Liberty Health Cover Policy Conditions

Corporate, SME and ME

2020 (LH20B)

LH20B_Final_28052020

Effective from October 2020

Table of Contents

1 Introduction

This document describes the terms and conditions applicable to the health insurance benefits covered under your Liberty Health Cover policy. These policy conditions must be read in conjunction with the benefit tables, which describe the benefits which you are entitled to and the limits attached to these benefits. These policy conditions together with the benefit tables, the Company Health Insurance Agreement and the application form constitute the agreement between the Policyholder, Insured Person and the Company. We have taken every effort to ensure that all the important information you require is in this policy conditions.

2 Definitions

Below is a list of words that are used throughout your policy. These words have the same meaning, as defined below, wherever they are used in your policy.

2.1 **Accident** means bodily injury caused solely by violent, accidental, external and visible means and not by sickness, disease or gradual physical or mental process.

2.2 **Acute Condition** means conditions that generally appear suddenly, progress rapidly and are relatively short in duration.

2.3 **Administrator** means any recognised body appointed by Us to administer this policy.

2.4 **Age** means the age (last birthday) of the Principal Member or Dependants as at the policy commencement or renewal date for the applicable Policy Year.

2.5 **Beneficiary** means the Principal Member and any person registered as a Dependant of a Principal Member who is entitled to benefits under this policy and who is not covered under another Benefit Plan (including any other Liberty Health Cover product).

2.6 **Chronic Condition** means conditions that require medication and treatment for more than three continuous months.

2.7 **Claim** means an itemized statement or invoice of services and costs provided by a Hospital, Medical Practitioner or Doctor submitted for payment.

2.8 **Clinical Funding Protocol** means a set of guidelines developed by Us to determine the appropriate funding and allocation of benefits for requested medical services. Their development is based on Evidence-based Medicine (EBM) principles.

2.9 **Claims Debt** means Claims paid by the Company that are recoverable from the Insured Person or Policyholder.

2.10 **Corporate client** means a Policyholder with 30 or more employees.

2.11 **Commencement Date** means the first day cover begins following acceptance by the Policyholder or as agreed between the Policyholder and Us.

2.12 The **Company, We, Our, Us, Insurer** means the insurer issuing this policy.

2.13 **Dependant** means:

- A Spouse or Living-in partner of the Principal Member or
- A Spouse, Living-in partner or child (as defined below) of a deceased Principal Member
- A natural child, stepchild, legally adopted child, or any child placed in the care and custody of the Principal Member or the Principal Member's Spouse or Living-in partner or where there is a liability for financial support enforceable by a court of law. A child Dependant must be:
  - up to the age of 21 (inclusive) or
  - between the ages of 22 and 25 (inclusive) provided that he or she can provide proof of registration as a full-time student at a recognized educational institution (student cards do not qualify) or
  - dependent on the Principal Member due to mental or physical disability (A copy of the Doctor's medical report confirming permanent disability may be requested)

Beneficiary Type	**Applicable Premium rate**
Principal Member	**ME** - relevant year of age rate **SME** - relevant year of age rate **Corporate** - Adult rate
A Spouse or Living-in partner of the Principal Member	**ME** - relevant year of age rate **SME** - relevant year of age rate **Corporate** - Adult rate, even if the Spouse or Living-in partner is under the age of 22 years
Child	**ME** - relevant year of age rate **SME** - relevant year of age rate **Corporate** - child rate applicable to 0-21 Premium age group

2.14 **Evidence-based Medicine** (EBM) is defined as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of Beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.

2.15 **Emergency Evacuation** means immediate and urgent movement and en-route care provided by medical personnel to an Insured Person being evacuated from their current location to the nearest medical centre in order to undergo care, on account of an Emergency Medical Condition.

2.16 An **Emergency Medical Condition** means a condition that happens suddenly and unexpectedly, requires immediate medical or surgical treatment for resuscitation and/or stabilisation and where failure to provide this treatment within 24-48 hours would result in serious impairment of bodily functions, serious dysfunction of a bodily organ or part, or would place the Insured Person's life in serious danger.

2.17 **Force Majeure** includes, acts of God, acts of the State or Government, Regulatory changes, exceptionally adverse natural disasters, riot, insurrection, sanctions, sabotage, terrorism, political or civil disturbance, war, boycotts, embargo, strikes, lock-out, shortages of labour or materials,

material delays in public transport or any similar circumstances beyond the reasonable control of the Insurer. Including but not limited to material changes in exchange rates.

2.18 **Benefit Plans** means the Benefit Plans as described in the benefit tables.

2.19 **Health Questionnaire** means the Application Form, signed by the Principal Member or Dependant. This also includes any written statement, representation or document given to Us that contains information relied on to issue this policy.

2.20 **Hospital** means an institution which is legally licensed as a medical or surgical hospital in the country in which it is located. It must be under the constant supervision of a Doctor.

2.21 **Insured Person** means a Beneficiary who has been accepted by the Insurer for coverage under this policy.

2.22 **Late Joiner** means a person who applies for cover after the Commencement Date of this policy.

2.23 **Life Changing Event** means divorce, marriage or retrenchment of Insured Person or Spouse's change of employment or death.

2.24 **Living-in partner** means a person with whom the Principal Member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

2.25 **Managed Healthcare Programme** means a healthcare delivery arrangement designed to ensure access to affordable, appropriate, good quality and effective healthcare that allows for the efficient utilization of benefits available to each Insured Person.

2.26 **ME client** means a Micro Enterprise comprising of a minimum of 1 employee and a maximum of 5 employees.

2.27 **Medical Practitioner or Doctor** means a person who is legally qualified in medical practice following attendance at a recognized medical school, to provide medical treatment and licensed by the competent medical authorities of the country in which treatment is provided but who should not be the Insured Person or the relative, sibling, Spouse, child or parent of the Insured Person.

2.28 The **Policyholder** means the employer group or sponsor who has purchased this policy in respect of its employees and is responsible for the payment of Premiums under this policy.

2.29 **Policy Year** means a period of 12 months starting from the Commencement Date of this policy and each consecutive 12-month period thereafter for which this policy is renewed.

2.30 **Pre-Existing Conditions** means any injury, illness, condition or symptom:

- for which treatment, or medication, or advice, or diagnosis has been sought or received or was foreseeable by the Insured Person prior to the policy Commencement Date, or

- which originated or was known to exist by the Policyholder or the Insured Person prior to the policy Commencement Date whether or not treatment, or medication, or advice, or diagnosis was sought or received.

2.31 **Pre-authorisation** means authorisation approved/given in writing in advance of a relevant healthcare service or treatment being provided.

