Central Provident Fund Board
79 Robinson Road, CPF Building, Singapore 068897

GENERAL INFORMATION ON MEDISHIELD SCHEME

MediShield is a basic medical insurance that helps Central Provident Fund (CPF) members and their dependants[1] meet large hospitalisation bills. MediShield works most effectively for hospitalisation at Class B2/C level in restructured hospitals.

Additional insurance coverage, for treatment in Class A/B1 in restructured hospitals or treatment in private hospitals, can be obtained by purchasing a Medisave-approved Integrated Shield Plan (IP). An IP is made up of MediShield and a Medisave-approved enhancement plan offered by a private insurer. For more information on IPs and the participating insurers, please visit CPF website at www.cpf.gov.sg.

WAITING PERIOD

There is an estimated waiting period of up to 2 months from the approval to the commencement of MediShield cover. During the waiting period, no claims are payable, until cover commences.

Members are required to inform the Board of any changes in their health status during the waiting period. The Board will not consider any claims for pre-existing medical condition(s) diagnosed before the commencement of MediShield cover that have not been disclosed to the Board.

All Singaporeans born on or after 1 March 2013 will be extended a cover from birth following birth registration and will not be subject to the waiting period.

Health Declaration:

Except for newborns covered from their date of birth, members and/or their dependants are required to declare any pre-existing health conditions before their MediShield covers commence. The Board will not consider claims from members who have given false or misleading information, or who have withheld material information when declaring their health conditions. In such events, their MediShield covers may also be cancelled.

BENEFITS & CLAIM LIMITS

MediShield covers hospitalisation expenses and certain approved outpatient treatments, such as kidney dialysis, chemotherapy and radiotherapy for cancer. A MediShield claim is calculated based on the lower of the claim limits as stated in Table A or a percentage of the charges incurred, depending on the ward type, citizenship status and the subsidy received as shown in the section on Pro-ration. The claim is also subject to a Deductible and Co-insurance.

[1] Dependants refers to members' immediate family members (i.e. spouse, parents, children or grandparents). Members and their dependants are covered individually under the scheme.

Table A – Benefits & Claims Limits

Benefits	Claim Limits
Inpatient/Day Surgery	
Daily Ward and Treatment Charge[i]	
- Normal ward	$450 per day
- ICU ward	$900 per day
- Community Hospital[ii]	$250 per day
- Psychiatric[iii]	$100 per day
Surgical procedure[iv]	
- Table 1 (less complex procedures)	$150
- Table 2	$360
- Table 3	$720
- Table 4	$800
- Table 5	$840
- Table 6	$960
- Table 7 (more complex procedures)	$1,100
Implants[v]	$7,000 per treatment
Radiosurgery[vi]	$4,800 per procedure
Outpatient Treatments	
Chemotherapy for Cancer	
- Per 7-day treatment cycle	$270
- Per 21 or 28-day treatment cycle	$1,240
Stereotactic Radiotherapy for Cancer	$1,800 per treatment
Radiotherapy for Cancer	
- External or Superficial	$80 per treatment day
- Brachytherapy with or without external	$160 per treatment day
Kidney Dialysis	$1,000 per month
Immunosuppressants for Organ Transplant	$200 per month
Erythropoietin for Chronic Kidney Failure	$200 per month
Maximum Claim Limits	
Per Policy Year	$70,000
Lifetime	$300,000
Maximum Coverage Age[vii]	92 (age next birthday)

[i] Includes meal charges, prescriptions, professional charges, investigations and other miscellaneous charges

[ii] Claimable only upon referral from an acute hospital for further medical treatment after an inpatient admission

[iii] Claimable up to 35 days per policy year

[iv] Classified according to their level of complexity, which increases from Table 1 to Table 7

[v] Includes:
- Intravascular electrodes used for electrophysiological procedures.
- Percutaneous Transluminal Coronary Angioplasty (PTCA) Balloons
- Intra-aortic balloons (or Balloon Catheters)

[vi] Includes Novalis radiosurgery and Gamma Knife treatments

[vii] With effect from 1 March 2014

DEDUCTIBLE AND CO-INSURANCE

MediShield has Deductible and Co-insurance features. Deductible is the initial amount an insured member needs to pay for claim(s) made in a policy year before any payout from MediShield. Co-insurance is the percentage of the claim that an insured member needs to pay, on the portion of the claim above the Deductible. The member's share of Co-insurance ranges from 10 to 20% of the claimable amount, depending on the size of the hospital bill. Details on Deductible and Co-insurance are shown in the table below.

