INDIVIDUAL AND CORPORATE

KINGA BODA HEALTH PRODUCT

INSURANCE POLICY

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 has paid the premium as consideration for such insurance.

NOW THIS POLICY witness that subjects 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 Member's medical expenses as herein defined in Section 2 - A, B, C, and D as a direct result of the 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/disability 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 an online form. 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 for the Member so affected shall be forfeited.
(b) Seek from the Member to be reimbursed for all costs incurred by the Company.

Dated at Nairobi this day of 2023

Authorized Officer

DEFINITION

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

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

"Annual Limit" shall mean the maximum benefits to which the insured is entitled 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 accommodation cost, including the standard meals the Hospital serves.

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

"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 occasionally.

"Date of Service" shall mean the date on which a consultation, visit, treatment, or procedure.

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

"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 instead of 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 an 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 the Company considers medical facilities to be inadequate for the medical case to a hospital in another geographical region where facilities are deemed adequate to manage the case or transportation of a Member from an accident scene to a hospital for

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

"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 physical and/or mental health.

"Income Compensation" shall mean an amount of benefit directly payable to a member in case of an admission at the Preferred Provider.

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

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

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

"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

"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.

Waiting period" The period set by the Insurer that the Member will not get services upon approval of the membership. The waiting period applies to specific illnesses, procedures, and medical treatment. The Waiting period will be waived when renewals are effected with another insurance service provider within one month of the expiry.

"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 per accepted medical standards.

"Members" A Member shall be any person who, with the Insurer's prior consent, shall have applied.

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

"**Permanent Total Disability (PTD)"** shall mean total and absolute disablement that entirely prevents an insured person from engaging in or giving attention to his or her usual occupation or any occupation for which the insured person is qualified and which, in all probability, be lasting and continuous for the lifetime of the insured person and continuous for the lifetime of the insured person.

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

"Preauthorization" shall mean the written prior approval that an insured member may need to assess certain medical services according to the scope of their medical cover.

"Preferred Provider" shall mean a medical provider the Company has appointed through 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.

Temporary Total Disablement" This is disability that renders the Insured entirely incapable of attending to his daily business or his usual occupation or if he has no business or occupation, from attending to any duties which he would normally carry him out in his daily life for a period of time.

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

"A 'Pre-Existing Condition" shall mean a medical condition (or complications of the medical condition) that has at least one of the following characteristics:

- A medical condition that a member knew they had, or ought reasonably to have known and can be medically proven they had either before becoming a Member of the Company for the first time, before reinstatement, before renewal, or before upgrading cover. This will apply whether or not a diagnosis was made, treatment/advice sought and/or treatment is given to the client/customer.
- Any chronic condition diagnosed within the first 90 days of joining cover unless specified otherwise in the policy schedule.
- Any known chronic ailment/condition existed in any previous year of cover.

"We" and "us" means AAR Insurance Kenya Limited.

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SUMMARY OF BENEFITS

SECTION 2

SUMMARY OF BENEFITS

A. Inpatient Benefits: Where applicable

The Company will indemnify the insured for accident and illness medical expenses listed below as per the recommended tariff up to a maximum of the benefit limit as specified in the policy schedule, provided the services were received at the Preferred Provider approved by the Company, and that preauthorization 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 practitioners, specialists, technicians, and physiotherapists in the Hospital only.
3. Radiology, pathology, Xrays and blood transfusions in the Hospital (Scans and MRIs are covered on pre-authorization basis)
4. The medication on discharge, "To Take Out," is subject to the maximum dosage.
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 the Hospital.
7. Hospitalization excludes consultations and all treatment before and after hospitalization.
8. Attendance of a qualified Nurse at the residence of the Member when confined to bed by a doctor's directive.
9. Cost of post-hospitalization care

In an accident, the Company must be informed of any admission within 24 hrs

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.

B. Rescue And Evacuation:

The Company shall, on being notified of an Emergency that requires rescue through the Administrator ground ambulance, undertake the Member's Rescue.

