Britam Insurance Company (Rwanda) Ltd
5th Floor, KIC (formerly Union Trade Centre)
P.O Box 913 Kigali, Rwanda
Tel: +250 788 198 000
Mobile: +250722316016 / +250788316016
Email: Rwanda@britam.com

Medical Insurance Agreement

SUBSCRIBER:

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The agreement is presented under the contents indicated below;

Contents

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This CONTRACT AGREEMENT is made on XXXXXXX as commencement date of the policy.

BETWEEN:

XXXXXXXX a registered Company having its offices situated in Kigali -Rwanda (hereinafter called "THE INSURED")

AND

Britam Insurance Company (Rwanda) limited, a limited liability company incorporated in the republic of Rwanda having its registered office in Kigali and of P.O.BOX 913, Kigali (hereinafter referred to as "BRITAM"), their successors in title, representatives and assigns on the other part.

WHEREAS:

XXXXXXXX is desirous of contracting BRITAM to insure the inpatient and outpatient benefits as per the benefit schedule below in categories at all medical service providers with partnership with Britam.

Britam has agreed to ensure the inpatient and outpatient benefits subject to the terms and conditions hereinafter appearing:

1) Term:

This agreement is for provision of medical services for a period of Twelve Months (12) months from the XXXXX to XXXXX.

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1. Definitions

Certain words and phrases that appear within this **Policy** have specific meanings, which are set out in this section. To enable **You** to recognise the defined words and phrases **We** have shown them in bold whenever they appear in this **Policy**.

Accident means bodily injury caused solely by violent, accidental, external and visible means and not by sickness, disease or gradual physical or mental process whilst this **Policy** is in force.

Acute means a **Medical Condition** that is brief, has a definite end point and which **We**, on **Advice,** determine can be cured by **Treatment**.

Advice means any consultation from a **Medical Practitioner** or **Specialist,** including the issue of any prescriptions.

Area of Cover means the Republic of Rwanda and elsewhere within the East Africa Community OR outside of the East African Community for **Emergency Treatment** or pre-authorised **Elective Treatment.**

Associated Provider means the **Healthcare Providers** approved by **Us** to provide **Treatment** for which a **Benefit** may be payable.

Benefit(s) means the insurance cover provided by this **Policy** and any extensions or restrictions as shown in the **Schedule of Benefits** or in any endorsements (if applicable).

Birth Defects mean any abnormality, disease, illness or injury present at birth whether diagnosed or not, hereditary conditions or any deformity arising during the antenatal stages of pregnancy or caused during child birth.

Child means a **Principal Member's** own son or daughter, step-son or step-daughter, or any dependant minor who is legally adopted who is in the **Principal Member's** custody.

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Chronic means a **Medical Condition** which has at least one of the following characteristics:

- it continues indefinitely and has no known cure
- it comes back or is likely to come back
- it is permanent
- Its signs and symptoms have been present for the last 3 months.

and requires long term monitoring, consultations, checkups, examinations or tests by a **Medical Practitioner**.

Co-payment means the amount that the **Member** will be required to contribute towards the cost of a **Medical Practitioner's** consultation fees for each consultation.

Congenital Conditions means intrauterine development of an organ or structure that **is abnormal with reference to form, structure or position.**

Date of Entry means the date shown on the **Schedule of Insured Persons** on which a **Member** was included under this **Policy.**

Day Surgery/ Procedure means any procedure performed as **Out Patient** but would ordinarily be performed as an **In Patient. Healthcare Provider** seek authorisation from **Us** prior to any **Day Case Surgery.**

Dependant(s) means one spouse and/or unmarried children who are not more than 21 years and residing with the **Principal Member** or less than 25 years old if in full-time education. Proof of continuous/on-going education should be attached.

Dependants Application Form mean the form that **Dependants** must sign to apply for cover under this **Policy,** including any written statement, representation or document given to **Us** which contains information **We** relied on in issuing this **Policy.**

Due Date means the Commencement date and subsequent **Renewal Dates**, as shown on the **Policy Schedule,** by which the **Premium** must be paid.

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Elective means planned **Treatment** which is **Medically Necessary**, but which is not required as an **Emergency**. **Health care providers** must seek authorisation from **Us** prior to any **Elective Treatment**.

Emergency means a situation or condition placing the **Insured Person** in an immediate life-threatening situation.

Healthcare Provider(s) means a person or place recognised by **Us** including:

(a) A registered **Medical Practitioner**, including general practitioner, physician, **Specialist**, surgeon, anaesthetist, pathologist, radiologist;
(b) A registered dentist, dental surgeon and maxilla-facial and oral surgeon, periodontist and orthodontist;
(c) A private or other hospital, clinic, nursing home, free standing theatre or rehabilitation service;
(d) A registered nurse or nurse-aide including services for terminally ill patients;
(e) A blood transfusion service and supplies;
(f) A pharmacy for drugs requiring a doctor's prescription, and run by a registered pharmacist;
(g) An optical centre run by a registered optician;
(h) A supplier of prostheses both internal and external

Insured Persons means the **Principal Member** and their registered **Dependants** named in **Schedule of Insured Persons.**

In-patient means **Treatment** for which an **Insured Person** is admitted for at least 24 hours to a hospital and for which the hospital makes a daily room and board charge.

Insurer(s) refers to those insurance companies named in the **Policy Schedule,** who provide the insurance under this Policy, each for their respective proportions.

Last Expense means a contribution towards funeral expenses in respect of any **Member** who dies during the **Period of Cover**

Liaison officer means the person appointed by **You** to represent **Your** interests and those of the **Members** on matters pertaining to the insurance through **Us**. Either Broker or Agent

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Lifestyle Benefit means cover for the cost of an approved annual "wellness" examination by a designated **Medical Practitioner**.

