Alliance Options Select

2024 June

The Terms and Conditions of Your Membership to Alliance Options Select

Introduction

Thank you for choosing this plan.

Alliance Options Select plans are managed and administered by Alliance Health Medical Fund, registered with and regulated by the Ministry of Health and Child Care of the government of Zimbabwe. All references to **"Alliance Health"** in this plan agreement should be taken to refer to **Alliance Health Medical Fund.**

It is our aim to provide you with a reliable Medical Plan that you can trust. In order to achieve this, it is extremely important that you fully understand how your plan works. This Agreement together with your Table of Benefits explains what is, and what is not covered by your Plan.

We ask you to please read this document as it explains: -

- how to manage your benefits,
- how to claim,
- what to do in the event of a medical emergency and
- what to do if you require in-patient or day-patient treatment.

Should you have any questions after reading this Agreement, please do not hesitate to contact us or your agent.

Overview of Benefits

Alliance Options Select (AOS) is a modular annual health insurance plan for individuals, families and companies.

There are four schemes with different levels of benefits.

The benefits of the plan are designed to assist with the member's access to, and use of, appropriate medical services for the maintenance of good health and for the treatment of disease, illness and injury.

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

Administration

ANNUAL CONTRACT

The plan is an annual contract which runs for 365 consecutive days starting from the commencement date. You, as the plan holder are liable for the full annual contributions for membership for the full twelve months of the contract.

The PLAN HOLDER for individual and family members is the PRINCIPAL MEMBER.

The company entity is the PLAN HOLDER and each registered employee/shareholder/director is a PRINCIPAL MEMBER.

ENROLMENT

Individuals must supply a completed and signed application form and/or necessary medical documentation. Membership Enrolment is not **automatic** and subject to acceptance by Alliance Health.

In the case of corporate groups, a company must supply: -

- A request for enrolment on a company letterhead specifying the start date of benefits
- A copy of their current CR14 certificate of registration
- A completed group registration form
- A copy of their ZIMRA registration
- A completed and signed application form for every PRINCIPAL MEMBER and their dependents

Please note that there can be no splitting of family members onto different schemes or plan variants

ELIGIBILITY

Any dependants over the age of 18 and not married to a PRINCIPAL MEMBER must complete and sign their own application form in full.

The standard maximum enrolment age is 54. Applicants aged 55 up to 60 can be accepted subject to underwriting and a percentage loading will apply to their subscription.

Groups/Corporates

- Membership is restricted to approved corporate groups of not less than 10 employees AT INCEPTION. Affinity groups are not eligible for group rates or for MHD status.
- Corporate groups with not less than 50 lives may apply for continuous transfer. This does **NOT** apply to **affinity** groups. Subject to underwriting, medical conditions may be loaded accordingly.
- If the number of PRINCIPAL MEMBERS is less than ten at renewal then the membership will be discontinued or continued with loaded contributions
- The AGE of the member is determined by the age of the member at the GROUP ENROLMENT DATE or at the most recent GROUP RENEWAL regardless of the enrolment date of the individual member

- The group must appoint a designated Group Secretary or Plan Administrator who will bear responsibility for ensuring that the membership rules are adhered to by all members and who will be the main point of contact
- The membership year runs from the specified start date for all employees.

COMMENCEMENT DATE

The start date of the membership will be the first day of the next month after receipt of all completed documentation, OR (on request) the first day of the month in which all completed documentation is received.

Benefit **use** cannot be back dated under any circumstances

If a new employee enrols, SUBSEQUENT TO THE PLAN HOLDER START DATE, then he/she is subject to all waiting periods and the enrolment is subject to acceptance by Alliance Health.

We reserve the right to apply special underwriting restrictions on benefit use and/or loadings on individual members to reflect exceptional risk in terms of health conditions, chosen lifestyles or occupations.

COMMUNICATION

DEPENDANT members can be added at the request of the appointed GROUP SECRETARY, and can only be added on the provision of a fully completed enrolment form accompanied by the written request on a company letterhead and this enrolment is subject to our acceptance.

Deletions from the list of group members and dependents (the GROUP CENSUS LISTING) can be made with thirty days' **ADVANCE** notice, with the notice in writing on a company letterhead, signed by the group secretary or any director

If any DEPENDANT member of the group marries or reaches the age of 18, then they are required to complete a new enrolment form and their continued membership will be at the discretion of Alliance Health

CONTRIBUTIONS

The contract is an ANNUAL contract with contributions due monthly in advance.
Payment of additional contributions/or contribution refunds as a result of additions and deletions to the membership can only be done after confirmation of enrolment or deletion. If a monthly invoice is generated before confirmation, then an amended invoice will be issued.

