Alliance health Options

2021

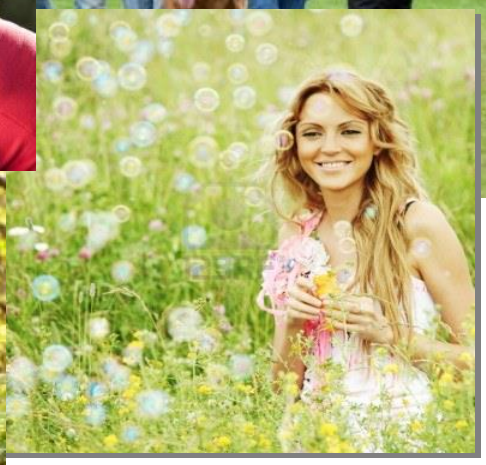
April

Dear New Member,

*Welcome to the **Alliance Health Options**. Thank you for choosing this plan.*

We ask you to please read this document as it contains all of the fine print regarding the terms and conditions of your membership agreement.

Contents of this document:



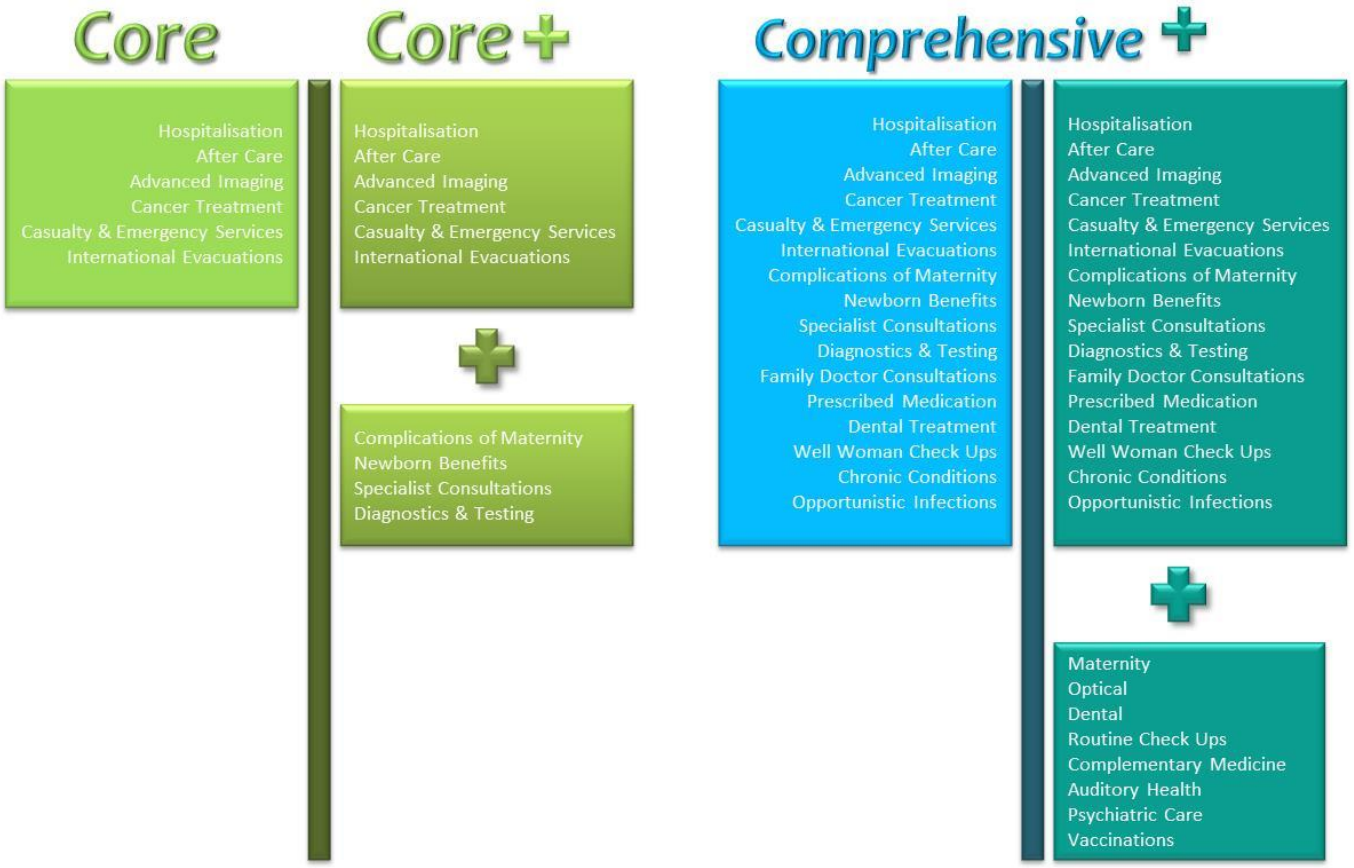
Overview of Benefits

Alliance Health Options is a modular annual health insurance plan for individuals, families and companies.

The first module is called CORE. This is a compulsory module. This module provides you with up to US$1,500,000 worth of cover per member per year. This offers you cover for mainly inpatient treatment, including Hospitalisation, MRI, PET and CT scans, Cancer Treatment, International Evacuations and Casualty and ER visits. *(This is providing you are not being admitted for an excluded condition*.)*

In addition to the CORE module, you can choose a higher level of benefit, the COREPLUS, or the COMPREHENSIVE or the COMPREHENSIVE PLUS benefits to suit your specific needs.

These benefits are detailed under the ***"What is Covered?"*** section of this booklet.



What Is Covered?

This section will explain what you are covered for in detail. All benefits are subject to the specific plan which you have joined. All amounts quoted will be in US$.

Where waiting periods are in place, they will refer to a member that has been on a level of cover that includes cover for that specific benefit for the time period specified. Waiting periods apply to each member individual, for example, each dependant, and each new addition to the plan.

Please see your list of benefits for any monetary limits that may apply on your level of cover, and whether or not the benefit applies to your specific plan.

NOTE: For FAMILY enrolments, BOTH parents and all minor children must be enrolled together on the same benefit level.

CORE BENEFITS: for all members.

1. In-patient and Day Patient Treatment – Hospitalisation and Surgery

To be eligible for cover under this benefit

- Your treatment **must** be authorised by Alliance Health.
- It must be medically necessary for you to occupy a hospital bed for the treatment you will receive.
- Your treatment must be provided by, or overseen by a **consultant**.
- Your room must cost no more than a standard single private room with a private bathroom.
- The treating hospital must be a recognised facility.
- The length of stay is medically necessary.
- The charges must be **reasonable and customary** to your area of treatment.

Alliance Health reserves the right to request medical reports, quotes and other information **before** an authorisation will be given.

You will be covered in hospital for:

a) **Intensive Care and Theatre** costs, including HCU, CCU and HDU if it is deemed medically necessary.
b) Hospital Accommodation – **Private room**
c) Nursing Fees, medical expenses and **ancillary charges**
d) **Professional Services** including physicians, surgeons, consultants, anaesthetists, medical practitioners' fees.
e) Additional private nursing services for members using private hospitals in Zimbabwe
f) **Prescribed Medicines**, drugs and dressings administered while the member is in hospital.
g) **Surgery**, including reconstructive surgery - following an accident or following surgery for an eligible medical condition. Must be undertaken within 12 months of accident/illness occurring. To restore natural appearance and function only.
h) **Prostheses** - Artificial body parts designed to form permanent parts of the member's body.
i) **Advanced Imaging** – MRI, PET and CT scans.
j) **Radiology**, Ultrasounds and X-Rays
k) **Pathology**, Diagnostic tests and procedures.
l) **Oncology** tests, drugs and consultancy fees.
m) Oncology treatment in-hospital including chemotherapy and radiotherapy.

n) **Physiotherapy** by a registered physiotherapist, when referred to by a medical practitioner, Consultant or Specialist.
o) Parental Accommodation for a member under the age of 16 years in the hospital. The parent must be a member of Alliance Health Options plan.
p) Infant Accommodation – costs relating to a new born infant (up to 18 weeks old) to accompany its mother (the member) whilst she is receiving treatment as an in-patient in a hospital.
q) **Renal and Peritoneal Dialysis** – immediately pre- and post-operatively, in connection with acute secondary failure when dialysis is part of intensive care, or if it is needed as a result of chronic and irreversible End Stage Renal Disease or renal failure in both kidneys provided it is not caused by illness or injury related to alcohol or drug abuse.
r) **Blood Transfusions** including the costs of blood and blood equivalents, blood products and transport.
s) Treatment for allergic reactions
t) Psychiatric treatment for up to 30 days (available after 12 months continuous membership of the plan). Member must be directly under the care of a registered psychiatrist, whilst admitted in a recognised psychiatric unit. Please refer to the Table of Benefits for further information.

2. Emergency Medical Services

a) **Ambulance Services**

- Emergency Medical Services ambulance transportation to the nearest facility where appropriate treatment can be provided.
- Transport from the hospital to another medical facility as part of an in-patient stay for further tests or procedures recommended by your consultant.
- Local air ambulance (pre-authorisation is required)

b) **International Medical Evacuations**

- When preauthorisation has been given.
- You will be transported to the nearest appropriate medical centre within your area of cover.
- You may be accompanied by a family member where it is deemed necessary and safe by the attending EMS crew.
- See further information in the evacuation section of this booklet.

