3

PREMIUM

Insurance period

7.—(1) The insurance period of an insured person's MediShield Life cover is a period of 12 months starting on the date of commencement or renewal of that insurance cover.

(2) Paragraph (1) applies unless a shorter period applies under any other provision of these Regulations, or the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015.

Amount of premium

8. The premium for each insurance period of an insured person's MediShield Life cover is determined according to the following formula:

$$A + B - C,$$

where A is the standard premium specified on the website at https://www.moh.gov.sg applicable to the insured person for that insurance period;

B is the amount of premium loading applicable to the insured person and payable as premium for that insurance period under regulation 9, if any; and

C is the premium rebate specified on the website at https://www.moh.gov.sg applicable to the insured person for that insurance period, if any.

[S 231/2025 wef 01/04/2025]

Premium loading

9.—(1) Subject to paragraphs (4) and (5), if the Board is satisfied that the insured person satisfies such criteria, relating to health or other matters, as the Minister may determine, premium loading is payable as premium —

(*a*) unless sub-paragraph (*b*) applies, for the first 10 insurance periods of the insured person's MediShield Life cover; or

(*b*) if the insured person's MediShield Life cover replaced the insured person's pre-existing MediShield cover under regulation 20(1)(*a*), for 10 consecutive insurance periods starting with the insurance period that commences immediately after the end of the first insurance period of the person's MediShield Life cover.

(2) If the Board first discovers, after the start of the first 10 insurance periods referred to in paragraph (1)(*a*) or the 10 consecutive insurance periods referred to in paragraph (1)(*b*) (as the case may be), that the criteria for premium loading mentioned in paragraph (1) were satisfied, then —

(*a*) premium loading is payable as premium for the next 10 insurance periods starting on or after the date when the Board made that discovery; or

(*b*) if the Board approves an application by the insured person to apply premium loading to the insurance periods under paragraph (1)(*a*) or (*b*) (as the case may be) instead, premium loading is payable in accordance with paragraph (4).

[S 933/2020 wef 03/11/2020]

(3) The amount of premium loading payable in respect of each insurance period of the insured person's MediShield Life cover under paragraph (1) or (2) is 30% of the standard premium specified on the website at https://www.moh.gov.sg applicable to the insured person for the insurance period for which the premium loading is payable.

[S 231/2025 wef 01/04/2025]

(4) Where, under paragraph (2)(*b*), premium loading is applied to any insurance period for which the premiums have already been paid —

(*a*) the amount of premium loading for that insurance period is due and payable to the Board at such times and in such manner as the Board may require; and

(*b*) the Board may, in accordance with regulation 10, deduct the whole or part of that amount from the medisave account of the CPF member who paid the insured person's premium for that insurance period.

(5) Despite paragraphs (1) and (2), premium loading is payable as premium for a shorter period, as the Board may determine, if the Board is satisfied that the insured person meets such criteria, relating to health or other matters, as the Minister determines justifies a shorter period of premium loading.

(6) The criteria for premium loading mentioned in paragraph (1) includes the following:

(*a*) the insured person was suffering from a pre-existing medical condition;

(*b*) where the insured person's MediShield Life cover commences on the person's date of birth under regulation 4(1A), the insured person would have been regarded as having a pre-existing medical condition had the MediShield Life cover instead commenced on the date the insured person became a citizen or permanent resident of Singapore.

[S 933/2020 wef 03/11/2020]

Payment of premium, interest or penalty

10.—(1) Unless the Board decides to apply any other provision of this regulation, the premium payable for any insurance period of an insured person is to be deducted from —

(*a*) the insured person's medisave account; or

(*b*) a CPF member's medisave account if —

(i) the insured person is a dependant of the CPF member; and

(ii) the Board has approved an application by the CPF member for payment of that premium from the CPF member's medisave account.

(2) Subject to paragraph (3), if the premium for —

(*a*) a previous insurance period of an insured person; or

(*b*) a policy year of an insured person's pre-existing MediShield cover which was replaced, under these Regulations or the MediShield Life Scheme (Private

Medical Insurance Scheme) Regulations 2015, by the insured person's MediShield Life cover,

was deducted from the medisave account of a CPF member who is not the insured person, the Board may continue to deduct the premium for each subsequent insurance period of the insured person's MediShield Life cover from that CPF member's medisave account.

(3) If the amount standing to the insured person's credit in the insured person's medisave account, after the insured person attains 21 years of age, is sufficient to pay the premium for the next insurance period of the insured person, the Board may —

(*a*) cease to deduct the premium for that insurance period and any subsequent insurance period from the medisave account of a CPF member under paragraph (2); or

(*b*) if the CPF member authorises the Board in writing, continue to deduct the premium from the CPF member's medisave account.

(4) Paragraphs (5) and (6) apply if —

(*a*) the insured person had not attained 21 years of age at the beginning of the insurance period for which the premium is payable; and

(*b*) the amount standing to the insured person's credit in the insured person's medisave account is insufficient to pay the premium for that insurance period.

(5) For the purposes of section 4(1)(*c*)(ii) and (2)(*a*) of the Act, the Board may deduct the premium —

(*a*) from the medisave account of the insured person's male parent; or

(*b*) from the medisave account of the insured person's female parent, if the amount standing to the insured person's male parent's credit in that parent's medisave account is insufficient to pay the premium payable or that parent has died.

(6) Despite paragraph (5), for the purposes of section 4(1)(*c*)(ii) and (2)(*a*) of the Act, if the Board considers it appropriate in the circumstances of any case, the Board may deduct the premium from —

(*a*) the medisave account of any one of the insured person's parents; or

(*b*) the medisave accounts of more than one of the insured person's parents, in such proportion as the Board may determine.

(7) If the amount standing to the insured person's credit in the insured person's medisave account is insufficient to pay a premium for an insurance period of the insured person, the premium for that period is payable by, and may be deducted under section 4(2)(*b*) of the Act from the medisave account of, any of the following persons:

(*a*) the spouse of the insured person who, when the payment is to be deducted, has attained 16 years of age;

(*b*) a CPF member from whose medisave account payment has been deducted —

(i) for the whole or part of the insured person's premium under any insurance policy;

(ii) under the Central Provident Fund (Medisave Account Withdrawals) Regulations (Rg 17) for any medical treatment or services received, or to be received, by the insured person; or

[S 403/2023 wef 31/12/2021]

(iii) under section 16B of the Central Provident Fund Act 1953 for any long-term care required by the insured person.

[S 933/2020 wef 03/11/2020]

[S 403/2023 wef 31/12/2021]

(8) Where the suspension of collection of the relevant amount of an approved OS ends under the terms and conditions of the OS scheme, the relevant amount may also be deducted (in whole or in part) from the medisave account of any of the following persons:

(*a*) the approved OS;

(*b*) any CPF member who made the OS application, on behalf of the approved OS, pursuant to which the collection of the relevant amount was suspended.

[S 300/2018 wef 14/05/2018]

(9) Subject to paragraph (10), a CPF member may, by giving notice to the Board, withdraw from paying, from the amount standing to that member's credit in that member's medisave account, the premium for any insurance period of an insured person's MediShield Life cover.

(10) Despite paragraphs (1) to (7), but subject to paragraph (11), if the Board has received, from a CPF member, a notice under paragraph (9) to withdraw from paying the premiums for any insurance period of an insured person, the Board must not deduct payment of the premium for that insurance period from the CPF member's medisave account.

(11) Except with the Board's approval —

(*a*) a CPF member may not withdraw under paragraph (9) from paying any premium payable by the CPF member under section 4(1)(*c*) of the Act;

(*b*) a CPF member, who has applied to the Board for an insured person's outstanding premium to be paid by a lump sum deduction from that CPF member's medisave account, may not withdraw under paragraph (9) from paying that outstanding premium; and

(*c*) an approved OS or a CPF member, mentioned in paragraph (8), may not withdraw under paragraph (9) from paying the relevant amount mentioned in paragraph (8).

[S 300/2018 wef 14/05/2018]

(12) The Board's approval mentioned in paragraph (11) may be granted —

(*a*) subject to such conditions as the Board may impose; and

(*b*) only if the Board is satisfied that there are exceptional reasons to allow the withdrawal from making the payment.

[S 300/2018 wef 14/05/2018]

(13) The Board may —

(*a*) deduct from the CPF member's medisave account, under this regulation, an amount not exceeding the amount standing to the credit of the CPF member in the medisave account to pay the whole or part of the premium; and

[S 300/2018 wef 14/05/2018]

(*b*) permit any deficiency to be paid in such manner as the Board thinks fit, subject to such terms and conditions as the Board may impose.

[S 300/2018 wef 14/05/2018]

(14) The Board may cancel its approval for payment of a premium for the MediShield Life cover of an insured person to be deducted from a CPF member's medisave account if —

(*a*) the deduction from the CPF member's medisave account breaches these Regulations or the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015; or

(*b*) the insured person or the CPF member made a false representation to the Board, or furnished the Board with any false information, in connection with the application for payment of a premium for the MediShield Life cover of an insured person to be deducted from a CPF member's medisave account.

(15) If the Board's approval for payment of premiums for an insured person's MediShield Life cover to be deducted from a CPF member's medisave account is cancelled under paragraph (14) —

(*a*) the CPF member must, if required by the Board, refund to the CPF member's medisave account the amount of moneys withdrawn from that account, which could not have been withdrawn if the cancelled approval had not been given (called the affected moneys); or

(*b*) the Board may —

(i) refund from the Fund to the CPF member's medisave account the affected moneys paid as premiums for the insured person's MediShield Life cover; and

(ii) require payment of the resulting shortfall in the premiums under section 6 of the Act or in accordance with the other provisions of this regulation.

(16) Despite paragraph (15)(*a*), if the CPF member has paid the affected moneys to an insurer —

(*a*) the insurer must transfer the moneys to the Board; and

(*b*) the Board must refund the moneys, transferred in sub-paragraph (*a*), to the CPF member's medisave account.

(17) Regulation 11 applies instead of paragraph (15) if the insured person's MediShield Life cover is terminated or cancelled.

(18) In this regulation, "insurance period of an insured person" means an insurance period of an insured person's MediShield Life cover.

(19) This regulation applies to any interest or penalty imposed under section 11(1)(*a*) or 17 of the Act (as the case may be) in respect of the premium for an insurance period, in the same way that this regulation applies to that premium.

[S 300/2018 wef 14/05/2018]

[S 731/2018 wef 01/11/2018]

Refund of premium, interest or penalty

11.—(1) Subject to section 5 of the Act, where a person's MediShield Life cover is terminated during an insurance period under these Regulations, the amount of the premium paid for the insurance period pro-rated in respect of the period of the insurance cover that remains unexpired when the person's MediShield Life cover ceases is to be refunded from the Fund.

(2) Subject to section 5 of the Act, where a person's MediShield Life cover is cancelled under regulation 5, all premiums, interest and penalties paid for the cancelled insurance cover are to be refunded from the Fund.

