
Living Offshore?
Here's what you should know
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Medical/ Health Insurance

Medical/Health Insurance is a policy that pays for your medical treatment in a hospital, and can include outpatient treatment in a clinic that is not a hospital. International medical insurance additionally almost always includes an air ambulance evacuation benefit.

IPMI (International Private Medical Insurance)

International Medical/Health Insurance (IPMI), is a policy that covers your medical expenses internationally in any country in the world, or within a limited geographical international area. It is typically for expats, but some policies can be sold to local nationals as well. It also allows travel to potentially any country in the world for medical treatment, including your home country so you can be close to family and friends. There are about 30 providers offering International Private Medical Insurance (IPMI) policies, about 15 from the English speaking world.

Local Nationals Who Want International Cover

Many wealthy citizens of Latin America understand that medical technology in their home country is not the latest or the greatest, and they want the option of treatment in Miami. The latest technology for cancer treatment, and orthopedic joint replacement is available there. Also, many families want US citizenship for their child which means birth in the United States, you can buy maternity insurance for that. If you want both UK citizenship and EU & Irish citizenship giving birth in Northern Ireland is the place to go for that. You can buy maternity insurance for that. The author had a baby in the UK and it cost $20,000 in a private hospital.

The Fundamental Underlying Principle of the Insurance Business

The fundamental underlying principle is that all parties must act with the utmost of good faith. Without this principle the insurance industry would not work. This

means that the insurer will pay all valid claims, and that the applicant answers all questions honestly so that the risk can be underwritten and assessed properly.

The Difficulty of Finding Good Information about IPMI:

It is almost impossible for uninformed consumers to find any meaningful information about IPMI on the web. They don't know what they want, and have no idea if the website they are viewing offers what they want. Even from brokers, it is difficult to know, or to verify that their recommendation is the best deal, or what the caveats are, or if there is a conflict of interest. Well-meaning expats frequently give misdirection by providing inaccurate or just plain wrong information. Some claim that the domestic insurance broker they relied on for 20 years back home helped them. Domestic brokers are the first to admit this is a specialty area and they have little or no idea about the subject.

Warning: Recently going to the choosemexico.com website we saw they have a partner expat broker. This firm listed 9 insurers they represent but 7 of 9 of these products were reject fails in our opinion. All 7 had bad policy wording, with 3 you can't sue them if you have a dispute, 1 had an underwriter with a junk credit rating, some have poor or no regulation, and one had a dodgy domicile. Interestingly, the 7 fails all had one thing in common apart from bad wording, and the 2 passes had the opposite thing in common. The broker had no clue about any of this. How are you as a consumer to make a wise choice when brokers offer fails, and have no idea what the failure points are? All broker firms advertising on the web and social media have this same problem, they represent fails, and will sell them to you! In this e-book, we will inform so you can go forth armed with the knowledge base and with the right questions to ask. If you are a competing broker, we respectfully ask that you cease reading this e-book immediately.

The difference between Medical and Travel Insurance

This is a very confusing subject, not least because Americans call travel insurance travel-medical insurance. Also, there are thousands of brokers on the web selling medical insurance domestically in the USA, and other countries. Then there are thousands of domestic brokers from multiple countries selling travel insurance. Then you have about 30 firms selling IPMI from different countries, then the hundreds of brokers selling their products. Brokers often make it seem they are a provider on the web, so it is sometimes difficult to tell who you are dealing with.

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The web is very confusing on this subject and because everybody uses the same search terms, the search engines serve everything, mostly what you don't want.

To understand the difference between travel and medical insurance it is important to list the 4 types of treatment categories which are in general;

1. Accidents
2. Emergencies
3. Urgent Medical Treatment
4. Elective Medical Treatment

Medical insurance covers all of them, travel insurance covers only accidents and emergencies, typically only while traveling outside of your home country.

Medical insurance is guaranteed to be renewable; travel insurance is not renewable only extendable at the insurer's option. Medical insurance is always a year-long contract, you can buy travel insurance by the day, week, month, or even for several years. Take the case of urgent medical treatment (3), if you were diagnosed with cancer while on a trip, it is not life or death to spend a couple of weeks to wind up your affairs and return home to commence treatment that your medical insurer at home will pay for, but your travel insurer certainly won't pay for. With Elective Medical Treatment (4) like a hip replacement or hernia surgery for example, your travel insurer certainly will not pay for that! Understand that the underlying assumption behind temporary travel trip insurance is that you have medical insurance back home to cover urgent and elective medical treatment, and the continued treatment of accidents and emergencies after the travel insurer gets you back home, or you return home yourself.

The Structure of IPMI Firms

1. **Underwriter:** This is usually a separate entity that provides a financial guarantee for the payment of claims. Some IPMI firms are self-underwritten because they are owned by large underwriters like Allianz or AXA. More often they are underwritten by firms you haven't heard of, although Lloyds is one familiar name. A few firms are public companies, or subsidiaries of public companies and are self-underwritten CIGNA. The underwriter delegates binding authority to the IPMI firm to accept policies and bind risk.

2. **Claims Department:** This section processes claims, determines eligibility and medical necessity, negotiates with hospitals, pays them directly, reimburses, and in some cases denies claims.
3. **Assistance Department:** This section directly assists insured people in trouble. For example, they arrange evacuations, get you to a hospital, answer questions, and advise what to do when an insurable event occurs. Some insurers have their own assistance departments, but many use outside multi-national assistance firms or small specialized country assistance firms with specific country expertise. The large assistance firms were all French, they are Europe Assistance, Mondiale, International SOS. Often the number to call in an emergency will not be the insurers, but one of these firms. The first two have been bought by big underwriters. For example, Mondiale was bought by Allianz.
4. **Underwriting Department:** since the IPMI firm has binding authority from the underwriter, they decide whether or not to accept your application, i.e., to take on the risk. They may impose conditions depending on your medical history, or reject you entirely.

Warning: There are scams out there advertising on social media (see our appendices). Bona fide insurers ask medical history questions and basic questions such a height and weight in their applications. For example, if your Body Mass Index (BMI) is too high and you are morbidly obese, a bona fide medical insurer will reject you. If they don't ask these questions, they have no way of knowing that you are very unhealthy. The scam will take your money and reject your claim because you are morbidly obese! A firm that has no medical questions on their application is a scam, see the appendix for an example of this.

The Structure of IPMI Policies

Just like all cars are almost all similar in that they have 4 wheels, all medical insurance policies are analogously similar. Insurers create a plan which is divided into benefit levels, the benefit levels generally are divided into 3 categories that are incremental in terms of added benefits and increased price for you to choose from.

Benefit Level One: Inpatient or Hospital Cover

This level covers hospitalization. It only covers outpatient that is directly related to a hospital stay in a limited way. For example, it might also cover 90 days of post hospital outpatient treatment. It is an inexpensive option because hospitalization is a rare event in anyone's life. This is almost always taken with a large deductible of $2500 or greater. Why? Because the money you save by taking a large deductible every year more than compensates for the deductible you might pay in the rare event you claim.