2.32 **Provider Network** is a network of healthcare providers with whom We contracted and have negotiated tariffs for the provision of healthcare services. These healthcare providers will be paid directly by Us in accordance with the negotiated tariffs, specified benefit limits and subject to the conditions of this policy.

2.33 **Premium** means the premium payable by the Policyholder to Us for the benefits payable under this policy as set out in clause 4.

2.34 **Premium Debt** means Premiums outstanding by a Policyholder.

2.35 **Principal Member** means an employee who is employed on a full-time, permanent basis and full-time employees who retire from the services of an employer who is the Policyholder and are eligible for cover at the date of retirement.

2.36 **Reasonable and Customary Charges** means charges for healthcare which We consider to be reasonable and customary if they are within a general level of charges being made by other healthcare providers of similar standing in the locality where the charges are incurred when giving like or comparable treatment, services or supplies to individuals of the same gender and of comparable age for a similar disease or injury.

2.37 **Region of Cover** means the territories or countries stipulated in the benefit tables in which the Insured Person will be covered under this policy.

2.38 **Roaming** means where a Beneficiary electively obtains medical services outside the country of residence, in line with the Region of Cover on their selected Benefit Plan and that does not require an Emergency Evacuation.

2.39 **Secondment** means a temporary transfer to another job or post within the same organization for a period of more than three months.

2.40 **SME client** means a Small to Medium Enterprise comprising of a minimum of 6 employees and a maximum of 29.

2.41 **Specialist** means a qualified and licensed Doctor, possessing the necessary additional qualifications and expertise to practice as a recognized specialist of diagnostic techniques, treatment and prevention, in a particular field of medicine including but not limited to psychiatry, neurology, paediatrics, endocrinology, obstetrics, gynaecology and dermatology.

2.42 **Spouse** means the person to whom the Principal Member is married in terms of any law or recognised custom and includes a Living-in partner.

2.43 **Trauma** means an injury caused by an extrinsic agent.

2.44 **Waiting Period** means the period of time from the policy Commencement Date during which this policy does not cover any treatment made necessary by any cause. Premiums remain payable during the course of this Waiting Period.

3 General Policy Conditions

3.1 Insurance Cover

We have partnered with local insurers to license and insure the Liberty Health Cover policy in the local country where the policy is issued. Please contact Us, or visit Our website (www.libertyhealth.net) for the list of Our local insurance partners.

The Liberty Health Cover policy is reinsured through a cell captive arrangement established with Swan Reinsurance PCC (registered in Mauritius, registration no.C105419). The cell, including its risks and liabilities, are fully owned and backed by us.

3.2 Applicable Law

This policy will be governed by and construed, determined and enforced in accordance with the law of the country in which this policy is issued.

3.3 Assignment

The Policyholder or the Insured Person will have no rights to assign this policy or any insurance coverage effected under this policy.

3.4 Non-disclosure

If an Insured Person makes a false declaration or knowingly fails to disclose that he has or is suffering from an illness or condition, then the Company reserves the right to:

- impose Waiting Periods
- impose Premium loadings
- specifically exclude benefits in respect of a particular medical condition, disease, disorder or disability that existed at the time of application for coverage under this policy
- Terminate the cover of the Insured Person
- Recover any or all medical costs incurred in respect of this condition from the Insured Person

The Company shall notify the Insured Person in writing of any limitation, Premium loading, or specific exclusion imposed or termination of the policy.

3.5 Residence

The Insured Person must reside in the country in which this policy is issued or registered in order to qualify for coverage under this policy, except where otherwise agreed beforehand between the Policyholder and the Company.

3.6 Commencement of coverage

3.6.1 This policy will only commence once the application form has been accepted by the Company and the Policyholder has paid the Premium due in full. No backdated changes will be allowed.

3.6.2 All completed application and amendment forms are valid for a period of 90 (ninety) days from the date of declaration as indicated by the applicant.

3.6.3 If the application for coverage under this policy is approved by Us during a month within a Policy Year, then the Commencement Date of cover will be the first day of the month immediately following the month in which the application for coverage is approved. Alternatively, an Insured Person can opt for immediate coverage, but will be charged for the full month's Premium in which the policy is activated.

3.6.4 All Dependants must be registered under the same Benefit Plan as the Principal Member. A Dependant cannot select a different Benefit Plan to that of the Principal Member.

3.6.5 In the case of newborns, application should be made within 60 (sixty) days of the date of birth, a copy of the birth certificate or Hospital confirmation reflecting the baby's name must be provided with the application.

3.6.5.1 If the newborn is registered within the 60 day period, coverage will commence from date of birth. Any Claims incurred for the newborn during this period may be submitted for payment once the newborn has been registered. Premiums will be charged from the first day of the month immediately following the month of birth.

3.6.5.2 If the newborn is not registered within 60 (sixty) days of birth, then coverage under this policy will not commence from the first day of birth. Instead, coverage for the newborn will commence as specified in sub-clause 3.6.1 and subject to underwriting as specified in sub-clause 3.16.

3.6.5.3 In the event of an emergency should the newborn require in-hospital care immediately following the birth and prior to discharge, the newborn will be covered under the mother's policy for In-Patient benefits only for the first 15 (fifteen) days from date of birth.

3.7 Age Limit

This policy will not cover a new applicant over the age of 70 years old.
An existing Insured Person who was less than 70 years old when cover under this policy originally commenced but who subsequently aged beyond 70 years old, will continue to be covered under this policy.

3.8 Changing Benefit Plans

An Insured Person can only change their Benefit Plan at policy renewal subject to giving Us written notice 30 (thirty) days prior to policy renewal.

3.9 Termination of Insured Person's Coverage

An Insured Person's cover under this policy will terminate on the date any one of the following events first occurs:

a) the entire policy will be terminated as provided in sub-clause 3.10 of this section or an Insured Person's cover is terminated as per clause 3.12;
b) where the Insured Person no longer qualifies for cover;
c) in the case of a Dependant, where the Principal Member is no longer eligible for coverage under this policy;
d) non-payment of Premiums due under this policy.

The Policyholder must provide Us with 1 (one) calendar month written notice of the termination, for any reason whatsoever, of a Principal Member and/or Dependants of any such change. Should such notification reach Us after the notice period and Claims have been paid in respect of the Principal Member or Dependants We reserve the right to:

- Charge Premiums for the period for which Claims were paid even if the Principal Member or Dependants were no longer eligible for cover
- Decline funding for any Claims received after the notice period.
- Recover the costs of any Claims paid by Us from the Policyholder

When a Dependant ceases to be eligible as a Dependant, he/she shall no longer be deemed to be registered as such for the purpose of this policy or entitled to receive benefits, regardless of whether notice has been given in terms of this policy or otherwise.

