

(effective 1st September 2008)

**GOODHEALTH**<sup>SM</sup>  
An Aetna Company

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# Definitions

To help You understand Your Policy the following words and phrases used anywhere within Your Policy have specific meanings, which are set out in this section. To enable You to recognise the defined words and phrases We have shown them in bold wherever they appear in Your Policy.

## Accident

An unexpected, unforeseen and involuntary external event resulting in injury occurring whilst Your Policy is in force.

## Acute

A Medical Condition which is brief, has a definite end point and which We, on Advice or General Advice determine can be cured by Treatment.

## Act of Terrorism

An act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in conjunction with any organisation(s) or government(s), committed for political, religious, ideological or ethnic purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

## Advice

Any consultation from a Medical Practitioner or Specialist including the issue of any prescriptions or repeat prescriptions.

## Appliances

Devices and equipment when used as an integral part of a surgical procedure administered by a Medical Practitioner or Specialist.

## Area of Coverage

Area 1: Africa plus India, Pakistan and Bangladesh

Area 2: Worldwide excluding USA

Area 3: Worldwide

## Benefits

The insurance coverage provided by this Policy and any extensions or restrictions shown in the Policy Schedule or in any endorsements (if applicable).

## Bodily Injury

Injury which is caused solely by an Accident which results in the Insured Person's dismemberment, disablement or other physical injury.

## Chronic

A disease, illness or injury that has at least one of the following characteristics:

- It continues indefinitely and has no known cure
- It comes back or is likely to come back
- It is permanent
- You need to be rehabilitated or specially trained to cope with it
- It needs long-term monitoring, consultations, check-ups examinations or tests.

## Co-Insurance

The percentage of the total value of the incurred expenses for which the Policyholder/Insured Person is responsible.

## Congenital Anomaly

A genetic, physical, or (bio) chemical defect, disease or malformation, which may either be hereditary/familial or due to an influence during gestation up to birth, and which may or may not be obvious at birth.

## Continuous Transfer Terms

The acceptance by Us of Your original Date of Entry as shown by Your current insurer will be applied to Your Policy with Us. We will maintain Your existing underwriting or special acceptance terms, as offered by Your existing insurer, such as any moratoria or specific exclusions and Your Policy with Us will be governed by the terms and conditions of Our Policy. Any transfer will be subject to no enhanced Benefits being provided. We reserve the right at all times to decline a Continuous Transfer Terms application without giving any reason.

## Country of Nationality

For the purpose of this Policy this will be the country for which You hold a passport.

## Country of Residence

The country in which You have Your habitual residence (residing for a period of no less than six months per Period of Cover) at the time this Policy is first taken out or at each subsequent Renewal Date.

## Date of Entry

The date shown on the Policy Schedule on which an Insured Person was included under this Policy.

## Day-Patient

An Insured Person who is admitted to a Hospital and uses a Hospital bed but does not stay overnight.

## Dental Practitioner

A person who is licensed by the relevant licensing authority to practice dentistry in the country where the dental Treatment is given.

## Dependants

One spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with You, or 23 years old if in full-time education, at the Date of Entry or at any subsequent Renewal Date. The term partner shall mean husband, wife or the person permanently living with You in a similar relationship.

All Dependants must be named as Insured Persons in the Policy Schedule.

## Direct Settlement Network/Provider Network

(Only available in certain countries)

The medical providers where You are able to obtain Treatment for valid Medical Conditions and where the expenses will be settled directly by Us. You are still responsible for any Co-Insurance or Excess applicable to Your Policy, which must be settled directly with the medical providers at the time of Treatment.

Please Note: Where You receive Treatment for a Medical Condition that is not covered within the terms of Your Policy, You remain liable for the costs of such Treatment, which must be settled in full upon request. Failure to act accordingly will result in the suspension or cancellation of Your Policy, without refund of premium.

### Drugs and Dressings

Essential drugs, dressings and medicines prescribed by a **Medical Practitioner** or **Specialist** and which are not available without prescription.

### Elective

Planned **Treatment** which is **Medically Necessary**, but which is not required as an **Emergency**.

### Emergency

A sudden, serious, and unforeseen **Acute Medical Condition** or injury requiring immediate medical care.

### Evacuation

Where **Treatment** is not available at the place of the incident this refers to the costs incurred in moving an **Insured Person** from the place of incident to an appropriate medical facility in **Your** geographic **Area of Coverage**, as determined by the attending **Medical Practitioner** or **Specialist** in conjunction with **Our** medical advisors. All airline tickets are limited to economy class.

### Excess

The amount payable by an **Insured Person** in respect of expenses incurred before any **Benefits** are paid under the **Policy**, as specified in **Your Policy Schedule**.

### Expatriate

Any persons living or working outside of the country for which they hold a passport, for a period exceeding six months per **Period of Cover**.

### General Advice

**Advice** from the relevant professional body to establish medical practice and/or established medical opinion in relation to any **Medical Condition** or **Treatment**.

### Group

A compulsory enrolment of all employees (minimum of three employees) covered under a single insurance agreement, purchased by their employer as an employee benefit, and where identical benefits have been provided to each member and accepted as such by **Us**.

### Hereditary

Transmitted from parents to offspring; inherited and which presents symptoms at birth.

### Hospital

An establishment that is legally licensed as a medical or surgical **Hospital** under the laws of the country in which it is situated.

### In-Patient

An **Insured Person** who stays in a **Hospital** bed and is admitted for one or more nights solely to receive **Treatment**.

### Insured Person/You/Your

The **Policyholder** and/or the **Dependants** named on the **Policy Schedule**.

### Local National

Any persons living or working in the country for which they hold a passport for a period exceeding six months per **Period of Cover**.

### Medical Condition

Any injury, illness or disease, including psychiatric illness.

### Medical Practitioner

A person who has attained primary degrees in medicine or surgery by attending a medical school recognised by the World Health Organisation and who is licensed by the relevant authority to practice medicine in the country where the **Treatment** is given.

### Medically Necessary

**Treatment** which, in the opinion of a qualified **Medical Practitioner**, is appropriate and consistent with the diagnosis and, which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the **Insured Person's** condition or the quality of medical care rendered.

### New Born

A baby who is within the first 16 weeks of its life following delivery.

### Organ Transplant

The replacement of vital organs (including bone marrow) as a consequence of an underlying eligible **Medical Condition**.

### Out-Patient

An **Insured Person** who receives **Treatment** at a recognised medical facility, but is not admitted to a **Hospital** bed as an **In-Patient** or **Day-Patient**.

### Palliative Treatment

Any **Treatment** given, on **Advice** or **General Advice**, for the purpose of offering temporary relief of symptoms. **Palliative Treatment** is not given to cure the **Medical Condition** causing the symptoms. For the purpose of this **Policy**, **Palliative Treatment** will include renal dialysis.

### Period of Cover

The **Period of Cover** set out in the **Policy Schedule**. This will be a 12-month period starting from the **Date of Entry** or any subsequent **Renewal Date** as applicable.

### Policy

**Our** contract of insurance with **You** providing cover as detailed in this document.

### Policyholder

The person or company named as **Policyholder** in the **Policy Schedule**.