3. Out-Patient Treatment

This is treatment that does not require you to occupy a hospital bed.

a) Advanced Imaging – MRI and PET scans which must be prescribed by a specialist. CT scans when referred by your specialist consultant or family doctor.
b) Oncology Tests, drugs and consultation fees. This **only** applies to members undergoing eligible cancer treatment and not wellness check ups. See further information regarding the out-patient benefits found in the Table of Benefits.
c) Out-patient chemotherapy and radiotherapy.
d) After Care – rehabilitation and home nursing where

4. Optical Benefit

Treatment requiring surgery this will apply to new conditions only. This benefit is for surgery for diseases that have affected the eye only.

5. Dental Benefit

a) For the emergency treatment in the event of accidental damage to **sound natural teeth**. Authorisation must be requested within 7 days of the accident, unless hospitalised for other more severe injuries which must be seen to before treatment of teeth can take place. This benefit cannot be used if the damage was caused through eating.
b) Dental Surgery for the removal of impacted, buried or unerupted teeth, wisdom teeth removal and retained dental roots. (Available after 12 months continuous membership on the plan)

6. Trauma Benefit

a) Emergency treatment, including preventative and/or prophylactic ARV and HIV testing for members who have survived an incident of assault, rape or physical abuse (within 72 hours) need reports from doctors and police?
b) Psychological Counselling for Trauma following an incident of assault, rape, physical abuse or amputation.
c) Rabies and tetanus vaccinations as well as any antibiotics administered will be covered in the event of a Trauma only, under this specific benefit.

7. **Chronic Medical Conditions**

Stabilisation of acute exacerbations/episodes of chronic medical conditions which have developed after the members join date or covered under MHD benefit conditions and can be defined as life threatening Acute on Chronic episodes.

8. After Care

a) Out Patient rehabilitation immediately following hospitalisation. Up to US$20,000 per membership year.
b) Primary care services of a registered nurse in your home immediately after, or instead of, in patient or day-patient treatment. Up to US$3500 per membership year.

9. Organ Transplant

Costs of the surgical procedures in performing an organ transplant in respect of the member as a recipient and not the organ donor. This will cover for transplants for the following organs: Heart, Heart/lungs, Lungs, Kidney, Kidney/Pancreas, Liver, Allogenic Bone Marrow, Autologous Bone Marrow.

10. a) Evacuation, Travel, Accommodation and Repatriation Costs

Evacuation costs of moving a member to the nearest appropriate medical facility, within the area of cover, for the purpose of admission for treatment as an in-patient or day-patient. The evacuation benefit is restricted to members receiving pre-authorised treatment whilst admitted to a hospital in a country other than their country of residence

See further information under the Evacuation section of this booklet.

b) Experimental treatment

Members who undergo experimental treatment for life threatening illnesses may not claim the costs of treatment, or the costs of treating resulting side effects from Alliance Health Options. However, where such treatment is the members clear preference, and is recommended by the treating practitioner and is available under a strictly controlled and properly administered legal

trial, then subject to eligibility members may claim benefits from the benefit for INTERNATIONAL EVACUATION, TRAVEL, ACCOMMODATION AND REPATRIATION benefit

11. Repatriation, Burial or Cremation of Mortal Remains

In the event of a death, the cost of preparation and air transportation of the body, mortal remains or the ashes of the deceased member, from the place of death to the home country, or the preparation and local burial or cremation of the mortal remains of the member who dies outside the home country.

STEP-UP BENEFITS

12. Accident and Emergency Treatment Outside Area of Cover.

a) The cost of emergency medical treatment received in a country or territory outside the determined geographic area of benefits.
b) The cost of emergency medical evacuation to the nearest appropriate medical facility and costs of repatriation of the member back to the home country.

13. Hospice and Palliative Care – See Benefit Schedule

You will be covered after diagnosis of a terminal condition, when treatment can no longer be expected to cure your condition, for:

- Palliative treatment, including acute and chronic management of symptoms. For a period of…

14. Emergency Medical services

a) Casualty and Emergency Rooms Services for the Treatment of Injuries, Sudden High Fevers or Other Life-Threatening Conditions.
b) After Hours Consultations at a 24 Clinic

15. Benefit for Out-Patient Treatment

a) Professional services and Specialist Consultations, including Physicians, Surgeons, Consultants, Anaesthetists.
b) Diagnostic Tests and Procedures (excluding check-ups) – including x-rays and Pathology.
c) Physiotherapy by a registered physiotherapist, when referred by a medical practitioner, consultant or specialist.
d) Family Doctor Medical Practitioners fees
e) Prescribed Medicines, Drugs and Dressings (excludes prescribed drugs which may be available as over the counter purchases)
f) Complimentary Medicines and Treatment by a Registered Therapist
g) Psychiatric Treatment (12 month waiting period)
h) Hormone Replacement Therapy

16. Routine Check-ups - 6 month waiting period applies

a) PAP smears
b) Mammograms and Bone Density Scans
c) Annual Medical Checkups and cancer screening
d) Vaccinations
e) Prostate Checks

17. Maternity Benefits – After 10 months continuous cover on a level of cover that includes the maternity benefit.

a) Complications of pregnancy and maternity – treatment of a medical condition which arises during the antenatal stages of a pregnancy, or a medical condition which arises during childbirth and requires a recognised obstetric procedure, or treatment that is required as a result of conception or the treatment of a conception. These benefits are restricted to emergency medical services, casualty and in hospital services.
b) Newborn Benefits- costs related to the assessment and treatment of the new born babies in hospital at birth or after birth for seven days after birth (available after 10 months continuous membership on the plan, before the baby is born)
c) All in-patient and day patient hospital services relating to maternity (up to 21 days)
d) In-patient obstetric, gynaecological, midwife, paediatrician and other services required.
e) Outpatient obstetrical expenses including pre-natal and post-natal care.
f) Pregnancy and Childbirth – Costs associated with normal pregnancy and childbirth, pre- and post-natal check-ups and delivery costs.
g) Outpatient Obstetrical expenses relating to Caesarean Section Deliveries including Pre-Natal and Post-Natal care.
h) Congenital conditions will be covered to a limit of $ 100,000 per lifetime, if the new born baby was born to a mother who qualifies for maternity benefit. Limited to the costs of treatment of conditions that are present at birth and diagnosed before the new born baby leaves the hospital, and which can be considered medically necessary.

18. Optical Benefits-6 month waiting period (benefit restricted to once every 24 months)

a) Optical Examination
b) Prescription eyeglasses or contact lenses

19. Dental Benefits-6 month waiting period (benefit restricted to once every 24 months)

a) Dental treatment- including fillings, extractions, root canals, gum treatment
b) Dental X-rays- except for when relating to orthodontic treatment.
c) Crowns and Bridges
d) Consultation and Examination fees
e) Hygienist: cleaning, polishing and scaling
f) Orthodontic treatment or treatment relating to orthodontic will not be covered under this benefit.

20. Auditory Health Benefits-6 month waiting period (benefit restricted to once every 24 months)

a) Hearing Tests and Examinations
b) Hearing Aid Apparatus

21. Chronic Medical Conditions

a) Stabilising of an acute EMERGENCY exacerbations/episodes of pre-existing chronic medical conditions (non-MHD) declared on joining (BENEFIT APPLIES TO EMERGENCIES REQUIRING IMMEDIATE HOSPITALISATION AND APPLIES TO 72 HOURS PER EVENT)
b) Routine Management and treatment including check-ups, diagnostics, treatments and prescribed medication of chronic medical conditions which developed after the members join date.

20. Opportunistic Infections Benefit (Additional Benefit Requires Registration)

a) Prophylactic Anti-Retroviral medication for childbirth to prevent mother to child transmission of HIV/AIDS
b) Treatment, prescribed drugs and medication for the suppression of opportunistic infections for registered members (subject to 36 months waiting period)
c) Laboratory testing (subject to a 36-month waiting period)

21. Countries and Territories in which Full Benefits Use may be Authorised

- Botswana
- India
- Kenya
- Lesotho
- Malawi
- Mauritius
- Mozambique
- Namibia
- South Africa
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zimbabwe

21. War and Civil Unrest

There are no benefits for treatment resulting from war, invasion, act of foreign enemies, hostilities (weather declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion, martial law, loot, sack or pillage unless the member sustains bodily injury whilst an innocent bystander. If the member sustains bodily injury whilst an innocent bystander, then the member will be covered up to a maximum amount of US$100,000 per member per incident.

WAITING PERIODS

The following waiting periods apply to benefit use.