Table B – Deductible & Co-insurance

Deductible[1]	
For ages 80 and below, as of age next birthday	
- Class B2	$2,000
- Class C	$1,500
- Day Surgery	$1,500
For ages 81 to 92, as of age next birthday	
- Class B2	$3,000
- Class C	$2,000
- Day Surgery	$3,000
Co-insurance[2]	
All Ward Classes & Day Surgery	
Claimable Amount[3]	
$0 - $3,000	20% of claimable amount above Deductible (if applicable)
$3,001 - $5,000	15%
Above $5,000	10%
Outpatient Treatments	20%

[1] Deductible is waived for outpatient treatments.
[2] Co-insurance for outpatient treatments is 20% of a percentage of the charges incurred.
[3] Claimable amount is the lower of the claim limit in Table A or a percentage of the charges incurred.

ILLUSTRATION ON HOW DEDUCTIBLE WORKS

A 50 year-old insured member's current policy year starts on 1 March 2013 and ends on 28 February 2014. Upon renewal, his next policy year starts on 1 March 2014 and ends on 28 February 2015. He is hospitalised twice and warded in a Class B2 ward on both occasions.

Scenario One: Both hospitalisation stays are within the current policy year, one in August 2013 and the other in October 2013.

(a) If the claimable amount for the 1st hospitalisation is $2,000 and the 2nd hospitalisation is $2,500, the Deductible payable by the insured member for the two claims would be:

	1st hospitalisation (August 2013)	2nd hospitalisation (October 2013)
Deductible	$2,000	$0*

*The insured member has paid the full Deductible of $2,000 for the policy year. Hence, there is no Deductible payable for the second claim which is in the same policy year.

(b) If the claimable amount for the 1st hospitalisation is $1,500 and the 2nd hospitalisation is $2,000, the Deductible payable by the insured member for the two claims would be:

	1st hospitalisation (August 2013)	2nd hospitalisation (October 2013)
Deductible	$1,500	$500*

*The insured member has paid only part of the Deductible of $1,500 for his first claim. Hence, he has to pay the balance of $500 for his second claim which is in the same policy year.

Scenario Two: The 1st hospitalisation is in August 2013 and the 2nd hospitalisation is in August 2014 (the next policy year). In this case, the Deductible payable for the two claims would be:

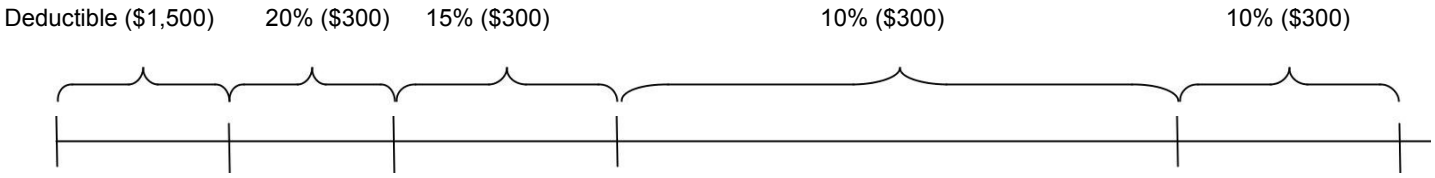
	1st hospitalisation (August 2013)	2nd hospitalisation (August 2014)
Deductible	$2,000	$2,000*

* The insured member needs to pay the Deductible of $2,000 for the 2nd hospitalisation as it occurs in a different policy year.

ILLUSTRATION ON HOW CO-INSURANCE WORKS

A 50 year-old insured member is warded in Class C. His claimable amount[1] works out to be $8,000. He pays the Deductible of $1,500 and his Co-insurance is then computed as follows: 20% of the claimable amount from $1,501 to $3,000 (i.e. 20% of $1,500 = $300); 15% of the claimable amount from $3,001 to $5,000 (i.e. 15% of $2,000 = $300), and 10% of the claimable amount above $5,000 (i.e. 10% of $3,000 = $300). His Co-insurance payment is therefore $900. He has to pay $2,400 ($1,500 Deductible plus $900 Co-insurance) out of the total claimable amount of $8,000. MediShield pays the balance of $5,600. This is illustrated in the following diagram:

[1] Claimable amount is the lower of the claim limit in Table A or a percentage of the charges incurred.