### Policy Schedule

The schedule giving details of the **Policyholder** and the **Insured Persons**, **Policy** details and endorsements (if applicable).

### Private Room

Single occupancy accommodation in a private **Hospital**.

### Qualified Nurse

A nurse whose name is currently on any register or roll of nurses, maintained by any Statutory Nursing Registration Body within the country in which they are resident.

### Reasonable and Customary Charges

The average amount charged in respect of valid services or **Treatment** costs, as determined by **Our** experience in any particular country, area or region and substantiated by an independent third party, being a practising **Surgeon/Physician/Specialist** or government health department.

### Related Condition

Any injuries, illnesses or diseases are **Related Conditions** if **We**, on **General Advice**, determine that one is a result of the other or if each is a result of the same injury, illness or disease.

### Rehabilitation

Assisting an **Insured Person** who, following a **Medical Condition**, requiring physical therapy and assistance in independent living, to restore them as much as **Medically Necessary** or practically able, to the position in which they were prior to such **Medical Condition** occurring.

### Renewal Date

The anniversary of the **Commencement Date** of the **Policy**.

### Specialist

A registered **Medical Practitioner** who currently holds a substantive consultant appointment in that speciality, which is recognised as such by the statutory bodies of the relevant country.

### Treatment

Surgical, medical or other procedures, the sole purpose of which is the cure or relief of a **Medical Condition**.

### Underwriters

Those insurance companies named as **Underwriters** in **Your Policy Schedule**.

### We/Our/Us

Goodhealth on behalf of **Underwriters** as detailed in **Your Policy Schedule**.

# Cover

We will provide cover for the **Treatment of Medical Conditions** which first manifest themselves during any **Period of Cover** and where **Treatment** is actually given during the current **Period of Cover** or where such **Medical Conditions** have manifested themselves prior to the **Date of Entry** but have been declared to and accepted by Us in writing.

The following **Benefits** are covered under this **Policy**, up to a maximum of US\$1,500,000 per **Insured Person** per **Period of Cover**. We will provide **Benefits** for the following, subject to the level of cover chosen and the **Benefits** detailed in **Your Policy Schedule**. Any **Benefits** listed below which do not appear in **Your Policy Schedule** are not covered. All costs incurred must be **Medically Necessary** and subject to **Reasonable and Customary Charges**.

## Foundation

We cover the costs for:

### 1. Medical Practitioner and Specialist fees

- a) **Medical Practitioner** fees including consultations.
- b) **Specialist** fees as an **In-Patient**, **Day-Patient** or **Out-Patient**.
- c) Diagnostic and surgical procedures as an **In-Patient**, **Day-Patient** or **Out Patient**, including pathology, X-rays, MRI and CT scans.
- d) Anaesthetist fees.
- e) Physiotherapy on referral by a **Specialist** is restricted to 10 sessions per **Medical Condition**, after which it must be further reviewed by a **Specialist**. A medical report will be required for **Out-Patient** physiotherapy after 10 sessions. A referral letter/report must be submitted with the first claim for such **Treatment**.
- f) **Treatment** administered by registered chiropractors, osteopaths, homeopaths, podiatrists and acupuncturists when given under the direct control of and following referral by a **Medical Practitioner** or **Specialist**. Limited to 10 sessions per **Medical Condition** in aggregate.
- g) Alternative medicine administered by a **Specialist** is covered up to an annual limit of US\$250 without referral and up to US\$1,000 upon pre-authorisation by Us per **Period of Cover**.
- h) **Primary Care Benefits**  
**Medical Practitioner** consultations: initial (the primary) consultation with a **Medical Practitioner** for a new **Medical Condition**, plus any subsequently prescribed **Drugs and Dressings**, for the purpose of receiving **Advice** or **Treatment**. Limited to US\$1,500 per **Insured Person** per **Period of Cover**.

### 2. Hospital Charges

Accommodation limited to a standard **Private Room** and associated charges, including admittance to the intensive care unit as an **In-Patient** or **Day-Patient** and charges for nursing by a **Qualified Nurse**, theatre fees and other charges incurred for the **Treatment** of the **Medical Condition**.

### 3. Home Nursing

Nursing care given outside a **Hospital** which is immediately received subsequent to **Treatment** as an **In-Patient** or **Day-Patient** on the recommendation of a **Specialist** and must be provided by a **Qualified Nurse**. Limited to 30 days per **Medical Condition**. All **Treatment** under this **Benefit** is conditional upon pre-authorisation from Us. Without **Our** written confirmation prior to such **Treatment**, **We** will not be liable to pay any **Benefit**.

### 4. Prescribed Drugs and Dressings

**Drugs and Dressings** medicines and **Appliances** prescribed by a **Medical Practitioner** or **Specialist**.

### 5. Reconstructive Surgery

Reconstructive surgery required as a result of an **Accident** or illness which occurred during the **Period of Cover** and is undertaken within 12 months of the **Accident/illness** occurring to restore natural function or appearance, subject to the cover being in force.

### 6. Psychiatric Illness

- a) **Out-Patient Treatment**, including **Specialist** consultations, limited to a maximum of US\$4,500 per **Medical Condition** per **Period of Cover**.
- b) **In-Patient Treatment** in a recognised psychiatric unit of a **Hospital**, limited to 30 days per **Period of Cover**.

All **Treatment** under this **Benefit** must be pre-authorised by Us and must at all times be administered under the direct control of a registered psychiatrist. Without **Our** written confirmation prior to such **Treatment**, **We** will not be liable to pay any **Benefit**. However, the initial consultation with a **Medical Practitioner** (not a psychiatric **Specialist**), which results in a psychiatric referral is covered without the requirement for pre-authorisation.

This **Benefit** does not become effective until at least two years continuous membership has been held (**Psychiatric Benefit Entitlement Date**). No **Benefits** are payable in respect of this **Benefit** for any **Medical Condition**, or any **Related Condition**, which existed at any time prior to **Your Psychiatric Benefit Entitlement Date**.

### 7. Accidental Damage to Teeth

**Treatment** initially received in a dental surgery or in an **Accident** and **Emergency** ward of a **Hospital** within seven days of incurring accidental damage caused to sound, natural teeth, except when the accidental damage has been caused through eating, when given by a **Medical Practitioner** or **Dental Practitioner** limited to US\$3,750 per event.

### 8. Routine Pregnancy and Childbirth

Costs associated with normal pregnancy and childbirth and any **Related Condition** incurred where the date of conception is after the first 12 months from the purchase date of this **Benefit** or the **Date of Entry**, whichever is the later.

**Benefits** are limited to childbirth, pre and post-natal check-ups and delivery costs.

All costs relating to complications of pregnancy and/or childbirth following assisted conception will be limited to this Benefit.

Benefit is limited to US\$4,500 for each pregnancy.

#### 9. Complications of Pregnancy

Treatment of a **Medical Condition** which arises during the antenatal stages of pregnancy, or a **Medical Condition** which arises during childbirth and requires a recognised obstetric procedure. Benefit is payable where the date of conception is after the first 12 months from the purchase date or **Your Date of Entry**, whichever is the later.