The following terms and conditions shall apply:

1. The Company/Administrator shall endeavour to ensure that a qualified Doctor and/or nurse are on board the ambulance undertaking the rescue.
2. The Company/Administrator shall endeavour to transport the ill/injured person to the nearest approved provider.
3. The Company/Administrator 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, the condition of the ill or injured person is such that it is necessary to terminate the rescue or change the 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

4. The Company shall not be liable for any injury or loss suffered by a Member of 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 labor 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 ground ambulance for any reason whatsoever or breakdown in or failure of communications for any reason.

5. 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 chargeback 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 before 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 specific 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 rescue was not an emergency or a result of a self-inflicted injury and an injury arising out of negligence.

6. The Company will facilitate the provision of Reasonable and Customary care, and other medical services and treatment when transporting the Member to the Hospital. The applicable limit will limit the costs of all these services together.

7. The Company will only provide evacuation to a Member who is entitled to such service, is so ill or injured that his life is in immediate danger, and 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

8. The Company reserves the right to seek the advice of its medical advisor whose opinion will be binding upon all parties to the Contract.

9. The Company's maximum liability shall not exceed the benefit limit stated in the Schedule.

C. Temporary Total Disability (TTD):

The Company of being notified of the above claim, shall determine the liability payable to the Member based on the received medical reports and pay the Member as per the payable limits as stipulated by IRA or as determined by the company.

The following conditions shall apply:

1. Benefits arising from temporary disablement only payable where the disablement occurs within a period of 12 calendar months of the Accident.
2. Payments under event C and/or D may be withheld until the total amounts payable to the insured has been proved and determined to the Company's satisfaction.

D. Daily Cash Compensation:

The Company shall, on being notified of the admission of a member in one of the approved provider, reimburses the amount due to the Member based on the nights of admission to a maximum of 30 nights in a year, provided that the Member has been admitted for more than 24 hours in a Preferred Provider.

E. 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 the Company approved treatment rendered by the Preferred Provider:

1) All general practitioners and specialist consultations, treatments, and investigations (including pathology and x-ray) were 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:

1) 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.

2) Child vaccinations will be as per the KEPI list, must be obtained from the prescribed providers and will count as a visit.

3) 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.

4) Postnatal Care is the period from delivery to six (6) weeks after delivery. This covers delivery-related complications, excluding contraceptive management.

All the above benefit(s) are subject to the overall limit as stated in the Schedule, copayment, excess, visit fees and levy.

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 the Company has approved him to do so.

3) Outpatient services incurred within the waiting periods.Claim

4) Is incurred outside the preferred provider panel.

F. Permanent Total Disablement (PTD):

The Company, on being notified of the above claim, will indemnify the Member to the applicable limit subject to the following conditions:

1) The degree of permanent Disablement will be determined immediately it is established or as soon as it can be reasonable assumed that there will be no further improvement or worsening of the insured persons' condition in consequence of the Accident but not later than 24 months from the date of loss.

2) If the insured person’s existing permanent disablement is aggravated by an accident, the benefit may be claimed equivalent only to a percentage of the amount insured for PTD pro rata to the difference in degree of PTD before and after the Accident

3) Benefits arising from above are only payable when the the disablement occurs within 12 calendar months of the Accident.

Special Exclusions

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

1) For permanent total disablement except on proof of satisfactory to the Company that the disablement will in all probability continue for the remainder of the insured person’s life

2) For more than 100% of the principal sum when more than injury occurs arising out of the same

3) Accident occurring while the Insured is travelling in, boarding, or alighting from any aerial device except as a passenger in any properly licensed private and/or commercial aircraft, including but not limited to accidents occurring while the Insured is acting as an operator, pilot or member of the air crew or undertaking any aerial activity, navigation or technical operation therein or thereon

GENERAL EXCLUSIONS

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GENERAL EXCLUSIONS

The Company shall not be liable in respect of:

