Plan Agreement

2021

April

MULTImed
PRIVATE MEDICAL COVER

The Terms and Conditions of
Your Membership to Multimed

Alliance health

contents

The terms and conditions found in this document are effective for all membership contract commencing or renewing from 01 April 2021.

Terms and conditions apply

- ***Errors and omissions***
- ***Rates correct at the time of going to print as per the month indicated. Please request the latest version of this document from clientservices@healthzim.com***
- ***Terms and conditions are subject to change with notice being given. Date of last revision: April 2021***

INTRODUCTION

Thank **you** for choosing a Multimed Health **Plan**. Multimed plans are managed and administered by Alliance Health (Pvt) Ltd. All references to "Alliance Health" in this plan agreement should be taken to refer to Alliance Health (Pvt) Ltd.

It is **our** intention to provide **you** with a first-class standard of service at all times. If **you** feel that **we** have not provided **you** with a first-class standard of service or that any decision **we** have made regarding a claim is unfair and not in accordance with the terms and conditions of this **agreement**, please contact the Multimed General Manager:

7 Fleetwood Road, Alexandra Park, Harare
Tel: +263 - (0)772 126 120, (0)8677000716, (0)8677020406, (0)778 244 128/9
Email: clientservices@healthzim.com

Please provide **your** full contact details, **your claim** number (if applicable) and **plan** number together with as much information as **you** can regard **your** query, comment or complaint.

We will acknowledge all complaints be either by e-mail, telephone or fax by the end of the following working day. **You** will receive a detailed written response within 10 working days of issuing **our** acknowledgement.

It is our aim to provide **you** with a reliable Medical **Plan that you** can trust. In order to achieve this, it is extremely important that **you** fully understand how **your plan** works. This **Agreement** together with **your** Table of Benefits explains what is**,** and what is not**,** covered by your Multimed **Plan**.

This **Agreement** explains:
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- how to manage **your benefits** and how to use **plan**,
- how to **claim**,
- what to do in the event of a medical **emergency** and
- what to do if you require **in-patient** or **day-patient** treatment.

It is important that **you** spend a few moments reading this **Agreement** to ensure that **you** are satisfied with the cover **we** are providing and that it meets all **your** requirements. Should **you** have any questions after reading this **Agreement**, please do not hesitate to contact **us** or **your** agent.

As you read through this **Agreement** and Table of Benefits, you will note that some words and phrases have been written in **bold** type. That's because they have specific meanings that are relevant to this **Agreement**. These words have been defined within the Definitions section of this **Agreement**.

Multimed Plan Agreement

This Plan Agreement containing Definitions, Conditions and Exclusions forms part of your contract with Multimed and must be read in conjunction with the Application Form(s), Benefit Table and Certificate of Membership.

The Terms and Conditions defined and explained in this Plan Agreement apply to you and your dependants as stated in the schedule of covered persons on the Certificate of Membership (Membership Certificate).

We reserve the right to amend this Plan Agreement within 30 days of members being notified in writing of such changes.

The Purpose of Your Plan

The purpose of **your plan** is to provide cover against financial losses due to **the costs of** an **unexpected** medical event that happens after **your commencement date** of **your plan**. This means, subject to the terms and conditions of cover, **you** will be covered for the cost of medical treatment for unforeseen medical conditions that first manifest themselves after **your commencement date**. (Subject to underwriting approval, this restriction may be waivered or adjusted for members with the Medical History Disregarded option.)

ADMINISTRATION

Annual Contract

The **plan** is an annual contract which runs for 365 consecutive days starting from the **commencement date**. You, as the plan holder are liable for the full annual contributions for membership for the full twelve months of the contract.

The plan holder for individual and family members is the Principal Member.

The plan holder for company and group memberships is the nominated Administrator of the registered company, society or affinity group. The group may appoint a member or a third party to assume the responsibilities of the group secretary or agency.

Age Limits

You must be under the age of 75 at the time of joining.

Applicable Benefits and Contributions

The **benefits** and **contributions** applied to **your** plan will be those in force at the **commencement date** of the **plan** or any changes made thereafter subject to applicable waiting periods and exclusions.

Area of Cover

Your Benefits are limited to use in the territories of Africa and its surrounding islands **only**.

However, subject to the terms and conditions of cover, **you** are covered for **Accident** and **Emergenc**y medical treatment outside **your** specified geographical area of cover up to a maximum of US$50,000 per term of cover.

Under the **Accident** and **Emergency** medical treatment outside of your specified Area of Cover, the cost of Road Ambulance is covered from the scene of the accident to an appropriate Medical Facility if and where available.

Air ambulance services are not covered.

Costs of treatment for conditions pre-existing to your membership start date and related medical conditions will not be covered.

Area of Cover – EXCEPTION (War and Civil Unrest)

Treatment resulting from acts of war, invasion, act of foreign enemies, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion, martial law, loot, sack or pillage unless the member sustains bodily injury whilst an innocent bystander. If the member sustains bodily injury whilst an innocent bystander, then the member is only covered up to a maximum amount of US$50,000 per member per incident.

Break in Cover

If there is a break in cover for any reason whatsoever, **we** reserve the right to alter the terms of the **plan** and apply special conditions.

Commencement Date

In the case of individuals and families, subject to **our** acceptance, **your** cover under the **plan** will commence on the 1st day of the month following receipt of the fully completed appropriate Application Form. However, subject to our acceptance, **your** cover can be backdated to the 1st day of the month we receive **your** fully completed Application Form provided no new medical condition has manifested itself between the 1st of the month and the day we received the application form.

In the case of group schemes, **we** require the following forms and documents in order to start a group plan:

- Group Formation Form (to be completed by the group administrator)
- Certificate of Company Incorporation (copy) or Group Articles of Association (copy)
- Group Application Forms (to be completed by the principal member)

Within ten working days from the date of receipt of the fully completed Application Forms, **we** will notify the **plan holder,** or in the case of group schemes**, the plan administrator** of the **commencement date**.