3.10 Cancellation by the Policyholder

The Policyholder may cancel the policy by giving 90 (ninety) days advance notice in writing to Us. The cover on all Insured Persons will cease on the date the policy is cancelled.

In the event of Force Majeure, We reserve the right to cancel this policy with 30 days' notice by notifying the Policyholder in writing.

3.11 Renewal

At the renewal date (usually at the end of each Policy Year) the policy may be renewed for a further term of 1 (one) year subject to the mutual agreement between the Company and the Policyholder on the renewal terms. At policy renewal, the Company will review the benefits, policy conditions and Premiums subject to the mutual agreement of the Company and the Policyholder and subject to the Company giving the Policyholder 90 (ninety) days advance notice of the renewal terms in writing.

If renewal terms are not agreed and finalised by the renewal date, the cover for all Insured Persons will cease from the 1st day following the policy renewal date.

3.12 Fraud

If any Claim shall in any respect be false or fraudulent or if fraudulent means are used by the Insured Person or anyone acting on their behalf to obtain benefit under this policy, the cover for the Insured Person or at the discretion of the Insurer, the entire policy may be cancelled immediately and all benefits and Premiums forfeited. Legal action may also be instituted against the parties in question.

Fraud can be defined as any action committed with the aim of obtaining or procuring an advantage or profit from an unjustified or undue service at Our expense.

The following are examples of fraudulent behaviour of the Policyholder or Insured Persons, but not limited to:

- Drafting or use of a false document, including any supporting document, health invoice or other billing document
- Colluding with providers to submit fraudulent Claims
- Failure to report or declare any changes to any applicable documents
- Duplication, theft or borrowing of documents with the intention of obtaining services illegally
- Altering a medical insurance Claim for financial gain
- False billing of health services by a Beneficiary or service provider, in particular the billing of fictitious services
- Billing of unjustified healthcare services outside the medical prescription or the requirements of the patient
- Insured Persons allowing other non-insured individuals to use their membership card to access benefits
- Falsifying Claim invoices for Insured Person reimbursement
- Presenting fraudulent prescriptions at pharmacies

In the case where We find fraud, We may apply any of the following, or a combination of the following sanctions:

- immediate termination of the policy
- termination of the Insured Person's cover
- Instituting civil and/or criminal legal action

3.13 Membership cards

3.13.1 A membership card, per Beneficiary, is only issued upon receipt of a fully completed application form and if the Premium due has been paid in full.

3.13.2 Should the card be lost or stolen it is incumbent on the Policyholder and/or Insured Person to inform the Company immediately, failing which the Policyholder and/or Insured Person could be held liable for any Claims paid through misuse. The cost for producing additional card(s) will be at the cost of the Policyholder and/or Insured Person.

3.13.3 The utilization of the membership card by any person other than the Insured Person, with the knowledge or consent of the Insured Person, is an abuse of the benefits of the Benefit Plan and will be dealt with by the Company in accordance with sub-clause 3.12.

3.14 Pro-rated benefits

If an Insured Person joins the policy during a Policy Year, then out-patient annual benefit limits and Premiums will be pro-rated on a monthly basis to reflect that coverage does not apply for a full year.

3.15 Liberty Tariff or Provider Price List

The Liberty Tariff or Provider Price List means the agreed maximum amount of money We will pay for a particular medical expense (e.g. in-hospital treatment, consultations, medicines, procedures, examinations, etc.) to a Network Provider.

Where no tariff has been agreed with a medical service provider, We will pay what is considered Reasonable and Customary Charges within the country in which the treatment and services were obtained.

Where the provider charges above the agreed maximum tariff amount or what is considered reasonable and customary charges the patient will be liable for the payment of the difference between the two amounts.

3.16 Underwriting

3.16.1 For ME and SME clients, and Late Joiners (ME, SME and Corporate clients), the following may be applied at application for membership or in cases of non- disclosure (clause 3.4):

3.16.1.1 A Waiting Period of up to 24 months applicable for a specified condition, benefit limit (including maternity), avocation, occupation or general health status.

3.16.1.2 A Premium loading in respect of a specified condition, avocation, occupation or general health status.

3.16.1.3 A lifetime exclusion of cover in respect of a specified condition, avocation or occupation.

3.16.1.4 Decline cover.

3.16.2 Should an Insured Person undergo a Life Changing Event and apply to be admitted or re-admitted as an Insured Person on this policy within 30 (thirty) days of the Life Changing Event taking place, he or she shall be registered as an Insured Person without the imposition of any underwriting.

3.16.3 For Corporate clients <u>only</u> the following is applicable:

3.16.3.1 No underwriting shall be imposed on an Insured Person in respect of whom application is made for membership within 30 (thirty) days of a specified period of Secondment by the employer.

3.16.3.2 It is compulsory for an employee to apply for coverage under this policy within 30 (thirty) days of the policy Commencement Date or employment date of the employee in order to obtain coverage with no underwriting; such employees must be registered as from the date of employment or policy Commencement Date or underwriting will apply.

3.16.3.3 Dependants who apply for coverage within 30 (thirty) days of the policy Commencement Date or employment date of the employee will obtain coverage with no underwriting; such

Dependant must be registered as from policy Commencement Date or employment date or underwriting will apply.

3.16.3.4 In the case of a newborn, application must be made within 60 (sixty) days of the birth date in order to obtain coverage with no underwriting; such Dependants must be registered as from their date of birth or underwriting will apply.

3.16.3.5 In the case of an adopted child or child placed in the custody of an Insured Person, application must be made within 60 (sixty) days of the adoption or custody date in order to obtain coverage with no underwriting; such Dependants must be registered as from date of adoption or legal custody or underwriting will apply.

3.16.3.6 In the case of a newly married Spouse or Living-in partner, they must be registered for coverage under this policy within 30 (thirty) days of the marriage date or date of co-habitation, such Dependant must be registered as from date of marriage or date of co-habitation in order to obtain coverage with no underwriting otherwise underwriting will apply.

3.16.3.7 No underwriting will apply to a new subsidiary company acquired by an existing employer group provided application is made within 30 (thirty) days of the acquisition and the group size exceeds 29 employees.

3.16.4 All new applicants are required to complete a Health Questionnaire which forms the basis of the contract.

3.16.5 All application forms must be duly completed, together with the signature and date of declaration.

3.16.6 Any additional information, due to constraints of the form, can be completed on a separate sheet of paper.

3.16.7 All completed forms are valid for a period of 90 (ninety) days from the date of declaration as indicated by the applicant.

