

INDIVIDUAL & FAMILY

INSURANCE POLICY DOCUMENT



ALL YOU NEED TO KNOW

Regulated by IRA



PREAMBLE

WHEREAS the Insured named in the Policy Schedule has applied to AAR Insurance Kenya Limited through a signed proposal form (hereinafter referred to as the Company) for the medical insurance (hereinafter specified in respect of the Insured) and their dependants (hereinafter referred to as the Members) and has paid the premium as consideration for such insurance.

NOW THIS POLICY WITNESSES that subject to the terms, conditions and exceptions contained herein or endorsed hereon and the benefit limit stated in the Schedule, and further subject to reasonable and customary charges, the Company will cover the Members medical expenses as herein defined in Section 2 - A, B, C, D, E, F, G, H and I (as selected by the Insured at the commencement of the period of Insurance) as the direct result of a Member;

- (a) Sustaining accidental bodily injury during the period of insurance
- (b) Suffering Illness and/or disease during the period of insurance
- (c) The proximal cause of the accident/illness being an insured event

PROVIDED that as a condition precedent to the attachment of this insurance the Member shall have submitted, and the Company shall have accepted a Membership proposal/Application Form which shall be deemed to be incorporated herein and form part of this Contract.

The insurer and the Member shall be deemed to have disclosed all material facts relating to the risk insured by this policy in the Proposal Form, Application Form or separately in a letter. In the event of misrepresentation or non-disclosure of such facts the Company shall be entitled to;

- (a) Avoid this policy and all premiums paid in respect of the Member so affected shall be forfeited.
- (b) Seek from the member to be reimbursed all costs incurred by the company as a result.

Dated at Nairobi this _____ day of 20 _____

Authorised Officer _____

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DEFINITION



DEFINITIONS

In this policy, the following words and expressions shall have the following meanings as governed by the Company;

"Accident" shall mean any single unexpected external event, not being deliberately self-induced, occurring to a Member which immediately gives rise to a medical condition that did not previously exist, and which requires medical hospitalization and or treatment.

"Annual Limit" shall mean the maximum benefits to which the insured is entitled to in terms of this Policy document and the Health Plan (benefit schedule attached) joined in respect of a benefit year.

"Bed Limit" shall mean the cost of accommodation including the standard meals served by the hospital.

"Benefit Limit" This is AAR's liability as limited in events and amount to the limits and sub-limits specified in the Schedule / Health Plan as applying to each item or type of cover provided. The overall maximum limit stated thereon is the maximum amount recoverable under this Policy as a whole by any Member during any one period of insurance and in total in respect of any one covered claim or event

"Chronic Disease" means a medical condition which has at least one of the following characteristics:

- Has no known cure
- Is likely to recur
- Requires palliative treatment
- Needs prolonged monitoring/treatment
- Requires specialist training/rehabilitation
- Is caused by changes to the body that cannot be reversed

"Claim" shall mean the amount, which the Policy may pay to the member or Preferred Provider in respect of expenses, incurred by the Member and/or Dependent in accordance with the policy benefits eligible in terms of this Policy and the benefit schedule attached.

"Congenital abnormality" means a medical condition that is present at birth or before birth or is believed to have been present since birth. The condition could be inherited or caused by an environmental factor (i.e. regardless of cause)

"Commencement date" shall mean the date on which the Member Policy application is accepted by the Company and given as the date from which cover is effective.

"Compliance" shall mean adhering to treatment and lifestyle protocols as defined, determined, and Prescribed by the Company and can change from time to time.

"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 at a hospital.

"Dependant" shall mean:

- **"Spouse"** shall mean husband or wife of the Member as defined by the Kenyan law.
- A child who has not reached the eighteenth (18th) birthday, who is single, not self-supporting, including a stepchild, adopted child and/or a foster child. In the case of a foster child, the child will be required to have lived with the foster family before being accepted as a dependent and an affidavit sworn before a Commissioner for Oaths must be provided confirming a long-term relationship.
- A disabled child above 18 years, who due to mental or physical disability is not self-supporting,
- A child who has reached the eighteenth (18th) birthday, who is unmarried, is not self-supporting, has not reached the twenty fifth (25th) birthday and who is a full time student.
- Subject to the discretion of the Company, the following persons, including but not limited to, shall be excluded from the definition of "dependant": siblings, parents, parents-in-law; domestic employees and their children.

"Dental" shall mean medically indicated treatment to and for teeth.

"Dentist" shall mean a dental practitioner registered under the Medical Practitioners and Dentists Act.

"Effective Date" is the date that this medical insurance cover commences as shown on the Policy Schedule.

"Elective" shall mean a medical procedure that is performed by choice, as opposed to an emergency lifesaving procedure. Timing of the procedure may also be arranged to be mutually convenient for the patient and medical practitioner.

"Emergency" shall mean a sudden unexpected situation in which a Member requires immediate hospitalization and treatment to prevent a medical

condition that arises from Accident, injury or sudden illness that could result in death or serious impairment of bodily functions

"Evacuation" shall mean the transportation of a Member from a hospital in one geographical region. to another where medical facilities are considered by the Company to be inadequate for the medical case to a hospital in another geographical region where facilities are deemed adequate to manage the case.

