Liberty Health Cover Policy Conditions

Corporate, SME and ME

Mozambique

2024 (LH24)

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Chapter I: Introductory Note and Definitions

Clause 1 - Introductory Note

This document describes the terms and conditions applicable to the health insurance benefits covered and where applicable, the embedded funeral benefit under your Liberty Health Cover policy. These policy conditions must be read in conjunction with the benefit tables, which describe the benefits which you are entitled to, and the limits attached to these benefits. These policy conditions together with the benefit tables, the Company Health Insurance Agreement and the application form constitute the agreement between the Policyholder, Insured Person, and the Insurer. We have taken every effort to ensure that all the important information you require are in these policy conditions.

This Policy is constituted as follows:
Main Company Health Insurance Agreement and policy conditions - Health Benefit terms and general legal terms and Annexure A- Embedded Funeral Benefit.

The terms of the Main Company Health Insurance Agreement and policy conditions should be read with the Annexures hereto unless otherwise stated in the benefit specific Annexure.

Clause 2 - Definitions

Below is a list of words that are used throughout your policy. These words have the same meaning, as defined below, wherever they are used in your policy.

a. **Accident** means a sudden, unexpected, specific event occurring at a particular moment and a particular place, which event the Beneficiary could not foresee, anticipate, or envisage, and which results in visible, violent, external, and traumatic physical injury to the body, and not caused by sickness, disease or gradual physical or mental process.

b. **Acute Condition** means conditions that generally appear suddenly, progress rapidly and are relatively short in duration.

c. **Administrator** means any recognised body appointed by the Insurer to administer this policy.

d. **Age** means the age (last birthday) of the Principal Member or Dependants as at the policy commencement or renewal date for the applicable Policy Year.

e. **Beneficiary** means the Principal Member and any person registered as a Dependant of a Principal Member, for whom the Policyholder is willing to contribute towards his or her medical costs or Premiums, who is entitled to benefits under this policy and who is not covered under another Benefit Plan (including any other Liberty Health Cover product).

f. **Benefit Plans** means the Benefit Plans as described in the benefit tables.

g. **Business Day** means any day (other than a Saturday or Sunday or a declared public holiday) on which banks and insurance companies are generally open for normal business in the Republic of South Africa and/or in the country in which the policy is issued.

h. **Chronic Condition** means conditions that require medication and treatment for more than three continuous months.

i. **Claim** means an itemized statement or invoice of services and costs provided by a Hospital, Medical Practitioner or Doctor submitted for payment.

j. **Claims Debt** means Claims paid by the Insurer that are recoverable from the Insured Person or Policyholder.

k. **Clinical Funding Protocol** means a set of guidelines developed by the Insurer to determine the appropriate funding and allocation of benefits for requested medical services. Their development is based on Evidence-based Medicine (EBM) principles.

l. **Corporate client** means a Policyholder with 30 or more employees.

m. **Commencement Date** means the first day cover begins following acceptance by the Policyholder or as agreed between the Policyholder and the Insurer and upon receipt of the premium payment by the Insurer.

n. **Critical Care** means cover for services that are medically necessary but not available locally (in-country) for life-threatening, but non-emergency health conditions.

o. **Dependant** means:
   i. A Spouse or Living-in partner of the Principal Member or
   ii. A Spouse, Living-in partner, or child (as defined below) of a deceased Principal Member
   iii. A natural child, stepchild, legally adopted child, or any child placed in the care and custody of the Principal Member or the Principal Member's Spouse or Living-in partner or where there is a liability for financial support enforceable by a court of law. A child dependant must be:
      - up to the age of 21 (inclusive) or
      - between the ages of 22 and 25 (inclusive) provided that he or she can provide proof of registration as a full-time student at a recognized educational institution (student cards do not qualify). If no proof of studies is received, the Dependant will be resigned at end of the Policy Year in which they have turned 25 years old.
      - dependent on the Principal Member due to mental or physical disability (A copy of the Doctor's medical report confirming permanent disability may be requested)
      - a stillborn child, following 28 (twenty-eight) weeks of pregnancy, in respect of the Funeral Benefit only.

p. **Elective Roaming** means where a Beneficiary electively obtains medical services outside the country of residence, in line with the Region of Cover on their selected Benefit Plan and that does not require an Emergency Evacuation or Critical Care.

q. **Emergency Evacuation** means immediate and urgent movement and en-route care provided by medical personnel to an Insured Person being evacuated from their current location to the nearest medical centre in order to undergo care, on account of an Emergency Medical Condition.

r. An **Emergency Medical Condition** means a condition that happens suddenly and unexpectedly, requires immediate medical or surgical treatment for resuscitation and/or stabilisation and where failure to provide this treatment within 24-48 hours would result in serious impairment of bodily

functions, serious dysfunction of a bodily organ or part, or would place the Insured Person's life in serious danger.

s. **Employment Date** means the date of employment as provided by the Policyholder.

t. **Evidence-based Medicine (EBM)** is defined as the conscientious, explicit, and judicious use of current best evidence in making decisions about the medical care of Beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.

u. **Force Majeure** includes, acts of God, acts of the State or Government, legislative or regulatory changes, exceptionally adverse natural disasters, riot, insurrection, sanctions, sabotage, terrorism, political or civil disturbance, war, boycotts, embargo, strikes, lock-out, shortages of labour or materials, material delays in public transport or any similar circumstances beyond the reasonable control of the Insurer. Including but not limited to material changes in exchange rates.

v. **Fraud** can be defined as any action committed with the aim of obtaining or procuring an advantage or profit either where no medical care/services were factually procured or received, or from unjustified or undue medical care/service, at the Insurer's expense.

w. **Health Questionnaire** means the Application Form, signed by the Principal Member or Dependant. This also includes any written statement, representation or document given to the Insurer that contains information relied on to issue this policy.

x. **Hospital** means an institution which is legally licensed as a medical or surgical facility in the country in which it is located. It must be under the constant supervision of a Doctor.

y. **Illness** means a disease of the body or mind.

z. **Insured Person** means a Beneficiary.

aa. **The Insurer** means the Insurer issuing this policy.

bb. **Late Joiner** means a person who applies for cover:
   i. More than 30 (thirty) days after date of employment
   ii. As a Spouse, more than 30 (thirty) days after date of marriage
   iii. As a child Dependant, more than60 (sixty) days after date of birth or adoption

cc. **Life Changing Event** means divorce, marriage or retrenchment of Insured Person or the Spouse's change of employment or death. Moving from one insurer to another without a Life Changing Event does not apply for consideration of the waiver of underwriting.

dd. **Living-in partner** means a person with whom the Principal Member has a committed and serious relationship akin to a marriage based on objective criteria of mutual dependency and a shared and common household, irrespective of the gender of either party.

ee. **Managed Healthcare Programme** means a healthcare delivery arrangement designed to ensure access to affordable, appropriate, good quality and effective healthcare that allows for the efficient utilization of benefits available to each Insured Person.

ff. **ME client** means a Micro Enterprise comprising of a minimum of 1 employee and a maximum of 5 employees. It is compulsory for all employees of an ME to be registered, in order to qualify as a ME client**.**

gg. **Medical Advisor** means a medical doctor retained by the Insurer to advise on medical questions relevant to medical issues or treatment based on the Clinical Funding Protocols and available benefits and limits.

hh. **Medical Practitioner or Doctor** means a person who is legally qualified in medical practice following attendance at a recognized medical school, to provide medical treatment and licensed by the competent medical authorities of the country in which treatment is provided but who should not be the Insured Person or the relative, sibling, Spouse, child, or parent of the Insured Person.

ii. **The Policyholder** means the employer group or sponsor who has purchased this policy in respect of its employees and is responsible for the payment of Premiums under this policy.

jj. **Policy Year** means a period of 12 months starting from the Commencement Date of this policy and each consecutive 12-month period thereafter for which this policy is renewed.

kk. **Pre-authorisation** means authorisation approved/given in writing in advance of a relevant healthcare service or treatment being provided.

ll. **Pre-Existing Conditions** means any injury, illness, condition, or symptom:
   i. for which treatment, or medication, or advice, or diagnosis has been sought or received or which the Insured Person would reasonably have been aware of prior to the policy Commencement Date, or
   ii. which originated or was known to exist by the Policyholder or the Insured Person prior to the policy Commencement Date whether or not treatment, or medication, or advice, or diagnosis was sought or received.

mm. **Premium** means the premium payable by the Policyholder to the Insurer for the benefits payable under this policy.