Medical Cards refers to the Smart cards issued by **Us** and which incorporate **Member's** Name, Membership number and Name of The Scheme. The card has an inbuilt microchip that stores details of insured **Benefits** and limits**,** Records of utilization**, Date of Entry** and Date of Expiry**.** Members will need to have their fingerprints captured during the first visit to a service provider**.** The card is issued by **Us** to facilitate access to **Benefit** but always remains **Our** property.

Medical Condition means any injury, illness or disease.

Medically Necessary means a medical service or **Treatment**, which, in the opinion of a qualified **Medical Practitioner**, is appropriate and consistent with the diagnosis and, which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the **Insured Person's** condition of quality of medical care rendered.

Medical Practitioner means a person who has attained a primary degree in medicine or surgery by attending a medical school and who is licensed by the relevant professional body.

Member(s) means either a **Principal Member** or registered **Dependant** named on the **Schedule of Insured Persons** and for whom **You** pay **Us** a **Premium** to be covered under this **Policy**.

Member Application Form means the form completed and executed by the **Insured Person** signed to apply to receive benefit under this **Policy,** including any statements, representations or documents given to **Us** that contain information **We** relied on in issuing **Medical Card** to facilitate access to the **Benefits** provided under this **Policy.**

Out-patient means **Treatment** for an **Insured Person** by a recognised medical facility, but not involving admission to a Hospital bed as **In-Patient** or day-Patient.

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Ophthalmological treatment means treatment for eye conditions including infections and surgery excluding the optical services.

Optical Services means treatment to correct visual defects by using lenses and glasses done under Out-patient care.

Period of Cover means the period stated on the **Policy Schedule,** for which the

Premium has been received and accepted, during which this **Policy** is in force**,** and any subsequent period for which the **Premium** has been received and accepted, during which this **Policy** is in force. No **Benefit** will be payable under this **Policy** for any period for which the **Premium** is unpaid.

Policy means this document read in conjunction with **Your Proposal Form,** the **Policy Schedule, Schedule of Benefits** and the **Schedule of Insured Persons** which together make up **Your** contract with **Us**.

Policyholder/You/Your means the person, business, club, commission, authority, association or partnership named as the **Policyholder** in the **Policy Schedule.**

Policy Schedule means the schedule attaching to, and forming part of, this **Policy,** that provides details, *inter alia*, of the **Policyholder, Period of Insurance** and **Renewal Date,** the **Insurer(s), Premium** payable and any **endorsements** that may apply, or be applied, to the **Policy** from time to time.

Premium means the amount **You** are required to pay to **Us** to secure the insurance provided by this **Policy** prior to each **Period of Insurance** for each **Principal Member** and their registered **Dependants** listed on the **Schedule of Insured Persons**. Annual premium is collected before cover commences.

Pre-existing Medical Condition means any injury, illness, condition or symptom:

- for which **Treatment**, **Advice** or medication had been sought or received prior to commencement of the **Policy** for any **Insured Person**, or
- that originated or was known to exist by **You** or the **Insured Person** prior to commencement of the **Policy** whether or not **Treatment, Advice** or medication was sought or received.

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Principal Member(s) means the person who, by completing a **Member Application Form,** and has applied for and been granted entitlement to **Benefit** under this **Policy** and named as an **Insured Person** in the **Schedule of Insured Persons.**

Proposal Form means the form(s) **You** signed to apply for the insurance provided by this **Policy** by **Us,** including any written statement, representation or document given to **Us** which contains information **We** relied on in issuing this **Policy.**

Reasonable and Customary Charges means the average amount charged in respect to valid services or **Treatment** costs, in the place and at the time the **Treatment** was provided, as determined by **Our** experience, independent enquiry, rates agreed upon with our accredited providers and MINISANTE rate guidelines.

Declared Chronic Conditions means a **Chronic** medical condition suffered by any **Insured Person** that has been declared on the **Member Application Form**, and accepted by, **Us.**

Renewal Date means the date immediately following the date of expiry of each **Period of Insurance** and for which a further payment of **Premium** is due to mark the commencement date of a further **Period of Insurance** under this **Policy**.

Schedule of Benefits refers to a schedule detailing the health insurance **Benefits** provided by this **Policy**.

Schedule of Insured Persons refers to a schedule listing the **Principal Members** and their registered **Dependants** covered by **Us** under this **Policy**. All **Dependants** of any **Principal Member** must be named as **Insured Persons** in the **Schedule of Insured Persons** and the **Premium** charged accordingly.

Scope of Cover refers to whether the cover is Regional (East Africa with referral to India) or local (Rwanda Only)

Specialist means a registered **Medical Practitioner** possessing additional qualifications and expertise to practise as a recognised specialist in a particular field of medicine.

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Treatment means surgical, medical or other procedures with the purpose to cure or relieve a **Medical Condition.**

We/Us/Our means the **Insurer(s)** as detailed in **Your Policy Schedule.**

MEMBER EDUCATION, HEALTH TALKS & QUARTERLY REVIEW MEETINGS

- Britam will train members on scheme membership and service access procedures within 1 month of joining the scheme.
- In consultation with the Insured, Britam will organize for health talks yearly where members of the scheme will be educated on various topical issues such lifestyle diseases, stress management, HIV/AIDs etc.
- Britam will carry out review meetings on a quarterly basis with the report being shared with the Human resource or contact person.