[S 300/2018 wef 14/05/2018]

[S 933/2020 wef 03/11/2020]

(3) The Board may —

(*a*) credit the whole or such part, as the Board may determine, of any refunded premium, interest or penalty into the medisave account of the person who paid the premium, interest or penalty (as the case may be), regardless of how the premium, interest or penalty was paid; and

(*b*) where the refunded premium, interest or penalty mentioned in sub-paragraph (*a*) was paid by deduction from the same medisave account, also pay into that medisave account, the whole or such part, as the Board may determine, of the interest that would have been payable on the amount credited into that medisave account under sub-paragraph (*a*) if that amount had not been deducted from that medisave account.

[S 300/2018 wef 14/05/2018]

(4) Where —

(*a*) a Government grant is used (without first being credited to a person's medisave account) to pay the whole or any part of any premium, interest or penalty; and

(*b*) the premium, interest or penalty is to be refunded, in whole or in part,

the Board may pay to the Government from the refund, an amount not more than the amount of the Government grant.

[S 300/2018 wef 14/05/2018]

(5) The Board may deduct, from any premium, interest or penalty to be refunded, any payment that the insured person is liable to make under the Act.

[S 300/2018 wef 14/05/2018]

PART 4

CLAIMS

Benefits

12.—(1) Benefits may be claimed under the Scheme, in accordance with these Regulations, only for claimable medical treatment or services received by the insured person —

(*a*) from an approved medical practitioner employed or engaged by an approved medical institution; and

[S 231/2025 wef 01/04/2025]

(*b*) during the period when the insured person is insured under the Scheme.

[S 231/2025 wef 01/04/2025]

(2) No benefits may be claimed under the Scheme —

(*a*) for any treatment, service or item specified in the Third Schedule; or

(*b*) for any treatment, service or item assessed, by the Council or a committee appointed under section 8(4) of the Act, to be inappropriate in the circumstances of a particular case.

(3) An approved medical institution may submit claims directly to the Board, in the manner and subject to any terms and conditions required by the Board, for claimable medical treatment or services provided by the approved medical institution to the insured person.

[S 231/2025 wef 01/04/2025]

(4) Claims under the Scheme may be paid from the Fund.

Claim limits

13.—(1) The total amount of claims that may be paid under an insured person's MediShield Life cover in respect of each insurance period is an amount not exceeding an insurance period limit of —

(*a*) $100,000, if the insured person was admitted before 1 March 2021;

[S 231/2025 wef 01/04/2025]

(*b*) $150,000, if the insured person was admitted on or after 1 March 2021 but before 1 April 2025; or

[S 231/2025 wef 01/04/2025]

(*c*) $200,000, if the insured person was admitted on or after 1 April 2025.

[S 231/2025 wef 01/04/2025]

(2) Subject to paragraph (1), an insured person is entitled to claim under the Scheme, for each approved outpatient treatment, the lower of the following amounts:

(*a*) an amount determined in accordance with the following formula:

$$T \times P \times 0.9,$$

where P is the pro-ration factor specified in the Fourth Schedule applicable to the insured person in relation to the type of approved outpatient treatment received by the insured person; and

T is the total amount of the charges payable for the approved outpatient treatment received by the insured person;

(*b*) the total of the assured amounts for approved outpatient treatment received by the insured person.

(3) Subject to paragraphs (1) and (7), an insured person is entitled to claim, under the Scheme, for each approved medical treatment or services that is a claimable medical treatment or services received from an approved medical institution as an in-patient, under the MIC@Home programme, or as day surgical treatment (called the current claim), an amount ascertained by applying one of the following formulae to the approved medical treatment or services:

(*a*) if A is not more than $5,000, the formula is —

$$[(A - B) \times 0.9] - C;$$

(*b*) if A is more than $5,000 but not more than $10,000, the formula is —

$$[(\$5{,}000 - B) \times 0.9] + [(A - \$5{,}000) \times 0.95] - C;$$

(*c*) if A is more than $10,000, the formula is —

$$[(\$5{,}000 - B) \times 0.9] + (\$5{,}000 \times 0.95) + [(A - \$10{,}000) \times 0.97] - C,$$

where A is the sum of —

(*a*) the relevant amount for the approved medical treatment or services to which the current claim relates; and

(*b*) the relevant amount for all other approved medical treatment or services —

(i) with an admission date during the same insurance period as the approved medical treatment or services to which the current claim relates; and

(ii) in respect of which a claim was received by the Board before the current claim was received;

B is the lower of the following:

(*a*) A;

(*b*) the insured person's contribution for the approved medical treatment or services to which the current claim relates; and

C is the sum of all claims paid for all other approved medical treatment or services referred to in sub-paragraph (*b*) of the definition of A.

[S 231/2025 wef 01/04/2025]

(4) An insured person is entitled to claim, under the Scheme, for each claimable medical treatment or services (other than approved in-patient palliative care) received as an in-patient of any approved community hospital (called community hospital treatment), an amount calculated in accordance with the formula specified in paragraph (3), if —

(*a*) the insured person has received claimable medical treatment or services as an in-patient of an approved medical institution and, on the insured person's discharge from in-patient treatment provided by the institution, an approved medical practitioner of that institution certifies in writing that the insured person requires the community hospital treatment;

[S 231/2025 wef 01/04/2025]

(*aa*) a medical practitioner treating or assessing the insured person at the emergency department of an approved restructured hospital certifies in writing that the insured person requires the community hospital treatment;

[S 465/2018 wef 15/07/2018]

[S 231/2025 wef 01/04/2025]

(*ab*) the insured person has received MIC@Home treatment provided by an approved medical institution, and an approved medical practitioner of that institution certifies in writing that the insured person requires the community hospital treatment; or

[S 231/2025 wef 01/04/2025]

(*b*) the Minister approves the person's claim for the community hospital treatment.

[S 224/2020 wef 01/04/2020]

[S 231/2025 wef 01/04/2025]

(5) Subject to the claim limits in paragraphs (1) and (3), where, in connection with an organ transplant to an insured person, the insured person —

(*a*) is admitted to any approved permanent premises of an approved medical institution as an in-patient for any claimable medical treatment or services; or

[S 231/2025 wef 01/04/2025]

(*b*) receives any day surgical treatment in the approved medical institution,

the insured person is entitled to claim under the Scheme, as part of the charges incurred for such treatment, the amount of any organ transplantation costs that the insured person has incurred in connection with the organ transplant.

(6) Despite anything in these Regulations, for the purposes of paragraph (5), where the organ transplantation costs are incurred in connection with a living donor organ transplant of which the insured person is the recipient of the specified organ, the assured amount for any item of claimable medical treatment or services applies separately in relation to —

(*a*) the claimable medical treatment or services as received by the insured person; and

(*b*) the claimable medical treatment or services as received by the living organ donor.

[S 231/2025 wef 01/04/2025]

(7) In paragraph (3), "relevant amount", in respect of approved medical treatment or services received by the insured person from an approved medical institution as an in-patient, under the MIC@Home programme, or as day surgical treatment, is the lower of the following amounts:

(*a*) an amount determined in accordance with the following formula:

$$T \times P,$$

where P is the pro-ration factor specified in the Fifth Schedule applicable to the insured person in relation to the type of approved medical treatment or services received by the insured person; and

T is the total amount of the charges payable for the approved medical treatment or services received by the insured person;

(*b*) the total of the assured amounts for such approved medical treatment or services.

[S 231/2025 wef 01/04/2025]

(8) In this regulation —

"assured amount", in relation to each item of approved medical treatment or services received by a person insured under the Scheme, means the amount specified in the Sixth Schedule in

respect of that item of approved medical treatment or services;

"insured person's contribution", in respect of any approved medical treatment or services, means the amount of the insured person's contribution specified in the Seventh Schedule in respect of the approved medical treatment or services received by the insured person.

(9) This regulation applies subject to regulations 14 and 20.

Cross insurance period claim

14.—(1) An insured person's cross insurance period claim may be paid in respect of each relevant insurance period of the cross insurance period claim, instead of only in respect of the initial insurance period of the cross insurance period claim.

(2) Subject to paragraph (3), the amount of an insured person's cross insurance period claim that may be paid in respect of each relevant insurance period of the cross insurance period claim is an amount not exceeding the excess limit for that relevant insurance period determined in accordance with the following formula:

$$A - B,$$

where A is the insurance period limit specified in regulation 13(1) for the initial insurance period of the cross insurance period claim; and

B is the total amount of other claims —

(*a*) received before the Board received the cross insurance period claim; and

(*b*) paid under the person's MediShield Life cover in respect of the relevant insurance period to which the excess limit relates.

(3) If the initial insurance period of an insured person's cross insurance period claim is the insured person's first insurance period and regulation 20(1)(*a*) applies to that first insurance period, the value of A for the purposes of paragraph (2) —

(*a*) for the initial insurance period of the cross insurance period claim, is the insurance period limit specified in paragraph 3(3) of the Ninth Schedule; and

(*b*) for any subsequent relevant insurance period of the cross implementation claim, is $100,000.

(4) For the purposes of regulation 13(3) —

(*a*) an insured person's cross insurance period claim is to be treated as a single current claim for claimable medical treatment or services with an admission date during the initial insurance period of the cross insurance period claim; and

[S 231/2025 wef 01/04/2025]

(*b*) the calculation under regulation 13(3) —

(i) is to be applied to the whole of the insured person's cross insurance period claim only once; and

(ii) is not to be repeated in calculating the amount of the cross insurance period claim to be paid in respect of any relevant insurance period of the cross insurance period claim after the initial insurance period of the cross insurance period claim.

(5) In this regulation, in relation to a cross insurance period claim —

"final insurance period" means the insurance period in which the date of discharge of the claimable medical treatment or services to which the cross insurance period claim relates falls;

[S 231/2025 wef 01/04/2025]

"initial insurance period" means the insurance period in which the admission date of the claimable medical treatment or services to which the cross insurance period claim relates falls;

[S 231/2025 wef 01/04/2025]

"relevant insurance period" means each insurance period from the initial insurance period of the cross insurance period

claim to the final insurance period of the cross insurance period claim (both inclusive).

(6) This regulation applies subject to regulations 19 and 20.

Illustration

Assume a person's cross insurance period claim spans 3 relevant insurance periods, namely, the initial insurance period, the second relevant insurance period and the final insurance period.

Assume the amount of an insured person's cross insurance period claim, calculated in accordance with regulation 13(3), is $450,000.

Assume the excess limits of the person's cross insurance period claim, calculated in accordance with regulation 14(2), in respect of —

(*a*) the initial insurance period is $40,000;

(*b*) the second insurance period is $200,000; and

[S 231/2025 wef 01/04/2025]

(*c*) the final insurance period is $200,000.

[S 231/2025 wef 01/04/2025]

The total amount of the cross insurance period claim paid is $440,000, leaving only $10,000 of the cross insurance period claim unpaid.

