

(effective 1st October 2008)

GOODHEALTHSM
An Aetna Company

What to do when You need to make a claim

In order to ensure that You receive the best possible claims service We have compiled the following procedures which should be followed in the event of medical or dental Treatment being required by You or one of Your Dependants. Please read these carefully and in conjunction with the other sections of Your Policy.

EMERGENCY MEDICAL TREATMENT

In the event of Emergency admissions You should contact Your nearest Emergency Medical Helpline or the nearest Goodhealth Claims Centre listed below as soon as possible prior to or immediately following an In-Patient admission.

24-HOUR EMERGENCY MEDICAL HELPLINE

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

CLAIMS CENTRES

LONDON for Europe and the Rest of the World

2nd Floor
8 Eastcheap
London EC3M 1AE
United Kingdom
TF +1 866 320 4023*
Collect +1 813 775 0244
TF Fax +1 866 320 4024
E europeservices@aetna.com

MIAMI for North, Central, Latin America and the Caribbean

PO Box 144631
Coral Gables
FL 33134
USA
TF 1 800 912 2177 (inside USA only)
T + 1 305 423 0540
F + 1 305 443 6648
E claims@goodhealthamericas.com

DUBAI for the Middle East, Africa and Indian sub-continent

Suite 416
Oud Metha Building
PO Box 6380
Dubai
United Arab Emirates
T + 971 4 324 0040
F + 971 4 324 3550
E claims@goodhealth.ae

HONG KONG for Asia and the Pacific Rim

3204A, Tower 1
Admiralty Centre
18 Harcourt Road
Hong Kong
TF + 800 624 81000**
T + 852 2860 8000
F + 852 2866 2555
E claims@goodhealth.com.hk

Goodhealth Worldwide (Shanghai) Limited 1803

18/F Huaihai Zhonghua Tower
885 Ren Min Rd
Huangpu District
Shanghai 200010
China
T +8621 6326 2211
F +8621 6326 8525
E enquiries-sh@goodhealthchina.cn

* International toll free number requires an access code. Please refer to the website <http://www.goodhealthworldwide.com/contact.asp> to locate the number for the country from which You are dialling. If Your country is not listed, please call collect on +1 813 775 0244.

** Toll free number for Goodhealth Worldwide (Asia Pacific) Limited +800 624 81000 will operate from Australia, Hong Kong, Japan, New Zealand, Philippines, South Korea and Thailand. If You are calling from another location please dial +852 2104 7486 for policy administration and general enquiries or +852 2860 8000 for claims.

IMPORTANT

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

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

MEDICAL HELPLINE

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

Out-Patient Treatment

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

1. Outside the USA

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

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

Providing all relevant information is submitted to support **Your** claim, **We** will reimburse **You** accordingly by the payment method of **Your** choice. Please clearly state **Your** preferred payment method on **Your** claim form. Where this is by bank transfer clearly state the name of **Your** bank, account number and SWIFT (or IBAN) code. Provided all required information is present, eligible claims will be re-imbursed in fifteen (15) days.

Out-Patient Treatment within the Direct Settlement Network/Provider Network

For those in the relevant participating countries, **We** have arranged a **Direct Settlement/Provider Network**, enabling **You** to obtain **Out-Patient Treatment** at a wide number of selected medical centres where all eligible **Treatment** charges will be paid directly by **Us**.

When seeking **Out-Patient Treatment** at any of the participating centres (please refer to the Goodhealth **Provider Network** List), it is important that **You** present **Your** personal Goodhealth membership card to the medical centre before **Your Treatment** begins in order to ensure that **You** are not asked to settle any **Treatment** costs yourself.

- Present **Your** Goodhealth membership card to the medical centre when **You** arrive.
- Have a second form of identification available should it be required by the reception staff.
- Check the claim form that the medical centre will provide after **Your Treatment** and sign it to confirm that **You** have received the **Treatment** stated.
- Settle any charges made by the medical centre, which relate to either items not covered or ineligible **Treatment** that **You** may have received.

If **Your** Medical Practitioner needs to refer **You** to a **Specialist** (physiotherapy, chiropractic, osteopathic or any other **Specialist Treatment**), please ensure that **You** are given a referral letter.

IMPORTANT - Please remember that **Your** Goodhealth membership card should not be used to obtain any **Treatment** which falls under the exclusions of **Your** Policy.

2. Inside the USA

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

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

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

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

Day-Patient and In-Patient Treatment

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

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

1. Outside the USA

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

Release of Medical Information Form

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

Pre-certification Medical Form

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

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

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

2. Inside the USA

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

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

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

USA PROVIDER NETWORK

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

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

www.goodhealthworldwide.com/usefullinks.asp

Click on the link to the DocFind search engine. From there **You** can perform a search by address, name, specialty, and/or Tax ID Number. If **You** are unable to find details of **Your** preferred provider from this search facility or have any problems with the search engine please contact **Our** Miami office on 1 800 912 2176 (inside USA only) or +1 305 443 6267 for assistance.

Pre-authorisation

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

- Planned **In-Patient** or **Day-Patient Treatment** (hospitalisation)
- Any pregnancy or childbirth **Treatment**
- Planned surgery
- **Evacuation**
- Second Medical Opinions
- **Psychiatric Treatment** – **In-Patient**, **Day-Patient**, and **Out-Patient**
- Home Nursing Charges
- Planned MRI and CT Scans

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

Referral from a Medical Practitioner

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

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

CLAIM FORM

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

- The first page of the claim form has been completed in full by **You** for each **Medical Condition** treated. The declaration must be signed by the **Insured Person** and dated to enable the claim to be validated
- **You** attach to **Your** claim form the original paid receipts and any other documents pertaining to the claim (or other proof of payment) for all **Treatment** for which **You** are making a claim
- Where **Your Treatment** has been provided by a registered Physiotherapist, Chiropractor, Osteopath, Homeopath, Podiatrist or Acupuncturist, please ensure that **You** attach to **Your** claim form a copy of the referral letter that was provided by **Your Medical Practitioner**

- Where applicable laboratory tests results and/or x-rays were provided, please include the test results with **Your** claim
- For all claims under £125 or €/US \$200 per **Medical Condition**, **You** need only complete sections A, B and C and return **Your** claim form with the original receipt(s) showing the diagnosis and a full breakdown of costs for each condition being claimed for. ALL sections MUST be completed in full for hospitalisation claims and all claims over £125 or €/US \$200. A referral letter from **Your Specialist** should be attached when **You** are claiming for diagnostic tests.

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

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

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

All claims should be submitted by mail to the claims centre nearest to **Your Country of Residence**. (See below for **Our** claims centres' contact details).

GENERAL CLAIMS INFORMATION

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

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

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

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

CONTACT DETAILS

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

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

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