Beneficiary Type	**Applicable Premium rate**
Principal Member	**ME** - relevant year of age rate **SME** - relevant year of age rate **Corporate** - Adult rate
A Spouse or Living-in partner of the Principal Member	**ME** - relevant year of age rate **SME** - relevant year of age rate **Corporate** - Adult rate, even if the Spouse or Living-in partner is under the age of 22 years
Child and full-time students	**ME** - relevant year of age rate **SME** - relevant year of age rate **Corporate** - child rate applicable to 0-21 Premium age group

nn. **Premium Debt** means Premiums outstanding by a Policyholder.

oo. **Premium Loading** means the amount a higher-risk applicant's Premium will be increased, over and above a company's standard premium rate.

pp. **Principal Member** means an employee who is employed on a full-time, permanent basis and full-time employees who retire from the services of an employer who is the Policyholder and are eligible for cover at the date of retirement**.**

qq. **Provider Network** is a network of healthcare providers with whom We contracted and have negotiated tariffs for the provision of healthcare services. These healthcare providers will be paid directly by Us in accordance with the negotiated tariffs, specified benefit limits and subject to the conditions of this policy.

rr. **Reasonable and Customary Charges** means charges for healthcare which We consider to be reasonable and customary if they are within a general level of charges being made by other healthcare providers of similar standing in the locality where the charges are incurred when giving like or comparable treatment, services or supplies to individuals of the same gender and of comparable age for a similar disease or injury.

ss. **Region of Cover** means the territories or countries stipulated in the benefit tables in which the Insured Person will be covered under this policy.

tt. **Secondment** means a temporary transfer to another job or post within the same organization for a period of more than three months.

uu. **SME client** means a Small to Medium Enterprise comprising of a minimum of 6 employees and a maximum of 29.

vv. **Specialist** means a qualified and licensed Doctor, possessing the necessary additional qualifications and expertise to practice as a recognized specialist of diagnostic techniques, treatment, and prevention, in a particular field of medicine including but not limited to psychiatry, neurology, paediatrics, endocrinology, obstetrics, gynaecology and dermatology.

ww. **Spouse** means the person to whom the Principal Member is married in terms of any law or recognised custom and includes a Living-in partner.

xx. **Trauma** means an injury caused by an extrinsic agent.

yy. **Waiting Period** means the period of time from the policy Commencement Date during which this policy does not cover any treatment made necessary by any cause. Premiums remain payable during the course of this Waiting Period.

Clause 3 - Intention of the Policy Conditions

a. This policy conditions guarantees the Insured Person, in case of Illness or Accident occurring during its validity period, a set of healthcare services coverage as defined in these policy conditions in conjunction with the table of benefits contracted by the Policyholder.

Clause 4 - Scope of the Policy Conditions

a. This policy conditions signed by the respective Policyholder, the information provided for each Insured Person (via application form or take on spreadsheet), as well as all clinical documentation necessary for acceptance of risk by the Insurer, constitute the basis of the contract and are an integral part thereof, determining, in particular the covered risk.

Clause 5 - Contractual Guarantees

a. The insurance contract may guarantee, under the terms and within the limits established for this purpose in the General Conditions and in the benefit tables, the following covers:
    i. Hospitalisation
    ii. Medical emergencies in Mozambique, and other territories depending on the option chosen by the policyholder.
    iii. Outpatient treatment (Consultations, Examinations and Treatments)
    iv. Prostheses and other medical devices
    v. Medicines

b. The coverages contracted are set forth in these terms and conditions. The insurance contract may also include other coverages, as long as they are duly identified in the tables of benefits and defined by its own special conditions.

c. The Insurer guarantees the payment of healthcare services for the Insured Person within the contracted health benefits subject to timeous Premium payment, these policy conditions and clinical funding protocols by Policyholder, performed by the Provider network of health care providers, outside the network (with the Insured Person bearing all the respective costs, under the terms and limits established in the tables of benefits.

Chapter II: General Policy Conditions

Clause 6 - Insurance Cover

a. We have partnered with local insurers to license and insure the Liberty Health Cover policy in the local country where the policy is issued. Please contact the Insurer or visit our website (www.libertyhealth.net) for the list of our local insurance partners.

Clause 7 - Applicable Law

a. This policy will be governed by and construed, determined, and enforced in accordance with the law in Mozambique where this policy is issued.

Clause 8 - Assignment

a. The Policyholder or the Insured Person will have no rights to assign this policy, or any insurance coverage effected under this policy.

Clause 9 - Non-disclosure

a. If an Insured Person makes a false declaration or knowingly fails to disclose that he/she has or is suffering from an illness or condition, including receiving treatment/medication for any condition/diagnosis and possible future treatment, then the Insurer reserves the right to:
   i. impose Waiting Periods
   ii. impose Premium Loadings
   iii. specifically exclude benefits in respect of a particular medical condition, disease, disorder, or disability that existed at the time of application for coverage under this policy.
   iv. Terminate the cover of the Insured Person
   v. Recover any or all medical costs incurred in respect of this condition from the Insured Person

b. The Insurer shall notify the Insured Person in writing of any limitation, Premium Loading, or specific exclusion imposed or termination of the policy.

Clause 10 - Residence

a. The Insured Person must reside in the country in which this policy is issued or registered in order to qualify for coverage under this policy, except where otherwise agreed beforehand between the Policyholder and the Insurer

Clause 11 - Commencement of Coverage

a. This policy will only commence once the application form has been accepted by the Insurer and the Policyholder has paid the Premium due in full. No backdated changes will be allowed.

b. All completed application and amendment forms are valid for a period of 90 (ninety) days from the date of declaration as indicated by the applicant inclusive of required affidavits where and when required. Where the form exceeds the 90 (ninety) day validity, a new form will be required.

c. If the application for coverage of an Insured Person under this policy is approved by the Insurer during a month within a Policy Year, then the cover for such Insured Person will commence on the first day of the month immediately following the month in which the application for coverage is approved. Alternatively, an Insured Person can opt for immediate coverage, but will be charged for the full month's Premium in which the cover is activated.

d. All Dependants must be registered under the same Benefit Plan as the Principal Member. A Dependant cannot select a different Benefit Plan to that of the Principal Member. Claims against more than one health insurance provider at the same time is prohibited. A Principal Member or Dependant who is covered under more than one cover, MUST communicate it to the Insurer. Non-communication on additional covers will exempt the Insurer from any Claim payment under this policy.

e. In the case of newborns, application should be made within 60 (sixty) days of the date of birth, a copy of the birth certificate or Hospital confirmation reflecting the baby's name must be provided with the application.

f. If the newborn is registered within the 60 (sixty) day period, coverage will commence from date of birth. Any Claims incurred for the newborn during this period may be submitted for payment once the newborn has been registered. Premiums will be charged from the first day of the month immediately following the month of birth.

g. If the newborn is not registered within 60 (sixty) days of birth, then coverage under this policy will not commence from the first day of birth. Instead, coverage for the newborn will commence as specified in Clause 11a and subject to underwriting as specified in Clause 21.

h. In the event of an emergency should the newborn require in-hospital care immediately following the birth and prior to discharge, the newborn will be covered under the mother's policy for In-Patient benefits only for the first 15 (fifteen) days from date of birth.

Clause 12 - Age Limit

a. This policy will not cover a new applicant over the age of 70 (seventy) years. An existing Insured Person who was younger that than 70 years when cover under this policy originally commenced but who subsequently aged beyond 70 years old, will continue to be covered under this policy.

Clause 13 - Changing Benefit Plans

a. A Principal Member can only change their Benefit Plan at policy renewal subject to giving the insurer written notice 30 (thirty) days prior to policy renewal.

Clause 14 - Termination of Insured Person's Coverage

a. An Insured Person's cover under this policy will terminate on the date any one of the following events first occurs:
    i. the entire policy is terminated as provided in Clause 15 of this section or an Insured Person's cover is terminated as a result of fraud as per Clause 17.
    ii. where the Insured Person no longer qualifies for cover as they no longer qualify as a Principal Member or Dependant.
    iii. non-payment of Premiums due under this policy.

b. The Policyholder must provide Us with 1 (one) calendar month's written notice of the termination, for any reason whatsoever, of a Principal Member and/or Dependants of any such change. Should such notification reach Us after the notice period and Claims have been paid in respect of the Principal Member or Dependants, We reserve the right to:
    i. Charge Premiums for the period for which Claims were paid even if the Principal Member or Dependants were no longer eligible for cover.
    ii. Decline funding for any Claims received after the notice period.
    iii. Recover the costs of any Claims paid by the Insurer from the Policyholder

c. When a Dependant ceases to be eligible as a Dependant, he/she shall no longer be deemed to be registered as such for the purpose of this policy or entitled to receive benefits, regardless of whether notice has been given in terms of this policy or otherwise.

Clause 15 - Cancellation by the Policyholder

a. The Policyholder may cancel the policy by giving 90 (ninety) days' advance notice in writing to the Insurer. The cover on all Insured Persons will cease on the date the policy is cancelled.

b. In the event of Force Majeure, the Insurer reserves the right to cancel this policy with 30 days' notice by notifying the Policyholder in writing.