[S 135/2021 wef 26/02/2021]

[S 231/2025 wef 01/04/2025]

Reimbursement by another person

15.—(1) Where —

(*a*) an insured person's claim under the Scheme in respect of any approved medical treatment or services received by the insured person has been paid from the Fund; and

(*b*) another person, who is under an obligation (contractual or otherwise) to pay or reimburse the insured person for charges incurred in respect of the approved medical treatment or services, has made the payment or reimbursement,

an amount computed in accordance with the following formula becomes due and payable to the Fund by the insured person on the date such payment or reimbursement is made by that other person:

$$X + Y – Z,$$

where X is the total amount of the payment or reimbursement made by that other person;

Y is the total amount of the claim paid from the Fund under the Scheme; and

Z is the total amount of the charges incurred by the insured person.

(2) Paragraph (1) does not apply if the other person referred to in paragraph (1)(*b*) is an insurer under an obligation to pay or reimburse that insured person under an integrated shield plan.

(3) Where an insured person is insured under an integrated shield plan, regulation 10 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015 applies instead of paragraph (1).

PART 5

MEDISHIELD LIFE COMPONENT

Regulations apply with modifications

16. These Regulations apply to the MediShield Life Component of an insured person's integrated shield plan in the same manner as the Regulations apply to such an insured person's insurance cover under the Scheme, with the modifications specified in this Part.

Payment of premium

17.—(1) Subject to paragraph (4), regulation 4, except regulation 4(12) and (13), of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015 applies to the MediShield Life Component of an integrated shield plan, instead of regulation 10 of these Regulations.

(2) If the Board approves a withdrawal, under regulation 4(1) of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015, of moneys from a CPF member's medisave account for the payment of the premium for an insured person's MediShield Life Component, the Board may deduct the premium

from that CPF member's medisave account when the insurer notifies the Board that the premium is due.

(3) The Board is to pay into the Fund all moneys pertaining to the premiums of an insured person's MediShield Life Component which —

(*a*) are withdrawn under paragraph (2);

(*b*) transferred to the Board under regulation 6(2) of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015; or

(*c*) otherwise received by the Board.

(4) If the Board's approval for payment of premiums for an insured person's MediShield Life Component to be deducted from a CPF member's medisave account is cancelled under regulation 4(5) or (11) of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015 —

(*a*) the CPF member must, if required by the Board, refund to the CPF member's medisave account the amount of moneys withdrawn from that account, which could not have been withdrawn if the cancelled approval had not been given (called the affected moneys); or

(*b*) the Board may —

(i) refund from the Fund to the CPF member's medisave account the affected moneys paid as premiums for the insured person's MediShield Life cover; and

(ii) require payment of the resulting shortfall in the premiums under section 6 of the Act or in accordance with the other provisions of this regulation.

(5) Despite paragraph (4)(*a*), if the CPF member has paid the affected moneys to an insurer —

(*a*) the insurer must transfer the moneys to the Board; and

(*b*) the Board must refund the moneys, transferred in sub-paragraph (*a*), to the CPF member's medisave account.

(6) Regulation 11 applies instead of paragraph (4) if the insured person's MediShield Life cover is terminated or cancelled.

(7) If the additional private insurance cover of an insured person's integrated shield plan is terminated or cancelled, but the insured person's MediShield Life cover which had formed the MediShield Life Component of that integrated shield plan is not terminated or cancelled, regulation 10 will then apply to that person's MediShield Life cover.

Termination or cancellation

18.—(1) Subject to paragraph (2), if an insured person's integrated shield plan (called in this paragraph and paragraph (2) the earlier plan) is terminated or cancelled, the insured person's MediShield Life cover provided by the MediShield Life Component of that earlier plan continues, with the same insurance period as applied to that earlier plan (before that earlier plan was terminated or cancelled).

(2) If the insured person takes up another integrated shield plan (called in this paragraph the later plan) which commences immediately after the termination or cancellation of the earlier plan —

(*a*) the insured person's MediShield Life cover provided by the MediShield Life Component of the insured person's earlier plan (called the earlier MediShield Life cover) continues as the MediShield Life Component of the later plan, with an insurance period of 12 months commencing on the same date as the later plan; and

(*b*) the Board is to refund, to the person who paid the premium for the last insurance period of the insured person's earlier plan, the pro-rated amount specified in paragraph (4).

(3) If the insured person has a MediShield Life cover, which is not the MediShield Life Component of an integrated shield plan (called the earlier MediShield Life cover), in force immediately before the insured person takes up an integrated shield plan (called in this paragraph the later plan) —

(*a*) the insured person's existing MediShield Life cover continues as the MediShield Life Component of the later plan, with an insurance period of 12 months commencing on the same date as the later plan; and

(*b*) the Board is to refund, to the person who paid the premium for the last insurance period of the insured person's earlier MediShield Life cover, the pro-rated amount specified in paragraph (4).

(4) The pro-rated amount referred to in paragraph (2) or (3) is the premium paid for the earlier MediShield Life cover referred to in that paragraph, pro-rated in respect of the unexpired period of the last insurance period of that earlier MediShield Life cover, falling on or after the commencement date of the later plan referred to in that paragraph.

(5) Paragraphs (1) and (2)(*a*) do not apply if the insured person's MediShield Life cover (whether or not it is the MediShield Life Component of an integrated shield plan) is terminated under regulation 5(1) or 6(1) or paragraph 2 or 4 of the Tenth Schedule, immediately after the termination or cancellation of the earlier plan referred to in paragraphs (1) and (2).

[S 933/2020 wef 03/11/2020]

(6) Paragraph (3)(*a*) does not apply if the insured person's MediShield Life cover (whether or not it is the MediShield Life Component of an integrated shield plan) is terminated under regulation 6(1) or paragraph 2 or 4 of the Tenth Schedule, on the commencement of the later plan referred to in paragraph (3).

[S 933/2020 wef 03/11/2020]

(7) The MediShield Life Component which forms part of a person's integrated shield plan may be terminated or cancelled under these Regulations, whether or not the additional private insurance coverage of that integrated shield plan is also terminated or cancelled.

PART 6

TRANSITIONAL PROVISIONS

MediShield Scheme

19.—(1) A person's insurance cover under the MediShield Scheme in force immediately before 1 November 2015 is taken to be immediately replaced by insurance cover under the Scheme on 1 November 2015.

(2) Subject to these Regulations and the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015 —

(*a*) the revocation of the Central Provident Fund (MediShield Scheme) Regulations (Cap. 36, Rg 20) do not affect anything done under any provision of the revoked MediShield Regulations before 1 November 2015; and

(*b*) the revoked MediShield Regulations continue to apply in relation to every insurance cover under the MediShield Scheme which was in force before 1 November 2015 as if those Regulations had not been revoked.

(3) These Regulations and the revoked MediShield Regulations apply with the modifications in the Eighth Schedule.

First insurance period of Scheme

20.—(1) Despite regulation 7, the first insurance period of an insured person's MediShield Life cover which replaced the insured person's pre-existing MediShield cover under regulation 19(1) is —

(*a*) the period of the last policy year of the insured person's pre-existing MediShield cover falling on or after 1 November 2015, if any; or

(*b*) a period of 12 months commencing on 1 November 2015, if the last day of the last policy year of the insured person's pre-existing MediShield cover is 31 October 2015.

(2) Paragraph (1) applies unless a shorter period applies under these Regulations, or the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015.

(3) These Regulations and the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015 apply, in relation to the first insurance period of an insured person's MediShield Life cover to which paragraph (1)(*a*) applies, with the modifications in the Ninth Schedule.

Insurance cover of persons not citizens or permanent residents

21. These Regulations and the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015 apply, in relation to a person who, not being a citizen or permanent resident of Singapore, is insured under the Scheme under section 35(1) of the Act, with the modifications in the Tenth Schedule.

FIRST SCHEDULE

[*Deleted by S 231/2025 wef 01/04/2025*]

SECOND SCHEDULE

[*Deleted by S 231/2025 wef 01/04/2025*]

THIRD SCHEDULE

Regulations 2(1) and 12(2)

EXCLUDED TREATMENT, SERVICE OR ITEM

1. Treatment for or in respect of —

(*a*) any contraceptive operation or procedure;

[S 190/2019 wef 01/04/2019]

(*b*) infertility, sub-fertility or assisted conception; or

(*c*) sex re-assignment surgery.

2. Any surgical treatment or surgical implant for or in respect of the following conditions:

(*a*) trisomy 13;

(*b*) trisomy 18, with an admission date before 1 November 2018;

[S 731/2018 wef 01/11/2018]

THIRD SCHEDULE — *continued*

(*c*) bilateral renal agenesis;

(*d*) Bart's hydrops;

(*e*) alobar holoprosencephaly, with an admission date before 1 November 2018;

[S 731/2018 wef 01/11/2018]

(*f*) anencephaly.

3. Cosmetic surgery for self-beautification.

4. Dental work or dental treatment, except approved dental treatment.

5. Outright purchase of kidney dialysis machines, iron-lung and other special appliances.

6. Optional items such as television, telephone, special requested meals and other items which are not necessary for the treatment of any illness, condition or any injury or disability.

7. Private nursing.

8. Ambulance services.

9. Vaccination.

10. Treatment for injuries or disablement, directly or indirectly, resulting from —

(*a*) suicide, attempted suicide or intentional self-injury by the insured person, with an admission date before 1 March 2021;

[S 135/2021 wef 26/02/2021]

(*b*) deliberate exposure by the insured person to exceptional danger (except in an attempt to save human life);

(*c*) the insured person's own criminal act;

(*d*) drug addiction or alcoholism or the insured person being under the influence of drugs or alcohol, with an admission date before 1 March 2021;

[S 135/2021 wef 26/02/2021]

(*da*) addiction to any controlled drug that is specified in the First Schedule to the Misuse of Drugs Act 1973 or the insured person being under the influence of any such controlled drug; or

[S 135/2021 wef 26/02/2021]

[S 403/2023 wef 31/12/2021]

(*e*) the insured person's direct participation in any civil commotion, riot or strike.

THIRD SCHEDULE — *continued*

11. Treatment for injuries, directly or indirectly, resulting from war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military or usurped power.

12. Treatment for injuries, directly or indirectly, resulting from nuclear fallout.

13. Treatment received outside Singapore.

14. Treatment for which the insured person received reimbursements by workmen's compensation and other forms of insurance coverage.

15. Treatment for which the admission date was before the commencement date of the insured person's MediShield Life cover.

16. Daily board, ward services and treatment (including meals, prescriptions and professional consultations, investigations and other miscellaneous items) provided to the insured person while staying as an in-patient in any approved permanent premises of an approved medical institution on or after the claim bar date.

[S 465/2018 wef 15/07/2018]

[S 224/2020 wef 01/04/2020]

[S 231/2025 wef 01/04/2025]

16A. Daily treatment charges for any treatment provided to the insured person by an approved medical institution under the MIC@Home programme —

(*a*) if the period between the insured person's admission for treatment and discharge from treatment is less than 8 hours; or

(*b*) on or after the 7th calendar day after the earliest day when the insured person is certified, by a medical practitioner employed or engaged by the approved medical institution, to be medically fit for discharge from MIC@Home treatment provided by that approved medical institution.

[S 231/2025 wef 01/04/2025]

17. Treatment for or in respect of pregnancy, childbirth (including caesarean delivery) or abortion, except treatment for serious complications related to pregnancy and childbirth.