Premium Payment plan

a. **Full payment before cover commences.**

Basic premium
Mutuelle de santé of 5% of basic premium
Cost of cards for XX members
Administration fees per life (XXX)
VAT (18% of Admin fees)

Total Inpatient and Outpatient Amount

Total population of XX Staff members and XX dependants

Note: Quotation is attached as annex to this policy

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2. Insured Benefits

CATEGORY: REGIONAL COVER (ALL PROVIDERS IN THE PANEL IN RWANDA, UGANDA, SOUTH SUDAN, KENYA, TANZANIA, MALAWI, MOZAMBIQUE. INDIA AND SOUTH AFRICA ON REFERRAL) 100% COVERED ON IP & OP

Benefits	Annual Limit(RWF)	
Inpatient Overall		Per family
Outpatient Overall		Per family
Maternity within inpatient overall		Per female staff/ spouse
Congenital within inpatient Overall		
Inpatient Non accidental dental within inpatient Overall		Per family
Inpatient non accidental ophthalmology within inpatient Overall		Per family
Out- Patient Dental per family		Per family
Out- Patient Optical per family		Per family
Family planning within Outpatient Overall		Per visit
Hepatitis b Vaccine within Outpatient Overall		Per person
Circumcision within Outpatient Overall		For children and Adults
Pre-existing, chronic, HIV/AIDS, Psychiatric conditions within inpatient Overall		Per family
Covid-19 rider within inpatient		Per family
Plano glasses allowed for 10 people		Per person
XOL for only 5 Families		Per Family

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Funeral expenses		Per death Case
Policy No.	**BRW/----------**	
	All admissible inpatient claims shall paid XX% both in Rwanda and Regional	
	All admissible outpatient claims shall paid XX% both in Rwanda and Regional	
	Road ambulance for all emergency cases	
	MRI and other specialized scans are inclusive in your cover	
	Additional members both staff and dependents will attract additional premium on prorata basis	
	Membership smart card is XXX rwf per person	
	Minisante routine Immunization for children	

2.0 Inpatient coverage

The following **Benefits** are insured under this **Policy**. Not all of the **Benefits** necessarily apply to **Your Policy**, so please refer to the **Schedule of Benefits** for details of the specific entitlement under this **Policy** and the limitations that apply.

All costs must be for **Treatment** that is **Medically Necessary** and subject to **Reasonable and Customary** C**harges**.

2 Dental/Ophthalmological Inpatient

2.1 Accident Dental**/** Ophthalmological Treatment

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We pay for In Patient dental/ Ophthalmological **Treatment** required to restore or replace sound natural teeth/eye that have been lost or damaged in an **Accident** up to maximum In-patient limit.

2.1.1 **Illness** Dental / Ophthalmological **Treatment**

We pay for Inpatient Dental/ Ophthalmological treatment required that is as a result of illness up to the sub-limits stated in the **Schedule of Benefits.**

3 Hospital and Related Services

3.1.1 **Hospital** Treatment **and services**

We pay for hospital accommodation up to the sub-limit stated in **Your Schedule of Benefits,** diagnostic services, meal charges, nursing services, operating theatre charges**, Medical Practitioner(s)** fees, intensive care unit charges, **Specialist** consultation fees, anaesthetist fees and all drugs, dressing or medication ordered by a **Medical Practitioner** for in-hospital use. CT, PET and MRI scans are approved by **Us.**

The available modes of communication may be used to contact the company including phone calls, personal visits, emails, etc

We do not pay for the cost of services that are not **Medically Necessary** (e.g. telephone, faxing charges and newspapers, video cassettes, slippers, flannel, extra meals etc).

Hospital accommodation charges- you are entitled to a single private room ward with the limit of **100,000RWF** in Rwanda and **150 USD** outside Rwanda in all hospitals, VVIP is not covered by this policy.

3.2 Day Surgery/Procedure

We pay for **Medically Necessary** surgical procedures and **Treatment** ordered by a **Medical Practitioner** at a hospital but does not require an overnight stay. This MUST be under general anaesthesia and this must be pre-authorised by **Us.** We must receive

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notification of the scheduled procedure by the hospital/client at least 48 hours before the procedure date.

3.3 **Hospital accommodation for the accompanying parent of a** Child (**Lodger fee)**

We pay for accommodation charges for one parent /Guardian sharing the room with a **Child** who is an **Insured Person** and is under thirteen years.

3.4 Emergency **ambulance services**

We **pay for ambulance services which include road ambulance to a hospital for the** Insured Person**. Only on emergency cases that are life threatening.**

3.5 Emergency Treatment **outside the** Area of Cover

This will be covered however, member will pay out of pocket and seek refund upon return. Reasonable and customary rates will apply.

3.6 In-patient Psychiatric Treatment

We **pay for** In-patient Specialist **consultations at registered psychiatric units of a hospital, subject to the limits shown in the** Schedule of Benefits, **where the** Insured Person **has been referred by a** Medical Practitioner. **Pre-authorisation from** Us **is required and a copy of the referral letter must be submitted with the first claim.**

3.7 In-patient **Physiotherapy** Treatment

We **pay for** In-patient Specialist **consultations up to the sub-limits stated in the** Schedule of Benefits **when the** Insured Person **has been referred by a** Medical Practitioner. **A copy of the referral letter must be submitted with the first claim for such** Treatment.

3.8 Chronic Benefit

We **will pay for** chronic **conditions subject to the limit shown in** Your Schedule of Benefits **and** Chronic **conditions having been declared.**

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3.9 Infertility

Treatment **directly or indirectly arising from or required in connection with male and female birth control, infertility and/or fertility and sterilisation (or its reversal). Will not be covered.**

3.10 Emergency **medical evacuation abroad.**

We will cater for the cost of treatment and accommodation for the client and one accompanying person within the set benefit limits.

