MANAGEMENT RULES AND SCHEDULE OF BENEFITS
for
NORTHERN ALLIANCE PLANS
NOVEMBER 2013

DIGEST OF RULES

This digest of rules contains a summary of those Rules of the Society which the Management Committee considers will be of significance and as a guide to members of the Northern Alliance plans. These Rules, which may be amended from time to time, are formulated in terms of the Constitution of the Northern Medical Aid Society, as registered with the Ministry of Health and Child Welfare in conformity with the Medical Aids Act of the Parliament of Zimbabwe.

OBJECTIVES

The Northern Medical Aid Society is a non profit making organisation operating throughout Zimbabwe, formed with the object of utilising funds raised from membership subscriptions to enable it to defray a significant portion of expenditure incurred by members and their registered dependants on medical, dental and other treatment and the purchase of prescribed medicines and drugs.

MANAGEMENT

The general business of the Society is under the control and supervision of a Management Committee consisting of not less than six, nor more than ten members, elected as representatives at the Annual General Meeting from amongst the members.

ADMINISTRATION

The day to day administration of membership enrolments, marketing activities, claims adjudication, payments, resignations, terminations and all related business is carried out by the nominated secretaries, Alliance Health, who report to the Management Committee.

MEMBERSHIP

Membership of the Northern Alliance plans is open to individuals, families and the employees of employers who are approved and admitted as Constituent Bodies, provided that applicant/s meet the prescribed requirements. **The Management Committee reserves the right to refuse any application for any reason without explanation.** The Management Committee reserves the right to request medical reports and further information before adjudicating the acceptability of any application.

NEW MEMBERS

All new members and/or dependants have benefit immediately on admission, with the exception of waiting periods as outlined below. All new members are required to pay the initial three months subscriptions, upon joining, upfront. This period may be revised from time to time or waived at the discretion of the Management Committee.

CONTINUATION OF MEMBERSHIP

The rules of the Society provide for continued membership in the following circumstances:

1. As a pensioner-Employees retiring either on pension or on account of age, ill health or other disability, who at the date of retirement or termination of employment are over 65 years old.
2. As a widow or widower.
3. Employee leaving employment- (and dependants) resigning from a Constituent Body shall have rights, to be exercised not less than thirty days prior to the date of termination of their employment, to apply for the continuation of their membership of the Society and if accepted, they shall thereafter be covered as an individual or family and shall be responsible for their monthly subscriptions
4. Residence outside Zimbabwe – should a member decide to live outside of Zimbabwe, he/she may retain membership if they so wish. Membership under such circumstances shall be subject to Zimbabwe legal requirements, in particular those relating to Exchange Control. The member will also agree to such terms and conditions applicable to non-resident membership.

CONVERSION FROM OTHER NORTHERN MEDICAL AID SCHEMES

Should a member and/or dependant or Constituent Body wish to convert from a lower NMAS scheme, waiting periods can be carried over and any time accrued towards waiting periods will be considered

As the Northern Alliance scheme runs from January to December each year, new members of Northern Alliance who join the scheme after January of any year will have their benefits for that year pro-rated accordingly.

The listed waiting periods and restrictions may be revised from time to time or can be waived at the discretion of the Management Committee.

UPGRADING OR DOWNGRADING BETWEEN SCHEMES

Members and constituent bodies may upgrade or downgrade between Schemes during the course of a year however this will be at the sole discretion of the Management Committee. Standard waiting periods will be applied to pro-rata increases in benefits. Under no circumstances can a member upgrade once he or she is aware of a potential medical condition which may result in a claim

DANGEROUS OCCUPATIONS, ACTIVITIES AND LIFESTYLES

As per the printed Northern Alliance "Medical and Other Loadings" table, dangerous occupations, activities, sport and lifestyles are subject to a Risk Assessment survey. Once a documented Risk Assessment has been completed, a potential new member's application may either have a premium loading placed on it or may be rejected. The costs of treatment for injuries and illness related to dangerous occupations, activities, sports and lifestyles may not be included in the benefits of membership. Dangerous occupations, activities, sports or lifestyles will only be covered if confirmed in writing by the Society.

