# THE HONG KONG BAPTIST UNIVERSITY

**Integrated Medical Scheme**
**(Effective 1 July 2021)**

## FOREWORD

This set of regulations presents general information describing the Integrated Medical Scheme (the Scheme) provided by the Hong Kong Baptist University (the University) for all eligible employees and where applicable, their dependent family members, with the aim of easing their financial burden normally accompanying accidents and illnesses.

The Scheme consists of the following benefit modules and the provision of benefits under the Scheme are subject to a list of exclusion items.

(i) Out-patient Benefits (Western Medicine)

(ii) Out-patient Benefits (Chinese Medicine)

(iii) Hospitalisation Benefits

(iv) Dental Benefits

(v) Maternity Benefits

(vi) Preventive Care

Item (iii) will be provided through insurance arrangement by an Underwriter appointed by the University while Primary Dental Care under item (iv) will be arranged through Managed Care model at a dental group appointed by the University. Appointment of service provider(s) will be made by the University periodically after taken into account the factors of cost effectiveness and service quality.

You are invited to familiarise yourself with the extent of protection offered as described in this set of regulations since your understanding of the Scheme will enable the University together with the service providers to render full and efficient service at all times and with minimum delay.

If there is any inconsistency or conflict between the Chinese version and English version of this set of regulations, the English version will prevail.

Human Resources Office

1 July 2024

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## 1. INTERPRETATION

1.1 "**Benefits**" shall mean medical and dental benefits under the Letter of Appointment providing for reimbursement of expenses incurred by a Member as a result of accidental bodily injury, disease or sickness.

1.2 "**e-Claim(s)**" shall mean the outpatient medical claim(s) which is / are submitted through the e-Medical Claims System.

1.3 "**Registered Medical Practitioner**", "**Surgeon**", "**Physician**", "**Doctor**", "**Anaesthetist**", "**Physiotherapist**", "**Chiropractor**" or "**Registered Chinese Medicine Practitioner**" shall mean a person duly qualified and legally registered as such in Hong Kong. The term "Registered Medical Practitioner" shall in particular mean a practitioner of western medicine.

1.4 "**Hospital**" shall mean any lawfully operating public or private hospital.

1.5 "**Qualified Nurse**" shall mean legally qualified Registered Nurse or Enrolled Nurse in Hong Kong.

1.6 "**Disability**" shall mean injury, sickness, disease or illness and shall include all disabilities arising from the same cause including any and all complications therefrom, except that where after 90 days following the latest medical treatment or consultation, no further treatment for the said disability is required, then any subsequent disability from the same cause shall be considered a separate disability.

1.7 "**Sickness**", "**Disease**" or "**Illness**" shall mean a physical condition marked by a pathological deviation from the normal healthy state.

1.8 "**Member**" where the context admits, includes the eligible staff and eligible family member(s) enrolled under the Scheme.

1.9 "**Eligible family members**" include legally married spouse as supported by a legal marriage certificate and dependent children.

1.10 "**Dependent children**", including step-children and adopted children, means:

- any unmarried sons and unmarried daughters under the age of 21 years;
- in the case of sons and daughters of 19 or 20 years of age, they must also be in full-time education or in full-time vocational training, or dependent on the appointee as a result of physical or mental infirmity.

Notwithstanding the above, the definition under the relevant Terms of Service shall prevail.

1.11 "**Medically Necessary Expenses**" shall mean medical expenses incurred solely by a medical service which is: -

- consistent with the diagnosis and customary medical treatment for the condition;
- in accordance with standards of good and prudent medical practice;
- not for the convenience of the Member or any person coming within the meaning of 1.3 above; and
- performed in the most reasonable "Setting" required for treatment of a covered Disability.

1.12 "**Setting**" shall mean the office of any person coming within the meaning of 1.3 above, a Hospital out-patient department or Hospital accommodation as appropriate for treatment.

1.13 "**Shortfall**" shall mean expenses incurred which are not covered in the Scheme or are in excess of the applicable benefit limits, whether incurred by the staff member or the dependants.

1.14 "**Currency**" - all monetary values in this set of regulations or elsewhere relating to the Scheme are expressed in Hong Kong Dollars ($).

## 2. ELIGIBILITY FOR BENEFITS

### 2.1 Who is Covered and When

2.1.1 Your eligibility for medical and dental benefits is determined according to the terms of your appointment with the University. If you are eligible and have registered for medical and dental benefits with the University, you may participate in the Scheme on the date of your assumption of duty. Under the arrangement of the Integrated Scheme, members cannot opt for either "medical" or "dental" benefits only. Hence, you are invited to make a decision on whether or not to register fully with the Integrated Scheme.

2.1.2 If according to the terms and conditions stated in your letter of appointment, your spouse and dependent children are also eligible for coverage under the University's Medical and Dental Scheme, they can also participate in the Scheme provided that you have indicated family members' registration for such benefits with the University via Human Resources System or through the "Registration Form on Personal Data & Benefits". They will become members on the date your membership is effective or on the date they become your spouse or dependent child (new born baby will be covered from 15 days' old) or on the actual date of registration, whichever is later, subject to the following conditions: -

(a) If your spouse or any of your dependent child is confined in a hospital on the date the benefits would otherwise have become effective, medical and dental benefits shall not become effective until the day immediately following the termination of such hospital confinement.

(b) Entry age for new Member should normally be under 65 while the coverage will be provided up to the age of 64. Staff members who are offered appointment extension beyond the said age limit, the University will pay the premium loading (as required by the Underwriter) in order to keep their membership on the Scheme. Staff members who have opted for the Voluntary Plan to enhance their hospitalisation benefits will need to bear the corresponding additional premium loading.

