Frequently Asked Questions for Insurance Companies (2022.07.01)

Content

Company Registration

Q1. Can a company apply for registration as a VHIS Provider before obtaining authorisation from the Insurance Authority ("IA") to underwrite insurance contract?

A1. Yes, provided that the company has obtained approval-in-principle granted by IA to underwrite insurance contract that either falls within Class 2 (sickness) of Part 3 of Schedule 1 to the Insurance Ordinance (Chapter 41) or combines long term business and additional business of the nature in relation to Class 2 (sickness) following paragraph 3 of Part 1 of Schedule 1 to the Insurance Ordinance (Chapter 41). Under such circumstances, the Health Bureau will process the application from the company for registration as a VHIS Provider. However, the Health Bureau will not approve the application unless and until the company has obtained the required authorisation from IA.

Q2. Is it necessary to submit Standard Plan for product certification alongside application for registration as a VHIS Provider?

A2. Yes. It is necessary because all registered VHIS Providers are required to offer Standard Plan in the market at all times.

Q3. Is there any requirement in terms of position held in the company for the staff who take up the roles of Authorised Person, Product Officer and Complaint Officer?

A3. There are no specific requirements, but the designated staff should be considered by the company fit and proper to take up the roles.

Q4. Can a designated staff take up more than one role among Authorised Person, Actuary, Product Officer and Complaint Officer?

A4. Yes.

Q5. Is the registration status as a VHIS Provider effective immediately upon notification of successful application?

A5. Yes, unless the Health Bureau indicates otherwise and specifies a later effective date.

Q6. Can a company request a later effective date in the application for registration as a VHIS Provider?

A6. Yes. Such request should be stated in the appropriate space of the application form, and will be considered by the Health Bureau on a case-by-case basis.

Q7. Are the companies de-registered as VHIS Providers still required to comply with the requirements stipulated in the Scheme Documents?

A7. Yes, to the extent of those requirements in the Scheme Documents that apply to the de-registered companies specifically. For example, the de-registered companies are required to renew the VHIS policies already issued according to the relevant requirements stated in Part 4 of the VHIS Certified Plan Policy Template (hereafter "Policy Template"), and observe the Code of Practice for Insurance Companies under the Ambit of the VHIS (hereafter "Code of Practice") as far as these policies are concerned.

Code of Practice

Q8. Is it necessary for VHIS Providers to issue both English and Chinese versions of the policy documents (e.g. policy terms and conditions, benefit schedule) to the policy holders?

A8. No. VHIS Providers are allowed to issue either English or Chinese version to the policy holders. Nevertheless, VHIS Providers are required to issue a version among these two language versions as requested by the policy holders.

Q9. Is it necessary for the policy holders and/or insured persons of VHIS policies to be Hong Kong residents?

A9. According to the Code of Practice for Insurance Companies under the Ambit of VHIS, the participating insurance companies are required to consider applications for Certified Plans in relation to insured persons being Hong Kong residents aged between 15 days and 80 years. However, it is at the discretion of the companies whether to consider applications in relation to insured persons being non-Hong Kong residents according to their business practices, and VHIS policies will not be eligible for tax deduction if the insured person is not a holder of Hong Kong Identity Card. VHIS Providers are required to remind the consumers during the selling process and upon enquiry about this. For details, see Section 26K of the Inland Revenue (Amendment) (No.8) Ordinance 2018.

Q10. Are VHIS Providers required to offer migration for the existing individual policy holders of indemnity hospital insurance plans (IHIP) if some benefits have been exhausted permanently (e.g. where benefits are counted per disability) ?

A10. Yes, VHIS Providers are required to offer migration for the individual policy holders of IHIP policies that had been effective before VHIS was implemented on 1 April 2019. Moreover, all benefits will be counted afresh upon migration to VHIS policies. For details, see Chapter 3 of the Code of Practice.

Q11. Are VHIS Providers allowed to re-underwrite the existing IHIP policies during the migration process?

A11. If migration is arranged in the form of renewal into the same plan with VHIS features incorporated, re-underwriting is not allowed unless the existing policy provisions do not provide guaranteed renewal. If migration is arranged in the form of option to convert into a different plan with VHIS features incorporated, re-underwriting is allowed subject to certain requirements. For details, see Chapter 3 of the Code of Practice.

Q12. Are there any other options that VHIS Providers are required to offer to the customers, if they decline the migration offer to renew their existing policies into Certified Plan policies, according to the arrangement under Section 3.4(a) of the Code of Practice?

A12. If the plan offered for renewal is a Flexi Plan, VHIS Providers are required to allow the existing customers, who decline the offer, to renew their policies into the Standard Plan policies. This requirement is not applicable if the plan offered for policy renewal is a Standard Plan. In any event, VHIS Providers are required to make the relevant information known to the customers when notifying them of the migration arrangement.

Q13. Are there any other options that VHIS Providers are required to offer to the customers if they decline the migration offer to opt for a Certified Plan policy according to the arrangement under Section 3.4(b) of the Code of Practice?