[S 190/2019 wef 01/04/2019]

18. Delivery procedure for childbirth (including caesarean delivery), except caesarean hysterectomy.

[S 190/2019 wef 01/04/2019]

THIRD SCHEDULE — *continued*

19. Any treatment, service or item received on or after 27 March 2020 but before 20 October 2020, for COVID-19 infection or otherwise, by an at-risk traveller as an in-patient while being treated for COVID-19 infection.

[S 192/2020 wef 27/03/2020]

[S 898/2020 wef 20/10/2020]

20. Any treatment, service or item received on or after 27 March 2020 but before 20 October 2020 by an at-risk traveller as an in-patient where —

(*a*) the admission is to test for suspected COVID-19 infection;

(*b*) the test is negative for COVID-19 infection; and

(*c*) the at-risk traveller does not need in-patient treatment for any other medical condition.

[S 192/2020 wef 27/03/2020]

[S 898/2020 wef 20/10/2020]

21. The cost of any cancer drug administered to an outpatient that is not an approved cancer drug.

[S 711/2022 wef 01/09/2022]

22. Any proton beam therapy, except approved proton beam therapy.

[S 769/2022 wef 01/10/2022]

FOURTH SCHEDULE

Regulation 13(2)(*a*)

PART 1

PRO-RATION FACTORS FOR APPROVED OUTPATIENT TREATMENT

(With admission date on or after 1 November 2015, and before 1 November 2016)

Subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Subsidised treatment	1	0.67	Not applicable
Non-subsidised treatment	1	1	1

FOURTH SCHEDULE — *continued*

PART 2

PRO-RATION FACTORS FOR
APPROVED OUTPATIENT TREATMENT

(With admission date on or after 1 November 2016, but before 1 April 2025)

Subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Subsidised treatment	1	0.67	Not applicable
Long term parenteral nutrition (*Non-subsidised*)	0.5	0.5	0.5
Cancer drug treatment and radiotherapy treatment (*Non-subsidised*)	0.5	0.5	0.5
Treatment for other approved outpatient treatments (*Non-subsidised*)	1	1	1

[S 731/2018 wef 01/11/2018]

[S 711/2022 wef 01/09/2022]

[S 231/2025 wef 01/04/2025]

PART 3

PRO-RATION FACTORS FOR
APPROVED OUTPATIENT TREATMENT
(OTHER THAN FOR RENAL DIALYSIS
OR ADMINISTRATION OF ERYTHROPOIETIN
FOR DIALYSIS AND CHRONIC RENAL FAILURE)

(With admission date on or after 1 April 2025)

Institution or subsidy status	Pro-ration factor for:

FOURTH SCHEDULE — *continued*

	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Approved public healthcare institution (*subsidised*)	1	0.56	Not applicable
Approved public healthcare institution (*non-subsidised*)	0.35	0.35	0.35
Approved private hospital	0.3	0.3	0.3

[S 231/2025 wef 01/04/2025]

PART 4

PRO-RATION FACTORS
FOR RENAL DIALYSIS OR
ADMINISTRATION OF ERYTHROPOIETIN
FOR DIALYSIS AND CHRONIC RENAL FAILURE

(With admission date on or after 1 April 2025)

Institution or subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Approved public healthcare institution (*subsidised*)	1	0.67	Not applicable
Approved public healthcare institution (*non-subsidised*)	1	0.56	0.56
Approved private hospital	1	0.56	0.56

FOURTH SCHEDULE — *continued*

Approved voluntary welfare organisation	1	0.67	0.56

[S 231/2025 wef 01/04/2025]

FIFTH SCHEDULE

Regulation 13(7)(*a*)

PART 1

PRO-RATION FACTORS FOR ADMISSION AS IN-PATIENT (OTHER THAN DAY TREATMENT PATIENT OR FOR APPROVED IN-PATIENT PALLIATIVE CARE) OR FOR DAY SURGICAL TREATMENT

(With admission date on or after 1 November 2015, but before 1 April 2025)

[S 286/2019 wef 01/04/2019]

[S 224/2020 wef 01/04/2020]

Ward class or subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Class C	1	0.44	0.2
Class B2	1	0.58	0.35
Class B2+	0.7	0.47	0.35
Class B1	0.43	0.38	0.35
Class A or approved private hospital (with admission date before 1 March 2021)	0.35	0.35	0.35
Class A (with admission date on or after 1 March 2021, but before 1 April 2025)	0.35	0.35	0.35
Approved private hospital (with admission date on	0.25	0.25	0.25

FIFTH SCHEDULE — *continued*

Ward class or subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
or after 1 March 2021, but before 1 April 2025)			
Approved community hospital (*subsidised*)	1	0.5	Not applicable (with admission date before 1 April 2020) and 0.5 (with admission date on or after 1 April 2020)
Approved community hospital (*non-subsidised*)	0.5	0.5	0.5
Short stay ward (*subsidised*)	1	0.58	0.35
Short stay ward (*non-subsidised*)	0.35	0.35	0.35
Day surgery (*subsidised*)	1	0.58	Not applicable
Day surgery (*non-subsidised*) (with admission date before 1 March 2021)	0.35	0.35	0.35
Day surgery (*non-subsidised*) in approved public healthcare institution (with admission date on or after 1 March 2021, but before 1 April 2025)	0.35	0.35	0.35

FIFTH SCHEDULE — *continued*

Ward class or subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Day surgery (*non-subsidised*) in approved private hospital or approved day surgery centre (with admission date on or after 1 March 2021, but before 1 April 2025)	0.25	0.25	0.25

[S 231/2025 wef 01/04/2025]

[S 224/2020 wef 01/04/2020]

[S 135/2021 wef 26/02/2021]

[S 231/2025 wef 01/04/2025]

PART 2

PRO-RATION FACTORS FOR TREATMENT AS DAY TREATMENT PATIENT

(With admission date on or after 1 April 2019)

Subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Subsidised	1	0.67	Not applicable
Non-subsidised	0.5	0.5	0.5

[S 286/2019 wef 01/04/2019]

FIFTH SCHEDULE — *continued*

PART 3

PRO-RATION FACTORS FOR
APPROVED IN-PATIENT PALLIATIVE CARE

(With admission date on or after 1 April 2020, but before 1 April 2025)

Institution or subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Any ward in a nursing home or hospice that is an approved in-patient palliative care institution	1	0.5	0.5
Subsidised ward in an approved community hospital that is an approved in-patient palliative care institution	1	0.5	0.5
Non-subsidised ward in an approved community hospital that is an approved in-patient palliative care institution	0.5	0.5	0.5

[S 224/2020 wef 01/04/2020]

[S 231/2025 wef 01/04/2025]

FIFTH SCHEDULE — *continued*

PART 4

PRO-RATION FACTORS
FOR DAILY WARD AND TREATMENT CHARGES
(EXCLUDING CHARGES FOR SURGICAL TREATMENT)
WHERE ADMITTED AS IN-PATIENT
(OTHER THAN DAY TREATMENT PATIENT)
OR FOR DAY SURGICAL TREATMENT

(With admission date on or after 1 April 2025)

Institution, ward class or subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Class C	1	0.5	0.2
Class B2 (including subsidised short stay ward)	1	0.5	0.35
Class B2+	1	0.5	0.35
Class B1	0.34	0.29	0.29
Class A (including non-subsidised short stay ward)	0.27	0.25	0.25
Approved private hospital	0.16	0.16	0.16
Day surgery (*subsidised*)	1	0.54	Not applicable
Day surgery (*non-subsidised*) in approved public healthcare institution	0.33	0.33	0.33
Day surgery (*non-subsidised*) in approved private hospital or approved day surgery centre	0.21	0.21	0.21

FIFTH SCHEDULE — *continued*

Subsidised ward in approved community hospital or approved in-patient palliative care institution	1	0.6	0.5
Non-subsidised ward in approved community hospital or approved in-patient palliative care institution	0.45	0.37	0.37

Note:

For the purposes of this Part, where —

(*a*) an insured person —

(i) is admitted as an in-patient of an approved restructured hospital;

(ii) is transferred to receive MIC@Home treatment; and

(iii) is discharged from receiving MIC@Home treatment without any further transfer back to any approved permanent premises of an approved restructured hospital; or

(*b*) an insured person —

(i) receives MIC@Home treatment (whether or not the insured person was transferred from any approved permanent premises of an approved restructured hospital);

(ii) is transferred to any approved permanent premises of an approved restructured hospital as an in-patient; and

(iii) is discharged from in-patient treatment at the approved permanent premises of that approved restructured hospital,

the pro-ration factor applicable to the ward class that the insured person was admitted or transferred to under paragraph (*a*)(i) or (*b*)(ii) applies to all daily ward and treatment charges incurred in relation to the admission, including the charges for MIC@Home treatment.

[S 231/2025 wef 01/04/2025]

FIFTH SCHEDULE — *continued*

PART 5

PRO-RATION FACTORS FOR CHARGES FOR SURGICAL TREATMENT

(With admission date on or after 1 April 2025)

Institution, ward class or subsidy status	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Class C	1	0.6	0.2
Class B2 (including subsidised short stay ward)	1	0.6	0.35
Class B2+	1	0.6	0.35
Class B1	0.35	0.3	0.3
Class A (including non-subsidised short stay ward)	0.25	0.25	0.25
Approved private hospital	0.1	0.1	0.1
Day surgery (*subsidised*)	1	0.58	Not applicable
Day surgery (*non-subsidised*) in approved public healthcare institution	0.25	0.25	0.25
Day surgery (*non-subsidised*) in approved private hospital or approved day surgery centre	0.15	0.15	0.15

[S 231/2025 wef 01/04/2025]

FIFTH SCHEDULE — *continued*

PART 6

PRO-RATION FACTORS
FOR MIC@HOME TREATMENT

(With admission date on or after 1 April 2025)

Applicable scenario	Pro-ration factor for:		
	Singapore citizen	Singapore permanent resident	Person who is not citizen or permanent resident of Singapore
Where an insured person is admitted for MIC@Home treatment without any transfer to or from an approved permanent premises of an approved restructured hospital	1	0.5	0.2

[S 231/2025 wef 01/04/2025]

SIXTH SCHEDULE

Regulation 13(8)

ASSURED AMOUNTS

(For approved medical treatment or services as in-patient, day surgical treatment or approved outpatient treatment, with admission date on or after 1 November 2015)

1. Daily ward and treatment charges (where admitted as an in-patient or for day surgical treatment) for any treatment for or in respect of any illness, disease or impairment (other than any mental illness or personality disorder) (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item) provided by —	
(*a*) an approved medical institution (other than an approved community hospital or	$700 per day