1 = CORE (1) Benefits (In-patient Hospitalisation)

Dental Surgery -	12 month waiting period
Psychiatric Treatment -	12 month waiting period
Chronic Medical Conditions -	6 month waiting period

1+2 = CORE PLUS (1+2) Additional Benefits and Waiting Periods

Dental Surgery -	12 month waiting period
Psychiatric Treatment -	12 month waiting period
Chronic Medical Conditions -	6 month waiting period
Complications of Maternity -	10 month waiting period
New-born Benefits -	10 month waiting period

1+2+3 = COMPREHENSIVE (1+2+3) Additional Benefits and Waiting Periods

Dental Surgery -	12 month waiting period
Psychiatric Treatment -	12 month waiting period
Chronic Medical Conditions -	6 month waiting period
Complications of Maternity -	10 month waiting period
New-born Benefits -	10 month waiting period
Mammograms and Bone Density Scan –	6 month waiting period
Opportunistic Infections Benefit –	48 month waiting period

1+2+3+4 = COMPREHENSIVE PLUS (1+2+3+4) Additional Benefits and Waiting Periods

Dental Surgery -	12 month waiting period
Psychiatric Treatment -	12 month waiting period
Chronic Medical Conditions -	6 month waiting period
Complications of Maternity -	10 month waiting period
New-born Benefits -	10 month waiting period
Mammograms and Bone Density Scan –	6 month waiting period
Opportunistic Infections Benefit –	48 month waiting period
Optical Benefits -	6 month waiting period
Dental (Hygienist) -	6 month waiting period
Auditory Health -	6 month waiting period
Annual Medical Check Ups -	6 month waiting period
Cancer Screening -	6 month waiting period
Maternity Benefits -	10 month waiting period
Psychiatric Treatment -	12 month waiting period

NEW ENROLMENTS

Loading/Discount Protocols

New applicants may be loaded for lifestyle choices (such as smoking)

Non-disclosure of Material Facts

If it is understood at any time that an enrolled member has made a false or incomplete declaration or has failed to accurately disclose his/her medical history then the administrators of the Alliance Health Options plans reserve the right to waiting periods of up to 48 months, impose contribution loadings of up to 250%, specifically exclude from benefits specific medical conditions, disorders or diseases and to recover any or all costs incurred by the fund.

RENEWALS

Declaration of Material Facts

Members and group administrators are required to declare any changes in lifestyle or group structure that may result in a material change to their risk profile and/or benefit use. The administrators of the Alliance Health Options plans reserve the right to vary contribution loadings at renewal on the basis changes in a member's risk profile.

ENDORSEMENTS

Foreign Treatment Costs

All outpatient treatment outside Zimbabwe is on a pay and claim basis. Members who incur financial liabilities for the costs of outpatient treatment are personally liable for all costs of treatment and for all costs of settlement unless a prior written agreement has been made with the administrators of the Alliance Health Options plans.

CHANGES TO MEMBERSHIP

Death

Should the main plan holder die, his/her dependants will be allowed to continue with their cover. In order for the membership to be continued, the surviving dependants are required to complete new Application Forms to facilitate the re-entry of updated data into our systems and in order to provide a signed agreement of the amended contract between the member and Alliance Health. Provided there is no break in cover, the new Application Forms will not be regarded as new enrolments. If the dependants do not wish to continue cover, they must inform us in writing either by letter, fax or email within four weeks of the main plan holder's death.

BENEFIT AND POLICY EXCLUSIONS

Unless specified in the Benefits Schedule/Table of Benefits, or in any written endorsement, or agreed by Alliance Health in writing, no claim can be made for compensation or payment for damage or expenses caused by or as a result of the following:

Abuse of Alcohol or Any Other Substance Whether Controlled or Not: Treatment for alcoholism, narcotics, drug and substance abuse/dependency or any addictive condition of any kind and any injury or illness arising from the Insured Person being under the influence of alcohol, drugs or any other intoxicating substance, including medicines prescribed by a medical Doctor or Consultant. Including treatment for smoking, or to give up smoking. General treatment of any withdrawal symptoms brought on by a prior addiction.

Acting Against Medical Advice: Failing to follow instructions or advice given to you by your family doctor, a general practitioner, specialist or therapist in regard of your diet, your exercise or any other factors.

Allergic Conditions and Disorders: Desensitising, or neutralising treatment for any allergic condition.

Artificial Life Maintenance: Where the treatment is not likely to result in recovery, or restore the member to their previous state of health. For example, if the member is in a persistent vegetative state or sustains permanent nerve damage

Benefits Not Stated: Costs of any medical treatment or service not listed, or specified in the Benefits Table.

Congenital Conditions: Claims arising from congenital illnesses, abnormalities or birth defects or abnormalities. *Please see benefit #62 for exceptions to this exclusion.*

Consequent and Subsidiary Costs: Cost that might be levied to the member as charges or fees for medical reports or other administration.

Contraception: Sterilisation, or reversal of, or any birth control or family planning methods even if medically necessary. Unless otherwise stated in the Table of Benefits as treatment that is a recognised contraceptive treatment being used to treat a different health condition where eligible. *Please see benefit #82.*

Cosmetic, prophylactic or remedial surgery: removal of fat or other surplus body tissue and any consequences of such Treatment, weight loss or weight problems/eating disorders, whether or not for psychological purposes, unless required as a direct result of an accident or surgery for cancer which occurs during the Period of Insurance.

Costs in Excess of Benefits: Medical Expenses in excess of a limit stated in the Benefit Schedule. Benefit limits may vary depending on the different plans.

Costs Incurred During Waiting Periods: No payments will be made for benefits where there is a waiting period until such time as the waiting period is satisfied.

Dental Treatment: Routine and restorative dental treatment. Any orthodontic treatment or treatment relating to orthodontic procedures will be excluded. For example, X-rays. Gingivitis or treatment of any gum disease, tooth decay. *Unless covered under benefits #68 to 72.*

Developmental Problems: treatment for physical development or mental development. Including but not limited to treatment for delayed development, accelerated development, learning difficulties or behavioural problems including ADHD, Social Anxiety and Performance Anxiety. Conditions such as dyslexia or short height will not be covered.

Equipment: Unless otherwise stated in the Table of Benefits the costs for purchase, hire, maintenance or testing of equipment, or devices including but not limited to: - crutches, wheelchairs, braces, supports, wheelchairs, diapers, inhalers, EpiPen's, dentures and glucometers. *Please see benefit #83*

Experimental Treatment or Unregistered Practice: Treatment and consequences of experimental and unproven Treatment or drug therapy. Drugs and other medicines purchased without a Physician's prescription and routine or preventative medicines. Members who undergo experimental treatment for

life threatening illnesses may not claim the costs of treatment, or the costs of treating resulting side effects from Alliance Health Options. However, where such treatment is the members' clear preference, and is recommended by the treating practitioner and is available under a strictly controlled and properly administered legal trial, then subject to eligibility members may claim benefits from the benefit for INTERNATIONAL EVACUATION, TRAVEL, ACCOMMODATION AND REPATRIATION benefit

Foot Care: Treatment of congenital and hereditary conditions including bunions and flat feet.

Fraud: Intentional or fraudulent acts by the Insured Person's part or on behalf of the Insured Person including non-disclosure of pertinent facts and information relating to pre-existing conditions or risk of injury/illness not disclosed on joining.

Genetic Testing: Where the tests are to determine the possibility of future development of a disease or condition or the inheritance of any particular genetic profile

Hazardous Sports or Activities: participation in any professional sports or hazardous sports, hobbies or activities. Including, but not limited to the following:

- Aerial Sport for example sky diving, paragliding etc
- Any Sport involving animals, for example Show Jumping, Polo etc
- Hunting
- Motor Sports
- Off-Piste Skiing
- Racing of any form, other than on foot.
- Scuba Diving to a depth greater than 30m, or where an appropriate certificate is not held.
- Speed Competitions
- Use of Firearms

If you think your profession, sport, or hobby could be defined as dangerous then please contact Alliance Health for clarification.

Hearing Loss: treatment for hearing loss, or partial hearing loss caused by ageing or congenital condition or abnormality.

Hereditary Conditions: Treatment of conditions, illness or diseases that have been passed down through the generations of your family, including any deformities or abnormalities unless otherwise specified for under the New Born benefit. *Please see benefit #62.*

HIV and AIDS: treatment and testing for HIV and AIDS. *Except where covered under benefits # 77 to 80.*

Home Visits: by a medical practitioner, specialist or nurse, unless prior authorisation has been given by Alliance Health in writing. *Please see benefit #33.*

Illegal or Criminal Activities: any injury sustained whilst the member is committing an illegal offence, or helping to commit such an offence.

Infertility treatment: IVF or any treatment to increase fertility or assist with reproduction including consequences thereof.

Maternity (All Costs Related to Conception): Unless where birth is due after the first 10 months of the mother's membership and the benefit is available on the plan (subject to 10 months waiting period from date of joining). Antenatal classes, midwifery, surrogate parenting and other costs not mentioned in *Benefits #61 to 67*.

Mental Health Counselling: Costs for consultations, discussions, group therapy and/or other treatment by a marriage counsellor, bereavement counsellor, family therapist or life coach unless certified as medically necessary and provided by a health professional recognised and registered with the appropriate health professions authority in the country of treatment.

Obesity: as well as any associated treatments such as but not limited to gastric bypass, gastrectomy, cholecystectomy, gall bladder removal when such treatments are for the purpose of weight control.

Organ Transplant: Costs associated with the location of a replacement organ. Or any costs incurred for the removal of the organ from the donor, or cost for the organ itself. AHO also will not cover all costs of administration and transportation of the organ. Costs of removing an organ from the member for transplantation into another person. Transplants involving mechanical or animal organs. Stem cell storage, or harvesting, when these cells will be used in possible future illness or disease.