DEFINITIONS OF TERMS USED

AMENDMENT OF RULES - shall mean any changes to the Rules that are deemed to be appropriate by the Management Committee.

AREA OF BENEFITS USE - shall refer to the territories listed below in which full benefits of membership to the Northern Alliance Plans may be used :-

Botswana, India, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe

CHILD shall mean a member's dependant child, step-child or legally adopted child under the age of 18 years, who is unmarried and who is not entitled to benefits from any other medical aid society.

CONSTITUENT BODY shall mean an employer or recognised body duly admitted to membership of the Society (subject to the discretion of the Management Committee).

DEPENDANT shall, subject to the Rules mean and include a person resident in Zimbabwe who is :

1. The legally recognised spouse of the member
2. A child of such member
3. The child of a Widow or Widower
4. The child of a judicially separated or divorced member who has legal custody of such child or;
5. The child, step child or adopted child of a member between the ages of 18 and 25 who is unmarried.
6. A member's child over 18 years of age who, owing to mental or physical defects or similar cause is not in receipt of a regular income subject to the discretion of the Management Committee and on such condition as it may specify.
7. On the recommendation of a member's parents or dependants spouses parents who are not more than 65 years old.

Provided that all persons mentioned above are not entitled to benefits from another medical aid scheme.

FRAUD
Shall mean any deliberate attempt to withhold, change or manipulate information which results in improper use of the medical plan and may result in the Society being financially prejudiced.

LIMIT OF THE SOCIETY'S LIABILITY
Shall mean the maxima that the Society may bear in terms of a claim or series of claims in one year

MEDICAL BENEFITS

Visits, consultation and procedures and operations undertaken by General Practitioners or by Specialists on members or their registered dependants will be paid according to what is understood to be Reasonable and Customary. Where the charges made by provider of medical services and/or treatment exceed levels that are Reasonable and Customary or where a member or his/her dependants exceed annual limits, the member is responsible for the resulting shortfall.

Ambulance Services
Air Ambulance Services - Pre-Authorisation is required prior to services being engaged.

Ground Ambulances - subject to the Annual Limits set out in the Benefit Table, the services of any necessary Ground Ambulance Service within a municipal area are paid as charged up to Reasonable and Customary charges for Primary Call, Procedure Call and Transfer Call.

Long range calls will be paid up to Reasonable and Customary charges per kilometre. Ground Ambulance Services are only covered if the service is of an "emergency critical care" nature. Members who abuse this

service will be required to pay the full cost.

Dental Benefits - the benefit covers the cost of all **normal dentistry** performed on members or their registered dependants. The member will be refunded subject to the Annual Limit set out in the Benefit Table if he/she has paid for treatment. The cost of orthodontic treatment will be treated the same as normal dentistry as set out above. Orthodontic Treatment has a 24 month waiting period from the join date. Children under the age of 12 are not eligible for the orthodontic treatment benefit.

Normal dentistry is :

- examinations
- tooth cleaning
- normal compound fillings
- simple or non-surgical extractions
- root canal treatment, new or repair of upper or lower dentures

Major restorative dental treatment covers fees of a dental practitioner and associated costs for the following specified procedures :

- removal of impacted, buried or un-erupted teeth
- removal of solid odontomes
- apicectomy, new or repair of bridge work, new or repair of crowns

Excluded from the dental benefit are pre-existing conditions, cosmetic dentistry, precious metal elements.

External Appliances - The Society pays for prosthetic devices needed as part of a member's treatment. By this the Society means an external artificial body part, such as a prosthetic limb or prosthetic ear which is required as a result of a members surgical procedure. The Society will not pay for maintenance of the prosthesis. The Society will not pay for any replacement prosthetic devices for adults including any replacement devices required in relation to a pre-existing condition. The Society will pay for the initial and up to two replacements per device for children under the age of 18 years.