"Exclusions" shall mean the conditions and/or services not covered by the policy.

"Health Plan" shall mean the benefit as selected by the member in terms of the subset of benefits as published from time to time.

"Hospital" means an establishment legally licensed as an institution for providing treatment under the laws of the country in which it is located.

"Illness" shall mean a state of physical and/or mental health.

"In Force" The Policy is in effect for the medical benefits specified in the Schedule.

"Inpatient" shall mean when a member or dependants is confined to a hospital facility for management that would not otherwise be treated as outpatient. The cost shall be recovered from the members hospitalization benefit.

"Insurer" shall mean the registered institution underwriting the policy.

"KEPI" shall mean Kenya Expanded Programme for Immunization.

"Lapse" means membership not renewed from the date of expiry.

"Loss date" shall mean the date when medical treatment regardless of where it is given.

"Maternity" shall mean the period during pregnancy and six weeks after delivery of the baby.

"Medical Advisor" shall mean a person registered as a medical practitioner under the country's Medical Practitioners' and Dentists Act and is appointed by the Company to provide medical expertise on matters referred to him or her.

"Medical Examination" shall mean a "head to toe" examination by the doctor approved by AAR Insurance and Laboratory tests (prescribed/ advised by the company whose results will be recorded in the manner prescribed by the company. The provider will give the member the Completed Medical Form

(Medical report), discuss with the member the findings of the medical. The onus lies with member to ensure that the medical report reaches the Company.

"Medically indicated/ medical necessity" means treatment prescribed by the member's medical practitioner, attending specialist/consultant, which is appropriate for the medical condition and is in accordance with accepted medical standards.

"Members" A Member shall be any person who with the prior consent of the insurer shall have applied to the Company for membership by submitting an application form and a declaration of health and whose application shall have been accepted in writing by the company, the terms, conditions, limitations and exceptions of this policy shall apply to every member unless otherwise specified.

"Optical" shall mean the benefit governed by Company protocol that covers for visual aids caused by the deterioration of eyesight and disease of the eye.

"Outpatient" shall mean any treatment and management of a patient that does not require medically indicated overnight confinement or stay in a hospital facility.

"Peer Review" shall mean team of doctors contracted by the Company to analyze and review medical cases.

"Permanent Total Disablement/ Disability" shall mean a medical condition not existing prior to the Accident, injury or illness immediately preceding hospitalization, which the Company has specifically agreed to provide for, and which condition in the Company's opinion precludes any possibility of a Member continuing to lead his former life and/or return to his previous employment after discharge from hospital.

"Policy" shall mean the written contract made or agreed to be issued by the company which includes the terms limitations, exceptions and conditions as specified on the application form, the policy document and policy schedule.

"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 Policy, whether such person shall be an Employer, individual or any other legal or natural person, who is responsible for the payment of premiums and who is responsible for signing the proposal form.

"Policy Review" shall mean the Company reserves the right to review the Member's Policy (Financial and Medical Underwriting). This review should be communicated in writing to member.

"Pre-Authorization" shall mean the written prior approval of the Company, required for all inpatient and outpatient occurrences as determined by the Company.

"Pre-existing Condition" shall mean either:

A medical condition which a Member had, knew or ought reasonably to have known and can be medically proven they had before becoming a Member of the Company either for the first time, before renewal, before reinstatement or before upgrading cover.

Any ailment/condition diagnosed within the first 180 days of joining cover and/or

Any known ailment that existed in any previous year of cover.

"Preferred Provider" shall mean a medical provider that has been appointed by the Company by means of a written agreement.

"Premium" shall mean the financial consideration payable by the Policy Holder to the Company for the Policy approved by the Company.

"Prescription" shall mean the medicine, which is prescribed by a registered medical practitioner and approved by the Company to do so for a condition under treatment, provided that such prescription shall not exceed one month's supply unless approved by the Company and in the case of inpatient treatment shall not exceed fourteen days.

"Professional Sports" shall mean a sport which remunerates a player as a means of livelihood.

"Reasonable and Customary" shall mean those services, costs or charges which do not exceed the general level provided or charged in the locality where the service, cost or charge is provided or incurred, when furnishing comparable treatment, services or supplies to individuals of the same sex and of similar age and income, for a similar disease or injury.

"Recommended Tariff" or "Tariff" shall mean the agreed fees between the Company and a Preferred Provider

"Rehabilitation" means treatment aimed at restoring health and/or mobility in order to allow the member to live a more independent life after a definite diagnosis and management. These will

include but not limited to crutches, corsets, in-sole inserts, wheelchairs, prosthesis, physiotherapy, occupational therapy and home nursing.

"Reinstatement" shall mean a member starting cover afresh after the cover has lapsed for more than 30 days. Terms and conditions of new membership apply including the applicable waiting periods.

"Reimbursement" shall mean the Company refund to a Member for pre-authorized services provided in an area with no Preferred Provider.

"Renewal date" means the anniversary of the commencement date of the health plan as specified on the valid Policy document and/or schedule

"Rescue" shall mean the ground or air ambulance transportation of a Member who has suffered a serious medical Emergency from the scene of the Emergency to the nearest suitable hospital where stabilization and management of the condition can be provided.