3.16.8 Persons who do not join within the timelines specified within clause 3.16.1 may be subject to Late Joiner underwriting.

3.17 Second Opinion

We may require a second opinion in respect of diagnosis, proposed treatment or medicine which may result in a Claim for benefits, and for that purpose the relevant beneficiary shall consult a dental or Medical Practitioner nominated by Us and at Our cost. In the event that the second opinion proposes different treatment or medicine to the first, We may require that the second opinion proposals be followed.

3.18 Legal Proceedings

No action in law or equity shall be brought to recover under the policy until after the expiration of 60 (sixty) days from the date that proof of a Claim has been furnished in accordance with the policy conditions. The parties have agreed that the law of the country in which this policy is issued shall

govern and control in the event of any conflict or dispute between the parties with regard to the policy, and that the parties submit themselves to that exclusive venue and jurisdiction for the resolution of any such conflict or dispute.

3.19 Arbitration

Any difference of medical opinion in connection with the results of any Accident, illness, death or expense will be referred to two medical experts appointed respectively, in writing, by the two parties to the dispute, for resolution by said experts. Any difference of opinion between the two medical experts shall be referred to an independent mediator, who shall have been nominated, in writing, by the two medical experts at the outset.

3.20 Events beyond the Insurer's control (Force Majeure)

Should the Insurer be prevented from carrying out any of its obligations in terms of this policy because of Force Majeure, We will notify the Policyholder/Insured Persons of the circumstances and nature of the Force Majeure as well as the estimated duration and extent to which the Insurer's performance is made impossible.

Under such circumstances, the Insurer's obligations under the policy will be suspended until the circumstances causing the Force Majeure ends and the Insurer will not be liable to the Policyholder/Insured Persons for any damages whatsoever caused to the Policyholder/Insured Persons due to the Insurer's inability to perform its obligations in terms of the policy. In the event of Force Majeure, the Insurer may cancel the policy by giving 30 (thirty) days' notice.

3.21 Adjustment of Benefits and Premiums

The Insurer reserves the right to appropriately adjust the Premiums or benefits payable (including any applicable guarantees) and the charges levied under this policy if:

- any legislation or regulation (including tax legislation or regulation) affecting this policy or the Insurer is introduced or changed, or
- the legal interpretation or understanding of any legislation or regulation (including tax legislation or regulation) affecting this policy or the Insurer has changed.

The Policyholder and Insured Persons (as applicable) will be notified in writing when these changes will take place.

3.22 Undertakings

3.22.1 Confirmation that all information is correct

The Policyholder guarantees that all information given to the Insurer and/or its Administrator at any time is complete and true. Information that affects the Insurer's decision to provide benefits is known as material information.

Where the Policyholder provides the Insurer and/or its Administrator with the personal information of an Insured Person, for example beneficiary or health information, the Policyholder guarantees that the Insured Person has given the Policyholder consent to provide the Insurer and/or its Administrator with their personal information.

Where any material information is not fully disclosed or is found to be untrue, the Insurer may decide to cancel the policy and/or not to pay any Claims or benefits.

4 Premiums

4.1 Premiums are payable in advance and the selected frequency may only be amended on the anniversary of the policy.

4.2 Premiums are payable monthly, quarterly, bi-annually or annually.

4.3 Premiums are payable in advance from the 1st of the month of the billed period (monthly, quarterly, bi-annually, annually) and by no later than the 7th of the first month of the billed period.

4.4 The first Premium must be physically received into the Company's nominated bank account before the Commencement Date of this policy to enable activation of benefits for Insured Persons.

4.5 Premiums must be paid directly to the Company and not a third party. Cover will not commence, nor the suspension of cover lifted until such time that the Premiums are reflected in the bank account of the Company.

4.6 Tax invoices will be produced for any amendments to add or end cover for Insured Persons processed up to the 15th of the current month.

4.7 Amendments to Insured Persons received after the 15th of the month will be reflected in the subsequent tax invoice.

4.8 Where a Policyholder pays monthly, quarterly, bi-annually or annually in advance amendments to Insured Persons will be invoiced monthly and is payable at the selected frequency.

4.9 Premiums will be appropriately adjusted from the first of the month following the month in which the amendments to Insured Person have been submitted.

4.10 The Company reserves the right to review Premiums at any time during a Policy Year due to unforeseen changes in policy taxes or legislation.

4.11 The Company reserves the right to suspend benefits to Insured Persons, if the Policyholder has not paid the full amount of the Premium due by the 14th of the month in which it became due. When the full amount of Premiums is paid, the Company shall reinstate benefits to Insured Persons.

5 Debt

5.1 Recovery of debt

5.1.1 Premium Debt

5.1.1.1 Premiums are payable by no later than the 7th of the month to which the invoice relates.

5.1.1.2 If no payment is received by the 14th of the month in which it became due, all benefits will be suspended.

5.1.1.3 If no payment is received within 2 (two) months of the 1st of the month in which it became due, the policy will be terminated and written notification will be sent to the Policyholder. The collection of the outstanding debt will be referred to a debt collection agency and where necessary, a legal collection process would be pursued.

5.1.2 Claims Debt

Active members

5.1.2.1 Claims Debt is payable immediately by the Insured Person.

5.1.2.2 If Claims Debt is not paid within 3 (three) months of the debt becoming due, benefits for the Insured Person will be suspended (Premiums will still be raised and invoiced). The Insured Person and the Policyholder will be informed via written correspondence.

Terminated members

5.1.2.3 Where an Insured Person has resigned and has outstanding Claims Debt, the Policyholder is responsible for the immediate payment of the Claims Debt.

5.1.2.4 If Claims Debt is not paid within 3 (three) months of the debt becoming due, the policy will be suspended. The Policyholder will be informed in writing.

6 How to claim

We will act in good faith in all Our dealings with the Policyholder and Insured Persons. The Policyholder and Insured Persons, in turn, must ensure that the following are observed:

6.1 The payment of treatment costs under this policy is subject to Our agreed tariffs in the relevant country where treatment is received. Where no tariffs have been agreed with a medical service provider, Claim payments will be reimbursed subject to what We consider to be Reasonable and Customary Charges in the country where treatment is received. The Insured Person is liable for treatment costs in excess of Our agreed tariffs or what We consider to be Reasonable and Customary Charges.

6.2 In-network treatment

If an Insured Person goes to Our Provider Network for treatment, then We will arrange direct payment for the cost of treatment to the healthcare provider up to the specified benefit limits and subject to the conditions of this policy.

An Insured Person must always present his/her membership card to the healthcare provider in order to receive treatment.