Over the Counter Medication: such as vitamins, or pain tablets, or ointments, or supplements that do not require a prescription to be purchased.

Performance Enhancement: Any medication or treatment that is related to a desired change or improvement of performance or behaviour.

Pre-Existing Medical Conditions: Medical Expenses for a Pre-existing Medical Condition or related condition for which the Insured Person has received or needed treatment, or medication, or sought advice for the said condition at any time prior to joining Alliance Health Options. Any Pre-existing Medical Conditions as defined unless otherwise declared on the Application Form and expressly confirmed acceptance by Alliance Health Options. Except where the member has been given a $5000 lifetime limit for EMERGENCIES relating to specifically mentioned medical conditions. This includes every condition that the Medical Advisory Board of AHO determines were in existence at or prior to your join date. *Please see benefit #57.*

Pregnancy Terminations: Where non-medically necessary.

Pregnancy, Conception, Childbirth and Post-natal costs whether normal or complicated, including the transfer of a pregnant woman to hospital to give routine childbirth or air travel when the Insured Person is more than 28 weeks pregnant, unless cover is provided under the Optional Maternity Benefit as shown in the Insured Person's Certificate of Insurance. *Please see benefits #61 to 67.*

Prophylactic or Preventative Treatment: The costs of surgery, or treatment, or service, or dietary supplements that are primarily for the prevention of possible ill-health, or to counter the natural effects of ageing. Malaria prophylaxis and vaccinations (except where stated in the Benefit Table), such as travel vaccinations, flu vaccinations, epidemics and pandemics, and any other vaccinations

Second Opinion: The administrators of the Alliance Health Options fund may allow or require a second opinion from a registered medical professional and reserves the right to submit for adjudication conflicting opinions to the Medical Directors of Alliance Health Options for resolution.

Self-Inflicted Injury and Negligence: Any self-inflicted injury, needless self-exposure to peril (except in an attempt to save human life), suicide or attempted suicide. If the member is involved, or participates, in activities or habits against the advice of a medical practitioner, or counsellor, or against health and safety regulations, where such involvement could lead to injury or harm. Members who require treatment to remedy the effects of an attempted suicide are restricted to emergency medical services and casualty for stabilisation up to a maximum cost of $1,500 and for no more than 24 hours.

Septoplasty: Septoplasty and/or Rhinoplasty for the correction of a deviated septum except where such surgery is required to correct damage which may have occurred in an accident that took place after the member's join date.

Sex Changes: any treatment directly or indirectly associated with sex changes or gender reassignments, or consequences of such treatment unless associated with newly born infants and subject to the benefits available to members under the New Born benefit. *Please see Benefit #61.*

Sleep-Related Breathing Disorders: Treatment for snoring, sleep apnoea and other related conditions.

Travel and Accommodation Costs: unless specifically agreed by Alliance Health and only for treatment received will be in-patient. Unless otherwise covered by your ambulance, or evacuation benefits.

Travel Costs: Travel costs for treatment, unless Pre-Authorised by Alliance Health Options. Travel costs (evacuation and/or repatriation) where the Insured has travelled against medical advice.

Treatment at and Admissions to Institutional Facilities: Treatment received in any facility that is not recognised as a hospital

Treatment by a Relative: Treatment performed by a Medical Practitioner or Specialist, who is related to the Insured Person, unless previously approved by Alliance Health.

Treatment for Eyesight: Normal eye tests. Non-Medical, or natural degeneration of eyesight, or treatment of such conditions. *Unless covered under Benefit #73*.

How to Claim

1. Your Claims Checklist

Before you try to submit a claim for costs incurred, please use the checklist below to verify that you have all of the required information and documentation: -

I have paid for treatment and I would like to claim back all costs		I have not yet received treatment. I would like Alliance Health to contact the provider of medical services and request the acceptance of a Guarantee of Payment so that I do not have to pay and claim*	
I have checked that the treatment was not for an ineligible condition or an excluded condition		I have checked that this service can be pre-authorised and that the provider of medical services is willing to accept a Guarantee of Payment	
I have checked the benefits of my plan level and I should be covered for this treatment		I have checked that the treatment was not for an ineligible condition or an excluded condition	
I have checked that the date of treatment was in the last **3 months**		I have checked the benefits of my plan level and I should be covered for this treatment	
I have a completed Claim Form, with every section complete, with both the doctor's and the main member's signatures		I have provided Alliance Health with a Medical Report from my doctor	
I have a receipt for every one of the payments I made		I have provided Alliance Health with the names and contact details of the providers of the treatment	
		I have provided Alliance Health with quotations of costs and the dates of the proposed treatment	
		I have a Claim Form ready for completion	

Pre-authorisation and guarantees of payment can **ONLY be placed for advanced imagery (MRI, CT, PET and Ultrasound Scans), diagnostics for surgery, for all treatment relating to cancer, for all hospitalisation and for consultations with specialists. Pre-authorisation is not required for family doctor consultations, medication or for casualty consultations for life threatening medical emergencies.*

Pre-Authorisation

Pre-authorisation means that you must contact Alliance Health before you use any of the benefits if your plan (except for family doctor consultations, medication or for casualty consultations for life threatening medical emergencies) – especially if you need us to arrange payment in advance. This is because we may need to advise you on your benefit limits, or we may need to arrange pre-payments to some specialists and service providers. Please note that unauthorised costs of international travel and accommodation are not refundable.

The information required for a quick pre-authorisation is as follows: - (a) we require a **medical report** (b) we require a **completed claim form** (or you can refer to the claim form from the initial consultation with your family doctor which you may have had) (c) the **names and contact details** of your chosen service providers (d) a **quotation** of costs

PLEASE NOTE: In all cases of hospitalisation your authorisation is limited to a period of not more than ten days. Authorisations MUST be renewed every ten days. Expenses arising from unauthorised hospitalisation will be for the member's account.

1) The Medical Report

The medical report should contain the following information: -

a. The case history
   i. When did you, or your dependent, first show symptoms?
   ii. When did you first seek advice?
   iii. How has the problem been dealt with to date?
b. What are the symptoms of the problem?
c. What is the magnitude of the problem (how is it affecting you)?
d. What is the probable cause and diagnosis (or the suspected cause and the tests that may be required to verify this)?
e. What are the recommendations for treatment?
f. What is the prognosis for the future after you have received treatment?

2) The Service Provider's Contact Details

a) The names and contact details of the medical professionals and service providers (radiology / specialists / etc)
b) Contact numbers for the member in the country of treatment
c) Contact email address for the member in the country of treatment

3) The Quotation of Costs

a) The estimated costs of treatment, scans, diagnostics and surgery – including surgeon charges, anaesthetist charges.
b) The estimated costs, and dates, of international travel supplied by a registered travel agent

All of this information should be sent together with a copy of the original referral note to clientservices@healthzim.com

What to do in an EMERGENCY

1. Please call an ambulance –

   ZIMBABWE

   ACE AIR & AMBULANCE: (242) 302141 /302364 / 0782 999 901/2/3/4

   EMRAS: **+263 4 250 011/2, +263 4 797 479**

   MARS: **+263 4 771 221 / 706 034** or **toll free 0800 3222 911**

   Please note that the use of any other ambulance services can only be on a pay and claim basis and should be pre-authorised by calling **08677000716 / +263 772 126 120**

2. If you choose not use an ambulance service, please proceed to the Accident & Emergency or Casualty facility nearest to you. Please remember to take your membership card with you and proof of your identity. **For any serious condition that may require a hospital admission, please proceed directly to the nearest HOSPITAL CASUALTY facility.**

3. If you have a personal Advisory Agent to assist with claims and benefits use, please call your agent to notify them. If you do not have a personal Advisory Agent, please notify Alliance Health on **+263 772 126 120** or clientservices@healthzim.com

COMPLAINTS

Whilst every effort is made to ensure that your membership to the Alliance Health Options international health plan is convenient, flexible and valuable to you, we understand that we may not always meet your expectations of service delivery or that you may find that you disagree with some of the adjudications and decisions that we make. We want to ensure that all of our dealings with you are fair and accurate, and that we are held to account for the quality of our service delivery.

If you feel at any time that we have not achieved this, then please do bring this to our attention by writing to our General Manager. Please note that emails are not generally useful for this purpose and that a hand written letter (or correspondence that has been printed out, signed and dated by you the member) is much more effective. We undertake to respond to your complaint within ten working days.

Any questionable adjudication of claims that are brought to the General Managers attention in this way are referred to our Medical Advisory Board of qualified, practicing medical professionals. The board will re-examine the claim (often requesting for further information) and then make their recommendations. In cases whereby we have failed to provide excellent service to you, the General Manager will review the incident and where appropriate will initiate appropriate changes to our systems and procedures to ensure better service delivery.

CONTACT US

Alliance Health

7 Fleetwood Road, Alexandra Park, Harare

2nd Floor, Joina City, CBD, Harare

7 Oak Avenue, Suburbs, Bulawayo

TELEPHONE: +263 (0) 778 244 128, 772 126 119, 8677000716, 8677020406,

EMAIL: clientservices@healthzim.com

www.alliancehealth.co.zw

Glossary of Useful Definitions

Please find below and in this section a list of definitions which is designed to help you in understanding the wording of your benefits. *

** This document includes excerpts taken from lists of definitions included in previous documents used by Alliance Health, as well as information readily available on free websites including personalinsure.about.com, www.nhscareers.nhs.uk, financial-dictionary.thefreedictionary.com, en.wikipedia.org*

A.