"Resident" shall mean domiciled in Kenya.

"Suspension" shall mean the temporary denial of medical services by the Company at its discretion.

"Termination" shall mean the cessation of the contractual relationship between the Company and the policy holder.

"Territorial scope" shall mean East Africa i.e. Kenya, Uganda and Tanzania.

"Treatment" means any medically necessary surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve, or cure a medical condition.

"Treatment Overseas" shall mean medical or surgical treatment offered to a Member outside the Territorial scope.

"Visit" shall mean the appointment with a medical Professional, from an approved medical provider.

"Waiting period" The period from the commencement date during which a Member is not entitled to any benefit except in the event of an accident as per the Policy Schedule.

"We, Us, Our" means AAR Insurance (K) Ltd

Words importing the singular number shall be deemed to include the plural number and vice versa. Where the context so admits, words denoting the masculine gender shall be deemed to include the feminine.

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SUMMARY OF BENEFITS



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A. INPATIENT BENEFITS

The company will indemnify the insured for medical expenses listed below as per the Recommended Tariff up to a maximum of the benefit limit as specified in policy schedule, provided the services were received at the Preferred Provider approved by the Company and that Pre-authorization has been obtained in writing:

1. Hospital accommodation fees, theatre fees, drugs, injections, material, dressings and materials used in theatre. Member's maintenance in any Hospital, Nursing Home or Sanatorium is subject to a second opinion by the Company's appointed medical advisor.
2. Costs of services provided by general practitioners, specialists, technicians and physiotherapists in hospital only.
3. Radiology, pathology, and blood transfusions in hospital (scans and MRI's are subject to Pre-Authorization by the Company).
4. Medication on discharge, "To Take Out", which is subject to maximum dosage for a fourteen (14) day period.
5. Intensive care and High Dependency Unit fees, subject to written reconfirmation with the Company every forty-eight (48) hours.
6. Road ambulance and rescue services to hospital. Cost of other transport or airfares for journeys within Kenya incurred in case of emergency in an attempt to save human life.
7. Hospitalization excludes consultations and all treatment prior to and after the period of hospitalization.
8. The company shall provide to the discharged Member one consultation to the Medical Advisor Post hospitalization.
9. Attendance of a qualified Nurse at the residence of the Member, when confined to bed by a doctor's directive.
10. Day Care Surgery.

The Company must be fully informed of and approve scheduled hospital admission at least forty-eight (48)

hours before such admission, and in the event of an Emergency, not later than twenty-four (24) hours after admission to hospital.

The Company shall reserve the right to a second medical opinion from a Peer Review or a team of specialist medical practitioners.

The company's liability shall be determined after the deduction of any National Hospital Insurance Fund (NHIF) rebate, which could and should have been claimed against the Hospital. All claims payable by the company shall be paid after NHIF deductions.

SPECIAL EXCLUSIONS

The company shall not be liable for payment in respect of: -

1. Expenses incurred in connection with and/or incidental to normal or abnormal Pregnancy and childbirth, miscarriage, abortion or any disorder of the reproductive system, including infertility, arising directly or indirectly from pregnancy unless otherwise specified in the benefit schedule
2. Expenses incurred in connection with Home Nursing or accommodation charges for any residential stay in hospital or registered nursing home which is arranged wholly or partly for domestic
3. Reasons or where treatment of any disease, illness or injury is not required or which could reasonably be provided whilst living in a normal place or residence, accommodation for permanent residence in a nursing home or hospital, a period of quarantine or isolation.

TREATMENT OVERSEAS**Emergency Treatment Overseas**

When the Member is temporarily outside the territorial scope, he/she is entitled to only emergency inpatient services and benefit to a total value limited by the stated maximum sum applicable to the relevant Health Plan. This entitlement only extends to one or more periods abroad totalling not more than forty-five(45) days in any one visit or in event of the visit

exceeding this total, it applies to the first forty-five (45) days abroad. The Company will not provide any outpatient, scheduled or non-Emergency hospital services outside the territorial scope. For North America, Europe and Australia the company will only meet fifty percent (50%) of the hospitalization cost or where the benefit limit is reached fifty percent (50%) of the benefit limit as per benefit schedule. This benefit shall be on a reimbursement basis and is not available for outpatient benefit.

Scheduled Treatment Overseas

The Company will indemnify the Insured for any costs incurred for a medical condition that warrants referral for treatment overseas provided the treatment is not available in Kenya and it is certified by the Company's independent Medical Practitioner as being necessary in advance of such travel and treatment. There has to be written authorization from the Company approving the overseas referral. Such referral will be to the Company's preferred provider at the recommended tariffs.

B. RESCUE AND EVACUATION:

The Company shall, on being notified of an Emergency that requires Rescue, arrange for a Company approved air or ground ambulance to undertake the Rescue of the Member.