Benefit Level Two: Outpatient Cover

This level adds outpatient specialist and general practitioner clinic care to Level One. It is a more expensive option because you are much more likely to visit a doctor's clinic than be hospitalized. This is almost always taken with a lower deductible of about $250.

Benefit Level Three: Executive Cover

This level would add rich maternity benefits, dental, and routine check-up benefits to the preceding levels and other perks. Individual expats almost never buy this type of plan, it is usually paid for by their employer and they max out on the benefits.

An additional type of Benefit Level...The Defined Benefit Level

A defined benefit level has defined benefits. This means a fixed dollar limit for some or even each particular benefit. For hospitalization, this might mean a limit of $600 per day for a room, and $1000 a day for an ICU bed. It might mean a limit of $75 for an outpatient visit, and $150 for an outpatient specialist visit. For somebody wanting inexpensive outpatient cover living in a place where outpatient treatment is inexpensive, this is sometimes a cheaper solution rather than the other more expensive benefit level types with no specific limits mentioned above. This all depends on where you live, and the local cost regime. Many IPMI insurers have multiple outpatient benefit levels each with a limit on annual outpatient claims of say $5,000, $10,000 and then unlimited with increased premiums for each level.

Warning: Make sure your defined benefit plan has a sufficiently large daily budget limit set for hospital and ICU beds. This is where you may come to financial grief with a defined benefit level plan.

Usual and Reasonable Customary Costs (URC)

URC wording is what governs the upper limit of all benefits in an insurance policy that don't have a set defined benefit limit already. URC stands for Usual and Reasonable Customary Costs. All benefit levels that are not defined benefit levels are URC limited.

In the past, this has meant that hospital bills submitted to insurers have always been paid, even if the insurer thinks it's highway robbery. Of late, we have seen this being challenged by insurers in several ways. Theoretically, insurers won't pay double the going rate if the **URC** rate for that country is half the bill presented. In this case you could be stuck with the shortfall.

It is important to coordinate with your insurer in advance of any scheduled hospitalization in order for them to make arrangements for payment, and to ensure there is no nasty unpaid surprise bill left for you to pay. Hospitals increasingly play games with insurers and overcharge them in various places. Insurers are taking steps to put a stop to this abuse which at the worse could mean that you have to reach into your pocket. This is unlikely to happen if you communicate with your insurer and cooperate with their claims management and assistance procedures.

In Mexico we have seen a list of 6 hospitals in Guadalajara and Cabo San Lucas where an insurer will automatically only pay 60% of the bill if you choose to attend those facilities for treatment. That's because these hospitals overcharge relative to URC, and the insurer warns you in advance. In places like Bangkok there are two very good hospitals, Bangkok International Hospital, and Bumrungrad Hospital with 5-star international ratings for excellence. These two hospitals were once the choice destination hospitals for treatment and evacuation in the SE Asia region, and also for medical tourism worldwide. They have gotten so bad in terms of outrageous charging, that some IPMI providers have banned them. You can go there, but the insurers won't pay! Bumrungrad and Bangkok used to send delegations to International Travel Insurance Conferences. I'll bet they don't do that anymore! You might think that this is unfair. It is however in your interest that insurers don't overpay and thus keep premiums low for all of us. Insurers also have to act to maintain competitive premiums with respect to other providers. These tactics are the only things they can do to prevent and defend themselves and you against abuse apart from leaving you with the shortfall to pay.

So far, we have not heard of this happening unless you clearly break the rules of the policy.

Hospitals like hotels have a produce stand business model. Think of produce stand inventory, once the fruit or vegetable is rotten, can they sell it? Hospital and hotel vacant rooms are like the rotten fruit, once the night has passed and the vacant room is unfilled, then that revenue opportunity is gone forever. This means that hospitals are very keen to keep their rooms filled and they will bargain with insurers. If you walk into a hospital without cooperating with the insurer, they will pay retail and they will be unhappy about that, and they can penalize you. Please cooperate with insurers and follow policy rules and this will keep premiums low for all of us. It is in your interest to do so.

Warning: There is one high profile insurer GeoBlue (Blue Cross Blue Shield International) whose name is one of the biggest healthcare brands in the world that is the only international health insurer that does not use URC as the limit for benefits. If you read the fine print, they talk about an "Allowed Amount." They actually say: "Our Allowed Amount is not based on URC" if a Non-Participating Provider's actual charge exceeds our Allowed Amount but is URC, you will pay the difference. Other providers at least honestly disclose limits (i.e., the Allowed Amounts) in defined benefit plans. With GeoBlue you have no idea what their allowed amounts are, and you are subject to their arbitrary "Allowed Amount" limits when you get a surprise that they are not paying the full amount, and you can have no idea what these limits are ahead of time!!

Although BSBC GeoBlue is the worst plan on the planet in our opinion (see the appendix), there is one other that doesn't use strictly use URC. This seems to be a French firm called Mobility Saint Honore (MSH), this firm is a good insurer, but they limit the maximum they will pay to URC or 4 times the cost base of "French Social Security Tarriff". They are the insurer for American Association of Residents Overseas (AARO) that is Paris based. We have no idea what the French limits to hospital medical costs are, and have no idea if this limit is reasonable, or if you could come to grief with this and have to pay out of pocket. Just understand that every other IPMI insurer has no limit other than URC unless otherwise expressly stated.

Overall limit to a medical insurance policy

This is the overall sum insured. American policies have a lifetime limit usually $1 million or $2 million. Policies from other countries have an annual limit, usually $1

million. Some policies for the inpatient benefit level have a limit of $500,000. The biggest claim we have ever seen in 30 years was $350,000, so these limits are more than adequate. There are now 2 firms offering cheap inpatient plans with limits of $250,000 and $160,000. Just be aware of the limits and satisfy yourself that they are sufficient for the place where you live. Our recommendation is at least $500,000.

The one benefit that has a sub-limit for most policies is organ transplant. It is usually $100,000. Organ transplant is a specious benefit because the insurer almost never helps you procure, or pay for the replacement organ, or its removal from the donor. Expats will almost never be able to get on the transplant list in their country of residence, and if they return home, they will be at the bottom of the waiting list. Consequently, if you need an organ transplant as an expat, you may be in a tough situation.

Purchasing Medical/Health Insurance?

Decision 1: Buy medical/health insurance, yes, or no?

Medical/Health insurance is an extraordinary product economically because the price elasticity of demand is a perfect 1. That means the demand for health insurance ceteris paribus (all other things being equal) is perfectly sensitive to price. If you decrease the price by half, you will get twice as many people buying it, if you double the price, you will have half as many people buying it. The only reason people don't buy health insurance is the price is too high, or it is unaffordable for them. If they can afford it, they will buy it generally speaking.

