Medical Benefits Scheme Handbook
醫療福利計劃手冊

Prepared by HFD (March 2023)

CONTENTS

Introduction

Hong Kong Productivity Council ("HKPC") cares about its staff members. An appropriate medical benefits scheme (including dental) is one of the most important elements of its overall benefits plans for staff.

This booklet spells out the procedures and rules of the scheme for your reference and answers the most common questions that you may have concern on the medical benefits provided by HKPC.

General Rules

1. It is scheme members' obligation to safe keep their medical cards. In the case of card loss, staff members should report loss to Human Resources Unit immediately to minimize any possible financial losses.

2. The medical card is not transferable and must be returned (together with dependants' medical cards, if any) to the Human Resources Unit upon ceasing to be a member of the Medical Benefits Scheme or on cessation of employment on the last working day.

3. Should there be any suspicion arises on use of medical benefits scheme, such as privilege of individual choice of doctor, heavy medical expenses is shown to have occurred, etc, the payment of any medical expenses may be withheld, and the staff member and/or his/her dependants concerned may be required to consult a designated doctor or a panel of doctors nominated by HKPC.

4. The conditions governing this scheme and/or the scale of medical benefits payable shall be subject to periodic review by HKPC as and when the need arises.

5. Where any doubt arises as to the interpretation of the meaning of these rules, the decision made by Executive Director is final.

Eligibility for Joining the Medical Benefits Scheme

1. All permanent and contract staff will join the Medical Benefits Scheme including Dental when joining HKPC.

2. Medical protection will also be provided for dependants of staff member who join the medical benefits scheme herein under described subject to the following conditions:

   (A) that the employment of the staff member with HKPC has taken effect;

   (B) that the dependant is either a spouse (up to the 60th birthday) and/or a wholly dependant and unmarried child, at the age of 15th days to 21st birthday, who is still in school as full time student. Student proof is required for aged over 18 as at renewal date.

   (C) that spouse and children of the staff joining the scheme shall register with HKPC at the following times, provided that he/she is not in receipt of similar medical benefits provided by his/her own employer (for spouse) or the employer of his/her parent (for child):
      (i) at the time the staff member joins the scheme;
      (ii) in the case of a single staff member, at the time of his/her subsequent marriage;
      (iii) in the case of children born subsequent to the registration date as from the date of their birth;
      (iv) in the case of child is legally adopted; or

(v) at such date as the management may for special reasons authorize.

However, the option must be exercised within **one month** of any family member becoming eligible.

If you and/or your dependants who do not apply to join the medical scheme within the stipulated one-month period, you may join subsequently subject to a reasonable explanation for the delay being given in writing with relevant supporting documents. Medical underwriting may be required by insurer and acceptance is subject to written confirmation from insurer.

3. A staff member and/or his/her family who subsequently withdraw from the Medical Benefits Scheme may only be readmitted to membership to the scheme subject to approval with justification.

4. Staff members who select not to join this scheme shall be entirely responsible for the payment of any medical expenses incurred by themselves and/or their families.

5. If two staff members employed by HKPC become couples, they can opt to change his/her medical scheme to the staff with higher benefit level as spouse while his/her own medical scheme as staff member shall be ceased. Nevertheless, staff member is still eligible in joining the dental scheme. However, this option will not be proceeded automatically. To exercise this option, eligible staff member should send a written notice to Human Resources Unit and staff member concerned will be notified by email upon successful application. Otherwise, both members shall remain at their own benefit levels according to their own terms of employment.

Termination of the Medical Benefits Scheme

All covered staff members and their dependant's coverage shall be ceased at the earliest of times indicated as below:

1. on the covered member's 60th birthday. (If the covered member is spouse of staff, the coverage for the spouse shall be ceased. If the covered member is a staff member, the coverage for him/her including his/her family members shall be terminated on the same day), or
2. on the date the staff member terminates services with HKPC, or
3. on the date the covered member's dependant ceases to be a dependant of the covered member.

Types of Medical Benefits Scheme

Upon successful application, scheme member will be eligible for the following:

1. Out-patient Services

(A) Non Panel Doctors

(i) Coverage :

Out-patient benefits payable under this scheme shall apply only to admissible medical expenses incurred by staff members and their dependants. Staff members and/or their dependants who are covered by this scheme may consult their own family doctor or a doctor of their own choice subject to the following conditions:

(a) that any doctor consulted must be a properly registered medical practitioner under the relevant legislation in Hong Kong;

(b) that any Chinese Medicine Practitioner, Bonesetter or Acupuncture consulted must be a Registered Chinese Medicine Practitioner under the relevant legislation in Hong Kong; or

(c) that Chinese Herbalist Consultation Benefit does not cover Tui Nai and massage therapy.

(d) other than exclusion items, only ONE consultation per item on the same day are eligible for claim and subject to the maximum reimbursement limit as stated below :

The maximum reimbursement limits (Different item can be visited once per day)	HK$ per visit
● General Consultation (Consultation fee & Medication)^	$360
● Chinese Herbalist Consultation (Consultation fee & Medication#)^	$300
● Chinese Bonesetter and Acupuncture (Consultation fee & Medication)^	$300
● Physiotherapy Treatments *^	$300
● Chiropractor Treatments *^	$300
● Specialist Consultation (Consultation fee & Medication) ^	$600
● Routine Health Check-up	$600 (per contract year)
● Vaccination	$600 (per contract year)
● Psychiatric-related treatments^	$600
● Psychological counselling **^	$600

* Subject to referral letter from Western General Medical Practitioner six months valid from signed date.

** Subject to referral letter from Psychiatrist six months valid from signed date.

For cases of Chinese Herbalist Consultation, claim should include consultation fee and medication fee. Medication fee alone will not be entertained. If the consultation fee is waived by the attending Chinese Herbalist doctor/clinic, relevant information should be shown

on the original receipt. However, the claims for Chinese medicine consultation and purchase of herbal medicine at separate practitioners or herbal stores on the same date or on a separate date within one week would be accepted so long as the consultation and the herbal medicine expenses were claimed together as one visit. Original copy of the official receipt and prescription sheet issued by the Chinese medical practitioner is required.

^The total overall maximum number of visit/claim is 30 per year per person including non panel and panel visits.

- Diagnostic Imaging and Laboratory Tests $2,000 per year
  (Subject to referral letter six months valid from signed date from Western General Medical Practitioner / Specialist for all diagnostic imaging and laboratory tests, or from a Registered Chinese Medical Practitioner or Chiropractor for X-ray only and laboratory tests)

- Prescribed Western Medication $6,000 per year
  Medically necessary western medication prescribed by a registered medical practitioner and obtained at any legitimate source under non-panel benefit or prescribed and obtained at the panel registered medical practitioner's clinic on the same day of consultation. This benefit limit is a combined limit for both non panel and panel visits.

(e) Mid-year join insured member will enjoy full-year benefit entitlement.

(ii) Application for Reimbursement :

Staff members have to pay the medical expenses first and claim for reimbursement afterwards. However, such medical claims shall be submitted to the Insurer within 90 days from the consultation date. To claim for reimbursement, staff member should submit the following documents and pay attention to the requirement listed as below:

(a) Medical Claim Form for each scheme member;

(b) original receipt(s) from doctor/clinic that the member attended, indicating the **diagnosis** made and giving a **detailed breakdown** on the medical expenses, i.e. consultation fees, medication fees, laboratory and X-ray examination fees, physiotherapy expenses and fees for minor operations performed at clinics;

(c) for cases of medical treatment, e.g. X-ray or laboratory tests, physiotherapy treatment or chiropractic treatment, a referral letter from a Western General Medical Practitioner and Specialists indicating the diagnosis is required. (Original referral letter for first visit on physiotherapy treatment, chiropractic treatment or X-ray, laboratory tests. Copied referral letter for follow-up medical treatments.) If the treatment has been stopped for more than 6 months continuously or the treatment is not for the same disability, another referral letter is required;

(d) for out-patient consultation at the General Out-patient clinics of Hospital Authority, sick leave certificate or certificate of consultation with diagnosis marked by the attending doctor, or self-declare the exact diagnosis on the receipt can be accepted for claim

assessment.

(iii) Reimbursement Schedule :

Claims will be collected by insurer from Human Resources Unit on every Monday 10:00 AM (If there is/are any holiday(s), the date will be adjusted accordingly.)

If the submitted claims are approved after assessment, staff member will receive the reimbursement and email notification within 10 working days.

(B) Panel Doctors

Scheme members are provided with doctor panel services as an alternative besides the reimbursement option. Insurer medical card(s) will be issued to the scheme members and with this card, scheme members can consult any appointed panel doctors of Insurer spreading over Hong Kong, Kowloon, New Territories, outlying islands and Macau **free of charge** but subject to the maximum benefits amount and maximum number of visits per year per person.

As the covered limit is the same as non-panel visit, for any uncovered item or extra/long term medication that exceeds the prescribed medicine's maximum annual limit, Insurer will charge the shortfall for the extra medication cost to scheme members.

Panel service is also eligible for Diagnostic Imaging and Laboratory Tests.

Pre-authorisation is required for (i) Diagnostic imaging or laboratory tests exceeds HK$2,000; (ii) treatment by a non panel specialist (only if referred by a panel general practitioner when the necessary specialty is not available with Insurer panel). The panel registered medical practitioner will help insured to seek pre-authorisation from Insurer. Please note that (i) if pre-authorisation is required for emergency situations after Insurer's office hours, subsequent authorization can be done on the next working day after treatment; (ii) if the insured do not obtain pre-authorisation or pre-authorisation is not approved, all eligible medical expenses will be paid under non panel benefit, if any.

Scheme members are required to settle shortfall expenses, if any, arising from use of this card promptly. In the event that the outstanding difference or shortfall remains not reimbursed to HKPC, the insurance services provider and/or related panel network for more than 30 days after receipt of the shortfall notice, Scheme members would consent and authorize HKPC to deduct such outstanding difference or shortfall from my salary through payroll for the settlement and set-off purposes.

Scheme members shall assume and accept full responsibility for controlling and monitoring the use of Corporate Medical Card(s) and medical credit facility by me and any Cardholder in accordance with the terms, rules and/or regulations under the Benefits Scheme.

Scheme members are advised to inform HKPC of any disputes arising from use of this card.

(i) Card Issuance :

Each eligible member including staff member and his/her dependants will receive a medical card for identification purpose. Their names and membership number will be printed on the medical card. Details of the panel doctors are posted and updated on Insurer website and mobile apps.

(ii) Arrangement before Card Issuance :

Members may consult Insurer panel doctors before they receive the medical card but will follow the procedures below:

(a) members must pay cash for such consultation when visiting the panel doctor; and

(b) after consultation, staff will have to submit all claims document for reimbursement as non-panel visit.

(iii) Arrangement after Card Issuance :

Upon receipt of the medical card, members may follow the arrangement below:

(a) members are required to show the Insurer medical cards together with the Hong Kong Identity Cards at the doctor's clinic for registration before receiving treatment; and

(b) after consultation, staff will have to sign a set of imprinted voucher provided by the clinic in order to certify attendance. A copy of the voucher will be given to the staff for future reference. Members do not need to submit the medical claim for reimbursement.