The following terms and conditions shall apply;

1. Whenever it deems necessary, the Company shall endeavour to ensure that a qualified Doctor and/or nurse are on board the air or ground ambulance undertaking the Rescue.
2. Depending on the severity of the injury or illness a Member may be flown either as a passenger on a commercial airline or on a chartered aircraft. The Company will base the decision on the medical and logistical circumstances of the case.
3. The aircraft captain undertaking an air rescue shall have sole discretion to decide how evacuation shall be undertaken. The Company will not be liable for injury or loss suffered by a Member as a result of this decision.
4. The Company shall endeavour to transport an ill or injured Member directly to a destination to enable him to receive medical attention at a suitable hospital. If for any reason beyond the control of the Company or if in the opinion of a doctor or the aircraft captain the condition of the ill or injured person is such that it is necessary to terminate the flight or depart from the flight schedule or change the airfield of destination, the Company and the Member shall be deemed to have authorized such termination, departure or change as the case may be without thereby incurring any liability.
5. The Company shall not be liable for any injury or loss suffered by a Member if the Rescue or hospitalization is delayed, hindered or prevented by any circumstances whatsoever beyond its control including but not limited to acts of war, civil commotion or strife, lock-outs, stoppages or restraint of labour from whatever cause whether partial or general, government interference or restrictions, acts of God, compliance with international, national or local civil aviation regulations or any other regulations having the force of law, adverse weather conditions or the immobilization of aircraft or ground ambulance for any reason whatsoever, or breakdown in or failure of communications for any reason.
6. The Company shall not be liable for any injury or loss sustained by a Member in the course of undertaking a Rescue save as provided by the Carriage by Air Act (Kenya Act No. 2 of 1993) or the relevant Carriage by Air legislation in the local jurisdiction.
7. The Company will only undertake a Rescue or provide medical services if a Member is seriously injured or ill and thus requires immediate hospitalization. The Company may charge back and recover from a Member the full cost of a Rescue or hospitalization in circumstances where The Company would not have judged such Rescue or hospitalization was not necessary had it been correctly appraised of the medical condition of the Member prior to such Rescue or hospitalization, or if in its opinion the Accident,

injury or illness giving rise to such Rescue or hospitalization could have been prevented or its consequences mitigated by the Member taking due and reasonable precautions which he failed to do. Whether or not a particular medical case falls into any particular category will depend upon the circumstances of the case. The company will seek to recover from the member the full cost of a rescue or hospitalization where it deems that the said rescue was not an emergency or was as a result of a self-inflicted injury and an injury arising out of negligence.

8. The Company will facilitate the provision of Reasonable and Customary care, and other medical services and treatment when transporting the Member to hospital. The costs of all these services together will be limited by the annual limit applicable to the relevant benefit. The Company has the right to decide who shall provide the appropriate service.
9. The Company will only provide evacuation to a Member who is entitled to such service and who is so ill or injured that his life is in immediate danger and who cannot obtain adequate medical treatment in the geographical region where the Emergency arises. The Company will decide on the necessity for such Evacuation in consultation with the treating Medical Advisor. The Company will pay for any one parent or guardian of a Member who is under eighteen years of age to accompany him.
10. The Company reserves the right to seek the advice of its own medical advisor whose opinion will be binding upon all parties to the contract.
11. The Company's maximum liability shall not exceed the annual limit stated in the Schedule.

C. MATERNITY BENEFITS (Where applicable)

The Company will indemnify the Member the proportion of expenses shown on the Policy Schedule arising from childbirth provided the Member is admitted in a hospital. The benefit shall cover delivery fees, consultation and treatment for both mother and child during the period of confinement/admission in hospital.

The Company shall also pay for cost arising out of miscarriage, complications during pregnancy and abortion provided that such abortion shall be certified by a gynaecologist and/ or a psychiatrist as being necessary to preserve the mental and/or physical health of the mother. The Company reserves the right to require the mother to be examined by a specialist of its choice.

The Company shall not be liable for payments in respect of expenses resulting from any existing pregnancy within the waiting period. The total amount payable under this section in any one period of insurance shall not exceed the maternity limit specified in the policy Schedule. This benefit only applies to the principal or spouse

D. OUTPATIENT BENEFITS (Where applicable)

The medical expenses listed below shall be considered for payment at the Recommended Tariff as agreed to between the Company and the Preferred Provider, up to a maximum of the benefit limit specified in the schedule of the selected option, provided that treatment rendered by the Preferred Provider was approved by the Company:

1. All general practitioners and specialist consultations, treatments, and investigations (inclusive of pathology and x-ray) provided. This includes outpatient visits, out of hospital consultations and procedures in rooms.
2. Medication prescribed by the general practitioner and/or specialist and dispensed by an approved pharmacist.

The following terms and conditions shall apply;

- Specialist Treatment. When a medical case is referred by a General Practitioner (GP) the Member shall be referred to the Company's panel of Preferred Provider. The referral shall be accompanied by authorized documentation.
- Child vaccinations will be as per the KEPI list, must be obtained from the prescribed providers and will count as a visit.

- Nutritional Services and advice include a consultation by a Nutritionist included in the Company's panel of preferred providers.
- Antenatal care is Care of pregnancy and pregnancy related conditions from conception to delivery. Covered under antenatal care is antenatal profile ultrasound, management of complications related to pregnancy and supplements as per the Company's guidelines.
- Postnatal Care is the period from delivery to six (6) weeks after delivery. This covers delivery related complications excluding contraceptive management.