#### 10. New Born Care

In-Patient Treatment of an **Acute Medical Condition** being suffered by a **New Born** baby which manifests itself within 30 days following birth. Benefit is limited to US\$10,000 and to a maximum of 30 days Hospital stay. Following the 30 day **New Born Benefit** period, excepting any **Medical Conditions** occurring or manifesting themselves during the 30 day period immediately following birth, **Your Dependant** will be eligible for cover up to the full provision of this Policy. Cover is subject to the child being included under their parent(s) Policy and premiums being paid in full.

#### 11. Parent Accommodation

Standard private Hospital accommodation in respect of one parent or legal guardian staying with an **Insured Person** who is under 18 years of age and is admitted as an **In-Patient** to a Hospital.

#### 12. New Born Accommodation

Hospital accommodation costs relating to a **New Born** baby to accompany its mother (being an **Insured Person**) whilst she is receiving Treatment as an **In-Patient** in a Hospital.

#### 13. Emergency Transportation

Emergency transportation costs to and from Hospital by the most appropriate transport method when considered **Medically Necessary** by a **Medical Practitioner** or **Specialist**.

#### 14. Evacuation

Evacuation costs of moving an **Insured Person** in the event of Treatment not being readily available at the place of the incident, to an appropriate medical facility in an alternative country of **Your** choice, within the geographic **Area of Coverage**, for the purpose of admission to Hospital as an **In-Patient** or **Day-Patient** (excluding all maternity or childbirth costs, except for Benefit 9 - **Complications of Pregnancy**). Evacuation is subject to written agreement from **Us** prior to travel and certified instructions from the attending **Medical Practitioner** or **Specialist** including confirmation that the required Treatment is unavailable at the place of incident. Extended to cover the costs for one other person to travel with the **Insured Person**, as escort, if **Medically Necessary**. Our medical advisors will decide the most appropriate method of transportation for the Evacuation and the most appropriate Hospital to which **You** will be evacuated.

Costs of Evacuation do not extend to include any Air-Sea rescue or mountain rescue costs that are not incurred at recognised ski resorts or similar winter sports resorts.

#### 15. Additional Travel Expenses (following Evacuation)

Reasonable travel costs:-

- Incurred by the **Insured Person** to and from medical appointments when Treatment is being received as a **Day-Patient**.
- For an accompanying person (where applicable) for non-Hospital accommodation where the **Insured Person** has been admitted as an **In-Patient** and for the duration of the **Insured Persons** stay as an **In-Patient** up to a daily limit of US\$120.
- For an accompanying person to travel to and from the Hospital to visit the **Insured Person** following admission as an **In-Patient**.

- For the **Insured Person** and one other accompanying person (where applicable) for non-Hospital accommodation only for immediate pre and post Hospital admission periods provided that the **Insured Person** is under the care of a **Specialist**. Up to US\$120 per day, per **Insured Person**. Up to US\$2,500 per **Insured Person**, per Evacuation.

- Economy class airline ticket to return the **Insured Person** and accompanying person who has travelled as an escort to the **Country of Residence** or to the country from where Evacuation occurred.

#### 16. Mortal Remains

In the event of death from an eligible **Medical Condition**:

- Costs of transportation of body or ashes of an **Insured Person** to his/her **Country of Nationality** or **Country of Residence**.  
or
- Burial or cremation costs at the place of death in accordance with reasonable and customary practice.

Up to US\$2,250 per **Insured Person**.

This Benefit is subject to written agreement from **Us**.

#### 17. Hospice Care Charges

Treatment provided by a Hospice for the care of an **Insured Person** with a terminal illness.

Such Treatment will cover:

- Palliative Treatment and other **Acute** and **Chronic** symptom management
- Medical social services under the direction of a **Medical Practitioner** or **Specialist**.
- Nursing care and home nursing (for up to eight hours in any one day)
- Physiological and dietary counselling

Benefits are limited to a period of 30 days for **In-Patient Treatment** and to a maximum of US\$5,000 for **Out-Patient Treatment**.

#### 18. Organ Transplant

Organ Transplants covered under this Policy are:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Allogenic bone marrow
- Autologous bone marrow

#### 19. Rehabilitation

Admission to a recognised Rehabilitation unit of a Hospital following Treatment for a **Medical Condition** where the **Insured Person** was confined to a Hospital as an **In-Patient** for at least three consecutive days, and where a **Specialist** confirms in writing that Rehabilitation is required. Admission to a Rehabilitation unit must be made within 14 days of discharge from Hospital.

Such Treatment should be under the supervision and control of a **Specialist** and would cover:

- Use of special Treatment rooms
- Physical therapy fees
- Speech therapy fees
- Other services usually given by a Rehabilitation unit including **Qualified Nurse** care but not including private or special nursing or **Specialist** services.

Limited to 120 days per **Medical Condition**.

#### 20. Ancillary Expenses

The purchase or rental of crutches or wheelchairs following Treatment as an **In-Patient** or **Day-Patient**. Cover is limited to US\$1000 per **Medical Condition**.

# Exclusions

This Policy does not cover expenses arising from:

1. Any **Medical Condition** or **Related Condition** for which **You** have received **Treatment**, had symptoms of, to the best of **Your** knowledge existed or **You** sought **Advice** for prior to **Your Date of Entry** (pre-existing **Medical Condition**). However, after two years' continuous membership, all pre-existing **Medical Conditions** (and **Related Conditions**) will become eligible for **Benefit** provided **You** have not:
  - a) Consulted any **Medical Practitioner** or **Specialist** for **Treatment** or **Advice** (including check-ups), or from which **You** have suffered from symptoms and/or
  - b) Taken medication (including drugs, medicines, special diets or injections) for a continuous period of two years after **Date of Entry** (two year moratorium) or
  - c) Where such **Medical Conditions** have previously manifested themselves, but have been declared to and accepted by **Us** in writing.
2.
  - a) **Treatment** of a **Medical Condition** which **We**, on **Advice** or **General Advice** determine is **Palliative Treatment** or a **Chronic Medical Condition**.
  - b) **We** will, however, pay for the stabilisation of **Acute** exacerbations of **Chronic Medical Conditions** that are not pre-existing **Medical Conditions**.
3. **Chronic** supportive **Treatment** of renal failure, including dialysis. **We** will however, pay for the cost of renal dialysis incurred:
  - a) Immediately pre and post-operatively
  - b) In connection with **Acute** secondary failure when dialysis is part of intensive care.
4. **Treatment**, which **We** determine on **Medical Advice** is either experimental or unproven.
5. Birth injuries, **Congenital Anomalies**, genetic deformities or diseases and **Hereditary Medical Conditions**.
6. Routine physical examination by a **Medical Practitioner**, including gynaecological investigations, routine tests, normal hearing tests, **New Born** neo-natal care, inoculations, vaccinations and preventative medicines.
7. Normal eye tests, non-medical/natural degenerative eye defects, including but not limited to myopia, presbyopia and astigmatism and any corrective surgery for non-medical/natural degenerative sight defects.
8. **Rehabilitation** except as provided in **Benefit 18** of the Policy.
9. **Treatment** received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments, or a **Hospital** where the **Hospital** has effectively become the **Insured Person's** home or permanent abode or where admission is arranged wholly or partly for domestic reasons.
10. **Cosmetic Treatment**, and any consequence thereof.
11. **Treatment** for weight loss or weight problems whether or not preceding or as a consequence of a psychiatric condition and any associated **Treatment** costs consequent of cosmetic surgery or arising as a result of an eating disorder or weight problem, including any required psychiatric **Treatment** where the psychiatric condition is a **Related Condition** to the eating disorder.
12. Costs of providing, maintaining or fitting any external prostheses or appliance, hearing and/or visual aids, or other equipment, medical or otherwise except as specified in **Benefit 20 – Ancillary Expenses**.
13. Costs incurred in connection with locating a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.
14. Any second or subsequent medical opinions from a **Medical Practitioner** or **Specialist** for the same **Medical Condition** unless it has been authorised by **Us** in writing.
15. Costs associated with normal pregnancy and childbirth and any **Related Condition** where the date of conception is within the first 12 months from purchase date of this **Benefit** or **Date of Entry** whichever is later.
16. Voluntary caesarean section costs or **Medically Necessary** caesarean costs due to previous non-Emergency caesarean sections.
17. Pregnancy terminations on non-medical grounds, antenatal classes, midwifery costs when not associated with delivery.
18. Complications of pregnancy costs arising where the date of conception is within the first 12 months from purchase date of this **Benefit** or **Date of Entry** whichever is later.
19. **Treatment** directly or indirectly arising from or required in connection with male and female birth control, infertility and/or fertility and sterilisation (or its reversal).
20. Any form of assisted conception or any complications thereof including, but not limited to, premature or multiple births following assisted conception.