A13. Irrespective of whether the plan offered for migration is a Standard Plan or a Flexi Plan, VHIS Providers are required to allow the existing customers, who decline the offer, to stay insured with their existing policies according to the existing policy provisions. If the plan for migration is a Flexi Plan, VHIS Providers are also required to allow the existing customers, who decline the offer, to opt to convert into a Standard Plan.

Product Compliance and Certification

Q14. Apart from different definitions, are there any other key differences between Enhanced Benefits and Other Benefits?

A14. Enhanced Benefits may be an embedded or optional product feature of a Certified Plan while Other Benefits must be an embedded product feature. Besides, the actuarially fair value of Enhanced Benefits is unrestricted while the actuarially fair value of Other Benefits must not exceed 10% of the actuarially fair value of the entire Certified Plan.

Q15. What are counted towards the actuarially fair value of a Certified Plan and what are not?

A15. Actuarially fair value refers to the cost of insurance and services for the benefit items of Certified Plans, including the estimated claims cost, and the cost of providing services where the benefit item involves service content (e.g. body check-up). Administrative overhead (such as policy administration and claims processing expenses), sales and marketing expenses (such as advertising expenses, commission expenses, and promotional discounts and bonuses), and profit margins are not counted.

Q16. If some benefits of the nature of Other Benefits do not fulfill the complying requirements (e.g. without guaranteed renewal or exceeding the 10% threshold of actuarially fair value), can they be packaged as non-VHIS insurance benefits which are offered to the buyers of the Certified Plan for free or with a premium?

A16. Yes, provided that –

(a) the policy terms and conditions for the non-VHIS insurance benefits must not contradict the objectives of the VHIS, and must not reduce the protection of the Certified Plans to the policy holders if the VHIS and non-VHIS benefits are provided by the same policy;
(b) VHIS Providers must make known to the consumers during the selling process and upon enquiry that the non-VHIS insurance benefits in this case do not form part of the Certified Plan, and so the attributable premium is neither subject to the VHIS regulation nor eligible for tax deduction;
(c) the premiums charged for the Certified Plan part must fulfill the interpretation of qualifying premiums for tax deduction under Section 26I and 26K of the Inland Revenue (Amendment) (No.8) Ordinance 2018;
(d) the concurrent uptake of the non-VHIS insurance benefits must not be a prerequisite for accepting application in the case of Standard Plan under the VHIS; and
(e) the cross-selling activities involved must not contravene the rules of VHIS and any applicable statues, laws, rules, regulations, codes or guidelines.

Q17. Section 6.5 of the Product Compliance Rules under the Ambit of the VHIS (hereafter "Product Compliance Rules") sets out the criteria for granting partial exemption to Flexi Plans from certain complying requirements, including "no lifetime benefit limit" and "no deductible". Amongst them, there is a criterion about removal of at least 10 out of the 12 itemised benefit limits under the Standard Plan framework. Does this criterion only cover benefit limits in dollar terms, or cover all benefit limits including the maximum number of days for room and board benefits in a policy year?

A17. This criterion only covers the benefit limits in dollar terms.

Q18. Is there any difference in complying requirements for no-claim discount (NCD) and no-claim bonus not in the form of cash (NCB)?

A18. If NCD is provided in a form of premium discount for the policy holders who have not made claims for a pre-defined period, it is considered a pricing decision which will not be regulated by the Health Bureau. Yet for the sake of premium transparency, the details of the premium discount have to be made clear to the consumers during the selling process and upon enquiry.

If NCB is provided in a form of benefit upgrade when there is no claim made during a pre-defined period, it is considered either an Enhanced Benefit or Other Benefit, depending on the nature of the upgraded benefit. The complying requirements of Enhanced Benefits or Other Benefits will apply accordingly.

Q19. Can "age" be defined differently among Certified Plans?

A19. As far as the policy terms and benefits of Certified Plans are concerned, "age" must universally refer to the attained age, i.e. "age last birthday".

As far as the premium schedule is concerned, the age definition may have 3 allowable variations including "age last birthday", "age next birthday" and "age nearest birthday". The definition adopted must be made clear to the consumers during the selling process and upon enquiry.

Q20. Where a Flexi Plan targets at a particular age group (e.g. younger people), is it exempt from the requirement of guaranteed renewal up to the age of 100?

A20. No, the Flexi Plan in entirety is still subject to guaranteed renewal up to the age of 100. Yet subject to the approval by the Health Bureau, the benefit levels of individual Enhanced Benefit or Other Benefit items within a Flexi Plan (e.g. inpatient maternity benefit as an Enhanced Benefit or outpatient maternity benefit as an Other Benefit) may be reduced according to a preset schedule (e.g. by age) at policy inception. For details, see Section 4.5 and 5.8 of the Product Compliance Rules.

Q21. Can a Certified Plan offer guarantee renewal beyond the age of 100?

A21. Yes. As this feature exceeds the minimum complying requirements of VHIS and is not one of the minor allowable variations prescribed in the Policy Template, the insurance plan concerned will be considered as a Flexi Plan in product certification.

