Head Office: First Assurance House, Clyde Gardens,
Gitanga Road, Lavington
P.O. Box 30064 00100
Nairobi, Kenya

MEDICAL INSURANCE POLICY

This Policy the Schedule and any memorandum thereon shall be considered one document and any word or expression to which a specific meaning has been attached in any of them shall bear such meaning throughout.

The Insured and the Company agree

1. The application form shall be incorporated in and be the basis of the contract
2. The Insured shall pay the Premium
3. The Company will provide the Insurance subject to the terms of this Policy
4. The Following shall be conditions precedent to any liability of the Company
   a) Observance of the terms of this Policy relating to anything to be done or complied with by the Insured or the Insured person.
   b) The truth of the proposal

Insurance

The Company will indemnify the Insured subject to the Overall Limit applicable to an Insured Person in respect of all Medical expenses necessarily incurred within twelve months of going on cover and as the direct result of an Insured person falling ill or sustaining accidental bodily injury during the Period of Insured.

The maximum amount payable by the Company for medical expenses in respect of

a) One claim or all series of claims consequent upon or attributable to one original cause shall not exceed the overall limit of indemnity applicable to the Insured person concerned.

b) Any one period of Insurance for all claims where the disease and/or illness or bodily injury becomes apparent during such period of Insurance shall not exceed the overall limit of indemnity applicable to the Insured person concerned.

The Company's liability shall be determined after the deduction of the National Hospital Insurance Fund rebate which could and should have been claimed against the Hospital.

Signed for and on behalf of **FIRST ASSURANCE COMPANY LIMITED**

Duly Authorised Signatory

1. GENERAL TERMS AND CONDITIONS

1.1 MEDICAL RECORDS

The Insurer or its agents shall hold all medical, clinical and other diagnostic patient information confidential in terms of internationally accepted practice.

1.2 AMENDMENT OF MASTER POLICY

Notwithstanding anything contained in this Master Policy, the Company shall have the right to amend, alter, rescind, or make any addition to any clause contained herein and inform all parties in writing at least one (1) month prior to amendment(s).

1.3 NOTICES

Any notice to a Member or Member's Department may be given by sending such notice through the post in a letter addressed to such a person at the last known address in the case of an individual and to an Employer in the case of an Employee. Any notice so sent shall be deemed to be served on the fourteenth (14^{th}) day following the date on which it was posted.

1.4 GEOGRAPHICAL LIMITS

This policy is valid within the Republics of Kenya, Tanzania and Uganda only.

2. DEFINITIONS

"Annual Limit" shall mean the maximum benefits to which the Member and Dependants are entitled to in terms of this Master Policy and the selected Option in respect of a Benefit Year.

"**Approval"** shall mean prior written approval by the Company.

"Benefit Year" shall mean a period of twelve (12) months from the commencement Date of policy cover. The Company may determine such other period as from time to time as may be necessary.

"Chronic Disease, illness or injury" shall mean a diagnosed chronic condition that has at least one of the following characteristics: no known cure, is recurrent, leads to permanent disability, is caused by changes to one's body which cannot be reversed or Hospitalize as life threatening, which requires one to be specially trained or rehabilitated or needs prolonged supervision, monitoring or treatment and will require ongoing medication for a period longer than four (4) months.

"Claim" shall mean the invoice indicating the amount, which the Medical Plan may pay on behalf of the Member to the Contracted Preferred Service Provider in respect of expenses incurred by the Member and his/her Dependants in accordance with the policy benefits eligible in terms of this Master Policy and the selected Option.

"Date of Service" shall mean the date on which a consultation, visit treatment, procedure or operation took place. In the event of Hospitalization, it shall mean the date of admission to a hospital.

"Dependant" shall mean:

A registered dependant described here below of such Member enrolled under the scheme and who is entitled to the policy cover of the selected Option:

One Spouse of the Member, who is legally married

- **A child who has not reached the eighteenth (18th) birthday**, who is single, not self-supporting, including a step child, adopted child and a foster child, provided that such child is not self-supporting. Children in full time education can be covered up age 26.

Subject to the discretion of the Company, the following persons, including but not limited to, shall be ***excluded*** from the definition of "Dependant": parents and parents-in-law; grandchildren; nephews and nieces; brothers and sisters; children placed with a legal guardian other than a foster child; domestic employees and their children.

"Commencement date" shall mean the 1st day of the month on which the Member and/or the Member's Dependant/s were registered onto the Medical Plan and became entitled to the policy cover in terms of this Master Policy.

"**Employee"** shall mean a person in permanent (as distinct from temporary or casual) employment with an Employer.