(iv) Free of Charge Service Item :

The following medical services/treatments at Insurer panel doctors' clinics or the appointed centers are subject to the maximum benefits amount and maximum number of visits per year per person and any extra charges shall be paid at clinic and no reimbursement can be made:

(a) General Consultation; and

(b) Specialist consultation*; and

(c) Chinese Medicine Practitioner/ Bonesetter; and

(d) Physiotherapy Treatment*; and

(e) Diagnostic Imaging and Laboratory Tests*

*Subject to referral letter from Panel Western General Practitioner, except Gynecology, Pediatrics & Family Medicine

(v) For Minors :

Staff member or their spouse should sign on the Insurer medical card(s) on behalf of dependant children who are under 12 and are regarded as minors. They should accompany their children when visiting panel doctors.

Under circumstances when minors are escorted or under the guardian of other adults in the family, it is advisable to prepare an authorization letter signed by the parent who have signed on the Insurer medical card of the minor and present it to the panel doctors, otherwise panel doctors may request them to pay for that visit and claim for reimbursement afterwards.

(vi) Card Loss :

In the event of card loss, a handling charge of HK$50 per card will be charged for 2nd & subsequent replacements.

Critical Illness Coverage

Special cover for staff members with critical illnesses for compassionate consideration:

(A) Eligibility: Staff member (not dependents) who suffers from the listed critical illnesses with medical proof from HKPC's designated medical practitioner and/or locally registered Western Medical Practitioner and is acceptable to HKPC.

(B) Approval: Subject to Executive Director's discretion and special approval on a case-by-case basis per policy year.

(C) Cover: Staff member's maximum number of clinical visits (applicable to general consultation and specialist consultation only) per policy year would be lifted but the maximum limit per visit shall still be applied.

(D) List of Covered Critical Illnesses :

1.	Stroke	13.	Surgery to Aorta	25.	Benign Brain Tumor
2.	Cancer (except Skin Cancer)	14.	Aplastic Anaemia	26.	Major Head Trauma
3.	First Heart Attack	15.	Major Organ Transplant	27.	Bacterial Meningitis
4.	Coronary Artery Surgery	16.	Major Burns	28.	Elephantiasis
5.	Other Serious Coronary Artery Disease	17.	Multiple Sclerosis	29.	Lupus Erythematosus
6.	Angioplasty and other Invasive Treatments for Coronary Artery Disease	18.	Paralysis	30.	SARS
7.	Heart Valve Replacement	19.	Poliomyelitis	31.	Myocardial Infarction
8.	Fulminant Viral Hepatitis	20.	Muscular Dystrophy	32.	Cardiomyopathy
9.	Chronic Liver Disease	21.	Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders	33.	Medullary Cystic Disease
10.	Pulmonary Arterial Hypertension (primary)	22.	Motor Neurone Disease	34.	Dissecting Aortic Aneurysm
11.	End-stage Lung Disease	23.	Parkinson's Disease	35.	Hemiplegia
12.	Kidney Failure	24.	Encephalitis	36.	Meningeal Tuberculosis

Notes : For the definition of above critical illnesses, please refer to Appendix A.

(E) Application for Reimbursement :

For first submission in each policy year, staff members have to apply in writing by providing the medical proof for Executive Director's approval. If there is any doubt, the Executive Director may require the

staff member concerned to consult a doctor or a panel of doctors for further clarification. After the case is approved, the relevant medical cost due to the same diagnosis shall be reimbursed subject to maximum limit per visit.

Staff members have to pay the medical expenses first and claim for reimbursement afterwards. However, such medical claims shall be submitted to the Insurer within 90 days from the consultation date by submitting the following documents:

(i) Medical Claim Form for each scheme member;

(ii) original receipt(s) from doctor/clinic that the member has attended, indicating the **diagnosis** and giving a **detailed breakdown** on the medical expenses, i.e. consultation fees and medication fees.

If staff members have not indicated the claims separately to Human Resources Unit, reimbursement will be made as normal outpatient benefit and no adjustment shall be made to revise the total number of visits reduction for the policy period.

(F) Reimbursement Schedule :

Claims will be collected by insurer from Human Resources Unit on every Monday 10:00 AM. (If there is/are any holiday(s), the date will be adjusted accordingly.)

If the submitted claims are approved after assessment, staff member will receive the reimbursement and email notification within 10 working days.

2. Maternity Hospitalization

(A) Eligibility :

(i) Female staff members/spouses of male staff members who have been accepted as members of HKPC's Medical Benefits Scheme, are eligible for reimbursement of medical expenses for maternity hospitalization.

(ii) In the case of couples who are both employed by HKPC, the maternity hospitalization coverage will be reimbursed in accordance to the benefits scheme being opted.

(B) Coverage :

(i) Subject to the rules hereof and of the Medical Benefits Scheme, the expenses incurred for maternity hospitalization under the following conditions will not be covered :

(a) any pregnancy that occurred prior to being accepted as a member of the Medical Benefits Scheme

(b) Within the first year of coverage, reimbursement for miscarriage claims will be made subject to a registered Western Medical Practitioner's expert advice on the date of Last Menstrual Period which should be a date occurring after being admitted into the Medical Benefits Scheme; and

(c) baby-related expenses.

(ii) Only the basic and medically essential expenses related to normal child delivery, caesarean childbirth or miscarriage will be covered. Twins, triplets, etc. irrespective or whether livebirth or stillborn, are considered as a single delivery. Assistance for homebirth will not be provided.

(iii) Subject to the rules hereof and of the Medical Benefits Scheme, the applicable maternity hospitalization benefits for each class of ward used is shown as follows :

Pay Scale/ Grade	Suggested Room Class	Miscarriage (HK$)	Normal Delivery (HK$)	Caesarean (HK$)
Grade 6-9	Private	10,000	20,000	30,000
Grade 4-5	Semi-Private	5,000	10,000	15,000
Grade 1-3	Ward	2,500	5,000	7,500

(iv) All claims for reimbursement are subject to the actual relevant expenses incurred, or the maximum eligible entitlement, whichever is less.

(v) Benefits payable under this scheme shall have worldwide coverage and such claims, together with all relevant original receipts, must be lodged with Insurer within 90 days after the date of discharge from hospital.

(vi) Eligible members covered by this scheme may consult doctors of their own choice, who must be

properly registered as Western Medical Practitioners under the relevant legislation.

(C) Application for Reimbursement :

To apply for reimbursement of Maternity Hospitalization expenses, members should submit the following documents to the insurer **within 90 days** after the date of discharge from hospital:

(i) Medical Claim Form; and

(ii) Original receipt indicating whether the pregnancy was resulted in a miscarriage, normal delivery or caesarean section and giving a detailed breakdown of the medical expenses, i.e. room and board, surgeon's operation fees, anesthetist's fees, operating theatre charges and other related expenses.

(D) Reimbursement Schedule :

Claims will be collected by insurer from Human Resources Unit on every Monday 10:00 AM. (If there is/are any holiday(s), the date will be adjusted accordingly.)

If the submitted claims are approved after assessment, staff member will receive the reimbursement and email notification within 10 working days.

3. Hospitalization

(A) Hospitalization Insurance :

Members are covered by a Hospitalization Insurance Scheme offered by the appointed insurer. Details of the insurance coverage are as follows:

HOSPITALIZATION BENEFITS	**Class 1 Grade 6-9 (HK$)**	**Class 2 Grade 4-5 (HK$)**	**Class 3 Grade 1-3 (HK$)**
Reimbursement Percentage	100%	100%	100%
Dependant Cover	Yes	Yes	Yes
Suggested Accommodation Level	Private	Semi-Private	Ward
1.Room/Board & Meal Charges per day limit	2,500	1,500	800
Maximum no. of days per year	182	182	182
2.In-patient Physician's Fees per day limit	2,500	1,500	800
Maximum no. of days per year	91	91	91
3.Miscellaneous Hospital Services, per disability per year limit	65,000	45,000	30,000
4.Surgeon's Fees, per disability per year limit			
● Complex Operation	90,000	70,000	45,000
● Major Operation	90,000	70,000	45,000
● Intermediate Operation	45,000	35,000	22,500
● Minor Operation	22,500	17,500	11,250
5..In-patient Specialist's Fees *			
Maximum limit per year	12,000	9,000	6,000
6.Private Nursing * per day limit	850	500	300
Maximum no. of days per year	91	91	91
7.Anaesthetist's Fees, per disability per year limit			
● Complex Operation	27,000	21,000	13,500
● Major Operation	27,000	21,000	13,500
● Intermediate Operation	13,500	10,500	6,750
● Minor Operation	6,750	5,250	3,375
8.Operating Theatre Fees, per disability per year limit			
● Complex Operation	27,000	21,000	13,500
● Major Operation	27,000	21,000	13,500
● Intermediate Operation	13,500	10,500	6,750
● Minor Operation	6,750	5,250	3,375

9.Intensive Care Unit * per disability per year limit	46,000	26,000	14,000
10.Pre-admission and Post-hospitalisation Outpatient Care, per year One pre-hospitalisation/pre-surgery visit and all post-hospitalisation/post-surgery visits on an out-patient basis within 6 weeks after discharge from Hospital or after surgery	2,500	1,800	1,000
11. Hospital Cash	1,250	750	400
Maximum no. of days per year (Payable in addition to Room and Board from the 1st day of Hospital Confinement in ward bed at Hospitals of Hospital Authority in Hong Kong)	182	182	182
Overall maximum limit per insured person per policy year for in-hospital and post-hospitalization expense	550,000	450,000	350,000

Remarks: * Subject to attending doctor's referral.

(B) Coverage :

(i) Doctor's consultation fees including fees for bedside visits by doctor(s) and surgeon(s).

(ii) Medicine including charges for prescribed drugs, medicines and injections.

(iii) Associated hospital fees including surgeons' operation fees, anesthetists' fees, operating theatre charges, charges for surgical appliances and equipment, room and board charges, food, dressings and plaster casts, oxygen and gas, glucose, physiotherapy, radiotherapy, laboratory tests, X-rays, ultrasound, ECG, electrocardiograms, radiography, basal metabolism tests, etc. subject to the maximum limit as stated in the benefit schedule.

(iv) The coverage excludes special meals, meals not consumed by patient, extra beds, television and other optional expenses.

(v) **"Disability"** means an illness or bodily injury and shall include all disabilities arising from the same cause including any and all complications there from, except that after ninety (90) days following the latest discharge from Hospital or the last consultation during which no treatment is received, any subsequent disability from the same cause shall be considered as a separate disability.

(vi) Post-Hospitalization follow up claim covers the treatments by the surgeon such as stitch off, etc. and/or follow up consultation by a physician within 6 weeks after discharge from hospital for the related sickness or after surgery.

(vii) Medically Necessary Advanced Diagnostic Scanning – MRI, CT scan & PET scan carried out at Hospitals, outpatient department of Hospitals, clinics or laboratory centres will be

covered under 'Miscellaneous Hospital Services'. (except outpatient panel network)

(viii) Benefits payable under this scheme shall have worldwide coverage.

(C) Application for Reimbursement :

(i) If scheme member requires hospital treatment, he/she requires to complete Medical Insurance - Hospitalization & Surgical Claim Form according to the stipulated instructions given and pass it to his/her attending doctor to complete the relevant part of the form. For medical claim arises from attending a government hospital, Part I of Hospitalization form should still be completed by the insured member and Part II of the form can be replaced by a sick leave/discharge certificate which details the diagnosis and length of hospital stay.