Decision 2: Which policy to buy?

Given that the price elasticity of demand is a perfect 1, you will buy the cheapest policy on offer ceteris paribus, but are all other things between policies really equal? The answer is no, there are a few things to consider…

Consideration 1: The Financial Stability of the Insurer

The insurer is usually backed by an underwriter, the underwriter guarantees the payment of claims and the insurer manages the risk pool. Sometimes in the case of underwriters like AXA and Allianz, they enter into the International Health insurance market directly using their own brand names, but surprisingly also underwrite other competing products. You can determine the financial stability of the underwriter by rating services such A.M. Best, and Standard & Poor's. If the rating is "A" or higher, then you have nothing to worry about. What is the reason

for worry? If there is a natural disaster such as a hurricane, pandemic, tsunami, or an earthquake, there might be a huge surge of claims, and this could potentially bankrupt a weak individual insurer or underwriter, but not a quality underwriter with a high financial strength rating.

Consideration 2: Policy Wordings

The policy wording is also important to consider. This is the basis of the contract you sign with the insurer. The major thing to look for in the policy wording is the wording governing pre-existing medical conditions and exclusions. If you were to buy car insurance after you had a car accident, would the car insurer pay that claim? The answer is no, you have to buy the car insurance before you had the accident. Similarly, health/medical insurers will not cover treatment of disease or illness you had before you bought the policy. So, it is very important to understand the wording governing this point.

Here are two examples of pre-existing conditions wordings, bad and good…

1. **Bad**: All pre-existing conditions (even the ones you could not have been aware of) are excluded. (This is policy **TICKING TIME BOMB #1**)

2. **Good**: Pre-existing conditions that you only could have been reasonably aware of, were symptomatic for, or had consultations for, are excluded.

Bad Policy Wording Case Study

Under the bad policy wording above, a woman in Hong Kong was denied cover for a bowel cancer claim after her 3rd annual policy renewal because the tumor existed prior to her policy start date. The denial letter from the insurer's Medical Director said, "the reverse extrapolation of the growth of the tumor shows with **medical certainty**, that it existed prior to the inception of the policy 3 years ago, and therefore the claim is denied."

She could not possibly have been aware of a tumor that was a few cells in size before she bought the policy, nobody could have possibly been aware of that. In good faith she bought the policy and, in our opinion, in bad faith her claim was denied, even though legally, the insurer was abiding by the contract. This could not have happened with the good policy wording and is **TICKING TIME BOMB #1** waiting to explode if you have the Bad Policy Wording. Also, be aware of the list of excluded conditions in the policy wording. It is important to understand what they are to avoid disappointment later.

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insurers today!

Two key phrases that are definite red flags of bad policy wordings ready to explode are use of the phrases "**medical certainty**," or worse, "**reasonable medical certainty**." In our opinion about half the policies on the market have the Bad wording on pre-existing conditions caveat emptor.

It recently came to our attention that the last hold-out insurer to have "medical certainty" in their policy wording changed that to the much worse for policyholders, "reasonable medical certainty." It is interesting to note that in discovering this we also learned this particular insurer now has two versions of their policy wording. One for those applicants that are transferring directly from a company plan for employees in the USA, and the other for everybody else and the policy wordings for these plans are respectively good and bad. What this proves to us is that insurers know very well they have deliberately chosen to have what we consider unfair and bad policy wording in their contracts in order to better be able to deny your claims. They know fully well because they employ actuaries that for example, that tell them 3% of the population has bowel cancer at any time, but most don't know they've had cancer for years until they've had a colonoscopy, which you should have at 5-year intervals after age 55. Really, since almost all of the bowel cancer happens amongst the older population, you might be able to say that 6-8% of the population has bowel cancer above age 55. So, if they can have weasel wording in their contracts that enable them to deny claims like this, then they and their underwriter will have higher profits. The good news is that you have a choice, you can buy a policy with good policy wording and they are not more expensive.

Other Little Known Bad Consequences of the Bad Policy Wording

Apart from the fact that your claim could be denied, there are other little considered bad consequences to having the Bad policy wording…

1. **Hospital Choke:** Some hospitals choke when they see your insurance card, and this leads to awkward moments. Why? If your policy has the bad wording, the insurer is incentivized to the endth degree to determine if your claim was a pre-existing condition, and they actively seek reasons to deny the claim. Consequently, they ask for a lot of information, documents, diagnostic reports etc., before they pay. This is bothersome to hospitals, and the insurers with bad policy wordings take exceedingly long times to

pay making their names a recurring bad theme in hospital accounts receivable overdue reports. If you have the good policy wording, insurers just pay.

2. **The Third Degree:** If you have the bad policy wording, your insurer will give you the 3rd degree in terms of seeking information to prove the bona fides of your claim. Once again, the bad policy wording incentivizes them to exhaustively investigate because they actively seek reasons to deny your claim. If you have the good policy wording, the insurer will just pay.

3. **Onus and Burden of Proof:** If you have the bad policy wording, the burden of proof is shifted to you to prove your claim is bona fide if there is doubt. The insurer will ask your doctor for medical history reports, but what if it is the case that you've been healthy up to the time your policy started, but 3 years later you had a heart problem as a result of some undiagnosed issue? If you can't provide reports, or any medical history of your issue, the insurer may label you uncooperative and then your claim goes into limbo and then is ultimately denied. Then you have to sue them. If you have the good policy wording, the insurer just pays.

Consideration 3: Method of Intake Underwriting ... two methods

Full Medical Underwriting Method

The default method of intake underwriting is called Full Medical Underwriting (FMU). Under this method insurers won't cover pre-existing medical conditions, but they may offer an exclusionary rider for a declared pre-existing condition as a condition for their acceptance covering everything else.

Moratorium Underwriting Method (Can Cover Pre-existing Conditions)

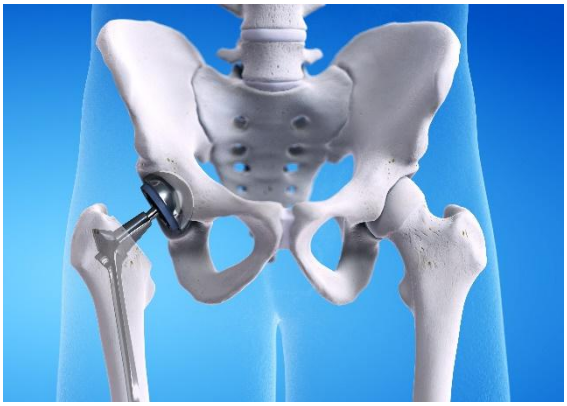
This section is for people that have pre-existing conditions. If you have a pre-existing condition such as having had a brush with cancer, or something else, it is possible to have this covered in the future. How can this be possible? The other method of intake underwriting is called Moratorium and not all insurers offer this option.