Communication

The **main plan holder** will receive all correspondence with regards to the **plan**. In the case of individual members, the main plan holder is the principal member. In the case of group members, the main plan holder is the group administrator as nominated on the group formation form.

*Also please note that there can be no splitting of plans within the same family. *

Contribution

If a **plan holder's** claim is covered and there is another plan of insurance or reciprocal health arrangement covering that same claim benefit, **our** liability will be limited to the rateable proportion of the claim.

Disclosure of Material Facts

You are obligated to disclose all material facts regarding your own and your dependant's medical history prior to purchasing a Multimed plan, as well as any other facts pertaining to your chosen occupation, hobbies, pastimes, or leisure pursuits which may reasonably be considered to place you at risk.

You must declare any factors or circumstances that may be relevant to an assessment of your health, or of the health of your dependants, or that may be relevant to the use of medical services by you or any of your dependants. You must declare any factors or circumstances of your occupation and/or lifestyle that may be relevant to an assessment of your health, or the health of your dependants, or the risk of incurring injury.

If it is understood at any time that an enrolled member has made a false or incomplete declaration or has failed to accurately disclose his/her medical history then the administrators of the Multimed plans reserve the right to waiting periods of up to 48 months, impose contribution loadings of up to 250%, specifically exclude from benefits specific medical conditions, disorders or diseases and to recover any or all costs incurred by the fund.

We rely on the information submitted in the application form to decide whether or not to accept your application for cover. We reserve the right to refuse enrolment under the plan based on the information supplied in the Application Form for whatever reason, or to apply special terms and conditions which will be specified in writing.

Eligibility

Eligibility is subject to **our** acceptance of an Application Form. **We reserve the right to reject enrolment applications without explanation.**

Subject to our acceptance, the **plan** is available to persons (subject to age limitations specified elsewhere in this **Agreement**) of all nationalities and their **dependants** residing in Africa and its surrounding islands. However, those persons who are subject to exchange controls or local licensing regulations or where cover is illegal under local legislation, cannot apply for cover.

In certain territories local taxation and/or government surcharges may be applied as required by local governing authorities.

If you take up temporary or permanent residence, for purposes of study, work, or any circumstances (other than tourism) in any other country in addition to your declared country of residence during your membership contract **you are required to notify us** and we reserve the right to modify or limit your benefits according to our assessment of the additional risks incurred.

If, for any reason you are to travel for 90 days or more outside your declared country of residence you are required to notify us and we reserve the right to modify or limit your benefits according to our assessment of the additional risks incurred.

Cover is not available to anyone residing outside Africa or surrounding islands. If during a Plan year **your Country of Residence** changes to outside Africa or surrounding islands, **your** cover will be limited to the Accident and Emergency Medical Treatment Outside Area of Cover benefit up until **your** renewal date. At renewal date, **we** will not be able renew **your** cover.

Membership is not currently available to anyone resident in South Africa, who is also a citizen of South Africa. If during a Plan year **your Country of Residence** changes to South Africa, and you are a citizen of South Africa, then **your benefits of membership** will be limited to benefits used outside South Africa up until **your** renewal date. At renewal date, **we** will not be able renew **your** cover.

The minimum age at entry for a **plan holder** is 18 years attained. Applicants under the age of 18 years attained **cannot** join as principal members / plan holders.

Persons listed as dependants must be either the legal spouse of the main member or minor children of the main member over whom the main member has legal guardianship.

Dependants over the age of 18 must complete and submit their own application forms.

The maximum entry age is 74 years attained.

Platinum Plus and Platinum Schools is only available for groups that will cover ten (10) or more **Principal Members** from inception. An eligible group must be a constituent body of employees, shareholders, directors, or other members of any society or legally constituted body. Alliance Health reserves the right to assess and adjudicate the appropriateness of any applicant constituent body and decline an application based on an adverse risk analysis.

The plan holder of every Platinum Plus group is deemed to be the nominated administrator of constituent body, or the appointed representative thereof. The plan holder undertakes to assist in the following administrative duties for the group members on behalf of Multimed: -

- Assessment and submission of completed applications for enrolment
- Assessment of claims (for completion and eligibility)
- Identification and elimination of claim errors and/or abuse
- Debt collection
- Management of renewals

With reference to Platinum Plus, the full membership contribution must be covered by the employer, or paid by the nominated group secretary/agency (i.e., the **plan holder**). Members and dependants are not allowed to enter into any agreement with the **plan holder** whereby any portion of the membership contribution is paid directly by the member and/or dependant to Multimed.

<u>Fraudulent Claims</u>

If a **plan holder** or his/her dependant(s) or group member(s) makes a fraudulent **claim** for any reason whatsoever, any benefit already paid or payable in relation to that **claim** shall be forfeited and if appropriate, the monies recovered. The **plan holders** cover will further be immediately cancelled from the date of the fraudulent claim.

<u>Jurisdiction</u>

This **plan** is governed by and will be interpreted in accordance with the laws of Zimbabwe and will be subject to the jurisdiction of the courts of Zimbabwe.

<u>Loading/Discount Protocols</u>

New applicants may be loaded for lifestyle choices (such as smoking).

<u>Medical History Disregarded (MHD)</u>

Every application for MHD is subject to a Medical History Declaration and Underwriters acceptance.

We reserve the right to refuse MHD cover, apply permanent exclusions, apply lifetime benefit limits or place waiting periods on certain medical conditions and related medical conditions.

Medical Records
By signing the application form, **you** give **us** full authority to obtain all information which may be required to support your application and/or a claim through a medical doctor, specialist, consultant physiotherapist, therapist, registered practitioner or medical service provider.

Membership Cards
All members and their dependants will be issued with a membership card. **You** should carry **your** membership card with **you** at all times. Furthermore, **you** should present **your** membership card when seeking treatment.