Accident
This refers to an unexpected, abrupt or unforeseen external event resulting in bodily injury and/or trauma.

Accompanying Person
This refers to one designated family member who travels with a member who is being evacuated to the nearest centre where appropriate treatment can be administered – restricted to a spouse, parent, step parent, sibling, child, step child, grandchild or guardian.

Accommodation
1 the state or process of adapting or adjusting one thing or set of things to another, the continuous process or effort of the individual to adapt or adjust to surroundings to maintain a state of homeostasis, both physiologically and psychologically.
2 provision for rest and sleep in a registered establishment

Active Treatment
Treatment of a disease, illness, trauma, injury or other adverse health condition that results in (i) substantial and effective recovery or (ii) restoration to a previous level of health

Acute Condition
Relating to a disease, trauma, injury or health condition that shows a rapid onset and a short, time definite, severe course. Acute health problems are characterized by an abrupt beginning with marked intensity or sharpness, subsiding after a relatively short period. Illnesses that are acute appear quickly and can be successfully diagnosed and treated.

Administration
The day-to-day administration of membership enrolments, marketing activities, claims adjudication and payments are carried out by Alliance Health. The adjudication of claims and medical conditions is carried out in conjunction with the Alliance Health medical advisory board.

Advanced Imaging
Scans used to produce images, including Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) x-ray Computed Tomography (CT), Diagnostic Sonography (Ultrasound), and Echocardiography but excluding standard x-rays.

Affinity Groups
An affinity group is a group of people who share interests, issues, and a common bond or background, and offer support for each other. These groups can be formed between friends, or people from the same community, workplace or organization. For recognition as an affinity group, a group should present a written constitution or rules of membership for underwriting consideration.

Please be advised of the following restrictions on underwriting for affinity groups: -

(1) The eligibility of each enrolment application is subject to our acceptance
(2) If a group is not a company or a society, we require a copy of the rules of membership (which should have at least 15 criteria/articles of membership)
(3) If a group has been on cover with a previous PMI, we require copies of the membership certificates
(4) The group secretary is responsible for the timeous payment of membership subscriptions - which must be made as lump sum payments either annually, or quarterly or monthly
(5) All applications must be completed and received at least ten working days (two weeks) before the proposed start date
(6) Additions to the group joining after the join date will need to be accompanied with complete medical reports or copies of medical files going back 24 months (in English)
(7) Alliance Health reserves the right to implement GROUP RATED membership rates for affinity groups at renewal based on their claims patterns
(8) We cannot accept affinity groups of less than ten principal members
(9) Married couples cannot apply as two principal members

There are some family groups who wish to be invoiced as a group so that the payment is made by one person (usually offshore). For example, if I were to join, and my mother were to join, and my aunt, and my grandmother, and my brother in the UK wanted to pay for our subscriptions - or if we wanted to use a family trust fund to pay the subscriptions - then it makes sense to group all of the individuals together so that there is one invoice for payment. The GROUP is registered with Alliance Health and is invoiced as such. This group would not be eligible for a company discount, as it is not a Company Group and it is **not** an Affinity Group. There would be no discount applied.

The formation of "non-genuine" groups that may be made up of arbitrary individuals and families, who intend to join together to form a group, and who wish to be accepted with a discount is not acceptable for our underwriting.

There is an audit procedure in place to check on the structure (i.e., risk vs discount) of every group on renewal, and we reserve the right to place any group-on-group risk rated tariffs at renewal. Should we come across any group that cannot provide copies of the company registration documents, (e.g., CR 14, ITF 263 in Zimbabwe) or the rules of membership for an affinity group, then any applied discounts will certainly be immediately removed on renewal.

Agreement
This refers to all of the information contained in this complete document as well as (i) your fully completed and signed enrolment application form, (ii) your certificate of membership (iii) the table of benefits (iv) any further endorsements or notations issued by Alliance Health.

Alliance Health
Alliance Health is a private company registered in Zimbabwe, providing administration, marketing and support services to members of different international health plans and medical aid societies. Alliance Health is registered with the Ministry of Health and Child Welfare and conforms to all of the requirements of the Medical Aids Act and the Health Act governing the activities of health care companies in Zimbabwe.

Alliance Insurance Company is a separate wholly owned Zimbabwean company which is duly licensed and regulated in terms of the Insurance Act. Commencing operations the 1st of January 2003, Alliance Insurance Company offers short term insurance and a significant proportion of our products are sold through intermediaries and brokerage services, who are in essence our strategic partners.

Alliance Health and Alliance Insurance Company continue to be focused on innovative product development and on delivering high levels of customer service. The strong balance sheets of both companies are geared to achieve acceptable solvency margins allowing us to pay claims expediently. The companies also boast a highly skilled and motivated human capital base with a wealth of experience in insurance and risk management.

Application Form
This term refers to the enrolment application form that you completed and which you signed on behalf of your dependents listing (i) the details of their identities and relationships to you (ii) all material facts relating to their medical histories and risk profiles for underwriting and registration (ii) your choice of plan and associated benefits

Area of Full Benefits
This refers to the territories listed below in which all of listed benefits of membership to the Alliance Options plans (refer to the Benefits Table) may be used: Botswana, India, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

Authorisation
Authorisation is the term used to describe the process used to establish and confirm that (i) the costs related to a member's treatment can be covered by the benefits available (ii) that the condition requiring treatment is eligible for benefit (iii) that direct settlement of costs can be negotiated with the providers of medical services (applies to oncology, evacuations and in-patient treatment). Requests for written authorisation should be made by the member to Alliance Health, tele: 04-700976 / 701764 / 700223 or by email to claims@healthzim.com.

Members MUST seek prior approval (i.e., authorization) before being hospitalized for elective treatment as well as having costly procedures such as CT and MRI scans, chemotherapy & radiotherapy, expensive medication, etc. Treatment costs that are not approved in advance may only be refunded to members on a pay and claim basis at 80% of reasonable and customary costs.

At least 2 working days are required to effect an authorization and for requests for Letters of Guarantee (LOG) to be placed with the treatment providers.

Verbal authorisation (in the case of emergencies) can be obtained by calling the after-hours pre-authorization numbers: 0772 126 120 or 0712 347 879

In order to provide authorization, Alliance Health will require (i) a medical report (ii) a quotation of costs (iii) the names and contact details of the proposed medical service providers

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B.

Benefits
Subject to the information and restrictions shown on the Table of Benefits, members are able benefit from the costs of consultations and procedures and operations undertaken by medical professionals on members or their registered dependants for eligible conditions being paid according to what is understood to be Reasonable and Customary. Where the charges made by provider of medical services and/or treatment exceed levels that are Reasonable and Customary or where a member or his/her dependants exceed annual limits, the member is responsible for the resulting shortfall.

Birth Defect
Birth defects are defined as any abnormality or disability arising during pregnancy, or caused during childbirth or any deformity or congenital anomaly.

Bodily Injury
Defined as an identifiable physical injury from trauma.

Broker
An Insurance Broker is someone who represents you with your insurance transactions, unlike an **agent**, who represents the company providing the insurance or membership scheme. In Zimbabwe it is a requirement for brokers of insurance products to be registered with the Commissioner of Insurance.

Regular face to face meetings with your agent or broker is critical in proper health scheme and/or health insurance planning. Use the checklist below to make sure you have all the information you might need to complete the various applications, have a meaningful discussion with your advisor and to make sure that you are able to select the best option for your requirements.

- The full names, dates of birth and ID numbers of all persons to be enrolled
- Complete medical histories, or records of hospitalisation and medication in the last 5 years

- Clear job titles and an understanding of which industries/career fields the applicants work in
- Copies of membership certificates of any previous memberships to any medical aid society schemes, membership plans or health insurance schemes
- Documents relating to any rejected claims or problems encountered with previous memberships to any medical aid society schemes, membership plans or health insurance schemes

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C.

Census of Members
This refers to the list of enrolled members updated on a monthly basis. Amendments to the census of any group or family membership must be provided to Alliance Health before the tenth working day of the preceding month for adjusted billing.

Certificate of Membership
The Membership Certificate means confirmation of the cover issued by Alliance Health, reflecting the details of your membership. Your Membership Certificate confirms the level of benefits and the Add-on's you have purchased plus your period of cover, your commencement date, your renewal date, your country of residence, your area of benefits, a schedule of members and any special terms or excess amounts pertaining to your specific membership.

Chronic
Refers to a medical condition which has at least one of the following characteristics:

- It continues indefinitely and has no known cure
- It recurs or is likely to recur
- Requires palliative treatment (relief/relieving without curing)
- Needs indefinite monitoring and /or treatment
- Requires rehabilitation and /or specialist training
- It requires long term monitoring, consultations, check-ups and examinations
- Is caused by bodily changes that cannot be reversed

Claim/Claims
Refers to documentation relating to the costs of professional medical treatment for specific injury, illness, accident, medical condition or dental condition which has been submitted by a service provider or by a member for reimbursement.

