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MyMoney's guide to medical insurance

Many people we have spoken to over the years, understand the basic concept of medical insurance but do not understand why they might need it, what the benefits are or how they go about buying it.

Especially if you are new to Hong Kong, medical insurance can seem very complicated and you may not have the time to search through all the providers, looking through the different plans and prices.

We have put together this handy guide to help you understand medical insurance so that you can make an informed decision as to if you need it, how much you need and how to get it.

You can read the whole guide or just skip to the sections which interest you the most.

Please contact a MyMoney.hk representative if you have any questions or queries:

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Public versus Private Medical Coverage

57% of the people living in Hong Kong have no medical insurance according to the Census and Statistics Department. This may be due to a shortage of spare time to organize cover or due to the fact that people just don't understand why they might need it.

In Hong Kong, the residents who have a Hong Kong identity card are very lucky and can use the public healthcare system at a heavily subsidized rate. Typically it costs just HKD$100 for a visit to A&E or to stay in a ward for the night.

Currently the population of Hong Kong is 7.2 million and there are only 27,000 public hospital beds available. This means that if you need additional care, surgery or specialized appointments you may have arduous waits until you actually see a doctor or have your surgery. Currently the average wait to see a specialist in the public healthcare system is 7 months.

As the population in Hong Kong increases from people getting older, immigration and medical tourists from China the healthcare system is showing signs of strain.

Public health establishments have reached, if not exceeded their maximum capacity which is limiting the capability to administer appropriate medical care in acceptable time limits.

For example, now, as soon as you find out your pregnant you have to book your bed for delivery otherwise all beds may be fully booked and you have no choice but to go private.

The government held talks as far back as 2008 to discuss the strain on the healthcare system and how to tackle this. One of the ways they have tried to combat this strain is by charging women who do not have a permanent Hong Kong ID card to pay US $5,000 for a 3 day, 2 night maternity package at public hospitals.

There are 12 private hospitals in Hong Kong, in 2010 these private hospitals provided 11% of hospital beds and served 21% of the total inpatients in Hong Kong. Private healthcare is becoming more and more popular to expats as they are becoming more aware of the benefits it provides.

Reasons why people buy Private Medical Insurance

- Reduced waiting times. You may have to wait several months for an important surgery or consultation in the public healthcare system. If you are in need of surgery and the waiting list is a couple of months, it can be a very worrying time for you and your family.
- For normal day to day complaints, expats can seek help from a private medical practitioner and the cost of this may be fully covered by your employer provided health plan, however for more serious complaints, surgery etc costs may not be fully covered.
- Hong Kong and China are second to the US for the highest medical costs in the world
- Specialist referrals – you can ask your G.P to refer you to an expert for specialist treatment or consultation.
- Expats sometimes prefer a western doctor for a number of reasons such as training and language.
- You can choose the surgeon, hospital or doctor you use for your treatment.
- Hong Kong Private hospitals are known for their state of the art equipment and nearly every hospital has been accredited via the Trent Accreditation Scheme of the UK demonstrating that all have the highest quality of service.

- In the public healthcare system you may have to stay overnight in a public unisex ward. With private health insurance you can stay in a private room which are often described as being on par to 5* hotel rooms.
- You may have access to any new specialist drugs and treatment; these may not be available on the public healthcare system due to expense.
- Overseas coverage – you won't have access to the subsidized local healthcare systems if you are abroad. This means visits to A&E, treatment or consultations can build up to an extraordinary amount of money. You need insurance to cover these expenses so you are not out of pocket.

What are the different options available with Medical Insurance?

Inpatient cover

Inpatient cover is on all medical insurance plans and is not optional.

The amount of cover differs between medical providers but typically means you are covered for all expenses related to medical treatments that involve a one night stay or more at a medical facility.

These include:

Room costs, medicines given, surgical, anesthetic, operating room fees and diagnostic tests.

Outpatient Cover

This is an optional benefit which you can add on to your inpatient cover.

This benefit provides cover for medical treatments which do not require an overnight stay in a medical facility.