"**Employee"** shall mean a person in permanent (as distinct from temporary or casual)considered to be in Full Time Active Service on any day if the employee is performing or is capable of performing, in the customary manner, all of the regular duties of employment

"Employer" shall mean a corporate employer or other entity providing Employment to persons exceeding ten (10) in number.

"Employment" shall mean service in the active permanent employment of an Employer.

"Exclusions" shall mean category of treatment, conditions, services, activities and/or their related or consequential expenses excluded from policy cover in terms of this Master Policy. **See Clause 13.**

"Hospital" means any institution that meets all of the following criteria:

1. Have diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of patients and sick persons by or under the supervision of a staff of medical practitioners.

2. Provides nursing service supervised by registered nurses or nurses with equivalent qualifications.

3. Is not other than incidentally either a mental institution or a convalescent home.

4. Is not a place of rest for the aged or a place for drug addicts or alcoholics or a health Hydro or natural cure clinic or similar establishment.

5. Is not an institution providing long-term care for the blind, deaf, dumb or other handicapped persons

"Individual" shall mean the principal person who applies for the policy cover in terms of this master Policy in his/her personal capacity and not as an Employee of an Employer.

"Insurer" shall mean a registered insurer underwriting the Medical Plan.

"Medical Advisor" shall mean a person qualified as a medical practitioner or specialist who is registered with the Kenya Medical Association and is appointed by the Medical Plan to provide medical expertise on matters referred.

"Member" shall mean the principal person entitled to the policy cover in accordance with the selected Option of the Medical Plan as set out in this Master Policy, excluding any Dependant of such principal person.

"Option" shall mean the benefit structure as selected by the Policy Holder.

"Policy Holder" shall mean the person who for the time being is the legal holder of the policy for securing the contract with the Company in terms of this Master Policy, whether such person shall be an Employer, individual or any other legal or natural person, which is responsible for the payment of Premiums under this Policy**.**

"Pre-Authorisation" shall mean the written prior Approval of the Company, required for all hospital admissions, CT scans, dental and optical treatment.

"Pre-Existing Condition" shall mean any injury, illness, condition or symptoms;

(a) For which medical advice, diagnosis, care or treatment was recommended, received or was foreseeable prior to the Commencement Date on which application for membership in terms of this master Policy was made or

(b) Which originated or was known by the Insured or the Member to exist prior to the commencement date whether or not treatment or medication, or advice or diagnosis was sought or received.

"Contracted Preferred Service Provider" shall mean a Service Provider that has been contracted by the Company.

"Premium" shall mean the annual premium payable by the Policy Holder to the Company before commencement of cover.

"Prescription" shall mean the medicine, which is prescribed by a person who is legally entitled to do so for a condition under treatment, provided that such prescription shall not exceed (1) one month's supply unless approved by the Company.

"Recommended Tariff" or "Tariff" shall mean the agreed tariff between the Company and a Contracted Preferred Service Provider.

"Congenital Condition" shall mean a genetic, physical or (bio) chemical defect, disease or malformation which may be either hereditary/familial or due to an influence during intra uterine development of the foetus and which may or may not be obvious at birth.

"Preterm/Prematurity" shall mean birth occurring before 38 completed weeks of pregnancy.

"Inpatient Treatment" shall mean Treatment which requires admission in and stay in a hospital or day care surgery.

"Outpatient Treatment" shall mean Treatment that does not requires admission in and stay in a hospital or day care surgery.

"Optical Treatment" shall mean Eye care, eye examination, eye follow-up care and prescription of glasses.

"Optical Treatment" shall mean Eye care, eye examination, eye follow-up care and prescription of glasses.

"Terrorist Act" shall mean any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption, or commission of an act dangerous to human life or property, against an individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests whether such interests are declared or not. Terrorisms shall include any act, which is verified or recognized as an act of terrorism by the Government of the country where the act occurs.

3. MEMBERSHIP/MEMBER

Cover may be extended at the discretion of the Company to:

3.1 An Employee of an Employer who has been or may be accepted as a Member, subject to medical underwriting.

3.2 An Individual who has been subjected to medical underwriting and who has subsequently been accepted as a Member.

3.3 A Dependant of a Member who has been registered as such under the Medical Plan, subject to medical underwriting.

All of who must be treated within the Republics of Kenya, Uganda and Tanzania

4. TERMS AND CONDITIONS OF MEMBERSHIP

4.1 A Prospective Member shall, prior to enrolment, complete and submit to the company the membership registration form, with one (1) recent coloured passport size photograph or – not older than 6 months.

The same shall apply in respect of every prospective Dependant.

4.2 The Applicant and his Dependants shall before being admitted to membership, furnish such information as the Company may require, including detailed medical history requested and additional medical examinations.