Under this method there is a Moratorium wait period where they will cover a pre-existing condition after the moratorium wait period has expired. Provided you

don’t have a recurrence, a symptom, a consultation, or take medication for that condition during the wait period, they will cover the condition as if it was a new condition afterwards. If you do have a recurrence during the moratorium wait period, then the wait period begins anew.

This does not apply to routine checks you might have after cancer to ensure that it hasn’t returned. It also does not apply to chronic conditions, as you will never get through a wait period, and never be cured. The Moratorium wait periods are 5 years for cancer, and 2 years for everything else. Generally, add 10% to the premium for Moratorium intake underwriting.

A Moratorium Case Study:



A woman in Tokyo had a hip replacement caused by a car accident in her twenties. While in her 40’s, she knew that she might need a new replacement at some point in the future because the technology of the day wasn’t the greatest. At the time she bought a moratorium policy and kept renewing for 7 years, then her hip suddenly gave out and she was able to get a new one paid for by the insurer.

Today’s joint replacement technology is much improved, and seems to last a life time. We have noticed on a recent review of policy wordings however that a new exclusion is being inserted in some policies; replacement of artificial joints is excluded. So, some insurers are getting wise to this type of case, and this is an important reminder to understand especially the exclusions on policy wordings.

Warning: There are two methods insurers use to determine renewal premiums. If you want to keep a policy for a long time such as a Moratorium policy, then you need to understand which method they use, and the potential pitfall. Please see the section on renewal premium rate setting below.

Consideration 4: Method of Setting Renewal Premium Rates... 2 methods

1. **Whole Book Method of Setting Renewal Premiums:** This method is easy to understand and obvious. Insurers look at claim costs, medical

inflation and other factors and raise premiums by a set percentage amount across the board to maintain profitability of their risk pool. They might have larger percentage increases for certain age bands. Premium tables for these firms are usually set for a year at a time, and they revise them annually. When you receive your renewal notice, if you checked the insurer's premium table, it will be the same price as on your renewal notice as you would expect.

2. **Cohort Method of Setting Renewal Premiums:** This method divides the risk pool into cohorts (small groups) by year class of joining, and further subdividing by age band, sex, and geographical location and the insurer then follows this group as it ages. Once the year class is established, it gets no new members. The exact method creating the cohort and assigning premium increases is opaque, but the point is they create small groups and assign premium increases for renewals as a result of the performance of that sub group. The premium tables we call entry premium tables because that is the price you pay only at the start of a new policy, and it will always be less than your renewal notice premium.

Good Points about the Cohort Method Firms

1. The entry premium tables sometimes don't change for as long as 4 years but usually every 2 or 3 for sure. That means while the Whole Book firms have been raising prices by 10% per year, the entry premium tables for Cohort firms have stayed the same, and therefore seem always lower and a good deal by comparison, plus they always start lower.

2. They offer very inexpensive worldwide cover enabling return to the USA for medical treatment. This is ideal for especially American and Canadian expats wanting worldwide cover and the right to travel home for treatment. They are inexpensive because they have excellent and experienced cost control in the USA, and agreements with hospital networks. For worldwide cover, they are less than half the annual cost of Whole Book firms, saving you thousands of dollars.

3. These firms don't care what nationality you are, so they will sell to local nationals that want cover in the USA. Firms from other parts of the world typically have restrictions from underwriters against insuring local nationals excepting local spouses of expats.

Bad points about the Cohort Method

First, understand that most expats are usually transient, they go abroad for a few years and then return home. That means by attrition, the cohort group over time only gets smaller as people return home usually after a 3-year period of being abroad. This means if there is a big claim in the group, then this could mean a big increase in premiums for that now smaller group in year 4 and 5 of renewals. One remedy to this is simply quitting your policy as many do because of the high renewal price. You can simply start a new policy at the low entry price thus saving thousands of dollars.

This obvious course of action accelerates the reduction in cohort group size such that eventually only the claimers that have to renew because they have an ongoing claim remain. These plans will start to get expensive in year 5 or 6 and after that can experience wild increases. We've seen sudden unexpected $20,000 increases per person per year and this is **POLICY TICKING TIME BOMB #2**.

If you were wanting a policy for the long term such as in the case of the Moratorium hip replacement lady example above, you should consider this information carefully. There is only one Cohort firm that offers Moratorium intake underwriting of new applications. It is unlikely you will ever get through a 5-year Moratorium period on cancer, or keep such a policy for the long term without restarting for 5 years.

Why do people buy Cohort type policies?

Almost nobody understands or knows they bought a cohort policy. Why? If you bought it directly on-line, the insurer certainly didn't tell you. Almost no brokers understand there is difference between insurers in this way, so they couldn't explain it to their client because they had no clue. Buyers like these policies because they are inexpensive, especially for worldwide cover. Even when buyers understand the difference, they would rather have the cheap cover for the first 3-4 years, than have longer term premium affordability, and predictable premium increases into the long-term future.

Warning: There is only one inexpensive cohort policy that has the **GOOD** policy wording which eliminates **POLICY TICKING TIME BOMB #1** completely, with that policy you can restart as many times as you want with no fear of bad consequences from unknown pre-existing conditions.

Consideration 5: Ability to Sue (Litigate) in the event of a Dispute

It is important to be able to sue your insurer in the event of a claim dispute. We have on 2 occasions have sent demand letters from lawyers in the same city as the HQ of the insurer, and they have suddenly capitulated and paid a claim that they were denying or holding up. Some plans have wording in their contracts that forces all disputes to arbitration. There are several US IPMI insurers that do this. Now you might think you can still sue them, but if you do that, their lawyer will file a motion to compel arbitration and the judge will grant it. Arbitration lawyers cost $600 per hour, and what are they going to arbitrate?? There is no halfway point here, either the insurer pays your valid claim or they don't, let a judge decide that. Do not buy any policy where there is mandatory arbitration for dispute resolution in the policy wording. We might note here that our in our favourite domicile there is a Government Insurance Ombudsman. You simply take your claim dispute to them and they will review it for free, and order the insurer to pay if they think you are in the right.

Particular Concerns for those aged 70-75 and up…

One thing about some cohort firms is they offer cut down plans after age 75, customers are supposed to convert to these old-age plans at age 75. This might seem to provide comfort to people buying at age 65 wanting long term cover after age 75, however they have the requirement that you have 10 years of continuous cover before you are eligible!

Is anybody going to meet that requirement? No. Whole book firms allow you to renew as long as you have continuous cover from the maximum age, they allow new enrollments. This maximum age depending on the provider, is usually 70 or 75. There are two Whole Book providers we know of selling new entry policies to those over age 75 to 85.