A declaration of health is required in respect of all **Dependants** who are born following assisted conception. We reserve the right to reject any application without giving any reason.

21. **Treatment** of impotence or any **Related Condition** or consequence thereof.
  22. **Treatment** directly or indirectly associated with a sex change and any consequence thereof.
  23. Venereal disease or any other sexually transmitted diseases or any **Related Condition**.
  24. Routine or restorative dental **Treatment**, whether or not performed by a **Medical Practitioner** or **Dental Practitioner** or a **Specialist** or an oral and maxillofacial surgeon.
  25. Orthodontic **Treatment**, gingivitis, and periodontitis or any **Related Condition**.
  26. Costs in respect of a psychotherapist, psychologist (unless referred to by and under the control of a psychiatrist under **Benefit 6** of this **Policy**), family therapist or bereavement counsellor.
  27. **Treatment** for learning difficulties, hyperactivity, attention deficit disorder, speech therapy and, developmental, social or behavioural problems in children.
  28. **Treatment** for alcoholism, drug or substance abuse or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or addiction.
  29. Suicide or attempted suicide, or any **Bodily Injury** or illness which is wilfully self-inflicted or due to negligent or reckless behaviour.
  30. Any injury sustained directly or indirectly as a result of the **Insured Person** acting illegally or committing or helping to commit a criminal offence.
  31. Travel and accommodation costs unless specifically agreed by **Us** in writing prior to travel. No travel and accommodation costs are payable where **Treatment** is obtained solely as an **Out-Patient**, including the costs of a hire car.
  32. Costs and expenses incurred where an **Insured Person** has travelled against **Medical Advice**.
  33. **Elective Treatment** received outside the **Area of Coverage**. However, **Accident** and **Emergency Treatment** is covered unless they are pre-existing **Medical Conditions** or where symptoms existed prior to the first date of travel. In the event of **Emergency Treatment** being required in the USA, **You** should contact **Us** or **Our** 24 hour Medical Helpline either before or as soon as possible after admission to the **Accident** and **Emergency** unit of the **Hospital**. Complications of maternity and/or childbirth are not deemed to be **Accident** or **Emergency Treatment** for the purposes of this **Policy**.
34. **Treatment** and expenses directly or indirectly arising from or required as a consequence of: war, invasion, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion, revolution, insurrection or military or usurped power, mutiny, riot, strike, martial law or state of siege or attempted overthrow of government or any **Acts of Terrorism**, unless the **Insured Person** sustains **Bodily Injury** whilst an innocent bystander up to a maximum amount US\$50,000 per **Insured Person** per incident.
  35. **Treatment** directly or indirectly arising from or required as a result of chemical contamination or contamination by radioactivity from any nuclear material whatsoever or from the combustion of nuclear fuel, asbestosis or any **Related Condition**.
  36. Regardless of any contributory clause(s), this insurance does not cover **Treatment** of a **Medical Condition** which is in any way caused or contributed to by an **Act of Terrorism** involving the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent.  
  
If **We** allege that by reason of this exclusion any claim is not covered by this insurance, the burden of proving the contrary shall be upon **You**.
  37. **Treatment** for sleep-related breathing disorders, including snoring, fatigue, jet lag or work-related stress or any **Related Condition**.
  38. Dietary supplements and substances which are available naturally and that can be purchased without prescription, including but not limited to vitamins, minerals and organic substances.
  39. Home visits by a **Medical Practitioner**, **Specialist** or **Qualified Nurse** unless specifically agreed by **Us** in writing prior to consultation.
  40. Human Immunodeficiency Virus (HIV) and/or HIV related illness including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, however caused.
  41. Hormone Replacement Therapy (HRT) or any similar or associated medication or **Treatment**.
  42. The **Excess** amount as shown in **Your Policy Schedule** will be deducted from all eligible medical expenses in respect of each new **Medical Condition**.

Additionally **Benefit** is payable for the medical expenses which arise as a result of an **Emergency**, which do not require **You** to seek **Treatment** in the **Accident** and **Emergency** unit of a **Hospital** whilst **You** are temporarily travelling in the USA and where the **Medical Condition** did not exist prior to travel. **Benefit** is limited to US\$500 per **Insured Person** and an **Excess** of US\$80 per **Medical Condition**.

Cover for **Accident** and **Emergency Treatment** outside **Your** selected **Area of Coverage** is for a maximum of 90 days during the **Period of Cover** and limited to a maximum of 60 days of **Treatment** per event.

# Product Options

The following Options only apply if they are specifically endorsed in Your Policy Schedule

## OPTION 001 - Exclude Pregnancy Cover

Cover under this Policy does not cover any expenses arising from or any costs associated with normal pregnancy, childbirth or Related Conditions.

For this Option only Benefit 8 is deleted.

## OPTION 002 - Major Medical Expenses

Cover under this Policy is limited to provide Treatment in respect of In-Patient and Day-Patient Treatment and Evacuation only. Cover also provides full refund for oncology, CT and MRI scans, Out-Patient surgery and Organ Transplants wheresoever the services are performed, subject always to the services being Medically Necessary and being no more than Reasonable and Customary Charges.

Cover is extended to provide Out-Patient consultative and diagnostic costs prior to Treatment as an In-Patient or Day-Patient or for follow-up costs, for up to 60 days following discharge from Hospital, up to a maximum of US\$1,700 for each new Medical Condition.

Where this Option is chosen to be included within Your Policy, Option 005, 007 and 008 are not available.

Where an Insured Person has previously elected to take this Option, and then elects to take an alternative Option at any subsequent Renewal Date, any Out-Patient costs associated with Treatment of an existing Medical Condition will be excluded.

This Benefit does not cover any expenses arising from or any costs associated with normal pregnancy, childbirth or Related Conditions.