The maximum benefit the Society will pay towards a prosthetic device is subject to the benefit limits :

10 degrees - $ 6,000.00 lifetime limit.
20 degrees - $ 8,000.00 lifetime limit
30 degrees - $10,000.00 lifetime limit

The definition of prosthetic: an artificial substitute or replacement of a part of the body such as an Arm or a Leg.

These Lifetime limits do not apply to Internal Prostheses.

Fertility/HIV Drugs - Medication relating to HIV will be paid up to the members' annual medicines and drug maxima. Fertility drugs relating to In-Vitro programmes re fertility will NOT be met by the Society.

Glucometer and Nebuliser - will be adjudicated by the Management Committee.

Government/ Municipal Hospital - covered subject to the terms and conditions of this plan.

Hearing Aids - will be adjudicated by the Management Committee after prior referral from a specialist physician and the waiting period having lapsed. This benefit is only available once every 5 years from the original date of purchase.

In-hospital drugs, dressings, blood transfusions - and any other medical requirements necessary in a hospital, private nursing home or administered by a medical practitioner will be paid.

Medical Specialists - such as Paediatricians, General Surgeons, Gynaecologists, Neurologists, Obstetricians, Radiotherapists and Orthopaedic Surgeons will be paid, provided the member's private practitioner or a specialist has certified that the services of a medical specialist are necessary.

Optical Appliances - glasses, contact lenses will be paid in full subject to the Annual Limits set out in the Benefit Table, from the anniversary date of purchase, within a two year period. The amount payable for eye tests will be subject to the Annual Limit set out in the Benefit Table. There is a 6 month waiting period for new members

Orthodontic treatment is dental treatment that corrects irregularities of the teeth or of the relation of the teeth to surrounding anatomy; treatment is usually by braces or mechanical aids. The Society will pay for one full treatment programme from beginning to end subject to the treatment plan being submitted to us for authorisation prior to the treatment commencing. The Society will not pay for more than one programme per person per lifetime. Children under the age of 12 are not eligible for the orthodontic treatment benefit. Orthodontic treatment has a 24 month waiting period.

Dental and orthodontic benefits are subject to the Annual limit set out in the benefit table. The member shall be refunded up to reasonable and customary rates

Orthopaedic and Medical Appliances - will be adjudicated by the Committee after prior referral from a specialist physician.

Pathology - Blood and Laboratory tests will be paid, subject to the Annual Limits set out in the Benefit Table.

Prescribed Medicine and Drugs - the cost of medicine and drugs prescribed by a medical practitioner or dentist provided that such medication/substances are not readily available as over the counter purchases. There is an overall limit on medicines and drugs as detailed on the Benefit Table. Any member that suffers from a chronic ailment (.i.e. diabetes, asthma, hypertension etc) and requires a constant supply of medication must register their ailment and medication requirement with the Society. The Society will then issue a Guarantee of Payment letter to the member's pharmacy. The medication will then be issued and the account will be claimed directly from the administrators, subject to the Annual Limit set out in the Benefit Table.

Private Hospitalisation - Hospitalisation in a private hospital or private nursing home will be paid up to a Private Ward fee. Private wards will be paid up to a maximum of 14 days.

Private Nursing - is paid up to $1000.00 per event, provided that the member's private practitioner or a specialist has certified that the services of a private nurse are necessary. This benefit is applicable only immediately following day-patient or in-patient treatment

Psychiatrist Care (including Psychiatrist and Psychologists) - paid in full up to Reasonable and Customary charges subject to the Annual Limits set out in the Benefit Table.

Radiology (including X-Rays, MRI and CT Scans) - will be paid subject to the Annual Limits set out in the Benefit Table. **Members must seek prior approval** and find out how much benefit they have available before going ahead with procedures such as CAT and MRI scans.