Evacuation

The ambulance gets you to the closest local hospital from where you had an accident. This could include a helicopter air ambulance. Most policies limit the ambulance benefit to $5000. Evacuation does not necessarily involve an

accident. Evacuation only occurs in order to save your life. Evacuation is from hospital A which has limited facilities and medical expertise, to hospital B that is the closest place where they are capable of treating you in order to save your life and could be in a different country or continent. Typically, the closest place is important because time is of the essence, and it needs to be the closest hospital literally in order to save your life. If there is a limit an evacuation benefit, it is usually set at $50,000.

Evacuation is usually a core benefit on the table of benefits where it is bundled into an IPMI program, but it can also be an add-on benefit in IPMI programs like CIGNA for example. Where it is an add on benefit, it typically costs $50-80 monthly, or $600- $1000 annually extra depending on your age. The bundled benefit is almost always a much better deal. There are some plans that have an extra charge for evacuation back to your home country, but is this really an option when you have to go to the closest place because time is of the essence in order to save your life?

Other considerations for evacuation are geographic. In the Caribbean area the default evacuation location is Miami and evacuations typically cost $20-30,000. Be aware that if you are not American or Canadian, in order to be evacuated to Miami you need to have a 10-year B1/B2 US Visa in your passport, or the air ambulance will not take off. Be aware there is no Visa free entry to the USA except for Canadians, certain nationalities get a waiver if and only if they are on a scheduled passenger flight to the USA. If you enter the USA on a private airplane like an air ambulance or yacht, you need to have the visa. If you don’t have the visa, they could seize the yacht or the aircraft. Generally, you need to have the worldwide geographic cover option to be treated in Miami from your insurer. If you are not insured, the hospital in Miami will need an advance deposit of $250,000 before an air ambulance will take off to fetch you. A survey of air ambulance firms in the USA confirms that some of them have never done a private patient funded evacuation. It almost never happens.

With some firms they will evacuate you to an area outside your geographic area of cover in order to save your life. In the Caribbean and surrounding area for example, the default evacuation destination is Miami. If you have purchased the much cheaper geographic premium option of Worldwide Excluding USA, they will still evacuate you to the USA. Some firms limit the time they will pay for treatment outside your geographic area of cover to 30 days. Each policy is different with respect to rules regarding this situation, find out before you buy if you want to save money with the cheaper geographical area.

There are some stand-alone evacuation-only policies that are for the self-insured. Be aware that just because you have a policy, that doesn't mean that an air ambulance will come and get you. If for example, you need to be evacuated to the USA because you are in Mexico or the Caribbean areas, unless a US hospital is willing to accept your case, the air ambulance will not take off. As above, Miami hospitals require an advance deposit of $250,000 before they will accept an uninsured patient. Try organizing that while dying on a gurney in an airport! People die on gurneys because they can't get evacuated even though they have evacuation insurance. If you have medical insurance with an evacuation benefit, there is never an issue and no deposit is required. The insurer's assistance arm will arrange everything to get you to that hospital including guarantying payment in advance.

In all cases be aware that the insurer must arrange and pay for the evacuation, or they won't cover it at all, or will only cover it partially. They will always get a much lower price than you could arranging it on your own paying retail. Be aware also that often there are exclusions regarding air ambulance or evacuation from ships or yachts.

Evacuation Case Study

George was an American expat living in Mexico, insured with an American Insurer with worldwide coverage, including an evacuation benefit, and was visiting home in Colorado. He was riding a horse in the mountains where there were no roads. The horse reared straight up on two legs and George slid off the back of the horse but the horse then fell and sat on him breaking his pelvis in 20 places, breaking ribs and puncturing a lung. He was bleeding out internally in a remote place. A helicopter air ambulance was called and the EMT's immediately made the decision not to take him to the closest hospital, but to the closest one with a trauma unit that could save his life in Arizona.

The first problem was his IPMI policy had a limit, as many do on the ambulance transport benefit, of only $5000. The insurer immediately paid that, and they paid the $300,000 hospital bill for the 2 months George spent in the ICU. However, the helicopter air ambulance bill was $50,000 and the air ambulance was trying to

collect $45,000 from George which he didn't have. This was the last thing George needed to deal with during his lengthy convalescence.

The American insurer argued that the ambulance benefit was limited to $5,000, and anyway, they never did evacuations within the USA so the evacuation benefit did not apply! George contacted his agent the author, and he pointed out to the insurer that if Roger had been taken to the closest hospital, he would have died, and if George had had lived long enough, he would only have had to be evacuated to the same hospital in Arizona with the trauma unit in order to save his life. That's what the evacuation benefit is for, and they couldn't place arbitrary geographical limits to it outside of the USA. The agent recommended a demand letter be sent from a lawyer in the same state as the insurer, which was done, and the insurer paid.

We can learn from this that evacuation benefits are important, and it is also important to use an experienced IPMI agent rather buying directly on the internet. The agent is as legally obligated as the lawyer you hire to advocate on your behalf, and only act in your best interest. If George had bought the same cover from the UK subsidiary of the same insurer, the UK Insurance Ombudsman would have immediately stepped in to order the insurer to pay up. It also can matter what country you buy the cover from, and what laws of what country govern the policy wording.

The Pre-authorization and the Pre-certification trap

Pre-authorization and **Pre-certification** are two terms that sound like they mean the same thing. They are approval consultation procedures you must undergo with your insurer before making a big claim. This is typically $500 or more with your insurer before you seek treatment. If you don't, then a penalty of 20% to 50% of the bill may be applied.

The benefit of **Pre-Authorization** is that you know ahead of time your insurer is informed, and approves the course of treatment and the hospital. The other benefit is they can most likely arrange to pay the hospital directly if it is a large sum getting discounts thus keeping premiums low for everybody. Obviously, this can't be done in the event of accidental trauma, and typically you have to notify the insurer as soon as possible.

Pre-Certification is an American term but it is confusing and ambiguous in that the procedure is necessary and penalty driven, but only certifies the medical

necessity of the intended course of treatment. A further process called **Verification of Benefits** must be carried out where the insurer confirms you have the benefit, but this still does nothing to confirm an acceptable hospital, arrange direct payment of the bill, or approval of the course of treatment. It is not the same one-stop-shopping procedure as Pre-Authorization.

Pre-Certification Case study

You have a heart attack and call your American insurer as required and get Pre-Certified. They confirm you've had a heart attack and agree on the medical necessity for immediate treatment Pre-Certifying you. It is a reasonable chance that the term Pre-Certification has lulled you into a false sense that you are covered, and the insurer will pay. Do not be confused, ask for Verification of Benefits. We remember a Provider Executive casting scorn on an insured for being surprised that her claim was rejected after Pre-Certification approved her. He said "Well, what could she expect? she never verified the benefits from us. How could you go into hospital without verification of benefits?" It's fine to say that, but if it is not clear that you have to verify the benefits after pre-certifying, and nobody tells you, then the term Pre-Certification is confusing, and could lead reasonable people to falsely believe they are covered. Ask stupid questions and make sure you know the procedures. Also, if you have the Bad policy wording, they may never Verify the Benefits because they can't be sure your claim isn't a result of a pre-existing condition!