These include:

Doctor's general visits, specialist fees, prescription medicine, diagnostic tests, home nursing and alternative therapies.

Dental Cover

This is an optional benefit available to you

Dental coverage varies greatly from one plan to the next. Usually there are options to be covered for routine dental such as examinations and cleaning. Also there are usually options to be covered for major treatments such as crowns, dentures and bridgework.

There are usually co-payments or maximum percentage of cost limits which apply to the dental options.

Evacuation & Repatriation Cover

Sometimes this is included in the basic cover but sometimes is provided as an optional benefit.

If you have worldwide cover, then no matter where you go in the world, your insurance will travel with you. If you find yourself suffering from severe illness or accident and the local medical services cannot help then your evacuation cover will ensure you are transported to the closest hospital who can provide your treatment. This can cost over US$50,000 so if you travel a lot then this cover is essential.

Repatriation is the same as evacuation however it provides you the option of getting treatment in your home country.

Make sure you read the policy & conditions for this option so you know when the insurer will allow this option to take place.

Maternity Coverage – Explained

Hong Kong's private hospitals are known for their state of the art equipment and leading client care. Due to this high quality of care they are also known for their high prices. Routine delivery costs and packages can vary from anywhere between US$6,000 and US$25,000.

To avoid this cost you may think you will go to a public hospital for your delivery. However due to the influx of expats and Chinese nationals then the strain on maternity departments are huge. You need to book your delivery bed as soon as you get pregnant and even then there is no guarantee that they will not be fully booked. In this case you will have to go private.

To try and ease the pressure on the public healthcare system the Hong Kong government introduced a mandatory pricing structure for foreign mothers wishing to give birth at local hospitals. Foreign nationals who do not have a permanent ID card must pay a booking fee of US$5000 for a three day, two night maternity package.

So, whether you go public or private for your delivery, there is a large out of pocket expense. This shows the need for insurance coverage if you are planning on having a child in Hong Kong.

Coverage Limits and waiting periods

Coverage limits vary greatly from one insurer to another, some have very low limits of US$6,000 whereas some have much higher limits of US$26,000. It is definitely worth comparing the plans and their maternity benefits to be able to find the right coverage and price for you.

Maternity options also have something called a "waiting period", this is the amount of time you need to wait before you can claim for any costs. Maternity costs for insurers are very high and they put in place a waiting period so that people don't just get a maternity plan for a year, claim as much as they can and cancel it once the baby has been born.

Waiting periods on the maternity option is between 8-12 months. Therefore any costs incurred within the first 8-12 months of your plan starting relating to maternity cannot be claimed back.

Details of maternity coverage

Maternity plans usually provide cover for:

Normal delivery, complications of delivery, pre & post natal treatments and examinations, hospital or home delivery and medically necessary c-sections.

You should always read the benefits table carefully to know exactly what is covered under the plan you choose so there are no unexpected costs borne by you due to the insurance not covering it.

Questions to ask yourself before you start looking

Private medical insurance can give you cover for treatment whether:

- You are an expat and want treatment in the country where you are currently living
- If you live in your home country, but want more treatment options such as being able to choose your own doctor, hospital or reduced waiting times
- You want treatment in another country

Do I need worldwide cover?

You can pick different coverage areas with medical providers but usually most cover for worldwide or worldwide excluding North America. If you don't come from the US or rarely go there, then it may be worth choosing the worldwide excluding North American option as this would be more cost efficient.

Do I need routine and complex dental care to be covered by my medical insurance plan?

When living at home or abroad, dental care can get very expensive. Usually inpatient medical insurance plans cover you for emergency dental treatment if you are admitted to hospital.

However you can add a dental care rider onto your medical plan which will cover the cost of dental treatment from regular checkups, scale and polishes to complex treatments such as crowns, dentures and bridges.

Do I need maternity care to be covered by my medical insurance plan?

Most inpatient medical insurance plans cover the cost of emergency treatment during pregnancy. However, if you are thinking of having a child then you may want to think about adding a maternity rider to your medical insurance plan. These usually give cover up to a maximum limit for routine costs such as pre and post natal checkups, scans and delivery costs.