Close Family Member
This refers to: spouse, parent, step-parent, parent-in-law, brother, brother-in-law, step-brother, sister, sister-in-law, step-sister, child, step-child, grandchild or guardian.

Commencement Date
This is specific to the date of joining or to any subsequent renewal date pertaining to a specific plan year as will be specified on a valid Certificate of Membership.

Complementary Medicine and Treatment
Complementary Medicine is the use of natural therapy and medicines to restore and maintain health *in addition to conventional medicine*. This includes osteopathic, chiropractic, acupuncture, herbal medicine, homoeopathy, naturopathy, reflexology, speech therapy, occupational therapy, anthroposophy and Chinese medicine. Eligible therapeutic interventions are restricted to those that (a) target the individual disease processes of conditions recognised by the World Health Organisation International Classification of Diseases or (b) assist in the recovery of injury related trauma. Practitioners must be suitably qualified and registered with the appropriate, recognised professional governing body. Alliance Health reserves the right to refer adjudication of claims to the Alliance Health medical advisory board for assessment against the criteria of the treatment being considered (1) medically necessary (2) treatment of an acute condition and (3) effective treatment

Complications of Pregnancy
Refers specifically to in-patient or day-patient treatment received for a medical condition that occurs during the antenatal stage of pregnancy or to a medical condition that occurs during childbirth and which necessitates a recognised obstetric procedure.

As an illustration we would consider treatment of the following:
- ectopic pregnancy (where the foetus is outside the womb)
- hydatiform mole (abnormal cell growth in the womb)
- retained placenta (afterbirth retained in the womb)
- placenta praevia
- eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)
- diabetes (if you have exclusions because of your past medical history which relate to diabetes, then you will not be covered for any treatment for diabetes during pregnancy)
- post-partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- miscarriage requiring immediate surgical treatment
- charges for other necessary care which is provided during hospitalisation for pernicious vomiting in pregnancy

Congenital Abnormality
Refers to any abnormality, deformity, disease, illness or injury which manifests at birth, whether diagnosed or not.

Consequential Loss
Refers to any cost incurred which may be associated with a claim but is not covered under the Plan. (e.g., loss of earnings as a result of a medical condition).

Contributions for Membership
All contributions are payable monthly in advance and any member that fails to pay by the 1st of each month will be suspended and no claims for the beneficiaries will be processed. All contributions received from members shall be supported with details of any changes i.e., Resignations, new additions, contact details, etc. In the case of any amendments, these must be provided in writing prior to or at the time of payment.

Country of Residence
Any territory in which you are resident for 90 days or more within a membership year

Critical
Means a medical condition which is unstable and serious for which the outcome cannot be medically predicted, the prognosis is uncertain and the patient concerned is in danger of dying.

D.

Date of Joining
Unequivocally means the date on which cover for the member and dependants, as shown on the Certificate of Membership under the Plan, first commenced.

Day-care Treatment
This refer to admission to a hospital, when a member is admitted for treatment and occupies a bed, but does not remain overnight.

Dental
Dental treatment is excluded except for (i) certain surgical procedures that can only be performed in hospital by specially trained maxillo-facial surgeons or (ii) covered under the Chronic Disease Management Program (iii) where such dental benefits are listed on the Table of Benefits under the member's plan.

Dependant
The term dependant shall mean and include a registered and duly enrolled member who is: -

a. The legal spouse of another adult main member;
b. A child of such an adult main member, or
c. The child of a member who is a widow or widower; or

d. The child of a judicially separated or divorced member who has legal custody of such child; or
e. The child, step-child or adopted child of a member, who is under the age of 18 and who is unmarried and who is not entitled to benefits from another medical aid scheme.
f. A member's child over 18 years of age who, owing to mental or physical defects or similar cause is not in receipt of a regular remuneration, subject to the discretion of Alliance Health and on such conditions as it may specify; or
g. On the recommendation of a member's parents or a dependant's spouse's parents who are not more than 65 years old.

Diagnostics
Diagnostics is the term used to refer to tests that may be conducted to determine the underlying causes of symptoms of ill health (including x rays, blood tests, pathology, advanced imaging, etc.) The costs of diagnostic testing can only be eligible for benefits on referral from a medical professional after a consultation – for an eligible condition.

Direct Billing Arrangement (DBA)
In some cases, the provider of medical services/treatment may prefer to bill us directly. You will then not be required to submit a claim form and original receipts. However, your medical service provider will require your signature on a completed claim form as proof that you have received medical treatment.

Drugs
The costs of medicine and drugs prescribed by a medical practitioner or dentist can be claimed back from the member's benefits provided that such medication/substances are not readily available as 'over-the-counter' purchases and that the treatment is for an eligible condition. There is no cover for 'over-the-counter' medication. The overall limits for medicines and drugs are detailed on the Benefit Table. Any member that suffers from a chronic ailment (i.e., diabetes, asthma, hypertension, etc,) and requires a constant supply of medication must register their ailment and medication requirement with Alliance Health.

E.

Emergency
A serious medical condition that occurs without warning (or with only immediate warning) and which may be life or limb threatening within a period of several hours (up to 12 hours.) Please note that the on-call personnel staffing ambulance service call centres in Zimbabwe can generally assist a member in understanding the severity of a sudden medical condition. If in doubt, please call an ambulance or your family doctor.

Equipment
Any external or internal device that supports, enhances, or otherwise facilitates the use and /or movement of a damaged limb or organ.

Exclusions
What is covered on your family or individual health insurance plan? What isn't? This can be a very distressing question for many. Health insurance companies are not immune from the blows to the economy therefore they have been reviewing their budgets and in doing so the "Exclusions" list in your health insurance plan has probably become longer.

It is just as important to understand what is not covered as knowing what is covered on your family or individual health insurance plan. To find out what is not covered take a look at your health insurance paperwork. If you cannot find it call your provider and they will send you an additional copy. Although the exclusions can be spread throughout your paperwork, generally you can find a list of exclusions in its own area usually listed as "Exclusions."

As you are reviewing your health insurance exclusions section, take a look at the size of the list. If your health plan has a very large exclusions list, they have tried to find everything and incorporate it there. But, if you find the exclusions list is short, be careful. A short exclusion list usually means other exclusions are listed throughout your paperwork. After you have read through your whole family or

individual health insurance plan's paperwork and highlighted every exclusion you can find take a look at the list of common exclusions below to make sure you haven't missed anything.

Typical Health Insurance Plan Exclusions:

1. Treatment for Pre-existing Health Conditions and related complications
2. Routine, Convenience, and Comfort Items: humidifiers, cough syrup,
3. Band-Aids, telephones, TV's, extra pillows...
4. Reconstructive/Cosmetic and/or Sex Change Surgery (Breast reconstruction is usually an exception and circumcision is commonly being considered cosmetic therefore may no longer be covered)
5. Home Care or Private Nursing
6. Dental Care, Hearing and/or Vision Aids
7. Elective Abortions
8. Reversals of Vasectomies or Sterilization (Tubes Tied)
9. Learning and/or Behavioural Problems
10. Experimental Treatments or Drugs and Non-Prescription Drugs

To make sure you don't get a bill that you did not expect it is important to know what is excluded. We have all heard the horror stories behind the $10 hospital pain pill (an over-the-counter aspirin) so how much do you think an extra pillow in the hospital might cost you?

F.

Family Doctor
Your family doctor is the doctor who you consult first for advice and assistance in dealing with any health problems. Your family doctor should be registered as a general practitioner, being the first point of contact for most medical services.

Family doctors who are registered as general practitioners provide a complete spectrum of care within the local community: dealing with problems that often combine physical, psychological and social components.
They attend patients in surgery and primary care emergency centres if clinically necessary, visit their homes and will be aware of and take account of physical, psychological and social factors in looking after their patients.

G.

General Practitioner
A general practitioner (GP) is a medical practitioner who treats acute and chronic illnesses and provides preventive care and health education for all ages and both sexes. They have particular skills in treating people with multiple health issues. GPs call on an extensive knowledge of medical conditions to be able to assess a problem and decide on the appropriate course of action. They know how and when to intervene, through treatment, prevention and education, to promote the health of their patients and families.

L.

Loading
Extra money that is paid in addition to the monthly/annual premium in order to cover certain, agreed pre-existing medical conditions/circumstances or dangerous lifestyle(s).

M.

Material Fact
Refers to statements made as being absolutely true and unbiased (with reference to medical information).

Maternity
The physical state of becoming a mother, resultant from the conception of a child.

Medical Advisory Board
A panel of recognised general practitioners who give professional advice when required by Alliance Health.

Medical History Disregarded
Members joining group underwritten plans can apply for Medical History Disregarded status (referred to as MHD). Long standing members (i.e., those with over 5 years membership) can also apply for MHD.

This means that standard restrictions regarding exclusions applied to pre-existing health conditions may be adjusted or waived. With regards to the way in which MHD is implemented, it is always subject to the material facts declared in the Medical History Declaration and Underwriters acceptance. Alliance Health reserves the right to refuse MHD cover, apply permanent exclusions or place waiting periods on certain medical conditions and related medical conditions.

The optional lifetime limitation on cover for certain pre-existing conditions (e.g., $20,000) is a risk management strategy that may be considered in order to provide protection to both the fund and to members with certain pre-existing conditions. It may be applicable to cardio-vascular benefits where members have pre-existing, but well managed, cases of cholesterol and/or hypertension.