Deductibles/ Excess 2 Types and 2 names…

Deductible is the American term, and Excess is the British English usage for the same thing. This is the amount you must pay with a claim. For example, if your claim was $10,000, and your deductible was $1,000, your insurer would pay $9,000 of the claim. Maximum deductible options do not generally exceed $10,000.

Annual Deductible: This type is taken once per year. For example, if your deductible was $1,000 and your first claim of the year was $10,000, as above the insurer would pay $9,000. If your 2nd claim of the year was 10,000 you would get a full refund on that claim and all other separate claims in that policy year.

Per Claim Deductible: This type is applied to all claims, but only once per course of treatment of the same disease, accident etc.

Deductible Excess Discussion: Generally, annual deductibles used to be an American policy design feature and the Per Claim Deductible was a British or European policy design feature. Now more British and European firms are offering annual deductibles, something the author prefers. Some have an annual deductible choice for the inpatient benefit level and per claim deductible for outpatient claims.

Other forms of Deductible Coinsurance and Co-pay…

In the IPMI market these are exclusively American policy features. Co-insurance is a deductible whereby a percentage of the claim is deducted. Co-pay is usually limited to outpatient claims but it is a fixed amount you must pay with each visit to an out-patient clinic.

Discussion Co-pay, and Coinsurance with IPMI

We have never seen co-pay on an individual IPMI policy except in country specific cases like Dubai. We have seen coinsurance on some American policies, but it seems that only claims for treatment in the USA generally attract coinsurance, or it is 20% inside the USA, and 10% outside the USA. It makes you think twice about traveling to the USA for medical treatment. The bottom line is that even without co-insurance, there are good policies that are less expensive than the ones that have it, and allow you to travel to the USA for treatment without a co-insurance penalty. There are some firms offering co-insurance on the outpatient benefits only. We actually like that structure, but don't buy a policy with co-insurance on inpatient benefits when you have other options.

Sailors / Yachties and the Retired

What is the best IPMI option for blue water cruisers? Most are older, and thus face higher premiums. Most however are very fit because of the life style, and if you aren't fit to start with, you soon will be! They wouldn't be out there if they had health challenges. Therefore, our recommendation is an inpatient plan with a high deductible. Take a high deductible because hospitalization is a rare event in anyone's life.

stant quote comparison of 10 plus

day!

The money you save on premiums more than compensates over the years where you don't claim, for the rare occasion where you might claim. What about outpatient claims? In the places where most people cruise, outpatient treatment is cheap, so pay for that yourself. You will save big money rather than paying for a policy that has outpatient general practitioner and specialist cover. The inpatient policy you do buy should cover outpatient specialist visits related to a hospital stay before and after in limited ways.

It seems Cruisers are lulled into a false sense of security by travel policies that will rescue you at sea and provide evacuation. If you really are a worldwide cruiser under sail, this idea might provide comfort. The author of this e-book has been a pilot for 40 years, and knows a thing or two about this scenario. If you dig into the policy wording of these types of policies, they will rescue you if and only if it is practical. A rescue at sea would be done with a helicopter equipped with a door winch and a winch operator and a rescue trained para-medic that would potentially descend to the vessel put the casualty in a basket stretcher and get hoisted back up into the helicopter. Helicopters don't fly fast, very far, or high, and they don't carry much load and no helicopter would have a door winch unless they were a Coast Guard type helicopter and in that case the rescue would be free. Rescues at sea are not practical unless you have trained aircrew and a door winch. Private helicopters simply don't have this equipment, so in almost all imaginable cases and places, rescue would never be practical. If the Coast Guard can't come, you are on your own because rescue is impractical. The insurer you paid the premium to will just call the Coast Guard, it's cheaper and faster for you to call the Coast Guard directly!

I owned a 45' Catamaran and cruised for 6 years. There was at day organized at Georgetown in the Exumas where lectures were given about everything from anchoring to 2 stroke motor maintenance, splicing etc. I was asked to give a lecture on insurance for cruisers. I was confronted with 100 people attending, the largest audience! I gave out all my business cards. The one question asked by all Americans after I gave them the price was, "is that the monthly price?" I answered no, "that's the annual price!" So, the premium was 12 times cheaper than what they expected it to be! So yachties pay attention, international medical insurance is much cheaper than you think it is going to be!! Strangely, very few of them buy it, or all they have is travel insurance and think they are covered adequately.

What is your cheapest deal in IPMI?

The cheapest deal in IPMI is an inpatient/ hospital plan with a big deductible. The maximum deductible is $10,000. The average deductible that people choose with an inpatient plan is $2,500. People choose a big deductible with an inpatient plan because a hospital stay is a rare event in anybody's life. You might choke at a $10,000 deductible as being too high, but there is one provider that has a unique extra add-on benefit that helps mitigate high deductibles. This add-on benefit is a daily cash payment of $100 per day spent in hospital.

If you're in hospital for 30 days that's $3000 the insurer is going to pay you. Each add-on benefit costs $100 extra per unit per year and you are limited to two units. So, if you bought two units for $200, that's $6000 per month they would pay which largely offsets any large deductible you choose.

About Maternity Cover, some Considerations…

Stretching our car insurance pre-existing conditions analogy above, suppose you were clairvoyant, and you knew that you were going to have a car accident. The limitation of this clairvoyance is you don't know how serious or trivial the accident was going to be, only that you were definitely going to have a car accident in the next 2 or 3 years. Knowing this information, would you buy the cheapest car insurance or the most comprehensive cover possible? Most people would say the latter.

Maternity is like that clairvoyant car accident situation in that couples plan maternity, but they don't know if it is going to be an easy birth or a complicated

birth with a several week premature baby in an incubator in an expensive neonate ICU. Accordingly, they should be thinking about a comprehensive policy with rich benefits instead of the minimum.

Insurers don't like any benefit where there is potentially no moral hazard. There is no risk to underwrite if a couple before they buy the policy has already decided to have a child. Some have benefits such as a $5,000 maximum limited benefit but only qualifying after 2 years and the maternity benefit costs $2,500 per year. Consequently, pay attention to where you live and the cost of these things and what the special maternity benefits included with the policy are.

Moral Hazard and Certain Benefit Types, Some Thoughts…

Many people insist on having routine physical exams as a benefit on a policy. They are always limited in some way, but consider the following argument. It is acknowledged that everybody should have a routine physical exam once per year. If you were an insurer offering to cover broken legs, is everybody going to have a broken leg every year? No, but if everybody on average were break a leg once a year, the cost of claims for a broken leg would be incorporated into the premium for broken leg insurance, plus profit, commission paid to the broker, plus claims and policy administration fees.