Cover under this Option is limited to a maximum of US\$1,000,000 per Insured Person per Period of Cover.

For this Option only Benefit 8 is deleted.

## OPTION 003 - Optional Excess Levels

The Excess shown on the Policy Schedule shall apply to all admissible expenses for Treatment of each new Medical Condition.

Where Option 002 has been purchased, the optional Excess levels are restricted to US\$250, US\$750, US\$1,500 and US\$4,000.

Where Option 005 has been purchased the optional Excess levels are restricted to US\$40, US\$80 and US\$150.

## OPTION 004 - Worldwide Elective Treatment Excluding USA

Cover under this Policy is extended to provide Elective Treatment worldwide excluding USA. All planned In-Patient or Day-Patient cover must be notified to Us prior to commencement of Treatment.

Accident and Emergency Treatment required in the USA will be reimbursed on a full refund basis unless such Treatment is as a result of a pre-existing Medical Condition or where symptoms existed prior to the first date of travel. Coverage is for a maximum of 90 days during the Period of Cover and limited to a maximum of 60 days of Treatment per event.

For this Option only the first paragraph of exclusion 33 is deleted and replaced with:

Accident and Emergency Treatment in the USA is covered unless they are pre-existing Medical Conditions or where symptoms existed prior to the first date of travel. In the event of Emergency Treatment being required in the USA, You should contact Us or Our 24 hour Medical Helpline either before or as soon as possible after admission to the Accident and Emergency unit of the Hospital. Complications of maternity and/or childbirth are not deemed to be Accident or Emergency Treatment for the purposes of this Policy.

## OPTION 005 - Worldwide Elective Treatment

(Not available where Option 002 has been purchased)

Cover under this Policy is extended to provide Elective Treatment in the USA.

Costs will be reimbursed on a full refund basis, subject to the level of Excess shown in Your Policy Schedule, where In-Patient or Day-Patient Treatment is received within Our Provider Network, or where Out-Patient Treatment is provided. In-Patient or Day-Patient Treatment received outside Our Provider Network will be subject to 50% Co-Insurance and an annual maximum of US\$750,000 per Insured Person per Period of Cover. All planned In-Patient or Day-Patient cover must be notified to Us prior to commencement of Treatment.

For this Option only, exclusion 33 is deleted.

#### OPTION 006 - Medical History Disregarded

This Option is only applicable to **Group** schemes of 10 employees or more enrolled in a compulsory company **Policy** (compulsory means ALL employees and their **Dependants** are enrolled within 30 days of eligibility, ALL employees and their **Dependants** are deleted within 30 days of leaving the company employment. Any employee or **Dependant** not covered within 30 days of eligibility will be subject to individual underwriting).

Cover under this **Policy** is extended to include **Treatment** for **Medical Conditions** from which **You** have previously suffered, or **Related Conditions**.

For **Groups** of 10-19 employees a full declaration of health is required in respect of each employee and each of their **Dependants** and cover on a medical history disregarded basis will be at **Our** discretion.

For **Groups** over 19 employees, cover can be offered subject to a declaration of material facts being submitted by the **Group** administrator on behalf of the employees and their **Dependants**, and cover on a medical history disregarded basis will be at **Our** discretion.

**Continuous Transfer Terms** will be the only option available where the scheme was accepted by the previous insurer on a fully underwritten basis.

For this Option only exclusion 1 is deleted.

#### OPTION 007 - Chronic Conditions

(Not available where Option 002 has been purchased).

This Option is only applicable to **Group** schemes of three employees or more enrolled in a compulsory company paid **Policy**.

Cover under the **Policy** is extended to include routine management and **Palliative Treatment** incurred in connection with a **Chronic Medical Condition**.

Expenses are limited to routine check-ups associated with the **Chronic Medical Condition**, **Drugs and Dressings** prescribed for management of the **Medical Condition**, renal dialysis (where applicable), nursing, surgery and **Palliative Treatment**.

**Benefit** is limited to a maximum of US\$5,000 per **Insured Person** per **Period of Cover**.

For this Option only exclusions 2, 3 and 42 are deleted.

#### OPTION 008 - Routine Dental

(Not available where Option 002 has been purchased)

This Option is only applicable to **Group** schemes of three employees or more enrolled in a compulsory company paid **Policy**.

Cover under this **Policy** is extended to include the following **Benefits**:

Fees of a **Dental Practitioner** carrying out routine dental **Treatment** in a dental surgery. Routine dental **Treatment** is defined as:

- a) Examinations, tooth cleaning, normal compound fillings, simple or non-surgical extractions and root canal treatment.
- b) **Benefit** is limited to US\$400 for each **Insured Person** in each **Period of Cover** with a **Co-Insurance** of 25%
- c) **Benefit** is limited to maximum of five visits and/or services per **Insured Person** per **Period of Cover**
- d) Costs incurred within six months from the date of purchase of this Option or **Your Date of Entry**, whichever is the later, are excluded.

For this Option only exclusions 1, 24 and 42 are deleted.

# General Conditions

## 1. Policy

Your application form, Our written acceptance, Your Benefit schedule, Your Policy Schedule and the Policy wording must be read as one as they form the basis of Your contract with Us.

## 2. Contribution

If there is any other insurance covering any of the same Benefits, You must disclose or ensure that the relevant Insured Person discloses the same to Us and We shall not be liable to pay or contribute more than Our proper proportion. If it is found that You were repaid for all or some of those expenses by another source including any other insurance Policy (as outlined in General Condition 16), We will have the right to a refund from You. Where necessary We retain the right to deduct such refund from any impending or future claim settlements or to cancel Your Policy void from commencement, without a refund of premium - see General Condition 22.

## 3. Transfers

- a) Where You transfer to the Executive Healthcare Plan from any other of Our existing plans or, whilst covered under the Executive Healthcare Plan, You apply for and receive any enhanced Benefits or coverage (such as inclusion of an endorsement at any Renewal Date), any enhanced Benefits, coverage or maximum refundable amounts are restricted to new Medical Conditions which have not been previously suffered from, whether or not diagnosed, occurring after the date of transfer.
- b) Transfer from a Group to an individual Policy is subject to written approval from Us. Terms of cover may be subject to variation.
- c) Transfer from any other similar private medical cover provided by any other insurer is subject to completion of a Continuous Transfer Terms declaration form, submission of a copy of the expiring Policy and subject to there being no break in cover. We reserve the right at all times to decline an application without giving any reason and/or to offer alternative terms.

## 4. Family/Dependant Cover

You and Your Dependants are required to be covered under the same Policy with identical Benefits. Where We find that this is not the case, You will be asked to comply with this request at Your next renewal. Failure to comply with this condition will result in the termination of Your Policy.

## 5. Acceptance Clause

We are entitled to refuse to accept an application from any person without giving a reason. We maintain the right to ask You to provide proof of age and/or state of health of any person included in Your application. We reserve the right to apply additional endorsements, exclusions or premium increases to reflect any circumstances You advise in Your application form or declared to Us as a material fact.

## 6. Eligibility

The Policy is designed for Expatriate Residents of all African countries. Local Nationals can only be considered subject to Our approval. New applicants will be eligible for cover up until the age of 65. Individuals over the age of 65 are not eligible for cover unless the Insured Person's Date of Entry was prior to their 65th birthday.