All of the above benefit are subject to the overall limit and internal sub-limits as stated in the schedule, co-payment, excess, visit fees and levy where applicable as published from time to time.

SPECIAL EXCLUSIONS

The Company shall not be liable for payments in respect of:

1. Consultant's Fees unless reference to the Consultant is through the patient's General Practitioner who is in the panel of the Company's providers.
2. Drugs dispensed by a medical Practitioner unless he has been approved by the Company to do so.

E. DENTAL EXPENSES: OUTPATIENT ONLY (Where applicable)

In consideration of the payment of an additional premium the Company will indemnify the Member for the cost of dental treatment described below:

The cost of Dental Consultation resulting in treatment expenses, inclusive of Anaesthetist's fees, Hospital and Operating Theatre cost, covering Consultation, Simple extractions, Difficult extractions, Fillings (temporary, permanent, amalgam, composite, GIC), Scaling and polishing, Gum surgery, Root canal treatment, Pulpotomy & Minor Oral surgery. The cost of Dental Treatment to the teeth or damage to dentures caused solely by accidental external and

visible means or as a result of disease other than normal decay.

SPECIAL EXCLUSIONS

The Company shall not be liable for payments in respect of:

1. Dentures, bridges and plates unless damage to the said dentures bridges and plates becomes necessary as the result of bodily injury sustained by the Member caused solely and directly by accidental external and visible means.
2. 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 and visible means or as a result of disease other than normal decay.

The maximum amount recoverable in any one Period of Insurance shall be subject to the Limits of Indemnity specified in the policy schedule.

F. OPTICAL EXPENSES: OUTPATIENT ONLY (Where applicable)

In consideration of the payment of an additional premium the Company will indemnify the Member for the cost of eye treatment, prescribed lenses, Dioptre power +/- 0.25 D and more, one pair of frames per person per year, lenses may be replaced in the course of membership year to the maximum benefit per member for the year.

The maximum amount recoverable in any one Period of Insurance shall be subject to the Limits of Indemnity specified in the policy schedule.

SPECIAL EXCLUSIONS

The Company shall not be liable for payments in respect of:

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

2. The replacement of lenses unless necessitated in the course of further treatment in connection with the contingency insured hereby.
3. The cost of contact lenses

G. LAST EXPENSE

The Company will pay the Insured in respect of funeral expenses provided that the total payment in any one period of Insurance shall not exceed the limit stated in the policy Schedule and the cause of death is a condition that is covered.

The company shall, upon written notification of the death of a Member while this Policy is in force, pay to the Insured's appointed beneficiary the amount specified in the policy Schedule to cater for the funeral expenses.

H. SUPPLEMENTARY BENEFITS OR EXTENSIONS (Where applicable)

a. Personal Accident cover

It is hereby agreed that if during the period of insurance an Insured Person shall sustain Accidental Bodily Injury resulting solely and independently of any other cause within 24 calendar months and additional premiums for this benefit is accepted, the Company will pay to the Policyholder or their legal representatives the amount of benefit specified in the Schedule of Benefits.

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GENERAL EXCLUSIONS



GENERAL EXCLUSIONS

The Company shall not be liable in respect of: -

1. Any expenses for which the Member has been or can be reimbursed from any other Insurance or source including benefits received under any Workmen's Compensation Act or Government Schemes or Compensation except in respect of any excess of expenditure beyond the amount recovered from such other Insurance or source.
2. Any claim by or on behalf of any Member whose application for Insurance shall contain any misstatement or on whose behalf any material information shall have been withheld.
3. Any claim for expenses relating to any contingency arising whilst the Member is outside the territorial limits of East Africa, but this limitation shall not apply to any Member temporarily abroad on holiday or business, provided such period does not exceed forty- five (45) days in any one visit during the period of cover.
4. Expenses incurred in connection with Examinations for check-up purposes not incidental to diagnosis of a sickness or accidental bodily injury such as general health examinations, scans of any nature and / or expenses incurred in connection with any form of immunization / vaccination or any other form of disease / illness prevention test for basic health check Medical examinations for insurance or physical fitness purposes or costs in respect of examinations and inoculations for international travel unless where specified in the policy schedule.
5. Eye treatment and/or testing or the cost of eyeglasses or contact lenses and all associated services and products, hearing tests or the cost of deaf aids unless specified as covered under the benefits schedule.
6. Dental treatment, preventative dental examinations, prophylaxis treatment, scraping, scaling, cleaning, polishing, dentures, false teeth and/or orthodontic treatment, semi- precious or precious crowns unless specified as covered under the benefits schedule.
7. Expenses incurred in connection with congenital defects or anomalies unless declared at inception of cover, intentional self-injury or illness, deliberate exposure to exceptional danger (except in an attempt to save human life) or the Member's own criminal Act or resulting from dissipation or drunkenness, treatment of chronic alcoholism, intoxication, the use of drugs not prescribed by a physician or drug addiction. Patent/proprietary drugs (non-prescription drugs available to the general public without a prescription) and homoeopathic drugs, alternative medicine and hormonal replacement therapy, vitamins, tonics and mineral supplements.
8. Expenses incurred in connection with senility, insanity or conditions of a chronic or recurring nature unless specified in the policy schedule as covered.
9. Expenses incurred in connection with infertility, artificial insemination and enhancement of fertility or family planning. Any type of infertility treatment, contraception, sterilization or fertilization, treatment for sexual problem (including impotence, whatever the cause), sex changes assisted reproduction (e.g. IVF treatment), unless otherwise provided for under the terms and conditions of the health plan.
10. Expenses incurred in connection with convalescence, unless directly incidental to continued treatment prescribed by a doctor and falling under section 2.
11. Expenses incurred directly or indirectly as a result of a Member: -
 - a. Committing or attempting to commit suicide whether felonious or not or any wilful self-inflicted injury.
 - b. Operating, learning to operate or serving as a member of a crew of any aircraft or travelling in any aircraft being used for sky riding, racing, testing or exploration or engaging in aviation (other than as a fare-paying passenger in a fully licensed standard type of aircraft operated by a recognized Airline on a regular air route or in a fully licensed standard type aircraft, operated by a recognized Air Charter Company).
 - c. Involving in motorcycling on machines of greater than 125 c.c, polo, racing on horseback or riding and/or driving in any kind of race.