IMPORTANT:

1) **You** cannot transfer your membership card
2) **Your** card is the property of Multimed and must be returned when you're your membership is terminated
3) **Your** membership card is not a guarantee of payment or credit card
4) When being treated for **pre-authorised** treatment, **you** must produce either a passport or identity card as proof of identity
5) Additional charges will be levied for the issuing of replacement membership cards

Payment
Your plan will be considered suspended, and thereafter cancelled if full payment of membership contributions has not been received before the date of commencement of cover, or by the first (1^{st}) of every month in advance. Claim costs that are incurred whilst your membership is in arrears or is suspended, cannot be settled by Multimed.

We strongly recommend that members ensure that they maintain a full month's credit balance in their membership contributions to prevent the lapsing or cancellation of their policy.

Your payment is only considered to be received by Multimed once it has been clearly identified and reconciled to your account and receipted. Payments made without clear identification cannot be received. It is the member's duty to ensure that payments made are easily identified and reconciled to their contribution accounts.

Plan Term
Your plan is an annual, twelve-month contract with periodic payments. This agreement is a contractual obligation that will continue until it is either cancelled or has run for a period of 12 months from the **commencement date**.

Under no circumstances can plan cancellations be backdated.

Plan Denomination
The **plan** will be denominated in US dollars.

Subrogation
We reserve the right, with due discretion, to stand in for the **plan holder** for **our** own benefit in order to recover claims for indemnity or damages relating to costs or benefits paid or being payable under the plan, should the **plan holder** be unable to so do. We will not be liable for non-claimable losses for which the **plan holder** should resort to legal advice.

Table of Benefits
The benefits for each medical plan are shown in the Table of Benefits. **You** may only claim for cover as provided for under the specific plan that **you** have taken out. **Benefits not stated in the Table of Benefits cannot be claimed for.** The information provided in the Table of Benefits is subject to the terms and conditions of membership as set out in this Plan Agreement.

Transfer
The benefits of membership to group plans are only available for group members as long as they continue to remain members of the registered group, which is the main plan holder. If an individual member leaves the group and wishes to continue his/her membership to Multimed as an individual/family member, then a new application must be submitted for underwriting.

Provided **you** submit the application for continuation of cover before **you** leave the group **plan**, your transfer application will then be underwritten as either: -

1. A new member, with a new start date and with all waiting periods and the 24 moratorium to be applied from the new start date
2. A transfer member, with the start date backdated to the original date of enrolment as a member to Multimed, with all waiting periods and the application of the 24-month moratorium backdated to the same original join date.

MEMBERSHIP CONTRIBUTIONS

Membership Contribution Calculations

Your annual membership contribution will depend on **your** age, the ages and number of your **dependants**, **your** plan type, optional add-ons, **your** chosen excess amount, currency fluctuations, payment frequency and method of payment.

Membership Contribution Payments

Membership contributions are payable in advance on a monthly, quarterly or annual basis.

Membership contributions must be paid in US dollars.

Additional membership contributions that may be levied as a result of the addition of new dependants and/or covered persons are payable within 7 days of the issued invoice or statement.

Membership Contribution Payment Methods

For membership contribution payments, **you** can choose to pay by:

- Bank transfer
- Direct debit (if available)
- Cash

IMPORTANT: Your payment is only considered to be received by Multimed once it has been clearly identified, and reconciled to your account, and receipted. Payments made without clear identification cannot be received. It is the member's duty to ensure that payments made are easily identified and reconciled to their contribution accounts.

Late or Unpaid Membership Contributions

Regardless of **your** membership contribution payment method, **you** must ensure **your** membership contributions are paid on or before the membership contribution due date in order to enjoy the full **benefits** of **your plan**.

IMPORTANT: If **your** plan should be cancelled due to non-payment, then **you** will have to re-apply for cover and **you** will be charged the Membership contribution rates in force at the time of re-applying for cover. In addition, **your** new cover may be subject to new underwriting terms and conditions.

WARNING:

1) **We** will automatically cancel **your** cover if payment is not received within 7 (seven) days from the membership contribution due date.
2) All **claims** settlements will be suspended whilst membership contributions are outstanding and cannot be paid after the account is up to date.

Membership Contribution Increases

We reserve the right to amend membership contributions within 30 days of members being notified of such changes.

Membership contribution increases can be influenced by medical inflation, exchange rate fluctuations and changes to the regulations governing our operations. Certain factors contribute towards medical inflation such as (but not limited to): rising costs of prescription drugs, diagnostic procedures, hospital fees, Doctor's/Specialist charges, evacuation charges as well as technological advances in treatment techniques.

Membership contribution increases in United States Dollars can also be influenced by revaluations or devaluations of different regional currencies of countries where the costs of foreign treatment are incurred in local currencies.

Individual membership contribution rates are Community Rated. This means that **your** membership contribution will be calculated based on our membership contribution rates table and not based on **your** individual claims experience during the preceding year of cover.

Community Rated membership contributions are age banded and will get more expensive as **you** get older. (See Membership contribution Table for details.)

Membership contributions for group schemes may be claims related at renewal at our discretion. In other words, the renewal membership contribution increase may be determined by the preceding year's claims experience.

ADDITIONS, DELETIONS AND CHANGES

Adding Dependant(s) and Members

Subject to **our** acceptance, **you may** add new **dependants** after the **commencement date** of **your plan**. In the case of a group scheme, you can add a new member and his/her **dependants** after the **commencement date** of the group **plan**.

please note that there can be no splitting of plans within the same family

Provided that:

- In the case of Individual **plans**, a new Application form is submitted to us.
- In the case of a group scheme, a Group Member Application Form is submitted to us together with a written instruction on an official company/group letterhead signed by the appointed group secretary or company director.

Cover will start on the date that **we accept** the application form **or** at a future date specified by **you** in the application form provided it is the 1st day of the month. Should you wish your start date of benefits use to be the date of our acceptance of your application then you will be required to pay a full twelve months membership backdated to the first date of the month in which your application was accepted. Your membership benefits however will commence from the actual date on which your membership application form was accepted.