(ii) Scheme member must pay the hospitalization expenses incurred and claim for reimbursement afterwards. To apply, claimant should send the following documents to the Insurer within 90 days from the discharge date.

(a) a completed Hospitalization & Surgical Claim Form, or a completed Part I of Hospitalization & Surgical Claim Form and sick leave/discharge certificate issued by a government hospital.

(b) The original receipt(s) from the attending hospital, indicating the diagnosis and giving a detailed breakdown of the medical expenses, i.e. room charges, surgeon's operation fees, anesthetist's fees, operating theatre charges, consultation and medication fees for further out-patient visits, and all other detailed related expenses.

(c) For minor surgery performed in clinic, scheme members should follow the above procedures and requirement to claim for reimbursement.

(D) Reimbursement Schedule:

(i) Upon receipt of the relevant documents, the Human Resources Unit will forward the claim to insurer every Monday 10:00 AM.

(ii) Reimbursement on claims of hospitalization and follow up treatments within 90 days after discharged from hospital are subject to the assessment of the insurance company and maximum limit as stated in above benefit schedule.

(iii) Reimbursement including dependant's claim, if any, will be made by auto-pay to staff's payroll bank account, normally within 10 working days of receiving the claim.

(E) Schedule of Operations

This schedule is for reference only. The eligibility of the claim will depend on the terms and provision of policy, validity of membership and claim assessment will be based on the medical information submitted. Should there be any doubt arising, the decision made by Insurer is final.

The maximum amount applicable for an operation or procedure is calculated according to the classification listed below:

Description of Surgical Operations	**Classification of Operation**
Heart	
Coronary artery bypass graft surgery	Complex
PTCA with stent insertion	Complex
PTCA without stent insertion	Major
Cardiac catheterisation (including coronary arteriography)	Intermediate
Thyroid gland	
Total thyroidectomy	Major
Bilateral subtotal thyroidectomy	Major
Hemi-thyroidectomy	Intermediate
Fine needle aspiration (FNA)/biopsy of thyroid gland	Minor
Breast	
Partial/total mastectomy with axillary dissection / radical mastectomy	Major
Lumpectomy or partial/total mastectomy with/without biopsy of sentinel lymph node	Intermediate
Incision and drainage of breast abscess	Minor
Percutaneous fine needle biopsy of lesion of breast with/without ultrasound guided	Minor
Eye	
Unilateral/bilateral cataract extraction with insertion of intraocular lens	Intermediate
Laser photocoagulation/cryotherapy/radiotherapy of lesion of retina (and bilateral)	Intermediate
Excision/curettage/cryotherapy of lesion of eyelid(s)	Minor
Exploration of conjunctiva (including removal of foreign body)	Minor
Ear	
Tympanoplasty / myringoplasty	Major
Removal of foreign body from external auditory canal (and bilateral)	Minor
Myringotomy with/without insertion of tube	Minor
Nose	
Functional endoscopic sinus surgery (FESS)	Major
Septoplasty	Intermediate
Submucous resection of turbinate	Intermediate
Cauterisation of turbinate of nose (and bilateral)	Minor
Packing of cavity of nose (as sole procedure)	Minor
Antral puncture and wash-out (and bilateral)	Minor
Nasal/sinus endoscopy	Minor

Throat	
Laryngoscopy/microlaryngoscopy with/without biopsy/removal of lesion	Minor
Fibreoptic examination of trachea and bronchus including biopsy/removal of foreign body	Minor
Tonsillectomy (and bilateral)	Minor
Adenotonsillectomy (and bilateral)	Minor

Lungs	
Lobectomy (any approach)	Major
Surgical thoracoscopy with pleurodesis	Major
Pleural biopsy (open)	Intermediate
Bronchoscopy	Minor
Percutaneous lung biopsy	Minor
Tapping of pleural effusion (thoracentesis)	Minor

Oesophagus and stomach	
Partial/total gastrectomy with/without removal of lesion	Major
Upper G.I. endoscopy with/without biopsy/removal of lesion	Minor

Appendix	
Appendicectomy / laparoscopic appendicectomy	Intermediate

Large intestine and anus	
Haemorrhoidectomy / stapled haemorrhoidectomy	Intermediate
Excision/closure of anal fissure/anal fistula	Intermediate
Colonoscopy with/without excision biopsy/removal of lesion	Minor
Sigmoidoscopy with/without biopsy/removal of lesion	Minor
Injection/banding of haemorrhoids	Minor

Liver, gall bladder and bile duct	
Liver transplantation including recipient hepatectomy	Complex
Partial hepatectomy	Complex
Cholecystectomy with/without exploration of common bile duct	Major
Laparoscopic cholecystectomy with/without preoperative cholangiogram	Major

Urinary tract	
Extracorporeal shock wave lithotripsy	Intermediate
Endoscopic examination of bladder (including biopsy)	Minor

Genital tract – male	
Prostatectomy	Major
Radical prostatectomy (any approach), reconstruction of bladder neck including bilateral pelvic lymphadenectomy	Complex
Circumcision	Minor

Genital tract – female	
Radical hysterectomy and lymphadenoctomy (Werthelm's)	Complex
Subtotal/total hysterectomy (including abdominal/laparoscopically assisted/laparoscopic/vaginal approach) with/without removal of adnexa	Major
Laparoscopic myomectomy	Major
Unilateral/bilateral oopherectomy and salpingectomy (as sole procedure)	Intermediate
Abdominal/vaginal approach myomectomy	Intermediate
Laparoscopy and therapeutic procedures including laser, diathermy and destruction e.g. endometriosis, adhesiolysis, tubal surgery	Intermediate
Laparotomy / laparoscopic ovarian cystectomy (and bilateral)	Intermediate
Hysteroscopy with/without dilation and curettage with/without removal of lesion	Intermediate
Excision/marsupialisation of Bartholin's gland/cyst	Intermediate
Dilatation of cervix uteri and curettage of uterus including polypectomy and diathermy of cervix	Minor
Colposcopy (including biopsy, treatment of lesion of cervix uteri by cauterization, laser, diathermy, etc)	Minor

Skin and subcutaneous tissue	
Malignant melanoma excision including flap grafting	Intermediate
Excision of lesion of skin/subcutaneous tissue	Minor
Curettage/cryotherapy of lesion of skin including cauterisation	Minor
Primary suture of wound with involvement of deeper tissue	Minor
Removal of foreign body in deeper tissue	Minor
Drainage of lesion of skin including abscess	Minor
Fine needle aspiration cytology	Minor
Drainage of lesion of lymph node	Minor

Abdominal wall	
Primary repair of inguinal hernia, bilateral	Major
Primary repair of inguinal hernia, unilateral	Intermediate

Bones and joints	
Total knee replacement	Major
Total hip replacement	Major
Arthroscopy for diagnosis and/or treatment	Intermediate
Repair/reconstruction of ruptured Achilles tendon	Intermediate
Closed reduction of fracture with/without application of plaster of Paris	Minor
Removal of fracture implant (except spinal implant)	Minor
Excision of ganglion	Minor
Release of constriction of tendon sheath	Minor
Joint aspiration/injection	Minor

For operations not listed in this Schedule of Surgical Operations and not expressly excluded herein by any other condition of the Contract, Insurer will pay a Benefit using a classification at its own discretion depending on the complexity of the surgery involved.

This Schedule of Surgical Operations is for reference only and is subject to change from time to time without prior notice.

4. Dental

(A) Eligibility:

HKPC staff members are entitled to dental benefits**.** It is a dental prepaid scheme administered by appointed dental services company. HKPC will pay for the staff annual fees for coverage of specified standard dental services offered by a panel of Dentists.

Dependents of HKPC staff can enroll to the dental benefit package by bearing the annual fee themselves. However, no enrolment will be allowed for staff member's dependants if the staff member does not enroll in the scheme. Full fee will be charged to those staff member's dependant who join the scheme during the scheme year and no refund will be made for those who left the scheme during the scheme year.

(B) Details of the scheme :

(i) For children aged under 11 who doesn't have HKID card, he/she needs to provide his/her parent ID for enrollment.

(ii) Advanced telephone booking to the appointed dental clinic is required. He/she needs to provide his/her name, company name & HKID number for registration.

(iii) The scheme member MUST present his/her HKID card for verification during the clinical visit.

(iv) The appointment will be arranged on a first come first served basis and subject to the dentist's schedule.

(v) Dentist reserves the right to reject any member who does not attend the appointment punctually. If the scheme member cannot attend the appointment, he/she has to cancel the appointment 24 hours in advance.

(vi) After the consultation, scheme member will have to sign on the claim form in order to certify his/her attendance.

(vii) Scheme member is required to pay cash for treatments not covered in the standard package.

(viii) No reimbursement will be made for treatments served by non-appointed dentists or cash receipt issued by the appointed dentists.

(C) Standard Package (to be served by the appointed dentists)

(For each policy year from 1 April to 31 March)	**Limitation**
Scaling & polishing	Once a year
Oral examination including oral hygienic instruction	Unlimited
Intra-oral small film radiograph as necessary	Unlimited
Amalgam filling for posterior teeth (carious)	Unlimited
Composite filling for anterior teeth (carious)	Unlimited
Simple extraction (excluding wisdom teeth & surgical extraction)	Unlimited
Drainage of Abscesses (without surgery)	Unlimited
Emergency consultations & dressings for pain relief	Unlimited
Medications (pain killers & antibiotic)	Unlimited

Scheme members are required to bear their own expense on the treatments and/or services other than being covered by the Standard Package. Appointed dentists shall offer discount on the treatment and/or services other than the Standard Package to scheme members.

5. <u>Exclusion (Medical Coverage)</u>

Medical expenses related to the following cases are not covered by HKPC. These are:

1. Treatment, medical service, medication or investigation which is not Medically Necessary.
2. Any illness or bodily injury for which compensation is payable under any laws or regulations or any other insurance policy or any other sources except to the extent that such charges are not reimbursed by any such compensation, insurance policy or sources.
3. Any charges for accommodation, nursing and services received in health hydros, nature cure clinics, convalescent home, rest home, home for the aged or similar establishments.
4. Any charges in respect of surgical and non-surgical cosmetic treatment, Hair Mineral Analysis (HMA), health supplements or body weight control (unless approved by Insurer).
5. Any charges in respect of preventive measures, including but not limited to routine blood tests, general check-ups, vaccinations or inoculations, hearing tests, eye refraction including routine eye tests or any cost of fitting of spectacles or lens (unless it is payable under the relevant Benefits).
6. Congenital Conditions, Developmental Conditions or Hereditary Conditions.
7. Treatment that commenced during the first five (5) years from the Coverage Commencement Date of this Contract and which in any way arises from, is attributable to, or is consequential upon Human Immunodeficiency Virus Infection.
8. Sexually Transmitted (Venereal) Diseases or their sequel.
9. Treatment relating to pregnancy, including diagnostic tests for pregnancy or resulting childbirth, abortion or miscarriage (unless it is payable under Maternity Benefit); birth control or sterilisation of either sex; infertility including in-vitro fertilisation or any other artificial method of inducing pregnancy; or sexual dysfunction including but not limited to impotence, erectile dysfunction and pre-mature ejaculation, regardless of cause.
10. Misuse or overdose of drugs or being under the influence of alcohol, self-inflicted injuries or attempted suicide.
11. Treatment relating to any illness or bodily injury resulting from participation in criminal activities.
12. Alternative treatment including but not limited to Chinese Medicines treatment, acupuncture, acupressure, tui na, hypnotism, rolfing, massage therapy and aromatherapy (unless it is payable under Chinese Herbalist Benefit or Chinese Bonesetter Benefit).
13. Senile Dementia (including Alzheimer's disease), Parkinson's disease, psychological or psychiatric condition(s) of any and all kinds, including but not limited to psychoses, neuroses, depression, anxiety, anorexia nervosa, schizophrenia, behavioural disorders, delirium, insomnia, neurasthenia.
14. Any charges for the procurement or use of special braces and appliances including but not limited to spectacles, hearing aids and other equipments such as wheel chairs and crutches.
15. Any treatment or investigation related to dental or gum conditions (unless it is payable under Dental Benefit) except for Emergency treatment (not follow-up treatment) arising from Accidents or the extraction of impacted wisdom teeth during Hospital Confinement.
16. Treatment arising from war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military or usurped power or terrorist acts.
17. Non-medical services, including but not limited to guest meals, radio, telephone, photocopy, taxes (except the Value-Added Tax or Goods and Services Tax for medical services), medical report charges and the like.
18. Experimental and/or new medical technology / procedure not yet approved by Insurer.
19. Engaging or taking part in naval, military or airforce or any operation with any armed force; or any form of professional sports.