Rehabilitation (including Chiropractor) - Paid according to reasonable and customary charges subject to the annual limits set out in the benefit table. By this the Society means treatment administered by an osteopath, homeopath, ayurvedic medical practitioner, acupuncturist, massage therapist and activities such as yoga and pilates.

Theatre Fees - covered subject to the terms and conditions of this plan

MEMBER(S) shall mean a Constituent Body, Pensioner, Individual or Family.

OVERALL GLOBAL LIMITS
Is the maximum amount a member can claim per calendar year of the specified benefit plan limits.

These limits at the time of this edition are :

10 Degrees North - US$100 000
20 Degrees North - US$200 000
30 Degrees North - US$300 000

PRE-EXISTING MEDICAL CONDITIONS
A pre-existing health condition is any medical condition, complaint, illness or disease that was in evidence or was treated by a medical doctor/specialist on or at any time prior to the new member's join date. Such condition may be characterised by any of the following :

- The member had experienced signs or symptoms
- The member had sought medical advice
- The member had received medical advice, treatment or medication.

A pre-existing medical condition can affect a members' BENEFIT use. Although the Society may have accepted a member and the member is paying subscriptions, the member may not have benefits use (i.e. coverage) for any medical care or services related to a pre-existing medical condition unless it had been declared upon application for membership, and assessed by our medical advisory board, and accepted in writing.

If a new member has a pre-existing medical condition(s) that member may either :

1. Apply for the pre-existing medical condition to be accepted by the Society. If the member wishes to apply for benefit for a pre-existing condition, a completed application form together with a letter from the applicant's doctor/specialist must be submitted to Alliance Health for adjudication. If the pre-existing medical condition is accepted by our appointed Medical Director, a premium loading may be applied to that new applicant's monthly premium. This means that the new applicant will be able to claim for all costs associated with the treatment of pre-existing medical condition subject to both pre-authorisation for potential large cost and only to the benefit applicable to the chosen scheme.
   OR
2. Inform the Society of the existence of the pre-existing medical condition on the understanding that related claims will be excluded from benefit.

PRE-AUTHORISATION Members **MUST** seek prior approval (pre-authorisation) before being hospitalised for elective treatment as well as having procedures such as CT and MRI scans, chemotherapy & radiotherapy, medication, etc. Treatment costs that are not approved in advance may only be refunded to members on a pay and claim basis at the discretion of the Management Committee.

REASONABLE & CUSTOMARY

Shall refer to the average amount charged in respect of eligible medical services or treatment costs, as determined by experience in any particular country or territory within Africa and the surrounding islands.

RESIGNATION

Shall mean the notice period that a member will give to the Society of his/her/their intention to cease membership. The period of notice at the time of this edition is 3 calendar months. The Society reserves the right to pro-rata benefits according to the number of months of paid membership when a member notifies the society of resignation

SPECIFIED BENEFIT LIMITS

These are further limitations which specify the maximum amount a member can claim per calendar year (or other specified period of membership), and/or the maximum number of times a specific service may be used within a calendar year of the specified benefit plan limits. Benefit Limits - See Attachment.

SUBSCRIPTIONS

All subscriptions are payable monthly, in advance and any Member who fails to pay by the 1st of each month will be suspended and no claims will be processed. Should payment not be received by the 1st of the month, cover shall only be reinstated from the date of the receipt of subscriptions. Claims that fall within the period when subscriptions are in arrears will not be considered for payment even after subscriptions have been paid All subscriptions received from the Members shall be supported with details of any changes, i.e. resignations, new additions, contact details, etc. In the case of any amendments, it is mandatory that a "Subscription Return Sheet" be completed with the payment. The Management Committee may amend the contribution rates from time to time if financial pressure warrants such.