Member pays $2,400 to meet the Deductible and for Co-insurance ($1,500 + $300 + $300 + $300 = $2,400).

COVER PERIOD AND RENEWAL

A MediShield policy year refers to the 12-month period from the date the cover begins. For example, for a cover that starts on 1 March 2013, the policy year of the cover is from 1 March 2013 to 28 February 2014.

For newborns covered from their date of birth, the 1st policy year will commence on their date of birth to the day before their birth month in the following year. Subsequent policy year will follow the 12 month-period. For example, a newborn born on 14 March 2013 will be covered from 14 March 2013 to 28 February 2014. The subsequent policy year will commence on 1 March 2014.

The Board will automatically renew MediShield coverage for an insured member at the end of each policy year after premium payment from his or his payer's Medisave Account. However, the cover will not be renewed if any of the following events occurs:

- The premiums are not paid within the grace period of 2 months.
- The insured member has reached 92 years of age.
- The insured member has informed the Board to terminate his MediShield cover.
- The insured member's total claim has reached the lifetime claim limit.

PREMIUM PAYMENT

MediShield premiums increase with age. The premiums payable when a cover is issued or renewed is based on the insured member's age on his next birthday. Premiums for the different age groups effective from 1 March 2014 are as follows:

Age Next Birthday	Yearly Premiums (Inclusive of 7% GST)	Age Next Birthday	Yearly Premiums (Inclusive of 7% GST)
1 - 20	$50	71 - 73	$560
21 - 30	$66	74 - 75	$646
31 - 40	$105	76 - 78	$775
41 - 50	$220	79 - 80	$865
51 - 60	$345	81 - 83	$1,123
61 - 65	$455	84 - 85	$1,150
66 - 70	$540	86 - 92	$1,190

Premiums are deducted yearly from the insured members' or their payers' Medisave Accounts to renew their covers. If an insured member (or his payer) has insufficient savings in his Medisave, he will be notified in writing to top up the shortfall to his Medisave. If the payer does not top up the shortfall, the insured member will take over as the payer for his premiums should he have sufficient balance in his own Medisave Account. For members who have difficulties paying their own premiums, their immediate family members (i.e. spouse, parents, children or grandchildren) may help by taking over the premium payment using their Medisave savings. They can do so by submitting a change of payer request using his/her SingPass through our website via "my cpf Online Services''. An insured member's policy will lapse if the premium is not paid within the grace period of 2 months. He will then have to re-apply to join the scheme. The application will be subject to applicant's good health and approval will depend on the applicant's health condition then.

Please note that the premiums may be amended or varied from time to time. Members will be informed by the Board of any changes in the premium rates.

PREMIUM DISCOUNT

To make premiums more affordable for older insured members, those who join the scheme before age 60 (as of next birthday) will enjoy a premium discount from ages 71 to 90 years (as of next birthday). Members who join MediShield early and stay continuously insured will receive higher premium discount in future when they are older. The premium discounts effective from 1 March 2013 are as follows:

Age (as of next birthday) when joining MediShield	Premium discount amount for age band ($)					
	71 – 73	**74 – 75**	**76 – 78**	**79 – 80**	**81 – 83**	**84 - 90**
30 and Below	156	184	209	246	434	449
31 – 40	117	138	157	184	326	336
41 – 50	78	92	104	123	217	224
51 – 60	39	46	52	61	108	112

PRO-RATION OF MEDISHIELD CLAIMS

MediShield premiums are the same for all insured members in the same age group. MediShield payouts are therefore similar for all insured members regardless of their subsidy status.

To ensure a similar payout across all MediShield insured members for the same treatment received, all bills will be pro-rated to their equivalent full-subsidy Class B2/C bill size, before the MediShield payout is calculated:

- Pro-ration of Class A/B1 and Private Hospital Bills
  Bills for higher class wards (e.g. Class A, Class B1 and private hospitals) are pro-rated to their equivalent Class B2 bill size based on the pro-ration factors in Table C.