We will issue **you** with a revised **Certificate of Membership** detailing the **date of joining** and any special terms that may apply.

Payment of any additional membership contributions will be the **plan holder's** responsibility.

Under no circumstances will we backdate the use of benefits.

Adding New-born Children

We will automatically provide membership benefits for new-born children without an application form up to 30 days following birth on a pay and claim basis providing that an application form for the new born child is received and adjudicated and accepted within 30 days following birth.

After 30 days, the new-born child will require an application form for submission and the membership start date cannot be backdated to the date of birth.

Provided that **you** submit the Application Form before the **dependant(s)** is 30 days old (1) the **moratorium** will not be applied to the new-born child's cover and (2) the **date of joining** will be the date of birth.

If **you** submit the Application Form to **us** after the **dependant(s)** is 30 days old, (1) a **moratorium** will be applied to the new-born child's cover and (2) the **date of joining** will be as of the date **we** receive the Application Form or a future date chosen by **you**.

An invoice or statement and a revised **Certificate of Membership** reflecting these changes will be issued and sent to the **plan holder**.

Under no circumstances will **we** backdate cover.

Payment of any additional membership contributions will be the **plan holder's** responsibility and must be paid within 7 (seven) days of the invoice.

Removing Principal Members and Dependants

Provided there are no pending claims, outstanding claims and that the contributions made cover claims incurred and subject to **our** acceptance, a **principal member** and/or a **dependant** may be removed from cover after the **commencement date** of the **plan**. The removal request will have to be made in writing by letter, or completion of the appropriate termination agreement, with 30 days' notice required.

If any **claim** has been submitted and accepted by **us**, the full annual membership contribution for the covered person must be paid to Multimed.

It is the **plan holder's** responsibility to ensure that the member's membership card is returned to **us** as soon as the member's cover has been cancelled.

We are unable to backdate removal under any circumstance.

WARNING: If a membership card is used to get **treatment after** the member has been removed, the plan **holder will** be responsible for paying any costs incurred for the treatment.

Death

Provided that a claim has not been submitted and accepted by **us**, membership contributions will be prorated accordingly. A reconciliation statement and a revised **Certificate of Membership** reflecting these changes will be issued.

If a **claim** has been submitted and accepted by **us**, the full annual membership contribution for the deceased must be paid to Multimed. **IMPORTANT: We** will request a Death Certificate before a refund is issued.

Should the main plan holder die, his/her dependants will be allowed to continue with their cover. In order for the membership to be continued, the surviving dependants are required to complete new Application Forms to facilitate the re-entry of updated data into our systems and in order to provide a signed agreement of the amended contract between the member and Alliance Health. Provided there is no break in cover, the new Application Forms will not be regarded as new enrolments. If the dependants do not wish to continue cover, they must inform us in writing either by letter, fax or email within four weeks of the main plan holders' death

Provided no claims have been submitted and accepted by us, membership contributions will be prorated accordingly. A reconciliation statement and a revised **Certificate of Membership** reflecting these changes will be issued.

If a **claim** has been submitted and accepted by **us**, the full annual membership contribution for the member must be paid to Multimed.

Cancellation Conditions

This **plan** can be cancelled by **you** within 30 days of commencement date.

If **you** choose to cancel the **plan,** we will require **your** written instructions directing **us** to cancel your plan. If the **plan** is cancelled by **us**, we will write to **your** last known address informing you of the cancellation.

Cancellation of membership after 30 days of membership – Individual and Family Members

Provided that no claims have been submitted and accepted, and then **we** will issue a pro-rata refund of membership contributions applicable to the future months of the membership i.e., for the remainder of the 12-month contract. Any subsequent notification of a claim will not be entertained. If any claims have been submitted and accepted, there will be no refund due, and the member is liable for full payment of all contributions due for the full twelve months of the membership contract.

Under no circumstances will we backdate cancellation.

Cancellation of membership after 30 days of membership – Group Members

Provided that no claims have been submitted and accepted by an individual member of a group, then **we** will issue a pro-rata refund to the **plan holder** of those membership contributions applicable to the future months of the membership up to the renewal of the group contract i.e., for the remainder of the 12-month contract. Any subsequent notification of a claim for the cancelled individual will not be entertained. If any claims have been submitted and accepted for the particular individual, then there will be no refund due, and the plan holder is liable for full payment of all contributions due for the full twelve months of the membership contract.

Under no circumstances will we backdate membership cancellations.

Changing your plan type

You are **only able** to affect an upgrade or downgrade **your plan** type during a **plan year** on the 1^{st} day of the month at the annual renewal of your contract. Please inform **us** in writing either by letter, fax or e-mail of your intended change, providing us with 30 days' notice. Please note that our acceptance of your change in plan type will be determined by past or pending claims.

Changing your Country of Residence and Address

You can change your Country of Residence and address during a **plan year** we require notification.

If you take up temporary or permanent residence, for purposes of study, work, or any circumstances (other than tourism) in any other country in addition to your declared country of residence during your membership contract you are required to notify us and we reserve the right to modify or limit your benefits according to our assessment of the additional risks incurred.
Please inform **us** in writing either by letter, fax or e-mail.

IMPORTANT: **Your** area of benefits use is restricted to the countries of Africa and surrounding islands only. Regardless of the circumstances, **you** will only be covered for **Accidents** and **Emergencies** if you change **your** Country of Residence to a country based outside of Africa or the surrounding islands.

Continuation of Cover for Members Leaving a Group Plan

Subject to **our** acceptance and eligibility, as a member of a group **plan**, **you** can be transferred to an Individual **plan** when **your** cover with the group **plan** comes to an end.

Provided **you** submit the application for continuation of cover before **you** leave the group **plan**, your transfer application will then be underwritten as either: -

1. A new member, with a new start date and with all waiting periods and the 24 moratorium to be applied from the new start date
2. A transfer member, with the start date backdated to the original date of enrolment as a member to Multimed, with all waiting periods and the application of the 24-month moratorium backdated to the same original join date.