(c) The aforesaid arrangement does not apply to spouse members. Their membership will expire on their 65$^{th}$ birthday. Members are therefore advised to make appropriate arrangement for medical coverage for their family members in due course.

(d) For spouse and dependent children enrolling to the Scheme subsequently, their Scheme effective date will commence on the start date of the next policy year, i.e. 1 July. However, this constraint does not apply to newly married spouse and newborn baby, who are allowed to join the Scheme during the policy year.

2.1.3 Married staff member(s) may change the registration for medical and dental benefits from spouse's employer to the University's provision only while they are actively at work.

### 2.2 Married Couple both working in the University

2.2.1 Where a married couple both work for the University, each of them and their dependants (if any) is only eligible for one membership, at any time, in the Scheme provided by the University.

2.2.2 If the couple are eligible for different levels of benefits, one of them can choose to take up "dependant" status in the Scheme of the other. All children (if any) will be enrolled in the Scheme of the parent with "employee" status.

2.2.3 If the couple are eligible for the same benefit, each of them will have "employee" status and

all their children must be enrolled as "dependants" of one parent only.

2.2.4 Please note under this arrangement, the "employee" or "dependant" status of an employee cannot be changed unless:

(a) one member of the couple leaves the University service;
(b) there is a change in the benefit entitlement / level of one of the employees (e.g. promotion); or
(c) there is a special event, such as having a new-born, divorce.

2.2.5 When there is a change in the "employee" or "dependant" status of an employee or a shift of "dependant" to another parent, both the "employee" or "dependant" under the new membership are required to adhere to the policy conditions set by the Underwriter of hospitalisation benefits.

2.2.6 The above arrangement applies within the Scheme as well as outside the Scheme when one member of the couple is eligible for an alternative medical benefits, such as an accident travel insurance which includes a medical insurance element, provided by the University.

2.3 **Benefits Group Classification***

For the purpose of defining hospital and maternity benefits, staff and their eligible family members are classified as follows:

| | | |
|---|---|---|
| Group I | - | General Staff (Band A – C) and Research Staff |
| Group II | - | Instructor / Lecturer Staff, Executive / Professional Staff (Band D1 – E2), Research Assistant Professor and Senior Research Staff |
| Group III | - | Academic Staff, Senior Instructor / Senior Lecturer or above and Managerial / Senior Professional Staff (Band F or above) |

** unless otherwise stipulated in individual staff's contract or pertinent document*

2.4 **Benefit Regarding due to Change in Appointment Terms**

If your Terms of Service changes, your group classification and coverage will be adjusted with effect from the date of such change. However, if due to sickness or injury you are not actively working in full time employment on such date, your coverage will not be adjusted until the date on which you return to full time active work. When an eligible family member is confined in a hospital on the date of your change of group classification, the coverage will not be adjusted until the date immediately following the termination of the hospital confinement. Nonetheless, benefit so claimed got to be deducted from the upward adjusted benefits.

## 3. HOW TO JOIN THE SCHEME

3.1 All eligible new employees may enrol via Human Resources System or a registration form which is sent by the Human Resources Office (HRO). You should complete and return the registration form to the HRO within **ten days** from the date of commencement of duty.

3.2 Delay in returning the enrolment will affect the effective date of provision of medical & dental benefits to you. If enrolment procedures are not completed within **one month** after your commencement of duty, your coverage under the Scheme will be subject to the approval of the Underwriter and the University Administration.

3.3 For enrolment purpose, you should advise the HRO of changes in your eligible family member's data as soon as possible, and in no event later than one month after date of such change. For staff who is

taking maternity leave, enrolment of her newborn babies should be completed within **one month** after her assumption of duty. For any delay in notification, the respective membership effective date will be subject to the approval of the Underwriter and the University Administration.

## 4. MEMBERSHIP

### 4.1 Evidence of Membership

4.1.1 After your enrolment request being vetted by the HRO, you will receive a Staff Card encoded "Y", "I" or "(mm/yy)I". If you are married, the eligible family members will each be issued an Affiliate Card with a similar code. On completion of the Scheme enrolment, you will be given a membership no. by the Underwriter and your benefit group together with the plan enrolled will also be translated to a benefit class. Your medical eligibility together with the membership no. and benefit class can be found via the Underwriter's website / mobile app. When making enquiries with and submitting forms to the Underwriter, the membership no. will be an identifier of an insured member with the Underwriter.

4.1.2 Any newly enrolled staff members and their eligible family member(s) are subject to an exclusion of 'pre-existing conditions' not being covered. The current policy states that 'pre-existing conditions' is not covered during the initial six months of membership in the Scheme. The month and year in the bracket of the Staff / Affiliate cards is for referencing the exclusion period. The meaning of 'pre-existing conditions' goes under paragraph 6.4 below.

### 4.2 Termination or Change of Membership

4.2.1 When you cease to be employed by the University, your coverage under the Scheme will cease on the same date. If for any reason a serving staff (and their eligible family members) will leave the Scheme for some time but re-join within the same financial year, your benefit entitlement for out-patient benefits (both for western medicine and Chinese medicine), dental benefits and preventive care will then be the remaining balance left in the same financial year, i.e. the annual benefit limits or quotas will not be refreshed as a result of your re-joining the Scheme. The same arrangement applies when a member has his / her membership status changed from "staff" to "spouse" or vice versa.