Clause 16 - Renewal

a. At the renewal date, based on the group start and end date as specified in the master services contract (usually at the end of each Policy Year) the policy may be renewed for a further term of 1 (one) year subject to the mutual agreement between the Insurer and the Policyholder on the renewal terms. At policy renewal, the Insurer will review the benefits, policy conditions and Premiums subject to the mutual agreement of the Insurer and the Policyholder and subject to the Insurer giving the Policyholder 90 (ninety) days advance notice of the renewal terms in writing. All outstanding Premium Debt must be settled before the renewal.

b. Child Dependants aged 22 - 25 at time of renewal are required to submit current proof of studies. Child Dependants aged 25 at time of renewal will be automatically resigned. The Principal Member will be notified in writing of the resignation.

c. If renewal terms are not agreed and finalised by the renewal date, the cover for all Insured Persons will cease from the 1st day following the policy renewal date.

Clause 17 - Fraud

a. If any Claim shall in any respect be false or fraudulent or if fraudulent means are used by the Insured Person or anyone acting on their behalf to obtain benefit under this policy, the cover for the Insured Person or at the discretion of the Insurer, the entire policy may be cancelled immediately, and all benefits and Premiums forfeited. Legal action may also be instituted against the parties in question.

b. The following are examples of Fraud committed, including but not limited to:
   i. Drafting or use of a false document, including any supporting document, health invoice or other billing document
   ii. Colluding with providers to submit fraudulent Claims.
   iii. Failure to accurately report, update or declare medical information (condition/treatment/diagnosis) and changes thereto and submit to already submitted documents, if the information or circumstances reflected in those documents have changed.
   iv. Duplication, theft or borrowing of documents with the intention of obtaining services illegally.
   v. Altering a medical insurance Claim for financial gain
   vi. False billing of health services by a Beneficiary or service provider, in particular the billing of fictitious services
   vii. Billing of unjustified healthcare services outside the medical prescription or the requirements of the patient
   viii. Insured Persons allowing other non-insured individuals to use their membership card to access benefits.
   ix. Falsifying Claim invoices for Insured Person reimbursement
   x. Presenting fraudulent prescriptions at pharmacies

c. In the case where the Insurer identify Fraud, the Insurer may apply any of the following, or a combination of the following sanctions:
   i. immediate termination of the policy
   ii. termination of the Insured Person's cover
   iii. Instituting civil and/or criminal legal action.

Clause 18 - Membership Cards

a. A membership card, per Beneficiary, is only issued upon receipt of a fully completed application form and if the Premium due has been paid in full.
b. Should the card be lost or stolen it is incumbent on the Policyholder and/or Insured Person to inform the Insurer immediately, failing which the Policyholder and/or Insured Person could be held liable for any Claims paid through misuse.
c. The cost for producing additional card(s) will be at the cost of the Policyholder and/or Insured Person.
d. The utilization of the membership card by any person other than the Insured Person, with the knowledge or consent of the Insured Person, is an abuse of the benefits of the Benefit Plan and will be dealt with by the Insurer in accordance with Clause 17.

Clause 19 - Pro-rated Benefits

a. If an Insured Person joins the policy during a Policy Year, then out-patient annual benefit limits and Premiums will be pro-rated on a monthly basis to reflect that coverage does not apply for a full year.

Clause 20 - Liberty Tariff or Provider Price List

a. The Liberty Tariff or Provider Price List means the agreed maximum amount of money We will pay for a particular medical expense (e.g., in-hospital treatment, consultations, medicines, procedures, examinations, etc.) to a Network Provider.

b. Where no tariff has been agreed with a medical service provider, the Insurer will pay what is considered Reasonable and Customary Charges within the country in which the treatment and services were obtained.

c. Where the provider charges above the agreed maximum tariff amount or what is considered Reasonable and Customary charges the patient will be liable for the payment of the difference between the two amounts.

Clause 21 - Underwriting

a. Should an Insured Person undergo a Life Changing Event and apply to be admitted or re-admitted as an Insured Person on this policy within 30 (thirty) days of the Life Changing Event taking place, he or she shall be registered as an Insured Person without the imposition of any underwriting.

b. For Corporate clients **only** the following is applicable:
    i. No underwriting shall be imposed on an Insured Person in respect of whom application is made for membership within 30 (thirty) days of a specified period of Secondment by the employer.
    ii. It is compulsory for an employee to apply for coverage under this policy within 30 (thirty) days of the policy Commencement Date or Employment Date of the employee in order to obtain coverage with no underwriting; such employees must be registered as from the date of employment or policy Commencement Date, or underwriting will apply.
    iii. Dependants who apply for coverage within 30 (thirty) days of the policy Commencement Date or Employment Date of the employee will obtain coverage with no underwriting; such Dependant must be registered as from policy Commencement Date or Employment Date of the Principal Member, or underwriting will apply.

iv. In the case of a newborn, application must be made within 60 (sixty) days of the birth date in order to obtain coverage with no underwriting; such Dependants must be registered as from their date of birth or underwriting will apply.
v. In the case of an adopted child or child placed in the custody of an Insured Person, application must be made within 60 (sixty) days of the adoption or custody date in order to obtain coverage with no underwriting; such Dependants must be registered as from date of adoption or legal custody, or underwriting will apply.
vi. In the case of a newly married Spouse or Living-in partner, they must be registered for coverage under this policy within 30 (thirty) days of the marriage date or date of co-habitation, such Dependant must be registered as from date of marriage or date of co-habitation in order to obtain coverage with no underwriting otherwise underwriting will apply.
vii. No underwriting will apply to a new subsidiary company acquired by an existing employer group provided application is made within 30 (thirty) days of the acquisition and the group size exceeds 29 employees.

c. All new applicants are required to complete a Health Questionnaire which forms the basis of the contract.

d. All application forms must be duly completed, together with the signature and date of declaration.

e. Any additional information, due to constraints of the form, can be completed on a separate sheet of paper.

f. All completed forms are valid for a period of 90 (ninety) days from the date of declaration as indicated by the applicant.

g. Persons who do not join within the timelines specified within this Clause may be subject to Late Joiner underwriting and the Commencement Date will be the first of the following month inclusive of underwriting. No back dating will be allowed.

h. For ME and SME clients, and Late Joiners (ME, SME, and Corporate clients), the following may be applied at application for membership or in cases of non- disclosure (Clause 9):
i. A Waiting Period of up to 24 months applicable for a specified condition, benefit limit (including maternity), avocation, occupation, or general health status.
ii. A Premium Loading in respect of a specified condition, avocation, occupation, or general health status.
iii. A lifetime exclusion of cover in respect of a specified condition, avocation, or occupation.
iv. Decline cover.

Clause 22 - Second Opinion

a. We may require a second opinion in respect of diagnosis, proposed treatment or medicine which may result in a Claim for benefits, and for that purpose the relevant Beneficiary shall consult a dental or Medical Practitioner nominated by the Insurer and at our cost. In the event that the second opinion proposes different treatment or medicine to the first, the Insurer may require that the second opinion proposals be followed.

Clause 23 - Legal Proceedings

a. No action in law or equity shall be brought to recover under the policy until after the expiration of 60 (sixty) days from the date that proof of a Claim has been furnished in accordance with the policy conditions. The parties have agreed that the law of the country in which this policy is issued shall govern and control in the event of any conflict or dispute between the parties with regard to the policy, and that the parties submit themselves to that exclusive venue and jurisdiction for the resolution of any such conflict or dispute.

Clause 24 - Arbitration

a. Any difference of medical opinion in connection with the consequences of any Accident, illness, death, or expense will be referred to two medical experts appointed respectively, in writing, by the two parties to the dispute, for resolution by said experts. Any difference of opinion between the two medical experts shall be referred to an independent arbitrator, who shall have been nominated, in writing, by the two medical experts at the outset. The arbitrator's decision in the matter will be final.

Clause 25 - Events Beyond the Insurer's Control (Force Majeure)

a. Should the Insurer be prevented from carrying out any of its obligations in terms of this policy because of Force Majeure, the Insurer will notify the Policyholder/Insured Persons of the circumstances and nature of the Force Majeure as well as the estimated duration and extent to which the Insurer's performance is made impossible.

b. Under such circumstances, the Insurer's obligations under the policy will be suspended until the circumstances causing the Force Majeure ends and the Insurer will not be liable to the Policyholder/Insured Persons for any damages whatsoever caused to the Policyholder/Insured Persons due to the Insurer's inability to perform its obligations in terms of the policy. In the event of Force Majeure, the Insurer may cancel the policy by giving 30 (thirty) days' notice.

Clause 26 - Adjustment of Benefits and Premiums

a. The Insurer reserves the right to appropriately adjust the Premiums or benefits payable (including any applicable guarantees) and the charges levied under this policy if:
    i. any legislation or regulation (including tax legislation or regulation) affecting this policy, or the Insurer is introduced or changed, or
    ii. the legal interpretation or understanding of any legislation or regulation (including tax legislation or regulation) affecting this policy or the Insurer has changed.
    iii. The Policyholder and Insured Persons (as applicable) will be notified in writing when these changes will take place.