4.3 The Member's Dependant shall be entitled to the Dependant benefits as set out in the Option benefit schedule.

4.4 A person who has not reached the eighteenth (18^{th}) birthday may not be considered as a Principal member.

4.5 Membership is restricted to a person in Formal Employment who has not reached the seventieth (70^{th}) birthdays, but who joined prior to the age of sixty five (65) years. A Member or retiree who has reached the seventieth (70^{th}) birthday is not permitted to retain his membership and the membership will lapse automatically on the Last day of the policy year of his seventieth (70^{th}) birthday.

4.6 The Company may notwithstanding anything to the contrary contained in this Master Policy.

4.6.1 Exclude any Employee, Individual or Dependant from membership.

4.6.2 Defer the acceptance of any application for membership provided that any such applicant may be re-instated on compliance with such terms and conditions as the Company may determine.

4.7 In the event that Premiums are in arrears the Company shall withhold payment of any benefit in respect of any service, for a Policy Holder. The Individual or Employer shall refund the Company in full for Claims paid by the Company under these circumstances.

4.8 The Company or its duly authorized representative shall be entitled to contact the Member and/or the Member's Dependant and/or relevant medical practitioner or Contracted Preferred Service Provider for the purpose of case management and cost containment.

4. 9 In cases of illness of a protracted nature, the Company shall have the right to insist that a Member or Member's Dependant consult a Contracted Preferred Service Provider that the Company may nominate. If the specialist's advice is not acted upon, no further benefits will be allowed for that particular illness.

4.10 The Company reserves the right at any time to exclude or impose a waiting period, the duration of which shall be decided upon by the Company regarding the cover for a Pre-Existing Condition, a Chronic Disease, Pregnancy and Childbirth and illness or ailment of the Member and/or Member's registered Dependant.

4.11 The Company reserves the right at any time to refer the Member and their Dependants to a Contracted Preferred Service Provider for the provision of treatment of an illness of a protracted nature, a Pre-Existing Condition, a Chronic Disease, Pregnancy, Childbirth and illness or ailment of the member and/or Member's registered Dependant. If the Member and/or the Member's Dependant does not act upon the Contracted Preferred Service Provider's advice or fails to consult with the Contracted Preferred Service Provider, the Company may at its sole discretion, allow no further benefit in respect of the particular condition for which the Member/Dependant was referred.

4.12 The Company reserves the right at any time to refer the Member and/or the member's Dependant to a Contracted Preferred Provider of its choice where it is of the opinion it is necessary to control the cost of Claims.

4.13 No Member and/or Member's Dependant shall be entitled to change the Selected Option during a Benefit Year. However a Member and/or Member's Dependant can change the Option at the renewal of the Policy.

4.14 On admission to the Medical Plan every Member and/or Member's Dependant shall be deemed to have acknowledged that this Master Policy and any amendments shall bind him and his Dependant thereto by virtue of his signature on the membership registration form.

5. CHANGE OF DEPENDANT STATUS AND MEMBER INFORMATION

5.1 The Member shall inform the Company within three (3) days of the occurrence of any event which results in any one of his/her Dependants no longer satisfying the conditions in terms of which he/she may be a Dependant, and the registration of such Dependant shall immediately cease.

5.2 The Member whose marital status (legal or customary) changes subsequent to joining the Medical Plan and who wishes to register his/her Dependants, is required to notify the Company within fifteen (15) days thereof. Premiums will be levied at the amended rate from the first day of the month in which they are married.

5.3 The Member who wishes to register a child as a Dependant shall notify the Medical Plan within fifteen (15) days of birth, fostering or legal adoption of a child and shall apply to the Company to register such child as a Dependant.

5.4 The Employer shall not be entitled to substituting membership with a new Employee. In such instances the new Employee shall be subjected to the rules and regulations of the Medical Plan.

5.5 The Employer and/or Member must notify the Company of any change of address. The Company shall not be held liable if Member's rights are prejudiced or forfeited as a result of his neglect to comply with the requirements of the Master Policy.

6. MEMBERSHIP CARDS

6.1 A Member shall be provided with a main membership card, containing his/her particulars and those of his/her Dependants and reflecting Commencement Date of cover and benefit option. The membership card shall be shown to the Contracted Preferred Service Provider prior to the delivery of service and a copy of the service record should be attached to the invoice to constitute a valid claim.

6.2 The membership card remains the property of the Company and shall be returned to the Company on cessation of membership.