Q22. Can a Certified Plan share the same marketing name with another Certified Plan or a non-VHIS plan offered by the same VHIS Provider? What about sharing the same marketing name with another insurance plan offered by another company?

A22. Sharing of the same marketing name with another insurance plan offered by the same VHIS Provider is not allowed so as to avoid confusion to the consumers. The Health Bureau will not regulate sharing of the same marketing name with another plan offered by another company but the companies concerned would need to observe relevant laws including the Trade Marks Ordinance (Chapter 559).

Q23. If a Flexi Plan provides customers with different choices of combinations between Basic Benefits and Enhanced/Other Benefits (e.g. choices by ward class and optional Supplementary Major Medical (SMM) cover), can these combinations share the same marketing name?

A23. Certified Plans with variation limited to benefit limits, target ward class and/or currency denomination are allowed to adopt the same marketing name. However, different combinations will be considered by the Health Bureau as unique Certified Plans and so unique product certification number will be assigned for each combination. In order to avoid confusion to the consumers, the Health Bureau may indicate additional description after the marketing name on the official VHIS website (e.g. ward class) where appropriate. For details, see Section 12 of the Product Compliance Rules.

Q24. Under the circumstances in Q.23, how many application forms are required in the product submission for certification?

A24. Only one application form is required. The application form asks for the relevant information.

Q25. Are VHIS Providers allowed not to consider applications for Certified Plan that involve more than one insured persons or policy holders?

A25. As Certified Plans are not allowed to cover multiple insured persons, VHIS Providers should not consider the relevant applications and should explain this to the consumers during the selling process and upon enquiry. As to multiple policy ownership, VHIS Providers are allowed to consider the relevant applications in accordance with their prevailing underwriting practices which must be consistently applied to all VHIS customers. Besides, all VHIS policies with multiple policy holders are required to adopt the standardised policy terms and conditions under Part 9 of the Policy Template.

Q26. If there are more than one policy holders, is it necessary to appoint a Representative Policy Holder in the VHIS policy?

A26. No. If Representative Policy Holder is not appointed, any instruction or notice to the insurers shall be given jointly by all policy holders and vice versa. For details, see Section 2 of Part 9 of the Policy Template.

Q27. According to Section 1(a), (c) and (d) of Part 6 of the Policy Template, Flexi Plans may specify the choice of territories, healthcare service providers and/or ward class for the higher/enhanced coverage, but the limitation shall not apply to the terms and benefits within the scope of Standard Plan Terms and Benefits. What does this mean?

A27. This means that that the expenses incurred in the territories, healthcare service providers and/or ward classes excluded (or not specified for inclusion) in the higher/enhanced coverage of the Flexi Plans are still claimable, but the clams calculation will be based on the Standard Plan Terms and Benefits published by the Health Bureau rather than the Flexi Plans concerned. Assuming that there is a Flexi Plan targeting at semi-private ward class and excluding the United States in its territorial coverage, and that a person insured with this plan receives inpatient treatment in a semi-private ward of a hospital in the United States, he/she can only claim the relevant expenses up to the benefit limits of the Standard Plan (e.g. HK$750 for daily room and board expenses). See Q.31 - Q.35 for more illustrative examples.

Subject to approval by the Health Bureau, a Flexi Plan may also specify whether the claims made in the situation mentioned above are counted towards the annual benefit limit of the plan or subject to other limitation rules of the plan (e.g. deductible if any). See also Q.29.

Q28. Are Flexi Plans allowed to exclude coverage of treatments or services received in certain hospitals outside of Hong Kong (e.g. hospitals lower than Grade 3A in the mainland of China)?

A28. Yes, but the treatments or services received in the excluded hospitals are still claimable according to the Standard Plan Terms and Benefits published by the Health Bureau. See also Q.27.

Q29. Under the situations in Q.27, are there any complying requirements on the content of the limitation?

A29. The limitation must not compromise the "better-off principle" and the principle of clarity. According to Section 1 of the Product Compliance Rules, the design of Flexi Plans must adhere to the "better-off principle" entailing terms and benefits that will bring more protection to the customers when compared with a Standard Plan while policy holders' entitlement to the Basic Benefits would not be adversely affected, save for the exceptions in Section 6.5. In other words, even though Flexi Plans may impose limitations on certain coverage, the limitation shall **not** undermine the basic protection offered under the Standard Plan.