4.2.2 If any of the family members no longer fulfil the eligibility requirements under the Scheme at any time after they are enrolled, the staff member must notify the HRO by submitting the relevant form within **one month** of the change in eligibility.

## 5. GENERAL INFORMATION

### 5.1 Staff's Responsibilities

Any case of dishonesty or wilful misrepresentation in the claiming of benefits may result in suspension or termination of eligibility for benefits, and render the staff member concerned liable to disciplinary action. The University reserves the right to recover any benefits that may have been unduly given to the staff member.

### 5.2 Data Privacy

5.2.1 From time to time, it is necessary for the University administration to supply members'

personal data and medical information under the Scheme to the Underwriter, appointed Chinese medicine clinic(s), appointed dental group, medical consultant, departments / offices of the University processing staff benefits and auditors appointed by the University for carrying out audit procedures that may be required from time to time.

5.2.2 The purposes for which data relating to Members may be used are as follows: -

(a) enrolments to the Scheme, and in addition, any amendment, termination or renewal of membership;
(b) issuing Staff ID Card and Affiliate Card(s);
(c) processing of medical or dental claims; and
(d) claims analysis.

5.2.3 The Underwriter, appointed Chinese Medicine Clinics and appointed dental group will pass your medical information, such as details of your claim reimbursement / medical shortfall, to you via the University. The University has access to the information as and when necessary. Please be assured that all the information required is on need basis and will be treated in the strictest confidence by the relevant parties.

5.2.4 As Members of the Scheme, you have the right to check whether the data users hold data about you and require the data users to correct any data relating to you which is incorrect. But the data users will have the right to charge you a reasonable fee for processing any of such data access request.

## 5.3 Medical Charges in Hong Kong

You should note that charges for medical services in Hong Kong can vary from doctors to doctors or from hospitals to hospitals. The actual charges often depend on the type of treatment given and to some extent on the location and facilities available. You are strongly advised to consult the attending doctor or the hospital concerned on the medical charges before you seek medical treatment.

## 5.4 Professional Liability

You should note that dentists of the appointed dental group are not agents or employees of the University. The University is therefore not responsible for any disputes or any acts of negligence on the part of this appointed service provider.

## 5.5 Emergencies

You may seek treatment at any Accident & Emergency Department of Government Hospital or call for ambulance services at time of emergency.

## 5.6 Personal Conversion Plan after Termination of Membership

When staff leave the University service, they (and their eligible family members) can join a personal conversion plan with hospital & surgical coverage (and out-patient coverage, if agreeable) offered by the appointed Underwriter at the time of transfer. Eligible family members approaching the insured age limit and will have their membership expired under the Integrated Medical Scheme may also consider joining such conversion plan. You can obtain information and enrolment form from the website of the HRO. The University does not guarantee or make presentations in regard to, and expressly disclaims responsibility for the personal conversion plan offered by the appointed Underwriter.

5.7 **Disputes**

For any case in doubt, such as whether a specific item is claimable or not, the University Administration after consulting the Consultant / Underwriter for professional opinion will have the final decision.

5.8 **Amendments**

The Hong Kong Baptist University reserves the right to modify, amend or discontinue any or all the provisions of its Integrated Medical Scheme at any time. Staff will be notified of any changes to the Scheme or changes to the appointed dental group or Underwriter through HRO website, emails or e-Announcements.

## 6. GENERAL EXCLUSIONS

6.1 Medical expenses incurred outside Hong Kong.

6.2 Routine or general check-up or routine blood tests, health examinations, check-ups or tests not incidental to treatment or diagnosis of a covered disability. (Note: An annual physical / gynaecological check-up for staff aged 35 and above will be separately covered by the University.)

6.3 Cost incurred as a result of treatment, which is not medically necessary, or expenses not incurred as a result of accidental bodily injury, disease or sickness, as well as any experimental, investigational or unproven treatments.

6.4 Injuries or sickness arising prior to effective date of membership in the Scheme and which presented signs or symptoms of which the Member was aware or should reasonably have been aware of. Nonetheless, expenses incurred for such disability shall be considered covered expenses after an Insured Member has joined the scheme for six months. (*Please refer to a **list of pre-existing conditions** for details*.)

6.5 Treatment directly or indirectly arising from self-inflicted injuries or sexually transmitted diseases.

6.6 Treatment directly or indirectly arising from infertility including in-vitro fertilization or any other artificial method of inducing pregnancy.

6.7 Birth control or sterilization.

6.8 Treatments, supplies and prescribed drugs for smoking cessation programmes and the treatment of nicotine addiction.

6.9 Prescribed drugs used in connection with drug addiction, alcoholism, weight reduction, and treatment of baldness.

6.10 Treatment which in any way arises from, is attributable to, or is consequential upon Human Immunodeficiency Virus Infection (AIDS).

6.11 Treatment for congenital abnormalities or diseases. (Note: Previous "Old Scheme" members who had been receiving reimbursement on this item on or before 30 June 2004 would not be affected by this exclusion item.)

6.12 Treatment (including psychological therapy and counselling and psychiatric treatment) directly or indirectly arising from any insanity, psycho-geriatrics or psychiatric condition including but not confined to psychoses, neuroses of any kind, anorexia nervosa, bulimia, schizophrenia and other behavioural disorders except that minor psychiatric conditions such as stress, anxiety and depression will be covered under out-patient benefits and for staff members only.

6.13 Charges for Blood and Blood Plasma.

6.14 Charges for procurement or use of special braces, appliances, spectacles, hearing aids, wheelchairs, crutches, any implants, contact lenses, correction of eye refraction, prosthesis, fitting of the same or other medical equipment, and non-medical services such as television, telephone and domestic use equipment and appliances.