6.3 Should the card be lost or stolen it is incumbent on the Employer/Individual to inform the Company immediately, failing which the Employer/Individual could be held personally liable for any Claims paid through misuse. The cost of producing amended/additional card(s) will charged by the Company at prevailing market rates

6.4 The utilization of the membership card by any person other than the Member or the Member's Dependant, with the knowledge or consent of the Member, is an abuse of the benefits of the Medical Plan and will be dealt with by the Company in accordance with **Clause 8.**

6.5 A registered Dependant whose membership expires. **(see Clause 7.7)**during a Benefit Year will no longer enjoy the benefits from the date when such a change happens despite his details appearing on the card of the Member.

6.6 The membership card of the Member shall be returned to the Company upon termination or expiry of membership. Any utilisation of the card to access medical services thereafter shall result in the Member, whose membership has been terminated, and the Employer, being liable in respect of the costs of such Claims.

7. CESSATION OF MEMBERSHIP

The insurance shall cease in respect of the following;

7.1 Member(s) who attain the age of sixty five (65^{th}) coincidental with the annual renewal date of this policy or otherwise at the next renewal date immediately following attainment of age 65.However the insured may be admitted as a new member subject to prior approval been provided by the company. All Corporate Members who have reached 70 years required to submit a comprehensive medical report on joining unless prior authority has been given by the Company.

7.2 The Member who ceases to be an Employee shall cease to be a Member, from the last day of Employment. In such a case all rights of the Member to medical benefits in terms of the Medical Plan shall cease from the last day of Employment by the Employer except for Claims in respect of services rendered prior to the last day of cover of the Member in terms of the Master Policy. Any additional notice period between the Employer and the Member shall not extend the policy cover of the Member.

7.3 In the event of any Member withdrawing from the Medical Plan, refunds for premiums Shall be considered in accordance with the Premium Refund Policy

7.4 The Policy shall terminate on the death of the member if there is no dependant. The continuation of insurance in respect to the Dependants shall be subject to or otherwise full premiums been paid at the time of death of a principal member.

7.6 Failure to pay Premiums will result in the termination of the policy. In such a case the Company may refuse to pay benefits in respect of any Member and/or his Dependant for so long as any amount due to the Medical Plan remains unpaid by the Policy Holder or the Member.

7.7 Other instances where the benefits of the Member's Dependants may be terminated at the direction of the Company are as follows:-

7.6.1 In the case of a spouse, whenever the spouse is divorced from the Member.

7.8 A Member shall forthwith notify the Company of any circumstances as a result of which a Dependant ceases to be a Dependant. The Member who fails to notify the Company as required shall be liable to repay to the Company any Claim that may have been paid in but which would not have been paid otherwise, plus interest on the amount from the date of payment to the date of repayment.

7.9 This Policy shall terminate automatically forthwith in the event of any contravention or breach of the Master Policy by the member or his/her registered Dependant. The Member or its registered Dependant shall not be entitled to any benefits under the Policy from the date when such a breach happens.

8. ABUSE OF PRIVILEGES AND MISREPRESENTATION

8.1 Subject to the provisions of **Clause 14**, the **C**ompany may, notwithstanding the provisions set out in the policy, exclude from benefits or terminate the Policy of an Employer, Member or Member's Dependant whom the Company finds guilty of abusing the Medical Plan at any time during the course of a Benefit Year.

8.2 In such a case the Member may be required to refund to the Company any sum which, but for the abuse of the Medical Plan, would not have been disbursed on behalf of the Member and/or the Member's Dependant.

8.3 In addition to the remedies set out in **Clauses 14.1 and 14.2** the Company reserves the right to lay the relevant criminal charges against the person, member or Contracted Preferred Service Provider, found guilty of so abusing the Medical Plan.

9. PREMIUMS

9.1 Premiums shall be paid annually in advance, in respect of contributions made by Employers on behalf of their Employees and annually in advance in respect of an individual, or as otherwise agreed upon.

10. PREMIUM REFUNDS

10.1 The refund of Premiums shall be considered at the discretion of the Company only where **NO CLAIM** has been received or paid and only in instances where the Employer for whatever reason terminates employment.

10.2 In instances where an Employer wishes to request a refund for an ex-Employee, such application must be lodged with the Company, only if payable in accordance with **Clause 11.1.** The refund of Premium shall be calculated on a pro rata basis subject no claims incurred and/or reported in respect of the particular member(s)/family for the remaining period of the policy.

11. LIABILITY

11.1 The Employer shall give the Company notice in writing of termination of Employment of each of the Member Employees leaving the Employment of the Employer and the date of such termination.

11.2 The liability of the Member shall be limited to the balance of the unpaid Premiums, not paid by the Employer, together with any sum required by the Company to be refunded to the Company in terms of Claims paid by the Medical Plan, outside the benefits to which the Member / or the member's Dependant is entitled to. In the event of the Member's policy cover ceasing, any amounts still owing by such Member shall be paid over to the Company and shall be a debt due by such a Member to the Medical Plan and recoverable by it.