SIXTH SCHEDULE — *continued*

approved in-patient palliative care institution), with admission date on or after 1 November 2015 but before 1 March 2021	
(*aa*) an approved medical institution (other than an approved community hospital or approved in-patient palliative care institution), with admission date on or after 1 March 2021 but before 1 April 2025:	
(i) where admitted as an in-patient	$800 per day, and an additional $200 per day for the first 2 days of each admission
(ii) where admitted for day surgical treatment	$800 per day
(*ab*) an approved medical institution (other than an approved community hospital or approved in-patient palliative care institution), with admission date on or after 1 April 2025:	
(i) where admitted or transferred as an in-patient	$830 per day, and an additional $800 per day for the first 2 days of each admission
(ii) where admitted for day surgical treatment	$830 per day
(*b*) an approved community hospital (other than in respect of any approved in-patient palliative care provided by the approved community hospital as an approved in-patient palliative care institution), with admission date on or after 1 November 2015 but before 1 March 2021	$350 per day
(*c*) an approved community hospital (other than in respect of any approved in-patient palliative care provided by the approved	

SIXTH SCHEDULE — *continued*

	community hospital as an approved in-patient palliative care institution) for —	
	(i) rehabilitative care, with an admission date on or after 1 March 2021 but before 1 April 2025	$350 per day
	(ii) sub-acute care, with an admission date on or after 1 March 2021 but before 1 April 2025	$430 per day
	(*d*) an approved community hospital (other than in respect of any approved in-patient palliative care provided by the approved community hospital as an approved in-patient palliative care institution) for —	
	(i) rehabilitative care, with an admission date on or after 1 April 2025	$370 per day
	(ii) sub-acute care, with an admission date on or after 1 April 2025	$570 per day
1A.	Daily treatment charges for any treatment for or in respect of any illness, disease or impairment (other than any mental illness or personality disorder) (inclusive of prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item) provided by an approved medical institution under the MIC@Home programme, with an admission date on or after 1 April 2025	$830 per day, and an additional $800 per day for the first 2 days of each admission
2.	Daily ward and treatment charges (where admitted as an in-patient or for day surgical treatment) for any treatment for or in respect of any mental illness or personality disorder (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item) provided by an approved medical institution, with admission date on or after 1 November 2015 but before 1 March 2021	$100 per day up to 35 days per insurance period

SIXTH SCHEDULE — *continued*

2A.	Daily ward and treatment charges for any treatment for or in respect of any mental illness or personality disorder (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item) provided by, with admission date on or after 1 March 2021 but before 1 April 2025 (up to 60 days per insurance period) —	
	(*a*) an approved medical institution for day surgical treatment	$160 per day
	(*b*) the Institute of Mental Health as an in-patient	$160 per day
	(*c*) an approved medical institution not mentioned in paragraph (*b*) as an in-patient	$1,000 per day for the first 2 days of each admission and $160 per day for the third and subsequent days of each admission
2B.	Daily ward and treatment charges for any treatment for or in respect of any mental illness or personality disorder (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item) provided by, with admission date on or after 1 April 2025 (up to 60 days per insurance period) —	
	(*a*) an approved medical institution for day surgical treatment	$230 per day
	(*b*) the Institute of Mental Health as an in-patient	$230 per day
	(*c*) an approved medical institution not mentioned in paragraph (*b*) as an in-patient	$1,630 per day for the first 2 days of each admission and $230 per day for the third and subsequent days of each admission

SIXTH SCHEDULE — *continued*

3.	Daily ward and treatment charges (where admitted as an in-patient) in Intensive Care Unit (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item), with admission date on or after 1 November 2015 but before 1 March 2021	$1,200 per day
3A.	Daily ward and treatment charges (where admitted as an in-patient) in Intensive Care Unit (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item), with admission date on or after 1 March 2021 but before 1 April 2025	$2,200 per day, and an additional $200 per day for the first 2 days of each admission
3B.	Daily ward and treatment charges (where admitted as an in-patient) in Intensive Care Unit (inclusive of meal charges, prescriptions and professional charges, investigations and other miscellaneous charges, unless listed under any other item), with admission date on or after 1 April 2025	$5,140 per day, and an additional $800 per day for the first 2 days of each admission
4.	Surgical Treatment listed in the Table of Surgical Procedures for Medisave Scheme issued by the Ministry of Health, with admission date on or after 1 November 2015 but before 1 January 2020:	
	(*a*) Table 1	$200
	(*b*) Table 2	$480
	(*c*) Table 3	$900
	(*d*) Table 4	$1,150
	(*e*) Table 5	$1,400
	(*f*) Table 6	$1,850
	(*g*) Table 7	$2,000
4A.	Surgical Treatment listed in the Table of Surgical Procedures issued by the Ministry of Health, with admission date on or after 1 January 2020 but before 1 April 2025:	
	(*a*) Table 1A	$240

SIXTH SCHEDULE — *continued*

(*b*) Table 1B	$340
(*c*) Table 1C	$340
(*d*) Table 2A	$580
(*e*) Table 2B	$760
(*f*) Table 2C	$760
(*g*) Table 3A	$1,060
(*h*) Table 3B	$1,160
(*i*) Table 3C	$1,280
(*j*) Table 4A	$1,540
(*k*) Table 4B	$1,580
(*l*) Table 4C	$1,640
(*m*) Table 5A	$1,800
(*n*) Table 5B	$2,180
(*o*) Table 5C	$2,180
(*p*) Table 6A	$2,360
(*q*) Table 6B	$2,360
(*r*) Table 6C	$2,360
(*s*) Table 7A	$2,600
(*t*) Table 7B	$2,600
(*u*) Table 7C	$2,600
4B. Surgical Treatment listed in the Table of Surgical Procedures issued by the Ministry of Health, with admission date on or after 1 April 2025	
(*a*) Table 1A	$240
(*b*) Table 1B	$420
(*c*) Table 1C	$490
(*d*) Table 2A	$760
(*e*) Table 2B	$1,120
(*f*) Table 2C	$1,120

SIXTH SCHEDULE — *continued*

(*g*) Table 3A	$1,390
(*h*) Table 3B	$1,740
(*i*) Table 3C	$1,920
(*j*) Table 4A	$2,310
(*k*) Table 4B	$2,370
(*l*) Table 4C	$2,460
(*m*) Table 5A	$2,700
(*n*) Table 5B	$3,270
(*o*) Table 5C	$3,270
(*p*) Table 6A	$3,540
(*q*) Table 6B	$3,540
(*r*) Table 6C	$3,540
(*s*) Table 7A	$3,900
(*t*) Table 7B	$3,900
(*u*) Table 7C	$3,900
5. Renal dialysis, received as outpatient medical treatment, on or after 1 November 2015 but before 1 March 2021	$1,000 per month
5A. Renal dialysis, received as outpatient medical treatment, on or after 1 March 2021 but before 1 April 2025	$1,100 per month
5B. Renal dialysis, received as outpatient medical treatment, on or after 1 April 2025	$1,750 per month
6. Surgical implants and approved medical consumables	$7,000 per treatment
7. Approved cancer drugs administered for treatment of neoplasms, received as outpatient medical treatment, where the approved cancer drugs administered in a month are listed in the CDL under —	
(*a*) in the case of treatment of only one neoplasm — only one of the following categories:	

SIXTH SCHEDULE — *continued*

(i) Category 1	$200 per month
(ii) Category 2	$400 per month
(iii) Category 3	$600 per month
(iv) Category 4	$800 per month
(v) Category 5	$1,000 per month
(vi) Category 6	$1,200 per month
(vii) Category 7	$1,400 per month
(viii) Category 8	$1,600 per month
(ix) Category 9	$1,800 per month
(x) Category 10	$2,000 per month
(xi) Category 12	$2,400 per month
(xi*a*) Category 13	$2,600 per month
(xii) Category 15	$3,000 per month
(xiii) Category 16	$3,200 per month
(xiii*a*) Category 17	$3,400 per month
(xiv) Category 19	$3,800 per month
(xv) Category 26	$5,200 per month
(xvi) Category 27	$5,400 per month
(xvi*a*) Category 39	$7,800 per month
(xvii) Category 46	$9,200 per month
(xviii) Category 48	$9,600 per month
(*b*) in the case of treatment of only one neoplasm — more than one of the categories listed in paragraph (*a*)	The highest amount per month specified in respect of any category of the approved cancer drugs administered in that month
(*c*) in the case of treatment of multiple neoplasms concurrently — only one of the categories listed in paragraph (*a*) for each neoplasm	The sum of the amount per month specified in respect of the category of

SIXTH SCHEDULE — *continued*

	the approved cancer drugs administered in that month for each of the neoplasms treated concurrently
(*d*) in the case of treatment of multiple neoplasms concurrently — more than one of the categories listed in paragraph (*a*) for each neoplasm	The sum of the highest amount per month specified in respect of any category of the approved cancer drugs administered in that month for each of the neoplasms treated concurrently
(*e*) in the case of treatment of multiple neoplasms concurrently — only one of the categories listed in paragraph (*a*) for at least one neoplasm and more than one of those categories for at least one neoplasm	The sum of — (i) the amount per month specified in respect of the category of the approved cancer drugs adminis tered in that month for each neoplasm treated with only one of the categories; and (ii) the highest amount per month specified in

SIXTH SCHEDULE — *continued*

		respect of any category of the approved cancer drugs adminis tered in that month for each neoplasm treated with more than one of the categories
7A.	Cancer drug treatment (excluding the cost of any cancer drug administered) for only one neoplasm, received as outpatient medical treatment, where treatment is received on or after 1 September 2022 but before 1 January 2023	$1,200 per year
7B.	Cancer drug treatment (excluding the cost of any cancer drug administered) for only one neoplasm, received as outpatient medical treatment, where treatment is received on or after 1 January 2023	$3,600 per year
7C.	Cancer drug treatment (excluding the cost of any cancer drug administered) for multiple neoplasms concurrently, received as outpatient medical treatment, where treatment is received on or after 1 December 2023	$7,200 per year
8.	Radiotherapy treatment received as outpatient medical treatment:	
	(*a*) External radiotherapy, where treatment is received on or after 1 November 2015 but before 1 March 2021	$140 per treatment
	(*aa*) External radiotherapy (excluding hemi-body radiotherapy), where treatment is received on or after 1 March 2021 but before 1 April 2025	$300 per treatment

SIXTH SCHEDULE — *continued*

(*ab*)	Hemi-body radiotherapy, where treatment is received on or after 1 March 2021 but before 1 April 2025	$900 per treatment
(*ac*)	External radiotherapy (excluding hemi-body radiotherapy), where treatment is received on or after 1 April 2025	$400 per treatment
(*ad*)	Hemi-body radiotherapy, where treatment is received on or after 1 April 2025	$620 per treatment
(*b*)	Superficial X-ray, where treatment is received on or after 1 November 2015 but before 1 March 2021	$140 per treatment
(*c*)	Brachytherapy (with external radiotherapy), where treatment is received before 1 April 2025	$500 per treatment
(*ca*)	Brachytherapy (with external radiotherapy), where treatment is received on or after 1 April 2025	$620 per treatment
(*d*)	Brachytherapy (without external radiotherapy), where treatment is received before 1 April 2025	$500 per treatment
(*da*)	Brachytherapy (without external radiotherapy), where treatment is received on or after 1 April 2025	$620 per treatment
(*e*)	Stereotactic radiotherapy, where treatment is received before 1 April 2025	$1,800 per treatment
(*ea*)	Stereotactic radiotherapy, where treatment is received on or after 1 April 2025	$460 per treatment
(*f*)	Approved proton beam therapy for a Category 1 clinical indication listed in the Approved Indications for PBT, where treatment is received on or after 1 October 2022 but before 1 April 2025	$300 per treatment
(*fa*)	Approved proton beam therapy for a Category 1 clinical indication listed in the Approved Indications for PBT, where treatment is received on or after 1 April 2025	$400 per treatment