6.15 Cosmetic surgery, any treatment for the purpose of beautification unless necessitated by an accident

or illness during the period of membership, treatment of acne, routine eye or hearing tests, preventive vaccinations.

6.16 Treatment directly or indirectly arising from or consequent upon war (whether war is declared or not), invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolution, insurrection or military or usurped power or terrorist acts, or racing on horses or wheels.

6.17 Rest cures or treatment in sanatoria, clinical home care, custodial care in any setting; day care; hospice; private duty nursing, respite care.

6.18 Alternative treatments (such as but not limited to hypnotism, acupressure, rolfing, massage therapy, aroma therapy, and other forms of alternative treatment).

6.19 Other education treatment (such as but not limited to occupational therapy, speech improvement, health treatment classes and nutritional treatments, or group support treatments).

6.20 Room, board, general nursing care or special hospital services not in accordance with the diagnosis and treatment of the condition for which the hospital confinement is required.

6.21 Any treatment not performed or referred by registered medical practitioners.

6.22 Expenses that are recoverable from a third party.

## 7. OUT-PATIENT BENEFITS (WESTERN MEDICINE)

### 7.1 **Extent of Coverage**

This benefit covers expenses incurred while members are being treated or examined by a Registered Medical Practitioner (i.e. medical doctor / physician in western medicine), Registered Physiotherapist / Chiropractor at the out-patient department of a hospital, clinic, medical centre, medical laboratory, not including admission to a hospital. The Scheme will provide out-patient benefits for:

(i) General / Specialist Consultation
(including a normal course of medication; for medication of 30 days or more, it will be classified as long-term medication)
(ii) Referred Physiotherapy / Chiropractic Treatments
(iii) Diagnostic X-Ray Examination (including Advanced Scanning) and Laboratory Tests
(iv) Long-term medications prescribed for 30 days or more

7.1.1 Members are free to consult any registered medical practitioners of their choice (either general practitioners or specialists), but are limited to one consultation per day unless justification can be provided that there is a genuine need for the member concerned to receive more than one consultation for one day. The University reserves the right to request for additional information for claim for reimbursement and to confine such reimbursement to one consultation per day.

7.1.2 The annual overall reimbursement limit for each Scheme member as specified is at Appendix I. Members will contribute a percentage as specified in the same Benefit Schedule while the University will reimburse the remaining portion of each medical bill subject to the annual limit / sub-cap.

7.1.3 Written referral from Registered Medical Practitioner is required for the following treatment items:

- Diagnostic X-Ray Examination and Laboratory Tests (referral letter issued by a registered Chinese medicine practitioner of the University appointed Chinese medicine clinic is also acceptable). However, if you intend to claim the Advanced Diagnostic Scanning from "Miscellaneous Hospital Charges", please read para. 9.3.3(d) for different arrangement.
- Physiotherapy and Chiropractic Treatments

7.1.4 Long-term Medication

The University will directly reimburse medical expenses incurred as a result of long-term medication arising from chronic or prolonged illnesses. Long-term medication is defined as medication prescribed for 30 days or more. Reimbursement can be claimed subject to the following:

(a) such medication being prescribed by a Registered Medical Practitioner in western medicine;
(b) such medication being purchased from any licensed pharmacy or the attending doctors' clinic [Note: The University encourages members to purchase long-term medication from licensed pharmacies. However, if members wish to purchase long-term medication from their attending doctor's clinics, they are strongly advised to compare the prices of medications between the doctor's clinics and licensed pharmacies in order to protect their interest.]; and
(c) the amount so reimbursed will be governed by the annual sub-limit made available for Laboratory tests and long-term medication set for each individual Member (please refer to Appendix I).

## 7.2 **Claim Procedures**

7.2.1 In seeking any covered out-patient (Western Medicine) services, members should settle the medical bills first and claim for cash reimbursement from the Finance Office (FO) afterwards as follows: -

(a) Members can submit their e-Claims using the e-Medical Claims System and attach the relevant official receipt from clinic or similar out-patient setting mentioned in paragraph 7.1 above as supporting document, with the following items clearly shown on the receipt: -

- patient's full name
- date of Consultation
- diagnosis *(self declaration of diagnosis is only acceptable for receipts issued by Government clinics or HA hospitals' out-patient department)*
- name of the doctor
- signature of the doctor
- charges for each item such as: consultation, medications, duration of the prescription and other procedures (with full details of procedures performed)

(b) If you claim reimbursement for (i) X-ray, (ii) Laboratory Test, (iii) Physiotherapy, or (iv) Chiropractic Treatment, a scanned copy of referral letter (refer to 7.1.3 for details) should be attached to the e-Claim. The referral will remain valid for a period of 6 months from the referral letter's issue date, provided that the diagnosis remains the same. For items (iii) and (iv), follow-up visits within 6 months from the date of the last visit for treatment of the exact diagnosis do not require a new referral letter. If there is a change in diagnosis, a new referral letter is required.

(c) For long-term medications purchased from licensed pharmacy:

(i) You should request the attending doctor to issue a prescription or letter with issued date, diagnosis, the name of the medication prescribed, the dosage and the duration of the prescription duly signed by the attending doctor and with doctor's chop.

(ii) You should then submit the e-Claim with the receipt for the prescribed

medication and attached the prescription/letter.

(iii) The pharmacy receipt should record the name, quantities and prices of medications purchased and the name of the patient to whom it is issued.