Medical Insurance
What is Medical Insurance and what are the differences between membership to a Medical Aid scheme and a Health Insurance plan?

Medical Aid	Health Insurance
Medical aid is provided by a society of members* who pool their monthly contributions to provide a fund for health care costs	Health insurance is provided by a company, owned by shareholders, with insurance and reinsurance treaties funding the risk of claims
Medical aid is a not-for-profit enterprise	Health insurance is a business enterprise, designed to provide a return on investment to shareholders
Medical aid societies are managed by appointed boards (who are appointed by members annually and who are usually members themselves)	Health insurance companies are managed as commercial enterprises
Medical aid benefits cover the entire spectrum of medical treatment, from discretionary, low cost, high frequency events to non-discretionary, high cost, low frequency events	Health insurance is most cost effective at providing benefits for unforeseen, non-discretionary, infrequent, high-cost health care events
Medical aids are (in general) designed to provide members with **access** to health care at all levels	Health insurance is (in general) designed to provide members with financial protection against the crippling costs of expensive, sophisticated health care treatment of unforeseen events – the costs of which might prove to be catastrophic
Medical aids often have tiered schemes with different benefit limits for each scheme, but the same service benefits across all levels	Health insurance generally provides for tiered schemes with different service benefits at each level, but with similar or substantial global limits for each level
Medical aids encourage cost control through the use of standard tariffs, co-payments and particular limits per event	Health insurance may offer the option of discounted contributions in return for the member accepting excess payments
Medical aids generally do not vary contributions according to individual risk profiles (e.g., age or profession)	Health insurance does generally charge members for additional risk incurred (e.g., correlated to the member's age or profession or other risk factor)

Medical aids generally control against fund abuse through the use of waiting periods	Health insurance generally controls against fund abuse through the use of exclusions

**Medical aid societies were originally designed to be societies of constituent bodies (i.e., societies of corporate entities/companies) providing employee health care benefits and were not designed for individual family membership.*

Medical Practitioner
A recognised professional in the field of medical science who is (i) qualified through the successful completion of study at a medical school listed in the World Directory of Medical Schools by the World Health Organisation (ii) registered and licenced to practice by the relevant national and/or state authorities in the country of practice in the pertinent field of the complaint being treated

Medically Necessary
Means treatment that is appropriate for medical reasons, necessitates treatment or intervention or the mediation of a medical condition which is covered under the terms and conditions of this agreement and which will result in the member's state of health being materially improved.

Medical Report
A medical report should contain the following information: -

(1) The case history
    a. When did the member first show symptoms?
    b. When did the member first seek advice?
    c. How has the problem been dealt with to date?
(2) The symptoms of the problem
(3) The magnitude of the problem
(4) The cause and diagnosis (or the suspected cause and the tests that may be required to verify this)
(5) Recommendations for treatment
(6) The prognosis

Why do we ask for a medical report?
We need to have a medical report so that we are able to have enough information to identify all of the parameters of the particular medical problem. This information is necessary for us to understand the associated costs and process the claim quickly. Our international underwriters also require detailed information for audit purposes and in order to assess our risk for re-insurance. The more information we have, the quicker we can get claims assessed and paid and the more accurate our re-insurance will be. Accurate re-insurance treaties are essential for us to maintain our membership rates at their current levels.

Medication
For a substance to be eligible for benefit as MEDICATION it must satisfy the following criteria (unless otherwise stated in writing from Alliance Health): -

- It must be a substance that is to be used to treat a recognised condition and to bring about an improvement in the member's overall health
- It must be a substance that is legally available via a pharmacy prescription in the country in which it is prescribed and purchased
- The prescribing medical practitioner must be qualified and registered with the appropriate professional and state authorities in the country of the prescription
- The substance must be appropriately registered with the relevant professional, state and drug control authorities in the country of the prescription

Moratorium
A moratorium is a period of time during which certain defined occurrences or behaviours (proscribed circumstances) should or should not take place. If the complete period of time elapses, and none of the

proscribed circumstances have occurred, then the moratorium period is complete. If at any time any of the proscribed circumstances re-occurs, then the moratorium period starts again from the end of that event. With regards to health insurance a moratorium refers to a period of time during which a member should not seek treatment, medical advice, testing or experience symptoms of particular medical conditions (usually pre-existing health conditions). The moratorium must elapse before claims for pre-existing conditions may be eligible under the Plan.

N.

Natural Teeth
Means any teeth that are original and organic and are not artificial replacements or implants.

O.

Obesity
Means any member whose body mass index (BMI)is greater than 30.0 whether pre-existing or not.
BMI = mass(kg) / (height)(metres)

Orthodontic
The treatment of problems concerning the position and appearance of the teeth and jaws including oral cavities.

Out-patient Treatment
Means treatment at a hospital, consulting room, surgery or at an out-patient clinic where a member does not occupy a bed.

P.

Palliative
Treatment that reduces pain and/or maintains the symptoms of a condition without curing the cause.

Pay and Claim
For all eligible costs of treatment and/or medical services members must pay all costs and then complete a claim form for submission to Alliance Health for processing. The claim will be received, adjudicated, processed and the costs reimbursed to the main member. The only exceptions to this may be in cases where the providers of medical services may have agreed to settle the costs directly with Alliance Health or where the providers have accepted a Letter of Guarantee (LOG) from Alliance Health or another case manager on behalf of Alliance Health.

Plan
Refers to the contract between you and us, to provide cover in accordance with the Table of Benefits, general conditions, benefit conditions and benefit exclusions contained within your Plan documents.

Plan Administrator
Mean the person appointed by you, the Plan holder to administrate the member's group healthcare plan and to act as the co-ordinator with ourselves.

Plan Year
Means the 12-month period starting from your commencement date as is shown on the valid Certificate of Membership.

Plan holder
Mean the person or the organisation or company to which we have issued the Plan, and is named on a valid Certificate of Membership.

Pre-Authorise(d) or Pre-Authorisation
The process via which a member seeks approval/permission from us before undertaking treatment or incurring costs. Pre-authorisation may be denied or revoked if new information subsequently negates a claim. Failure to obtain pre-authorisation may result in claim rejection.

Pre-Existing Health Conditions

A pre-existing health condition is any health condition, complaint, illness or disease that was in evidence before or at the time of the member's join date. Such a condition may be characterised by any of the following:

- The member had experienced signs or symptoms
- The member experienced symptoms
- Testing provided evidence that the condition was in existence
- The member had sought medical advice
- The member had received medical advice, treatment or medication

A pre-existing condition can affect your BENEFIT USE. Although the health plan provider (Alliance Health) has accepted you and you are paying your membership fees, you **may** not have coverage for any care or services related to your pre-existing condition.

For example: Margaret is a 38-year-old woman who works as a legal advisor. She has been suffering from migraines for three months. She recently decided to join a private health insurance plan that includes drug coverage in the available benefits. The only affordable health plan she could find had an exclusion for pre-existing conditions (i.e., in her case for migraines as well as any related and/or underlying conditions). After joining the plan, she consulted her family doctor concerning the migraines and was diagnosed with high blood pressure, which is now well controlled on two medications. However, all of her claims (including doctor visits, check-ups, tests and medications) related to her migraines and high blood pressure, (and any complications of the condition) are declined. They are excluded as pre-existing conditions. However, within that first year of coverage, Margaret also got flu and a urinary tract infection – both of which were completely covered because they were not pre-existing conditions.

[NOTE: On the Alliance Options plans that include out-patient services, Margaret would still able to claim casualty and emergency benefits (up to $5,000 in her lifetime) for any cardio-vascular complaints (like a heart attack that may be related to her pre-existing condition of hypertension) or migraines or problems related to hypertension.]

Some examples of the most common medications, conditions and resulting excluded medical conditions (examples) are listed in the table below for your convenience: -

Condition	Typical Medication	Excluded from Benefits of Membership
Gout	Allopurinol	Renal treatment (including kidney failure)
Heartburn	Omeprazole	Ulcers and digestive tract complaints
Hypertension	Atenolol, Enalapril, HCT, Nifedipine, Losartan, Amlodipine	Cardio-vascular treatment (including heart attacks and strokes), Renal treatment (including kidney failure)
Elevated Cholesterol	Atorvastatin, Simvastatin	Cardio-vascular treatment (including heart attacks and strokes)
Osteoporosis	Diclofenac, Fosamax, Besemax	Fractures, muscular/skeletal treatment
Depression/Stress	Fluoxetine, Sertraline	Psychiatric treatment

Preventative Treatment

Refers to treatment intended to stop a condition which does not yet exist or which has no present symptoms.

Primary Treatment

Means the initial medical care a patient receives from a medical professional (usually a general practitioner) before referral to a specialist/consultant for further treatment.

Private Room

A private room in a hospital is defined as a room in which the patient is alone in that room.

Professional Sports

Sports played as a paying job, NOT as a hobby, which makes up the principal source of your income.

Psychiatric
Relating to that which affects the mind, emotions or mental function of a person be it organic, traumatic or reactive in origin.

R.

Reasonable and Customary

This shall refer to the average amount charged in respect of eligible medical services or treatment costs, as determined by our experience in any particular country or territory

Rehabilitation
A planned programme of treatment in which the convalescent or disabled person progresses towards, or maintains the maximum degree of physical and psychological independence of which he is capable.