- d. Participating in 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.
- e. Involvement in professional sports, league sports, winter sports, hunting, mountaineering necessitating the use of ropes or guides or any especially hazardous pursuit unless covered under the benefits schedule.
- f. Participating in armed forces service or operations.
- 12. Any claim in connection with any injury or disablement directly or indirectly caused by or contributed to by participation in: -
 - a. Riot, strike demonstrations, unrest or civil commotion.
 - b. Civil war, political unrest or strife, rebellion, revolution, insurrection or military or usurped power.
 - c. Any declared or undeclared war or the like, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not).
 - d. Nuclear fission, ionising radiation or contamination by radioactivity from nuclear fuel or waste.
 - e. 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, skiing, river-rafting, kayaking as well as other activities where the member or dependent deliberately exposes himself or herself to substantial danger.
- 13. Any losses or damages arising directly or indirectly from any acts of terrorism.
- 14. Unless otherwise decided by the Company, the Policy will not pay expenses incurred in connection with any of the following:
 - a. Treatment of sickness or injury sustained by a member or a dependent due to their NEGLIGENCE.
 - b. Treatment of obesity and slimming preparations.
 - c. Patent foods, special diet, weight control or baby food, baby supplies and similar aids, sunscreens, shampoos, medicated soap and skin cleansing remedies.
 - d. Domestic and biochemical remedies.
 - e. Medical costs related to or incurred in a research environment and clinical trials.
 - f. Cosmetic procedures including but not limited to gastroplasty, bat ears, blephoroplasty, breast augmentations, dermabrasions, liposuction, part and/or full nasal reconstructions, lipectomies, face lifts, breast reduction or breast enlargement, revision of scars or such other procedures that the medical advisor deems cosmetic.
 - g. Travel expenses other than ambulance costs, where a medical practitioner certifies the use of an ambulance as necessary.
 - h. Holidays for recuperative purposes.
 - i. All costs in respect of pre-existing conditions unless declared at commencement of policy.
 - j. All costs relating to the purchase of medicines prescribed by a person not legally entitled to prescribe such medicines.
 - k. All costs for services rendered by:
 - a. Persons not registered, as a Preferred Provider in the approved manner,
 - b. Any institution/hospital or service provider not registered in terms of any law and as a Preferred Provider.
 - l. All costs relating to the difference in Recommended Tariff and the actual cost charged by the Preferred Provider.
- 15. All costs arising out of treatment not set out in Section 2 which include:
 - a. Costs relating to private nursing
 - b. Costs relating to non-medical treatment
 - c. All costs related to interest charged and legal fees arising out of overdue Medical accounts.
 - d. All costs relating to appointments not kept or cancelled by a Member or the Dependant.
 - e. Any care as may be determined to be not medically necessary.
 - f. Internal surgical prosthesis including pacemakers & electronic devices unless covered as per policy schedule.
 - g. Sleep apnea, sleep related breathing disorders, snoring, or insomnia.