3.11 Elective overseas treatment

This is determined by the **Scope of Cover.** Flight tickets and Hotel accommodation will not be covered**.**

2.3 Maternity cover

If this **Benefit** is included in **Your Schedule of Benefits**, **We** will pay for medical services subject to the sub-limit stated on **Your Schedule of Benefits**

Medical services include ante-natal care, new-born accommodation, post-natal care (six weeks from date of delivery) and complications brought about by the pregnancy. Complications include:

- backache, high blood pressure, vaginal bleeding, nausea
- non-elective caesarean section which has been prescribed by a **Medical Practitioner**
- spontaneous abortion and **Medically Necessary** termination
- Miscarriage, ectopic pregnancy and still birth.
- Pre-mature labour

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2.4 Reconstructive surgery

We **will pay for** Medically Necessary **reconstructive surgery resulting from** Accident **or illness occurring during the** Period of Cover **and undertaken within twelve months of the** Accident **or illness.**

2.5 Organ transplants

We will pay for heart and Kidney organ transplants where the **Insured Person** is the recipient. This will include hospitalisation, consultations, Anti-rejection drugs, pathology and Radiology. Subject to exclusions outlined in 3.3 below.

2.6 Last Expense

If this **Benefit** is included in **Your Schedule of Benefits We** will contribute the amount specified in the **Schedule of Benefits** towards the funeral expenses incurred in respect of any **Member** who dies during the **Period of Cover**.

3. Costs We don't cover as inpatient;

There are some costs and expenses that are not covered by this **Policy**. Please ensure that **You** and all **Members** read and understand this section as **We** will not pay for expenses arising from:

3.1 Pre-existing Medical Conditions

We **do not pay for** Pre-existing Medical Conditions **unless declared to** Us **on the** Member Application Form **or** Dependant Application Form**.**

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3.2 **Addictive conditions/disorders and alcoholism, drug and solvent abuse**

We do not pay for any **Treatment** required for, or arising from any addictive condition or disorder, or misuse and/or abuse of drugs or alcohol, or substance or solvent abuse, even if it is related to prescribed drugs.

3.3 Organ transplants

We do not pay for, liver, lung, eye or bone marrow transplants or costs in connection with locating a replacement organ or any costs incurred for removal from the donor, transportation costs of the donor and all associated administration costs.

3.4 Contamination

We do not pay for the **Treatment** of any conditions arising directly or indirectly from chemical or biological contamination or contamination caused from nuclear fission, ionising radiation or by radioactivity from nuclear fuel or waste or asbestos or any other cause.

3.5 Cosmetic Surgery

We do not pay for operations or **Treatments** which are not **Medically Necessary**, including operations or **Treatment** of a cosmetic nature whether or not such operations or **Treatment** shall have been advised on clinical grounds.

We will pay for a surgical operation or **Treatment** to restore the **Members** appearance after an accident, or after surgery for breast cancer, provided the accident and/or breast surgery occurred after the **Member's Date of Entry** and provided the original **Treatment** for the accident or breast cancer surgery was paid for by **Us**.

3.6 Rehabilitation **unless it forms an integral part of** Treatment **received as an** In-patient **and is under the supervision of a** Specialist.

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3.7 Criminal Activity

We do not pay for any **Treatment** arising from or related to injuries sustained whilst engaging in a criminal or unlawful act.

3.8 Experimental drugs and Treatment

We do not pay for any **Treatment** which **We** determine on **Advice** opinion is either experimental or has not been proved to be effective based on established medical practice.

3.9 Other exclusions of the policy.

- Pregnancy terminations **on non-medical grounds, antenatal classes, Midwifery costs when not associated with delivery.**
- **Any form of assisted conception or any complications thereof.**
- Treatment **of impotence or any related condition.**
- **Weight management** treatments **and** drugs**.**
- Treatment **other than by registered** medical practitioners,
- **Hormonal replacement therapy**
- **Hearing tests and cost of hearing aids**
- **Diagnostic equipment (e.g., Glucometers, BP machines etc.) and hearing aids.**

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3.10 Foetal Surgery

We do not pay for surgery undertaken on a baby whilst it is in the mother's womb.

3.11 **We do not pay for** Treatment **for learning difficulties, hyperactivity, attention deficit.**

Disorder, speech therapy, developmental and behavioural problems in children.

3.12 **We do not pay for Orthodontic** Treatment **or related conditions.**

3.13 Prosthesis**, corrective devices and medical appliances which are not surgically required.**

3.14 Health hydros and sauna baths

We do not pay for the use of health hydros, sauna baths, exercise centres or any similar establishments or private beds registered as nursing homes attached to such establishments or a hospital where the hospital has effectively become the **Member's** home or permanent abode.

3.15 Professional sports **and wilful exposure to needless danger**

We do not pay for **Treatment** required while a **Member** is engaged in any professional sporting activity, or any sport or activity reasonably considered by **Us**, and at **Our** discretion, as being of a dangerous nature including but not limited to parachuting, gliding, paragliding, parascending, white water rafting, canoeing, underwater diving involving the use of any artificial apparatus, hang gliding, or bungee jumping; or any occupation reasonably considered by **Us**, and at **Our** discretion, as being of a dangerous nature, including, but not limited to mining, construction and security unless previously disclosed and accepted by **Us**.

3.16 Health examinations and vaccinations

We do not pay for medical examinations and vaccinations arising from insurance or travel requirements, immigration, flying licenses and the like apart from those

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included on the **schedule of** benefits. We will pay for MINISANTE/KEPI vaccines for children up to 4 years. This will exclude baby friendly vaccines.

3.17 **Search and rescue**

We do not pay for search and rescue operations if a **member** is lost in a remote area.

3.18 **Self-inflicted injuries**

We do not pay for the **Treatment** of self-inflicted injuries. **We** do not pay for **Treatment** of disease, illness or injuries sustained whilst a **member** is under the influence of alcohol and/or drugs.