This is exactly what happens with annual physical exam benefits. If you have the benefit, then there is no reason not to have the exam and make a claim. There is little or no risk to underwrite that you won't have the exam and claim. Consequently, these types of benefits are priced into the premium of the policy. In many cases it is cheaper and smarter to buy the policy without the luxury benefits and pay for annual medical exam yourself. You will save money. Of course, one of the reasons these benefits exist is if an employer is paying the premium on your behalf, and that is almost always the reason Executive benefit levels exist and almost always the reason why individuals never buy them for themselves.

A Word About our Quote Engine on www.worldexpathealth.com

Our quote system is unique in that it compares insurers competing for your business on an equal basis. We make them work for you. We compare inpatient plans with deductibles closest to $2500, and outpatient plans with deductibles

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closest to $250. These are the two benefit levels and deductibles people almost always buy. No other web based IPMI quote system does this, they don't give you an apples-to-apples comparison, and because these are the only benefit levels you can compare equally. We give you an ascending order report of premiums, plus a read first document that explaining the policy options of each firm.

All other quote systems compare on the basis of your country of residence only, because that's all they ask for. Why? Because it's algorithmically simple computer programming to do it this way. Americans for example typically want cover back home in the USA so they can travel there for medical treatment, so those quote systems don't tell you what worldwide cover including the USA costs. With our quote system you can indicate you want cover in your home country, or if you have special circumstances, a drop-down list where you can pick as many countries as you want. Our system not only compares plans on an equal benefit basis as closely as is possible, we give cover all the geographical premium choice variables you could want.

Our quote system is the most useful on the web as it tells you exactly what you want to know. The quote system is only a starting point though as you might want a higher deductible, or have special circumstances like pre-existing conditions. We are happy to discuss any of these concerns or your needs, and explain your options.

Why World Expat Health?

With 25 years in the IPMI business, you can be sure that we will help you make a sound decision when purchasing your IPMI Policy. You're guaranteed to save money and receive no nonsense information any time you have questions, plus we give you the solution with our instant quote reporting tool from 10 insurers to find your best deal. We know who the cohort insurers are, and those with the bad policy wordings. We can steer you through the process with you being confident that you are informed with no policy ticking time bombs waiting to explode at a later date. We've given you all the questions to ask above, and hope that you will contact us when it is time to buy, or tell us what policy you have so we can tell you if you have a hidden explosive device in your present policy.

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Thank you for downloading this e-book!

We generally don’t name providers in this e-book because we want you to make up your own mind on the basis of the information we provided as a consumer to ask the right questions in order to make a good purchase decision. We have made two exceptions to this in the interest of protecting you from harm in the case of what we consider to be fraud in the case of Regency Healthcare, and in the case of an offer from Blue Cross Blue Shield GeoBlue that has so many things wrong with it, that we were left in a state of choking apoplectic incredulity when we read their policy wording. Don’t be fooled by the brand name, this policy is garbage. We consider these policies to be ticking time bomb policies waiting to explode on buyers.

Appendix 1: **Regency Healthcare for Expats**

Aka Medical for Nomads

Pensions for Nomads

Life Insurance for Nomads

There is a firm that aggressively advertises on Face Book and YouTube under two names, one is **Regency Healthcare** and **Medical/ Pensions/ Life Insurance for Nomads** (by Regency Healthcare) This firm has no underwriter and they are regulated by the Nevis Financial Services Authority and operate under the laws of Nevis. Nevis is a tiny strato volcano island in the Caribbean with a population of 10,000. It is part of the tiny island country of St. Kitts and Nevis.

The applications for a policy with this firm have no medical questions, not even height or weight. No bona fide medical insurer would fail to ask medical questions. They only have a zero deductible option which sounds good, but is something else no bona fide insurer would have. They have a website called nowcompare.com where they compare several insurer prices and magically, Regency always has the best price, and Regency is also rated with the highest star rating. What they don't disclose is their off-the-charts conflict of interest, and their ownership of this bait and switch unethical website.

They have an impressive list of offices around the world but if you call their offices during working hours in the USA for example, you will get an answering machine. That's because their actual "office" aka boiler room is in Hong Kong. If you try claiming you might get frustrated to the point of angry outbursts when they give you excuses, but don't curse and swear at them. Why? This is reason enough for them to terminate all communication regarding your claim and not pay it. I've never seen this type of warning from any other insurer, I wonder why? Reading their policy wording on claims regarding accidents on motorcycles for example, you will see ridiculous wording that you will see in no other policy, plus cancer treatment is limited to $20,000.

We realized what Regency's game was when we pretended to be potential customers and were contacted by their incredibly slick continuously closing telephone sales people from Hong Kong. Their Whatsapp portraits indicate they should have been runway models, not doing telephone sales! They persistently asked for middle names, but their cover was blown when they asked me if those middle names appeared on my Visa or MasterCard! Those are the only questions that their policy application forms have, the credit card mandate fields!! They expertly try to extract this information, then close you. They say they can have insurance in place immediately with no wait!! You will get immediate confirmation! You are not insured now, are you? We can get you covered right away!! There were 10 follow up attempts over the next month from a UK number at 4 AM UK time, but regular office hours Hong Kong time. They don't quit. Do not light the fuse on this **TICKING TIME BOMB!** Do not buy life insurance, a regular monthly investment/ pension plan, or health insurance from these fraudsters. This is a ponzi scheme with zero financial transparency that Facebook and Youtube will not stop promoting, despite the fact they have been told multiple times about it. One year later they are still contacting me!

Appendix 2: GeoBlue by Blue Cross Blue Shield

GeoBlue is the trade name **Worldwide Insurance Services, LLC** (Worldwide Services Insurance Agency, LLC in California and New York), also known under the brand name HTH Worldwide is an independent licensee of the Blue Cross Blue Shield Association (BCBS) of which they own 51% and display proudly the BCBS logos. This underwriter of this insurer is a Bermuda firm called 4 Ever Life International Ltd. wholly owned by BCBS which issues a Master Group certificate to the Global Citizen's Association owned by GeoBlue, to which you have to join in order to get covered by GeoBlue. In the early 2000's BSBC bought 51% of Worldwide Insurance Services LLC.

4 Ever Life International Ltd. has an A.M. Best financial strength rating of A-stable, but Geo Blue couches this with the warning caveat: **THE INABILITY OF 4 EVER LIFE INTERNATIONAL LIMITED TO PAY CLAIMS IS NOT COVERED BY THE INSURANCE GUARANTY FUNDS OF THE DISTRICT OF COLUMBIA OR OTHER JURISDICTIONS IN THE UNITED STATES OF AMERICA.** That's because it's non-admitted insurance and sold on a surplus lines basis. These are US technical legal insurance terms which mean you have no recourse to any state regulator or adjudicator if you have a dispute with this firm, only the courts you might think, but wait, with GeoBlue, you have no recourse to litigation!!