11.3 The liability of the Company shall in all cases be limited to either the overall Annual Limit of the Option specified in the contract in the normal course of events or the annual Premium paid to the Medical Plan, where it is the opinion of the Company and/or its medical Advisor that fraud, abuse, over utilization or excessive Claims have occurred.

12. EXCLUSIONS

Unless otherwise decided by the Company, the Medical Plan will not pay expenses incurred in connection with any of the following:-

12.1 Treatment of sickness or injury sustained by a Member or a Dependant and for which any other party may be liable, unless otherwise provided for by this Master Policy.

12.2 Expenses incurred by a Member or Dependant in the case of or arising out of willful self-inflicted injury, attempted suicide or suicide (whether sane or insane), Members own criminal Act, Injury or sickness caused by alcohol or drug abuse diligence, intoxication, or injury sustained whilst in a state of insanity.

12.3 Expenses arising out of Psychiatric illness and/or insanity expenses shall be limited to specified percentage (%) of the limit.

12.4 Patent/proprietary (drugs available to the general public without a Prescription), costs relating to immunosuppressant drugs and homoeopathic drugs.

12.5 Patent foods or baby food inclusive of Formula Milk & Clothes, and similar aids, sunscreens, shampoos and/or treatment relating to Acne, e.g. Cleansing lotion, soaps, gels , skin cleansing remedies, Basins, Buckets ,Flannels, Bathroom Slippers, DVD-RW & Flask Disk, Oral Kit(Tooth Paste/Brush),Thermometers ,Sanitary Towels/PADS;

12.6 Domestic and biochemical remedies;

12.7 Medical costs related to or incurred in a research environment;

12.8 Cosmetic treatment , procedures or plastic surgery whether or not for psychological purposes, including but not limited to gastroplasty, bat ears, blephoroplasty, breast augmentations, dermabrasions, liposuction, part and/or full nasal reconstructions, lipectomies, face lifts and revision of scars.

12.8.1 Treatment for obesity and slimming preparations; - whether for medical reasons or cosmetic purposes, investigative procedures ,treatment of a routine nature and/or such other procedures that the Medical Advisor deems cosmetic, unless arising from an accident , in the event of trauma or cancer.

12.9 Costs arising out of Treatment for injuries of voluntary participation in riots, demonstrations, unrest and civil or other war ("declared or undeclared");

12.10 With respect to the risks and consequences of war and terrorism, all consequences of active Participation of the Insured (and/or his/her covered dependants) in operations of war and terrorism are explicitly excluded from coverage except where applicable, to the extent only of adopting or taking such action or steps as were reasonably necessary for the protection of himself, his family or their property.

12.11 Medical examinations for employment, costs in respect of examinations not incidental to diagnosis, insurance or physical fitness purposes and inoculations for international travel as well as food handlers examinations. Unless for declared medical condition approved on underwriting or for a recently diagnosed condition.

12.11.1 Costs relating to Vaccination, or any treatment undertaken or carried out as a preventative measure

12.12 Travel expenses other than emergency ambulance costs;

12.13 Holidays for recuperative purposes, cost related to Private nursing or residential stay in a private hospitals or Health Hydros other than as provided for in the benefits.

12.14 Stop smoking aids, vitamins, tonics and mineral supplements unrelated to a specific medical condition and which have not been prescribed by a doctor.

12.15 Family planning and treatment for infertility i.e. costs of treatment related to infertility, contraception and or sterilization, impotence, artificial insemination and Sex enhancement drugs.

12.16 All costs in respect of Pre-Existing & Chronic Conditions that were specifically excluded in writing when the Member joined the Medical Plan or which were not disclosed on the Members' application form.

12.17 All costs relating to the purchase of medicine or for services rendered by:

12.17.1 persons not registered with the Medical Plan, as a Medical Practitioner or as a Contracted preferred Service Provider, in the approved manner and,

12.17.2 any institution/hospital, not registered in terms of any law and as a Contracted Preferred Service Provider.

12.18 All costs arising out of injuries sustained whilst participating in extreme sports, speed contests with the assistance of any type of mechanical apparatus including, but not limited to: motor vehicle racing, motor cycle racing of any description, boat racing and ski racing, aircraft racing, diving and aerobatics;

12.19 All costs arising out of injuries sustained whilst participating in activities which are in the Company's view inherently hazardous including, but not limited to active voluntary service in any military or paramilitary organization, martial arts, parachuting, hang gliding, paragliding, bungee jumping, advanced mountain climbing, river-rafting, kayaking as well as other activities where the Member or Dependant deliberately exposes himself or herself to substantial danger;

12.20 All costs by which the Annual Limits of a Member or Dependant in respect of the relevant options are exceeded, for any treatment.