SIXTH SCHEDULE — *continued*

	(*g*) Approved proton beam therapy for a Category 2 clinical indication listed in the Approved Indications for PBT, where treatment is received on or after 1 October 2022 but before 1 April 2025	$500 per treatment
	(*ga*) Approved proton beam therapy for a Category 2 clinical indication listed in the Approved Indications for PBT, where treatment is received on or after 1 April 2025	$620 per treatment
	(*h*) Approved proton beam therapy for a Category 3 clinical indication listed in the Approved Indications for PBT, where treatment is received on or after 1 October 2022 but before 1 April 2025	$1,800 per treatment
	(*i*) Approved proton beam therapy for a Category 3 clinical indication listed in the Approved Indications for PBT, where treatment is received on or after 1 April 2025	$460 per treatment
9.	Immunosuppressants for organ transplant, received as outpatient medical treatment, where treatment is received on or after 1 November 2015 but before 1 March 2021	$200 per month
9A.	Immunosuppressants for organ transplant, received as outpatient medical treatment, where treatment is received on or after 1 March 2021 but before 1 April 2025	$550 per month
9B.	Immunosuppressants for organ transplant, received as outpatient medical treatment, where treatment is received on or after 1 April 2025	$710 per month
10.	Erythropoietin drug for chronic renal failure or dialysis treatment, received as outpatient medical treatment before 1 April 2025	$200 per month
10A.	Erythropoietin drug for chronic renal failure or dialysis treatment, received as outpatient medical treatment on or after 1 April 2025	$220 per month
11.	Radiosurgery treatment, with admission date on or after 1 November 2015 but before 1 March 2021	$4,800 per treatment

SIXTH SCHEDULE — *continued*

11A.	Radiosurgery treatment, with admission date on or after 1 March 2021 but before 1 April 2025	$10,000 per course of treatment
11B.	Radiosurgery treatment, with admission date on or after 1 April 2025	$15,700 per course of treatment
12.	Long term parenteral nutrition, received as outpatient medical treatment before 1 April 2025	$1,700 per month
12A.	Long term parenteral nutrition, received as outpatient medical treatment on or after 1 April 2025	$2,200 per month
13.	Autologous bone marrow transplant for the treatment of multiple myeloma, received as day treatment patient, with admission date on or after 1 April 2019	$6,000 per treatment
14.	General palliative care received as an in-patient of an approved in-patient palliative care institution, with admission date on or after 1 April 2020 but before 1 February 2024	$250 per day
14A.	General palliative care received as an in-patient of an approved in-patient palliative care institution, with admission date on or after 1 February 2024	$460 per day
15.	Specialised palliative care, or a combination of specialised and general palliative care, received as an in-patient of an approved in-patient palliative care institution, with admission date on or after 1 April 2020 but before 1 February 2024	$350 per day
15A.	Specialised palliative care, or a combination of specialised and general palliative care, received as an in-patient of an approved in-patient palliative care institution, with admission date on or after 1 February 2024	$500 per day

[S 231/2025 wef 01/04/2025]

Note:

Where an insured person's MediShield Life cover is terminated during any calendar month, if the assured amount for any item of approved medical treatment or services received by the insured person during that calendar month or any subsequent calendar month is specified per month in the table, the whole of the

SIXTH SCHEDULE — *continued*

assured amount continues to apply to such medical treatment or services received during each of those calendar months.

[S 731/2018 wef 01/11/2018]
[S 286/2019 wef 01/04/2019]
[S 866/2020 wef 01/01/2020]
[S 224/2020 wef 01/04/2020]
[S 135/2021 wef 26/02/2021]
[S 711/2022 wef 01/09/2022]
[S 769/2022 wef 01/10/2022]
[S 28/2023 wef 01/02/2023]
[S 165/2023 wef 01/04/2023]
[S 532/2023 wef 01/08/2023]
[S 532/2023 wef 01/11/2023]
[S 772/2023 wef 01/12/2023]
[S 772/2023 wef 01/02/2024]

SEVENTH SCHEDULE

Regulation 13(8)

PART 1

INSURED'S CONTRIBUTION

(For admission as in-patient
(other than day treatment patient or for approved in-patient palliative care),
on or after 1 November 2015, but before 1 April 2025)

[S 286/2019 wef 01/04/2019]
[S 224/2020 wef 01/04/2020]

	Amount (in any insurance period)
1. Where the ward of discharge in respect of the approved medical treatment or services received is Class "C" in an approved restructured hospital or (for admission before 1 April 2020) approved community hospital —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$1,500

SEVENTH SCHEDULE — *continued*

(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000

2. Where the ward of discharge in respect of the approved medical treatment or services received is Class "B2" and above in an approved restructured hospital or (for admission before 1 April 2020) approved community hospital or in an approved private hospital —

(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$3,000

3. [*Deleted by S 231/2025 wef 01/04/2025*]

4. Where the ward of discharge in respect of the approved medical treatment or services received, as an in-patient of an approved community hospital admitted on or after 1 April 2020 but before 1 April 2025, is a subsidised ward in the approved community hospital —

(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$1,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000

5. Where the ward of discharge in respect of the approved medical treatment or services received, as an in-patient of an approved community hospital admitted on or after 1 April 2020 but before 1 April 2025, is a non-subsidised ward in the approved community hospital —

(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling	$2,000

SEVENTH SCHEDULE — *continued*

after the first day of the insurance period in respect of which the claim is made	
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$3,000

[S 231/2025 wef 01/04/2025]

[S 224/2020 wef 01/04/2020]

[S 135/2021 wef 26/02/2021]

[S 135/2021 wef 26/02/2021]

[S 231/2025 wef 01/04/2025]

PART 1A

INSURED'S CONTRIBUTION

(For admission as in-patient (other than for approved in-patient palliative care) on or after 1 April 2025)

	Amount (in any insurance period)
1. Where the ward of discharge in respect of the approved medical treatment or services received is Class "C" in an approved restructured hospital —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,750

SEVENTH SCHEDULE — *continued*

2. Where the ward of discharge in respect of the approved medical treatment or services received is Class "B2", "B2+" or "B1" in an approved restructured hospital —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$3,500
3. Where the ward of discharge in respect of the approved medical treatment or services received is Class "A" in an approved restructured hospital or approved private hospital —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$3,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$4,500
4. Where the ward of discharge in respect of the approved medical treatment or services received, as an in-patient of an approved community hospital is a subsidised ward in the approved community hospital or in a subsidised short stay ward —	

SEVENTH SCHEDULE — *continued*

(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,750

5. Where the ward of discharge in respect of the approved medical treatment or services received, as an in-patient of an approved community hospital is a non-subsidised ward in the approved community hospital or in a non-subsidised short stay ward —

(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$3,500

Note:

For the purposes of this Part, where —

(*a*) an insured person —

(i) is admitted as an in-patient of an approved restructured hospital;

(ii) is transferred to receive MIC@Home treatment; and

(iii) is discharged from receiving MIC@Home treatment without any further transfer back to any approved permanent premises of an approved restructured hospital; or

SEVENTH SCHEDULE — *continued*

(*b*) an insured person —

(i) receives MIC@Home treatment (whether or not the insured person was transferred from any approved permanent premises of an approved restructured hospital);

(ii) is transferred to any approved permanent premises of an approved restructured hospital as an in-patient; and

(iii) is discharged from in-patient treatment at the approved permanent premises of that approved restructured hospital,

the ward of discharge for the insured person is the ward mentioned in paragraph (*a*)(i) or (*b*)(ii).

[S 231/2025 wef 01/04/2025]

PART 1B

INSURED'S CONTRIBUTION

(For day surgical treatment, with admission date on or after 1 November 2015)

1. Where the approved medical treatment or services received consists of day surgical treatment or radiosurgery treatment received as day surgery —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$1,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made, with admission date on or after 1 November 2015 but before 1 March 2021	$3,000

SEVENTH SCHEDULE — *continued*

(*c*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made, with admission date on or after 1 March 2021	$2,000

[S 231/2025 wef 01/04/2025]

PART 2

INSURED'S CONTRIBUTION

(For treatment as day treatment patient, on or after 1 April 2019 but before 1 April 2025)

	Amount (in any insurance period)
1. Where the approved medical treatment or service specified in the Eleventh Schedule is subsidised —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$1,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
2. Where the approved medical treatment or service specified in the Eleventh Schedule is not subsidised —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
(*b*) in the case where the insured person is 81 years of age or older at the person's next	$3,000

SEVENTH SCHEDULE — *continued*

	Amount (in any insurance period)
birthday falling after the first day of the insurance period in respect of which the claim is made	

[S 286/2019 wef 01/04/2019]

[S 231/2025 wef 01/04/2025]

PART 3

INSURED'S CONTRIBUTION

(For approved in-patient palliative care, with admission date on or after 1 April 2020)

	Amount (in any insurance period)
1. Where the ward of discharge, in respect of the approved in-patient palliative care, is a ward in an approved permanent premises of a nursing home that is an approved in-patient palliative institution, with admission date before 1 April 2025 —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$1,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
2. Where the ward of discharge, in respect of the approved in-patient palliative care, is a subsidised ward in an approved permanent premises of an approved community hospital that is an approved in-patient palliative care institution, with admission date before 1 April 2025 —	

SEVENTH SCHEDULE — *continued*

	Amount (in any insurance period)
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$1,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
3. Where the ward of discharge, in respect of the approved permanent premises of an approved community hospital that is an approved in-patient palliative care institution, with admission date before 1 April 2025 —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$3,000
4. Where the ward of discharge, in respect of the approved in-patient palliative care, is a subsidised ward in an approved permanent premises of an approved in-patient palliative care institution, with admission date on or after 1 April 2025 —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,000

SEVENTH SCHEDULE — *continued*

	Amount (in any insurance period)
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,750
5. Where the ward of discharge, in respect of the approved in-patient palliative care, is a non-subsidised ward in an approved permanent premises of an approved in-patient palliative care institution, with admission date on or after 1 April 2025 —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,500
(*b*) in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$3,500

[S 231/2025 wef 01/04/2025]

[S 224/2020 wef 01/04/2020]

PART 4

INSURED'S CONTRIBUTION

(For MIC@Home treatment,
with admission date on or after 1 April 2025)

1. Where an insured person is admitted for MIC@Home treatment without any transfer to or from an approved permanent premises of an approved restructured hospital —	
(*a*) in the case where the insured person is below 81 years of age at the person's next birthday	$2,000

SEVENTH SCHEDULE — *continued*

	falling after the first day of the insurance period in respect of which the claim is made	
(*b*)	in the case where the insured person is 81 years of age or older at the person's next birthday falling after the first day of the insurance period in respect of which the claim is made	$2,750

[S 231/2025 wef 01/04/2025]

EIGHTH SCHEDULE

Regulation 19(3)

TRANSITIONAL PROVISIONS RELATING TO MEDISHIELD SCHEME

Claims in respect of last policy year

1.—(1) The last day of the last policy year of a person's pre-existing MediShield cover is taken to be 31 October 2015.