Related condition
Refers to a disease or illness or injury resulting in a medical condition that is caused by a pre-existing condition or results from the same underlying cause as a pre-existing condition.

Road Ambulance
Refers to a vehicular road ambulance to transport a patient, as required due to an emergency or medical necessity to the nearest available appropriate hospital.

Routine Health Check
Means any diagnostic test/screening carried out where no medical conditions or symptoms are present.

S.

Specialist/consultant
Means a medical practitioner who is practicing and holds the following in the country where treatment is provided:

- A consultant appointment, or
- A recognised certificate of higher specialist training in the field of medicine for which treatment is being sought.

T.

Therapist
Is either a chiropractor, osteopath, homeopath, acupuncturist or Chinese herbalist who is qualified and licensed in the country in which treatment is sought.

Treatment
Means any surgical or medical services, including diagnostic tests, that are required to diagnose, relieve or cure a medical condition.

U.

Underwriting
Underwriting for insurance is the process of identifying and selecting who and what the insurance company decides to insure. This is based on a risk assessment. It is pretty much the "behind the scenes" work in an insurance company where they determine who is insured and how much in insurance premiums, they will charge the insured person. Insurance underwriting also involves choosing who the insurance company will not insure.
Example:
Jane went to her insurance agent to get a car insurance policy. After she told the insurance agent that she had driven without a license and insurance for 5 years and was in jail for reckless driving three times, the insurance agent said that their insurance underwriting department would not insure her because they feel she is too much of a risk.

Your Benefit Restrictions (What we don't cover)

Why do we have restrictions on benefit use?

The unfortunate truth of providing generous benefits of up to US$1,500,000 for private international treatment (with no co-payments or shortfalls against reasonable and customary rates charged by private medical professionals) is that we have to clearly define what we are able to afford to include in treatment and what we are not able to afford. Otherwise, we would not be able to provide membership at such affordable rates.

Our primary objective is always to provide the best possible international treatment for injuries sustained in accidents (including motor vehicle accidents), for cancer, for heart attacks and strokes, for joint replacements, for maternity cases and for other very serious (and expensive) medical treatment. We aim to accomplish this at a reasonable cost to members. The result of this trade off means that we have to be very focussed and specific as to what costs we can afford to include in the benefits of membership – and those that we **exclude**. The list below sets out the standard exclusions that are applicable to all members. Any exceptions must be provided to you in writing and must be renewed every year at your renewal date.

1. **Pre-existing Health Conditions.** Did you join the Alliance Health Options plan with any history of hospitalisation, the use of prescribed medication or ongoing minor health problems that may require attention from time to time? You cannot use your benefits of membership for the costs of treatment or medical advice and attention that relate to any such health condition that you may have had at the time of joining, or at any time before you joined. This includes conditions that in the professional opinion of our Medical Advisory Board, were in existence at or prior to your join date. This does not include recurrences of tropical or parasitic diseases such as bilharzia and malaria, unless they are related to an underlying, ongoing condition that may already be causing damage to your immune system.
2. **Congenital Health Conditions.** As with all other internationally underwritten health plans, our underwriting does not allow us to carry the risks of treatment costs that are related to genetic disorders or syndromes. However, in the case of new born babies, who are born to members after at least ten months membership to the plan, then **we will pay up to $100,000** for all treatment costs of all conditions affecting the new born child that are present at birth or contracted or diagnosed before the new born child leaves the hospital, and which can be considered medically necessary.
3. **Performance Enhancement.** The benefits of membership to the Alliance Health Options plan can only be used for treatment or medical services that can be deemed MEDICALLY NECESSARY, that is to **prevent a FURTHER CRITICAL deterioration** in a member's state of health or wellbeing that is unrelated to the normal natural processes of aging. As such, any medication or treatment that is related to an improvement of performance, or for the mediation of developmental lags and barriers to learning in children, would not be considered

to be medically necessary and cannot be claimed for. This exclusion also applies to treatment of infertility, fertility treatment and all costs related to the treatment of sexual dysfunction.

4. **Dangerous Activities.** There are certain activities which members may undertake which will place the members at significantly higher risk of injury or disease. Where members choose to undertake such activities on a regular or professional basis, they are consciously choosing to live a lifestyle that is more dangerous or has a greater than average risk of requiring expensive medical treatment. Such risks are out of the ordinary, and are not part of the typical risk profile that our underwriters have used to cost out our risk exposure. As such we will not be able to provide treatment for injuries or ill-health that are a result of such activities. If you are concerned that your profession, sport or hobby could be deemed to be dangerous, then please contact our Membership Department for further advice and guidance.
5. **Negligence and Self-Inflicted Injuries.** You cannot use your benefits of membership for the costs of treatment, or medical advice and attention that may relate to any such health condition or injury that is a result of activities or habits that you may have participated in and persisted in against the advice of a medical practitioner, against the advice of a counsellor, against the health and safety recommendations and practices of your employer, or which may be a result of you not taking due care to follow instructions or take precautions, or which could be reasonably assumed to result in harm or injury to yourself. This includes drug, alcohol and other substance abuse as well as the operation of machinery.
6. **Experimental or Unregistered Practices.** Unless otherwise explicitly sanctioned and pre-authorised by our Medical Advisory Board the benefits of membership cannot be used to fund treatment that may be regarded as experimental, or is outside of common medical practice or involves the use of substances, medication, activities, equipment and personnel who are not registered with the appropriate authorities in the country of treatment.
7. **Breaking the Law.** You cannot use your benefits of membership for the costs of treatment, or medical advice and attention for any condition that may be the result of any activity that is in contravention of the law.
8. **Benefits Not Stated.** You cannot use your benefits of membership for the costs of any medical services or treatment that are not listed and specified on the table of membership benefits provided.
9. **Consequent and Subsidiary Costs.** You cannot claim back any costs that might be levied to you as charges or fees for medical reports, or for administration (including the completion of claim forms as required)
10. **Equipment.** Unless otherwise stated the benefits of membership cannot be used to fund the purchase, hire, maintenance or testing of equipment or devices including, but not limited to: - crutches, wheelchairs, braces, supports, wheelchairs, diapers, inhalers and glucometers
11. **Prophylactic and Preventative Treatment.** You cannot use your benefits of membership for the costs of any medical surgery, or treatment, or services, or dietary supplements that are primarily for the prevention of possible disease or ill-health, or to counter the natural effects of aging.

IMPORTANT CHANGES TO BENEFITS SEPTEMBER 2017 -2021

Description	Benefit
Additional Congenital Benefit	An additional benefit of USD 10,000 for the treatment of congenital conditions when the condition has only manifested after the member's join date and cannot be considered a pre-existing condition by normal definition
Bone Marrow Transplants	Specific clarification that surgical costs of bone marrow transplants are covered in full as medically necessary treatment under in-hospital benefits, but that costs related to donor search costs and donor testing, are not eligible for benefit
Customary and Reasonable	Further definition to note that awards are limited to the USD rates charged at inception of the Service Provider Service Level Agreement, or the previous year, unless otherwise negotiated
Dental Implants	Inclusion of dental implants as eligible for benefit as per fillings, crowns and bridges under the relevant dental benefit
Dental Surgery	Medically necessary dental surgery is eligible for benefit whether in or out of hospital
Dental Treatment (Accidental Damage)	Medically necessary dental surgery for the treatment of accidental damage to teeth is eligible for benefit whether in or out of hospital
Diagnostic testing for cardio-vascular disease	The advanced imaging benefit to include coronary calcium scans for the accurate assessment of both acute and chronic cardio-vascular disease
Epidurals for pain control during childbirth	The maternity benefit includes the full costs of prescribed epidurals as medically necessary for pain control during the birthing process
Evacuation by Commercial Airline	The benefit is limited to reasonable and customary charges, which may be established by way of comparing three quotations
Idiopathic scoliosis – equipment benefit	Members diagnosed after their join date with idiopathic scoliosis can utilise relevant benefits for equipment that provides effective treatment and which may obviate requirements for higher cost surgical interventions
Kidney Dialysis	The benefits for kidney dialysis are restricted to in-hospital treatment of acute kidney failure or acute on chronic episodes
Maternity Benefits	This benefit can be utilised as per the benefit table for the biological child of a member, restricted to the membership benefits of the mother
Maternity Benefits Waiting Period	The maternity waiting period for a spouse does not apply in cases when the father has been a member for 5 years or more
New-born Benefits	To specify that these benefits are from either the mother's benefit, or from the father's benefit, but cannot be amalgamated from both parents
Physiotherapy benefit for recovery from joint surgery	To include costs of prescribed physiotherapy treatment for recovery and rehabilitation after knee surgery, including the use of registered cold pressure devices
Stem Cell Tissue Storage	Inclusion of stem cell tissue storage benefit for new born infants (50% co-payment applies)
Short Term Cover for returning immediate family	Cover for immediate family members visiting a plan holder for a maximum of 90 days. The cover is only for Accidents and Emergencies only and exclude cover for any pre-existing conditions

Terms and conditions apply

- ***Errors and omissions***
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- ***Terms and conditions are subject to change with notice being given. Date of last revision: April 2021***