Clause 27 - Undertakings

a. The Policyholder guarantees that all information given to the Insurer and/or its Administrator at any time is complete and true. Information that affects the Insurer's decision to provide benefits is known as material information**.**

b. Where the Policyholder provides the Insurer and/or its Administrator with the personal information or health information of an Insured Person, the Policyholder guarantees that the Insured Person has given the Policyholder consent to provide the Insurer and/or its Administrator with their personal information.

c. Where any material information is not fully disclosed or is found to be untrue, the Insurer may decide to cancel the policy and/or not to pay any Claims or benefits.

Chapter III: Payment of Premiums

Clause 28 - Premiums

a. Premiums are payable in advance and the selected frequency may only be amended on the anniversary of the policy.

b. Premiums for SME clients (6-29 employees) and Corporate clients (30+ employees) are payable monthly, quarterly, bi-annually or annually, unless specified in terms of the regulatory requirements within a specified territory. In the latter instance the regulatory requirements will prevail.

c. Premiums for ME clients (maximum of 5 employees) are payable annually in advance. Premiums for Dependants added during the Policy Year are payable prior to the benefits being activated and within 30 (thirty) days of Dependant being added.

d. Premiums are payable in advance from the 1st of the month of the billed period (monthly, quarterly, bi-annually, annually) and by no later than the 7th of the first month of the billed period.

e. The first Premium must be physically received into the Insurer's nominated bank account before the Commencement Date of this policy to enable activation of benefits for Insured Persons.

f. Premiums must be paid directly to the Insurer and not a third party. Cover will not commence, nor the suspension of cover lifted until such time that the Premiums are reflected in the bank account of the Insurer.

g. Tax invoices will be produced for any amendments to add or end cover for Insured Persons processed up to the 15th of the current month.

h. Amendments to Insured Persons received after the 15th of the month will be reflected in the subsequent tax invoice.

i. Any outstanding credit note adjustment invoices are not refundable on an active policy but will be offset against future Premium invoices. Should a Policyholder terminate their policy with the Insurer then any credit notes or refunds due on Premiums will only be refunded 3 (three) months after cover on the policy has been terminated.

j. Where a Policyholder pays monthly, quarterly, bi-annually, or annually in advance amendments to Insured Persons will be invoiced monthly and is payable at the selected frequency.

k. Premiums will be appropriately adjusted from the first of the month following the month in which the amendments to Insured Person have been submitted. Where an Insured Person joins or resigns during a billing period, the Premiums will be adjusted on a monthly and not a daily basis.

l. The Insurer reserves the right to review Premiums at any time during a Policy Year due to unforeseen changes in policy taxes or legislation.

m. The Insurer reserves the right to suspend the payment of Claims and the policy for the Insured Persons if the Policyholder has not paid the full amount of the Premium due by the 14th of the month in which it became due. When the full amount of Premiums is paid, the Insurer shall reinstate benefits to Insured Persons.

Chapter IV: Debt Collection

Clause 29 - Debt

a. Premium Debt
   i. Premiums are payable by no later than the 7th of the month to which the invoice relates.
   ii. If no payment is received by the 14th of the month in which it became due, no Claims will be processed, and the policy will be suspended.
   iii. If no payment is received within 2 (two) months of the 1st of the month in which it became due, the policy will be terminated, and written notification will be sent to the Policyholder. The collection of the outstanding debt will be referred to a debt collection agency and where necessary, a legal collection process would be pursued.

b. Claims Debt
   i. Insured Persons
      - Claims Debt is payable immediately by the Insured Person.
      - If Claims Debt is not paid within 3 (three) months of the debt becoming due, benefits for the Insured Person will be suspended (Premiums will still be raised and invoiced). The Insured Person and the Policyholder will be informed via written correspondence.

   ii. Previously Insured Persons
      - Where an Insured Person has resigned and has outstanding Claims Debt, the Policyholder is responsible for the immediate payment of the Claims Debt.
      - If Claims Debt is not paid within 3 (three) months of the debt becoming due, the policy will be suspended. The Policyholder will be informed in writing.

Chapter V: Form of Claims Submission

Clause 30 - Claims Submission

How to Submit Claims

We will act in good faith in all our dealings with the Policyholder and Insured Persons. The Policyholder and Insured Persons, in turn, must ensure that the following are observed:

a. The payment of treatment costs under this policy is subject to our agreed tariffs in the relevant country where treatment is received. Where no tariffs have been agreed with a medical service provider, Claim payments will be reimbursed subject to what We consider to be Reasonable and Customary Charges in the country where treatment is received. The Insured Person is liable for treatment costs in excess of our agreed tariffs or what We consider to be Reasonable and Customary Charges.

b. In-network treatment
   If an Insured Person goes to our Provider Network for treatment, then We will arrange direct payment for the cost of treatment to the healthcare provider up to the specified benefit limits and subject to the conditions of this policy. An Insured Person must always present his/her membership card to the healthcare provider in order to receive treatment.

c. Out-of-network treatment
On specified Benefit Plans no Claims will be paid directly to a non-network provider or refunded to an Insured Person using the services of a non-network provider.

d. Out of country treatment
For the Benefit Plans that allow Elective Roaming, in the case where an Insured Person goes for treatment outside the country where this policy is issued, We will only fund treatment at our Provider Network. If there is no Provider Network in a specific country, We will pay Claims at what We consider to be Reasonable and Customary Charges, subject to Clause 30a. No costs related to travel and accommodation are funded for out of country treatment.

Claims for treatment outside of country of residence will be converted at exchange rate valid on the date of service or discharge in the case of hospitalisation.

e. Requirements for the submission of a Claim
In order to process and pay a Claim the following information must be clearly provided on the account:
i. Policy/Membership number
ii. Patient Name and Surname
iii. Date of birth
iv. Diagnosis
v. Date of service (for Hospital please include admission and discharge dates)
vi. Detailed Treatment or Service description for each item received/provided (i.e., name of medicine, ward level)
vii. Quantity (i.e., 30 Disprin, 3 days in general ward)
viii. Tariff code (if available)
ix. Amount charged per service or treatment received.
x. Name of treating Healthcare professional
xi. Facility Name (i.e., General Hospital, Africa Medical Clinic)
xii. Total charged (which must add up to the amounts charged individually on the account)
xiii. Pre-authorisation number (if applicable and where the service requires Pre-authorisation – see Clause 30g)
xiv. Proof of payment in the case of a refund to the Principal Member. Proof of payment can be submitted in the form of a copy of the Electronic Funds Transfer (EFT) payment, a debit/credit card payment transaction slip, or cash receipt. If the correct proof of payment is not attached, the account will be rejected.
xv. Signature of the patient or Principal Member if the patient is a minor.
xvi. Signature of the provider
xvii. Date of the account and account reference number

Failure to observe the above Claim conditions, without any reasonable explanation, may invalidate a Claim. It is recommended that the Insured Person keeps copies of any medical information that he sends to the Insurer. This will help the Insured Person keep track of what We owe to him and will be helpful if he needs to follow up on his Claim.

f. An Insured Person must make sure that he or she can afford treatment
The Insurer can determine if an Insured Person is eligible for a particular treatment in terms of his policy, as well as advise him whether he has funds available to pay for it (within benefit limits stated in the benefit table). However, it is up to the Insured Persons to confirm that they have funds available by checking with Us or referring to the benefit table and asking the Doctor or Hospital what the charge for treatment will be.

g. Services or benefits that require Pre-authorisation
For certain services or benefits the Insured Person must obtain Pre-authorisation from the Insurer. Services or benefits that require Pre-authorisation include:
   i. Hospitalisation (elective and non-elective)
   ii. Cancer treatment (in- and out-patient)
   iii. Renal (Kidney) dialysis (in- and out-patient)
   iv. Specialized radiology (in- and out-patient)
   v. Emergency Evacuation and air ambulance services (in-country and international)
   vi. Chronic medicines
   vii. External medical appliances and prosthesis
   viii. Orthodontics
   ix. Organ transplants
   x. Compassionate travel
   xi. Repatriation of mortal remains.
   xii. Non-emergency and air ambulance services
   xiii. Critical care
   xiv. High risk pregnancies (additional outpatient ultrasounds and consultations)
   xv. Rehabilitation, Private nursing, and Hospice care
   xvi. Travel and Accommodation

h. The relevant managed care application form and clinical information should be provided to the Insurer at least 2 (two) Business Days prior to the Dependant obtaining the treatment/service. If the Insured Person does not obtain Pre-authorisation, he may be held personally liable for his medical costs.

i. In case of an Accident or hospitalisation in the event of an emergency, written notification together with reasonable available supporting medical information must be submitted to the Insurer within 2 (two) Business Days of the event, or if it is a weekend or public holiday, on the next working day.

j. Where Pre-authorisation is required and is not obtained, We reserve the right to:
   i. Decline funding or
   ii. Apply a co-payment of 20% of the total value of the Claim.