(2) Sub-paragraph (1) does not apply for the purpose of determining the first insurance period under regulation 20(1).

Cross implementation claim

2.—(1) Regulation 14 does not apply to a cross implementation claim.

(2) Subject to sub-paragraph (3), the amount of an insured person's cross implementation claim that may be paid in respect of each period of the cross implementation claim referred to in sub-paragraph (*a*), or (*b*)(i) or (ii)(A) or (B), or (*c*) is an amount not exceeding the excess limit determined in accordance with the formula in sub-paragraph (*a*), or (*b*)(i) or (ii)(A) or (B), or (*c*), as the case may be —

(*a*) for any relevant policy year of the person's cross implementation claim before the last policy year of the person's pre-existing MediShield cover to which the cross implementation claim relates:

$$L - A,$$

where L is the policy year limit under regulation 10(5) of the revoked MediShield Regulations for the initial policy year of the cross implementation claim; and

A is the total amount of claims which were —

EIGHTH SCHEDULE — *continued*

(*a*) paid under the person's pre-existing MediShield cover to which the cross implementation claim relates in respect of the relevant policy year of that pre-existing MediShield cover; and

(*b*) received before the Board received the cross implementation claim;

(*b*) if —

(i) regulation 20(1)(*a*) applies to the first insurance period of the insured person's MediShield Life cover, for the cross implementation period of the insured person's cross implementation claim:

$$L - B - C,$$

where L is as defined in sub-paragraph (*a*);

B is the total amount of claims which were —

(*a*) paid under the person's pre-existing MediShield cover to which the cross implementation claim relates in respect of the last policy year of that pre-existing MediShield cover; and

(*b*) received before the Board received the cross implementation claim; and

C is the total amount of claims which were —

(*a*) paid under the person's MediShield Life cover to which the cross implementation claim relates in respect of the first insurance period of that MediShield Life cover; and

(*b*) received before the Board received the cross implementation claim;

(ii) regulation 20(1)(*b*) applies to the first insurance period of the insured person's MediShield Life cover —

(A) for the last policy year of the insured person's pre-existing MediShield cover:

$$L - B,$$

EIGHTH SCHEDULE — *continued*

where L is as defined in sub-paragraph (*a*); and

B is as defined in sub-paragraph (*b*)(i);

(B) for the first insurance period of the insured person's MediShield Life cover:

$$L - C,$$

where L is as defined in sub-paragraph (*a*); and

C is as defined in sub-paragraph (*b*)(i);

(*c*) for any relevant insurance period of the person's cross implementation claim after the first insurance period of the person's MediShield Life cover:

$$L - D,$$

where L is as defined in sub-paragraph (*a*); and

D is the total amount of claims which were —

(*a*) paid under the person's MediShield Life cover to which the cross implementation claim relates in respect of the relevant insurance period of that MediShield Life cover; and

(*b*) received before the Board received the cross implementation claim.

(3) For the purposes of sub-paragraph (2), if the Minister approves an insured person's application to apply a higher value of L in relation to the insured person's cross implementation claim in respect of any relevant insurance period of the insured person's MediShield Life cover, the value of L in respect of any insurance period to which the insured person's cross implementation claim relates —

(*a*) is a value specified by the Minister for that insurance period; and

(*b*) must not exceed —

(i) for the cross implementation period of the insured person's cross implementation claim, $100,000; and

(ii) for any other relevant insurance period, the insurance period limit under regulation 13(1) for that insurance period.

(4) The Board may pay cross implementation claims from the Fund.

EIGHTH SCHEDULE — *continued*

(5) In relation to a person's cross implementation claim —

"cross implementation period", in relation to an insured person's cross implementation claim, means the last policy year of the insured person's pre-existing MediShield cover and the first insurance period of the insured person's MediShield Life cover;

"final insurance period" means the insurance period in which the date of discharge of the approved medical treatment or services to which the person's cross implementation claim relates falls;

"initial policy year" means the policy year in which the admission date of the approved medical treatment or services to which the person's cross implementation claim relates falls;

"relevant insurance period", in relation to an insured person's cross implementation claim, means each insurance period between the first insurance period and the final insurance period (both inclusive) of the insured person's MediShield Life cover to which the cross implementation claim relates;

"relevant policy year", in relation to an insured person's cross implementation claim, means each policy year between the initial policy year and the last policy year (both inclusive) of the insured person's pre-existing MediShield cover to which the cross implementation claim relates.

NINTH SCHEDULE

Regulations 14(3) and 20(3)

MODIFICATIONS RELATING TO FIRST INSURANCE PERIOD

Definition

1. In this Schedule, "insured person's first insurance period" means the first insurance period of an insured person's MediShield Life cover to which regulation 20(1)(*a*) applies.

Premium for first insurance period

2.—(1) Regulation 8 does not apply to an insured person's first insurance period.

(2) The premium for the insured person's first insurance period is equal to the pro-rated amount of the premium under the MediShield Scheme for the period of the last policy year of the insured person's pre-existing MediShield cover falling

NINTH SCHEDULE — *continued*

on or after 1 November 2015 (called the unexpired period of the insured person's pre-existing MediShield cover).

(3) Any premium paid for the insured person's insurance cover under the MediShield Scheme in respect of the unexpired period of the insured person's pre-existing MediShield cover is to be credited towards the payment of that premium for the insured person's first insurance period.

Claim limits

3.—(1) This paragraph does not apply to an insured person's cross implementation claim.

(2) Sub-paragraph (3) does not apply to an insured person's cross insurance period claim with an initial insurance period which is the insured person's first insurance period to which regulation 20(1)(*a*) applies, except as provided in regulation 14(3)(*a*).

(3) Instead of applying regulations 13(1) (relating to a person's insurance period limit) and 14(2) (relating to the excess limit for a cross insurance period claim), the amount of a claim under an insured person's MediShield Life cover that may be paid in respect of the first insurance period of the person's insurance cover is an amount not exceeding the excess limit for the claim (called the current claim) determined in accordance with the following formula:

$$100{,}000 - X,$$

where X is the total amount of other claims (in dollars) —

(*a*) received before the Board received the current claim; and

(*b*) paid under —

(i) the person's MediShield Life cover in respect of the first insurance period of the person's MediShield Life cover; or

(ii) the person's pre-existing MediShield cover in respect of —

(A) the last policy year of the pre-existing MediShield cover; or

(B) the cross implementation period of a cross implementation claim made under the person's pre-existing MediShield cover.

(4) Instead of applying regulation 13(3), but subject to sub-paragraph (3), an insured person is entitled to claim under the Scheme, in respect of approved

NINTH SCHEDULE — *continued*

medical treatment or services received by the insured person in an approved medical institution as an in-patient or as day surgical treatment with an admission date in the insured person's first insurance period (called the current claim), an amount determined by applying one of the following formulae:

(*a*) if A is not more than $5,000, the formula is —

$$[(A - B) \times 0.9] - C;$$

(*b*) if A is more than $5,000 but not more than $10,000, the formula is —

$$[(\$5{,}000 - B) \times 0.9] + [(A - \$5{,}000) \times 0.95] - C;$$

(*c*) if A is more than $10,000, the formula is —

$$[(\$5{,}000 - B) \times 0.9] + (\$5{,}000 \times 0.95) + [(A - \$10{,}000) \times 0.97] - C,$$

where A is the sum of —

(*a*) the relevant amount for the approved medical treatment or services to which the current claim relates; and

(*b*) the relevant amount for all other approved medical treatment or services —

(i) with an admission date during the cross implementation period of person's current claim; and

(ii) in respect of which a claim under the the person's pre-existing MediShield cover or MediShield Life cover was received by the Board before the current claim was received;

B is the lower of the following amounts:

(*a*) A;

(*b*) the insured person's contribution for the approved medical treatment or services to which the current claim relates; and

C is the sum of all claims paid for the other approved medical treatment or services referred to in sub-paragraph (*b*) of the definition of A.

(5) The assured amount for any approved medical treatment or services under item 2 of the Sixth Schedule during the first insurance period of an insured

NINTH SCHEDULE — *continued*

person's MediShield Life cover, with an admission date during that period, is $100 per day, up to the number of days determined in accordance with the following formula:

$$35 - D,$$

where D is the number of days paid in respect of claims under the person's pre-existing MediShield cover —

(*a*) in relation to medical treatment, with an admission date in the last policy year of the person's pre-existing MediShield cover, under item 2 of Part VI of the Third Schedule to the revoked MediShield Regulations; and

(*b*) received by the Board before the person's current claim was received.

(6) In sub-paragraph (4) —

"assured amount", in relation to each item of approved medical treatment or services —

(*a*) in respect of which a claim is made under an insured person's MediShield Life cover, means the amount specified in the Sixth Schedule in respect of that item of approved medical treatment or services, with the modifications specified in sub-paragraph (5), if applicable; or

(*b*) in respect of which a claim is made under an insured person's pre-existing MediShield cover, means the amount specified in the second column of Part VI of the Third Schedule to the revoked MediShield Regulations in respect of that item of medical treatment;

"cross implementation period", in relation to an insured person's cross implementation claim, means the last policy year of the insured person's pre-existing MediShield cover and the insured person's first insurance period's MediShield Life cover;

"relevant amount" —

(*a*) in relation to approved medical treatment or services in respect of which a claim is made under an insured person's MediShield Life cover, means the lower of the following:

(i) the amount determined in accordance with regulation 13(7)(*a*);

NINTH SCHEDULE — *continued*

(ii) the total of the assured amounts of the approved medical treatment or services; or

(*b*) in relation to approved medical treatment or services in respect of which a claim is made under an insured person's pre-existing MediShield cover, means the lower of the following:

(i) the amount determined in accordance with regulation 10(9) of the revoked MediShield Regulations;

(ii) the total of the assured amounts of the approved medical treatment or services.

Insured person's contribution

4. In relation to a claim in respect of an insured person's first insurance period's MediShield Life cover which replaced the insured person's pre-existing MediShield cover under regulation 19(1), references in the Seventh Schedule to "the first day of the insurance period in respect of which the claim is made" are replaced by "the first day of the last policy year of the insured person's pre-existing MediShield cover".

TENTH SCHEDULE

Regulations 18(5) and (6) and 21

PROVISIONS APPLICABLE TO PERSONS TO WHOM SECTION 35(1) OF ACT APPLIES

Application

1.—(1) The following provisions do not apply to a person to whom section 35 of the Act applies:

(*a*) section 4(1)(*c*)(ii) and (2)(*b*) of the Act;

(*b*) regulations 4 (Commencement of insurance cover), 5 (Termination of insurance cover), 6 (Cancellation of insurance cover), 10 (Payment of premium) and 11 (Refund of premium).

(2) In this Schedule, "insured person" means a person insured under the Scheme under section 35 of the Act.