3.19 **Treatment** prior to **Date of Entry**

We do not pay for any **Treatment** that was given before a **Member's Date of Entry** or after cancellation of Membership or during any **Period of Cover** for which **We** have not received **Premium**.

3.20 Treatment **that is not stated in** Your Schedule of Benefits

3.21 Treatment **of any person who is not registered.**

We do not pay for any **Treatment** incurred by non-registered **Dependants** of a **Principal Member** or any other person who is not listed on **Your Schedule of Insured Persons.**

3.22 **Treatment** by a relative

We do not pay for any **Treatment** administered by family, or relatives of a **member,** whether qualified or not.

3.22.1 **Travel and accommodation** costs unless specifically agreed by **Us** in writing prior to travel. Costs and expenses incurred where an **Insured Person** has travelled against medical **Advice.**

3.23 **Elective Treatment** without prior written consent from **Us.**

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3.24 **Dietary supplements and substances** which are available naturally, Including but not limited to vitamins, minerals and organic substances.

3.25 Home visits by a **Medical Practitioner, Specialist** or nurse unless Specifically agreed by **Us** in writing prior to consultation.

3.26 **War Risk**

We do not pay for **Treatment** of any conditions arising directly or indirectly from or as a consequence of riot, strike or civil commotion, civil war, rebellion, revolution, insurrection or military or usurped power, any declared or undeclared war or the like, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) and acts of terrorism committed by a person or persons acting on behalf of or in connection with any organisation.

3.29 Injury or illness while serving as a full **time member of a police or military unit.**

3.30 Alternative Medicines

Prescribed alternative medicines such as homeopathy, acupuncture, Chinese, reflexology, Herbalists, Chiropractors, aromatherapy, patent medicines and household remedies. **Chiropractors** are however covered on referral from a specialist and upon preauthorisation by **Us** if this benefit is included on the **Schedule of benefits.**

4. Outpatient Coverage

Notwithstanding any provision in this policy to the contrary it is hereby DECLARED AND AGREED that the cover will cater for treatment expenses as a result of:

- Routine outpatient consultation,
- Diagnostic X-ray and Laboratory tests
- Radiology X-ray, ultra sound, EEG,ECG and computerized tomography, MRI scans
- Prescribed physiotherapy
- Prescribed drugs and dressings.
- Chronic conditions up to the full outpatient limit
- Referrals to specialist
- Cancer treatment
- HIV/AIDS (Voluntary counselling and testing & other related treatment) plus ARV's
- Dental cover. The Dental cover provides for cost of fillings, x-rays, extractions including surgical extraction together with anaesthetics fees.

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- Optical cover.
- Routine Antenatal check-ups (maximum two Ultrasound examinations).
- Postnatal care up to six weeks post-delivery.
- MINISANTE vaccines covered within the outpatient limit for children up to one and half years.
- Pap Smear & Prostrate surface antigen (PSA) test for employees/spouse at available credit facilities, RBS, and Lipid profile.
- Congenital conditions
- Vaccination for hepatitis B
- Circumcision for children
- Family planning up to the specified limit
- Infertility Investigations are covered
- Orthopaedic and braces are covered for the children not above 16 years
- Hearing aids are covered.

Additional Benefits.

- Gym and fitness services at discounted prices
- On site Medical clinics
- Travel Insurance for members
- Health talks
- Member education
- Monthly Utilization reports

5. Outpatient scheme exclusions

- Self-referred or self-prescribed treatment.
- Exceeded limits and claims incurred above the cover limit or outside policy benefits
- Benefits utilized above the cover limit.

- Weight management treatments and drugs.
- Nutritional supplements unless prescribed as part of medical treatment of specified conditions.
- Experimental treatment.
- Cost of hearing aids unless their use is necessitated by accidental* injuries.
- Treatment resulting from, or incidental to intentional self-injury, self-inflicted medical disorders/wounds, committing or attempting to commit suicide, non-adherence to medical advice, and wilfully exposing oneself to unnecessary danger except in an attempt to save human life.
- Cosmetic skin & beauty treatment (and consequent disorders), and/or cosmetic surgery unless the surgery is necessitated by accidental* injuries.
- Conditions related to drug abuse, over-indulgence in alcohol, participating in dangerous sports and/or any other sport as a professional, riots and strikes, law-breaking activities, and acts of terrorism.

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- War and kindred risks (acts of foreign enemy hostilities whether war is declared or not, civil war, rebellion, revolution, insurrection, or military power).
- Injuries or conditions resulting from military, naval or air force operations, and air travel except as a passenger on a registered commercial airline.
- Expenses recoverable under any other insurance, including benefits receivable under Workmen's Compensation Act and Government Schemes.
- Contamination from ionizing radiation or by radioactivity from nuclear fuel, waste, or fission.
- Cost of treatment in health hydros, nature cure clinics, homeopaths, Acupuncturists, Herbalists, unregistered medical practitioners/ nurses, or any arranged stay in hospital/nursing home for reasons other than treatment.
- Non-medical supplies i.e. Toothpaste, Mouthwash.
- Abortion
- Treatment outside the scope of cover.
- External surgical appliances (Frames, Wheelchairs).
- Diagnostic equipment (e.g Glucometers, BP machines etc.)
- Hormonal replacement therapy.
- Impotence or any related expenses.
- Dental exclusions: Outpatient dental prophylaxis, crowns, dental bridges, dental pontics, dental sealants, unauthorized oral surgery, replacement of natural teeth, dentures and Braces for adults.
- Optical exclusions**:** -Coloured contact lenses.

6. General Conditions

4.1 The Policy and Proposal

This **Policy**, together with **Your Proposal Form**, the **Policy Schedule,** the **Schedule of Benefits** and the **Schedule of Insured Persons** represents the contract between **You** and **Us.** The terms of this **Policy** apply to the **Policyholder** and all **Members** named in the **Schedule of Insured Persons** on attaching to the **Policy Schedule**.