For group members to enjoy use of benefits, the full contributions must be paid up to date.

Whilst contributions are outstanding, all benefits use is suspended, and claims cannot be settled for the period, even after payment of the outstanding amounts. We will automatically cancel your cover if payment is not received within 7 (seven) days from the membership contribution due date.

Alliance Health requires 30 days' notice in writing of membership cancellations, both for individual members and for the group account.

We reserve the right to levy additional administration charges for the costs of membership cancellation. Additional charges will be invoiced, and payment is required.

We reserve the right to levy additional administration charges for the costs of issuing replacement cards, revising billing, and amended membership certificates. If a new member does not collect their membership cards within 6 months from date of joining, they will be required to pay for the cards.

All membership cards and certificates of membership must be returned to Alliance Health with immediate effect from the cancellation date. This is the responsibility of the group secretary/ plan administrator.

Alliance Health must be notified in writing IMMEDIATELY of any material changes to the circumstances of the PLAN HOLDER and/or any MEMBER including: -

- Change of physical address
- Change of name
- Change of occupation
- Change of nominated Family Doctor

Upon notification to Alliance Health of any material changes to the circumstances of the PLAN HOLDER and/or any MEMBER the PLAN HOLDER is required to pay any additional contributions or loadings that may be required to continue membership of the plan.

Where there is a break in or a suspension of membership Alliance Health reserves the right to alter the benefits, apply new restrictions and to apply changes to conditions of membership

DISCLOSURE OF MATERIAL FACTS

Upon enrolment applicants are required to declare in full the circumstances and details of their medical histories and any other lifestyle choices or pastimes that may have an influence over the frequency and usage of medical services.

All pre-existing medical conditions must be declared.
In the event that such information is not declared Alliance Health reserves the right to withhold funding of medical expenses and to terminate the membership of the enrolled member.

RENEWALS

Subject to our approval, which shall be at our sole instance and discretion, you may renew your plan each year subject to payment of the renewal membership contribution. At all times your membership and concomitant benefits are subject to this Agreement and any or all Tables of Benefit in force and as amended from time to time.

Alliance Health has the right to vary the terms and conditions of membership, including benefits and contributions at any time through the provision of 30 days' notice. Individual member policies may not receive the renewal notice but will be advised of any changes in benefits and/or contributions at least 30 days in advance.

CANCELLATION CONDITIONS

If you choose to cancel the plan, we will require your written instructions directing us to cancel your plan. If the plan is cancelled by us, we will write to your last known address informing you of the cancellation.

Cancellation of membership after 30 days of membership – Individual and Family Members

Provided that no claims have been submitted and accepted, and then we will issue a pro-rata refund of membership contributions if applicable to the future months of the membership i.e., for the remainder of the 12-month contract. Any subsequent notification of a claim will not be entertained. If any claims have been submitted and accepted, there will be no refund due, and the member is liable for full payment of all contributions due for the full twelve months of the membership contract.

Under no circumstances will we backdate cancellation.

Cancellation of membership after 30 days of membership – Group Members

Provided that no claims have been submitted and accepted by an individual member of a group, then we will issue a pro-rata refund to the plan holder of those membership contributions applicable to the future months of the membership up to the renewal of the group contract i.e., for the remainder of the 12-month contract. Any subsequent notification of a claim for the cancelled individual will not be entertained. If any claims have been submitted and accepted for the particular individual, then there will be no refund due, and the plan holder is liable for full payment of all contributions due for the full twelve months of the membership contract.

Under no circumstances will we backdate cancellation.

CHANGING YOUR PLAN TYPE

You are only able to affect an upgrade or downgrade to your plan type on the 1st day of the month at the annual renewal of your contract.

Please inform us in writing either by letter, or e-mail of your intended change, providing us with 30 days **ADVANCE** notice. Please note that our acceptance of your change in plan type will be **determined** by past or pending claims. No downgrade will be allowed for a period of 12 months after giving birth, provided the pregnancy was covered by Alliance Health.

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$.

Benefit use for newly enrolled members is subject to waiting periods as per the table below. Waiting periods apply to each member individual, for example, each dependant, and each new addition to the plan.