內容

簡介

香港生產力促進局致力為僱員提供一個優良的工作環境，而適當的醫療福利計劃（包括牙科保健），更是整體僱員福利中不可缺少的一環。

這本小冊子旨在提供一些基本資料，使你對本局所提供的醫療福利更加了解。

一般規則

1. 計劃成員有責任小心保管醫療卡。員工如遺失醫療卡，須盡快通知人力資源組，以減少金錢上的損失。

2. 醫療卡是不可轉讓。當員工於其受僱之最後的一個工作日或醫療福利計劃之終止日，員工必須將醫療卡（如家屬參加了醫療保障，則須連同家屬之醫療卡）交還到人力資源組。

3. 本局如對員工使用醫療福利計劃有任何懷疑，例如濫用自由選擇醫生的權利，巨額的醫療開支等，總裁有權決定保留或拒絕支付任何有關之醫療費用和/或要求員工和/或他/她的家屬到本局指定之醫生就診。

4. 本計劃之所有條款及福利範圍均由本局定期或有需要時作出檢討及修訂。

5. 如對醫療計劃規則有任何詮釋的疑問，將以總裁的決定為最終。

參加手續及資格

1. 本局的常額及合約僱員在入職時，只要他/她並沒享有其配偶的僱主提供之醫療保障或牙科保健計劃，便可以自由決定是否申請加入此醫療及牙科保健計劃 （如欲只申請其一之保障計劃，即醫療或牙科，將不獲接受)。僱員可在加入本局後的**一個月內**，填妥醫療計劃申請表(包括牙科保健) A.F.312，交回人力資源組作申請。

2. 員工之直系親屬亦可參加本局之醫療福利計劃，惟須符合以下條件：

   (A) 有關員工已入職為本局僱員及員工已批核為醫療計劃之成員；

   (B) 其直系親屬，即員工之配偶(年齡於六十歲前)與及/或其由 15 日大至 21 歲及仍然在學的未婚子女。 18 歲以上(屆保單續保日期當日為準)子女必須提供學生証明文件。直系親屬必須持有香港身份證及居於香港；

   (C) 員工的配偶、子女如在沒有接受其配偶之僱主所提供的相同福利下，可於下列時間向本局申請參加本局之醫療福利：
   (i) 當有關員工申請加入醫療計劃時；
   (ii) 在入職時未婚及其後結婚之員工；
   (iii)在員工新生子女出生後；
   (iv) 在員工合法領養子女後；或
   (v) 在總裁於特別原因准許其加入時。

   在上述所提之各項條件內，員工均須於符合資格後之**一個月內**作出申請。

如員工的配偶、子女未在指定之一個月內提交申請，其亦可在以後加入，惟需以書面提出

延遲申請的理由及提供有關證明文件。保險公司有可能要求申請人提供健康報告或進一步健康審核，保險公司並不負責有關之費用，申請須由保險公司書面通知方為生效。

3. 員工及其家屬於退出計劃後，須提交充分的理由及經本局的批准，才可再申請加入。重新加入之成員，將會被視為“新成員”，並受新成員之條款限制。

4. 如員工及/或其家屬放棄參加此計劃，其本人及家屬之所有醫療費用須自行負責。

5. 倘若兩位員工均為本局職員，當雙方結婚時，其中一方可選擇轉換到醫療福利保障級別較高一方受保為配偶，而其原本之受保職員級別將被終止。不過，員工仍然有資格保留本身之牙科保健計劃。唯此安排並非自動性，員工若要選擇轉換醫療福利保障級別，需以書面通知人力資源組，而該有關申請成功與否將通過電子郵件通知。否則，雙方會保留為職員身份及本身之醫療福利保障級別。

終止醫療福利保障

所有僱員及其家屬之保障將會於下列情況下自動終止：

1. 受保人六十歲生日（如受保人為僱員之配偶，該名配偶之保障將即日自動終止。如受保人為僱員本人，則其本人及其家屬之保障，將一併於同一天終止）， 或

2. 僱員離職日， 或

3. 受保人之家屬終止成為受保人之家屬之生效日。

醫療福利種類

當加入醫療福利計劃的申請被批准後，你便會成為其中一位計劃成員，並享有以下福利:

1. 門診服務

(A) 非網絡醫生

(i) 保障範圍:

所有由本計劃提供之門診福利只包括在香港就診的費用。員工及其家屬可向其家庭醫生或選擇任何一位醫生就診，惟必須符合下列條件：

(a) 有關醫生須為根據香港有關法例註冊之醫生；

(b) 有關中醫，跌打或針灸醫師須為根據香港有關法例註冊之中醫；或

(c) 有關中醫治療並不包括推拿及按摩治療。

(d) 除不保事項以外，以下每項門診治療只限每日一次，亦可接受賠償申請及將根據最高賠償限額處理：

最高賠償限額（不同項目每天可看一次）	每次門診港幣
● 普通科（包括診金及藥物)^	$360
● 中醫治療（包括診金及藥物#)^	$300
● 跌打或針灸診治(包括診金及藥物）^	$300
● 物理治療*^	$300
● 脊椎治療*^	$300
● 專科(包括診金及藥物)^	$600
● 例行健康檢查	$600 （每合約年度上限）
● 防疫注射	$600 （每合約年度上限）
● 精神科相關治療*^	$600
● 臨床心理輔導**^	$600

* 需具普通科醫生轉介
(轉介信由簽發日起計六個月有效)

** 需具精神科醫生轉介
(轉介信由簽發日起計六個月有效)

\# 如屬中醫治療，申請須包括醫生診金及藥物費。單配藥之藥物費將不獲受理。但若主診中醫師/診所豁免醫生診金，相關豁免必須註明於單據正本上。然而，員工可把中醫的診金，與在不同的中醫診所或中草藥店購買中藥方上所列藥物的費用(當中的情況包括於同日或分開最多一星期的日期)合併作為一次之索賠。中醫發出之藥物處方正本與收據正本亦須交回。

^ 所有門診(包括網絡及非網絡醫生治療)每人每年上限為 30 次。

- 診斷影像及化驗 每年港幣二仟元正
  須獲註冊西醫（適用於所有診斷影像及化驗）或註冊中醫/脊醫（只適用於 X 光及化驗）由簽發日起計六個月的書面轉介
- 醫生處方西藥 每年港幣六仟元正
  非網絡:由註冊西醫處方並於合法來源取得的醫療必需西藥費用;
  網絡:由網絡註冊醫生在諮詢當天處方及取得的醫療必需西藥費用。此賠償額為網絡及非網絡的最高合併福利。

(e) 任何於年中加入之受保人可享整年度福利保障。

(ii) 申請付還手續 :

同事須先自行支付有關費用，然後申請付還。惟同事需於就診後**九十日內**向保險公司遞交下列文件申請及注意下列之要求：

(a)個別醫療計劃成員的醫療費用申請表格;

(b)由診所發出的單據正本，註明**診斷病症**及**費用的詳細分類**，例如診金、藥費、X 光費、醫學化驗費、物理治療費及診所進行的小手術費等；

(c)如屬特別治療: X 光/醫學化驗，物理治療及脊椎治療等，均需附上普通科醫生與專科醫生之轉介信。()(首次物理治療及脊椎治療或 X 光/醫學化驗需附上正本轉介信。為覆診則可用轉介信副本。）若覆診日期距離上次最後診症日期超過六個月或不同病症之治療，則需新的轉介信；

(d)有關在政府醫院門診部診症之賠償申請，可接受由主診醫生發出具病症之病假紙或由僱員自行申報之病症收據。

(iii) 醫療費用付還表 :

保險公司逢星期一(上午十時)會到本局收取由人力資源組收集的賠償申請表

如所提交之付還申請經查核後獲批准，員工會在十個工作天內收到付還之醫療費用及電郵通知。

(B) 網絡醫生

各員工及受保成員可以在付還制度之外，選擇使用網絡醫生服務。各成員將會獲發給一張保險公司醫療咭，憑咭到指定分佈於港、九、新界離島與澳門之網絡醫生的醫務所內就診，則**無須繳付任何費用**。唯此就診亦被計算及包括在門診每年每人最高次數之內。

由於保障範圍與非網絡醫生服務相同，所以對於任何不受保項目或需要額外/長期藥物超過醫生處方西藥的最高每年保障限額，保險公司將通知成員收取需要的額外醫療費用。

網絡保障範圍包括診斷影像及化驗的醫療開支。

以下治療項目必須獲得初步保障審核:(i) 費用超過港幣 2,000 元的診斷性 X 光檢

驗或化驗; (ii)非網絡專科醫生(必須由網絡普通科醫生轉介，並只限於保險公司網絡未能提供有關專科服務)。網絡註冊西醫將協助受保成員就以下項目向保險公司提出初步保障審核的申請。唯須注意(i) 如受保成員需向保險公司申請初步保障審核而在保險公司的辦公時間以外，成員需於下一個工作天向保險公司補辦初步保障審核手續;(ii)若受保人沒有獲得初步保障審核，或申請不獲接納，所有合資格醫療費用將按非網絡福利保障賠償。

使用此卡時如出現差額，計劃成員則需要支付差額。如在收到差額通知後超過 30 天仍未向生產力局、保險公司及/或相關網絡償還未償還的差額，計劃成員將同意並授權生產力局從薪資中扣除該等未償差額，用作償還用途。

