



Global Expatriate Healthcare Plan

Members Guide

LAMP



INTRODUCTION

Welcome to your Global Expatriate Healthcare Plan.

We know how important your health is to you, and so we aim to deliver the highest standards of service to our Members at all times. We have tailor-made our Plan and our service to meet the needs of your local healthcare system and to make your Plan easy to understand and convenient to use.

This Members Guide contains all the information you should need about the operation of your Plan, and how to access your healthcare insurance benefits and services.

The guide provides practical help regarding:

- How to contact us
- How your Plan is administered
- How to select a healthcare provider with direct settlement services - outpatient and dental care only
- When and how to obtain pre-authorisation
- What to do if you need inpatient treatment
- What to do if you need treatment outside your country of residence
- What to do in a medical emergency
- How to make a claim for reimbursement
- Other healthcare services available under your Plan

Please remember however that this Members Guide is a summary, and must be read in conjunction with your Policy Document which contains the full policy terms, and general conditions and exclusions, and your Membership Certificate which contains any personal exclusions which apply.

Please keep this Members Guide safely for your reference.

HOW TO CONTACT US

While it is important that you read and understand your members guide, we would encourage you to contact us at any time for any advice or assistance you may need.

If you have any queries regarding your membership, how to use your Plan, your coverage, how to obtain treatment, or how to make a claim, please call our members helpline on:

t: (+86) 400-680-8196 (toll-free)

or email to:

e: healthcare.cn@lampinsurance.com

HOW YOUR PLAN IS ADMINISTERED

When you enroll as a member of Global's Healthcare Plan, you will be issued with a membership pack containing, in addition to this Guide:

- **Your membership certificate**
This is the evidence of your cover and shows who is covered under the Policy and which Core Programme and Optional Extensions have been selected.
- **Your Policy Document**
This contains full details of the benefits, terms, conditions and exclusions of your insurance policy.
- **Your Table of Benefits**
This sets out the benefits and maximum amounts payable under each of the applicable Core Programmes and Optional Extensions covered under your Plan
- **Your membership card**
This card contains your personal membership and plan coverage details, and the relevant contact details that you will need in the event of an emergency or a claim. It can be carried with you at all times for quick reference, and can be presented to healthcare providers to identify you as a member if you require treatment
- **A list of healthcare providers with direct settlement services**
- **A claim form**
For you to complete and submit if you have a claim under your Plan.

You should familiarize yourself with the contents of your Membership Pack, and in particular with the Policy Document and Table of Benefits so that you understand what is and what is not covered under your Plan, and the applicable limits and exclusions. You

should also check and understand which Core Programme and Optional Extension benefits you are entitled to.

HOW TO SELECT A HEALTHCARE PROVIDER WITH DIRECT SETTLEMENT SERVICES

OUTPATIENT AND DENTAL CARE ONLY

The Direct Settlement Network in partnership with



Through LAMP's special arrangement with MediLink Global, an international third party administrator, LAMP is pleased to be able to offer our members access to an extensive and efficient network of quality healthcare providers who can offer the convenience of direct settlement for outpatient and dental care services.

A list of the healthcare providers which are affiliated to the Direct Settlement Network is contained in your Membership Pack, or is available from LAMP upon request. The list will be updated from time to time as the network is enhanced.

You will see that the MediLink Global logo is printed on your membership card, and the magnetic strip on the reverse enables verification and direct settlement of the eligible charges for your treatment to be processed electronically at most providers.

Some of the providers on the list, those marked with an asterisk, are not part of the MediLink-Global electronic healthcard network, and your charges will not be processed electronically, but your LAMP membership card will still be accepted manually for direct settlement at these facilities.

On presentation of your membership card, any eligible charges for outpatient treatment you receive at the affiliated healthcare providers will be billed directly to your insurance plan, subject to the terms, conditions, limits and exclusions of your policy.

Please note that our pre-authorization is required for any charges which will exceed US\$ 500, and that you will be responsible for paying any deductible, coinsurance, ineligible or excess charges which are not covered under your Plan.

To use the Direct Settlement Network, just follow these simple steps:

Step 1 –Select a participating healthcare provider

Consult the list in your Membership Pack, or contact LAMP for assistance.