6.3 Out-of-network treatment

On Benefit Plans with Provider Networks no Claims will be paid directly to a non-network provider or refunded to an Insured Person using the services of a non-network provider.

6.4 Out of country treatment

For the Benefit Plans that allow Roaming, in the case where an Insured Person goes for treatment outside the country where this policy is issued, We will only fund treatment at Our Provider Network. If there is no Provider Network in a specific country, We will pay Claims at what We consider to be Reasonable and Customary Charges, subject to clause 6.1. No costs related to travel and accommodation are funded for out of country treatment.

Claims for treatment outside of country of residence will be converted at exchange rate valid on the date of service or discharge in the case of hospitalisation.

6.5 Requirements for the submission of a Claim

In order to process and pay a Claim the following information must be clearly provided on the account:

- Policy/Membership number
- Patient Name and Surname
- Date of birth
- Diagnosis
- Date of service (for Hospital please include admission and discharge dates)
- Detailed Treatment or Service description for each item received/provided (i.e. name of medicine, ward level)
- Quantity (i.e. 30 Disprin, 3 days in general ward)
- Tariff code (if available)
- Amount charged per service or treatment received
- Name of treating Healthcare professional

- Facility Name (i.e. General Hospital, Africa Medical Clinic)
- Total charged (which must add up to the amounts charged individually on the account)
- Pre-authorisation number (if applicable and where the service requires pre-authorisation – see 6.8)
- Proof of payment in the case of a refund to the Principal Member. The only document We will accept as proof of payment is a receipt or proof of electronic (EFT) payment. If the correct proof of payment is not attached, the account will be rejected.
- Signature of the patient or Principal Member if the patient is a minor
- Signature of the provider
- Date of the account and account reference number

Failure to observe the above Claim conditions, without any reasonable explanation, may invalidate a Claim. It is recommended that the Insured Person keeps copies of any medical information that he sends to Us. This will help the Insured Person keep track of what We owe to him and will be helpful if he needs to follow up on his Claim.

6.6 Period for the submission of Claims

In order to qualify for the payment of benefits, a Claim must reach the Company within 120 (one hundred and twenty) days of the treatment or discharge date. A Claim submitted beyond this timeframe will not be paid.

6.7 An Insured Person must make sure that he or she can afford treatment

The Company can determine if an Insured Person is eligible for a particular treatment in terms of his policy, as well as advise him whether he has funds available to pay for it (within benefit limits stated in the benefit table). However, it is up to him to confirm that he has funds available by checking with Us or referring to the benefit table and asking the Doctor or Hospital what the charge for treatment will be.

6.8 Services or benefits that require Pre-authorisation

For certain services or benefits the Insured Person must obtain Pre-authorisation from the Company. Services or benefits that require Pre-authorisation include:

- Hospitalisation (elective and non-elective)
- Cancer treatment (in- and out-patient)
- Renal (Kidney) dialysis (in- and out-patient)
- Specialized radiology (in- and out-patient)
- Emergency Evacuation and air ambulance services (in-country and international)
- Chronic medicines
- Appliances and prosthesis
- Organ transplants
- Compassionate travel
- Repatriation of mortal remains
- Non-emergency ambulance services
- Annual Medical Examination (Pre-authorisation required only in Nigeria)

The relevant managed care application form and clinical information should be provided to the Company at least 48 (forty-eight) hours prior to the Dependant obtaining the treatment/service. If

the Insured Person does not obtain Pre-authorisation, he may be held personally liable for his medical costs.

In case of an Accident or hospitalisation in the event of an emergency, written notification together with reasonable available supporting medical information must be submitted to Us within 48 (forty-eight) hours of the event, or if it is a weekend or public holiday, on the next working day.

Where Pre-authorisation is required and is not obtained We reserve the right to:

- Decline funding or
- Apply a co-payment of 20% of the total value of the Claim

7 Benefits

This section should be read in conjunction with the benefit tables. Please refer to the benefit tables of your selected Benefit Plan to understand exactly what you are covered for under your policy. This section provides more detail on the benefits that you are entitled to under your policy where such detail is not included on the benefit tables.

Please note that benefits vary depending on the country and Benefit Plan selected and therefore may not be applicable to your Benefit Plan or country. Should you be unsure of what is applicable please call your in country office for clarification. Claims will not be funded for services that are not covered under your relevant Benefit Plan.

No Insured Person is entitled to assign, transfer, pledge or cede his/her benefits or rights to benefits in or from this policy.

7.1 Day-to-day Benefits (Out-patient)

This category of cover provides for out-patient medical treatment that does not require hospitalisation. The following services and treatment fall under this category of cover:

7.1.1 Out-patient treatment for Acute Conditions

This includes:

- General practitioner (GP) consultations.
- Specialist consultations.
- Pathology, i.e. blood tests requested by a Doctor in the course of your day-to-day consultations.
- Radiology, i.e. out-of-Hospital basic x-rays.
- Out-of-Hospital, non-surgical procedures, such as applying plaster of paris and stitches.
- Physiotherapy
- Biokinetics and chiropractics
- Psychology
- Occupational therapy
- Speech therapy / Audiology
- Hearing aid acoustician
- Podiatry
- Dietician
- Orthotist / Prosthetist
- These include medicines which are medically necessary and legally restricted to those prescribed by a Doctor for use by the Insured Person on an out-patient basis.
- Annual medical examination

7.1.2 GP consultations (applicable in Nigeria and Zimbabwe only)

Unlimited GP consultations at selected General practitioners. Consultations will be reimbursed at the Liberty tariff for Provider Networks. This limit does not apply to consultations with general practitioners outside of your country of residence (Nigeria or Zimbabwe).

7.1.3 Vaccinations

Childhood vaccinations for children below the age of six (6) years old (inclusive) will be covered under the acute medicines (day-to-day) benefit subject to the Company's clinical policy.

Childhood vaccinations up to and including age 6:

- Diphtheria
- German measles (Rubella)
- Haemophilus influenza type B
- Hepatitis A and B
- Measles
- Meningitis
- Mumps
- Pneumococcal infections
- Polio
- Rotavirus
- Tetanus
- Tuberculosis (BCG)
- Typhoid
- Vitamin A (not a vaccination but part of the schedule in some countries)
- Whooping Cough (Pertussis)

For older age groups access to the following will be covered:

- Hepatitis B
- HPV (subject to Pre-authorisation and clinical criteria)
- Influenza
- Meningitis
- Pneumococcal infections
- Tetanus
- Typhoid

Additional vaccinations covered for all ages:

- Yellow Fever
- Rabies*

*In an emergency please have the first dose dispensed. You must call us afterwards to inform us of the Claim, which once submitted will be processed in line with available benefits.