With maternity riders, there is usually a waiting period of 9-12 months. This means you need to have your medical insurance plan in place for 9-12 months before you have access to this particular cover.

Do I need to declare any pre-existing conditions?

Pre-existing conditions are any medical conditions which you have suffered from prior to taking out insurance. You need to declare all of these conditions on your insurance application otherwise the medical provider may not pay out when you make a claim.

Some medical providers cover pre-existing conditions, but only if certain criteria have been met.

Tips on how to Reduce the Costs of Medical Insurance

Just get the medical insurance coverage that you really need. If cost is especially important to you, you may decide only to get hospitalisation cover. This is a good idea if you are happy to cover the day to day expenses but want medical insurance to cover you for serious illnesses or accident.

Have an excess on your insurance plan. This is the amount of money that you pay first before the insurance company pays out. You can choose out of a nil, small, medium or large excess.

US medical treatment is very expensive so reduce the cost of your medical insurance by choosing to have worldwide excluding US coverage. This means you would be covered everywhere in the world apart from America for medical expenses. A lot of medical insurance plans do still cover you for short trips (such as holidays) that you take to the US.

Most medical insurance policies provide you with private rooms with inpatient treatments however to reduce the cost, you may want to elect for having semi private rooms. You can save up to 15% electing for this option.

If you receive some private medical insurance as part of your work contract then look at the coverage this provides. You can then decide if it is comprehensive enough to only get medical insurance which will kick in once you have used all of the limits of your work insurance.

Comparison websites promote competition between plan providers on prices. MyMoney.hk indicates how much money you have saved by using the website rather than going direct to the plan providers. Therefore you save money as well as time.

How to choose your medical insurance provider

Does the insurance provider offer everything you need?

There are so many medical insurance providers offering different types of plans. You should make sure the provider you decide to go with offers you the plan you want.

Is the insurer financially stable?

You should ask the medical insurance provider who insurers their company. Check the reputation and financial stability of the underlying insurer.

Does the insurance provider offer guaranteed renewals?

You should check that the medical plan has guaranteed renewals. This is because if you incur high costs one year due to expensive treatment then the insurer cannot refuse your renewal cover the next year.

Do they give you the option to manage your plan online?

If you travel a lot or don't have time to ring up the insurance provider to see the progress of your claim then many providers now have online logins where you can track claims and download claims forms for easy access.

Do they have a good service track record?

The medical insurance provider should have service guarantees around how fast they pay out claims or send out correspondence. Also to make communication easy and straight forward, ask if they have multi-lingual customer service representatives.

How do I buy medical insurance?

Use MyMoney.com.hk

You can go on our insurance comparison website and search for quotes in the comfort of your own home. You can change the requirements such as excess or people insured to find the plan suitable for your requirements. This is a computer system which searches though thousands of plans, an individual person is unable to search this many plans on their own. Once you have picked a plan you can apply.

If you don't want to look through all the plans yourself you could contact a representative of MyMoney.hk and get them to do this for you.

Use financial advisors

Financial advisors will be able to find out from you what type of plan you are after. They will be able to compare insurance plans to find the closest match to your specifications.

They can compare plans for you and make their recommendations. Financial advisors may have preferred plans though which they choose from whether it is right for you or not based on your requirements.

Go direct to the providers.

You can go directly to the insurance providers.

The providers will only be able to tell you about the plans they provide and therefore will not compare their products against the other products in the market in an impartial way. This means you may get the right plan for you out of the plans the provider offers but might not be the right plan in terms of the whole of the market.

Frequently Asked Questions

Question:
Why do the insurance premiums increase each year?

Answer:
This is due to a number of factors;

- Your age – each policy year you are 1 year older which means you present a larger risk to the insurers as are at higher risk of developing chronic conditions or having serious accidents
- Healthcare and Medical inflation. This is the yearly increase in the price of drugs and equipment.

Question:
If I make claims with my medical insurance will it affect the price of my premiums the next year like car insurance?