12.21 All costs arising out of Treatment by chiropractors, acupuncturists and herbalists, stays and/or maintenance or treatment received in nature cure clinics or similar establishments or private beds registered within a nursing home, sanatoria, convalescent and/or rest homes or 'cures' attached to such establishments;

12.22 All costs arising out of treatment which includes;

12.22.1 Costs relating to Private suites unless covered under the Medical Plan;

12.22.2 Costs relating to sexually transmitted/Venereal diseases including opportunistic diseases or other than payment of treatment in accordance with the benefit schedule;

12.22.3 Costs relating to circumcision unless after an accident, injury or trauma;

12.22.4 Costs relating to occupational therapy treatment out of hospital;

12.22.5 all costs related to interest charged and legal fees arising out of overdue Medical accounts unless it is proved to be as a consequence of fault on the medical Plan's part;

12.22.6 all costs relating to appointments not kept or cancelled by a Member or the Member's Dependant;

12.22.7 all costs or care relating to treatment consequential to medical procedures, Any treatment for injury, illness or disease termed as an exclusion for which the Medical Plan does not pay or non-medically necessary;

12.22.8 all costs for the boarding (lodging) of the mother in maternity cases once discharged, and boarding in any other cases unless otherwise agreed/approved by the company costs related to, diapers, basins & other personal items not payable;

12.22.9 all costs arising out of Pregnancy, childbirth, maternity benefits, abortion, miscarriage, ante-or-postnatal care, caesarean operation except for a first caesarean operation which must be certified by an independent medical examiner as being of vital necessity to the health of the mother and/or child (expenses for the baby are excluded). Expenses resulting from an existing pregnancy that was not disclosed at the inception of this insurance;

12.22.10 any costs arising out of an injury sustained by a Member and/or Member's dependant as a result of the wilful act of a family member;

12.22.11 any costs arising out of a Member and/or Member's Dependant donating any human tissue;

12.22.12 All costs or expenses recoverable under any other insurance or relating to Government Health Services Schemes of compensation e.g. National Hospital Insurance Fund (NHIF) including levies;

12.22.13 all costs relating to Prematurity, Congenital malformations and genetic related disorders;

12.22.14 all costs relating to Dental treatment (apart from Crowns, Caps, Bridges, Orthodontics, Self-prescribed scaling) or cost of dentures except for injury to natural teeth or dentures caused entirely by an accident;

12.22.15 all costs relating to Optical treatment (apart from laser eye surgery) or the cost of eyeglasses (excluding Plano lenses), except for injury to the eyes caused through an accident;

12.22.16 all costs relating to Massage (except where certified as a necessary part of treatment following an accident or illness covered under this Policy);

12.22.17 all costs relating to any claim for expenses related to an accident or illness which may have occurred prior to the effective date or illness occurring within Thirty (30) days of the effective date or to any illness where it was within the knowledge of a Member that he was suffering from it at the effective date.

12.23 Nuclear, naval, military or air force service operations or participation in operations of a planned military nature. Operations or participation in operations conducted by the civil or military authorities against bandits, terrorists or other such elements.

13. CLAIMS PROCEDURE AND PAYMENT

13.1 Every Claim submitted to the Medical Plan in respect of the rendering of any health care service as contemplated in this Master Policy, must contain the following particulars:

- Family name, initials and signature of the Member or Spouse.
- The first name of the patient as per the membership card.
- The name of the medical Plan Option
- The membership number
- The practice code/name of the supplier of the service, where applicable.
- The practice code/number/name and specialty of the supplier of the service where the service provider is in the employ or consulting on behalf of a Preferred Service Provider.
- The Date of Service.
- The nature and cost, according to the Tariff, of each service.
- Diagnosis or diagnostic code, where applicable.
- Copy of approved Pre-Authorisation when applicable.
- Copy of the service record on the Health Passport.
- The name of the referring medical practitioner.
- No photocopies or telefaxed accounts will be accepted
- Signature of the attending practitioner.

13.2 To qualify for benefits, a Claim shall be submitted to the Company not later than 90 days following the month in which the service was rendered.

13.3 It shall be the responsibility of the Member and the Contracted Preferred Service Provider to ensure that Claims submitted do not include any treatment or service related to Exclusions as per **Clause 12.**

13.4 The Member and the Member's Dependant must use the services or facilities of only a Contracted Preferred Service provider.

13.5 Where a member has paid an account to a non-service provider, the account together with the receipt and all the required Claim submission information, together with a detailed motivation, must be submitted in support of a refund. The refund, if approved, will be done according to the Recommended Tariff, if in excess of the Recommended Tariff.