Chapter VI: Benefits or Coverage of the Policy

Clause 31 - Policy Benefits or Coverages

a. This section should be read in conjunction with the benefit tables. Please refer to the benefit tables of your selected Benefit Plan to understand exactly what you are covered for under your policy. This section provides more detail on the benefits that you are entitled to under your policy where such detail is not included on the benefit tables.

b. Please note that benefits vary depending on the country and Benefit Plan selected and therefore may not be applicable to your Benefit Plan or country. Should you be unsure of what is applicable please call your in-country office for clarification. Claims will not be funded for services that are not covered under your relevant Benefit Plan.

c. No Insured Person is entitled to assign, transfer, pledge or cede his/her benefits or rights to benefits in or from this policy.

d. Out-patient treatment for Acute Conditions
This includes:
   i. General practitioner (GP) consultations.
   ii. Specialist consultations.
   iii. Pathology, i.e., blood tests requested by a Doctor in the course of your day-to-day consultations.
   iv. Radiology, i.e., out-of-Hospital basic x-rays.
   v. Out-of-Hospital, non-surgical procedures, such as applying plaster of paris and stitches.
   vi. Physiotherapy
   vii. Biokinetics and chiropractics
   viii. Psychology
   ix. Social worker
   x. Occupational therapy
   xi. Speech therapy / Audiology
   xii. Hearing aid acoustician
   xiii. Podiatry
   xiv. Dietician
   xv. Orthotist / Prosthetist
   xvi. Occupational Health therapy
   xvii. Acute medicines including medicines which are medically necessary and legally restricted to those prescribed by a Doctor for use by the Insured Person on an out-patient basis. In these circumstances, the dispensed quantity may not exceed the amount prescribed by the treating Doctor.
   xviii. Annual medical examination

e. Vaccinations
Childhood vaccinations for children below the age of six (6) years old (inclusive) will be covered under the acute medicines (day-to-day) benefit subject to the Insurer's clinical policy.
<u>Childhood vaccinations up to and including age 6:</u>
   i. Diphtheria
   ii. German measles (Rubella)
   iii. Haemophilus influenza type B
   iv. Hepatitis A and B
   v. Measles
   vi. Meningitis
   vii. Mumps
   viii. Pneumococcal infections
   ix. Polio
   x. Rotavirus
   xi. Tetanus

xii. Tuberculosis (BCG)
xiii. Typhoid
xiv. Vitamin A (not a vaccination but part of the schedule in some countries)
xv. Whooping Cough (Pertussis)

For older age groups access to the following will be covered:

i. Hepatitis B
ii. HPV (subject to Pre-authorisation and clinical criteria)
iii. Influenza
iv. Meningitis
v. Pneumococcal infections
vi. Tetanus
vii. Typhoid

Additional vaccinations covered for all ages:

i. Yellow Fever
ii. Rabies (In an emergency please have the first dose dispensed. You must call us afterwards to inform us of the Claim, which once submitted will be processed in line with available benefits.)

f. Chronic Conditions Benefit

In order to access the Chronic Conditions benefit an Insured Person, who is diagnosed with a Chronic Condition, will be required to obtain Pre-authorisation by registering on the Managed Healthcare Programme. To register on this programme, the treating Doctor together with the Insured Person will need to complete a chronic medicine application form and submit this form to Us. Treatment of Chronic Conditions will be subject to our chronic disease list, Clinical Funding Protocols, and approved medicine formularies.

It is important to note that if an Insured Person does not register on the Managed Healthcare Programme, then he/she will not be able to access the Chronic Conditions benefit.

Unless otherwise decided by Us, benefits in respect of medicine obtained on a prescription are limited to one month's supply (or to the nearest unbroken pack) for every such prescription or repeat thereof.

This benefit provides cover for the following services (for registered Chronic Conditions only):

i. Medication.
ii. consultations
iii. basic radiology
iv. pathology tests

Chronic Disease List	
Acne	Hypertension
Addison’s disease	Hyperthyroidism
Allergic rhinitis	Hypothyroidism
Alzheimer’s disease	Hypopituitarism
Anaemia	Malabsorption syndrome
Ankylosing spondylitis	Male hypogonadism

Chronic Disease List	
Anorexia nervosa	Meniere's disease
Arrythmias and conduction disorders	Menopausal and perimenopausal disorders
Asthma	Menorrhagia
Attention deficit hyperactivity disorder (ADHD)	Motor neuron disease
Barrett's oesophagitis	Multiple sclerosis
Benign prostatic hypertrophy	Muscular dystrophy
Bipolar mood disorder	Myasthenia gravis
Bronchiectasis	Neuropathy
Bulimia nervosa	Obsessive compulsive disorder (OCD)
Cardiac failure	Osteoarthritis
Cardiomyopathy	Osteoporosis
Chronic obstructive pulmonary disorder (COPD)	Paget's disease
Chronic renal disease	Paralytic syndromes and associated complications
Conn's syndrome	Parkinson's disease
Cor pulmonale	Pemphigus
Coronary artery disease/Ischemic heart disease	Polyarteritis nodosa
Crohn's disease	Polycystic ovarian syndrome
Cushing's disease	Polymyalgia rheumatica
Cystic fibrosis	Post-traumatic stress disorders
Deep vein thrombosis	Primary/idiopathic thrombocytopaenic purpura
Depression	Psoriasis
Dermatitis/eczema	Psoriatic arthritis
Dermatomyositis	Pulmonary interstitial fibrosis
Diabetes insipidus	Rheumatoid arthritis
Diabetes mellitus type 1	Rosacea
Diabetes mellitus type 2	Sarcoidosis
Diverticular disease	Schizophrenia
Dysrhythmias	Scleroderma and systemic sclerosis
Dystonia	Sicca syndrome
Endometriosis	Stroke
Epilepsy	Systemic lupus erythematosus
Generalised anxiety disorder (GAD)	Thrombosis and embolism
Glaucoma	Tourette's syndrome
Gastro-oesophageal reflux disorder (GORD)	Transient ischaemic attacks
Gout	Trigeminal neuralgia
Haemophilia	Tuberculosis
Hepatitis B	Ulcerative colitis
Hepatitis C	Urinary tract infection (chronic)
HIV/AIDS	Urinary incontinence
Hyperlipidaemia	Valvular heart disease
Hyperparathyroidism	Zollinger-Ellison syndrome
Hypoparathyroidism	

g. Optical benefits
The following optical benefits are covered on an out-patient basis:
i. 1 (one) eye examination annually
ii. Frames and lenses (including contact lenses) once every 2 (two) years for correcting refractive errors only.

h. Dental benefits
i. Basic Dentistry
This benefit covers the following dental treatments and services on an out-patient basis:
i. Dental consultations
ii. Basic dental procedures, including removal of teeth and roots, fillings, preventative treatment, scaling and polishing and x-rays.

j. Specialised Dentistry
Specialised dentistry including root canal treatment, dentures, inlays, crowns, bridges, periodontal treatment, orthodontic treatment, and dental surgery including maxilla facial and oral surgery and removal of impacted wisdom teeth. Orthodontic treatment will be restricted to members up to the age of 21 (twenty-one) years inclusive.

k. Maternity benefits
This benefit provides cover for benefits for in and out-patient maternity care.

l. Outpatient maternity care includes the following tests and services:

Maternity package	**Quantity**
Consultations	12
Ultrasound scans	3
VDRL	1
Rhesus blood group	1
Haemoglobin	1
HIV test	2
Dipstick protein and glucose	1
Down syndrome screening	1
1st and 2nd trimester serum biochemical markers	1
Chorionic villus sampling	1
Amniocentesis (subject to pre-authorisation)	1

Any additional maternity claims will be paid from the available day-to-day benefits.

m. High-risk pregnancies
In addition to the outpatient maternity benefits listed in Clause 31k. A high-risk pregnancy is defined as a pregnancy that threatens the health or life of the mother or fetus. In such cases we will fund additional consultations and ultrasound scans. Subject to enrolment for case management.

n. In-patient maternity (childbirth)
Under this benefit We cover in-Hospital maternity benefits including confinement, childbirth (natural delivery) and midwives.

Note: Childbirth by caesarean section is excluded except where there is a clinical indication for a caesarean section and where Pre-authorisation has been obtained from the Insurer.

As specified in Clause 11e - 11he, a newborn baby will be covered for 15 (fifteen) days immediately following the birth of the child under the mother's policy subject to the in-patient maternity benefit limit specified in this clause.

o. Neonatal care

This benefit covers the treatment costs for neonatal care required in the case of a newborn baby. In particular, this benefit covers the following:

i. Neonatal ward (incubator)
ii. Phototherapy
iii. Congenital abnormalities
iv. Prematurity

Note: This benefit will apply from birth until the baby has been discharged.

p. Hospital Benefits (In-patient)

Before an Insured Person begins treatment as a Hospital in-patient (except in cases of Accident or an Emergency Medical Condition), the Insured Person must obtain Pre-authorisation from Us at least 2 (two) Business Days before the Hospital admission. The request should be submitted electronically in writing or via the call centre. If the Insured Person does not obtain Pre-authorisation, he may be held personally liable for his medical costs.

Pre-authorisation allows Us to ensure that the most appropriate treatment is provided at the most appropriate cost and enables Us to monitor the quality of care that the Insured Person receives.