(iv) Validity of the prescription / recommendation letter is for a period of six consecutive months from the date of issue.

(d) For long-term medications obtained from doctor's clinic, you have to ask the doctor to issue a separate receipt with clear indication of all the information in 7.2.1 (a) above, including in particular the duration of prescriptions.

(e) Staff may not be required to submit their original copies of the official receipts unless upon the selected claim was sampled for checking.

(f) For sampled checking at e-Claims, staff are required to submit the original official receipts and any other supporting documents to Finance Office within thirty (30) days upon receiving the e-notification.

7.2.2 All Claims should be submitted to FO via e-Medical Claims System within one month (30 days) from the date of consultation / treatment. The entitled reimbursement will be deposited directly to the Staff Member's payroll bank account. Late submission of claims will be rejected by FO.

## 8. OUT-PATIENT (CHINESE MEDICINE)

8.1 The University shall provide medical coverage for member consulting practitioners of Chinese Medicine, including consultation fee, medicine, acupuncture and bone-setting offered at University appointed Chinese medicine clinics up to a maximum benefit limit per visit as specified at Appendix II, which will be promulgated from time to time.

8.2 Members who visit the appointed Chinese medicine clinics should present their Staff / Affiliate Card as proof of identity. For members aged below 15, they are required to bring along in their first visit, either one of the following identity document: HKID, passport, or birth certificates on top of the Affiliate card for establishment of proper patient records.

8.3 Coverage will be restricted to treatment of illness, subject to the exclusion items as stated in Section 6.

8.4 For each visit, you will need to pay a registration fee (may vary according to the number of quota used) as specified at Appendix II, plus any amount charged by the appointed Chinese medicine clinics which is over and above the maximum benefit limit, and any amount charged for the exclusion items.

8.5 Coverage for each member will be defined as an annual quota of visits as specified at Appendix II, and limited to one visit per day. If you are found to have exceeded the benefit limits subsequently, you shall pay the excess amount to the Chinese medicine clinics. Any un-used visit quota at the end of the financial year will lapse.

8.6 Reimbursement is not required under this benefit module.

## 9. HOSPITALISATION BENEFITS

### 9.1 Introduction

Hospitalisation benefits are provided and underwritten by an Underwriter appointed by the University. While every effort has been made to ensure accuracy in the following descriptions, it must be clearly understood that the interpretation of any specific provisions of hospitalisation benefits under the Scheme by the Underwriter is final.

### 9.2 Schedule of Benefits

Please refer to Appendix IIIa-c for Schedule of the respective benefit groups. Each medical plan is inclusive of Part A – "basic hospital and surgical benefits, and Part B - Supplementary Major Medical Benefits. The Underwriter shall pay medical benefit for medically necessary expenses in accordance with the provisions herein below but subject to the maximum limits as specified in the Schedule.

### 9.3 Hospital & Surgical Benefits

Hospitalisation under the Scheme will be covered according to a schedule of benefits, if recommended by a Registered Medical Practitioner in western medicine, and such hospitalisation shall mean confinement in a Hospital where the Member is registered as a bed patient (no minimum confinement in terms of hours is required), except that no confinement in Hospital is required if surgical procedure is performed at Doctor's clinic or similar out-patient setting mentioned in paragraph 7.1. The extent of benefits covers the following hospital expenses: -

#### 9.3.1 Room, Board & General Nursing Care

Room, Board and General Nursing benefit shall be paid when, upon recommendation of a Registered Medical Practitioner, a Member is registered as a bed-patient in a Hospital for the treatment of a disability and incurs charges therefor. The amount of such benefit shall be equal to the normal, proper and actual charges for the accommodation, reasonable meal consumed and general nursing services made by the hospital during the member's hospital confinement, subject to the daily maximum limit shown in the Schedule of Benefits (Appendix IIIa-c). The maximum benefit for a relevant hospitalisation period is calculated by the daily limit to which the member is entitled times the number of days the hospital counts for the purpose of making room charges, subject to not exceeding the maximum number of days reimbursable for a defined disability.

**Second Claim Incentive Benefit** is payable in respect of a Hospital Confinement under this Scheme and such reimbursement has been paid by an insurance company other than Bupa (Asia) Limited [Bupa], the appointed Underwriter, or any company within the Bupa group of companies, this Benefit shall be paid on a per day basis in which Room and Board Benefit shall be payable for such day of Hospital Confinement. Such provision is exceptionally arranged by Bupa during the policy year 2024-25.

#### 9.3.2 Home Nursing

Home Nursing benefits shall be paid when a Member incurs expenses for services rendered by a Qualified Nurse in respect of nursing at the Member's home for such period or periods recommended by a Registered Medical Practitioner. The amount of such benefits shall be equal to the actual charges for such services but in no event shall the benefits payable under this provision exceed the limits or maximums as set forth in the Schedule of Benefits (Appendix IIIa-c).

9.3.3 **Miscellaneous Hospital Charges**

Miscellaneous Hospital Charges refers to all the necessary ancillary charges such as drugs, dressings, x-ray and laboratory tests, etc., required for performing the medical treatment at hospital. Benefits shall be paid subject to the maximum shown in the Schedule of Benefits (Appendix IIIa-c) in respect of the relevant charges made by the Hospital during the time that a Member is registered and staying as a bed-patient in a Hospital for treatment of a disability. Members' attention is drawn to the following scenarios: -

(a) Drugs and medicines consumed in Hospital are covered. Discharge medication, clearly shown in the hospital bill which is reasonable and customary will also be reimbursable.