By the principle of clarity, the terms of the limitation must be clear and must provide at least the following information –

(a) All the relevant definitions e.g. which territories are excluded, which healthcare service providers are included, and how different ward classes are defined;
(b) Other criteria to trigger the limitation e.g. voluntary ward upgrade;
(c) All the adjustment rules e.g. the percentage of downward benefit adjustment by scale of upgrade, the basis of adjustment by benefit limit or eligible expenses;
(d) Coordination with other limitations e.g. which limitation to apply first in claims settlement if deductible and ward upgrade limitation co-exist; and
(e) Detailed arrangements if the eligible expenses are claimable under the Standard Plan scenario according to the "better-off principle", e.g. whether the calculated claims are still subject to the benefit limitation rules of the Flexi Plan (e.g. itemised and annual benefit limits, deductible), whether the expenses in excess of the benefit limits under the Standard Plan scenario are still claimable under the Flexi Plan scenario, and whether the policy holders can opt for claims settlement for all eligible expenses under the Flexi Plan scenario if the adjusted claims outcome is more favorable than the unadjusted claims outcome under the Standard Plan scenario.

Q30. For the Flexi Plans allowed to have lifetime benefit limit according to Section 6.5 of the Product Compliance Rules, what are the obligations of the VHIS Providers for the policy holders if the lifetime benefit limit has been reached?

A30. As in the case of all Flexi Plans, the VHIS Providers are required to provide the policy holders with the option to switch to the Standard Plan without re-underwriting upon policy renewal. If a policy holder has claimed up to the lifetime benefit limit, the VHIS Provider concerned is still required to provide such an option upon (or before) next policy renewal, thereby enabling the policy holder to enjoy continuous protection under the Standard Plan coverage up to the age of 100. For the relevant scheme rules, please see Section 2.11 of the Code of Practice and Section 4 of Part 4 of the Policy Template.

Claim settlement

Q31. Mr. Wong is insured under a Flexi Plan with ward class being targeted at semi-private wards. According to the policy terms and conditions of the Flexi Plan, (i) an adjustment factor of 50% will be applied to the eligible expenses if a higher ward class is used voluntarily; and (ii) the excess of expenses over benefit limits under the Standard Plan scenario will not be eligible for further claims settlement. Mr. Wong recently underwent a surgery in a hospital and opted for private ward accommodation voluntarily. The expense incurred was HK$100,000. What is the claims amount payable to Mr. Wong?

A31. Since the ward upgrade is voluntary, the eligible expenses are subject to the 50% adjustment before claims settlement under the Flexi Plan. According to the "better-off principle", the claims outcome with adjustment must be no less favourable than the claims outcome without adjustment under the Standard Plan scenario. See the following calculation for illustrative purpose whereby the claims amount payable to Mr. Wong is HK$45,000.

Items	Amount (HK$)
(a) Expenses incurred	100,000
(b) Expenses incurred after 50% adjustment under the Flexi Plan scenario	= (a) x 50% = 50,000
(c) Assumed benefits payable under the Flexi Plan scenario	40,000
(d) Assumed benefits payable under the Standard Plan scenario based on unadjusted expenses at HK$100,000	45,000
(e) Final claims payable: whichever higher of (c) and (d)	= Max. [(c), (d)] = 45,000

Q32. What if the Flexi Plan in the example of Q.31 has a deductible of HK$10,000 per policy year (as a special exemption granted by the Health Bureau)?

A32. Assuming that the policy terms and benefits have stipulated that the eligible expenses shall have the ward upgrade adjustment factor applied prior to the deductible and that the deductible shall apply irrespective of whether adjustment for ward upgrade applies or not, the calculation will be revised as follows and the claims amount payable to Mr. Wong will become HK$35,000.

Items	Amount (HK$)
(a) Expenses incurred	100,000
(b) Expenses incurred after 50% adjustment under the Flexi Plan scenario	= (b) x 50% = 50,000
(c) Assumed benefits payable under the Flexi Plan scenario	40,000
(d) Assumed benefits payable under the Standard Plan scenario based on unadjusted expenses at HK$100,000	45,000
(e) Compare (c) and (d), whichever higher	= Max. [(c), (d)] = 45,000
(f) Less: deductible	(10,000)
(g) Final claims payable	= (e) – (f) = 35,000

Q33. Mrs Tam is insured under a Flexi Plan with the United States excluded from its worldwide cover. She was recently confined in a hospital in the United States with expenses incurred at HK$40,000. What is the claims amount payable for this confinement?

A33. The expenses are only claimable up to the coverage equivalent to the Standard Plan. See the following calculation for illustrative purpose whereby the claims amount payable to Mrs Tam is HK$30,000.

Items	Amount (HK$)
(a) Expenses incurred	40,000
(b) No benefits payable under the Flexi Plan scenario as the treatment is received in excluded territories	0
(c) Assumed benefits payable under the Standard Plan scenario based on expenses incurred at HK$40,000	30,000
(d) Final claims payable: whichever higher of (b) and (c)	= Max. [(b), (c)] = 30,000

Q34. Miss Chan is insured with a Flexi Plan that restricts the choice of doctors to a prescribed list. She recently underwent a day surgery and the surgeon is not on the prescribed list. The expenses incurred amounted to HK$15,000. What is the claims amount payable?

A34. The expenses are only claimable up to the coverage equivalent to the Standard Plan. See the following calculation for illustrative purpose whereby the claims amount payable to Miss Chan is HK$12,000.