Answer:
This depends on the type of medical insurance plan you have opted for and is a very important consideration. The better medical insurance providers use community pricing. This means the cost of claims made is spread across the "community" so that the increase in premiums can be kept to a minimum. With this type of medical insurance plan, you can expect to pay the same price as anyone your age, your sex with the same cover and you

will not get priced out of your medical insurance when you need it most.

Question:
If I buy a maternity medical insurance plan and there is a waiting period, will no costs be covered if I get pregnant during that waiting period?

Answer:
You will not be covered for any costs during the waiting period but will be after. For example if you get pregnant during the waiting period but have your child after the waiting period then your scans before the birth will not be covered but the birth and post birth costs will be covered.

Question:
If I am pregnant when I take out maternity medical insurance will my baby have guaranteed acceptance to the policy?

Answer:
As you will still be in the waiting period when your baby is born then this is not a covered pregnancy, therefore when the baby is born, the usual application process will occur to add your baby to your plan including the underwriting process.

Always check the plan details to see what is covered and what isn't covered during the waiting period and after in terms of your baby

Question:
What does guaranteed renewal mean?

Answer:
Guaranteed renewal means each year you can renew your policy and the insurer will not decline your renewal request. If there isn't a guaranteed renewal feature then the insurer could decline your renewal request if you made large claims the year before.

Question:
If I move away from Hong Kong will my insurance plan stay in place?

Answer:
This depends on where you are moving to and if it is back to your home country or not. Each provider differs on this but majority say if you are still an expat in the country you are moving to then they will still cover you depending on if the laws of that country allow medical insurance. Your premiums are likely to change depending on the country you move to.

Question:
How can I pay for my medical insurance?

Answer:
Most medical providers offer, monthly, quarterly, semi-annual and annual payments however some firms do not offer monthly. You should be made aware of any increases in premiums due to paying it in more installments. Firms can increase the premium by up to 7% for monthly payments.

Glossary

Term	Descriptions
Additions	Persons added to a policy at renewal or mid-term. In some cases, persons added to a policy mid-term will enjoy pro-rata premiums.
Annual Contract	All health insurance policies are annual contracts with either guaranteed or non-guaranteed renewal.
Annual Limit	The overall maximum sum that the policy will cover in any one year.
Application Form	A form which must be completed and submitted in order for cover to come into effect.
Area of Cover	The geographic area in which the health insurance policy will provide cover.
Benefit Limit	A sum, shown on the plan's Benefit Schedule, showing any limit applied to a particular illness or service type. E.g.: Physiotherapy: US$1,000 per year.

Benefit Schedule	The official document outlining precisely what you are covered for. Includes details on any benefit limits.
Benefits	Services, procedures, medicine, durable medical equipment that the policy will cover. Shown in full in the benefits schedule attached to the policy.
Claim Form	A form which must be completed and submitted along with supporting documents. Forms the basis of claims submission. Some providers do not require claim forms or originals.
Claim Submission	The process of sending in a claim and requesting reimbursement for eligible expenses from the health insurance provider. Usually involves the completion of a claim form with receipts, invoices and a breakdown of services received attached.
Clinic Network	A collection of medical facilities at which insured persons will be able to present their member card and enjoy direct billing. The size and scope of the clinic network varies from provider to provider.
Conditionally Renewable	If a policy is conditionally renewable, the Insurer reserves the right to not offer renewal of the policy.

Covered Service	A medical procedure or treatment that is covered by the benefits of the policy.
Deductible	A sum of money that will need to be settled before the benefits of the policy will provide cover. Deductibles tend to be higher sums of money and applied on an annual basis. Once the annual deductible has been settled, the full benefits of the policy will provide cover.
Definitions	The official definitions of the policy as listed in the policy terms and conditions of the policy. Forms the basis of the insurance policy's contract.
Dependent	The immediate family of an insured person. Dependents may be added to an individual or group policy, subject to the approval of the policyholder and insurer.
Direct Billing	A general term relating to how your claims are reimbursed. If you use direct billing, then you can leave clinics after receiving treatment without paying. The clinic will then settle the bill directly with your insurance provider.
Disability	A health condition / conditions caused by an injury. Sometimes benefits are applied on a "per Disability" basis, meaning that a particular medical condition will only receive a certain amount of benefits as stipulated on the Benefits Schedule.