13.6 Hospital admissions, scans, dental and optical treatment and any exclusion without a Pre-authorization, shall result in the non-payment of such a claim. Pre-authorization is the responsibility of the Member and the Contracted Preferred Service Provider. In the event of an emergency admission, the Pre-Authorization must be obtained from the Company within twenty fou r(24) hours of such admission or during the office hours of the first business day following a weekend or a public holiday.

13.7 Where the service of a Contracted Preferred Service Provider is utilised for Emergency Transportation, Medical Treatment, Provision of Medication and Hospitalization, the Company reserves the right to only meet Claims by such a Contracted Preferred Service Provider in accordance with the Option Benefits. This Master Policy and any amendments thereto shall take precedence over any agreements entered into with such Preferred Service Provider.

13.8 A statement setting out particulars of the circumstances in which the injury was sustained shall support Claims for treatment of injuries. It is a requirement of this Master Policy that that a Member and the staff representative of an Employer and the Contracted Preferred Service Provider certify such a Claim

13.9 The Medical Plan shall only pay a Claim, in accordance with the Tariff, on behalf of a Member or a Dependant directly to a Contracted Preferred Service Provider that has rendered such treatment or service.

13.10 Where an agreement exists between a Contracted Preferred Service Provider and the Company, the Company will pay the Contracted Preferred Service Provider directly for the services rendered. Such payment shall be made according to the selected Option and the Tariff.

13.11 Where the Medical Plan has paid an account or portion of an account, or any benefit, to which the Member or Dependant is **NOT** entitled, whether payment is made to the Member or to the Contracted Preferred Service Provider, the amount of any such overpayment shall be recoverable from the payee.

13.12 Unless otherwise agreed to by the Company, a Claim not in accordance with the Recommended Tariff shall not be paid. The Company may pay directly to the Member the benefit to which the Member may have been entitled to, had the account been rendered in accordance with the Recommended Tariff. Any outstanding balance due to the Contracted Preferred Service Provider shall be payable by the Member/Employer.

13.13 Where the Company is of the opinion that a Claim is incorrect or unacceptable for payment based on this Master Policy, the Company shall notwithstanding the provisions of any other clause herein, notify the Member, Employer and the Contracted Preferred Service Provider, within (30) thirty days after receipt thereof and shall state the reasons why such Claim is incorrect or unacceptable for payment. The member and/or the Service Provider shall thereupon return such corrected Claim as provided for in **Clause 13.1** during the time frame provided for in **Clause 13.2.**

13.14 The member must disclose to the Company any amount, which has been recovered or may be recovered by the Member as compensation from any other insurance or any other source, in respect of any illness or accident. Such amount shall be deducted from the Claim payable by the Company in terms of the Option benefits in respect of such accident or illness, provided that the Company may in its discretion decide in any particular case to make such deductions or make part of such deduction only.

13.15 The Medical Plan shall not pay any Claim pertaining to any Exclusion, see **Clause 12,** for which a Member and/or Dependant has received treatment. In such a case the payment for such treatment shall be payable directly by the Member or Employer to the service provider.

14 DISPUTES

14.1 The decision of the Medical Advisor will be prima facie proof of any of the following facts:

14.1.1 The nature of any physical defect, physical deficiency or injury in a Member or member's Dependant (all of which shall hereinafter be referred to as the "Condition").

14.1.2 The nature of any service required dealing with the Condition.

14.1.4 The level, type and duration of the service appropriate to any Condition.

14.1.5 Whether the place or treatment facility is appropriate to any particular Condition.

14.1.6 The occurrence or otherwise of any abuse of privilege including but not limited to fraud, abuse or unnecessary utilisation of medical benefits.

14.1.7 Any dispute arising out of the provision of benefit shall be referred to the Medical Advisor.

14.1.8 The Parties in any dispute referred to in **Clause 15.2** above shall have the right to be heard either in person or through a representative.

14.1.9 Process in any legal proceeding against the Company may be served at the registered office of the Company. The legal costs related to any legal proceedings shall be carried by the claimant, unless specifically otherwise determined by a Court with jurisdiction.

15. BENEFITS

15.1 The Medical Plan consists of the Options as specified in Annexure A hereto as amended from time to time.

A).In-patient benefit

i. Hospital treatment and services:

All necessary medical treatment and services provided by or on the order of a Physician to the Member when admitted as a registered general patient to a hospital. Cover includes hospital accommodation (up to the cost of general ward bed in that hospital), nursing care, diagnostic, laboratory or other medically necessary facilities and services, physician's, surgeon's, anaesthetist's or physiotherapist's fees, operating theatre charges, intensive care unit charges, specialist consultations or visits and all drugs, dressings or medications prescribed by treating medical advisor for in-hospital use.

ii. Day Case Surgery.

iii. Pre-Hospitalisation Diagnostic Services.