1. Expenses incurred in connection with congenital defects or anomalies, intentional self-injury or illness, deliberate exposure to exceptional danger (except in an attempt to save human life) or the Member's criminal Act or resulting from dissipation or drunkenness, treatment of chronic alcoholism, intoxication, the use of drugs not. Patent/proprietary drugs (non-prescription drugs available to the general public without a prescription), homoeopathic drugs, alternative medicine and hormonal replacement therapy, vitamins, tonics, and mineral supplements.
2. Expenses incurred in connection with convalescence, unless directly incidental to the continued treatment prescribed by a doctor and falling under section 2.
3. 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. Cosmetic procedures that the medical advisor deems cosmetic.
    c. Travel expenses other than ambulance costs, where a medical practitioner certifies the use of an ambulance as necessary.
    d. Holidays for recuperative purposes.
    e. All costs in respect of pre-existing conditions.
    f. All costs relating to the purchase of medicines prescribed by a person not legally entitled to prescribe such medicines.
    g. All costs for services rendered by:
        i. Persons not registered as a Preferred Provider in the approved manner,
        ii. Any institution/ hospital or service provider not registered in terms of any law and as a Preferred Provider
        iii. All costs relating to the difference in Recommended Tariff and the actual charge by the Preferred Provider.

4. All costs arising out of treatment not set out in Section 2 include:
    a) Costs relating to private nursing
    b) Costs relating to non-medical treatment
    c) All costs related to interest charges and legal fees arising from overdue Medical accounts.
    d) All costs relating to appointments not kept cancelled by a member
    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) All costs for last expenses resulting from other conditions other than the Accident
    h) Treatment by a medical practitioner, specialist, or consultant who is in any way related to the insured person.
    i) Treatment for any incident after the end of the trip
5. Cost relating to dental and optical
6. Physiotherapy, psychological, day-care surgeries, chemotherapy, radiotherapy
7. Cost relating to Maternity and any related ailment.

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PROVISIONS AND GENERAL CONDITIONS

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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 effect when a member has paid the premium to AAR Insurance Kenya Limited
3. 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 the Hospital or exhaustion of benefit or death or two (1) day from the expiry date of the policy.
4. 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.
5. Premium: The Member will pay a Premium to AAR Insurance Kenya Limited daily or monthly as may be agreed between the Insurer and the client.
6. Identification of Members: Members will be identified using membership ids as per the AAR protocol.
7. Additional members joining mid-month will be required to pay premium relating to the outstanding period towards the month end provided it is not past the 10th.
8. Submission of Claims: In the event of any admission giving rise to a claim under this Policy the claim administrator will notify the Company in writing of any such claim and submit a duly claim form on behalf of the Member within twenty-four (24) hours.
9. Preauthorization. Upon evacuation and stabilization of the Member, the claim administrator will share a preauthorization to admit members who may require critical care. Thus, the Company will bear no responsibility financially, legally, or otherwise for expenses incurred without the preauthorization. In the event of an emergency, preauthorization must be obtained from the Company within six (6) hours of such admission.
10. Fraudulent Claims: If any claim made shall be fraudulent or intentionally exaggerated or any false declaration or statement shall be made in support thereof, then The Company shall void this policy. The insured shall forfeit all premiums paid into the policy. The Company shall seek to recover any claims paid fraudulently from the Member.
11. Reimbursement:
    a. 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.
    b. If an accident necessitates the patient to be hospitalized in a provider not in panel, the provider will be reimbursed at 100% of the recommended tarrifs.
    c. If the Accident necessitates the Member to be hospitalised in the nearest facility and having been rescued by our Ambulance, the provider will be reimbursed 100% of the stabilisation cost and 80% of any other cost that may be required after stabilization.
12. The parties agree to settle any disputes arising from this policy through Court annexed mediation
13. Jurisdiction: Any legal proceedings instituted in connection with this policy shall be brought before a court of competent jurisdiction in the Republic of Kenya.
14. Time Bar: in the event of the Company disclaiming liability in respect of any claim, hereunder the Company shall not be liable 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
15. The Company will have the right to insist that a particular member consult any specialist that the Company /administrator may nominate while on 14 day post hospitalization period.
16. Pandemics, epidemics and outbreaks will be covered to the extent to which it has been purchased by the Member.

17. 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 ratable to the loss company shall not be liable to pay or contribute more than its ratable proportion of any loss which the sum insured hereby bears to the total amount/loss payable.

18. 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.

19. Waiting Periods:
    A. Where applicable, there is a 30-day waiting period for illness-related visits and admissions.
    B. There are no waiting periods for all accident-related claims
20. 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 according 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