- h. All costs for last expenses relating to excluded conditions
- i. Journeys from the country of residence, specifically made for the purpose of obtaining medical treatment, unless pre- authorized by the Company
- j. Any journey, activity, action or pursuit undertaken against the advice of a medical practitioner, specialist/ consultant, registered nurse or therapist.
- k. Treatment by a medical practitioner, specialist or consultant who is in any way related to the insured person.
- l. Experimental or unproven treatment, unless AAR has given specific pre- authorization.
- m. Treatment incurred as a result of the removal of a donor organ from a donor, or treatment for removal of an organ from an insured person for purposes of transplantation into another person and any complications arising thereafter.
- n. Cryopreservation, implantation or re- implantation of living cells or living tissue including stem cell therapy, whether autologous or provided by a donor.
- o. Hormone Replacement Therapy (HRT), unless in connection with, and immediately after a pre-authorized surgical procedure or unless otherwise provided for under the terms and conditions of the health plan.
- p. All costs arising from the release of weapon/s of mass destruction, (nuclear, biological or chemical) whether such involves an explosive sequence/s or not.
- q. All costs arising from contamination from chemical, biological and nuclear materials, including water products from the combustion of nuclear fuel.
- r. Learning difficulties and/or disorders, developmental problems and speech and/ or voice problems.
- s. Cosmetic, reconstructive, or remedial treatment, whether or not for psychological reason, and/ or any complications arising thereafter, unless medically indicated and required as the direct result of a covered medical condition which occurs after the date of joining.
- t. Treatment in a nursing home, hydro, spa, health farm or similar establishment.
- u. Myopia, hypermetropia, astigmatism, natural/ non-medical degenerative sight defects, non-medical/natural degenerative hearing defects and aids to assist eyesight and hearing, unless otherwise provided for under the terms and conditions of the health plan.
- v. Compulsive or addictive eating disorders and/ or homesickness, unless otherwise provided for under the terms and conditions of the health plan.
- w. Treatment after the expiry date of the policy, or after the expiry date of a member's cover, whichever occurs first
- x. All costs for the boarding of the parent for children over twelve (12) years old.
- y. Any direct or indirect consequences, loss or bodily injury or sickness relating to a disease declared as a pandemic outbreak or contributed to by any medical condition that is declared to be an outbreak or epidemic in unless provided in the schedule of Benefits.

4

PROVISIONS AND GENERAL CONDITIONS



PROVISIONS AND GENERAL CONDITIONS

1. **Policy and policy schedule:** This policy, the proposal form and the Schedule shall be read together as one contract and any word or expression to which a specific meaning has been attached in any part of this Policy or of the Schedule shall bear such specific meaning wherever it may appear.
2. **Commencement/Inception of Insurance:** Insurance shall only be in force or effective when the Proposal or application form has been accepted by the Company and the Insured has paid the premium.
3. The Insured shall give notice to the Company immediately there is any material change in his/her business / occupation or residence, health status, family and next of kin changes and shall pay any additional premium required by the Company in consequence thereof.
4. **Pre-existing, congenital and chronic conditions:** Claims from such medical conditions will be covered under pre-existing/congenital/chronic limit subject to the applicable terms and conditions of the policy including but not limited to waiting periods
5. Claims shall only be covered under the terms and conditions applicable to the policy in place at the loss date until medically indicated discharge from hospital or exhaustion of benefit or death or 90 days from expiry date of the policy. Where a member renews cover while still admitted, the liability of the company to the continuing admission is limited to that of the previous policy period. For new policies the company shall not accept liability for any admissions that started prior to commencement date of cover.
6. **Evidence required by the Company:** Every person applying to be insured under this contract shall furnish to the Company at his own expense all such medical and other evidence as the Company may reasonably require and shall submit to medical examination by a Medical Officer to be appointed by the company if so required. During the term of the contract, the Company shall have the prerogative to require further medical examination and to have free access to medical records as may be deemed necessary.
7. **Approved Hospitals and Doctors:** The Insurance expressed in this Policy shall be operative in respect of treatment received in any legally recognized medical facility or from any legally registered medical practitioner registered with the respective Medical Practitioners and Dentists Board. Acupuncturists, Acupressurists, Herbalists, Chiropractors and other alternative medicine practitioners are not recognized under this policy.
8. **Premium:** All premium is payable to the Company annually in advance.
9. **Membership cards:** As evidence of membership and for identification purposes, the Company may issue all persons insured with membership cards, which should be produced at medical credit facilities to enable a member access service. The Member is fully responsible for unauthorized use of the membership cards.
10. **Mid-term addition of members:** a proportionate premium as per Company policy shall be paid by members joining cover mid-term. Premium for rider benefits (like dental, Maternity and Optical) is not prorated.
11. **Mid-term removal of members from cover:**
 - a. The company shall refund proportionate premiums for Members who leave the policy subject to no claim on any benefit for the member(s) during the policy period.
 - b. Upon death of the principal member, members of his family who are entitled to benefit as his dependants at the time of his death may continue to be insured for the remainder of the period of Insurance within which such death shall have occurred.
12. **Company's Right to Decline Renewal:** The Company shall not be bound to renew this Policy nor give notice that it is due for renewal. The Company shall have the right to decline or to qualify the terms of the Insurance in respect of all or any Members on giving to the Insured 7 days registered notice in writing prior to any Annual Renewal Date.
13. **Cancellation:** The Company may cancel this Policy by sending 21 days' notice in writing to the Insured's last known address and it is deemed to

have been received. In such event the Company shall refund to the Insured a pro-rata portion of the premium for the unexpired term of the current period of Insurance. The policyholder may cancel this Policy by giving 21 days' notice in writing and the refund of any premiums shall be at the sole discretion of the Company. Refund of premium in both cases will be subject to no reported and/or incurred losses or claims.