In cases of Accident or an Emergency Medical Condition, written notification together with reasonable available supporting medical information must be submitted to Us within 2 (two) Business Days of the event, or if it is a weekend or public holiday, on the next working day.

The following Hospital benefits are covered under this policy:

q. Hospital Treatment and Related Services

Cover includes:

i. Hospital accommodation in a standard private room.
ii. In-Hospital fees for Doctors, Specialists, surgeons, anaesthetists, physiotherapists, or other relevant Specialist consultations rendered in Hospital.
iii. Operating theatre charges.
iv. Medicines to take home (limited to 14 days' supply)
v. Apparatus, material, and ward and theatre medicines used in Hospital.
vi. Accommodation charges incurred by one parent sharing the Hospital room of an Insured child under 12 (twelve) years old (inclusive), where the latter is treated at a Hospital, as an in-patient for a period, and the treating Physician has advised in writing that a parent should remain with the insured child.

r. Psychiatric Hospitalisation
This benefit pays for the costs of psychiatric treatment received as an in-patient in a psychiatric unit of a Hospital. All treatment must be administered under the direct control of a registered psychiatrist.

s. Rehabilitation, Private nursing, and Hospice care
This benefit pays for the costs of rehabilitation, private nursing/home care and hospice care in lieu of hospitalisation. Services should be provided at a registered facility or by a registered healthcare provider. This must follow a Hospitalisation and excludes cost associated with respite care, support for activities of daily living and frail care. This benefit is inclusive of but not limited to accommodation, nursing, medicines, auxiliary services such as physiotherapy and speech therapy, and consultations. Access to this benefit is subject to Pre-authorisation, approval of the treatment plan and subject to the relevant benefit and ongoing case management.

t. Prosthesis and devices
Under this benefit and subject to Clinical Funding Protocols, We will pay for the costs of:
   i. Artificial limbs
   ii. Internal (surgically implanted) devices and prostheses, such as: pacemakers, orthopaedic prostheses including hip replacements.
   iii. Orthopaedic implants e.g., bone lengthening devices, spinal plates, and screws.
   iv. Endo-vascular devices
   v. Devices for the central nervous system, cardiac system, and ophthalmic and auditory system.

u. External Medical Appliances
We will pay for external medical appliances, including wheelchairs, glucometers, hearing aids, and large orthopaedic orthotics e.g., below knee walking boot.

v. Specialised Radiology
Under this benefit, the Insurer will cover the costs of specialized radiology required in or out of Hospital, (PET-CT scans, Radioisotope scans, Computed tomography (CT) scans and Magnetic resonance imaging (MRI) scans). All specialized radiology (in or out of Hospital) is subject to Pre-authorisation and Clinical Funding Protocols.

On certain Benefit Plans, specialized radiology is only covered in cases of Trauma. Please refer to your benefit table or contact your local office to confirm benefits and obtain Pre-authorisation.

w. Ambulance benefit
We will pay for emergency in-country ambulance services (mode determined by logistics) to transport the Insured Person to the nearest, appropriate in-country medical facility for treatment. Pre-authorisation is required for ambulance services where the evacuation or medical condition does not qualify as an Emergency Medical Evacuation or as an Emergency Medical Condition respectively or where the ambulance services (mode determined by logistics) are required cross-border or via air. Approval is subject to Clinical Funding Protocols.

x. Major diseases benefit
Up to the major disease benefit limit and subject to Pre-authorisation and Clinical Funding Protocols, this benefit covers the cost of treatment (in and out of Hospital) for oncology (cancer), organ transplants and renal (kidney) dialysis.

y. Oncology

This benefit covers the costs of cancer treatment irrespective of whether such treatment is received as a registered in-patient or as an out-patient at a registered cancer treatment centre. The benefit is provided when patients are undergoing active cancer treatment, including associated costs up to and including a period of 5 (five) years (after active treatment) to allow for adequate follow-up once a patient is in remission.

In particular, the Insurer cover the following and is subject to Clinical Funding Protocols:

i. Chemotherapy / oncology medication in accordance with evidence-based guidelines. Refer to the Specialised Oncology Medicine List for associated medicines that are either excluded or are subject to specific Pre-authorisation criteria.
ii. Radiotherapy
iii. Specialized radiology:
    - CT / MRI scans (2 per Insured Person per annum)
    - PET scans (1 per Insured Person per annum)
    - Bone scans (1 per Insured Person per annum)
iv. Consultations
v. Pathology
vi. Hospitalisation for in-patient cancer treatment.
vii. Once a patient is in remission, the type and frequency of healthcare services required for follow-up care will be Pre-authorised depending on the type of cancer being monitored and the period of time that has elapsed since the initial diagnosis.

z. Organ Transplants

This benefit covers the cost of operations for the transplantation of the kidneys, heart, liver, lung, cornea, or bone marrow where the Insured Person is the recipient, but does not include:

i. Any costs related to or for the organ donor or cadaver, including organ harvesting.
ii. Transportation of the patient or organ.

Other medical costs associated with an organ transplant are also covered, including:

i. Hospitalisation
ii. Consultations
iii. Anti-rejections drugs (in and out of Hospital)
iv. Pathology
v. Radiology
vi. Donor matching limited to immediate family members defined as biological parents, children, and siblings.

aa. Renal dialysis

This benefit covers the treatment costs for renal (kidney) dialysis irrespective of whether such treatment is received as a registered in-patient or as an out-patient at a legally registered dialysis centre.

Associated medical costs are also covered, including hospitalisation (for in-patient treatment), consultations, medication and pathology. This benefit excludes the reimbursement for automated peritoneal dialysis.

bb. International Benefits (only applicable to selected Benefit Plans)

cc. International Emergency Medical Evacuation
In the case of an Emergency Medical Condition and where treatment is not available locally, the Insurer will pay for the transportation costs for the Insured Person to be evacuated from the country where the Emergency Medical Condition occurred to the nearest, appropriate medical facility within the Region of Cover. The nearest medical facility could be within the country where the Emergency Medical Condition occurred. The following classes of conditions could result in an Emergency Evacuation:

dd. Accidents
An Insured Person will be evacuated to an appropriate facility in the event that the required specialty is not available in the country where the Insured Person is at time of Accident. Whether a specific specialty is required will be determined by our Medical Advisor in terms of advice received from the treating in-country Doctor. The Medical Advisor may from time to time request an additional opinion from an alternative Specialist. In terms of intensive care unit (ICU) care being required, the presence of an ICU in country will determine that the Insured Person is treated in country for ICU care.

ee. Non-Accident Related Acute Conditions Requiring Specialist Treatment
A member will be evacuated for an acute event to another country if there is no Specialist ordinarily available in the country to manage the particular condition. In this regard, the following will be accepted as appropriate to treat conditions requiring Specialist treatment:
i. Medical conditions – Physician
ii. Surgical conditions – General Surgeon
iii. Emergency Evacuations will not be carried out for deteriorating Chronic Conditions.

ff. International Emergency Evacuation will be subject to the approval of our Medical Advisor, availability of benefits (dependent on the Benefit Plan selected) and policy conditions. our Medical Advisor will, in consultation with the relevant medical professionals and subject to our internal evacuation criteria (amended from time to time), determine whether an Insured Person's medical condition constitutes a serious or life-threatening Emergency Medical Condition that requires immediate evacuation to obtain treatment in order to avoid death or serious impairment to an Insured Person's immediate or long-term health prospects. The seriousness of the medical condition will be judged within the context of the Insured Person's geographical location and local availability of treatment or medical facilities.

gg. General evacuation principles
The following evacuation principles apply:
i. The transferring Doctor is responsible for assessing the stability of the patient to travel; that it is in the patient's best interest to be evacuated; and that the patient's prognosis will be materially improved by evacuation.
ii. Appropriate referral screening, clinical examination, special investigations, and stabilization/resuscitation of the patient has to be completed by the referring Doctor, if possible.
iii. Care initiated by the transferring facility may need to be continued during transport.
iv. All relevant clinical documentation must accompany the patient with regard to the assessment and management prior to evacuation (copies of tests done, medication given and referral letter to the accepting Doctor).
v. A decision on the mode of transport will be made.

vi. Evacuation will be either “inter-Hospital transfers” (from one medical facility to another – within the Region of Cover), or “primary response” (where patient has received no or only pre-Hospital care).
vii. The decision as to which mode of transport is used will reside with the Emergency Evacuation services employed and our Medical Advisor. (Many factors need to be considered, including landing areas, mobilization time, weather en-route, time and distance of the flight and certain legal restrictions may also apply such as a limitation requirement i.e., a two-engine aircraft, or at night.)

Following an international Emergency Evacuation, We will pay for the costs to transport the patient back to his country of residence, provided that these costs are pre-authorised by Us.

hh. Critical Care Benefit (in and out of country)
In case of a medically necessary, non-emergency life threatening condition where treatment for inpatient care is not available locally, care may be accessed in-county, elsewhere in Africa or in India. Cover includes travel/accommodation and treatment costs. Follow-up care will be funded locally. If the necessary level of care is not available locally, a maximum of one follow-up consultation within a year of the initial Critical Care medical travel event may be considered. This benefit is subject to the Overall limit and pre-authorisation.