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The brings up another question, what legal domicile of governing law governs this contract? Every international contract has a section referring to the domicile of governing law in the case if a dispute. We couldn't find this anywhere! We read the 60-page policy wording and did a word search and it simply doesn't say. The Master Policy is also silent on this point. Where would you go to sue them? The GeoBlue rep we spoke with who had worked for the firm for 12 years couldn't answer this question!!

What it does say is that all disputes not resolved by GeoBlue's claims appeal procedure must be resolved through arbitration by the American Arbitration Association under its Commercial Arbitration Rules in King of Prussia Pennsylvania. Any attempt to use the courts would be met by a motion to compel arbitration which would be granted since it is in the agreement. Also, that the arbitration shall be final, non-reviewable, non-appealable, and binding on the parties and may be enforced by any court having jurisdiction. Don't laws have jurisdiction over contracts? Not with GeoBlue, apparently you have no appeal to a real judge, only an arbitrator in their home town. This firm doesn't trust the law except when they need to enforce a judgment! That's probably because you've surrendered rights as a member of their Global Citizen's Assoc. It is interesting that the only 2 AAA arbitrators in Philadelphia with charge out rates of $600 hourly were not interested in arbitrating a dispute with BCBS as they did not respond to enquiries. So, if you have a dispute with GeoBlue, good luck!!

It further states the Individual Certificate of Coverage describes the main features of the insurance. It does not waive or alter any of the terms of the Master Group Certificate issued to the Global Citizens Association. If questions arise, the Policy Wording or, if it is silent, the Master Group Certificate, will govern. This wording of this very short 2-page master certificate is the governing policy wording as it supersedes any other documents that you are issued with. It says in section "5.5 (b) The Certificate issued to each Insured, including the Insured's Application and any Exhibits, Schedules, Endorsements or Riders attached to it, is only an outline of the insurance provided under this Policy. The Certificate is subject to all terms and conditions in this (Master) Policy." This is very disturbing because if the policy wording is only an "outline", the Master policy doesn't actually say anything regarding benefits. I believe this structure exists to limit your right of recourse in the case of a dispute, and or is a requirement for them to operate as a US entity selling to US Citizens to dodge state by state regulation. The fact that anything

other than the Master Policy is only an outline, and no benefit is outlined in the Master Policy means theoretically they can get away with doing anything they want, and you can't sue them!

All international medical insurance policies except GeoBlue have a limit to any claim pay out under any overall benefit limit, or a sub-limit if there is one, as stated in the policy of URC. This means Usual and Reasonable Customary Costs (URC). That means if you go to a hospital that charges 3 times the going URC rate for that area or country, then you might have a problem and have to reach into your pocket. To add another nail in the coffin of GeoBlue, the amount they will pay is based on the amount they specify as their "Allowed Amount," and they warn you in their policy wording that it is not based on URC! If URC is higher than the "Allowed Amount" you have to pay the difference out of your own pocket! I'll bet the "Allowed Amount" is never higher than URC! You really never know where you stand with this company, they just make it up as they go along! Every other insurer pays the going URC rate, with Geo Blue you have no idea how much they will pay. This doesn't bode well in the case of arbitration of a dispute since they can pull anything out of their ass claiming they paid the "Allowable Amount." You are not privy to their menu of allowable amounts at any time. They can defeat any attempt at recourse through Arbitration before it gets started just by pulling out their allowable amount card. I'll bet they've never had a single Arbitration of a dispute! There's no point in playing a rigged game you are going to lose. This is a defined benefit plan where the insurer holds the defined benefits as a corporate secret! Why would anybody buy a plan like this?

Yet another nail in the coffin of GeoBlue is co-insurance, they have 20% in Network and 40% out of network charges in the USA. They limit this in their policies in addition to the deductible, but why pay any co-insurance at all if you can buy a cheaper policy with no co-insurance!

In summary the benefits of this policy are only an outline, the allowable limits of the only outlined benefits are a corporate secret, and you can't sue them if you are unhappy, only arbitrate a dispute. What is there to arbitrate, a mere outline with an allowable limit known only to them? This is a joke!

Also, this very one-sided policy can only be sold to Americans, nobody else need apply, or inflict themselves with this firm. There are expat insurance firms that have won "Plain English" Language awards for their policy wordings. GeoBlue

policy wording(s) gets our award for the most badly written and ridiculously one-sided document we've ever seen!

Epilogue, a word from the Author...

I wrote this short e-book book because it is almost impossible to get meaningful information on this subject from the internet. Also, misdirection from well meaning expats on this subject is common. Also, domestic insurance brokers in many countries have products on the shelf that they will certainly sell you, but they have no idea if there are fatal flaws in the policy wording, or if the products are any good, then they go back to selling car or household fire insurance. What we find worse is brokers that supposedly specialize in this business that sell any product good or bad, simply because they take the path of least resistance to make a sale. There's a reason why the cheapest policy is cheap, a combination of bad policy wording, and cohort setting of renewal premiums, the two policy ticking time bombs! The sad thing is, the brokers selling these products have no clue.

Recently we were perusing the site choosemexico.com and an information site for prospective expats that are interested in moving there. They have a partner expat insurance broker site in Utah that displays 9 insurers they represent on their website. Upon examination 7 of these products were fails in our opinion. Why would a product fail? Here are the reasons...

1. Bad policy wording
2. Bad domicile (as in the Turks and Caicos or Nevis)
3. Light or no regulation
4. Junk credit rating of underwriter
5. Inability to sue in the event of a claim dispute (any product that mandates compulsory arbitration of dispute resolution)

The dangerous thing for customers that buy from this broker is that he has no idea that his products fail, let alone why they fail! In many cases the 7 products fail for multiple reasons. Virtually any advert you see on the net show logos from firms whose products are fails. Caveat emptor!

At Worldexpathealth we represent firms that have...

1. Only good policy wordings
2. Gold standard domicile

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3. Gold standard regulation (that won't allow bad policy wordings!)
4. Financial Strength A rated or higher underwriters
5. Ability to sue for redress of grievance

And it should be noted that in our favourite domicile there is a government Insurance Ombudsman's Office. If you do have a claim dispute, you can take your complaint to that office. They will examine your case for free, and order the insurer to pay if they think you are in the right! You don't have to sue your insurer.

The author of this book has been an expat for 30 years in 8 countries in Asia mostly, and in Latin America now. He also attended numerous international travel and health insurance conferences, and also medical tourism conferences. He has contacts at the highest levels of the insurers he prefers, so if clients have problems, he can easily pick up the phone and trouble shoot. We specialize in this business as expats for expats.

The final word is that good policies don't cost more. We know the best combinations of good and inexpensive, and if you are looking for cover, or if you have discovered your policy has a failure point, then we invite you to start a conversation with us.

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