Your completed, signed and dated **Proposal Form** is an integral and crucial part of **Your** contract with **Us** and the insurance **We** provide. **You** must ensure that **Your Proposal Form** and all the **Member Application Forms** and **Dependant Application Forms** (if applicable) that **You** provided have been honestly, fully and accurately completed, and that **You** and the **Principal Members** have made full disclosures of all the facts relating to their health and to the health of their registered **Dependants**.

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4.2 Age limit

Principal Members and spouses must be under 60 years of age at the **Date of Entry** and once admitted into the scheme they shall be covered up to maximum age of 65 years. The minimum joining age for children is 0 days upon clinical discharge and a maximum of 21 years at each subsequent **Renewal Date** provided they are unmarried, or less than 25 years old if in continuous full-time education. **We** shall require evidence of continuous full-time education.

4.3 Commencement of Your cover

Cover will commence from the **Date of Entry** or upon payment of due premium. **We** will not commence cover until **We** have accepted **Your Proposal Form** and **We** have received payment of **Your Premium** in full.

4.4 Contribution

If there is any other insurance covering any of the **Benefits** provided by this **Policy You** must disclose the details or ensure the relevant **Insured Persons** discloses the same to **Us** and **We** shall not be liable to or contribute more than **Our** proportionate share.

4.5 Extent of cover

This **Policy** covers the **Members** listed on the **Schedule of Insured Persons** against the cost of the necessary, recognised medical **Treatment** of **Acute** conditions and **Declared Chronic Conditions**, within the limits and sub-limits as stated in the **Schedule of Benefits**. **We** would prefer that **Treatment** is carried out by a **Healthcare Provider** on **Our Associated Provider List**. **We** will pay **Reasonable and Customary Charges** for covered **Treatment** and **We** will only pay for **Treatment** or services received during the **Period of Cover**.

Treatment or services rendered by **Healthcare Providers** outside the **Associated Providers List** will be reimbursed according to **Your Schedule of Benefits** and on the basis of **Reasonable and Customary Charges** for the **Treatment** provided.

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Our liability is limited to the sub-limits stated in **Schedule of Benefits.** The annual limit and specific sub-limits per **Insured Person** stated in the **Schedule of Benefits** is the maximum amount recoverable under the **Policy** during the **Period of Cover**

4.6 Appointment of a **Liaison Officer**

You will be required to appoint a **Liaison Officer** who will represent **Your** interests and the interests of the **Members** on all matters pertaining to this **Policy**.

4.7 Health **Benefits**

You have purchased the **Benefits** (stated in **Your Schedule of Benefits**) for the **Principal Members** and registered **Dependants** listed in the **Schedule of Insured Persons**. All registered **Dependants** of a **Principal Member** will be entitled to the same **Benefits** as the **Principal Member** or as stated on the Schedule of Benefits.

You must ensure that all **Members** familiarise themselves with the **Benefits** covered. **We** will only pay for the **Benefits** stated in the **Schedule of Benefits**. If the **Member** incurs costs for **Benefits** that are not covered, they will have to pay these costs themselves. If any **Member** incurs costs in excess of the limits stated in the **Schedule of Benefits**, **You** will have to pay the difference.

4.8 Currency

The **Benefit** limits are set out in Rwandan Francs (Rwf.)

4.9 Paying **Your Premium**

All **Premiums** are payable within 15 days from commencement of this policy. **You** are responsible for the payment of the full annual **Premium** for each **Period of Cover** upon commencement of the cover.
In the event that any **Premium** due is not paid to **Us** by the **Due Date We** reserve the right to terminate this **Policy** without notice and **We** shall be discharged from all liabilities.

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4.10 Changes in **Premium** rate

The **Premium** payable may vary at renewal and will be reviewed prior to the expiry of each **Period of Cover**. **Premiums** may be adjusted and / or special conditions, exclusions or limitations applied to individual **Members** who disclose a medical history that presents the likelihood of a higher than normal frequency or cost of claims.

6.11 Unpaid **Premium** or late payment of **Premium**

We reserve the right to cancel cover for the **Members** listed on **Your Schedule of Insured Persons** if **You** fail to pay **Your Premium** on or before the **Due Date**. If **You** pay the outstanding **Premium** within thirty (30) days **We** will allow the cover to be restored without existing **Members** being required to complete new **Member Application Forms** and/or **Dependant Application Forms.**

If **Premium** is outstanding for more than thirty (30) days, cover will only be reinstated upon receipt of satisfactory declarations of good health for all existing **Members** and subject to immediate payment of all outstanding **Premium**. If any **Member**'s state of health has changed **We** reserve the right to decline to continue to insure such a **Member**.

If **Premium** remains outstanding for more than ninety (90) days **You** will have to re-apply for this **Policy.**

6.12 Addition or deletion of **Members and** replacement of damaged or lost cards

To add new **Members** into the existing scheme, **You** must submit a completed and signed **Member Application Form** for the **Principal Member** and/or **Dependant Application Form** for the **Dependants** whose cover is to commence, in addition relevant documents must be attached i.e Copy of National ID/Passport, Birth Certificate for children and Marriage Certificate for spouses.

Termination of cover for an **Insured Person** occurs upon request by **You** or on the date of retirement, resignation or termination of employment. **We** must receive written notification from the HR to terminate cover for an **Insured Person.**

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All instructions for additions and deletions take effect immediately on advice of the Human Resource and/or receipt of the Medical cards for deleted members. These instructions MUST be channelled through the Human resource in writing.

Premium for new members will be charged on pro-rata basis for the remaining period. An alternative of replacement of joiners with leavers shall be acceptable subject to quarterly reconciliation.