Cover includes:
i. Inpatient treatment, oncology treatment and out-patient services that are necessary to determine a treatment plan or as a follow up to previous treatment approved under the critical care or evacuation benefits.

Funding will be subject to the following criteria:
i. Treatment must be deemed medically necessary and clinically appropriate.
ii. The treatment is not available locally.
iii. For conditions likely to shorten the person’s life, and lead to their death within the next 10 years.
iv. Treatment will be subject to obtaining authorization prior to the transfer and treatment taking place.
v. Treatment will be curative and not palliative.
vi. The treatment is within our clinical funding protocols.
vii. We select the appropriate facility and country in which the treatment will be obtained.

Treatment that is not covered:
i. Experimental treatment
ii. Second opinions
iii. Treatment for the deterioration of a chronic condition
iv. A specific treatment that is not available in-country, but where an alternative clinically appropriate treatment is available in-country.
v. Any treatment that was self-funded outside region of cover without Pre-authorisation
vi. Standard policy exclusions
vii. Treatment for palliative care

ii. Travel and Accommodation benefits for Critical Care and international Emergency Medical Evacuation cases (subject to Pre-authorisation and availability of benefits)

jj. Road travel (Applicable to Critical Care cases only)
   i. For in-country road travel where the facility or provider is 200km or more from the place of current residence of the patient.
   ii. Where a private vehicle is used for travel purposes, fuel will be refunded based on receipts and correlation with travel distance and dates.

kk. Air travel (Applicable to Critical Care and international Emergency Medical Evacuation cases)
   i. A return economy class flight
   ii. A return economy class flight for an accompanying family member (or another pre-specified person) if medically necessary or where the patient is a minor. This will be subject to the specified limit in the benefit tables for the patient.

For travel both in- and out- of country, services will be funded at the nearest, appropriate medical facility.
We fund ancillary charges pertaining to accommodation, food, and transport for the patient (unless they are in hospital) and an accompanying family member (or another pre-specified person) if medically necessary or where the patient is a minor. This will be subject to the specified limit in the benefit tables for the patient.

Pre-approved transport and accommodation costs are paid on a reimbursement basis unless this has been arranged and booked by Us.

To claim your in-country travel costs, you must:
   i. complete the standard travel reimbursement form that shows the point of departure, final destination and distance travelled and
   ii. submit the form with the fuel receipt that clearly shows the date.

ll. Travel and accommodation costs that we don’t pay:
   i. accommodation and travel costs which have not been pre-approved.
   ii. transport or accommodation costs for second opinions or self-referrals by you
   iii. accommodation costs for the night before or after your treatment or admission to hospital if you choose to travel early or stay beyond what we've authorised
   iv. transport or accommodation benefits for treatment that is considered cosmetic, including cosmetic orthodontics and optometry services.
   v. travel insurance
   vi. sundries cost such as internet access, pay-per-view TV, telephone, laundry costs, mini bar, and gratuities.
   vii. visa costs
   viii. transport costs from your place of residence to the airport and back
   ix. car rental
   x. airport or long-term parking costs
   xi. living allowance if you stay with friends or family.
   xii. additional accommodation costs for the patient once admitted to hospital; hospital costs are in lieu of accommodation costs.

mm. Repatriation of mortal remains

In the event that an Insured Person dies outside his home country during an international Emergency Evacuation or Critical Care transfer, We will pay for the costs of preparation and transportation of the Insured Person's mortal remains from the place of death to his home country, or We will pay for the costs of preparation and local burial of the mortal remains in the country where death occurred. We will only pay up to the cost of a standard repatriation coffin.

Payment of the costs related to the repatriation of mortal remains is subject to our Pre-authorisation.

nn. Elective Roaming

Applicable to beneficiaries on Benefit Plans where the Region of Cover extends beyond the country of residence. Members may elect to obtain medical services outside their country of residence but within their Region of Cover, these will be funded in line with available benefits and policy rules. Travel and accommodation costs for the patient and any accompanying family members are not funded. Standard pre-authorisation and clinical funding protocols apply.

Chapter VII: General and Specific Policy Exclusions (Treatment and/or Services Not Covered)

Clause 32 - General Policy Exclusions

Under this policy, there are certain costs which the Insurer does not cover. The following treatment items, conditions, activities and their related or consequential expenses are excluded from the policy and the Insurer will not be liable for them:

a. **Any treatment or medical intervention that is excluded from cover and/or is not supported by our Clinical Funding Protocols.**

b. **Cosmetic treatments and plastic surgery, including keloidal scar tissue removal.**

c. **Pre-Existing Conditions as defined unless otherwise declared on the application form and expressly confirmed acceptance by the Insurer.**

d. **Prescribed alternative medicines such as, but not limited to, homeopathy, acupuncture, Chinese medicine, reflexology, aromatherapy, and household remedies.**

e. **Services or treatment in any home, spa, hydro-clinic, sanatorium, or frail care facility.**

f. **Costs associated with respite care, support for activities of daily living, or long-term care in a facility that is not a registered healthcare facility.**

g. **Treatment related to infertility, impotence, or sexual dysfunction.**

h. **Treatment by the Insured Person himself, family member or Spouse.**

i. **Non-compliance to medical treatment.**

j. **All costs relating to muscular, skeletal, or human organ or tissue transplant from a donor to a recipient and all expenses directly or indirectly related to organ transplantation (except as defined under the Organ Transplant benefit).**

k. **Stem cell transplants for indications outside those supported by recognised international treatment guidelines.**

l. **Treatment and/or death as a result of self-inflicted injury, attempted suicide, abuse of alcohol and drug addiction or abuse including the complications associated with any of the above. Apart from a maximum of 3 (three) days to medically stabilise the Insured Person.**
   Note: **In respect of the Funeral Benefit self-inflicted injuries within the first 24 months following the commencement date are excluded.**

m. **Experimental, investigational, or pioneering medicines or medical/surgical techniques not commonly available which the Insured Person chooses to receive even though treatment usually and customarily provided for the medical condition concerned is available within the Region of Cover of the policy.**

n. **Injury or illness while serving as a full-time member of a police or military unit and treatment resulting from active or voluntary participation in war, invasion or act of foreign enemy, hostilities, civil war, rebellion, revolution, riot, civil commotion or any illegal or criminal activity including resultant imprisonment.**

o. **Travel costs or non-medical costs, unless specifically provided for in the policy.**

p. **Malaria prophylaxis and vaccinations, such as travel vaccinations, epidemics and pandemics, and any other vaccinations.**

q. **Hospital in-patient treatment if the Insured Person could have been treated properly for the condition as an out-patient.**

r. **Charges for appointments not kept.**

s. **Costs or benefits payable under any legislation or corresponding insurance cover relating to occupational death, injury, illness, or disease, including fit-for-work and occupational health assessments.**

t. **Costs relating to Injuries and or medical conditions resulting from illegal events, extreme sports or activities including but not limited to: Rock climbing, mountaineering, potholing, skydiving, parachuting, hang-gliding, piloting a plane (unless approved by Us in writing), parasailing, ballooning, all diving (unless the person concerned has been duly qualified and certified as a diver by an internationally recognized giving organization or unless such person is at the time of the happening of the event giving rise to a claim actually receiving diving instruction from a duly qualified and certified diving instructor), racing of any kind other than on foot and all professional or inherently dangerous sports unless declared to and accepted by Us in writing prior to the event giving rise to a claim.**

u. **The cost of transporting an Insured Person by means of your own transport, and the cost of medical treatment given by the following parties unless We agree in writing to meet such costs:**
   i. **By the Principal Member for their own medical treatment or for any of their registered Beneficiaries**

ii. incurred by the Policyholder's personnel or for medical services rendered by the Policyholder's own medical facilities.
iii. By a third party under a contract between that third party and the Policyholder.

v. Costs arising out of any litigation or dispute between the Insured Person and any medical person or establishment from whom treatment has been sought or given, or any other costs not directly and specifically related to the payment of the medical expenses covered by the policy.

w. Any loss or damage, cost or expense of whatever nature directly or indirectly caused by, resulting from or in connection with any of the following even though some other cause or event may contribute at the same time or in any other sequence to the loss:
i. ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel
ii. the radioactive, toxic, explosive, or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component.
iii. any weapon of war employing atomic or nuclear fission and/or fusion or other like reaction of radioactive force or matter.

x. Services or treatments where Pre-authorisation should have been obtained and was not.

y. Any specialized oncology medicine listed as an exclusion in our list of Specialised Oncology Medicines.