We advise that you contact the direct settlement provider to make an appointment.

Step 2- Eligibility Verification

When you visit the provider, please present your Membership Card along with your photo ID (ID cards, passports) at the front desk.

*Providers who can accept the MediLink-Global electronic healthcard, will swipe the Membership Card through a dedicated Point-of-Sale (POS) device and print out an Eligibility Verification slip.

Step 3 – Complete a Claim Form

Depending on the providers procedures they may ask you to complete and sign a claim or treatment form, which they will submit to us with their invoice.

Step 4 - See the Doctor

Please ask your doctor to fill in the medical information on the claim or treatment form, and confirm with his/her signature.

Step 5 – Benefit Verification

The provider will verify your benefits.

*Providers who can accept the MediLink-Global electronic healthcard, will input your treatment details to the POS device in order to facilitate an online real-time validation and claim confirmation. The machine will print out a claim confirmation slip once the confirmation is done. Please read the slip carefully and sign it once you have confirmed all the contents.

Step 6 – Discharge

The provider will submit their invoice to us for all eligible charges. If there are any amounts which are not eligible under your insurance, you will be responsible for paying these yourself directly to the provider.

*If for any reason the swipe card system is unavailable or is not functioning, the front desk staff at the provider will be able to contact MediLink-Global to do an off-line manual transaction for you in accordance with above steps.

The providers' benefit verification is a preliminary assessment of your coverage. In the event of any miscalculation you remain responsible for any ineligible charges which may be determined in the final adjudication of your claim upon receipt of the invoice from the provider.

If your treatment is not covered by your Plan or if coverage is temporarily unable to be confirmed, direct settlement may be declined. In this case, you may still proceed with treatment at your own expense, and if you feel that the treatment should be covered by your Plan, you can submit a claim for reimbursement with the required supporting documentation (see the section below: How to make a claim for reimbursement).

Please remember you can always call us at any time if you require any advice or assistance in selecting an appropriate healthcare provider, or if you need any help in accessing the direct settlement network.

Our members helpline telephone number is:

**t: 400 820 7118 (within mainland China)
(+86) 400 820 7118 (outside China)**

We can assist you by

- verifying your coverage
- determining whether the services or supplies are covered
- helping select an appropriate provider
- ensuring treatment is medically necessary, thereby minimizing the out-of-pocket cost to you
- liaising with the provider to resolve any problems with your utilization of the direct settlement network.

The direct settlement facility is provided to you for your convenience but you are not obliged or restricted to use of the direct settlement network providers only. You can choose to use any recognised healthcare provider who is not part of the direct settlement network, and pay for the treatment initially yourself, then submit a claim to us for reimbursement of the eligible charges. See the section on How to Make a Claim for Reimbursement for more details. **Please remember however, that you must still seek our pre-authorisation for any charges which will exceed US\$500.**

WHEN AND HOW TO OBTAIN PRE-AUTHORISATION

You must contact us in advance for pre-authorisation in any of the following circumstances:

- when you know that any treatment you require of any kind is likely to cost in excess of US\$500 (including Inpatient, Day-care, Outpatient and Dental Treatment, as well as transportation and ancillary costs.
- when you know that you require admission to a hospital as an inpatient or for day-care
- when a doctor has recommended you for specialist treatment or for any kind of surgery
- if you require rehabilitation services
- if you wish to claim for Elective Medical Transfer

If the treatment scheduled is eligible for cover, we can confirm the level of benefit applicable to the medical provider and authorise treatment, subject to the terms and conditions of the Policy. When the Claim is subsequently fully validated, we will arrange for costs to be settled direct to the provider.

Please note that if we authorise treatment which ultimately transpires to be ineligible you will be responsible for repaying to us all costs we have paid, within one month.

In case of an emergency, if you are physically prevented from contacting us immediately, you or someone designated by you must contact us within 48 hours. You must make no admission of liability, offer, promise or payment without our prior consent. We must be telephoned first.

Please be aware that if you fail to follow these conditions, you will be liable to pay a co-insurance share of 25 per cent of the cost of treatment and services incurred.