For compulsory Group schemes, ALL employees and their Dependants must be enrolled within 30 days of eligibility, ALL employees and their Dependants must be deleted within 30 days from when their employment ceased.

Any employee or their Dependant not enrolled within 30 days of eligibility will be subject to individual underwriting. Under the terms of this Policy, cover is not available to persons where the Country of Residence is outside any of the African countries, irrespective of their Country of Nationality.

If during the Policy year Your Country of Residence is outside any of the African countries, We will not be able to offer You renewal.

## 7. Compliance with Policy Terms and Conditions

We shall not be liable under this Policy in the event of any failure by an Insured Person to comply with its terms and conditions, except where the circumstances of any claim are unconnected with such failure and no fraud is involved.

## 8. Medical Evaluation

We reserve the right to request further tests and/or evaluation where We decide that the condition being claimed for may be directly or indirectly related to an excluded condition.

## 9. Change of Risk

The Policyholder must inform Us as soon as reasonably possible of any material changes relating to any Insured Person which affect information given in connection with the application for cover under this Policy. We reserve the right to alter the Policy terms or cancel cover for an Insured Person following a change of risk.

## 10. Policy Duration and Premiums

- a) The Policy is for one year and is renewable for successive one year periods, subject to the terms in force at the time of each Renewal Date and to payment of the premium.
- b) The premium payable may be changed by Us from time to time. If You move into a higher age band, the premium will increase at the next Renewal Date. However, this Policy will not be subject to any alteration in premium rates generally introduced until the next Renewal Date.
- c) All premiums are payable in advance of any cover under this Policy being provided.
- d) Your Policy is an annual contract and You are responsible for the whole year's premium even if We have agreed that You may pay by instalments.

#### 11. Government Taxes

To reflect any change in insurance premium tax or other government levies, **We** may alter the terms and conditions of this **Policy** at any **Renewal Date**. A copy of the current **Policy** terms will be sent to **You** at such time.

#### 12. Break In Cover

Where there is a break in cover, for whatever reason, **We** reserve the right to reapply exclusion 1 in respect of pre-existing **Medical Conditions**.

#### 13. Children

**New Born** children will be accepted for cover (subject to the limitations of **Benefit 10**) from birth. Acceptance of **New Born** babies is subject to written notification within 30 days of birth and receipt of the full premium within a further 30 days following notification.

Children who are not more than 18 years old residing with **You**, or 23 years old if in full-time education, at the date of joining or at any annual **Renewal Date**, will be accepted for cover as **Your Dependants**. Children will not be accepted for cover, unless on a **Policy** with a legal parent or guardian and subject to the identical **Benefits** applying to all parties.

A declaration of health is required in respect of all **Dependants** who are born following assisted conception. **We** reserve the right to reject any application without giving any reason.

#### 14. Alterations

- a) **We** may alter the terms and conditions of this **Policy** at any **Renewal Date**. A copy of the current **Policy** terms will be sent to **You** at such time. **You** may cancel **Your Policy** within 15 days following any **Renewal Date** and provided **You** have not made a claim, **We** will refund **Your** premium. **We** will give **You** reasonable notice of such alterations. **We** will send details of such alterations to the address **We** have for **You**. However, the alterations will take effect even if **You** do not receive them for any reason.
- b) No alteration or amendment to the **Policy** terms will be valid unless it is in writing from **Us**.

#### 15. Waiver

Waiver by **Us** in any instance of any term or condition of this **Policy** will not prevent **Us** from relying on such term or condition in other instances.

#### 16. Cancellation

In the event of any non-payment of premium, **We** shall be entitled to cancel this **Policy**. **We** may at **Our** discretion reinstate the cover if the premium is subsequently paid, though terms of cover may be subject to variation. Whilst **We** shall not cancel this **Policy** because of eligible claims made by any **Insured Person**, **We** may at any time terminate an **Insured Person's** cover if he/she or the **Policyholder** has at any time:

- a) Mised **Us** by misstatement.
- b) Knowingly claimed **Benefits** for any purpose other than as are provided for under this **Policy**.
- c) Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to **Our** detriment.
- d) Otherwise failed to observe the terms and conditions of this **Policy** or failed to act with utmost good faith. If the **Policy** is cancelled by the **Policyholder** at any time other than following the **Renewal Date** there will be no return of premium.

#### 17. Applicable Law

The law applicable to this **Policy** shall be as specified in the **Policy Schedule**, unless **You** have requested an alternative, which has been accepted in writing by **Us**. If no law is specified then the **Policy** shall be construed according to the laws of England and shall be subject to the non-exclusive jurisdiction of the courts of England and Wales.

#### 18. Arbitration

All differences relating to the claim amount arising out of the **Policy** shall be referred to the decision of an arbitrator to be appointed in writing by both parties. If the parties cannot agree upon a single arbitrator, then two arbitrators should refer the matter for review, one to be appointed in writing by each of the parties. Should the two arbitrators fail to agree, then an independent umpire should be appointed in writing by the arbitrators within 30 days from the date of disagreement. The umpire shall sit with the arbitrators and preside at their meeting and the making of an award within 60 days of the first meeting shall be a condition precedent to any right of action against the **Underwriters**.

If the **Underwriters** disclaim liability to **You**, **Your** legal/personal representatives or any claimant, for any claim hereunder, and such claim is not within 12 calendar months from the date of such disclaimer referred to arbitration under the provisions herein contained, then the claim shall be deemed for all the purposes to have been abandoned and shall therefore not be recoverable hereunder.

#### 19. Several Liability

The various **Underwriters** of this **Policy** to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The **Underwriters** are not responsible for the subscription of any co-subscribing **Underwriter** who for any reason does not satisfy all or part of its obligations.

#### 20. Fraudulent/Unfounded Claims

If any claim under this **Policy** is in any respect fraudulent or unfounded, all **Benefits** paid and/or payable in relation to that claim shall be forfeited and (if appropriate) recoverable. In addition all cover in respect of the **Insured Person** shall be cancelled void from **Date of Entry** without refund of premiums.

#### 21. Liability

**Our** liability shall cease immediately upon termination of the **Policy** for whatever reason, including without limitation non-renewal and non-payment of premium.

#### 22. Premium Refunds

After the first 15 days of cover from **Your Date of Entry** **You** will not be entitled to any refund of premium, either in full or in part, for whatever reason.

#### 23. Re-Assignment

If there is more than one **Insured Person** over the age of 18 and the **Policyholder** dies, this **Policy** will automatically be transferred to the oldest **Insured Person** over the age of 18 years who shall upon the date of death of the **Policyholder** become the **Policyholder** for the purposes of this **Policy** and be responsible for paying the premium.

#### 24. Third Parties

The only parties to this contract are the **Policyholder** and **Us**. No other person, including any **Insured Person**, has any right under the Contracts (Rights of Third Parties) Act 1999 to enforce this **Policy** or any part of it.