Items	Amount (HK$)
(a) Expenses incurred	15,000
(b) No benefits payable under the Flexi Plan scenario as the doctor providing services is not on the prescribed list	0
(c) Assumed benefits payable under the Standard Plan scenario based on expenses incurred at HK$15,000	12,000
(d) Final claims payable: whichever higher of (b) and (c)	= Max. [(b), (c)] = 12,000

Q35. What if Miss Chan in the example of Q.34 has made claims earlier in the policy year and given the annual benefit limit, the remaining benefit balance payable is HK$5,000 for the year?

A35. The claims amount payable to Miss Chan becomes HK$5,000 in this example.

Items	Amount (HK$)
(a) Expenses incurred	15,000
(b) No benefits payable under the Flexi Plan scenario as the doctor providing services is not on the prescribed list	0
(c) Assumed benefits payable under the Standard Plan scenario based on expenses incurred at HK$15,000	12,000
(d) Final claims payable: whichever higher of (b) and (c)	= Max. [(b), (c)] = 12,000
(e) Remaining benefit balance payable at HK$5,000 given the annual benefit limit of the current policy year	5,000
(f) Final claims payable: whichever lower of (d) and (e)	= Min. [(d), (e)] = 5,000

Q36. Mr. Law, aged 24, has been insured under a Certified Plan since 1 January 2020. In July 2021 (i.e. within his second policy year), he was diagnosed with pre-existing condition ABC and received a surgical treatment that charged him HK$18,000 in the same month. Are benefits payable for the treatment, and will the condition be covered by this policy upon renewal?

A36. If Mr. Law was not aware of the condition ABC when he applied for the Certified Plan coverage, it would be considered as an unknown pre-existing condition that can be covered by all Certified Plans subject to a waiting period of 3 years with reimbursement ratio at 0%, 25% and 50% respectively for the first 3 years. Since unknown pre-existing conditions are not subject to re-underwriting, the condition ABC will continue to be covered by the policy upon renewal. As regards the expenses incurred for the surgical treatment, the benefit payable would be partial as the treatment occurred in the second policy year. See the following calculation for illustrative purpose whereby the claims amount payable is HK$4,000.

Items	Amount (HK$)
(a) Expenses incurred	18,000
(b) Assumed benefits payable under the Certified Plan	16,000
(c) Final claims payable subject to 25% reimbursement as the treatment occurs in the second policy year	= 16,000 x 25% = 4,000

Q37. What if the condition ABC in the example of Q.36 is congenital in nature?

A37. According to Part 7 Section 12 of the Policy Template, congenital diseases that have manifested or been diagnosed when or after the insured person reached the attained age of 8 years are covered. Since Mr. Law was diagnosed with the condition ABC after the age of 8 years, it would be treated as an unknown pre-existing condition irrespective of whether ABC is a congenital disease or not.

Q38. Mr. Chung is insured under the Standard Plan. On 1 September of Year X, he was admitted to a hospital in Hong Kong as a result of mental breakdown. How are the expenses incurred during the confinement payable under the Standard Plan policy?

A38. All eligible expenses incurred during confinement in Hong Kong as recommended by a specialist doctor, including those for room and board, attending doctor's visit, prescribed medicine, relevant treatment and psychological consultation during the confinement, are covered under the benefit item of psychiatric treatments subject to the ceiling of $30,000 per policy year.

Q39. What if the expenses incurred in the example of Q.38 exceed the benefit limit of $30,000 per policy year for the benefit item of psychiatric treatments?

A39. The excess will not be covered by the Standard Plan. The excess may be covered by the Flexi Plan, though, depending on the product design (e.g. higher benefit limit, supplementary major medical coverage).

Q40. Does the claim for expenses incurred in the example of Q.38 affect Mr. Chung's entitlement to other benefit items (e.g. maximum 180 days per policy year for room and board)?

A40. No, the expenses claimed under the benefit item for psychiatric treatments would not be counted towards the itemised limits of other benefit items in the benefit schedule of the Standard Plan.

Q41. Mr. Lam is insured under the Standard Plan. On 1 September of Year X, he was admitted to a hospital in Hong Kong as a result of mental breakdown. On 6 September of the same year, he was injured in a slip-and-fall accident in the hospital and underwent a surgery afterwards. How would the expenses incurred be payable by the psychiatric benefits in the benefit schedule? What about those expenses like room and board that cannot be broken down by the two different diagnoses?

A41. The expenses related to mental breakdown would be covered by the psychiatric benefits while those related to the slip-and-fall accident would be covered by other benefit items. For the expenses that cannot be so apportioned (room and board from 6 September onward), they would be covered by the psychiatric benefits as the confinement is initially for the purpose of psychiatric treatments. See the following example for illustrative purpose.