Automatic termination

2.—(1) Despite regulation 19(1), where the last day of the last policy year of an insured person's integrated medical insurance plan with a MediShield Component

TENTH SCHEDULE — *continued*

is on 31 October 2015 and the insured person is not a citizen or permanent resident of Singapore on 1 November 2015, the MediShield Component ceases immediately before 1 November 2015 and is not replaced by any MediShield Life Component.

(2) Where the last day of the last policy year of an insured person's integrated medical insurance plan with a MediShield Component is on or after 1 November 2015 —

(*a*) the integrated medical insurance plan continues as an integrated shield plan with a MediShield Life Component for the unexpired period of the integrated medical insurance plan; and

(*b*) the MediShield Life Component is terminated and will not be renewed after the end of the period referred to in sub-paragraph (*a*), unless the insured person is a citizen or permanent resident of Singapore immediately after the end of that period.

Payment of premium

3.—(1) Unless the Board decides to apply any other provision of this paragraph, the premium payable for any insurance period of an insured person is to be deducted from —

(*a*) the insured person's medisave account; or

(*b*) a CPF member's medisave account —

(i) if the insured person is a dependant of the CPF member; and

(ii) the Board has approved an application by the CPF member for payment of that premium from the CPF member's medisave account.

(2) Subject to sub-paragraph (3), if the premium for —

(*a*) a previous insurance period of an insured person; or

(*b*) a policy year of an insured person's pre-existing MediShield cover which was replaced, under these Regulations or the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015, by the insured person's MediShield Life cover,

was deducted from the medisave account of a CPF member who is not the insured person, the Board may continue to deduct the premium for each subsequent insurance period of the insured person's MediShield Life cover from the medisave account of that CPF member.

(3) If the amount standing to the insured person's credit in the insured person's medisave account, after the insured person attains 21 years of age, is sufficient to

TENTH SCHEDULE — *continued*

pay the premium for the next insurance period of the insured person, the Board may —

(*a*) cease to deduct the premium for that insurance period and any subsequent insurance period of the insured person from the medisave account of a CPF member under sub-paragraph (2); or

(*b*) if the CPF member authorises the Board in writing, continue to deduct the premium from the CPF member's medisave account.

(4) The Board may deduct the premium payable for the insured person's MediShield Life cover from the medisave account of a CPF member under sub-paragraph (1) or (2) only if the amount standing to the credit of the member's medisave account is sufficient to pay the premium.

(5) A CPF member may, by giving notice to the Board, withdraw from paying, from the amount standing to that member's credit in that member's medisave account, the premium for any insurance period of an insured person's MediShield Life cover.

(6) If the Board has received, from a CPF member, a notice under sub-paragraph (5) to withdraw from paying the premiums for any insurance period of an insured person, the Board must not deduct payment of the premium for that insurance period from the CPF member's medisave account.

(7) The Board may —

(*a*) refund to the CPF member's medisave account the whole or such part, as the Board may determine, of any amount deducted from a CPF member's medisave account to pay for any premium of an insured person; and

(*b*) also pay into the medisave account of the CPF member, the whole or such part, as the Board may determine, of the interest that would have been payable on the amount of the refund under sub-paragraph (*a*) if that amount had not been deducted from the CPF member's medisave account.

(8) Despite sub-paragraph (4), where the premium payable for any insurance period of an insured person is to be deducted from a CPF member's medisave account, and the amount standing to the CPF member's credit in the medisave account is insufficient to pay the premium, the Board may permit any deficiency to be paid in such manner as the Board thinks fit, subject to such terms and conditions as the Board may impose.

(9) The Board may cancel its approval for payment of a premium for the MediShield Life cover of an insured person to be deducted from a CPF member's medisave account if —

TENTH SCHEDULE — *continued*

(*a*) the deduction from the CPF member's medisave account breaches these Regulations or the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015; or

(*b*) the insured person or the CPF member made a false representation to the Board, or furnished the Board with any false information, in connection with the application for payment of a premium for the MediShield Life cover of an insured person to be deducted from the CPF member's medisave account.

(10) If the Board's approval for payment of premiums for the MediShield Life cover of an insured person to be deducted from a CPF member's medisave account is cancelled under sub-paragraph (9) —

(*a*) a CPF member must, if required by the Board, refund to the CPF member's medisave account the amount of moneys withdrawn from that account, which could not have been withdrawn if the cancelled approval had not been given (called the affected moneys); or

(*b*) the Board may —

(i) refund from the Fund to the CPF member's medisave account the affected moneys paid as premiums for the insured person's MediShield Life cover; and

(ii) require payment of the resulting shortfall in the premiums under section 6 of the Act or in accordance with the other provisions of this regulation.

(11) Despite sub-paragraph (10)(*a*), if the CPF member has paid the affected moneys to an insurer —

(*a*) the insurer must transfer the moneys to the Board; and

(*b*) the Board must refund the moneys, transferred in sub-paragraph (*a*), to the CPF member's medisave account.

(12) Paragraph 5 applies instead of sub-paragraph (10) if the insured person's MediShield Life cover has been terminated or cancelled.

(13) In this paragraph, "insurance period of an insured person" means an insurance period of an insured person's MediShield Life cover.

Termination or cancellation of insurance cover

4.—(1) An insured person's MediShield Life cover is terminated and ceases on the earliest of the following times:

TENTH SCHEDULE — *continued*

(*a*) immediately after the last day of the insurance period of the insured person's MediShield Life cover unless the insurance cover is renewed under paragraph 6;

(*b*) when the insured person's insurance cover ceases under sub-paragraph (2), (3) or (4);

(*c*) immediately after the day when the insured person dies.

(2) Subject to sub-paragraph (3), where an insured person gives written notice to the Board to terminate that person's MediShield Life cover, that person's insurance cover ceases —

(*a*) if a date is specified in the notice as the last day of the insurance cover, immediately after that date, or immediately after the date on which the Board receives the written notice, whichever is the later;

(*b*) if no date is specified in the notice as the last day of the insurance cover, immediately after the day on which the Board receives the written notice; or

(*c*) despite sub-paragraphs (*a*) and (*b*), on such later date, as soon as practicable and not later than the day after the end of the insurance period of the insurance cover, as determined by the Board.

(3) Subject to sub-paragraphs (4) and (5), if an insured person with MediShield Life cover (called the earlier plan) is subsequently insured under any medisave-approved plan (called the later plan), then immediately before the person's insurance cover under the later plan commences, the earlier plan is terminated and ceases.

(4) Subject to sub-paragraph (5), if the Board reinstates the earlier plan —

(*a*) the earlier plan continues as if it had not ceased under sub-paragraph (3), on such terms and conditions as the Board may require; and

(*b*) the later plan is terminated on the date that the insured person's earlier plan is reinstated.

(5) If a claim has been made under the earlier plan, the Board may postpone the termination of the earlier plan to a date specified by the Board.

(6) The Board may cancel an insured person's MediShield Life cover if —

(*a*) the Board has reason to believe that —

(i) the insured person is incapacitated, or is suffering from a terminal illness or disease, before the commencement date of the person's pre-existing MediShield cover; or

TENTH SCHEDULE — *continued*

(ii) the insured person lacks capacity within the meaning of section 4 of the Mental Capacity Act 2008, and the insured person's lack of capacity is likely to be permanent, before the commencement date of the person's pre-existing MediShield cover;

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(*b*) the insured person, or any CPF member who applied for the insured person's pre-existing MediShield cover —

(i) made or furnished to the Board any statement or fact that is false or misleading in a material particular; or

(ii) failed to disclose to the Board any material facts,

which if known to the Board, would have reasonably affected the Board's decision to issue the insured person's pre-existing MediShield Life cover; or

(*c*) where the insured person's MediShield Life cover is the MediShield Life Component of the insured person's integrated shield plan, the insurer has cancelled the insured person's integrated shield plan.

(7) Where the Board cancels an insured person's MediShield Life cover under sub-paragraph (6), the insured person is, on such cancellation, taken never to have been insured under the Scheme.

Refund

5.—(1) Where an insured person's MediShield Life cover ceases under paragraph 4(1)(*c*) or is terminated under paragraph 4(2) or (3), the Board must refund the amount of the premium pro-rated in respect of the unexpired period of the insured person's MediShield Life cover.

(2) Where an insured person's MediShield Life cover is cancelled under paragraph 4(6), the Board must refund all the premiums paid for the insurance cover.

(3) If any claim has been made under the person's MediShield Life cover before the insurance cover is cancelled under paragraph 4(6), the Board must refund the premiums paid for all the insurance periods after the insurance period in which the last claim was made under the person's MediShield Life cover.

(4) Where an insured person's MediShield Life cover is cancelled under paragraph 4(6)(*a*), in addition to the refund under sub-paragraph (2) or (3), the Board may refund the whole or such part, as the Board may determine, of the interest that would have been payable on the amount of the refund if that amount

had not been deducted from the medisave account of the person who paid the premium.

(5) Any refund of a premium under this paragraph is to be paid into the medisave account of the person who paid the premium.

Renewal of insurance cover

6.—(1) The insured person's MediShield Life cover is renewed for an insurance period starting immediately after the expiry of the last insurance period for which the premium has been paid.

(2) If, at the time of renewal of an insured person's MediShield Life cover or on such later date as the Board may determine, the amount standing to the credit of the insured person in that person's medisave account is insufficient to pay the premium payable for the insured person's MediShield Life cover, the insurance cover is not renewed.

(3) Despite sub-paragraph (2), on the application of the insured person or an approved payer for the insured person's MediShield Life cover, the Board may renew the insurance cover, subject to such terms and conditions as the Board may impose.

(4) In this paragraph, "approved payer", in relation to an insured person, means a CPF member from whose medisave account the premiums of the insured person's MediShield Life cover or medisave-approved plan are to be paid.

Reinstatement of MediShield Life cover

7.—(1) A person's insurance cover terminated or cancelled under paragraph 2 or 4 may, with the Minister's approval, be reinstated for any period and subject to any terms and conditions specified by the Board.

(2) If a person's insurance cover is reinstated under sub-paragraph (1), the Board may take all necessary steps to restore the person's position under the Scheme, including all or any of the following steps:

(*a*) adjust the amount standing to the credit of the person or the person who had paid the person's premium for MediShield Life cover in the person's medisave account, including the payment or deduction of any interest relating to the amount adjusted;

(*b*) adjust the amount standing in the MediShield Life Fund;

(*c*) recover any shortfall in the premium paid in accordance with section 6 of the Act;

(*d*) pay any benefit that should have been paid.

ELEVENTH SCHEDULE

Regulation 2(1)

APPROVED MEDICAL TREATMENT OR SERVICE FOR DAY TREATMENT PATIENT

1. Autologous bone marrow transplant for the treatment of multiple myeloma.
[S 286/2019 wef 01/04/2019]

Made on 28 October 2015.

TAN CHING YEE
Permanent Secretary,
Ministry of Health,
Singapore.

[MH 96:27/12; AG/LEGIS/SL/176A/2015/2 Vol. 6]

(To be presented to Parliament under section 34(4) of the MediShield Life Scheme Act 2015).