計劃成員應根據福利計劃的條款、規則和/或規定，承擔並接受控制和監督本人和任何持卡人對醫療卡和醫療網絡設施的使用的全部責任。

若計劃成員使用此卡時出現任何糾紛，需通知本局。

(i) 發咭安排

每位合資格的受保人(包括僱員和他/她的家屬)將獲發醫療咭以作識別。醫療咭上印有姓名及員工編號。員工可於保險公司網上查詢系統內查閱有關網絡醫生之辦公時間及地址。

(ii) 發咭前的安排

於未獲發保險公司醫療咭前仍可到網絡醫生就診，惟須循下列手續：

(a) 受保人於網絡醫生診治後須以現金支付當次診金及有關費用

(b) 於診症後，受保人須遞交醫療費用申請表格及是次就診之正本收據並按非網絡醫生診症申請付還。

(iii) 發咭後的安排 :

於收到醫療咭後可根據以下步驟就診:

(a) 受保人每次前往網絡醫生診所就診時，須出示醫療咭及身份証以便登記;及

(b) 診症後，受保人須在已壓印的賠償單據上簽名。簽妥後，單據副本將交回該受保人保存以作參考之用,受保人無須付款,因此亦毋須申請付還醫療費用。

(iv) 免費服務項目:

於保險公司的網絡醫生診所內就診或接受以下服務，均限制於每次保障最高限額及每年每人最高次數限額之內，在門診支付的任何額外費用均不會作出賠償:

(a) 普通科門診;或

(b) 專科門診*;或

(c) 中醫師/跌打醫師;或

(d)物理治療*;或

(e)診斷影像及化驗*

* 須獲註冊網絡西醫書面轉介, 婦科、兒科及家庭醫學則除外

(v) 年幼持咭者：

員工或其配偶應替其十二歲以下之年幼子女簽署醫療咭；並須陪同前往網絡醫生處就診。

於個別情況而家長未能親身攜同子女應診，則須預備授權書予同行之家人。否則網絡醫生有權對該次診斷收費，而同事只可於日後申請醫療費之付還。

(vi) 遺失醫療咭 ：

凡遺失醫療咭者，於補發第二次新咭時需每咭繳付手續費港幣五十元元正。

2. 重症門診保障

對僱員罹患本局指定之重症，提供附加保障：

(A) 受保資格 : 員工（保障並不包括家屬）需罹患本局指定之重症及能提供由醫生發出之醫療報告証實。

(B) 審核 : 需由總裁按每個案批核並每年重批。

(C) 保障 : 員工因此症引起之門診每年次數限額將免除,唯每次最高之賠償額不變。

(D) 受保之重症

1.	中風	13.	主動脈手術	25.	良性腦腫瘤
2.	癌症（皮膚癌除外）	14.	再生障礙性貧血	26.	嚴重頭部創傷
3.	首次心臟病	15.	主要器官移植	27.	細菌性腦(脊)膜炎
4.	冠狀動脈手術	16.	嚴重燒傷	28.	象皮病
5.	其他嚴重冠狀動脈疾病	17.	多發性硬化症	29.	紅斑狼瘡症
6.	血管成形術及其他冠狀動脈疾病之創傷性療法 *	18.	癱瘓	30.	非典型肺炎
7.	心瓣置換	19.	脊髓灰質炎	31.	心肌梗塞
8.	暴發性病毒性肝炎	20.	肌肉營養不良症	32.	心肌病
9.	慢性肝病	21.	亞爾茲默氏病 / 不可還原之器質腦退化性疾病	33.	腎髓質囊腫病
10.	肺動脈高血壓（原發性）	22.	運動神經原疾病	34.	主動脈夾層瘤
11.	末期肺病	23.	柏金遜病	35.	偏癱
12.	腎衰竭	24.	腦炎	36.	結核腦膜炎

有關上述重症之定義，請參考附件一。

(E) 申請重症門診費用付還程序：

於每一保險年度首次申請此項保障者，申請人必須以書面申請並提供由註冊醫生發出之醫療報告證實所患重症給本局審批。如有疑問，總裁有權要求員工到指定之醫生作進一步驗證。當個案審批後，因此症引起之門診費用可申請付還，唯每次最高賠償額不變。

員工需先行支付有關醫療費用，然後申請付還。惟同事需於就診後**九十日內**向保險公司遞交下列文件申請:

(i) 個別醫療計劃成員的醫療費用申請表格;

(ii) 由診所發出的單據正本，註明診斷病症及費用的詳細分類，例如診金、藥費。

員工必須在付還表格內列明此項目申請為重症門診，因員工沒有列明該申請而導致該醫療費用受到一般門診處理及扣除每年次數限額，本局將不會再作出調整。**療費用付還表 ：**

保險公司逢星期一(上午十時)會到本局收取由人力資源組收集的賠償申請表

如所提交之付還申請經查核後獲批准，員工會在十個工作天內收到付還之醫療費用及電郵通知。

3. 產科住院

(A) 受保資格

(i) 凡已登記入本局醫療福利計劃之女性僱員及男性僱員的配偶均可享有產科住院福利。

(ii) 如果夫婦都是受僱於本局，產科住院福利保障將根據已被選擇之計劃作出賠償。

(B) 保障範圍 ：

(i) 本局醫療計劃之一般規則均適用於產科住院福利，惟以下情況則不在保障之列：

(a) 在參與醫療計劃之前，受保人已懷孕；

(b) 在受保後首一年內，有關流產費用之賠償申請，須具註冊西醫証明受保人最後經期日在參與醫療計劃之後；或

(c) 有關初生嬰兒的一切醫療費用。

(ii) 本局的產科住院福利只包括所有有關順產、剖腹產子及流產的基本費用。雙胞胎、三胞胎或多產只按一次單獨生產計算。而在家中產子則不在保障範圍之內。

(iii) 與住院服務類似，產科住院福利所享有的住院保障乃按僱員在總薪級表的薪級點而有所不同。詳情如下：

薪級點/ 職系	建議病房等級	流產	順產	剖腹產子
6-9 級	私家房	$10,000	$20,000	$30,000
4-5 級	二等房	$5,000	$10,000	$15,000
1-3 級	大房	$2,500	$5,000	$7,500

（iv）所有賠償均須根據實際費用計算，且不可超過上文(iii)段提及之上限。

（v）此福利適用於世界各地，惟必須於出院後**九十日內**連同收據正本向保險公司申請。

（vi）員工或已登記的成員可自由選擇任何一位根據有關法例註冊的醫生就診。

(C) 申請付還手續：

員工需於出院後**九十日內**向保險公司遞交下列文件申請：

(i) 醫療費用申請付還表格；

(ii)由醫院所發出的單據正本，註明是屬於順產、流產或剖腹產子，及費用的詳細分類，例如病房租金、手術費、麻醉費，及住院診金等。

(D) 每月醫療費用付還的預定表：

保險公司逢星期一(上午十時)會到本局收取由人力資源組收集的賠償申請表

如所提交之付還申請經查核後獲批准，員工會在十個工作天內收到付還之醫療費用及電郵通知。

4. 住院治療

(A)住院保險 ：

各成員的住院治療是經由本局指定保險公司所提供的住院保險保障，詳情如下：

	計劃一	**計劃二**	**計劃三**
	職系 6-9 級	職系 4-5 級	職系 1-3 級
住院福利	**(港幣)**	**(港幣)**	**(港幣)**
賠償比例	100%	100%	100%
家屬保障	有	有	有
建議病房等級	私家房	半私家房	大房
1. 病房及膳食費（每日）	2,500	1,500	800
每年最高日數	182	182	182
2. 住院治療醫生費（每日）	2,500	1,500	800
每年最高日數	91	91	91
3. 醫院雜項費用（每症每年最高賠償額）	65,000	45,000	30,000

4. 外科醫生手術費（每症每年最高賠償額）			
● 複雜手術	90,000	70,000	45,000
● 大手術	90,000	70,000	45,000
● 中手術	45,000	35,000	22,500
● 小手術	22,500	17,500	11,250
5. 住院專科醫生費*（每年最高賠償額）	12,000	9,000	6,000
6. 註冊護士看護費*（每日）	850	500	300
每年最高日數	91	91	91
7. 痲醉師費（每症每年最高賠償額）			
● 複雜手術	27,000	21,000	13,500
● 大手術	27,000	21,000	13,500
● 中手術	13,500	10,500	6,750
● 小手術	6,750	5,250	3,375
8. 手術室費（每症每年最高賠償額）			
● 複雜手術	27,000	21,000	13,500
● 大手術	27,000	21,000	13,500
● 中手術	13,500	10,500	6,750
● 小手術	6,750	5,250	3,375
9. 深切治療費* 每症每年最高賠償額	46,000	26,000	14,000
10. 入院前及出院後門診 每年最高賠償額 （包括一次入院前門診及出院後／手術後 6 星期內註冊主診西醫建議之跟進療程）	2,500	1,800	1,000
11. 住院現金	1,250	750	400
每年最高日數	182	182	182
（除付還病房及膳食費外，額外賠償予受保人於香港醫院管理局轄下大房病床留院第一日始計算）			
每人每年最高賠償額	550,000	450,000	350,000

註解: * 需具主診醫生轉介

(B) 保障範圍 :

(i) 醫生診症費用包括巡房費用、專科診斷及外科醫生費。

(ii) 藥物及有關費用包括處方藥物及藥劑注射。

(iii) 其他有關的支出例如外科手術、麻醉師、手術室、外科儀器、病房租金、食物、敷料、石膏、氧氣、葡萄糖、物理治療、放射治療、實驗室化驗、X 光、超音波檢驗、心電圖、心動電流像、X 射線治療、基礎代謝測試等，均按照住院福利表最高限額賠償。

(iv) 住院保障並不包括特別膳食、非病人本身食用之膳食、加床、電視機費及其他選擇性服務。

(v) 病症是指損傷或疾病。同樣疾病將當作同一病症處理，除非任何受傷或病症由不同病因引起或由出院後或最後覆診日期或最後接受治理起計相隔超過 90 日，並於此期間內不需為該病症接受任何形式的治療，便以新病症處理，以較後者為準。在考慮是否同一病症時，全部相關的治療個案也需要一併考慮，縱使計劃成員可能並沒有為部份治療提出索償。

(vi) 出院後覆診費用保障受保人於出院後 6 星期內內該主治醫生或手術後診查及處方費用。

(vii) 於醫院，醫院轄下門診部門，門診與化驗所進行具醫療需要之先進造影 – 磁力共振、電腦掃描及正離子核磁素描將以醫院雜項作為賠償(網絡醫生除外)

(viii) 此福利適用於世界各地。

(C) 申請付還手續 :

(i) 如計劃成員需入院接受治療，他/她必須填寫「醫療保險－住院及手計術賠償表」。表格中相關部份需分別由住院者及其主診醫生填寫。如屬政府醫院則無須由主診醫生填報，但需附上註明診斷病症及住院日期之病假證明書或出院紙及填寫住院索賠申請表第一部份。

(ii) 計劃成員須先自行安排繳付住院費用，然後申請付還。有關計劃成員須於出院後**<u>九十日內</u>**向保險公司遞交下列文件申請及注意下列之要求：

(a) 已填妥之「醫療保險－住院及手術賠償表」或政府醫院所發之病假證書及填寫「醫療保險－住院及手術賠償表」第一部份。

(b) 由醫院所發出的單據正本，註明住院原因及費用的詳細分類，例如病房租金、 手術費、手術室費、麻醉費、住院診金及葯費等。

(c) 在診所內進行之小手術，亦可按相同程序申請付還。

(D) 付還形式：

(i) 保險公司逢星期一(上午十時)會到本局收取由人力資源組收集的賠償申請表

(ii) 住院治療及出院後九十天內覆診之該付還金額，乃根據保險公司的批核指示及賠償表之最高限額。

(iii) 賠償款項約在十個工作天內，由保險公司以自動轉賬形式支付到員工之發薪戶口。

(E) 外科手術表

此外科手術表只供參考之用。每一索償個案會根據保險合約條文理賠。另外，亦會依據成員所遞交的資料審核索償個案及成員身份。如出現任何爭議或問題，一律以保險公司作出之決定為準及最後定案。