Effective Date	The date on which the policy becomes active, meaning you are covered under the benefits of the policy as per the policy terms and conditions.
Eligible Expenses	Expenses that will be reimbursed as per the benefits and terms and conditions of the policy.
Eligible Persons	Persons who may be added to the policy, usually limited to the policyholder's spouse and any children.
Emergency Hotline	In an emergency, seek treatment as soon as possible. Nearly all providers offer 24 hour hotlines if you need access to your benefits on an urgent basis. The hotline will be operated by the provider or a specialist partner.
Enrolment	The process of entering a policy. Usually involves the completion of an application form which includes a medical questionnaire.
Excess	Generally a small sum of money which you will have to fund before your plan will cover treatment. Excesses are usually applied on a per claim basis and start at around US$40 per claim. Once the excess for your claim is settled, the full benefits of the policy will cover your treatment.

Exclusions / Excluded	Exclusions applied to you for a pre-existing condition or other health condition. Excluded conditions are not covered by the policy.
Experience Rating	Usually applied to Group Policies. Renewal premiums are assigned based on the claims experience of that particular group in the immediate preceding years.
Full Medical Underwriting	A style of underwriting for enrolment into a health insurance policy. All applicants complete full medical questionnaires and submit prior to the policy effective date. Any declared conditions are excluded or covered with a loading. This way, you should understand the full implications and cover of your pre-existing conditions before committing to a policy.
Fully Covered	If a benefit is shown as Fully Covered or 100%, it means the service is covered up to the overall annual limit of the policy. If not Fully Covered, it will be subject to any limit shown on the benefit schedule.
General Exclusions	A list of treatments; circumstances; and / or illnesses, usually shown in the Policy Terms and Conditions, which are always excluded by the policy.
Group Policy	A policy that is owned by a company to insure its employees and in some cases their dependents.

Hospital & Surgical	Benefits, claims, treatment relating to treatment at a hospital or involving a surgical procedure.
Individual Policy	A policy that is owned by an individual person to insure him/herself and his/her immediate family.
In-patient	Treatment received at a hospital, either as a day-patient or admitted patient.
Insurer	The company who provides the financial strength behind your plan. The insurer of your plan will fund all claim payments.
International Private Medical Insurance	A medical insurance plan that is designed with a high standard of service and benefits in mind. Not necessarily for expats, but always providing a certain level of cover and geographic portability.
Letter of Guarantee / Guarantee of Payment	In the event of a large claim, an insurer will issue a Letter of Guarantee. The insurer must be informed as soon as possible and any documents supporting the claim must be submitted. The insurer will then work directly with the hospital and formally guarantee to pay any eligible expenses on behalf of the insured person.
Maternity Benefit	Benefits that will reimburse expenses relating to pre-natal, post-natal and childbirth.

Maximum Entry Age	The maximum age at which an insurer will accept persons into a policy.
Maximum Renewable Age	The maximum age at which you will be allowed to renew the policy. When you reach the maximum renewable age, you will not be offered renewal of the policy.
Medical Inflation	The increase in costs of medical treatment. This includes but is not limited to: doctors' fees, costs of medicine, general hospital fees etc.
Medical Insurance Plan	An insurance plan that is designed to reimburse expenses relating to medical treatment.
Medical Insurance Provider	The company who administers and / or maintains the medical insurance plan.
Medical Questionnaire	A questionnaire that asks about your current health status and past medical history. Usually included in the application form. This is reviewed as part of the underwriting process.
Medical Underwriting	The process by which providers assess applications. This is almost exclusively based on the declarations made in medical questionnaires and the profile of the applicant.