7.1.4 Out-patient benefit for Chronic Conditions

In order to access the Chronic Conditions benefit an Insured Person, who is diagnosed with a Chronic Condition, will be required to obtain Pre-authorisation by registering on the Managed Healthcare Programme. To register on this programme, the treating Doctor together with the Insured Person will need to complete a chronic medicine application form and submit this form to Us. Treatment of Chronic Conditions will be subject to Our chronic disease list, Clinical Funding Protocols and approved medicine formularies.

It is important to note that if an Insured Person does not register on the Managed Healthcare Programme, then he/she will not be able to access the Chronic Conditions benefit.

7.1.5 This benefit provides cover for the following services (for registered Chronic Conditions only):

- medication
- consultations
- basic radiology
- pathology tests

Chronic Disease List	
Acne	Hypertension
Addison's disease	Hyperthyroidism
Allergic rhinitis	Hypothyroidism
Alzheimer's disease	Hypopituitarism
Anaemia	Malabsorption syndrome
Ankylosing spondylitis	Male hypogonadism
Anorexia nervosa	Meniere's disease
Arrythmias and conduction disorders	Menopausal and perimenopausal disorders
Asthma	Menorrhagia
Attention deficit hyperactivity disorder (ADHD)	Motor neuron disease
Barrett's oesophagitis	Multiple sclerosis
Benign prostatic hypertrophy	Muscular dystrophy
Bipolar mood disorder	Myasthenia gravis
Bronchiectasis	Neuropathy
Bulimia nervosa	Obsessive compulsive disorder (OCD)
Cardiac failure	Osteoarthritis
Cardiomyopathy	Osteoporosis
Chronic obstructive pulmonary disorder (COPD)	Paget's disease
Chronic renal disease	Paralytic syndromes and associated complications
Conn's syndrome	Parkinson's disease
Cor pulmonale	Pemphigus
Coronary artery disease/Ischemic heart disease	Polyarteritis nodosa
Crohn's disease	Polycystic ovarian syndrome
Cushing's disease	Polymyalgia rheumatica
Cystic fibrosis	Post-traumatic stress disorders
Deep vein thrombosis	Primary/idiopathic thrombocytopaenic purpura
Depression	Psoriasis
Dermatitis/eczema	Psoriatic arthritis
Dermatomyositis	Pulmonary interstitial fibrosis
Diabetes insipidus	Rheumatoid arthritis
Diabetes mellitus type 1	Rosacae
Diabetes mellitus type 2	Sarcoidosis
Diverticular disease	Schizophrenia
Dysrhythmias	Scleroderma and systemic sclerosis
Dystonia	Sicca syndrome
Endometriosis	Stroke

Chronic Disease List	
Epilepsy	Systemic lupus erythromatosus
Generalised anxiety disorder (GAD)	Thrombosis and embolism
Glaucoma	Tourette's syndrome
Gastro-oesophageal reflux disorder (GORD)	Transient ischaemic attacks
Gout	Trigeminal neuralgia
Haemophilia	Tuberculosis
Hepatitis B	Ulcerative colitis
Hepatitis C	Urinary tract infection (chronic)
HIV/AIDS	Urinary incontinence
Hyperlipidaemia	Valvular heart disease
Hyperparathyroidism	Zollinger-ellison syndrome
Hypoparathyroidism	

7.1.6 Out-patient maternity benefits

This benefit provides additional day-to-day benefits to cover the costs of out-of-Hospital maternity care, including consultations, basic radiology (such as ultra-sounds), blood tests and other diagnostic tests. The maternity benefits specified in this clause apply ***in addition*** to the other day-to-day benefits specified throughout this clause. This means that if this benefit is fully used by an Insured Person, then the Insured Person can access his/her other day-to-day benefits for out-of-Hospital maternity care.

7.1.7 Basic Dentistry

This benefit covers the following dental treatments and services on an out-patient basis:

- Dental consultations
- Basic dental procedures, including removal of teeth and roots, fillings, preventative treatment, scaling and polishing and x-rays

7.1.8 Specialised Dentistry

Specialised dentistry including root canal treatment, dentures, inlays, crowns, bridges, periodontal treatment, orthodontic treatment and dental surgery including maxilla facial and oral surgery and removal of impacted wisdom teeth. Orthodontic treatment will be restricted to members up to the age of 21 (twenty-one) years inclusive.

7.1.9 Optical benefits

The following optical benefits are covered on an out-patient basis:

- 1 (one) eye examination annually
- Frames and lenses (including contact lenses) once every 2 (two) years

7.2 Hospital Benefits (In-patient)

Before an Insured Person begins treatment as a Hospital in-patient (except in cases of Accident or an Emergency Medical Condition), the Insured Person must obtain Pre-authorisation from Us at least 48 (forty-eight) hours before the Hospital admission. The request should be submitted electronically or via the call centre in writing. If the Insured Person does not obtain Pre-authorisation, he may be held personally liable for his medical costs.

Pre-authorisation allows Us to ensure that the most appropriate treatment is provided at the most appropriate cost and enables Us to monitor the quality of care that the Insured Person receives.

In cases of Accident or an Emergency Medical Condition, written notification together with reasonable available supporting medical information must be submitted to Us within 48 (forty-eight) hours of the event, or if it is a weekend or public holiday, on the next working day.

The following Hospital benefits are covered under this policy:

7.2.1 Hospital Treatment and Related Services

Cover includes:

- Hospital accommodation in a standard private room.
- In-Hospital fees for Doctors, Specialists, surgeons, anaesthetists, physiotherapists, or other relevant Specialist consultations rendered in Hospital.
- Operating theatre charges.
- Medicines to take home (limited to 14 days' supply)
- Apparatus, material, and ward and theatre medicines used in Hospital.
- Accommodation charges incurred by one parent sharing the Hospital room of an Insured child under 12 (twelve) years old (inclusive), where the latter is treated at a Hospital, as an in-patient for a period, and the treating Physician has advised in writing that a parent should remain with the insured child.

7.2.2 Ambulance services

We will pay for road ambulance services to transport the Insured Person to the nearest, appropriate in-country medical facility for treatment. Pre-authorisation is required for Non-emergency and Cross Border ambulance services and is subject to Clinical Funding Protocols.

7.2.3 In-patient maternity (childbirth)

Under this benefit We cover in-Hospital maternity benefits including confinement, childbirth (natural delivery) and midwives.

Note: Childbirth by caesarean section is excluded except where there is a clinical indication for a caesarean section and where Pre-authorisation has been obtained from Us.