TERMINATION OR EXPULSION

Shall mean the Society's prerogative to sever the membership of a member/dependants or constituent body for failure to observe the Rules of the Society, having been given notice of such deviation.

WAITING PERIOD

Shall mean the period of time which precludes any use of specific benefit. Waiting periods may be amended from time to time as deemed relevant by the Management Committee.

1. The benefit for routine dental treatment has a 6 month waiting period after the start date of membership.
2. The benefit for orthodontic treatment has a 24 month waiting period. Children under the age of 12 years are not eligible for the orthodontic treatment benefit except where special dispensation has been granted by the Management Committee
3. The benefit for optical appliances has a 6 month waiting period after the start date of membership. This benefit is only available once every 24 months from the anniversary date of the last purchase.
4. The maternity benefit has a 12 month waiting period from the start date of membership.
5. The benefit for wellness checks has a 12 month waiting period from the start date of membership.
6. The benefit for hearing aids has a 3 month waiting period after the start date of membership and is only available to members once every 5 years from the date of initial purchase.
7. Oncology has a 6 month waiting period from the start date of membership.
8. There is a 9 month waiting period for elective surgery

WHAT TO DO WHEN YOU NEED TREATMENT

Out-Patient Treatment Please read the Benefit Table to determine the Global and Annual Limits and contact Alliance Health to confirm available limits before claiming.

Pay and Claim Members must pay for the full costs of all out-patient services / treatment / medication incurred within the area of benefits use unless a direct billing arrangement has been arranged between the Society and the provider. Once treated, the service provider will provide the member with a Medical Claim Form which must be completed in full. When completed, please send the Medical Claim Form and original receipts to the Claims Team at Alliance Health for processing.

Once the Alliance Health receive the member's claims, the claim will be adjudicated for processing. Provided there are no outstanding issues regarding the claim, the member will be refunded within 30 days of the Claims Team receiving all the required documentation. Companies must submit all completed claims/documents to the Alliance Health claims team through their company scheme Administrator.

All claims should be submitted to the society as soon as possible, but no later than 90 days from the date of treatment. Claims submitted later than this will not be paid by the society. If good reason for the late submission of a claim exists, the Management Committee, on application and at its sole discretion may agree to pay the claim in whole or in part.

Important :

1. All therapist treatment, specialist treatment, pathology, MRI, PET and CT scans, chemotherapy and radiotherapy must be referred by either the member's medical practitioner or specialist. The Society reserves the right to decline the claim if the member was not referred.
2. The member must obtain pre-authorisation before out-patient psychiatric treatment, MRI, PET and CT scans, chemotherapy and radiotherapy. The Society reserves the right to decline the claim if the member did not obtain pre-authorisation.

In-Patient and Day Patient Treatment

Important: Members must obtain pre-authorisation for all in-patient or day-patient treatment. This includes all elective treatment. The Society reserves the right to decline the claim if the member did not obtain pre-authorisation. In a case of a medical emergency, the Society should be contacted within 72 hours of admission.

Pay and Claim Once treated, the service provider will provide the member with a Medical Claim Form which the member should complete. When completed, please send the Medical Claim Form and original receipts to the Claims Team for processing.

Direct Billing In some cases, the medical service provider will prefer to bill the Society directly. The member will then not be required to submit a Claim Form and original receipts. However, the medical service provider will require the member's signature on a Claim Form as proof that the member has received medical treatment.

Do not hesitate to contact the Claims Team should you require any further advice.

CLAIMS PAYMENT

The Society will settle all eligible claims in accordance with the annual Benefit and Reasonable and Customary charges unless stated otherwise in this document.

CLAIMS PAYMENT

All claims will be refunded in the currency of legal tender via bank transfer to the nominated bank account.

FOREIGN TREATMENT – IN PATIENT

Any member contemplating foreign treatment must provide a specialist referral letter to that effect before any foreign treatment is sought. The Society requires a full breakdown of all estimated costs including hospitalisation, anaesthetic costs, specialist fees, pathology, radiology, etc from the foreign service providers.

