Bupa Global Latin America

Product Update Guide

Bupa Insurance Company
Trinidad and Tobago

2024


Bupa
Coverage | Services
We updated our benefits and services to improve your coverage.
Section 1

Corporate Products

We have improved the Pregnancy, Maternity and Childbirth benefits.

We increased the coverage of normal delivery from US$5,000 to US$8,000 for options 1 and 2.

Policy language remains as follows:

PREGNANCY, MATERNITY, AND BIRTH

a. Normal delivery: Medical expenses related to a normal delivery are covered up a maximum of eight thousand dollars (US$8,000) per pregnancy, with no deductible, when the insured mother has been covered under this membership for a continuous ten (10) calendar month period prior to the actual delivery date

We have improved coverage of Maternity Complications

The amount of Maternity Complications coverage is increased.

- For option 1
  From US$100,000 to US$150,000 per lifetime
- For option 2
  From US$350,000 to US$400,000 per lifetime

We have eliminated the maximum limit of visits to doctors and specialists per year.

The maximum limit of twenty (20) visits to doctors and specialists per year for contracting options 1 and 2 is eliminated.

Policy language remains as follows:

OUT-PATIENT SERVICES: Coverage is only provided when medically necessary. Doctor/specialist consultation fees: Doctor and specialist fees for a consultation received as out-patient treatment are covered as indicated in your Table of Benefits.

We have included the extension of coverage for eligible dependents due to the death of the Principal Insured.

Extended coverage is included for one (1) year at no cost for eligible dependents, for contracting options 1 and 2

Policy language remains as follows:

OTHER BENEFITS AND LIMITATIONS
Extended coverage for eligible dependents due to the death of the primary insured:
In the event that the policyholder dies, the Insurer will provide continued coverage for the surviving dependents insured under this policy for one (1) policy year at no charge if the cause of the death of the policyholder results from a covered condition (an accident, Illness or ailment) under this policy. This benefit applies only to covered dependents under the existing policy and will automatically terminate for a surviving spouse in the event of marriage or if a surviving dependent is issued their own separate policy.

This coverage will not be applicable if the beneficiaries of the deceased request the return of any unearned premium payable upon death pursaunt to the Terms of the General Conditions.

EXPLANATION OF BENEFITS, EXCLUSIONS AND DEFINITIONS

PRODUCTS:

INDIVIDUAL & CORPORATE

We have amended the exclusion for contraceptive drugs or devices to cover treatments and/or devices whose use is required to treat a disease or condition covered by the policy and whose primary purpose is not birth control.

MEDICATION WITHOUT PRESCRIPTION
Any contraceptive medication or device, except when its primary purpose is not contraceptive but rather medically necessary to treat a medical condition or diagnosis.

We have included the definition of Notification to provide greater clarity in case of emergencies.

NOTIFICATION: The Insured has a mandatory obligation to communicate a notification to the Insurer about the occurrence of an accident or the need to receive emergency treatment. This notification must be made within the first seventy-two (72) hours from the onset of the need for treatment. A third party may provide the notification on behalf of the Insured should the Insured be unable to do so themself. All notifications must be communicated through the accepted support channels, which are specified on the insurance card.

We have eliminated the requirement to present a study certificate to determine the eligibility of a dependent over 18, either to enter the policy or make a claim.

Eligibility Clause
Dependent coverage is available for the Policyholder's dependent children up to their twenty-fourth (24th) birthday, if single when the policy is issued and renewed. Coverage for such dependents continues until the next policy anniversary date or the next renewal date, whichever comes first, following the attainment of twenty-four (24) years of age, if single.

Proof of Claim Clause
...dependent children who have already reached nineteen (19) years of age must submit a written statement signed by the main Insured confirming that said dependent children are unmarried.

We have included the definition of Professional or Compensatory Sports to provide more clarity to the coverage of dangerous and extreme sports.