As specified in clause 3.6.5, a newborn baby will be covered for 15 (fifteen) days immediately following the birth of the child under the mother's policy subject to the in-patient maternity benefit limit specified in this clause 7.2.3. As an exception, any complications related to the newborn will be covered under the neonatal care benefit specified in clause 7.2.4.

7.2.4 Neonatal care

This benefit covers the treatment costs for neonatal care required in the case of a newborn baby. In particular, this benefit covers the following:

- Neonatal ward (incubator)
- Phototherapy
- Congenital abnormalities

- Prematurity

Note: This benefit will apply from birth until the baby has been discharged.

7.2.5 Psychiatric Hospitalisation

This benefit pays for the costs of psychiatric treatment received as an in-patient in a psychiatric unit of a Hospital. All treatment must be administered under the direct control of a registered psychiatrist.

7.2.6 Prosthesis and devices

Under this benefit and subject to Clinical Funding Protocols, We will pay for the costs of:

- Artificial limbs
- Internal (surgically implanted) devices and prostheses, such as: pacemakers, orthopaedic prostheses including hip replacements
- Orthopaedic implants e.g. bone lengthening devices, spinal plates and screws.
- Endo-vascular devices
- Devices for the central nervous system, cardiac system and ophthalmic and auditory system.

7.2.7 External Medical Appliances

We will pay for external medical appliances, including wheelchairs; glucometers, hearing aids, and large orthopaedic orthotics (e.g. back braces).

7.2.8 Specialised Radiology

Under this benefit, We will cover the costs of specialized radiology required in or out of Hospital, (PET-CT scans, Radioisotope scans, Computed tomography (CT) scans and Magnetic resonance imaging (MRI) scans). All specialized radiology (in or out of Hospital) is subject to Pre-authorisation and Clinical Funding Protocols.

On certain Benefit Plans, specialized radiology is only covered in cases of Trauma. Please refer to your benefit table or contact your local office to confirm benefits and obtain Pre-authorisation.

7.3 Major disease benefit

Up to the major disease benefit limit and subject to Pre-authorisation and Clinical Funding Protocols, this benefit covers the cost of treatment (in and out of Hospital) for oncology (cancer), organ transplants and renal (kidney) dialysis.

7.3.1 Oncology

This benefit covers the costs of cancer treatment irrespective of whether such treatment is received as a registered in-patient or as an out-patient at a registered cancer treatment centre. The benefit is provided when patients are undergoing active cancer treatment, including associated costs up to and including a 12 (twelve) month period (after active treatment) when the patient is in remission.

In particular, We cover the following and is subject to Clinical Funding Protocols:

- Chemotherapy / oncology medication in accordance with evidence-based guidelines. Refer to the Specialised Oncology Medicine List for associated medicines that are either excluded or are subject to specific Pre-authorisation criteria.
- Radiotherapy
- Specialized radiology:
  - CT / MRI scans (2 per Insured Person per annum)
  - PET scans (1 per Insured Person per annum)
  - Bone scans (1 per Insured Person per annum)
- Consultations
- Pathology
- Hospitalisation for in-patient cancer treatment.

7.3.2 Organ Transplants

This benefit covers the cost of operations for the transplantation of the kidneys, heart, liver, lung, cornea or bone marrow where the Insured Person is the recipient, but does not include:

- Any costs related to or for the organ donor or cadaver, including organ harvesting and donor work-up testing.
- Transportation of the patient or organ.
- Search or crossmatch for the donor match, either locally or internationally.

Other medical costs associated with an organ transplant are also covered, including:

- Hospitalisation
- Consultations
- Anti-rejections drugs (in and out of Hospital)
- Pathology
- Radiology

7.3.3 Renal dialysis

This benefit covers the treatment costs for renal (kidney) dialysis irrespective of whether such treatment is received as a registered in-patient or as an out-patient at a legally registered dialysis centre.

Associated medical costs are also covered, including hospitalisation (for in-patient treatment), consultations, medication and pathology.

This benefit excludes the reimbursement for automated peritoneal dialysis.

7.4 International Emergency Evacuation (only applicable to selected Benefit Plans)

7.4.1 International Emergency Evacuation

7.4.1.1 In the case of an Emergency Medical Condition and where treatment is not available locally, We will pay for the transportation costs for the Insured Person to be evacuated from the country where the Emergency Medical Condition occurred to the nearest, appropriate medical facility within the Area of cover. The nearest medical facility could be within the country where the

Emergency Medical Condition occurred. The following classes of conditions could result in an Emergency Evacuation:

Accidents

An Insured Person will be evacuated to an appropriate facility in the event that the required specialty is not available in the country where the Insured Person is at time of Accident. Whether a specific specialty is required will be determined by Our Medical Advisor in terms of advice received from the treating in-country Doctor. The Medical Advisor may from time to time request an additional opinion from an alternative Specialist. In terms of ICU care being required, the presence of an ICU in country will determine that the Insured Person is treated in country for ICU care.

Non-Accident Related Acute Conditions Requiring Specialist Treatment

A member will be evacuated for an acute event to another country if there is no Specialist ordinarily available in the country to manage the particular condition. In this regard, the following will be accepted as appropriate to treat conditions requiring Specialist treatment:

- Medical conditions – Physician
- Surgical conditions – General Surgeon

Emergency Evacuations will not be carried out for deteriorating Chronic Conditions.

7.4.1.2 International Emergency Evacuation will be subject to the approval of Our Medical Advisor, availability of benefits (dependent on the Benefit Plan selected) and policy conditions. Our Medical Advisor will, in consultation with the relevant medical professionals and subject to Our internal evacuation criteria (amended from time to time), determine whether an Insured Person's medical condition constitutes a serious or life threatening Emergency Medical Condition that requires immediate evacuation to obtain treatment in order to avoid death or serious impairment to an Insured Person's immediate or long-term health prospects. The seriousness of the medical condition will be judged within the context of the Insured Person's geographical location and local availability of treatment or medical facilities.

7.4.1.3 General evacuation principles

The following evacuation principles apply:

- The transferring Doctor is responsible for assessing the stability of the patient to travel; that it is in the patient's best interest to be evacuated; and that the patient's prognosis will be materially improved by evacuation.
- Appropriate referral screening, clinical examination, special investigations and stabilization/resuscitation of the patient has to be completed by the referring Doctor, if possible.
- Care initiated by the transferring facility may need to be continued during transport.
- All relevant clinical documentation must accompany the patient with regard to the assessment and management prior to evacuation (copies of tests done, medication given and referral letter to the accepting Doctor).
- A decision on the mode of transport will be made.