The **commencement date** for **your** new Individual **plan** will be the first day after leaving the group **plan**.

If **you** submit the application for continuation of cover after **you** leave the group **plan**, the **moratorium** will be applied to **your** new individual **plan** and **you** will be subject to the new terms and conditions of cover applicable at the time.

Changing the Group's Cover

Subject to our approval, members on a group plan are welcome to upgrade their **plan** type at the renewal date of the annual contract. Members can **ONLY** downgrade or upgrade their plan type at renewal.

The **plan administrator** or group administrator must inform **us** in writing on a company letterhead of proposed changes, with 30 days' notice.

RENEWALS

Individual Renewals

You may renew **your plan** each year subject to payment of the renewal membership contribution and subject to the **Agreement** and Table of Benefits in force at the time of the renewal date.

Prior to **your renewal date**, **you** will be issued with instructions of how to proceed with **your** renewal either directly from us or via your agent/broker.
Your renewal membership contribution will be based on **your** age, the ages of dependants and number of dependants, **your** plan type, optional add-ons, **your** chosen excess amount, payment frequency and method of payment.

Group Renewals

A group may renew its group **plan** subject to the **Agreement** and Table of Benefits in force at the time of each renewal date as well as the receipt of the renewal membership contributions.

Prior to the **renewal date**, the **plan administrator** will be issued with instructions of how to proceed with the group renewal.

Renewal Membership Contribution Calculations

Membership contributions for groups with fewer than 50 **principal** members will be Community Rated. This means the group renewal membership contribution will be calculated based on the annual membership contribution rates table (less the appropriate discount) and not based on the groups claims experience during the preceding year of cover. Membership contributions for groups with fewer than 50 **principal** members are age banded and will get more expensive as the member gets older. (See Membership contribution Table and discounts for details.)

Membership contributions for groups with more than 50 **principal** members will be claims related. This means the group renewal membership contribution will be calculated based on the group's claims experience during the preceding year of cover.

Renewing Dependents Cover

Children covered under **your plan** can continue to be covered under **your plan** at renewal as long as (1) they are under 18 years old; (2) unmarried and (3) they are under 25 years of age and in full-time education.

If **your** child does not comply with the above and wishes to continue with cover, they can submit an Application Form to have their own **plan**. Provided there is no break in cover, their **date of joining** will remain the same as **your date of joining**. If there is a break in cover, their application for cover will be treated as a new application for cover and will be subject to the **moratorium** and standard application for cover protocols.

Declaration of Material Facts

Members and group administrators are required to declare any changes in lifestyle or group structure that may result in a material change to their risk profile and/or benefit use. The administrators of the Multimed plans reserve the right to vary contribution loadings at renewal on the basis changes in a member's risk profile

WHAT TO DO WHEN YOU NEED TREATMENT

You **must obtain pre-authorisation** for any of the following: -

- air evacuations
- admission to a hospital,
- in-patient or day-patient treatment,
- psychiatric treatment,
- advanced imaging (MRI, PET and CT scans),
- treatment for cancer (including chemotherapy and radiotherapy)

We reserve the right to decline your claim or only pay 80% of the eligible treatment costs if you do not obtain pre-authorisation.

IMPORTANT:

a) Unless **you** have an excess or deductible applied to **your plan** and subject to the benefit limits and treatment provider acceptance, **you** may not be required to pay for any **pre-authorised treatment where this is practical**. All eligible treatment costs will be paid directly to the relevant treatment providers as long as the treatment providers are willing to accept third party payments. However, **you** will always be required to submit a fully completed Medical Claim Form for every transaction related to treatment.

b) In some cases, there may be a delay in issuing authorisation because **your** treatment provider(s) may take their time providing the relevant information **we** require in order to issue the authorisation.

IMPORTANT: Whether or not we have pre-authorised costs, if it transpires that your medical condition or treatment is not covered by your plan, you will be responsible for all the costs. If we have already settled the medical costs on your behalf, you will be responsible for repaying to us the full amount that we have paid within 30 days of notification.

The final adjudication of treatment as medically necessary and/or of pre-existing medical conditions, and of further conditions related to thereof, or considered to be complications thereof, by the Alliance Health Medical Advisory Board is acknowledged by all parties to be binding and final.

Pre-authorisations Within Zimbabwe

You must provide us with a ****Medical Report** from the treating Dr/Specialist, a completed claim form and a full contact list of all the service providers. If we are happy with the Medical Report, we will send the service provider a **Letter of Guarantee** which is proof that you are covered and a guarantee that we will pay for the full medical costs. If the medical report is unclear or insufficient, we may request copies of your medical records. It is your duty to provide us with full access to such information as we may require from your medical records.

Pre-authorisations Outside Zimbabwe, But Within Your Area of Cover (Specified Territories in Africa and Surrounding Islands)

Contact the nominated international service and case management provider, as per the details that may be found on your member card and/or membership certificate. Once you have contacted the nominated international service and case management provider, then you must contact our emergency numbers in Zimbabwe – as found on the membership card provided to you.

If you are in South Africa, please contact **Meridian Medical Assistance (Pty) Ltd** whose details are as follows and can also be found on the membership card and membership certificate: +27 11 792 8796/0287, Cell +27 71 886 5250 or assistance@mmassist.co.za MMA will arrange Guarantee of Payment once they have been notified and you have provided them with all the necessary information. Once you have contacted MMA, then you must contact our emergency numbers in Zimbabwe – as found on the membership card provided to you.

Meridian Medical Assistance (Pty) Ltd will require a ****Medical Report (refer overleaf)** and follow a similar pre- authorisation process as above.