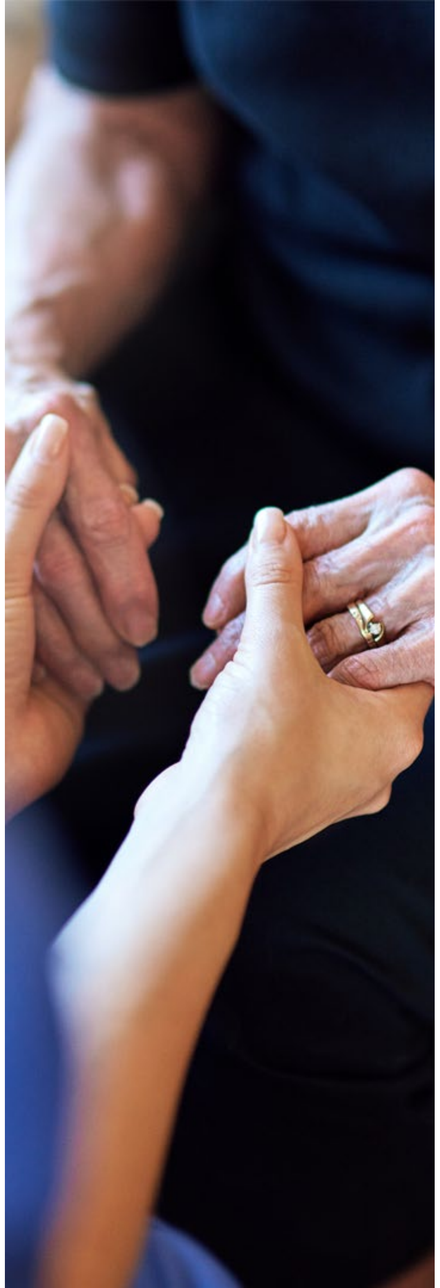
PROFESSIONAL OR COMPENSATORY SPORT

The practice of sports professionally or for compensation refers to a voluntary sports practice carried out by athletes, either on their own account or within the organization or direction of a club, league, sports entity or similar, through an established relationship of a regular nature and receiving or with the intention to receive, in exchange, a remuneration derived from this sporting practice in the form of salary, sponsorship or another type of financing or remuneration, and including the respective training even when no compensation is received for it.

We have updated the definition of Hospice/Terminal Care for Palliative Care in order to be more accurate.

PALLIATIVE CARE

Palliative care will be understood as care provided to patients who do not respond to the curative procedure and are in the terminal stage. They represent an approach to improving the quality of life of patients and their families facing the problems associated with life-threatening diseases. It includes the prevention and relief of suffering through the early identification, assessment and treatment of pain and other physical, psychosocial, and spiritual problems.



We have clarified “Palliative Care” coverage for patients in the terminal stage.

PALLIATIVE CARE FOR TERMINAL PATIENTS

Palliative care will be understood as care provided to patients who do not respond to the curative procedure and are in the terminal stage with a life expectancy of six (6) months or less. Derived from this coverage, the Insurer will pay for the services if the Insured receives a diagnosis of a terminal illness and if he or she can no longer receive treatment that leads to recovery for up to a maximum of twelve (12) months.

The Insurer will pay only for one of the following options:

1. Services of specialized centers for terminal patients and palliative care, the service consists of:

   - Accommodation in a hospice.
   - Care of a professional nurse, qualified by the competent national authority where the treatment or service is received.
   - Prescribed medications and therapies to reduce body pain.
   - Physical, psychological, social, and spiritual care

2. Home nursing services for terminally ill and palliative care patients, the service consists of:

   - Care of a professional nurse, qualified by the competent national authority where the treatment or service is received.
   - Prescription medications and therapies to reduce body pain.
   - Custodial care provided by a qualified professional nurse.

These services must be approved in advance by the Insurer.

PRODUCTS
CORPORATE

It is written in the policy that the expenses incurred by the insured during the last 3 months of the policy year will be used to accumulate the deductible corresponding to the following year.

DEDUCTIBLE
The eligible expenses incurred by the insured during the last three (3) months of the policyyear that are used to accumulate the corresponding deductible for that year, will be applied to the insured's deductible for the following policy year, provided there are no eligible expenses incurred within the first nine (9) months of the policy year. In the event that the benefit is granted to apply the insured's deductible for the following policy year, and the insured subsequently submits claims or reimbursement requests for eligible expenses during the first nine (9) months of the policy year, the benefit granted will be reversed and the insured will be responsible for paying the deductible for the following policy year.

We have clarified the coverage of bone marrow transplant for cancer treatment.

Option 1 and 2
Cancer treatment (chemotherapy/ radiation therapy/**bone marrow transplant**)

Policy language remains as follows:

OTHER BENEFITS AND LIMITATIONS
CANCER TREATMENT: Medical fees specifically related to the preparation and administration of cancer treatment, including bone marrow transplant, radiation therapy, chemotherapy, and oncology, are covered up to one hundred percent (100%). Hospital charges for the administration of tests and medications, such as those required for chemotherapy, that are specifically related to cancer treatment are also covered one hundred percent (100%). All benefits are payable up to the maximum limit per policy year indicated in the Table of Benefits.

PRODUCTS:
INDIVIDUAL

We have improved the coverage of declared pre-existing conditions by providing coverage under the regular policy limits for those conditions that have not been excluded, limited or subjected to waiting periods during the underwriting process. The coverage and limitations will be defined in the Particular Conditions and the general and specific waiting periods are maintained as indicated in the policy.

PREEXISTING CONDITIONS

The declared pre-existing conditions will be covered according to the approval criteria by the Insurer. They will be detailed in your policy documents at the time of approval and will not be subject to a waiting period, except for specific conditions established in the benefits of your plan and contracted policy.