Diagnosis 1: 1 September - Admission – mental breakdown – treatment till discharge **Diagnosis 2: 6 September - Accident (a surgery is required) – treatment till discharge**		
Eligible expenses	**Psychiatric benefits**	**Other benefit items**
(a) Room and board[1]	✓	
(b) Misc - Medicine and drug[2]	✓	✓
(c) Misc - X-ray[3]		✓
(d) Attending doctor's visit fee[4]	✓	✓
(e) Surgeon's fee[3]		✓
(f) Anaesthetist's fee[3]		✓
(g) Operating theatre charges[3]		✓

[1] Room and board expenses from 6 September onward cannot be apportioned and would be covered by psychiatric benefits as the confinement is initially for psychiatric treatments.

[2] Expenses can be apportioned according to the prescription information.

[3] Expenses are solely for non-psychiatric treatments due to the slip-and-fall accident.

[4] Expenses can be apportioned according to the specialty of attending doctors.

Q42. What if in the example of Q.41, Mr. Lam no longer requires treatment for mental breakdown from 10 September onward but confinement is still required for treatment due to the slip-and-fall accident?

A42. The expenses related to mental breakdown would be covered by psychiatric benefits while those related to the slip-and-fall accident would be covered by other benefit items. For the expenses that cannot be so apportioned (room and board for 6-9 September), they would be covered by psychiatric benefits as the confinement is initially for the purpose of psychiatric treatments. For all the expenses from 10 September onward (including room and board), they would be covered by other benefit items as the confinement becomes solely for non-psychiatric treatments. See the following example for illustrative purpose.

On 1 September - Admission - mental breakdown – treatment till 9 September **On 6 September - Accident (a surgery is required) – treatment till discharge** **On 10 September – Treatment is no longer required for mental breakdown but confinement solely for treatment due to the accident is still required**		
Eligible expenses	**Psychiatric benefits**	**Other benefit items**
(a) Room and board	✓[1] (for 1-9 September)	✓[5] (10 September onward)
(b) Misc - Medicine and drug[2]	✓ (for 1-9 September)	✓ (6 September onward)
(c) Misc - X-ray[3]		
(d) Attending doctor's visit fee[4]	✓ (for 1-9 September)	
(e) Surgeon's fee[3]		
(f) Anaesthetist's fee[3]		
(g) Operating theatre charges[3]		

[1] Room and board expenses for 6-9 September cannot be apportioned and would be covered by psychiatric benefits as the confinement is initially for psychiatric treatments.

[2] Expenses can be apportioned according to the prescription information.

[3] Expenses are solely for non-psychiatric treatments due to the slip-and-fall accident.

[4] Expenses can be apportioned according to the specialty of attending doctors.

[5] Room and board expenses from 10 September onward are solely for non-psychiatric treatments and would be covered by the room and board benefit item.

Q43. What if in the example of Q.41, Mr. Lam was first admitted to the hospital on 26 August of Year X for undergoing a surgery for a fractured elbow, and was subsequently prescribed with medication for depression on 1 September?

A43. The expenses related to depression would be covered by the psychiatric benefits while those related to fractured elbow would be covered by other benefit items. For the expenses that cannot be so apportioned (room and board from 1 September onward), they would be covered by other benefit items as the confinement is initially for the purpose of non-psychiatric treatments. See the following example for illustrative purpose.

Diagnosis 1: 26 August - Admission – surgery for fractured elbow – treatment till discharge **Diagnosis 2: 1 September – Depression – treatment till discharge**		
Eligible expenses	**Psychiatric benefits**	**Other benefit items**
(a) Room and board[1]		✓
(b) Misc - Medicine and drug[2]	✓	✓
(c) Misc - X-ray[3]		✓
(d) Attending doctor's visit fee[4]	✓	✓
(e) Surgeon's fee[3]		✓
(f) Anaesthetist's fee[3]		✓
(g) Operating theatre charges[3]		✓

[1] Room and board expenses from 1 September onward cannot be apportioned and would be covered by the room and board benefit item as the confinement is initially for non-psychiatric treatments.

[2] Expenses can be apportioned according to the prescription information.

[3] Expenses are solely for non-psychiatric treatments due to elbow fracture.

[4] Expenses can be apportioned according to the specialty of attending doctors.

Q44. What if in the example of Q.43, Mr. Lam no longer requires treatment of fractured elbow from 3 September onward but confinement is still required for treating depression?

A44. The expenses related to depression would be covered by psychiatric benefits while those related to fractured elbow would be covered by other benefit items. For the expenses that cannot be so apportioned (room and board for 1-2 September), they would be covered by other benefit items as the confinement is initially for non-psychiatric treatments. For all the expenses from 3 September onward (including room and board), they would be covered by psychiatric benefits as the confinement becomes solely for psychiatric treatments. See the following example for illustrative purpose.

On 26 August - Admission – surgery for fractured elbow – treatment till 2 September **On 1 September – Depression – treatment till discharge** **On 3 September – Treatment is no longer required for fractured elbow but confinement solely for treating depression is still required**		
Eligible expenses	**Psychiatric benefits**	**Other benefit items**
(a) Room and board	✓[5] (3 September onward)	✓[1] (from 26 August to 2 September)
(b) Misc - Medicine and drug[2]	✓ (1 September onward)	✓ (from 26 August to 2 September)
(c) Misc - X-ray[3]		
(d) Attending doctor's visit fee[4]	✓ (1 September onward)	
(e) Surgeon's fee[3]		
(f) Anaesthetist's fee[3]		
(g) Operating theatre charges[3]		

[1] Room and board expenses for 1-2 September cannot be apportioned and would be covered by the room and board benefit item as the confinement is initially for non-psychiatric treatments.