Member Card	A form of identification issued to any insured person. Usually in the form of a plastic card, showing you general details and useful contact numbers for the policy.
Mid-Term	Any movement, addition, deletion, change affecting the policy during the policy year, as opposed to at the start or renewal of the policy.
Moratorium	A style of underwriting for enrolment into a health insurance policy. Usually requires a less detailed application form compared to Full Medical Underwriting. The general condition is that any condition which you suffer from in the first e.g. 2 years of the policy will be automatically excluded.
www.mymoney.com.hk	Run and maintained by Capstone Financial (HK) Ltd., Mymoney.com.hk is Hong Kong's number one comparison site for life and medical insurance products.
Name List	A list of all persons insured by the policy.
Nil Deductible / Excess	Plans that have no deductible or excess will offer cover from the first dollar of expenses incurred. For example, if you submit a claim for US$250, then you will reimbursed US$250 (as per the benefits and terms of the policy).

North American Exclusion	Plans which have a North American Exclusion will exclude and / or restrict treatment in the United States and other North American countries.
Online Services	Most providers offer information and services in secure online platforms. Functionality between health insurers varies, from a basic information sharing platform to interactive claim submission and health tips.
Optional Benefit	Most insurance policies are based primarily upon Hospital and Surgical benefits. Depending on the plan design offered by the provider, you may be able to add benefits on an optional basis. Typical examples of optional benefits include dental benefits and maternity benefits.
Out-patient	Treatment, procedures, medication that are administered with no involvement from a hospital. Main examples include medication and services rendered by General Practitioners and Specialists at their clinics.
Pay and Claim	Treatment that you pay for and then claim from your insurance provider at a later date.

Payment Interval	Although premiums are usually shown on an annual basis, many providers offer payment intervals, meaning the premium can be paid quarterly, semi-annually etc. Payment intervals do sometimes require a minor surcharge to be paid.
Policy Documents	All documents and items relating to the policy. Including but not limited to the policy terms and conditions; benefit schedule; name list.
Policy Terms and Conditions	A key official document outlining any terms, conditions, general exclusions that affect the policy. The main document governing your health insurance policy.
Policy Year	The official time period in which the policy is in effect. E.g. 10 January 2014 to 9 January 2015. If the policy is renewed, this period will be extended by one year. If not renewed, cover will cease on the last day of the policy year.
Policyholder	An Individual or Company, named as the owner of the policy.
Pool	A means by which Insurers group their policies. For example a pool of individual policies may include over 3,000 policies, all with similar benefits and paying a similar premium.

Pool Rating	Most individual plans are pool rated. This means that individual policyholders will not be penalised for their claims. Premiums will however increase based on the general performance of the individual pool and as a result of general medical inflation.
Pre-Authorisation	Required for most hospital claims. The insurer / provider must be informed of treatment before treatment. The insurer / provider will then set up a letter of guarantee with the treating hospital.
Premium	The sum of money that must be paid for the policy to come into effect. The cost of the insurance.
Provider	A hospital, clinic or other medical facility that provides medical treatment and services.
Published Premiums	The official prices of plans as offered by providers. These can give an indication as to the cost of insurance, but may change after the completion of the application process which includes underwriting. The premium you pay will depend upon which provider, plan, benefits you choose and your age at time of application.
Renewable for Life	A policy that is renewable for life must be renewed for as long as the policyholder wants.

Renewal	The period at which the policy is coming to an end and needs to be renewed for another year.
Renewal Premium	All health policies are annual contracts. The renewal premium is the cost of renewing the policy for another year.
Third Party Administrator	A company that may administer a medical insurance plan but does not fund claims. Claims will be funded by the insurer that backs the plan.
Underwriting	The process by which medical insurance providers and insurers assess the risk involved in providing medical insurance cover. Includes premium setting, setting of benefit levels, and writing of policy terms and conditions.
Waiting Periods	Some benefits in health insurance policies will only available after a certain period of time. For example, certain dental or maternity benefits will only be available after e.g. 10 months of cover.
Worldwide	Plans that are Worldwide provide cover for elective and emergency treatment anywhere in the world.