Clause 33 - Specific Exclusions

a. Anabolic steroids and testosterone

b. Art therapy

c. Autopsies

d. Humidifiers

e. Medicated shampoos and conditioners, including those for hair loss. This limitation does not include those preparations used for the treatment of lice, scabies, and other microbial infections as well as coal tar preparations for the treatment of psoriasis.

f. Preparations for age and gender related hair thinning

g. Any medical services and charges incurred by a surrogate parent or intended parent in a surrogacy.

h. Psychometry and neurofeedback

i. Unregistered medicines

j. Massages

k. Vitamins (including multivitamins), mineral supplements, tonics, or any combination thereof.

l. **Treatment for Obesity**

m. **Sleep therapy**

n. **Slimming preparations**

o. **Soaps, scrubs, and other cleansers**

p. **Sunglasses, readers, coloured contact lenses, contact lens preparations and any optical frames and lenses not used for the purposes of correcting a refractive error.**

q. **Sun screening and sun tanning preparations**

r. **Toiletries**

s. **Treatment for hair removal**

t. **Cosmetic breast surgery e.g., reductions/enlargements/mastopexy and procedures for any complications as a result of prior cosmetic breast surgery.**

u. **Management of gynaecomastia**

v. **Search and rescue**

w. **Dental implants**

x. **Refractive eye surgery or laser eye treatment**

y. **Food and nutritional supplements, including baby food and special milk preparations.**

z. **Anti-smoking preparations**

aa. **Repairs to prosthesis and devices (as specified under Clause 31t) or external medical appliances (as specified under Clause 31u.)**

bb. **Any health technology, procedure, or medicine deemed as a Policy Exclusion following the conclusion of an evidence-based health technology assessment process.**

cc. **Probiotics**

dd. **Ozone therapy and hyperbaric oxygen therapy**

ee. **Foot orthotics, shoe inserts, and specialized/orthopaedic footwear**

ff. **Any financial shortfalls on medicines that may arise due to a provider charging in excess of reasonable and customary rates for medicines dispensed.**

Chapter VIII: Obligations and Rights of the Parties; Final Provisions

Clause 34 - Obligations of the Policyholder and Insured Persons

a. In case of a Claim covered by the present contract, the Policyholder, and the Insured Person, under the penalty of being held liable for losses and damages, undertake to
   i. Inform the Insurer of all known pre-existing health conditions.
   ii. Inform the Insurer in writing, of any claim, within the 120 days immediately after its occurrence.
   iii. Perform, whenever requested, exams that will be paid by the Insurer at named doctors, ceasing the Insurer's responsibility if not performed.
   iv. Authorise, in the scope of a Claim that causes a request for provision or reimbursement for health care under the insurance contract, the Doctors and other professionals or health care institutions used, to provide the Doctor designated by the Insurer, with the information requested by the latter, relative to their health condition and the clinical services provided.

b. For the Policyholder and the Insured Person to qualify for the payment of benefits, a Claim must reach the insurer within 120 (one hundred and twenty) days of the treatment or discharge date. A Claim submitted beyond this timeframe will not be paid.

c. The Insurer will not be responsible for the consequences of any delay or negligence attributable to the Insured Person in resorting to assistance, the same happening if he/she refuses to follow the prescribed treatment.

d. The Policyholder and the Insured Person are liable, in legal terms, for losses and damages in cases of Fraud, simulation and falsehood, to justify health expenses or any other malicious use of means aiming at an abusive use of the contract in order to obtain an illegitimate benefit.

e. The Insured Person shall have the burden of proving the veracity of the declarations, and the Insurer may require any appropriate means of proof within its reach.

Clause 35 - Obligations of the Insurer

a. It is the Insurer's obligation to fulfil its commitments to the Policyholder and the Insured Persons in a timely manner, namely:
   i. Provide the Membership Card and/or membership certificate, as well as provide information about the services and/or changes in the Provider Network
   ii. To analyse promptly and diligently the requests for Authorisation
   iii. Make the payment of the benefits according to the terms and conditions, the Benefit Plan and within the deadline foreseen in this policy conditions.

Clause 36 - Final Provisions

Contact Us

If you have any further questions regarding your policy, or if you are dissatisfied with any aspect of your policy, please contact the insurer your financial adviser/intermediary, or visit our website *https://www.libertyhealth.net/mozambique/en/*

Annexure A: Embedded Funeral Benefit

The terms and conditions of the main policy conditions apply unless otherwise stated in this schedule.

EMBEDDED FUNERAL POLICY TERMS & SCHEDULE Funeral Benefit (Family)	
Eligibility	All members who are active members of Liberty Health Cover are eligible to join the Funeral scheme.
Benefit Description	The Benefit covers the Principal Member, Spouse and Children. The Funeral Benefit pays out a lump sum in the event of Death of an eligible member. If family cover is selected, the benefit will pay out a lump sum in the event of Death of the eligible member's spouse or child.
Insured Event	Death of the Insured Persons.
Cover	If the Principal Member and/or Dependants ceases to be a Beneficiary of the health insurance policy by virtue of Death, withdraws (resign), retires, or no longer meet any of the eligibility criteria, cover will cease immediately.
Benefit Cease Age	Cover terminates when the Beneficiary reaches cover cease age.
Waiting Period	No Waiting Period will apply to the Funeral Benefit. No Waiting Period will apply on Death due to accidental causes.
Claim Notification Period	6 months The Policyholder/Beneficiaries shall give written notice to Global Alliance of any benefit claim within the Claim Notification Period. If a benefit claim is to Global Alliance after the expiry of the Claim Notification Period, Global Alliance
Document Submission Period	12 months An electronic mail transmission sheet is insufficient proof that Global Alliance has received the requisite notification, or any other documents or information referred to in the benefit schedules. The Scheme must take reasonable steps to ensure that Global Alliance has received the relevant correspondence or documentation.
Payment of Benefits	On the Death of any Dependant, the death benefits will be payable to the Principal Member, or such other person or persons as the Insurer considers entitled thereto for the cost of funeral services (nominated beneficiary).
Funeral Benefit Exclusions	Please refer to Clause 8 and 9 of the main policy conditions.
Claim Documentation	• Completed and stamped funeral claim form. • Certified copy of proof of death or medical certificate; or burial order. • Certified copy of acceptable form of identification for the claimants and the member. • In the event of Death due to unnatural causes, a certified copy of the police report. • Global Alliance reserves the right to call for any additional information or documentation in order to assess the claim. All costs associated with obtaining and attaining of documents shall be borne by the member. The onus of proving any claim rests on the insured.

EMBEDDED FUNERAL POLICY TERMS & SCHEDULE **Funeral Benefit (Family)**	
Territorial limits of cover	This Policy shall extend to cover all persons of Mozambique. Cover is limited to Mozambique. Should a life assured be looking to reside in another country, Global Alliance will provide cover on the Funeral Benefits only for the life assured in their new country of residence subject to the life assured not residing in the following excluded countries: 1. Mali 2. Libya 3. Burundi 4. Somalia 5. South Sudan 6. Iraq 7. Afghanistan 8. Iran 9. Pakistan 10. Syria 11. Yemen 12. Gaza Strip 13. West Bank 14. Zimbabwe 15. Nigeria Cover on the Funeral Benefit will cease within 30 (thirty) days of entering the new country of residence.
Premium Review	Refer to Clause 28. Global Alliance reserves the right to change the premium rate on a date other than the annual premium review date or annual review date upon 1 (one) calendar month's written notice to the Policyholder if: • The number of members to be insured in terms of this Policy either increases or decreases by more than 15% • A new associated or subsidiary company of the Policyholder commences participation in this Policyholder; or There is a change to the benefit structure under this Policy; or • the business activities of the Policyholder change to an extent that, in Global Alliance's opinion, Global Alliance's risk under this Policy changes in any material respect; or • The Policyholder commences business activities in another region of the Territories to an extent that, in Liberty Life's opinion, Liberty Life's risk under this Policy changes in any material respect.
Exemption from Liability	After payment of the benefit, Global Alliance will be exempted from any liability whatsoever and the Policyholder accepts all liability in respect of the benefit concerned.

EMBEDDED FUNERAL POLICY TERMS & SCHEDULE **Funeral Benefit (Family)**	
Claims, Queries / Complaints	**Claims:** To Claim a Benefit on your Policy, please contact Global Alliance Mozambique. **Queries / Complaints:** Discuss the issue with Global Alliance Mozambique on our helpline +258 21 493 108/18 or email info@ga.co.mz. **Dispute resolution** Any dispute arising out of or in connection with this Plan will in the first instance be referred to the Parties for discussion and resolution at an inter Party meeting to be held 7 (seven) Business Days after notification (by either Party) of a dispute. If the dispute is not resolved at the inter Party meeting, then at the option of either Party, the dispute may be referred to arbitration by an independent arbitrator to be agreed between the parties.
Definitions **Funeral Benefit** shall mean the Benefit set out in the Schedule, which is payable if a claim on the life of the Member is admitted as a valid claim by Global Alliance. **Death** shall mean the Insured Event that is the Death of the Principal Member or any of the defined Dependants. **Insurance** means the Insurance in terms of which Global Alliance provides Benefits for Members in terms of this Policy.	