****The Medical Report must include the following details:**

a) Full details of the condition including
   - **I. presenting symptoms**
   - **II. the date when the member first had signs, symptoms, treatment, tests or sought advice for the condition or any related condition.**
   - **III. Significant findings on clinical examination and tests if already done;**

b) Proposed treatment including names of procedure(s);

c) Proposed costs (specialists costs, anaesthetists costs, hospital costs and all other costs associated with treatment and rehabilitation);

d) Further management plan, including estimated length of stay in hospital and rehabilitation;

e) Full names and contact details of all attending service providers.

Day-to-Day Out-Patient Treatment Within Zimbabwe

Bronze and Silver plans do not cover day-to-day medical services as they are hospital plans with limited out-patient benefits. **Pre-authorisation is always required for the use of all benefits on Bronze and Silver.**

Treatment	***Authorisation***
Hospitalisation Advanced Imaging Cancer Treatment Psychiatric Care	*Pre-authorisation is always **REQUIRED***
Annual Check Ups Casualty and Emergencies Diagnostic Testing Specialist Consultations Treatment by Therapists X-rays and Imaging	*Authorisation is always **ADVISED***
Family Doctor Consultations Prescribed Medication	*Authorisation is not generally required for members of the Gold, Platinum and Platinum PLUS plans*

If you are in doubt as to the eligibility of your treatment, please email us at claims@healthzim.com for authorisation.

IMPORTANT: Treatment received from a **therapist**, specialist or consultant must always be on referral from the **medical practitioner** who is your family doctor. **We** reserve the right to decline **your** claim if **you** were not referred. If you are in doubt as to the eligibility of your treatment, please email us at claims@healthzim.com for authorisation.

If you are a member of the Gold or Platinum plan, you must show the service provider your Membership Card or Membership Certificate on every occasion. If the service provider is on a direct billing arrangement with us, they will not charge you for treatment unless it is a pre-existing medical condition or related to a pre-existing medical condition. After the treatment, the service provider will then send us their invoice and a claim form for processing.

If the service provider is not yet on direct billing terms with us, they will ask you to pay upfront. This then means you must complete a Claim Form, attach the original receipt and send it to us. We will refund you within 14 working days of receipt of the fully completed claim as long as all the necessary supporting documentation has also been submitted.

Day-to-Day Out-Patient Treatment Outside Zimbabwe

All outpatient treatment outside Zimbabwe is on a pay and claim basis. Members who incur financial liabilities for the costs of outpatient treatment are personally liable for all costs of treatment and for all costs of settlement unless a prior written agreement has been made with the administrators of the Multimed plans. Members must provide original copies of fully completed claim forms, all invoices and all receipts to Alliance health for settlement.

Treatment at Emergency Rooms, Trauma Centres and Casualty Departments

(A) Within Zimbabwe:

Subject to the terms and conditions of cover, the costs of all medically necessary treatment at Emergency Rooms, Casualty Departments and Trauma Centres for all members will be **covered in full for the first two visits** to an Accident and Emergency facility or Trauma Unit or Emergency Rooms facility for every member for every 12-month membership contract.

(B) Within Area of Cover (South Africa):

Subject to the terms and conditions of cover, the costs of all medically necessary treatment at Emergency Rooms, Casualty Departments and Trauma Centres for **Gold** and **Platinum** members will be covered in full **covered in full for the first two visits** to an Accident and Emergency facility or Trauma Unit or Emergency Rooms facility for every member for every 12-month membership contract.

The costs of treatment for **Bronze** and **Silver** members will only be covered if the member is subsequently admitted as an in-patient or day-patient to a hospital. (**Bronze** and **Silver** plans are hospital plans.)

If you are in South Africa, please contact **Meridian Medical Assistance (Pty) Ltd** whose details are as follows and can also be found on the membership card and membership certificate: +27 11 792 8796/0287, Cell +27 71 886 5250 or assistance@mmassist.co.za MMA will arrange Guarantee of Payment once they have been notified and you have provided them with all the necessary information. Once you have contacted MMA, then you must contact our emergency numbers in Zimbabwe – as found on the membership card provided to you.

(C) All Other Territories:

You **must first** contact our emergency numbers in Zimbabwe – as found on the membership card provided to you.

If you are unable to connect to our designated emergency numbers in Zimbabwe, then please contact **Meridian Medical Assistance (Pty) Ltd** whose details are as follows and can also be found on the membership card and membership certificate: +27 11 792 8796/0287, Cell +27 71 886 5250 or assistance@mmassist.co.za MMA will arrange to contact us on your behalf for authorisation once they have been notified and you have provided them with all the necessary information.

IMPORTANT:
Subject to the terms and conditions of cover and regardless of the circumstances, **you** will only be covered for **Accidents** and **Emergencies** up to $50,000 per annum outside your area of cover (refer to specifically listed African territories and offshore islands). This benefit operates on a pay and claim basis. Your emergency benefits for outside area of cover of $50,000 includes local road ambulance to the nearest appropriate medical facility. Your emergency benefits for outside area of cover **do not include** the costs of required air evacuations and/or repatriation.

Emergency Air Evacuations (Benefit is Restricted to Within Africa and Surrounding Islands ONLY)
Immediately contact the 24-Hour Pre-authorisation telephone number on your membership card. We will explain what is required in order to issue authorisation. The evacuation benefit is restricted to members receiving pre-authorised treatment whilst admitted to a hospital in a country other than their country of residence

IMPORTANT:
a) **We** will only cover the costs of an emergency evacuation if (1) **your medical condition** is **critical** and considered an **emergency** and if (2) **we** or **our** Medical Director is satisfied that there are no adequate medical facilities in **your** country that are able to treat the eligible medical condition. (See the Benefit Table for more details)

b) **We** will only cover the costs of evacuating **you** from within the specified listed territories within Africa and surrounding islands to the nearest suitable facility at a destination within Africa, or the surrounding islands.

c) **We** can only give the go ahead for an **emergency** air evacuation when (1) **we** are satisfied that all conditions in point a) above have been met and when (2) the attending medical doctor has informed us that **you** are stable enough to be air evacuated. This approval can sometimes be many hours after the initial evacuation request has been made.

d) The air ambulance company may be unable to arrange an **emergency** evacuation if the circumstances of a local situation make it impossible or unreasonably dangerous or impractical to enter a specific area or country to conduct an emergency evacuation.

