Central Provident Fund (MediShield Scheme) (Amendment No. 4) Regulations 2007

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No. S 701

CENTRAL PROVIDENT FUND ACT
(CHAPTER 36)

CENTRAL PROVIDENT FUND (MEDISHIELD SCHEME) (AMENDMENT NO. 4) REGULATIONS 2007

In exercise of the powers conferred by section 57 of the Central Provident Fund Act, the Minister for Manpower hereby makes the following Regulations:

Citation and commencement

1.—(1) These Regulations may be cited as the Central Provident Fund (MediShield

Scheme) (Amendment No. 4) Regulations 2007 and shall, with the exception of regulation 4(*a*), come into operation on 1st January 2008.

(2) Regulation 4(*a*) shall be deemed to have come into operation on 1st October 2005.

Amendment of regulation 2

2. Regulation 2 of the Central Provident Fund (MediShield Scheme) Regulations 2005 (G.N. No. S 427/2005) (referred to in these Regulations as the principal Regulations) is amended —

(*a*) by inserting, immediately after the words "surgical treatment" in the definition of "day surgical treatment", the words "(including any radiosurgery treatment)";

(*b*) by inserting, immediately after the word "radiotherapy" in paragraph (*c*) of the definition of "insured out-patient medical treatment", the word "treatment";

(*c*) by deleting paragraph (*f*) of the definition of "insured out-patient medical treatment";

(*d*) by deleting the words "medical, surgical, radiotherapy," in the definition of "medical treatment" and substituting the words "medical treatment, surgical treatment, radiotherapy treatment,";

(*e*) by inserting, immediately after the definition of "premium", the following definition:

" "pro-rating factor" means a pro-rating factor specified in the Sixth Schedule for medical treatment received by a person insured under the Scheme in Division 2 of Part II;";

(*f*) by deleting the definition of "subsidised day surgical treatment" and substituting the following definition:

" "subsidised", when used to describe any medical treatment received by a person, means that the person received a subsidy from the Government for that medical treatment;"; and

(*g*) by deleting the definition of "unsubsidised day surgical treatment" and substituting the following definition:

" "unsubsidised", when used to describe any medical treatment received by a person, means that the person did not receive

any subsidy from the Government for that medical treatment.".

Amendment of regulation 10

3. Regulation 10 of the principal Regulations is amended —

(*a*) by deleting paragraph (8);

(*b*) by deleting paragraphs (10) and (11) and substituting the following paragraphs:

"(10) Subject to paragraphs (1)(*c*), (2) and (5)(*c*), where in any policy year, an insured person has received at an approved hospital any medical treatment (excluding any medical treatment specified in paragraph (13)) as an in-patient or as day surgical treatment, and the insured person was admitted for such medical treatment on or after 1st July 2005, he shall be entitled to claim from the Board, in respect of such medical treatment, an amount ascertained in accordance with one of the following formulae:

(*a*) if the total of the relevant amounts for all such medical treatments received in the policy year is less than or equal to $3,000, the formula is —

	[(A – B) x 0.8] – C,	

	where	A	is the total of the relevant amounts for all such medical treatments received in the policy year;
		B	is the insured person's contribution specified in item (1) in Part II of the Fourth Schedule; and
		C	is the total claim paid in the policy year;

(*b*) if the total of the relevant amounts for all such medical treatments received in the policy year is more than $3,000 but less than or equal to $5,000, the formula is —

	[($3,000 – B) x 0.8]	
	+ [(A – $3,000) x 0.85] – C,	

	where	A	is the total of the relevant amounts for all such medical treatments received in the policy year;
		B	is the insured person's contribution specified in item (1) in Part II of the Fourth Schedule; and
		C	is the total claim paid in the policy year; or

(*c*) if the total of the relevant amounts for all such medical treatments received in the policy year is more than $5,000, the formula is —

	[($3,000 – B) x 0.8] + ($2,000 x 0.85)	
	+ [(A – $5,000) x 0.9] – C,	

	where	A	is the total of the relevant amounts for all such medical treatments received in the policy year;
		B	is the insured person's contribution specified in item (1) in Part II of the Fourth Schedule; and
		C	is the total claim paid in the policy year.

(11) Subject to paragraphs (1) to (7), where in any policy year, an insured person has received any insured out-patient medical treatment, he shall be entitled to claim from the Board, in respect of such medical treatment, the lower of the following amounts:

(*a*) 80% of the total of the charges incurred for such