Refund of prorated premium for staff who have left will only occur where no inpatient and outpatient claim has been incurred and will be done every quarter.

For lost or stolen cards the HR must report in writing to the company and the cost of reprinting the card will be bore by the member or the organization.

For damaged cards, the member must surrender the damaged card before issuance of a new one. The cost of printing will be bore by the member.

6.13 Transfers

If a **Principal Member** and **Dependants** wish to change their cover to provide for lower **Benefits**, **You** must tell **Us** in writing and **We** will make the change from the beginning of the following month after the receipt of such a letter. Any **Premium** refund resulting from the change will be subject to there having been no previous claims.

If a **Principal Member**, with any registered **Dependants**, wishes to transfer to higher **Benefits**, they must complete a new **Member Application Form** and/or **Dependant Application Form** and make a full declaration of any changes in their state of health since their **Date of Entry** and **You** must submit it to **Us** with a covering letter. At **Our** discretion, **We** may apply **Waiting Period(s)** if their state of health has changed since their **Date of Entry** or **We** may refuse to increase their cover. Any increase in cover will be subject to **Us** having received payment of the appropriate additional **Premium** from **You**. Upgrade of cover can only be accepted at renewal, one month after renewal or when a member is promoted to an upper job category.

6.14 Children

Cover for new born children occurs upon notification by the client and payment of premium. The existing **Principal Member** needs to complete a **Dependant**

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Application Form within 30 days of birth. Bills incurred by new born after delivery but before discharge shall be payable within the maternity limit.

Children under the age of 21 years and not married or 25 years if in full time education and are residing with the **Principal Member,** are eligible for cover as **Your** registered **Dependants.** Children are subject to identical cover as the legal parent or guardian or as agreed upon between the Insured and Insurer

6.15 Liability

Our liability shall cease immediately upon termination or cancellation of the **Policy** or **Insured Person** for whatever reason and upon benefits full utilisation as stated in the **Schedule of Benefits**. It is **Your** responsibility to collect all **Medical Cards** and return them to **Us. We** shall not be liable for any medical expenses incurred upon termination or cancellation of the cover for either the **Insured Person** and/or **Policyholder.**

6.16 Non- Disclosure

In case an insured person makes a false declaration or knowingly fails to disclose that he has or is suffering from an illness or condition, then the company reserves the right to impose waiting periods, impose premium loadings or 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. The company will notify the insured person in writing of any limitation, premium loading or specific exclusion imposed.

6.17 Administration fees

We charge an administration fee of Rwf.15, 000.00 per person per annum. This caters for the annual fee plus cost of the smart access fee.

7. Making a claim

Claims may only be made for **Treatment** or medical services rendered during the **Period of Cover.**

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7.1 Submitting a claim

If a **Member** wishes to make a claim for reimbursement it must be submitted:

a) On **Our** health insurance claim form.
This form shall show the **Principal Member's** name and address, claiming **Member's** name and date of birth, Membership number, date of **Treatment**, details of diagnosis and **Treatment** given, fees charged, **Members**' signature and **Medical Practitioner's** signature and official rubberstamp.

b) On a recognised hospital or pharmacy claim form.
This form shall show the **Principal Member's** name and address, sick **Member's** name and date of birth, Membership number, date of **Treatment**, details of diagnosis and **Treatment** given, fees charged, **Members**' signature and **Medical Practitioner's** signature

c) On a *bona fide* original invoice.
This invoice shall show the **Member's** name and address, the membership number and signature and must provide sufficient detail of **Treatment** or services rendered to enable **Us** determine the correct amount payable to the **Principal Member** or **Medical Practitioner**. If the invoice emanates from a foreign source, **Our** reimbursement will be to the **Principal Member**.

d) On a *bona fide* original invoice from a foreign **Healthcare Provider** for **Treatment** received outside the borders of Rwanda, which has been referred by a **Specialist**, in Rwanda, to the foreign **Healthcare Provider** because such **Treatment** is not available within Rwanda and for which **We** have issued a guarantee of payment to the foreign **Healthcare Provider**. **We** may, before paying the claim, require further information as may be reasonably necessary for that purpose.

7.2 Settling Your claims

Upon receipt of claims from **Members** or **Healthcare Providers**, **We** register the claims for assessment and payment directly to the **Healthcare Provider** or reimburse the **Member** as required.

Claims for medical **Treatment** incurred in Rwanda are acceptable for assessment and payment direct to the **Healthcare Provider**, if the **Medical Practitioner** concerned is on **Our Associated Provider List**.

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For **Treatment** incurred outside the borders of Rwanda, a claim will be accepted by **Us** for assessment, if the **Healthcare Provider** rendering the **Treatment** or service is a **Medical Practitioner** in terms of the laws of the country concerned and if such **Treatment** is a **Benefit** available in the **Schedule of Benefits**. A **Member** must seek approval from **Us** for any scheduled foreign **Treatment**. This must be done prior to receiving the **Treatment** and **We** will issue a written notification authorising **Treatment.**

Any treatment accessed outside our panel of providers both locally or within geographical regions members will require to pay and seek reimbursement as per policy conditions.

Claims shall be considered only if received by **Us** within ninety (90) days from the date of **Treatment**. **We** will reject any claim which is submitted after this period.

All **Members** should consider details of the nature of an illness or their **Treatment** to be confidential.

7.3 Approved hospitals

We will settle claims directly with **Healthcare** P**roviders** and **Medical Practitioners** who are on **Our Associated Provider List**. Some **Healthcare Providers** are NOT on **Our Associated Provider List** and will not have agreements with **Us**.