BENEFIT	WAITING PERIOD
Appliances and Equipment	12 months (benefit is once every 2 years)
Dental (routine)	6 months
Dialysis	24 months
Emergency Services following an accident	No waiting period – but authorisation is required
Good Health / Well Being Check Ups	12 Months
Maternity	12 months
Non-emergency use of all other outpatient services	3 months minimum unless otherwise stated
Hospital & Surgery	6 months
Optical (routine)	9 months (benefit is once every two years).
Orthodontics	24 months (benefit is once per lifetime)
Prosthetics and Joint Replacements*	4 years*
Therapy Benefit (incl. mental health)	12 months
Funeral Grant	12 months

****WAITING PERIODS WILL APPLY FOR THE DIFFERENCE IN BENEFITS THAT HAVE BEEN ADJUESTED UPWARDS WHEN ONE UPGRADES.**

Benefits are not pro-rated for individuals who join during the contract year

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

PROSTHETICS & JOINT REPLACEMENTS

The use of any benefits for treatment related to the purchase and use of internal prosthetics as well as the use of benefits for joint replacements is subject to a **4-year waiting period** unless

the member has been involved in an accident that has resulted in loss of a limb or irreversible damage to a limb/joint that then requires replacement. IN ADDITION: members are only eligible for joint replacements if the member's Body Mass Index (BMI) is less than 34.

EMERGENCY MEDICAL SERVICES

Benefits include local ambulance services for response to life threatening emergencies and for hospital transfers as well as benefits for casualty/accident and emergency/24-hour clinics. This benefit is restricted to life or limb threatening medical emergencies and non-emergency visits may be claimed limited to 2 non-emergency visits per member per year. The A&E, Caualty,24Hr Clinic benefit is limited to the amount on the table of benefits. Hospital admissions that may be required, to be funded from Hospital and Surgery benefit
Pre-authorisation is required for benefit use.

HOSPITAL & RELATED SERVICES

Benefits include accommodation (up to a semi-private / two bedded ward on Select 1&2 and up to a private room on Select 3&4 (if fees fall within 200% of ZRVS tariff) or as equivalent to Zimbabwe) in a private medical facility registered to operate as a private hospital, meal charges, general nursing services, diagnostic services, laboratory testing, specialist charges, operating theatre charges, intensive care and high care unit charges, drugs, dressings and medications as per the service specific limits and sub-limits specified in the Table of Benefits. This also includes treatment for cancer, casualty ward accident and emergency services, day surgery, treatment for injuries/trauma, kidney dialysis, organ transplants, physiotherapy, psychiatric treatment, surgery, and equipment required to facilitate recovery, but in each case the specified discipline or treatment specific sub-limits apply. **Pre-authorisation is required for benefit use.**

ADVANCED IMAGING

Benefits are for MRI, CT and PET scans that are required in order to investigate the causes of a medical event (prolonged discomfort, illness, injury, trauma, or diagnostic testing suggestive of neoplasms)
Pre-authorisation is required for benefit use.

OUT PATIENT SERVICES

Benefits include family doctor consultations, prescribed drugs, contraception, pathology*, imaging*, optical* (refraction, lenses, frames), reproductive health*(contraception, hormone replacement therapy), auto-immune health, dental health*, orthodontics*, nursing at home*, therapy* (physiotherapy, occupational therapy, speech therapy, chiropractor), appliances and equipment, specialist consultations*, hearing tests and treatment. Orthodontic treatment is covered for members aged 12 up to 23.
***Pre-authorisation is required for benefit use.**

Each benefit listed is the full benefit up to renewal for each member.

Benefit use is driven by the AHFoZ codes used by the treating practitioner/service provider. The AHFoZ codes specify the discipline of the provider and the treatment provided, regardless of the nature of the complaint (chronic/acute) or the location of the patient (in hospital/out of hospital). Claims are then allocated accordingly to benefits. Please refer also to the table of benefits for benefit limits and waiting periods

Claims Procedures

Claims can only be made against the benefits listed, for the diagnosis, treatment and management of conditions recognised as debilitating diseases, disorders or conditions that left untreated would result in the inevitable consequence of death or permanent serious debilitation to the member.

Claims for outpatient services are a on a pay and claim basis only unless a specific service provider direct billing agreement has been concluded between Alliance Health and the Service Provider. All costs relating to inpatient treatment, advanced imaging, diagnostic testing and specialist consultations must be pre-authorised by Alliance Health.

Settlement of costs and provision of benefits are subject to the tariffs, limits and waiting periods specified on the Table of Benefits for Alliance Options Select.

Claims for **level one** and **level two** scheme claims are paid at AHFoZ tariffs up to the annual limits specified.

Claims for **level three** and **level four** scheme claims are paid up to 200% of AHFoZ tariffs and up to the annual limits specified. All costs that are over and above AHFoZ tariffs will be settled by the MEMBER.

Claims can only be paid for the appropriate services related to the discipline under which the Medical Service Provider has registration for with the appropriate authorised regulatory body in the country of treatment.

On receipt of a claim made against benefits for any member Alliance Health has full authority to obtain all information relating to the claim, the event and the circumstances surrounding the event from relevant medical personnel subject to privacy laws of the Republic of Zimbabwe.