- Evacuation will be either “inter-Hospital transfers” (from one medical facility to another – within the Region of Cover), or “primary response” (where patient has received no or only pre-Hospital care).
- The decision as to which mode of transport is used will reside with the Emergency Evacuation services employed and Our Medical Advisor. (Many factors need to be considered, including: landing areas, mobilization time, weather en-route, time and distance of the flight and certain legal restrictions may also apply such as a limitation requirement i.e. a two-engine aircraft, or at night.)

7.4.1.4 Following an international Emergency Evacuation, We will pay for the costs to transport the patient back to his country of residence, provided that these costs are pre-authorized by Us.

7.4.2 Compassionate travel

We will pay the expense of the cost of one economy class return airfare and all ancillary charges (accommodation, food and transport only) up to the limit as stated in the benefit tables, for a family member to join an Insured Person who requires international Emergency Evacuation.

Compassionate travel will be subject to Our Pre-authorisation and availability of benefits.

7.4.3 Repatriation of mortal remains

In the event that an Insured Person dies outside his home country during an international Emergency Evacuation, We will pay for the costs of preparation and transportation of the Insured Person’s mortal remains from the place of death to his home country, or We will pay for the costs of preparation and local burial of the mortal remains in the country where death occurred. We will only pay up to the cost of a standard repatriation coffin.

Payment of the costs related to the repatriation of mortal remains is subject to Our Pre-authorisation.

8 What We don't cover

Under this policy, there are certain costs which We do not cover. The following treatment items, conditions, activities and their related or consequential expenses are excluded from the policy and the Company will not be liable for them:

8.1 Any treatment or medical intervention that is excluded from cover and/or is not supported by Our Clinical Funding Protocols.

8.2 Cosmetic treatments and plastic surgery.

8.3 Pre-Existing Conditions as defined unless otherwise declared on the application form and expressly confirmed acceptance by Us.

8.4 Prescribed alternative medicines such as, but not limited to, homeopathy, acupuncture, Chinese medicine, reflexology, aromatherapy and household remedies.

8.5 Services or treatment in any home, spa, hydro-clinic, sanatorium, private nursing/home care, frail care or long term care facility that is not a Hospital as defined.

8.6 Tests or treatment related to infertility, contraception (with the exception of the product being used for another indication other than contraception, where the indication is supported by Company's Clinical Funding Protocols), impotence or sexual dysfunction.

8.7 Treatment by the Insured Person himself, family member or Spouse.

8.8 All costs relating to muscular, skeletal or human organ or tissue transplant from a donor to a recipient and all expenses directly or indirectly related to organ transplantation (except as defined under the Organ Transplant benefit).

8.9 Treatment of self-inflicted injury, attempted suicide, abuse of alcohol and drug addiction or abuse including the complications associated with any of the above.

8.10 Experimental, investigational or pioneering medicines or medical/surgical techniques not commonly available which the Insured Person chooses to receive even though treatment usually and customarily provided for the medical condition concerned is available within the Region of Cover of the policy.

8.11 Injury or illness while serving as a full-time member of a police or military unit and treatment resulting from voluntary participation in war, invasion, civil war, rebellion, revolution, riot, civil commotion or any illegal act including resultant imprisonment.

8.12 Travel costs or non-medical costs, unless specifically provided for in the policy.

8.13 Malaria prophylaxis and vaccinations, such as travel vaccinations, epidemics and pandemics, and any other vaccinations.

8.14 Hospital in-patient treatment if the Insured Person could have been treated properly for the condition as an out-patient.

8.15 Charges for appointments not kept.

8.16 Costs relating to Injuries and or medical conditions resulting from extreme sports or activities including but not limited to: Rock climbing, mountaineering, potholing, skydiving, parachuting, hang-gliding, piloting a plane (unless approved by Us in writing), parasailing, ballooning, all diving (unless the person concerned has been duly qualified and certified as a diver by an internationally recognized diving organization or unless such person is at the time of the happening of the event giving rise to a claim actually receiving diving instruction from a duly qualified and certified diving instructor), racing of any kind other than on foot and all professional or inherently dangerous sports unless declared to and accepted by Us in writing prior to the event giving rise to a claim.

8.17 Costs or benefits payable under any legislation or corresponding insurance cover relating to occupational death, injury, illness or disease.

8.18 The cost of transporting an Insured Person by means of your own transport, and the cost of medical treatment given by the following parties unless We agree in writing to meet such costs:

- Your personnel or at Your medical facilities
- By a third party under a contract between that third party and you.

8.19 Costs arising out of any litigation or dispute between the Insured Person and any medical person or establishment from whom treatment has been sought or given, or any other costs not directly and specifically related to the payment of the medical expenses covered by the policy.

8.20 Any loss or damage, cost or expense of whatever nature directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at the same time or in any other sequence to the loss:

- ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel
- the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component
- any weapon of war employing atomic or nuclear fission and/or fusion or other like reaction of radioactive force or matter.

8.21 Services or treatments where Pre-authorisation should have been obtained and was not.

8.22 Any specialized oncology medicine listed as an exclusion in Our list of Specialised Oncology Medicines.

9 Other exclusions

9.1 Anabolic steroids and testosterone

9.2 Art therapy

9.3 Autopsies

9.4 Humidifiers

9.5 Medicated shampoos and conditioners, including those for hair loss. This limitation does not include those preparations used for the treatment of lice, scabies and other microbial infections as well as coal tar preparations for the treatment of psoriasis.

9.6 Unregistered medicines

9.7 Massages

9.8 Multivitamins and tonics (except where stated in the benefit tables)

9.9 Treatment for Obesity

9.10 Sleep therapy

9.11 Slimming preparations

9.12 Soaps, scrubs and other cleansers

9.13 Sunglasses, readers, coloured contact lenses, contact lens preparations

9.14 Sun screening and sun tanning preparations

9.15 Toiletries

9.16 Treatment for hair removal

9.17 Breast reductions or enlargements and gynaecomastia

9.18 Search and rescue

9.19 Dental implants

9.20 Refractive eye surgery or laser eye treatment

9.21 Food and nutritional supplements, including baby food and special milk preparations

9.22 Anti-smoking preparations

9.23 Repairs to external medical appliances as specified under 7.2.7

9.24 Any health technology, procedure, or medicine deemed as a Policy Exclusion following the conclusion of an evidence-based health technology assessment process.

9.25 Probiotics

10 Contact Us

If you have any further questions regarding your policy, or if you are dissatisfied with any aspect of your policy, please contact Us, your financial adviser/intermediary, or visit Our website.