有關手術費用之賠償額，是按照以下外科手術表中各類型手術而計算：

外科手術分類項目	**手術類別**
心臟	
經皮穿冠狀動脈血管成形術及支架內置術	複雜
經皮穿冠狀動脈血管成形術（不設支架）	大
心導管插入術（包括冠狀動脈造影術）	中
冠狀動脈搭橋手術	複雜
甲狀腺	
甲狀腺完全切除術	大
雙側甲狀腺次全（亞全）切除術	大
甲狀腺單側切除術	中
針取甲狀腺細胞手術 / 甲狀腺活組織檢查	小
乳房	
乳房部份 / 完全切除術並包括腋下淋巴切除手術 / 根治性乳房切除術	大
乳房腫瘤切除術或部份 / 完全乳房切除術（包括或不包括前哨淋巴腺活組織檢查）	中
乳房膿腫切開及引流	小
乳房病變經皮針吸活組織檢查（包括或不包括超聲波檢查）	小
眼部	
單側 / 兩側白內障摘除術包括晶體植入術	中
視網膜病變激光凝固療法 / 冷凍療法 / 放射療法（包括兩側）	中
眼瞼病變切除術 / 刮除術 / 冷凍療法	小
結膜探查（包括異物清除術）	小
耳	
鼓室成形術 / 鼓膜成形術	大
外耳道異物清除術（包括兩側）	小
鼓膜切開術（包括或不包括置管）	小
鼻	
鼻中隔成型術	中
黏膜下鼻甲切除術	中
鼻甲燒烙術（包括兩側）	小
鼻腔填法（作為獨立手術）	小
鼻竇穿刺術及清洗（包括兩側）	小
鼻 / 鼻竇內窺鏡檢查	小
功能性鼻竇內窺鏡手術	大

咽喉

喉鏡 / 電子顯微喉鏡檢查（包括或不包括活組織檢查 / 病變切除）	小
氣管及支氣管纖維內窺鏡檢查（包括活組織檢查 / 異物清除術）	小
扁桃腺切除術（包括兩側）	小
增殖腺扁桃體切除術（包括兩側）	小

肺

支氣管鏡檢查	小
經皮針刺肺活組織檢查	小
抽肺積水（胸腔穿刺）	小
胸膜活組織檢查（開放性）	中
肺葉切除術（任何方式）	大
胸腔鏡手術與胸膜黏合術	大

食道及胃

部份 / 全胃切除術（包括或不包括病變切除術）	大
上消化道內窺鏡檢查及治療（包括或不包括活組織檢查 / 病變切除術）	小

闌尾

闌尾切除術 / 腹腔鏡闌尾切除術	中

大腸及肛門

痔瘡切除術（內 / 外） / 吻合器痔瘡切除術	中
肛裂切除術 / 肛口閉合術	中
結腸內窺鏡檢查及治療（包括或不包括活組織檢查 / 病變切除術）	小
乙狀結腸內窺鏡檢查（包括或不包括活組織檢查 / 病變切除術）	小
痔瘡注射 / 結紮	小

肝、膽囊及膽管

肝臟移植術包括受者肝臟切除術	複雜
部份肝臟切除術	複雜
膽囊切除術（包括或不包括膽總管探查）	大
腹腔鏡膽囊切除術（包括或不包括手術前膽管造影術）	大

泌尿系統

體外震波碎石法	中
膀胱內窺鏡檢查（包括活組織檢查）	小

男性生殖系統

前列腺切除術	大
根治性前列腺切除術（任何方法），包括重建膀胱頸及骨盆兩側淋巴結切除術	複雜
包皮環切術	小

女性生殖系統

宮腔鏡（包括或不包括子宮擴刮術）（包括或不包括病變切除術）	中

巴多林氏腺的切除或袋形縫合術	中
根治性子宮切除及淋巴結切除術	複雜
子宮次全 / 完全切除術（包括經腹手術 / 腹腔鏡輔助手術 / 腹腔鏡手術 / 經陰道式手術）包括或不包括附件切除	大
經腹腔鏡子宮肌瘤切除術	大
單側或兩側卵巢及輸卵管切除術（作為獨立手術）	中
經腹子 / 經陰道進行宮肌瘤切除術	中
腹腔鏡檢查及治療（包括激光療法及透熱療法，例如治療子宮內膜異位症、盆腔黏連、輸卵管手術）	中
開腹 / 經腹腔鏡卵巢囊腫切除術（包括兩側）	中
子宮頸擴張及子宮內膜刮除術（包括息肉切除術及子宮透熱療法）	小
陰道鏡檢查（包括活組織檢查及使用燒烙激光透熱等方法治療子宮頸部病變等）	小

皮膚及皮下組織

惡性黑色素瘤切除術包括皮瓣移植	中
皮膚或皮下組織病變切除術	小
皮膚病變刮除術 / 冷凍療法包括燒烙術	小
傷口縫合術包括深層皮膚組織	小
深層組織內異物清除術	小
皮膚病變、膿腫引流術	小
針取細胞術	小
淋巴結病變引流術	小

腹

腹股溝疝修補術，兩側	大
腹股溝疝修補術，單側	中

骨及關節

關節鏡進行之檢查及 / 或治療	中
跟腱斷裂後修補 / 重建術	中
骨折閉合性復位術（包括或不包括石膏固定）	小
拆除骨折植入物（脊椎植入物除外）	小
腱鞘囊腫切除術	小
肌腱狹窄鬆解術	小
關節抽液 / 注射	小
全膝關節置換	大
全髖關節置換	大

備註： 若有關手術項目未包括於上表內，保險公司將參照上表同等嚴重性的手術分類作為賠償之基礎，並保留最後之賠償金額決定權。

5. 牙科保健

(A) 受保資格：

本局的員工可獲得牙科保健。這是一項預付牙科保健計劃，由特約牙科保健公司負責管理。根據這項計劃，符合資格的員工可獲得指定牙科醫生所提供的特定標準牙科保健服務，而本局會支付有關的年費。

本局的員工也可替其直系家屬參加這項計劃，惟年費需由員工支付。但若員工並未參加該牙科保健計劃，其直系家屬之報名將不被接納。如該計劃成員若在計劃年內退出，員工為其直系家屬繳交之年費將不獲退還。

(B) 計劃詳情：

- **i.** 若參加這項計劃的員工子女年齡未滿 11 歲且沒有身份證，請以其父母之身份證進行登記。
- **ii.** 就診前必需致電各指定牙醫診所進行電話預約登記。在登記時需提供會員姓名，公司名稱及身份證號碼。
- **iii.** 就診時，各會員**必需**出示身份證以確認身份。
- **iv.** 所有預約服務，以先到先得及駐診牙醫當天之時間表為準則。
- **v.** 各會員需按預約時間準時到達診所。如未能依時到達，該診所有權拒絕提供服務。會員如未能在預約時間內依時出席，須提早廿四小時前致電診所取消預約登記。
- **vi.** 就診後，各會員需簽署賠償表格，以便核對。
- **vii.** 任何非保健計劃內的牙科服務，會員需自行負責及繳付現金。
- **viii.** 非特約牙醫提供之牙科服務或由特約牙醫簽發之現金收據，一律不獲賠償。

(C) 基本牙科保健計劃(由特約指定牙醫提供牙科保健服務)

(保障週期為每年四月一日至明年三月三十一日)	**限制**
洗牙石／牙漬	每年一次
口腔檢查及口腔健康講解	無限
口腔 X-光片檢查（按需要）	無限
銀粉補牙（由蛀牙引起）(包括臼齒及前臼齒)	無限
瓷粉補牙(由蛀牙引起)(只限門牙及犬齒)	無限
普通脫牙（不包智慧齒及手術脫牙）	無限
牙瘡治療（非手術）	無限
緊急治療及臨時補牙止痛服務	無限
藥物（止痛藥及抗生素）	無限

一切不包括在以上計劃內之牙科服務，會員需自行負責及繳付現金，特約牙醫會提供各會員折扣之優惠。

6. 不受保障範圍（醫療保險）

以下是一些不受本局醫療福利計劃保障之醫療項目：

(A) 與就診病無關之住院膳宿費、陪人費、特別看護費、客人膳食費、額外病床、非醫療性的個人服務及其他特殊費用包括但不限於器官、輪椅、拐杖等費用。

(B) 非因意外引起的矯視包括但不限於近視、遠視、散光、老花、斜視、驗眼、配鏡、聽覺測驗或助聽器等輔助費用；義肢和施行美容治療或整容手術費用。

(C) 一切牙齒護理包括但不限於每年例行檢查、洗牙、鑲牙、箍牙、牙齒矯正等及牙科手術(唯正常牙齒因意外受傷而引起的必要牙科手術或牙肉感染治療，或於承保表上註明之項目除外)。

(D) 因戰爭(不論宣戰與否)、罷工、暴亂、革命、叛變、恐怖主義活動或其他類似戰爭的行為或參加軍警工作直接或間接引致的傷害或疾病。

(E) 精神病包括但不限於生理或心理失調所引起的精神紊亂、神經衰弱、厭食、失眠等。

(F) 因懷孕(包括產前產後檢查)、流產、分娩(包括自然分娩及剖腹產)、墮胎、絕育、避孕、不育及其併發症或一切有關的治療費用，唯於於承保表上註明之項目除外。

(G) 自加傷害、自殺(不論其清醒與否)、酒醉、精神錯亂或吸食軟性藥物(包括吸食毒品)。

(H) 觸犯或參與不合法行為所致之傷害。

(I) 先天異常，即出生時存在的疾病並在 12 歲前出現，包括但不限於遺傳病如兔唇、畸形足、胎記、骨或肌肉不正常生長、腦麻痺等；發展異常包括但不限於偏平足、隱睾症等；嬰兒黃疸病。

(J) 定期、例行常規健康檢查或休養之醫療費用。

(K) 接受預防注射疫苗之費用。

(L) 有關性能力、性病、愛滋病及其併發症引起的治療費用。

(M) 受保人可依例申請僱員補償保險的賠償或其他保險計劃可支付的賠償。唯賠償不足之醫療費用，本保險公司將按本保單條款及承保表內所列的最高賠償金額規定給予適當的賠償。