If a plan holder or member makes a claim that is for unregistered services, or for services not rendered, or for benefits not stated, or for undeclared pre-existing conditions, or for costs that may be recovered from other parties, or otherwise considered to be fraudulent in any respect. Alliance Health reserves the right to repudiate the claim and terminate the member's benefits immediately.

Alliance Health reserves the right to limit benefits to rateable proportions of the total costs in the event of other insurance policies, medical aid society memberships, national social security schemes providing 'double cover' for the member's liabilities.

BENEFIT 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.

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.

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

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 medically necessary or 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 tariff or 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. Payments will not be made for any costs incurred during said waiting periods.

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.

Foot Care: Treatment of congenital and hereditary conditions such as but not limited to Bunions (hallux valgu) which is a deformity of the base joint of the big toe.

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

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

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

In hospital Costs: non-medically necessary goods and services including telephone, Wi-Fi, television, newspapers and massages.

Maternity (All Costs Related to Infertility and Conception): Unless where birth is due after the first 12 months of the mother's membership and the benefit is available on the plan (subject to 12 months waiting period from date of joining).

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. Whether regarded as life threatening or not.

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.

Orthodontic Treatment: Orthodontic treatment for members below the age of 12 and above the age of 23 is not covered**.** Spark aligners are considered cosmetic hence not covered.

Over the Counter Medication: such as vitamins, or pain tablets, or ointments, or supplements that do not require a prescription to be purchased **OR** any such medication that is not registered with the Medicines Control Council of Zimbabwe (MCCZ). Regardless if a prescription has been given by a Medical Practitioner.

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 Options Select. Any Pre-existing Medical Conditions as defined **unless otherwise declared on the Application Form and expressly confirmed acceptance by Alliance Health**. This includes every condition that the Medical Advisory Board of AHO determines were in existence at or prior to your join date.

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, except where cover is provided under the Maternity Benefit.

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 treatments and tests: Any treatments or tests required as second opinion unless authorised by Alliance Health in writing.

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.

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.

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

Travel Costs: Travel costs for treatment. 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

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: -

CHECKLIST

I have paid for treatment and I would like to claim back all costs	
I have checked that the treatment was not for an ineligible condition or an excluded condition	
I have checked the benefits of my plan level and I should be covered for this treatment	
I have checked that the date of treatment was in the last 3 months	
I have a completed Claim Form, with every section complete, with both the doctor's and the main member's signatures	
I have a receipt for every one of the payments I made	
I have a Claim Form ready for completion	

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 this service can be pre-authorised and that the provider of medical services is willing to accept a Guarantee of Payment	
I have checked that the treatment was not for an ineligible condition or an excluded condition	
I have checked the benefits of my plan level and I should be covered for this treatment	
I have provided Alliance Health with a Medical Report from my doctor	
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	

**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 dependant, 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.

All of this information should be sent together with a copy of the original referral note to callcentre@healthzim.com. Alliance Health reserves the right to refer to a Provider recommended by MMA for cost containment.

What to do in an EMERGENCY

1. Please call an ambulance.

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 Toll Free 08080569 or **+263 772 126 120** or callcentre@healthzim.com

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COMPLAINTS

Whilst every effort is made to ensure that your membership to the Alliance Options Select 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 Head of Operations. 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 Manager's 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

TELEPHONE: +263 (0) 8677000716, 772126120, 772 126 119, 86 77 020 406,

EMAIL: membership@healthzim.com

WEBSITE: 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 Select schemes may be used:

Select 1 & Select 2- Full benefit use in India, Zimbabwe and Zambia. India and Zambia are covered on a pay and claim basis.

Select 3 & Select 4- Full benefit use in India, South Africa, Zambia and Zimbabwe. Out of hospital claims for India, South Africa and Zambia will be covered on a pay and claim basis.

Authorisation
Authorization 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 authorization should be made by the member to Alliance Health, tel: 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 authorization (in the case of emergencies) can be obtained by calling the afterhours pre-authorization numbers: 0772 126 120 or 08677000716

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-ons 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.

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

If Legal documentation can be provided the following may be considered: -

a) The child of a member who is a widow or widower; or
b) The child of a judicially separated or divorced member who has legal custody of such child; or
c) 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.
c. 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
d. 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

This is treatment that is not covered by Alliance Options Select medical aid.

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.

Foreign Treatment
Claims will be reimbursed according to Alliance Health reserves the right to allow treatment in India and Malawi

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.

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.

NB: Terms and conditions apply

- *Errors and omissions*
- *Terms and conditions correct at the time of going to print as per the month indicated. Please request the latest version of this document from membership@healthzim.com*
- *Terms and conditions are subject to change with notice being given. Date of last revision: June 2024*

Alliance Options Select