- Pro-ration of Class B2/C Bills for Singaporeans
  As subsidies in Class B2/C wards in restructured hospitals will be means-tested to better focus subsidies on needy Singaporeans, all patients will continue to be subsidised in Class B2/C wards but to different degrees. Class B2/C bills for Singaporeans receiving adjusted subsidies due to means-testing will be pro-rated based on the adjustment in subsidy. For more information on means-testing, please visit the Ministry of Health website at www.moh.gov.sg.

- Pro-ration of Bills for Singapore Permanent Residents
  Singapore Permanent Residents (SPRs) currently receive less subsidies than Singapore citizens. With means-testing, SPRs utilising Class B2/C wards will receive less subsidies than Singapore citizens of an equivalent income level. Class B2/C bills for SPRs receiving adjusted subsidies due to means-testing will first be pro-rated based on the adjustment in subsidy. The pro-ration factor due to citizenship status will then be applied before the payout is calculated (Table C).

You may refer to the illustrations under MediShield Claim Computation.

Table C – Percentage of Charges Incurred

Ward Class	Percentage of Charges Incurred Used to Calculate MediShield Claim[1]		
	Singaporeans	SPRs	Foreigners[2]
C	100%	44%	20%
B2	100%	58%	35%
B2+	70%	47%	35%
B1	43%	38%	35%
A / Private Hospital	35%	35%	35%
Subsidised Short Stay Ward	100%	58%	35%
Private Short Stay Ward	35%	35%	35%
Subsidised Day Surgery	100%	58%	Not Applicable[3]
Private Day Surgery	35%	35%	35%
Subsidised Outpatient	100%	67%	Not Applicable[3]

[1] The applicable percentages may change if there are further changes to hospital subsidies for non-citizens. The up-to-date percentages are published on CPF website at www.cpf.gov.sg.

[2] This is applicable to insured members who have renounced their Singapore Citizenship/Permanent Residency but choose to remain covered under MediShield.

[3] Foreigners are not eligible for subsidised day surgery and subsidised outpatient treatment.

If you wish to have higher coverage than what MediShield provides, you may apply to any of the participating insurers for a Medisave-approved Integrated Shield Plan.

EXCLUSIONS UNDER THE MEDISHIELD SCHEME

The following treatment items, procedures, conditions, activities and their related complications are not covered by MediShield and cannot be claimed:

- Expenses incurred before the commencement of the insured member's MediShield cover
- Expenses incurred for the entire period of stay in hospital if the insured member is admitted to the hospital before the commencement of his MediShield cover
- Any pre-existing illnesses, diseases or impairments from which the insured member was suffering from prior to the commencement of his MediShield cover except where such pre-existing illnesses, diseases or impairments have been accepted by the Board in writing
- Ambulance fee
- Cosmetic surgery
- Maternity charges (including Caesarean operations) or abortions
- Dental work (except due to accidental injuries)
- Infertility, sub-fertility, assisted conception or any contraceptive operation
- Sex change operations
- Optional items which are outside the scope of medical treatment
- Overseas medical treatment
- Private nursing charges
- Purchase of kidney dialysis machines, iron-lung and other special appliances
- Treatment which has received full reimbursement from Workmen's Compensation and other forms of insurance coverage
- Treatment of any illness, disability, injury or any condition arising from or due to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)
- Treatment for drug addiction or alcoholism
- Treatment of injuries arising directly or indirectly from nuclear fallout, war and related risk
- Treatment of injuries arising from direct participation in civil commotion, riot or strike
- Treatment of self-inflicted injuries or injuries resulting from attempted suicide
- Vaccination
- Congenital anomalies, hereditary conditions and disorders (e.g. hole-in-heart, hare lip) that were diagnosed before 1 March 2013 or the commencement of the insured's MediShield cover, whichever is later[1]
- Mental illness and personality disorders that were diagnosed before 1 March 2013 or the commencement of the insured's MediShield cover, whichever is later[1]

[1] Any condition(s) accepted by the Board in writing will continue to be covered. MediShield will exclude any surgical interventions for the following rare congenital conditions which are severe and fatal by nature: Trisomy 13, Trisomy 18, Bilateral Renal Agenesis, Bart's Hydrops, Alobar Holoprosencephaly, Anecephaly.