(b) Expenses for Laboratory test that comes after a surgical procedure (e.g. Biopsy) performed at doctor's clinic or similar out-patient setting mentioned in paragraph 7.1 above will also be covered.

(c) Administration of blood or blood plasma is covered, but not the cost of blood or blood plasma itself.

(d) Pursuant to the Agreement between the University and Bupa during the Scheme years of 2024-25, Miscellaneous Hospital Charges cover (i) Advanced Diagnostic Scanning (such as MRI, CT Scan, PET Scan and CT Angiogram), (ii) Cancer Treatments (such as chemotherapy, radiotherapy, target therapy, cyberknife and gamma knife, which listed in the Hospital Authority Drug Formulary) and (iii) Renal Dialysis Treatments (such as haemodialysis or peritoneal dialysis), if they are done in outpatient setting. These should be regarded as privileged offers from Bupa.

9.3.4 **Physician's Hospital Visit (for non-surgical cases only)**

(a) Physician's Hospital Visit is used to cover charges for physician's hospital visit, treatment or consultation during a hospital confinement where no surgical procedure is performed for the same disability.

(b) In general, Physician's Hospital Visit can be extended to cover one pre-hospitalisation and post-hospitalisation follow-up consultations within 6 weeks from the date of discharge from hospital.

(c) However, expenses for more than one treatment, visit or consultation, surgical or nursing service, during any one 24-hour period will not be covered. In no event shall the benefit payable exceed the limits or maximums as set forth in the Schedule of Benefits (Appendix IIIa-c).

9.3.5 **Surgical and Attendance Fees**

This benefit shall mean surgeon's fees actually charged for the surgical operation(s) performed for treatment of the disability and will be paid according to the classification of operation and subject to the maximum benefit limit as shown for the operation in the Schedule of Benefits. The classification is in accordance with a schedule approved by appropriate professional body and adopted by the appointed Underwriter. You are strongly urged to check this Classification Schedule with the Underwriter at its hotline, and to request from your Surgeon an estimated costs (which should include attendance by the surgeon during hospital confinement), before undergoing any type of surgical procedure other than emergency operations. The benefit payable is subject to the following: -

(a) If a claim case involves more than one surgical procedures and are supported by more than one discrete disability respectively, then irrespective of whether the surgical procedures are performed through a single incision or different incisions at the same surgical session, the respective maximum reimbursable limits will be determined by the classification of the surgical procedures that have been undertaken respectively.

(b) If there is only one disability but involves more than one surgical procedure, then no matter they are done in one or more than one surgical session, reimbursement for expenses of all such procedures shall not exceed the maximum benefit limit of the operation that has the highest classification among all the other surgical procedures performed.

(c) If any alternative procedures [including but not limited to X-ray, any other radioactive substances (except chemotherapy & radiotherapy), cryosurgery and radium] are used for treatment in place of any cutting operation listed in the Classification Schedule, the Underwriter will, subject to all of the other provisions for Surgical Benefit, pay a benefit which is usual and customary for such treatment up to the amount provided for in the Schedule of Benefits (Appendix IIIa-c) with reference to the Classification Schedule, whichever is applicable, subject to the maximum limits as specified therein.

(d) **Outpatient Surgery Cash Allowance** (equivalent to the maximum daily benefit limit of Room and Board of one day) would be payable to Scheme members if they go through any one of the following surgical procedures that are reimbursable under the Surgical Fees but are done in outpatient setting, such as doctor's clinic or a day case centre: (i) Arthroscopy, (ii) Bronchoscopy, (iii) Colonoscopy, (iv) Colposcopy, (v) Cystoscopy, (vi) Esophagogastroduodenscopy, (vii) Haemorrhoid Artery Ligation (HAL)/ Rubber Band Ligation (RBL), (viii) Hysteroscopy, (ix) Loop Electrosurgical Excision Procedure (LEEP) and (x) Stapled Haemorrhoidectomy; notwithstanding this allowance is not on the benefits schedules, such provision will be exceptionally arranged by Bupa during 2024-25.

9.3.6 **Anaesthetist's Fees**

Benefits are payable for the actual charges made by the Anaesthetist subject to the maximum limits provided for in the Schedule of Benefits (Appendix IIIa-c).

9.3.7 **Operating Theatre Charge**

Benefits are payable for the use of the operating theatre for carrying out any surgical procedure during hospital confinement subject to the maximums set forth in the Schedule of Benefits (Appendix IIIa-c).

9.3.8 **In-hospital Specialist Fees (Non-surgical)**

A benefit shall be paid in an amount equal to the actual charges made by a Specialist (non-surgical) to whom the Member has been referred by the attending Physician or Surgeon for another disability during hospital confinement but in no event shall exceed the maximum limit as set forth in the Schedule of Benefits (Appendix IIIa-c).