(N) 因參與或從事危險活動包括但不限於吊索跳、滑翔風箏、滑翔飛機、跳傘、激流、水肺潛水、攀山、攀石等。

(O) 在水療中心、天然治療中心、復康院、療養院、老人院或類似機構提供的醫療服務費用。

(P) 其他的另類治療包括但不限於按摩、推拿、催眠、香薰治療、瑜珈、足部治療、職業治療或營養治療等。

(Q) 屬補養性質的藥物索償。

(R) 預防及調理性質之治療。

(S) 體重控制及其相關之治療。

(T) 醫療報告之費用。

Listed of covered Critical Illnesses

1.	**Stroke -中風** Any cerebrovascular incident, producing neurological sequelae, lasting more than twenty-four (24) hours and including infarction of brain tissue, cerebral haemorrhage, thrombosis or embolization from an extracranial source. Evidence of permanent neurological deficit must be produced. 中風指由於任何腦血管意外產生並超過二十四小時的神經後遺症。中風包括腦細胞組織梗塞、腦出血、血栓或由腦以外原因引致血栓塞。「受保人」必須提供永久性神經虧損證明。
2.	**Cancer (except Skin Cancer) - 癌症（皮膚癌除外）** Cancer is defined as a focal autonomous new growth of abnormal cells which has resulted in the invasion of normal tissues. Such Cancer must be positively diagnosed upon the basis of a microscopic examination of fixed tissues, or preparations from the haemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspect tumour, tissue or specimen. Clinical diagnosis does not meet this standard. Cancer of the skin, except for Malignant Melanoma, and non-invasive carcinoma-in-situ and CIN lesion of whatever histology, grade or classification shall not be included. 癌症(不包括皮膚癌)是指新的不正常細胞在某一焦點範圍內獨立生長，並侵入其他正常的細胞組織。癌病須根據固定細胞組織的微切片檢查或血液系統的細胞檢查作為確實的「診斷」。被懷疑是腫瘤的組織或樣本必須經過細胞結構及形態分析並符合癌症斷診之條件，一切皆以此為「診斷」基礎。臨床「診斷」的結果並不符合以上的標準。 皮膚癌(除惡性黑素瘤外)、原位癌(癌細胞在某一焦點範圍內獨立生長，但還未侵入其他正常細胞組織)和各級別之子宮頸表層細胞之癌變皆不包括在此保障範圍內。
3.	**First Heart Attack -首次心臟病** Death of a portion of the heart muscle as a result of inadequate cardiac blood supply. The diagnostic criteria to be met are: (a) a current history of typical chest pain; (b) current elevation of cardiac enzymes; and (c) new electrocardiographic changes. 因心臟血液供應不足，引致部份心臟肌肉壞死。 「診斷」標準必須包括以下情況： (a) 最近的典型的胸痛病歷； (b) 新近出現心肌酵素提高的情況；及 (c) 心電圖產生新近的變化。
4.	**Coronary Artery Surgery -冠狀動脈手術** The actual undergoing of open chest surgery to one (1) or more coronary arteries due to disease of those arteries. Angioplasty, laser or other intra-arterial procedures, are excluded from this definition. 因冠狀動脈疾病，而確實已接受一條或以上冠狀動脈作開胸手術。但不包括血管成形術，激光治療或其他在動脈之內做的手術程序。
5.	**Other Serious Coronary Artery Disease –其他嚴重冠狀動脈疾病** The narrowing of the lumen of at least three (3) arteries by a minimum of sixty percent (60%), as proven by coronary arteriography, regardless of whether or not any form of coronary artery surgery has been performed. 其他嚴重的冠狀動脈疾病不論是否需要作任何類型的冠狀動脈手術，須經冠狀動脈造影術證明最少三條冠狀動脈管腔有 60%以上的收窄。

6.	**Angioplasty and other Invasive Treatments for Coronary Artery Disease -** **血管成形術及其他冠狀動脈疾病之創傷性療法 ＊** The Insured Person actually undergoes balloon angioplasty, atherectomy or laser treatment to correct a narrowing (minimum of 50% stenosis) of two (2) or more major coronary arteries and shows a history of physical activity/exercise limiting symptomatology. Such history shall consist of : (a) symptoms which are sufficiently severe to indicate that the Insured Person's future level of exercise tolerance would be restricted at a minimal level to prevent further episodes of chest pain; (b) a specialist medical opinion which defines the need to limit physical exercise so as to minimize moderate to severe anginal pain. Medical evidence shall include all of the following: (a) full report from attending Cardiologist; (b) evidence of significant and relevant ECG changes (ST segment depression of two (2) millimetres or more); and (c) angiographic evidence to confirm the location and degree of stenosis of two (2) or more major coronary arteries. 「受保人」確實已接受冠狀動脈疾病之創傷性療法，如氣漲法血管成形術、動脈粥瘤清除手術、或激光治療法以糾正最少兩條主要冠狀動脈狹窄（最少 50%狹窄）及顯示在手術前有體能及運動能耐受阻之徵狀。 病歷必須包括： （a） 嚴重的病徵，足以顯示「受保人」的活動能耐只局限於最低水平，以防止胸痛； （b） 醫學專家建議限制運動，以減少出現中度至嚴重的心絞痛。 醫學證明應包括下列各項： （a） 主診心臟科醫生的詳細報告； （b） 心電圖有顯著及相關變化的證明（ST 段降低 2 毫米或以上）；及 （c） 經血管造影術證明最少兩條主要冠狀動脈狹窄的位置及程度。
7.	**Heart Valve Replacement – 心瓣置換** The actual undergoing of open-heart surgery to replace and/or dilate cardiac valves as consequence of heart valve defects. 心臟瓣膜缺陷而確實已接受剖開心臟之手術，以置換及 / 或擴張心臟瓣膜。
8.	**Fulminant Viral Hepatitis –暴發性病毒性肝炎** This is defined as a submassive to massive necrosis of the liver caused by the Hepatitis virus leading precipitously to liver failure. The diagnostic criteria to be met are: (a) a rapidly decreasing liver size; (b) necrosis involving entire lobules, leaving only a collapsed reticular framework; (c) rapidly degenerating liver function tests; and (d) deepening jaundice. 因肝炎病毒所導致的廣泛性塊肝壞死，以至產生肝衰竭。 「診斷」標準包括下列各項： （a） 肝臟急劇縮小； （b） 小葉完全壞死，只剩下倒塌的支架結構； （c） 肝臟功能測試急劇退化；及 （d） 嚴重及持續加深之黃疸。

9.	**Chronic Liver Disease –慢性肝病** End-stage liver failure as evidenced by all of the following: (a) permanent jaundice; (b) ascites; and (c) hepatics encephalopathy. Liver disease secondary to alcohol or drug misuse is excluded. 末期肝衰竭必須有下列所有的症狀證明： （a） 持續性黃疸 ； （b） 腹水腫 ；及 （c） 肝性腦病 。 因酒精或濫用藥物而引起的繼發性肝病不在保障範圍內。
10.	**Pulmonary Arterial Hypertension (Primary) –肺動脈高血壓（原發性）** This is defined as an increase in the blood pressure in the pulmonary arteries caused by either an increase in pulmonary capillary pressure, an increase in pulmonary blood flow or pulmonary vascular resistance. The following diagnostic criteria must be met: (a) dyspnea and fatigue; (b) increased left atrial pressure (at least twenty (20) units more); (c) pulmonary resistance of at least three (3) units above normal; (d) pulmonary artery pressures of at least forty (40) mmHg; (e) pulmonary wedge pressure of at least six (6) mmHg; (f) right ventricular end-diastolic pressure of at least eight (8) mmHg; and (g) right ventricular hypertrophy, dilation and signs of right heart failure and decompensation. 是指因肺毛細血管壓力增加、肺血流量或肺血管阻力增加而引致肺動脈血壓增加。 「診斷」須包括下列各項標準： （a）呼吸困難及疲勞 ； （b）左心房壓力增加（最少提高 20 個單位）； （c）肺阻力比正常最少高出 3 個單位 ； （d）肺動脈血壓最少 達到 40 毫米水銀柱壓力； （e）肺血管楔壓最少達到 6 毫米水銀柱壓力 ； （f）右心室的舒長末期壓最少達到 8 毫米水銀柱壓力；及 (g) 右心室肥大、擴張，出現右心心力衰竭和喪失代償功能的徵狀。
11.	**End-stage Lung Disease –末期肺病** End-stage Lung Disease including interstitial lung disease, requiring extensive and permanent oxygen therapy as well as FEV 1 test result of less than one (1) litre obtained with the use of bronchial dilator. 包括間質性肺疾病，須要廣泛及永久的氧氣療法，以及 FEV1 測驗結果在使用氣管擴張藥物後低於 1 公升。
12.	**Kidney Failure –腎衰竭** End-stage failure, which presents as chronic irreversible failure of both kidneys to function, as a result of which regular renal dialysis is initiated or renal transplantation carried out. 兩個腎臟的功能已出現慢性及不可逆轉的末期衰竭情況，因而須進行定期之腎臟透析法或接受腎臟移植手術。
13.	**Surgery to Aorta – 主動脈手術** The actual undergoing of surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition aorta shall mean the thoracic and abdominal aorta but not its branches. 因心臟主動脈疾病而確實已接受切除及置換主動脈之手術。但只包括胸部及腹部的主動脈，而非其分支血管。

14.	**Aplastic Anaemia – 再生障礙性貧血** Chronic persistent bone marrow failure which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one (1) of the following: (a) blood product transfusion; (b) marrow stimulating agents; (c) immunosuppressive agents; or (d) bone marrow transplantation. 慢性及永久性的骨髓衰竭而導致貧血、嗜中性白血球減少及血小板減少之出現，須接受下列最少一項的治療： (a) 輸血； (b) 刺激骨髓藥物； (c) 免疫系統抑制性藥物；或 (d) 骨髓移植。
15.	**Major Organ Transplant – 主要器官移植** Actually having undergone, as a recipient, a transplant procedure involving any of the following organs: kidney, heart, liver, lung, bone marrow or pancreas. 確實已接受器官移植手術者，包括腎、心臟、肝、肺、骨髓或胰腺等器官。
16.	**Major Burns – 嚴重燒傷** Third Degree Burns (full thickness skin destruction) covering at least twenty percent (20%) of the body surface. 身體表面最少有 20%的皮膚受到三級燒傷(皮膚全層燒傷)。
17.	**Multiple Sclerosis – 多發性硬化症** Unequivocal diagnosis by a consulting neurologist confirming the following combination of: (a) symptoms referable to tracts (white matter) involving the optic nerves, brain stem and spinal cord, producing well-defined neurological deficits; (b) a multiplicity of discrete lesions; and (c) a well documented history of exacerbations and remissions of said symptoms / neurological deficits. 經神經病學專家顧問清楚「診斷」並肯定出現下列所有現象： (a) 有關神經束支（白質）的病徵，包括視神經、腦幹和脊髓而引致可明確界定的神經系統缺損； (b) 多次不連續不同位置的病徵；及 (c) 對上述的病徵或神經系統的缺損有詳細的病歷記錄，包括病情變壞及復原的病史。
18.	**Paralysis – 癱瘓** The complete and permanent loss of use of both arms or both legs, or one (1) arm and one (1) leg, through paralysis, caused by Sickness or Injury, except when such Injury is self-inflicted. 因癱瘓導致雙手、雙腳或一手一腳完全及永久失去活動能力，癱瘓須由疾病或受傷引致，但不包括自致的受傷。
19.	**Poliomyelitis – 脊髓灰質炎** Polio shall be defined as infection with the polio virus, leading to paralytic disease. Cases not involving "paralysis" shall not be eligible for the benefit, and "paralysis" shall require confirmation by a certified consulting neurologist. 脊髓灰質炎是指受脊髓灰質炎病毒的感染而引致癱瘓性之疾病。不涉及「癱瘓」的個案將不會得到賠償，而「癱瘓」的情況需要得到神經病科專家顧問的確認。
20.	**Muscular Dystrophy – 肌肉營養不良症** The Diagnosis of Muscular Dystrophy shall require confirmation by a consulting neurologist, and such shall have to be based on a combination of three (3) out of four (4) of the following: (a) family history of other affected individuals; (b) clinical presentation including absence of sensory disturbance, normal cerebro-spinal fluid and mild tendon reflex reduction;