Diagnostic laboratory testing, scans (X-ray, CT-Scans, MRI, electrocardiograms, electroencephalograms) or other necessary medical diagnostic procedures ordered by a medical advisor, specialist or consultant and which results in the Member being admitted (on the same day the tests are done) as a registered general patient to a hospital for treatment of the specific medical condition diagnosed, provided that such medical condition is covered.

iv. Local Road and Air Ambulance Services:

Ambulance services for transportation of a sick Member to the nearest center of medical excellence in the event that treatment is not available or from an area where facilities for adequate care do not exist will be covered within the annual inpatient limit.

Cover for in-patient services are subject to the annual maximum limit.

B).Out-patient benefit

Medically necessary treatment and planned procedures, consultations or tests that are carried out by a specialist or general medical advisor but do not require an overnight stay and defined as:

i. Out-patient Services

Outpatient services provided by or on the order of a Medical advisor who is licensed as a general practitioner, specialist or consultant and to whom the member has been referred.

ii. Diagnostic Services

Diagnostic laboratory testing, radiographic and procedures used to diagnose or treat medical conditions. Such services must be provided or ordered by a Medical advisor and must be covered.

iii. Outpatient Prescriptions

Drugs and medicines, the use of which is restricted to the order of a medical advisor and prescribed for the use by the member as an outpatient.
Cover for outpatient services are subject to the annual maximum limit.

C).Maternity benefit

Cover will be extended to the Member for the proportion of expenses arising from childbirth provided the Member is admitted in a hospital as a general patient. The benefit shall cater for delivery fees, consultation and treatment for both mother and child only during the period of confinement/admission in hospital. All cost arising out of miscarriage and abortion provided that such abortion shall be certified by a gynecologist and/or a psychiatrist as being necessary to preserve the mental and/or physical health of the mother shall be covered.
The company reserves the right to require the **mother** to be examined by a medical advisor or specialist of its choice. The benefit is not available for dependant children.

Unless otherwise decided the Medical plan will not pay expenses in respect of:

(i) Expenses resulting from use of incubators for premature babies or babies born with deformities.

The total coverage under this clause in any one period of insurance shall not exceed the annual maximum limit

D).Optical Benefit

Cover will be extended to the Member for the proportion of expenses arising from the cost of eye glasses, eye testing and provided that the total coverage under this clause in any one period of insurance shall not exceed the annual maximum limit.

Unless otherwise decided the Medical plan will not pay expenses in respect of:

i. The replacement of frames unless directly caused as a consequence of an accident giving rise to an injury to an eye.

ii. The replacement of lenses unless necessitated in the course of further treatment in connection with the contingency insured hereby.

E).Dental Benefit

Cover will be extended to the Member for the proportion of expenses arising from the cost of dental consultation resulting in treatment expense, inclusive of anaesthetist's fees, hospital and operating theatre costs.

Unless otherwise decided the Medical plan will not pay expenses in respect of:

i. The cost of replacement or repairs of old dentures, bridges and plates unless damage to the said dentures, bridges and plates arises as the result of bodily injury sustained by the Member caused solely and directly by accidental external and visible means.

ii. The cost of orthodontic treatment of a cosmetic nature unless such treatment becomes necessary as the result of bodily injury sustained by the Member caused solely and directly by accidental external visible means or as a result of disease other than normal decay

The maximum amount recoverable in any one filling or extraction and the total coverage under this benefit in any one period of insurance shall not exceed the annual maximum limits.

F).Excess Of Loss benefit

The company will cover expenses incurred by a Member after limits under the in-patient has been exhausted. The maximum liability shall not exceed the specified maximum limit.

Deleted

G).Last Expense benefit

The company shall, upon written notification of the death of a Member while this Policy is in force, pay to the Insured or such other person or persons as the Insured may in writing direct, the amount specified in the Schedule to cater for the funeral expenses.

15.2 The Member may request an Option change only after a benefit year.

15.3 A Member and/or his Dependant are entitled to benefits under the Policy as per the Option, which has been chosen and paid for

16.1 Overall Limits.

16.1.1 Each benefit group has specified Annual Limit, which will be applied to either the Member or the registered Dependants. The annual Limits differ according to the Option chosen by the Member.

16.1.2 The Member who joins the Medical Plan during the course of a benefit year will have Benefits and Annual Limits pro-rated on a monthly basis from the date of joining.

16.1.3 Notwithstanding anything contained in this Master Policy, benefits payable from one Option are not transferable to any other existing Option.