If a **Member** receives medical **Treatment** or services from one of these **Healthcare Providers,** the **Member** will be required to settle the charges for the **Treatment** or services rendered and submit the invoices to **Us** for reimbursement. Invoices and receipts in such instances must have **Member's** name and membership number and show sufficient detail on the **Treatment** or services rendered to allow **Us** to assess and reimburse the **Member. We** will reimburse based on **Reasonable and Customary Charges** for the **Treatment** or service given and in accordance with **Your Schedule of Benefits**.

7.4 Proof of claim

Original documentation and receipts together with a fully completed claim form signed by the **Medical Practitioner** submitted within the time limits stated earlier. Photocopies are not acceptable.

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7.5 Claims for an illness or injury caused by a third party

If one of the **Members** listed on **Your Schedule of Insured Persons** is claiming for an illness or injury that was caused by a third party they must let **Us** know in writing straight away, or indicate to **Us** on the claim form. **We** will then pay **Benefit** in accordance with the terms of this **Policy** provided the **Member** takes all reasonable steps required by **Us** to recover from the person at fault (such as through the third party's insurance company) the cost of the **Treatment** paid by **Us**.

If the **Member** is able to recover the cost of any **Treatment** for which **We** have paid, the **Member** must repay that amount to **Us**.

7.6 Members who are covered by another insurance plan

If any **Member** listed on **Your Schedule of Insured Persons** has any other insurance cover or right to compensation for the cost of **Treatment** for **Benefits** the **Member** has claimed from **Us**, **You** must tell **Us** in writing as soon as possible or the **Member** must tell **Us** on the claim form. If the **Member** does have other insurance cover or right to compensation, **We** will only pay **Our** share of the cost of **Treatment.**

7.7 Medical Evaluation

We reserve the right to request further tests and/or evaluation where **We** are of the opinion that the condition being claimed for may be directly or indirectly related to an excluded condition.

7.8 Fraudulent/Unfounded Claims

If any claim under this **Policy** is in any respect fraudulent or unfounded, all **Benefits** paid and/or payable in relation to that claim shall be fortified and recoverable. Further, the **Insured Person** shall be cancelled from **Date of Entry** without refund of **Premium.**

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7.9 Subrogation

We reserve the right of subrogation. **You** have no entitlement to admit liability for any eventuality or give promise of undertaking on **Our** behalf that may prejudice our subrogation rights; only **Our** written consent will suffice.

8. Cancellation

a. In the event of non-payment of **Premium**, **We** reserve the right to cancel this **Policy**.

b. **We** may at any time terminate an **Insured Person's** cover if the **Member** or the **Policyholder** has at any time:
- misled **Us** by misstatement
- knowingly claimed **Benefits** for any purpose other than as are provided under this **Policy**
- agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to **Our** detriment
- Otherwise failed to adhere to the terms and conditions of this **Policy** or failed to act with utmost good faith.

c. **We** or **You** may cancel **Your Policy** by sending a thirty day notice by registered mail to the last known address and in such event **You** shall be entitled to the return of any **Premium** corresponding to any unexpired **Period of Cover** less an premium for member who have incurred a claim.

9. Renewing cover

9.1 You may apply to renew cover at the expiry of each **Period of Cover** from the **Renewal Date**. **We** have the right to vary terms, conditions and exclusions of the **Policy** at each renewal and notice of our intention to do so will be provided to **You** at least thirty days in advance of the **Renewal Date.** No alterations or amendments to the **Policy** will be valid without a written notification signed by Britam and the Insured.

9.2 Registered **Dependants**

Any registered **Dependant** can continue to be covered subject to the age limits under this **Policy. We** shall require evidence of continuous full-time education for children over the age of twenty one years.

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When a registered **Dependant** marries, or reaches the age of Twenty One (21) years at their **Renewal Date** or when they cease being in full time education, or, if they are in continuous education but have reached the age of Twenty Five (25), they are no longer eligible to be covered as a **Child** under this **Policy**.

9.3 Renewal **Premium**

Your Premium for each new **Period of Cover** will depend on the performance of the scheme which shall be measured by the loss ratio, the number and age of **Members** and their **Benefits**. Future renewal **Premium** is subject to change. Annual premium shall be expected before cover commences

9.4 **Your** renewal **Premium** invoice

We will send **You** a renewal **Premium** invoice that will indicate the total **Premium** due for the year and will show **Your Schedule of Insured Persons**. This renewal **Premium** invoice will be sent to **You** 60 days prior to **Your Renewal Date with a reminder 30 days to expiry**.

10. Arbitration and jurisdiction

Any dispute arising from this agreement shall be resolved as follows:

(a) The parties shall endeavour to resolve the dispute by negotiation in the first instance. Any party to the difference shall issue a notice of its intention of referring the dispute for negotiation within thirty (30) days from the day either party declares that a dispute has arisen.
(b) The dispute or any issues not resolved by negotiation within (30) days of commencement of the negotiation, or of an extended period as the parties may agree, shall be referred to a competent Rwandan court of law.

A dispute that is not referred to the negotiation and Court of Law process for determination within twenty four (24) months after it arose shall be considered abandoned.

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11. Making a complaint

If **You** feel dissatisfied with any aspect of your policy or **Our** relationship with **You** in respect of **Your Policy We** would like to hear about it.

Please feel free to contact us or your usual intermediary. Or write to us on the below address.

Head of Medical Business,

Email: omatura@britam.com

Phone:0785144539

5th Floor, UTC Building,

PO Box 913

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IN WITNESS WHEREOF_THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES THIS XX DAY OF XXX.

SIGNED on behalf of **XXXXX**

SEALED with the COMMONSEAL of THE INSURED

SIGNED on behalf of **BRITAM INSURANCE COMPANY (CO.) RWANDA LTD**

CHIEF EXECUTIVE OFFICER ----------

Authorized signatory:-

MANAGER-MEDICAL ----------