	(c) characteristic electromyogram; or (d) clinical suspicion confirmed by muscle biopsy, which in the opinion of the Company confirms the diagnosis of Muscular Dystrophy. 肌肉營養不良症的「診斷」必須得到神經病科專家顧問的確認，而「診斷」必須根據下列四種情況的其中三項： (a) 家族史內有其他家庭成員受到相同疾病之影響 (b) 臨床檢驗包括：無官感神經紊亂、正常腦脊液及輕微腱反射的減退； (c) 特殊的肌電圖； 或 (d) 臨床推測必須有肌肉活動組織檢查加以證實，而有關「診斷」需獲得本公司認可。
21.	**Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders -** **亞爾茲默氏病 / 不可還原之器質腦退化性疾病** Deterioration or loss of intellectual capacity or abnormal behaviour as evidenced by the clinical state and accepted standardised questionnaires or tests arising from Alzheimer's Disease or Irreversible Organic Degenerative Brain Disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Insured Person. The Diagnosis must be clinically confirmed by a Registered Medical Practitioner. 經臨床狀態及標準問卷、測驗證明思考能力退化、喪失，或行為舉止之失常是由亞爾茲默氏病/不可還原之器質腦退化性疾病引致。因神經機能疾病、精神病及任何藥物、酒精引起的機能失調，並導致嚴重性之思維能力及社交活動能力退減，進而影響「受保人」須接受持續性之照顧不包括在內。「診斷」須由適合的顧問醫生作臨床驗證。
22.	**Motor Neurone Disease – 運動神經原疾病** Unequivocal diagnosis of Motor Neurone Disease by a certified consulting neurologist supported by definitive evidence of appropriate and relevant neurological signs and investigation. 運動神經原疾病經神經病專科醫生，根據明確、相關及合理的神經科症狀及檢查，而作出無可置疑之「診斷」為運動神經原疾病。
23.	**Parkinson's Disease – 柏金遜病** Unequivocal diagnosis of Parkinson's Disease by a certified consulting neurologist where the following conditions exist: (a) cannot be controlled with medication; (b) shows signs of progressive impairment; and (c) Activities of Daily Living assessment confirms the inability of the Insured Person to perform without assistance three (3) or more Activities of Daily Living as defined hereinabove. Only idiopathic Parkinson's Disease is covered. Drug-induced or toxic causes of Parkinsonism are excluded. 經神經病專科醫生作出無可置疑之「診斷」為柏金遜症，病情包括下列各項: (a) 無法以醫藥療法控制； (b) 有逐漸轉壞的症狀；及 (c) 按「日常生活活動」評估確定「受保人」無法在不受輔助的情況下完成最少下列三項事情：洗澡、穿衣、如廁、進食及上下床(或從椅子坐起)。 本計劃只保障不明起因的柏金遜症，因藥物或中毒導致的柏金遜症除外。
24.	**Encephalitis – 腦炎** Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) resulting in significant and serious permanent neurological deficit as certified by a consultant neurologist. The permanent neurological deficit must be documented for at least four (4) weeks. 因嚴重的腦物質(大腦半球、腦幹或小腦)炎症導致嚴重的永久性神經虧損。有關「診斷」必須獲神經病專家顧問確認，並證明永久性神經虧損已持續不少於四星期。

25.	**Benign Brain Tumor – 良性腦腫瘤** A non-cancerous tumour in the brain which must be confirmed by imaging studies such as CT scan or MRI. Cysts, granulomas, malformations in, or of, the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are excluded. 指非惡性腦腫瘤，良性腦腫瘤必須以影像研究如 CT 掃瞄或磁場共鳴造影確定，唯囊腫、肉芽腫、腦動脈或靜脈畸形、血腫、腦垂體或脊骨腫瘤等均不包括在良性腦腫瘤的定義內。
26.	**Major Head Trauma – 嚴重頭部創傷** Major trauma to the head with disturbance of the brain function confirmed by definite diagnosis by a certified consultant neurologist. The disturbance must result in a permanent bedridden situation or the inability to perform three (3) or more Activities of Daily Living as defined hereinabove. These conditions have to be medically documented for at least three (3) months. 由神經病科專家顧問確定腦功能因嚴重創傷而受損，並導致必須永久臥床或不能完成日常生活活動的其中最少三項活動。「日常生活活動」的定義已列明於上。有關喪失活動能力的情況必須有醫學證據證明已持續不少於三個月。
27.	**Bacterial Meningitis – 細菌性腦（脊）膜炎** Bacterial Meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit. The Diagnosis must be confirmed by a consultant neurologist and evidence of permanent neurological deficit must be documented for at least three (3) months. 由細菌感染引致腦或脊髓發炎，並導致永久性神經虧損。有關「診斷」必須獲神經病科專家顧問確認，並證明永久性神經虧損已持續不少於三個月。
28.	**Elephantiasis – 象皮病** The end-stage lesion of filariasis, characterised by massive swelling in the tissues of the body as a result of obstructed circulation in the blood or lymphatic vessels. Unequivocal diagnosis of elephantiasis must be clinically confirmed by an appropriate consultant, including laboratory confirmation of microfilariae. Lymphedema caused by infection with a sexually transmitted disease, trauma, post-operative scarring, congestive heart failure, or congenital lymphatic system abnormalities is excluded. 指末期絲蟲病，其性質為身體組織因血液循環受阻或淋巴管堵塞而全面腫大。明確的「診斷」必須由適當的顧問醫生臨床證實及以微絲蚴的化驗結果確認。因性接觸、外傷、手術後的疤、充血性心衰竭或先天性淋巴系統不正常等情況引致的淋巴水腫均不包括在此項「危疾」的定義內。
29.	**Lupus Erythematosus – 紅斑狼瘡症** A chronic remitting relapsing inflammatory multisystem disease in which tissues and cells are damaged by deposition of pathogenic autoanibodies and immune complexes. Diagnosis will be based of the following conditions are satisfied: **(a)** Clinically there must be at least four out of the following presentations suggested by the American College of Rheumatology: (i) Malar rash, (ii) Discoid rash, (iii) Photosensitivity, (iv) Oral ulcers, (v) Arthritis, (vi) Serositis, (vii) Renal disorder, (viii) Leukopenia (<4,000/uL) or Lymphopenia (<1,500/uL) or Haemolytic anemia or Thrombocytopenia (<100,000/uL), (ix) Neurological disorder; and (b) two or more of the following tests being positive: (i) Anti-nuclear antibodies,

	(ii) LE cells, (iii) Anti-dsDNA, (iv) Anti-Sm (Smith 1gG autoantibodies). 指一種慢性及間斷復發的多系統炎性疾病。該疾病由致病性之先體或免疫組合體的積聚，因而破壞細胞及組織。紅斑狼瘡的「診斷」基於下列的條件： (a) 根據美國風濕學會的建議，至少具有下列任何四個臨床症狀： (i) 頰疹， (ii) 盤狀疹， (iii) 對光敏感， (iv) 口腔潰瘍， (v) 關節炎， (vi) 漿膜炎， (vii) 腎功能失調， (viii) 白血球過少(<4,000uL)或淋巴細胞過少(<1,500uL)或溶血性貧血或血小板過少(<100,000uL)， (ix) 神經障礙； 及 (b) 在下列任何兩個或以上的檢驗裡呈陽性反應： (i) 抗核抗體， (ii) 狼瘡細胞， (iii) 狼瘡縷去氧核醣核酸抗體， (iv) 梅毒血清。
30.	**SARS – 非典型肺炎** Severe Acute Respiratory Syndrome/Atypical Pneumonia must be diagnosed and confirmed by clinical and pathological tests by the appropriate medical authority in the country of diagnosis. 由當地官方合適的醫療機構經過臨床及病理學之測試後診斷及確認患上嚴重急性呼吸系統綜合症 – 非典型肺炎。
31.	**Myocardial Infarction – 心肌梗塞** The first occurrence of myocardial infarction which means the death of a portion of the heart muscle, as a result of an acute interruption of blood supply to the myocardium. The diagnosis must be based on a history of typical chest pain, new electrocardiographic changes proving infarction, and significant elevation of cardiac enzymes. Angina is specifically excluded. 首次心肌梗塞指因血液供應不足，而導致部份心臟肌肉壞死，其診斷必須依據胸痛病歷，近 期心電圖之改變及心臟酵素顯著增加。心絞痛並不在此承保範圍。
32.	**Cardiomyopathy – 心肌病** The occurrence of a cardiomyopathy where the following conditions are met : (a) there is persistent impairment of left ventricular function (diastolic or systolic) for at least six (6) months, despite optimal treatment; and (b) physical impairment to the degree of class 4 of the New York Heart Association Classification of cardiac impairment. Cardiomyopathy directly related to alcohol misuse is excluded. 心肌病須符合下列各項要求: (a) 即使在最適當的治療下，左心室功能（擴張或收縮）持續受損最少六個月 ; 及 (b) 有關之身體受損在 New York Heart Association Classification of Cardiac Impairment 中最少達到第四級之程度。 倘心肌病與濫用酒精有直接關係，則不在此承保範圍內。

33.	**Medullary Cystic Disease – 腎髓質囊腫病** Medullary Cystic Disease where the following criteria are met: (a) the presence in the kidney of cysts in the medulla, tubular atrophy and interstitial fibrosis; (b) clinical manifestations of anaemia, polyuria, and progressive deterioration in kidney function; and (c) the diagnosis is confirmed by renal biopsy. 腎髓質囊腫病之診斷須符合下列要求 ： (a) 於腎臟內發現腎髓質有囊腫、腎小管萎縮及間質纖維化等現象； (b) 貧血、多尿及腎功能逐漸衰退之臨床證明；及 (c) 有關診斷由腎活組織檢查確定。
34.	**Dissecting Aortic Aneurysm – 主動脈夾層瘤** A condition where the inner lining of the aorta (intima layer) is interrupted so that blood enters the wall of the aorta and separate its layers. Diagnosis must be confirmed by computed tomography (CT) scan, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA) or angiogram and attested by a cardiovascular specialist. 因主動脈內膜 （血管內膜層） 破裂，以致血液流入主動脈內壁。受保人須經電腦斷層掃描（CT） 、磁力共振掃描（MRI） 、磁力共振血管檢驗法（MRA） 或血管掃描檢驗以確定患上此症，最後並須由心血管科專家加以印證。
35.	**Hemiplegia – 偏癱** The total and permanent loss of the use of one side of the body through paralysis caused by illness or injury, except when such injury is self-inflicted. 因疾病或受傷（自致之傷害除外）導致癱瘓以致半邊身體完全及永久失去功能。
36.	**Meningeal Tuberculosis – 結核腦膜炎** Meningitis caused by tubercle bacilli. 由結核桿菌導致之腦膜炎。