WHAT TO DO IF YOU NEED INPATIENT TREATMENT

All inpatient treatment must be pre-authorized in accordance with the previous section.

If you are recommended for inpatient treatment you must contact us, or ask your physician to contact us as soon as is practical, so that we can verify your eligibility and benefits, approve the choice of provider, and authorize your treatment in advance of your admission.

If your treatment is pre-authorized by us, we can normally then contact the facility to which you are going to be admitted, and arrange for them to invoice us directly for your inpatient charges. This will ensure that your admission is well-managed, and relieves you of any worries about the insurance administration or payment procedures.

Our pre-authorization may initially be for a specific medical procedure, or period of stay, or amount. In such cases, if it is anticipated that the pre-authorized limit will be exceeded, you or the provider must contact us again to request and extension of our authorization.

If you are admitted to hospital as an emergency, and are physically prevented from contacting us immediately, you or someone designated by you must contact us within 48 hours. You must make no admission of liability, offer, promise or payment without our prior consent. We must be telephoned first.

Please be aware that if you fail to follow these conditions, you will be liable to pay a co-insurance share of 25 per cent of the cost of treatment and services incurred.

Please see the section entitled “What to do in a medical emergency” for details of how to contact our 24-hour emergency medical assistance company.

WHAT TO DO IF YOU NEED TREATMENT OUTSIDE YOUR COUNTRY OF RESIDENCE

If you need treatment outside of your country of residence, you should proceed as follows:

Step 1 – are you covered in the country concerned ?

Check that the country is within the Geographical Area you have selected, and which is specified in your Membership documents.

In countries outside of your selected Geographical Area, a limited amount of Out-of-Area cover for emergency treatment only may be included under your Plan, but please check your Table of Benefits carefully for details.

Step 2 – find a suitable medical provider

You can either:

- find a medical provider of your own choice
- contact our members helpline for advice or referral
- contact our 24-hour emergency medical assistance company for help

Step 3 – how to pay ?

If you have found a medical provider of your own choice, you can pay the charges yourself, and submit a claim for reimbursement. See the section “How to make a claim for reimbursement”.

If you contact us or our 24-hour emergency medical assistance company, we may, in many circumstances, be able to arrange direct settlement of the charges with the medical provider concerned.

Treatment in the U.S.A - please note that special arrangements exist for treatment in the U.S.A. Through partnerships with specialist US healthcare management companies, we can provide access to an extensive Preferred Provider Organisation network. For all treatment in the USA, outpatient or inpatient, you can call us for referral to an in-network provider. Please remember that you must call us in any event for pre-authorisation of any costs in excess of US\$500.

WHAT TO DO IN A MEDICAL EMERGENCY

In the event of an emergency, if you require evacuation, medical transfer repatriation, or for referral to a medical practitioner or a hospital, please call our 24-hour assistance company toll-free on:



**t: 400 820 7118 (within mainland China)
(+86) 400 820 7118 (outside China)**

or if the toll-free number is unavailable:

(+86) 21 339 27299

The emergency medical assistance service is provided by Assistance Online China Ltd

HOW TO MAKE A CLAIM FOR REIMBURSEMENT (IN A HOSPITAL, CLINIC INCLUDED ON THE DIRECT SETTLEMENT PROVIDERS)

If you choose to go to a hospital, clinic or provider that is not included on the Direct Settlement Providers list you will normally need to pay for your treatment then submit a claim to LAMP for reimbursement.

1. Submit the original bills and formal receipts of the claim expenses along with a completed claim form.
2. Make sure that the original bills and receipts show the date of treatment, patient's name, and diagnosis with attending physician's stamp and signature.
3. Submit the doctor's referral in claiming any Specialist, X-Ray or Laboratory expenses.
4. You can either email the details to LAMP at healthcare.cn@lampinsurance.com or send to us at the following address:-

LAMP International Healthcare
Suite 335, 3/F., Apollo Building,
1440 Yan An Road (M.),
Shanghai 200040,

Upon receiving the required claim documents, we will:

1. Assess the claim; if the claim is accepted we will settle the claim in pre-agreed payment method. Payment will be made within 10 working days of receipt
2. If we need further information we will let you know within 10 working days.