## 9.4 <u>Supplementary Major Medical Benefits</u>

9.4.1 The supplementary major medical benefits (SMM) is designed to provide a higher protection to members for in-patient charges incurred which is medically necessary, reasonable and customary while in hospital; and with the following features:

(a) Such benefit will make reimbursement up to the reimbursement percentage (as listed below) for expenses in excess of the itemised hospital and surgical benefits as set out in Part A of the Schedule of Benefits, subject to the lump-sum maximum limit per disability as put under Part B of the Schedule of Benefits.
(b) Normally, SMM is not payable for any excess in room, board and general nursing care charges.
(c) A payment of a fixed deductible per confinement/claim is needed (please refer to Appendix IIIa-c).
(d) Members are advised to take note of their eligible room type in respect of their Benefit Group. Scenarios (4) to (6) below illustrate cases of a member staying in a room type higher than his/her entitlement:

| | Entitlement | Room Type where Treatment is received | Reimbursable % |
|---|---|---|---|
| (1) | Ward | Ward | 80% |
| (2) | Semi-private | Semi-private | 80% |
| (3) | Private | Private | 80% |
| (4) | Ward | Semi-private | 50% |
| (5) | Semi-private | Private | 50% |
| (6) | Ward | Private | 25% |

9.4.2 During the agreement period of 2024-25, Bupa allows SMM to cover shortfall of the following items:

(a) daily room, board and general nursing care charges;
(b) day surgery done at out-patient setting;
(c) advanced diagnostic scanning;
(d) cancer treatment listed in the Hospital Authority Drug Formulary done in out-patient setting; and
(e) renal dialysis treatments done in out-patient setting.

However, the above privileged offers from Bupa cannot be guaranteed beyond scheme year 2024-25 or when the University appoints another Underwriter.

9.4.3 Illustration:

Group II member (Basic Plan)
Eligible Room Type : Semi-private
No. of Hospitalisation Days : 5 days
Operation : Intermediate level

| **Itemised Benefit at Part A** | **($) Entitled Benefit** | **($) Presented Amount** | **($) Reimbursed Amount** | **($) Shortfall Amount** |
|---|---|---|---|---|
| Room & Board | 710/day | 4,000 | 3,550 | 450 |
| Miscellaneous Hospital Service | 14,000 | 14,000 | 14,000 | - |
| Surgical Fees | 11,800 | 16,000 | 11,800 | 4,200 |
| Anaesthetist's Fees | 4,130 | 4,600 | 4,130 | 470 |
| Operating Theatre | 4,130 | 4,000 | 4,000 | - |
| Total reimbursement under Part A | | 42,600 | 37,480 | **5,120** **(Claimable Amount for Part B)** |
| **Lump-sum Benefit at Part B** | | | | |
| ($5,120 – $500[#]) x 80% | 80,000 | | 3,696 | |
| **Total Reimbursement under Part A & Part B** | | 42,600 | 41,176 | **1,424** **(Net Shortfall)** |

[#] deductible limit per confinement

Shortfall Expenses to be borne by the member: $1,424; Reimbursement ratio: 96.6%

9.5 **Voluntary Plan**

9.5.1 Members may on a voluntary basis, pay an additional premium at their own expense, opt for the Voluntary Plan – Sapphire Plan to upgrade their Hospitalisation Benefits. The Schedule of Benefits under the Voluntary Plan, showing the upgraded benefits levels are shown at Appendix IIIa-c.

9.5.2 **Conditions to Note:**

(a) Participation in the Voluntary Plan is on a family basis, including all eligible family member(s) who have opted medical benefits from the University.

(b) Participation in the Voluntary Plan is on an annual basis, from 1 July (or from the date of assumption of duty in case of a new appointee) to 30 June of the following year. Staff members will be invited to signify their options to join or continue participating in the Voluntary Plan before the commencement of each Scheme Year on 1 July as requested by the Underwriter.

(c) If no enrolment is received by the deadline that HRO announces every year, staff members will be deemed having decided not to participate in the Voluntary Plan as of 1 July of the year and the hospitalisation benefits (including those for their eligible family members) under the Integrated Medical Scheme will be covered under the Basic Plan only.

(d) By signifying the option to join or continue participating in the Voluntary Plan, the staff member agrees and authorizes the payment of the required premium being made by payroll deduction.

(e) Members cannot withdraw from the Voluntary Plan during the course of the Scheme Year. If Staff leave the University service, or their eligible family members have to leave the Scheme for any reason (e.g. reaching the age limit), their membership in the

Voluntary Plan will lapse automatically and the remainder of the premium will not be refunded.

(f) Bupa exceptionally allows upgrade of benefits from Basic to Voluntary Plan without the following restriction on annual enrolment during 2024-25, as below:

- If a member is afflicted with an illness, it is the market norm that the upgrade of benefits will only take effect after a clean record of 90 days following the latest medical treatment for the same illness.

*This privileged offer from Bupa cannot be guaranteed beyond scheme year 2024-25 or when the University appoints another Underwriter.*

(g) All other terms and conditions apply to the Basic Plan are also applicable under the Voluntary Plan.

9.6 **Claim Procedures**

Members have to:

(a) Settle the hospital bill first and obtain an official receipt with full details from hospital, with the following items clearly shown on the receipt: -

- patient's full name
- period of hospitalisation or date of day ward charges or date of clinical operation performed
- diagnosis
- operation performed (if applicable, with full description of the procedure(s) involved)
- name(s) of all the attending doctors / surgeons
- signature of the doctor
- charges (with detailed breakdown)

*Note: Please be assured that all the above information necessary for process of reimbursement will be treated in the strictest confidence by the Underwriter.*

(b) Download a Hospital & Day Surgery Claim Form from the website of FO, HRO, or the Underwriter and complete the required information by you and the attending doctor. You are advised to get a copy of the Form ready and have your doctor completed all the medical related information before you are discharged from hospital or leaving a day case medical centre so as to avoid any unnecessary charges.

(c) Follow the claims procedures outlined by the Underwriter and make online submission whenever possible, as it is efficient and convenient. Alternatively, members may opt to submit their paper claims directly to the Underwriter by mail. It is important to note that all claims must be submitted within 90 calendar days from the date of discharge or consultation. Any submission beyond this timeframe will result in rejection by the Underwriter.