[2] Expenses can be apportioned according to the prescription information.

[3] Expenses are solely for non-psychiatric treatments due to elbow fracture.

[4] Expenses can be apportioned according to the specialty of attending doctors.

[5] Room and board expenses from 3 September onward are solely for psychiatric treatments and would be covered by psychiatric benefits.

Q45. After the conditions have been diagnosed, certain investigations (e.g. blood tests, genetic tests) may be necessary before commencement of non-surgical cancer treatments to identify whether and which type of treatments suit the patients. Are the expenses incurred in such investigations covered by the Standard Plan?

A45. Yes, provided that the investigations are considered medically necessary by the doctor in charge for the purpose of treatment planning, and monitoring of prognosis and development during the course of treatment.

Q46. If cancer drugs falling within the definition of "prescribed non-surgical cancer treatments" under the Certified Plan Policy Template are taken at home according to the doctor's advice, are the drug expenses claimable?

A46. Yes, provided that the treatments involved must be prescribed by a Registered Medical Practitioner on the ground of medical necessity, regardless of the method of drug administration (including when and where a treatment is conducted) that the Registered Medical Practitioner considers appropriate.

Q47. How far does the Standard Plan cover dental treatment, and how far can a Flexi Plan provide dental benefits?

A47. Except for emergency dental treatment and dental surgery during confinement arising from an accident, dental treatment is not covered under Standard Plan. See Section 7 of Part 7 of the Certified Plan Policy Template for details.

Subject to the relevant compliance requirements stated in Chapter 4 of the Product Compliance Rules, the following benefits can be accepted as an Enhanced Benefit that forms part of a Flexi Plan –

(a) Inpatient emergency dental treatment (including dental surgery) not arising from an accident
(b) Inpatient non-emergency dental treatment (including dental surgery)
(c) Outpatient emergency dental treatment (including dental surgery)

Subject to the relevant compliance requirements stated in Chapter 5 of the Product Compliance Rules, the outpatient non-emergency dental treatment (including dental surgery) can be accepted as an Other Benefit that forms part of a Standard Plan or a Flexi Plan.

Q48. Are treatments of COVID-19 infection covered by VHIS?

A48. As in the case of all medically necessary treatments, eligible expenses on the treatments of COVID-19 infection (including expenses incurred for hospitalisation, day case procedures and prescribed diagnostic imaging tests in Hong Kong and elsewhere in the world) must be covered as part of the basic protection offered by all VHIS Certified Plans. The basic protection refers to the terms and benefits of Standard Plan or that part of Flexi Plans equivalent to the terms and benefits of Standard Plan.

Q49. What about treatments due to adverse reactions to COVID-19 vaccinations?

A49. The treatments likewise fall within the scope of basic protection offered by all VHIS Certified Plans. See Q.48 for details.

Q50. How to determine the surgical category if a surgical procedure performed is not included in the Schedule of Surgical Procedures under the Policy Template?

A50. If a surgical procedure performed is not included in the Schedule of Surgical Procedures, the VHIS Provider may reasonably determine its surgical category by making reference to the gazette published by the Government, or any other relevant publication or information including but not limited to the schedule of fees recognised by the government, relevant authorities and medical association in the locality where the surgical procedure is performed.

For purchase of the Government Gazette, please contact the Publications Sales Unit of the Information Services Department on 2537 1910 or visit the Online Government Bookstore at www.bookstore.gov.hk.

If the surgical procedure is not included in the Government Gazette or any other relevant publication or information, the classification should be determined by VHIS Provider by comparing the intensity and relativity of the surgical procedure concerned against the Schedule of Surgical Procedures/ surgical category in the Government Gazette.

Q51. Are value-added tax ("VAT") and goods and services tax ("GST") levied on medical fees and expenses charged by the authorities in the locality where the medical service is rendered covered by VHIS?

A51. Yes. VAT and GST levied on medical fees and expenses that fall within the benefit coverage of VHIS Certified Plans shall be payable as part of the Eligible Expenses according to the terms and benefits.

Q52. How would the VAT and GST stated in Q.51 be payable?