We have improved the definition of “Country of Residence” as follows

COUNTRY OF RESIDENCE
The country where the Insured (principal, spouse and dependent children) has declared in the Insurance Application to have his/ her physical residence and resides for a minimum of one hundred and eighty (180) continuous or discontinuous days during the calendar year, has indicated to have his/ her physical residence, or his/her country of origin, or the country he/she has informed the insurer to be his/her residence afterwards in writing.

We have imrpved the “Change of country of residence” clause specifying a maximum period to notify a change of country of residence.

CHANGE OF COUNTRY OF RESIDENCE
The insured must notify the insurer in writing of any change of his/ her country of residence within a maximum period of thirty (30) calendar days of its occurrence. A change of country of residence may result in modification of coverage, deductible, or premium according to the geographical area, or nonrenewal or cancellation of coverage subject to the Insurer’s procedures. Should the change in residence be to the United States of America, the Insurer reserves the right to not renew or cancel the policy based on the Insurer’s procedures.

We have implemented “Country of Residence” clause, indicating the minimum and maximum period that the insured is entitled to coverege.

COUNTRY OF RESIDENCE
To be entitled to coverage, the Insured (principal, spouse, and dependent children) must be residents and live permanently in the country declared as residence in the Insurance Application for a minimum of one hundred and eighty (180) continuous or discontinuous days during the calendar year

This policy is not available to, nor can it be issued or renewed to, persons who reside in the United States of America for more than one hundred and eighty (180), continuous or discontinuous days in a period of three hundred and sixty-five (365) days regardless of the type of visa issued to the Insured or their immigration status.

Without prejudice to the foregoing, the Insurer reserves the right to evaluate the eligibility, early cancellation, or non-renewal of the policy, if any Insured (principal, spouse and dependent children) resides or is present in another country, other than the one declared as residence in the Insurance Application. The Insurer reserves the right to early cancellation should an Insured (principal, spouse and dependent children) switch their residence to the United States of America or another country other than the one declared as residence in the Insurance Application regardless of the type of visa issued to the Insured or their immigration status.

We have clarified in the "Eligibily" clause, that the insured cannot resides in United States for more than 180 days and a change of country of residence might result in early cancellation or non renewal of the policy.

ELIGIBILITY
This policy can only be issued to residents of Latin America or the Caribbean who are at least eighteen (18) years old (except for eligible dependents), and not older than seventy-four (74) years old. There is no maximum renewal age for insureds already covered under this policy.

This policy cannot be issued and is not available to persons permanently residing in the United States of America for more than one hundred eighty (180) days, continuous or discontinuous, in a period of three hundred sixty-five (365) days, regardless of the type of visa issued to the Insured or their immigration status.

....Without prejudice to the aforementioned, the Insurer reserves the right to evaluate the Policyholder's eligibility, early cancellation, or non-renewal of the policy, at the discretion of the Insurer, in the event of a change in country of residence or nationality.

If a dependent child marries, changes country of residence, or if a dependent spouse ceases to be married to the policyholder by reason of divorce or annulment, or changes country of residence, coverage for such dependent under this policy will terminate on the next anniversary or renewal date of the policy, whichever comes first

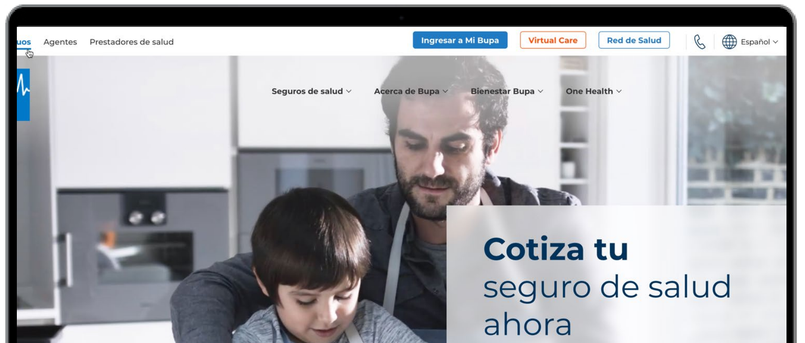
WE HAVE IMPROVED OUR CUSTOMER EXPERIENCE

We improve our customer experience from underwriting, being more emphatic and precise on the **“Medical Questionnaire”** included in the Insurance Health Application.

We have eliminated the physical Claim Request Form in order to request claims through digital channels.

PROOF OF CLAIM

The insured must request reimbursement throught my Bupa at www.bupasalud.com, or send an email to servicio@bupalatinamerica.com including copy of detailed invoices, medical records and proof of payment, within one hundred eighty (180) days after the treatment or service date. Without exception, to be considered valid, all invoices must comply with all current fiscal and legal requirements in the country where the service was provided.



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