(d) For medical claims submitted online, the Underwriter may request the original copies for audit purpose, so please keep the original documents for six months from the date of claim submission.

(e) e-Claims service is not applicable if Members need the return of certified true copy of receipts for filing another claim to a second insurer.

(f) All allowable reimbursements will be credited to the Staff Member's medical claim reimbursement bank account via autopay within two weeks upon receipt by the Underwriter if adequate information is provided. If cases are being rejected, the reason for rejection will be conveyed to you in two weeks' time. Staff members can update the medical claim reimbursement bank accounts via myBupa portal, while any subsequent updates to the HKBU payroll bank account will be sent to Bupa. These updated bank account details will replace the existing accounts used for receiving medical claim reimbursements. No notification about these changes will be sent to the staff member, as this is standard practice.

## 10. DENTAL BENEFITS

### 10.1 Extent of Coverage

Under the Scheme, coverage for primary and secondary dental treatment is provided at the University appointed dental group. The coverage of primary dental care is in accordance with a list of primary dental care items and the cost of secondary dental treatment incurred at dentists' clinics of the same appointed dental group will only be partially reimbursed. Please refer to Appendix IVa-b for the classification and description of the dental care items.

#### 10.1.1 Primary Dental Care

Adopting the model of Managed Care, the University pays an annual fee per head for all members to the appointed dental group. Within the scope of Primary Dental Service (see Appendix IV-a), there is no need for members to pay any extra charges and neither is there any reimbursement procedure to follow. Members may visit any dental clinics of the group (listed at Appendix IV-e) for service subject to prior appointment be made and Staff ID / Affiliate card being presented at time of consultation. For members aged below 15, they are required to bring along an identity document with photo (e.g. HKID, passport, school handbook) on top of the Affiliate card for verification.

#### 10.1.2 Secondary Dental Care

(a) Only secondary dental treatment provided at the appointed dental group will be partially covered. The University will be responsible for a maximum of 50% of the quoted reference prices listed at Appendix IV-b or 50% of the actual amount charged by the service provider, whichever is lower, and subject to an annual cap per member as specified in the same Appendix. Members should clarify with the attending dentist the service charge for the required services before committing the treatment.

(b) Subject to the same rules for claiming reimbursement, secondary dental care performed by specialists at the appointed dental service provider will also be claimable, though the listed quoted reference prices are based on fees charged by general dentists.

### 10.2 Claim Procedures

There is no claim procedures for Primary Dental Care treatment. As for Secondary Dental Care treatment, you should pay the bills in FULL, present a Secondary Dental Care Form (downloadable from FO/HRO's website) for the attending dentist's completion, and obtain an official receipt after treatment. In accordance with the regulations, you should submit the aforementioned documents (duly completed and signed) via the e-Medical Claims System **within one month (30 days)** from the date of treatment for FO's processing. The entitled reimbursement will be deposited directly to Staff Member's payroll bank account.

## 11. MATERNITY BENEFITS

### 11.1 Description of Benefits

For the purpose of this Scheme, the University regards pregnancy as a physical condition rather than an illness and it is therefore not included as an item for medical treatment. This benefit covers any cause, condition or complications resulting from any one pregnancy, childbirth, miscarriage or legal abortion. It is available to female member or the female eligible spouse. Coverage of pregnancy and maternity related expenses will be subject to the maximum benefit limit listed in the schedule of benefits and the member contributory percentage detailed at Appendix V. Eligibility for this benefit are subject to the following guidelines:

(a) Member claiming for Maternity benefit should have completed 40 weeks of continuous service in the University prior to the expected date of her or his spouse's commencement of maternity leave.

(b) Female member and spouse of male member may consult any Registered Medical Practitioners of their own choice.

(c) Classification of the Benefits Groups is the same as that for hospitalisation and the amounts quoted at Appendix V are maximum reimbursable limits which include expenses incurred for ante-natal & post-natal check-up within 6 weeks from the date of delivery/miscarriage.

(d) The benefit limit will not be raised for multiple births.

(e) For natural / spontaneous abortion (i.e. miscarriage) after 24 weeks of pregnancy, the hospital confinement benefit will be paid.

(f) Members on no-pay maternity leave will not be eligible for any maternity benefits, including reimbursement for pre-natal & post-natal check-up.

### 11.2 Claim Procedures

If you need to claim maternity benefits, you should submit e-Claims using the e-Medical Claims System and attach all relevant receipts. You should keep the receipts for ante-natal / post-natal check-ups and hospital bill for delivery and claim for reimbursement of these incurred expenses **in one lot within 1 month (30 days) after the maternity case has been concluded.** If you are taking maternity leave, claim for reimbursement should be submitted **within 1 month (30 days) after your resumption of duty**. The entitled reimbursement will be deposited directly to Staff Member's payroll bank account.

## 12. PREVENTIVE CARE

12.1 The Scheme provides a modest subsidy (please refer to Appendix VI) towards physical check-up for all eligible staff members aged 35 or above. Female staff members aged 35 and above may perform gynaecological check-up as part of the physical check-up but the total entitlement is subject to the same maximum reimbursable limit (please refer to Appendix VI).

12.2 The current mechanism has the flexibility of allowing claims in alternate years for a combined 2 years' benefit limit, subject to the guidelines as appended at Appendix VI.

12.3 Staff have to first settle the medical bill in full; claims for reimbursement can then be made via the e-Medical Claims System **within one month (30 days)** from the date of receipts. Please pay attention to the regulations which governed e-Claims.