14. **Submission of Claims:** In the event of any illness or accident giving rise to a claim under this Policy the Insured shall as soon as possible send notification in writing to the Company and submit a duly completed claim form within 30 days of the commencement of illness or the date of the accident or date of discharge. The Insured shall obtain and furnish the Company with all original bills, receipts and other documents upon which a claim is based and shall also give the Company any such additional information and assistance as the Company may require.
15. **Fraudulent Claims:** If any claim made shall be fraudulent or intentionally exaggerated or if any false declaration or statement shall be made in support thereof then this Policy shall be voidable by the Company. The insured shall forfeit all premiums paid into the policy. The company shall seek to recover any claims paid fraudulently from the member.
16. **Simultaneous Illness & Injuries:** All disorders or injuries existing simultaneously which are due to the same or related cause or any one accident shall be considered as one sickness or accidental bodily injury.
17. **Pre-authorization.** It is the responsibility of the Member and the Preferred Provider to seek pre-authorization. Thus the company will bear no responsibility financially, legally or otherwise for expenses incurred without the pre-authorization. In event of an emergency, the pre-authorization must be obtained from the Company within twenty four (24) hours of such admission.
18. **Reimbursement:** The Company shall only refund to a Member for pre-authorized services provided in an area with no Preferred Provider, this shall be at 80% of the cost as per the recommended tariffs.
19. The parties agree to settle any disputes arising from this policy through Court annexed mediation
20. **Jurisdiction:** Any legal proceedings instituted in connection with this Policy shall be brought before a court of competent jurisdiction in the Republic of Kenya.
21. **Time Bar:** In the event of the Company disclaiming liability in respect of any claim hereunder the Company shall not be liable in relation to such claim or possible claim after the expiry of three months from the date of such disclaimer unless the disclaimer shall be the subject of pending legal proceedings or court annexed mediation.
22. **Premium Financing.** Where a policy is paid for by way of premium financing arrangement by any recognized financial institution, the interest of the financier is noted in the policy. Further, the condition of policy cancellation stated in the policy document is hereby amended to that stated in the premium financing agreement signed by the insured. The financing institution is thus given rights upon notification to the member to apply for the cancellation or suspension of this policy only for the reason of default in premium payment. If there has been a claim prior to cancellation, the Company reserves the right to recover this amount from the insured.
23. **Other Conditions**
 - a. The Member will abide by all conditions set out in the management program for chronic conditions should the Member be diagnosed with a chronic condition covered by the policy. The company reserves the right to cancel the policy at any time should non-compliance with the management programme occur.
 - b. The Company or its duly authorized representative shall be entitled to contact the Member and the Dependent and/or relevant medical practitioner(s) for the purpose of case management and cost containment.
 - c. The Insured and the Company or its agents shall hold all medical, clinical and other diagnostic patient information confidential
24. The Company shall have the right to insist that a Member or Dependent consult any particular specialist that the Company may nominate. If the Member does not heed and act upon the

- mutually agreed specialist's advice, no further benefits will be allowed for that particular illness.
25. The Company may notwithstanding anything to the contrary contained in this policy document:
- Vary the terms of the contract for any member
 - Defer the acceptance of any application for membership. Any such applicant may be accepted on compliance with such terms and conditions as the Company may determine.
26. Contribution Clause: If at any time of any event in respect of which a claim arises, or which may be made under this policy issued by the company, there is any other insurance effected by or on behalf of the insured covering defined events, the company shall not be liable to pay or contribute more than its ratable portion of any sum payable in respect of such event. If any insurance effected by or on behalf of the insured is expressed to cover any of the defined events hereby insured but is subject to any provision whereby it is excluded from ranking concurrently with this policy either in whole or in part or from contributing ratably to the loss company shall not be liable to pay or contribute more than its rateable proportion of any loss which the sum insured hereby bears to the total amount/loss payable.
27. If a claim has been paid and it is discovered it ought not to have been paid under the terms and conditions of the policy, the company has the right to recover the payment from the insured.
28. Any treatment for a medical condition that occur within the waiting periods as specified in the policy schedule is excluded from the policy until the expiry of the said waiting periods.
29. Subrogation clause: The Insured Person shall do and concur in doing and permit to be done all such acts and things as may be necessary or required by the Company, before or after indemnification, in enforcing or endorsing any rights or remedies, or of obtaining relief or indemnity, to which the Company is or would become entitled or subrogated. Neither the policyholder nor any Insured Persons shall do any acts or things that prejudice these subrogation rights in any manner. Any recovery made by the Company pursuant to this clause shall first be applied to the amounts paid or payable under this Policy and the costs and expenses incurred in effecting the recovery, where after balance amount is payable to the policyholder. This clause would not be applicable for fixed benefit sections of Policy.
30. Force Majeure : Neither Party shall be liable to the other Party for any delay or failure to perform its obligations under the Agreement as a result of revolution or other civil disorders; belligerent aggression by an enemy or war; strikes; lack of available resources from persons other than parties to this Agreement; labour disputes; electrical equipment or system availability delay or failure; fires; floods; acts of God; government or regulatory intervention; or, without limiting the foregoing, any other causes not within its control, and which by the exercise of reasonable diligence it is unable to prevent, whether of the class of causes hereinbefore enumerated or not.

Kenya

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