EXAMPLES OF MEDISHIELD CLAIM COMPUTATION

Example 1 : Claim Computation for Singaporean in a Class C Ward

Ward Class: C
Length of stay: 10 Days (including 8 days in ICU)
Procedure Performed: Stomach Operation

	Hospital Bill[1]	MediShield Claim Computation
Daily Ward & Treatment Charges (for 2 days normal ward + 8 days ICU)	$5,300	$5,300[2]
Surgical Procedure (Table 6)	$550	$550[3]
Total	$5,850	$5,850
Less Deductible[4]	-	($1,500)
Claimable Amount (less Deductible)	-	$4,350
Less Co-insurance	-	($685)[5]
MediShield pays	-	**$3,665**
Medisave and/or Cash	-	$2,185

[1] As the insured member is a Singaporean who stayed in Class C ward, the MediShield claim is computed based on 100% of the bill.

[2] Lower of the claim limit for Daily Ward & Treatment Charges, [($450 x 2 days) + ($900 x 8 days)] = $8,100, or 100% of charges incurred of $5,300. Therefore, the claimable amount is $5,300.

[3] Lower of the claim limit in Table A for surgical procedure, $960 (Table 6), or 100% of charges incurred of $550. Therefore, the claimable amount is $550.

[4] The insured member is below age 80, subject to Deductible of $1,500 for Class C Ward.

[5] Co-insurance = ($1,500 x 20%) + ($2,000 x 15%) + ($850 x 10%) = $685.

Example 2 : Claim Computation for Singaporean in a Class A Ward

Ward Class: A
Length of stay: 18 Days
Procedure Performed: Hip Replacement
Pro-ration Factor based on Ward Class: 35%

	Hospital Bill	35% of Hospital Bill [1] (refer to Table C)	MediShield Claim Computation
Daily Ward & Treatment Charges (for 18 days)	$7,500	$2,625 ($7,500 x 35%)	$2,625[2]
Surgical Procedure (Table 5)	$5,000	$1,750 ($5,000 x 35%)	$840[3]
Implant	$4,000	$1,400 ($4,000 x 35%)	$1,400[4]
Total	$16,500	$5,775	$4,865
Less Deductible [5]	-	-	($2,000)
Claimable Amount (less Deductible)	-	-	$2,865
Less Co-insurance	-	-	($479.75)[6]
MediShield pays	-	-	**$2,385.25**
Medisave and/or Cash	-	-	$14,114.75

[1] As the insured member is a Singaporean who stayed in Class A ward, the MediShield claim is computed based on 35% of the bill.

[2] Lower of the claim limit in Table A for Daily Ward & Treatment Charges, ($450 x 18 days) = $8,100, or 35% of charges incurred of $7,500 = $2,625. Therefore, the claimable amount is $2,625.

[3] Lower of the claim limit in Table A for surgical procedure, $840 (Table 5), or 35% of charges incurred of $5,000 = $1,750. Therefore, the claimable amount is $840.

[4] Lower of the claim limit in Table A for implant, $7,000, or 35% of charges incurred of $4,000 = $1,400. Therefore, the claimable amount is $1,400.

[5] The insured member is below age 80, subject to Deductible of $2,000 for Class A Ward.

[6] Co-insurance = ($1,000 x 20%) + ($1,865 x 15%) = $479.75.

Example 3 : Claim Computation for Permanent Resident in a Class B2 Ward

Ward Class: B2
Length of stay: 54 Days (including 2 days in ICU)
Procedure Performed: Pancreas & Gall Bladder Operation
Pro-ration Factor based on Citizenship Status: 58%

	Hospital Bill	**58% of Hospital Bill[1]** (refer to Table C)	**MediShield Claim Computation**
Daily Ward & Treatment Charges (for 52 days + 2 days ICU)	$16,157	$9,371.06 ($16,157 x 58%)	$9,371.06[2]
Surgical Procedure (Table 6)	$823	$477.34 ($823 x 58%)	$477.34[3]
Total	$16,980	$9,848.40	$9,848.40
Less Deductible[4]	-	-	($2,000)
Claimable Amount (less Deductible)	-	-	$7,848.40
Less Co-insurance	-	-	($984.84)[5]
MediShield pays	-	-	**$6,863.56**
Medisave and/or Cash	-	-	$10,116.44

[1] As the insured member is a Permanent Resident who stayed in Class B2 ward, the MediShield claim is computed based on 58% of the bill.