#### 25. Subrogation

The **Policy** shall be subrogated to all rights of recovery that **You** have against any other party with respect to any payment made by that party to **You** due to any injury, illness or **Medical Condition** **You** sustain to the full extent of the **Benefits** provided or to be provided by the **Policy**. If **You** receive any payment from any other party or from any other insurance coverage as a result of an injury, illness or **Medical Condition**, **We** have the right to recover from, and be reimbursed by **You**, for all amounts **We** have paid and will pay as a result of that injury, illness or **Medical Condition**, from such payment, up to and including the full amount **You** receive.

**We** shall be entitled to full reimbursement from any other party's payments, even if such payment will result in a recovery which is insufficient to fully compensate **You** in part or in whole for the damages sustained.

**You** are required to fully cooperate with **Us** in our efforts to recover any payments made under the **Policy** including any legal proceedings which **We** may conduct and proceed on **Your** behalf at our sole discretion. **You** are required to notify **Us** within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of **Your** intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or **Medical Condition** sustained by **You** the **Insured Person**. Other than with **Our** written consent **You** have no entitlement to admit liability for any eventuality or give promise of any undertaking which is binding upon **You**, **Your Dependants** or any other person named in the **Policy**. In the event that any claim or dispute is made in respect of this subrogation or any part thereof including but not limited to any right of recovery provision which is ambiguous or questions arise concerning the meaning or intent of any of its terms, **We** shall for the avoidance of doubt have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

#### 26. Currency

The monetary limits applicable to **Your Policy** will be expressed in the same currency as **Your** premium. Claims paid in a local currency will be converted at the rate of exchange quoted by either the Financial Times or Reuters, at **Our** sole discretion, at the time **We** assess the claim. In certain geographical locations, **We** may be required to use an alternative published rate of exchange. **We** will advise **You** at the time of settlement the rate of exchange used and from which source this rate was derived.

# Claims Procedures

## IMPORTANT

In order to ensure that **You** receive the best possible claims service the procedures noted below should be followed in the event of **Treatment** being required by **You** or one of **Your Dependants**.

The settlement of **Your** claim may be delayed if **You** fail to complete **Your** claim form properly. Please note the requirements under the claim form section of this claims procedure.

## MEDICAL HELPLINE

All **Insured Persons** have access to **Our** Medical Helpline which is available 24 hours a day, 365 days a year and is staffed by multi-lingual operators who can arrange admission to **Hospital**, ambulance transfers and air **Evacuation** where necessary. To obtain medical assistance, please use the Medical Helpline number nearest to **You** as shown on **Your** membership card. **You** will need to provide **Your** name, reference number, telephone and/or fax number, location and **Medical Condition**. In any given situation, if **You** are unsure what to do, contact the Medical Helpline.

## OUT-PATIENT TREATMENT

**Out-Patient Treatment** is **Treatment** received in a doctor's office and does not require admission to a **Hospital** bed.

### 1. Outside the USA

**Out-Patient** services and **Treatment** received outside the USA are required to be paid by **You** at the time of **Treatment**. After paying for **Your Treatment** **You** must submit a claim form to **Us** to be processed. To ensure prompt settlement of these expenses, please make sure to take **Your** claim form with **You** in order for it to be completed by the treating General Practitioner, **Specialist** or **Dental Practitioner**.

Exceptions may be made for high cost procedures. In this case **You** will be required to contact **Us** prior to receiving **Your Treatment**, in order for **Us** to arrange direct payment with the medical facility concerned. Please note that not all medical facilities may accept direct payment with **Us**. In these instances **You** will be required to settle the bill and submit a claim to **Us** for reimbursement.

Providing all relevant information is submitted to support **Your** claim, **We** will reimburse **You** accordingly by the payment method of **Your** choice. Please clearly state **Your** preferred payment method on **Your** claim form. Where this is by bank transfer clearly state the name of **Your** bank, account number and SWIFT (or IBAN) code.

### 2. Inside the USA

Some policies allow for **Treatment** to be undertaken in the USA. Please check **Your Policy** to ensure that **You** have the appropriate coverage before undertaking any **Treatment** in the USA.

Where **Your Policy** allows, **Out-Patient** services and **Treatment** received within **Our Provider Network** can be billed to **Us** directly. In most cases, **You** will be required to show **Your** membership card to the provider who will contact **Us** to confirm direct billing. This may not immediately happen and, should **You** be asked to pay for the **Treatment**, please ensure **You** state clearly to the facility that **You** wish to have **Your** bill settled directly by **Us**, and for them to contact the number on the reverse of **Your** membership card.

In the unlikely event that **You** are still required to pay **Your** bill, please follow the steps as outlined in section 1 above.

**Our** claims department will process the claim according to the applicable portion payable by **Us** taking into account **Your Excess** and any **Co-Insurance** applicable. Once **Our** portion is paid, **We** will send both **You** and the provider an explanation of **Benefits** (EOB) with details of settlement and statement of what **You** are responsible for.

## DAY-PATIENT AND IN-PATIENT TREATMENT

**Day-Patient** and **In-Patient Treatment** are those that are received in a **Hospital**, and where it is **Medically Necessary** for **You** to be admitted to a **Hospital** bed, whether or not **You** need an overnight stay. **We** require that **Our** prior approval (pre-authorisation) be obtained for all planned **Day-Patient** and **In-Patient Treatment**.

For **Emergency** admissions **You**, the **Hospital** or a family member are recommended to contact **Us** to obtain pre-authorisation prior to **Your** leaving the **Hospital**. Failure to pre-notify **Your In-Patient** or **Day-Patient Treatment** will mean that **You** may only be eligible for reimbursement of a proportion of the costs incurred.

### 1. Outside the USA

When **We** have been pre-notified of an eligible **Day-Patient/In-Patient** stay **We** will attempt to arrange direct billing with the **Hospital** and the **Medical Practitioners** or **Specialists** concerned. **We** will send the **Hospital** a guarantee of payment to the value of the estimated cost of **Treatment** advised to **Us** by the relevant facility/provider, which will confirm to them that the **Treatment** is covered under **Your Policy**.

### Release of Medical Information Form

**You** will be required to complete a Release of Medical Information Form which **You** should forward to **Us** as soon as possible. Delays in completing this document may result in delays in receiving your **Treatment**.

### Pre-certification Medical Form

The **Hospital** is required to complete a pre-certification Medical Form outlining details of the **Medical Condition** and **Treatment** to be undertaken.

**We** cannot place a guarantee of payment without these two documents so please ensure that the **Hospital** confirms with **You** that these have been sent to **Us**. **We** will verbally confirm with **You** should **Your Treatment** be covered under the terms of the **Policy**. However, completion of pre-authorisation is conditional on the submission of **Our** guarantee of payment. **We** will notify **You** as soon as possible if the condition or **Treatment** required is not covered under the terms of **Your Policy**.

It may be that **We** are unable to implement a guarantee of payment before **Your Treatment** is undertaken. This may be due to delays in the **Hospital** providing **Us** with the appropriate medical information for **Us** to be able to confirm coverage. It is therefore important to contact **Us** as soon as possible prior to **Your Treatment** taking place to ensure **We** are able to place a guarantee of payment in due time. **We** would recommend that **You** do not delay **Your Treatment** if a guarantee of payment is not in place at the time **Your Treatment** is due.