For Approved Non-Emergency Evacuation Costs (travel and accommodation costs)

Pre-authorisation is required for every non-emergency evacuation and for every specific trip. All **non-emergency evacuations** must be approved by **us prior** to the non-emergency evacuation taking place. Approval can be obtained by you or your representative contacting the 24-Hour pre-authorisation phone number shown on the Membership Card.

We will only cover the costs of a non-emergency evacuation if (1) **your treatment** requires **in-patient** or **day-patient treatment** and (2) if **we** or **our** Medical Director is satisfied that there are no adequate medical facilities in **your** country and (3) **your** recovery will be substantially expedited. (See the Benefit Table for more details.)

Please obtain all of your receipts and boarding passes for all eligible transportation and accommodation costs. Together with a completed Claim Form, send the originals invoices together and the original receipt(s), as well as all air travel boarding passes to the Multimed Claims Team.

IMPORTANT:

a) All eligible non-**emergency evacuation refunds** are subject to the transportation taking place wholly within Africa and surrounding islands.

b) If you will be going to South Africa **for in-patient** or **day-patient treatment**, please contact the MMA Helpline prior to **your** departure. The MMA Helpline contact details can be obtained by contacting the 24-Hour Helpline on your membership card.

CLAIM PAYMENTS

Validity of Claims

Claims are valid for submission and settlement for three (3) months after the date of the last treatment.

Claim Adjudications

Incomplete claims cannot be processed. A claim requires a fully completed claim form, accompanied by all supporting documents. Initial claims assessments and adjudications are carried out by claims administrators. After the initial assessment the member may be requested to provide further information relating to the circumstances of the medical condition and/or treatment and/or other costs claimed. Claims are adjudicated on the strength of the information provided and according to the adjudicator's interpretation of the applicable benefits of membership to Multimed. Claim queries should be addressed to clientservices@healthzim.com for the reassessment of rejected or disputed claims the member must follow the standard complaints procedure outlined at the beginning of this document.

Settling Claims Directly with Treatment Providers

We settle all eligible **claims** in accordance with the payment instructions of the **treatment** providers detailed on the invoice and claim form.

Settling Claims Directly with Members

We settle all eligible **claims** in accordance with the recommendations outlined by **you** in the fully completed Claim Form.

Exchange Rates

If **you** wish to be refunded in a currency other than US$, **we** will use an exchange rate prevailing on the date of the receipt. **We** use a variety of international websites (including www.oanda.com) to obtain exchange rates.

We will not be responsible for any loss **you** may incur due to exchange rate fluctuations.

Claim Payment Methods

All claims are **refunded in** US dollars. However, we may be able to refund claims in different currencies on request subject to relevant foreign exchange laws and local banking legislation.

Eligible **claims** payments can be issued by:

- Bank transfer (most recommended)
- Cash

IMPORTANT: We will not pay any charges in respect of cashed foreign drafts/cheques.

IMPORTANT BENEFIT LIMITATIONS

You should be aware that the benefits of your membership to your Multimed may be subject to the following standard limitations unless otherwise specified on your Table of Benefits, or in any written plan endorsement, or agreed by us in writing.

Casualty and Emergency Room Visits – Your benefit for emergency room services is limited to two such visits per member per annum. There is no restriction on the number of visits to a Casualty facility for life threatening medical emergencies.

Complications of Maternity - These benefits are restricted to emergency medical services, casualty and in hospital services.

Elective treatment, including inpatient (hospitalisation and/or surgery) elective treatment for tonsillectomies, ear, nose and throat infections is subject to a 12-month waiting period after the member's join date.

Outpatient psychiatric and/or mental health treatment, including consultations and prescribed medication – 12 month waiting period after the member's join date.

Inpatient (hospitalisation and/or surgery) treatment for psychiatric and/or mental health problems – 24 month waiting period after the member's join date.

Treatment for complications of maternity and conception, (for members of Silver, Gold, Platinum and Platinum Plus plans) – 12 month waiting period before conception.

Benefits related to maternity and child birth, (for members of Platinum and Platinum Plus plans) are subject to a 12-month waiting period before conception.

Treatment for dermatology, including skin blemishes, moles, keratoses, and suspected melanomas is subject to a 12-month waiting period after the member's join date.

Dental Surgery, for the removal of impacted, buried or unerupted teeth is subject to a 12-month waiting period after the member's join date.

Routine Dental Treatment – (for members of the Gold, Platinum and Platinum Plus plans) is subject to a 6-month waiting period after the member's join date.

Wellness Benefit - (for members of the Platinum and Platinum Plus plans) is subject to a 12-month waiting period after the member's join date.

New Born Benefit – subject to a 12-month waiting period after the member's join date.

HIV/AIDS Benefit – subject to a 2-year waiting period *(please note that the separate trauma benefit provides for prophylactic ARV treatment and HIV testing that may be required as a result of trauma, an unsafe blood transfusion or rape)*

EXCLUSIONS

Your Multimed plan does not cover claims arising from or connected with the following Exclusions unless specifically specified on your Table of Benefits, in any written plan endorsement, or agreed by us in writing.

Abuse of Drugs Alcohol and Substances
Costs incurred in the treatment for, or arising out of the misuse or **abuse** of drugs (whether prescribed or not), substances, solvents and/or alcohol.

We don't cover the cost of any treatment of injuries or illnesses that may arise as a result of you being under the influence of alcohol.

Acting Against Medical Advice
Any journey, activity, action or pursuit undertaken against the advice of a **medical practitioner**, specialist / **consultant**, **registered nurse** or **therapist** that may result in the member requiring further advice, treatment or diagnostic procedures.