In addition to the above, the Society will also require full contact details of the foreign service provider/s prior to treatment. The Society will refund costs according to the Reasonable and Customary charges applicable to the territory/country/area of treatment and up to the member's annual medical maximum limit, as set out in the Benefit Table.

EXCLUSIONS

The Society will not pay for or meet the costs of :-

1. Pre-existing medical conditions or related medical conditions that the Management Committee in its discretion deem are not covered.
2. Pre-existing medical conditions or related medical conditions that are not declared on joining.
3. The testing of eyes except when undertaken by a registered Opthalmologist or Optometrist.
4. Accommodation in a hospital or nursing home where free hospitalisation has been obtained.
5. The treatment of an injury sustained by a member or dependant for which any other party may be liable.
6. The treatment of an illness or injury sustained by a member or dependant where in the opinion of the Management Committee, such illness or injury is directly attributable to irregular or immoral habits or the failure to carry out the instructions of a medical practitioner or specialist.
7. Claims which the Management Committee in its discretion consider to constitute overuse/abuse/misuse.
8. The treatment of an illness or injury which is the responsibility of any other medical benefit society, Workmen's Compensation, Commission or Insurance company.
9. The treatment of an illness or injury of a member or dependant arising out of wilful self injury, attempted suicide or breach of the law.
10. The purchase of medicine or drugs not included in a prescription from a medical practitioner
11. The purchase of medicines and drugs that are ordinarily available as over the counter drugs, even if prescribed by a doctor
12. The purchase of:
    - Bandages and aids
    - Supplements, patent and baby foods
    - Holidays for recuperative purposes
    - Travel and accommodation charges
    - Treatment for infertility
    - No maternity claims will be processed during the first 12 months of a new member and his/her dependants joining.
    - Cosmetic, reconstructive or remedial disorders whether or not for psychological reasons and or complications arising thereafter unless required as a direct result of a covered medical condition which occurs after the date of joining

    Unless approved by the Management Committee
13. Bariatric Surgery or Gastric Bypass Surgery.
14. Any claims involving Fraud or Dishonesty.
15. Claims occurring whilst subscriptions are in arrears.
16. Fertility drugs relating to In-Vitro programmes re fertility will NOT be met by the Society.

17. Dental treatment relating to pre-existing conditions.
18. Cosmetic dentistry.
19. Precious metal elements dentistry.
20. Orthodontic treatment for members under 12
21. Congenital Abnormalities or birth defects

BENEFIT TABLE

	10 Degrees North	20 Degrees North	30 Degrees North
GP Consultations (number of visits)	**15 visits**	**20 visits**	**25 visits**
Physiotherapy/Rehabilitation	**15 visits**	**20 visits**	**25 visits**
Dialysis	**$5,500**	**$7,700**	**$11,000**
Optical Appliances (every 24 months)	**$1,000**	**$1,500**	**$2,000**
Dental (including Orthodontics)	**$2,000**	**$2,500**	**$3,000**
External Appliances	**subject to adjudication**	**subject to adjudication**	**subject to adjudication**
Medicines and Drugs	**$2,200**	**$2,800**	**$3,300**
Psychiatric Care	**$1,650**	**$2,200**	**$3,300**
Pathology (Out patient)	**$1,000**	**$1,500**	**$2,000**
ARV/ART	**$1,000**	**$1,500**	**$2,000**
Hearing Aids (once every 5 years)	**$1,000**	**$1,500**	**$2,000**
Glucometer/Nebuliser	**$500**	**$1,000**	**$1,500**
Funeral Cover (services provided up to the value of)	**$1,100**	**$1,300**	**$2,100**

For any comments, queries or suggestions, please contact Alliance Health:

HARARE

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BULAWAYO

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Our telephone lines are open 8:00am – 4:30pm, Monday-Friday (excluding public holidays)

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