## 2. Inside the USA

Some policies allow for **Treatment** to be undertaken in the USA. Please check **Your Policy** to ensure that **You** have the appropriate coverage before undertaking any **Treatment** in the USA.

**Treatment** received within the **Provider Network** will be billed to **Us** directly. **Our** claims department will determine what portion of the invoice is applied to **Your Excess** and any **Co-Insurance** applicable and which portion is payable by **Us**. **We** will send **You** and the provider copies of the explanation of **Benefits** (EOB) detailing how the bill was settled and what amount **You** are responsible for.

**We** will notify **You** as soon as possible if the **Medical Condition** or **Treatment** required is not covered under the terms of **Your Policy**.

### USA PROVIDER NETWORK

**We** have made arrangements with many **Provider Networks** in the USA which, when **You** receive **Treatment** at these facilities will mean that **Your** costs for **Treatment** can be settled directly by **Us**.

**You** can find the **Provider Network** facilities in **Your** area by visiting the Goodhealth website:

[www.goodhealthworldwide.com/usefullinks.asp](http://www.goodhealthworldwide.com/usefullinks.asp)

Click on the link to the DocFind search engine. From there **You** can perform a search by address, name, specialty, and/or Tax ID Number. If **You** are unable to find details of **Your** preferred provider from this search facility or have any problems with the search engine please contact **Your** local Goodhealth office noted below for assistance.

### Pre-authorisation

**We** require members to obtain prior approval (pre-authorisation) from **Us** before commencing the following **Treatments**:

- Planned In-Patient or Day-Patient Treatment (hospitalisation)
- Any pregnancy or childbirth Treatment
- Planned surgery
- Evacuation
- Second medical opinions
- Psychiatric Treatment – In-Patient, Day-Patient, and Out-Patient
- Home nursing charges
- Planned MRI and CT Scans

Evacuations are supervised by **Your Medical Practitioner** or **Specialist** at the place of incident and by **Our** Medical Helpline and must be agreed by **Us** before Evacuation takes place.

### Referral from a Medical Practitioner

**We** will require a doctor's referral to be included whenever filing a claim for the following **Treatments**:

- Physiotherapy (Medical Practitioner referral accepted)
- Medical Practitioner or Specialist referral required
- Chiropractic Treatment
- Acupuncture Treatment
- Osteopathic Treatment
- Homeopathic Treatment
- Podiatric Treatment

### CLAIM FORM

When submitting any claim forms and any other documents pertaining to the claim, please ensure that:

- The first page of the claim form has been completed in full by **You** for each **Medical Condition** treated. The declaration must be signed by the **Insured Person** and dated to enable the claim to be validated
- **You** attach to **Your** claim form the original paid receipts and any other documents pertaining to the claim (or other proof of payment) for all **Treatment** for which **You** are making a claim
- Where **Your Treatment** has been provided by a registered Physiotherapist, Chiropractor, Osteopath, Homeopath, Podiatrist or Acupuncturist, please ensure that **You** attach to **Your** claim form a copy of the referral letter that was provided by **Your Medical Practitioner**
- Where applicable laboratory tests results and/or x-rays were provided, please include the test results with **Your** claim
- For all claims under US\$200 per **Medical Condition**, **You** need only complete sections A, B and C and return **Your** claim form with the original receipt(s) showing the diagnosis and a full breakdown of costs for each condition being claimed for. ALL sections MUST be completed in full for hospitalisation claims and all claims over US\$200. A referral letter from **Your Specialist** should be attached when **You** are claiming for diagnostic tests.

Please note that any charges that may be made by an attending **Medical Practitioner** for completing **Your** claim form are not eligible for reimbursement under the terms and conditions of the **Policy** and **You** will be responsible for settling these costs.

Where **Your** claim is in excess of US\$200 and it is not possible to have the claim form completed by the **Medical Practitioner**, **Specialist** or **Dental Practitioner**, **We** will accept the claim for assessment provided **Your** receipt(s) for **Treatment** include the date of service, the diagnosis of **Your Medical Condition**, the **Treatment** provided, the amount charged and the stamp of the facility concerned.

To ensure prompt settlement of any eligible claims please ensure that **You** submit all necessary documents at the time of the claim. **We** accept copies of original receipts to initiate the claim process and to facilitate the assessment of **Your** claim (i.e. if **You** submit claims via fax or email), however **We** require that **You** send the originals before any claims payment is made by **Us**.

All claims should be submitted by mail to the nearest Goodhealth claims centre noted below.

#### GENERAL CLAIMS INFORMATION

**We** reserve the right to reject any claim which is not submitted within 180 days of the date **Treatment** took place. All documents and materials (including but not limited to original accounts, certificates and x-rays) that **We** require to support a claim, shall be provided without expense to **Us** (including if requested by **Us** a medical report from **Your Medical Practitioner** or **Specialist** and details of the **Your** medical history).

In cases where medical information is required by **Us** for consideration of a claim but it is not made available to **Us**, it is **Your** responsibility to obtain such information from **Your** current or previous **Medical Practitioner**, as appropriate. Claims may only be made for **Treatment** actually given during a **Period of Cover** and **Benefit** will be available only for expenditure incurred prior to expiry or termination of such cover.

An **Insured Person** must, without delay, give **Us** written notification of any claim or right of action against any third party arising out of circumstances which gave rise to a claim under this **Policy** and must continue to keep **Us** fully informed in writing and take all steps **We** reasonably require in making a claim upon that other party. **We** shall be entitled to take legal action in any **Insured Person's** name for **Our** own benefit and claim for indemnity or damages or otherwise which relates to any **Benefits** and costs paid or payable under this **Policy**. **We** shall have full discretion in the conduct of any such proceedings and in the settlement of any such claim.

If **You** have any questions concerning the above or any other aspect of **Your Policy** please do not hesitate to contact **Your** local Goodhealth office.

All claims should be sent to:

Goodhealth Claims Service at the following claims offices:

Goodhealth Claims Administration  
GV07 1st Floor Unit 1  
Dubai International Financial Centre  
P.O. Box 6380  
Dubai  
United Arab Emirates  
Tel: +971 4 433 0400  
Fax: +971 4 324 3550  
Email: [claims@goodhealth.ae](mailto:claims@goodhealth.ae)

[www.goodhealthworldwide.com](http://www.goodhealthworldwide.com)

If **You** require **Emergency** assistance, **Evacuation**, or out of office hours assistance please contact the 24 hour Medical Helpline nearest to **You** on the following numbers:

Johannesburg	+ 27 11 541 1262
Americas:	+ 1 215 245 4707
Europe:	+ 44 (0) 208 762 8129
Hong Kong:	+ 852 2970 3045
Singapore:	+ 65 6338 9305
Jakarta:	+ 62 21 7591 2847

#### COMPLAINTS PROCEDURE

**Our** aim is at all times to provide a first class standard of service. However, there may be occasions when **You** feel that this objective has not been achieved. Should **You** have any complaint regarding this insurance **Policy** please contact in writing:

Managing Director  
Goodhealth Worldwide Limited - Regulated by DFSA  
GV07 1st Floor Unit 1  
Dubai International Financial Centre  
P.O. Box 6380  
Dubai  
United Arab Emirates

[www.executive-healthcare.com](http://www.executive-healthcare.com)



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An Aetna Company