[2] Lower of the claim limit in Table A for Daily Ward & Treatment Charges [(52 x $450) + (2 x $900)] = $25,200 or 58% of charges incurred of $16,157 = $9,371.06. Therefore, the claimable amount is $9,371.06.

[3] Lower of the claim limit in Table A for surgical procedure, $960 (Table 6), or 58% of charges incurred of $823 = $477.34. Therefore, the claimable amount is $477.34.

[4] The insured member is below age 80, subject to Deductible of $2,000 for Class B2 Ward.

[5] Co-insurance = ($1,000 x 20%) + ($2,000 x 15%) + ($4,848.40 x 10%) = $984.84.

Example 4: Claim Computation for Singaporean in a Class B2 Ward with subsidies adjusted due to means-testing

Ward Class: B2 Length of stay: 5 Days
Procedure Performed: Unilateral Knee Replacement Operation
Pro-ration Factor based on Actual Adjustment of Subsidy: 87.5%

	Hospital Bill[1]	**87.5% of Hospital Bill**[2] (based on actual adjustment of subsidy)	**MediShield Claim Computation**
Daily Ward & Treatment Charges (for 5 days)	$1,600	$1,400 ($1,600 x 87.5%)	$1,400[3]
Surgical Procedure (Table 6)	$784	$686 ($784 x 87.5%)	$686[4]
Implant	$3,000	$3,000[5]	$3,000[6]
Total	$5,384	$5,086	$5,086
Less Deductible[7]	-	-	($2,000)
Claimable Amount (less Deductible)	-	-	$3,086
Less Co-insurance	-	-	($508.60)[8]
MediShield pays	-	-	**$2,577.40**
Medisave and/or Cash	-	-	$2,806.60

[1] The insured member is a Singaporean who enjoys 60% subsidy for his Class B2 hospital bill after means-testing.

[2] The insured member's hospital bill is pro-rated to the equivalent full-subsidy Class B2 bill size.

[3] Lower of the claim limit for Daily Ward & Treatment Charges, ($450 x 5 days) = $2,250, or 87.5% of charges incurred of $1,600 = $1,400. Therefore, the claimable amount is $1,400.

[4] Lower of the claim limit in Table A for surgical procedure, $960 (Table 6), or 87.5% of charges incurred of $784 = $686. Therefore, the claimable amount is $686.

[5] Implant used in Class B2/C by Singaporeans and Permanent Residents are exempted from MediShield pro-ration.

[6] Lower of the claim limit in Table A for implant, $7,000, or 100% of charges incurred of $3,000. Therefore, the claimable amount is $3,000.

[7] The insured member is below age 80, subject to Deductible of $2,000 for Class B2 Ward.

[8] Co-insurance = ($1,000 x 20%) + ($2,000 x 15%) + ($86 x 10%) = $508.60

The MediShield Scheme is administered by the CPF Board under the provisions of the Central Provident Fund Act (Cap 36) and the Central Provident Fund (MediShield Scheme) Regulations as amended from time to time, and is subject to the terms and conditions imposed by the Board.

The information reflected is correct as at the time of publication in March 2014. For more information, and any changes thereafter please refer to CPF website at www.cpf.gov.sg. Please approach CPF Board if you have specific queries or clarifications about benefits for your health conditions. For enquiries, please call 1800 – 227 1188 or email member@cpf.gov.sg.

您也可以浏览公积金局网站www.cpf.gov.sg查阅上述信息的中文版本。如欲提出咨询, 请拨电1800-227 1188 或电邮至 member@cpf.gov.sg。

Anda boleh juga melihat maklumat di atas dalam Bahasa Melayu menerusi tapak web kami di www.cpf.gov.sg. Untuk pertanyaan, sila hubungi talian 1800 - 227 1188 atau e-mel kepada member@cpf.gov.sg.

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