A52. (a) Where the VAT or GST is incurred on an itemised basis, the VAT and GST associated with a specific benefit item shall be counted towards the Eligible Expenses payable under that particular benefit item –

Medical Bill			**Claims handling**
Service Description	**Amount $**		**Eligible Expenses $**
1. Room and Board (3 days) Add: 7% VAT	800 56		800 + 56 = 856
2. Drugs / Prescriptions / Injections Add: 7% VAT	700 49		700 + 49 = 749
3. MRI Add: 7% VAT	1,500 105		1,500 + 105 = 1,605
4. Doctor's Fee Add: 7% VAT	1,000 70	→	1,000 + 70 = 1,070
5. Daily Nursing Fee Add: 7% VAT	600 42		600 + 42 = 642
6. Visitor's meals Add: 7% VAT	100 7		0
7. Accident & Emergency Attendance Fee (VAT exempted by the government)	1,000		1,000
Total	**6,029**		***Total Eligible Expenses* = 5,922***

**Final amount of Eligible Expenses payable shall be subject to the Terms and Benefits.*

(b) Where the VAT and GST is incurred in a lump sum without itemised breakdown, such lump sum should firstly be allocated to the relevant expense items on a pro-rata basis, then the VAT or GST allocated to a specific item should be counted towards the Eligible Expenses payable under that particular benefit item. See the following calculation example for illustrative purpose –

Medical Bill		**Claims handling**	
Service Description	**Amount $**	**GST Apportioned $**	**Eligible Expenses $**
1. Room and Board (3 days)	800	56	800 + 56 = 856
2. Drugs / Prescriptions / Injections	700	49	700 + 49 = 749
3. MRI	1,500	105	1,500 + 105 = 1,605
4. Doctor's Fee	1,000	70	1,000 + 70 = 1,070
5. Daily Nursing Fee	600	42	600 + 42 = 642
6. Visitor's meals	100	7	0
7. Accident & Emergency Attendance Fee (GST exempted by the government)	1,000	0	1,000
Sub-total (before GST)	5,700	***Total Eligible Expenses**** ***= 5,922***	
Add: 7% GST	329		
Total (including GST)	**6,029**		

**Final amount of Eligible Expenses payable shall be subject to the Terms and Benefits.*

Tax Deduction

Q53. Is there any restriction on the means of premium payment for the purpose of claiming tax deduction? (For example, if part or all of the premium payable are settled by cash dollars accumulated under a credit card, is the total amount of premium settled eligible for tax deduction?)

A53. There is no restriction on the means of premium payment provided that –

(a) the means is legal; and

(b) the means is accepted by the insurance company for the purpose of fulfilling the premium payment obligation of the policy holders as stated in the terms and conditions of the VHIS policies.

Q54. As it takes time to settle for certain payment forms like credit cards and bank cheques, the date of premium payment by the consumer may differ from the date of receipt by the insurer. With the understanding that the premium payment date is used for determining the relevant year of assessment for tax deduction, is there any definition of the premium payment date (e.g. date of premium paid by customer or date of premium received/recorded by insurance company if they are not the same day)?

A54. For the purpose of enabling the policy holders to claim tax deduction, all VHIS Providers have to issue premium payment records with the premium payment dates shown. The definition of premium payment date should follow the administrative or accounting practice adopted by each VHIS Provider, and should consistently apply to all VHIS policies issued by the company. Moreover, VHIS Providers should make the relevant practices known to the consumers during the selling process and upon enquiry, and should ensure that the sales representatives and staff who handle the relevant enquiries are properly trained regarding the practice.

Q55. If there is a change of policy holder(s) during a year of assessment, how to determine the entitlement for tax deduction between the previous and current policy holders?

A55. Each of the persons concerned is only eligible to claim tax deduction for the amount of premium paid during the period when he/she or his/her spouse is the policy holder.

Consider an example of a policy year when person A is the policy holder of a VHIS policy from April 2019 to December 2019 while person B is the policy holder from January 2020 to March 2020 –

(a) If the premium amount is HK$12,000, paid annually and the payment date falls in April 2019, person A will be eligible to claim the annual premium for tax deduction, and the deduction allowed for person A will be HK$8,000 for that year of assessment (i.e. the rest HK$4,000 will not be eligible for tax deduction as it is beyond the HK$8,000 ceiling for that year of assessment); person B will not be eligible to claim tax deduction as the amount of HK$12,000 was paid before he/she became the policy holder.

(b) If the premium is paid by monthly instalments of which 9 instalments are paid during April 2019 to December 2019 and 3 instalments are paid during January 2020 to March 2020, the amount of qualifying premiums paid by person A and person B is HK$9,000 and HK$3,000 respectively. The two amounts of HK$9,000 and HK$3,000 can be counted separately towards the qualifying premiums deduction ceiling of HK$8,000 for each taxpayer in respect of each eligible insured person in that year of assessment. The allowable deduction for person A will be HK$8,000 (i.e. the rest HK$1,000 will not be eligible for tax deduction as it is beyond the HK$8,000 ceiling) while the allowable deduction for person B will be HK$3,000 (as the full amount is under the HK$8,000 ceiling).

Q56. If a personal income taxpayer is already subject to the standard tax rate of 15%, can he/she save taxes by claiming tax deduction for qualifying premium of VHIS policies?

A56. Yes. The net assessable income will be reduced by the amount of the qualifying premium before the standard tax rate applies. The tax savings will be equivalent to the multiple of the qualifying premium and 15%.