Alternative Treatments
Alternative treatments such as, but not limited: - to yoga, acupuncture, hydrotherapy, Pilates, colonic irrigation, health hydro's, natural cure spas, convalescence and relaxation or rest treatments.

Asbestosis
Treatment directly or indirectly arising from or required as a result of asbestosis or any related condition.

Benefit Restriction
Any benefit not on **your plan**, as specified in the Table of Benefits.

Bone Marrow and organ transplants
Bone marrow transplants, the acquisition or search costs of an organ, **treatment** incurred as a result of the removal of a donor organ from a donor, or **treatment** for removal of an organ from a member for the purposes of transplantation into another person and any complications arising thereafter.

Breaking the law
Any costs incurred due to the member breaking the law.

Burial and Cremation in own country
Burial, cremation or transportation where death of a member occurs in their **home country**.

Chronic Conditions
Treatment for a chronic condition unless clearly defined in your Benefit Table.

Circumcision
Circumcision, except where medically necessary for non-prophylactic reasons, or as a New-born benefit.

Compulsive Habits and Dependency
Treatment, therapy and/or medication that is to assist the member in achieving behavioural change, in overcoming a compulsive habit or any dependence or addiction. This exclusion includes interventions to assist members in overcoming smoking habits, and mediating the withdrawal symptoms of any kind.

Congenital Abnormalities or Birth Defect
Any congenital abnormalities or birth defects including but not limited to myopia, hypermetropia, astigmatism, natural/non-medical degenerative sight defects, non-medical/natural degenerative hearing defects and aids to assist eye sight and hearing.

Consequential Loss
Any **consequential loss** including but not limited to charges or fees incurred for the completion of Medical Claim Forms.

Contamination
The release of weapon/s of mass destruction, (nuclear, biological or chemical) whether such involves an explosive sequence/s or not. Contamination from chemical, biological and nuclear materials, including waste products from the combustion of nuclear fuel.

Cosmetic Surgery
Cosmetic, reconstructive, or remedial disorders, whether or not for psychological reasons, and/or any complications arising thereafter, unless required as the direct result of a covered **medical condition** which occurs after the **date of joining**.

Removal of fat from any part of the body, breast reduction or breast enlargement.

Criminal Activity
Any treatment arising out of injuries sustained whilst engaged in a criminal, illegal or unlawful act.

Cryopreservation & Implants
Cryopreservation, implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor.

Dental
Any dental treatment such as routine preventative dental examinations, prophylaxis **treatment**, scraping, scaling, cleaning, polishing, dentures, false teeth and/or **orthodontic treatment**, or crowns unless listed in the Table of Benefits.

Dietary Concerns

Special diet, weight control, children's food, baby supplies, vitamin, mineral or organic supplements.

Compulsive or addictive eating disorders and/or homesickness, anorexia nervosa, bulimia, bariatrics.

Disability Hardware

The rental or purchase of crutches, wheelchairs or other equipment, medical or otherwise, unless the equipment is in place of a plaster cast and is designed specifically to protect and assist in the rehabilitation process after surgery and has been fitted by a registered medical professional

Experimental Drugs and Treatments

Experimental or unproven **treatment**, unless **we** have given specific **pre-authorisation**. Members who undergo experimental treatment for life threatening illnesses may not claim the costs of treatment, or the costs of treating resulting side effects from Multimed. However, where such treatment is the members clear preference, and is recommended by the treating practitioner and is available under a strictly controlled and properly administered legal trial, then subject to eligibility members may claim benefits from the benefit for INTERNATIONAL EVACUATION, TRAVEL, ACCOMMODATION AND REPATRIATION benefit

Eyesight

Treatment to correct eyesight. Routine eye and sight tests, spectacles, contact lenses and other associated equipment unless listed in the Table of Benefits.

Family Member

Treatment by a **medical professional**, a **specialist** or a **consultant** who may also be related to the member in any way. This includes treatment costs incurred by clinics falling under the management or funding of the main plan holder, specifically when the main plan holder is a constituent body. A special dispensation is required for the waiver of this exclusion.

Fertility Treatment, Contraception, Sterilisation, Sexual Problems, Sex Changes

Any type of infertility **treatment**, contraception, sterilisation or its' reversal, fertilisation, **treatment** for sexual problems (including impotence, whatever the cause), sex changes, assisted reproduction (e.g., IVF **treatment**) unless provided for in the Table of Benefits. This exclusion extends to include any complications of fertilisation as well as premature or multiple births following assisted conception.

Foetal treatment

Any surgery to the foetus whilst still in the womb.

Foot Care

Podiatry, treatment of bunions (hallux valgus), orthotics and gait scans.

Hair Treatments

Treatment for loss or hair, wigs, scalp, alopecia.

Hazardous Sport, Hobbies and Occupations

Treatment resulting from participation in any hazardous sport, hobby or occupation of any kind unless agreed by us in writing. **IMPORTANT: Members must contact us if they need clarification on whether or not their sport, hobby or occupation is hazardous.**

Hearing

Treatment for or arising out of deafness caused by a congenital abnormality, maturing or ageing. Hearing tests and hearing aids unless as a result of an accident or illness which is covered under this plan.

HIV/Aids

Treatment or testing for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) or any related illnesses, infections or injuries resulting from HIV or AIDS except as provided for under the Table of Benefits.

Kidney Dialysis

Chronic supportive treatment of renal failure, including dialysis.

IMPORTANT: We will pay for the cost of renal dialysis incurred pre- and post-operatively and also in connection with acute secondary failure when dialysis is part of intensive/high care.

Learning Difficulties

Learning difficulties and/or disorders, developmental problems and speech and/or voice problems. Including ADD and ADHD unless agreed by us in writing.

Limit

Shall mean the **benefit limit** being exceeded of **your** plan, as listed and detailed on the Table of Benefits.

Medically Necessary

Treatment that **we** believe is not medically necessary.

Menopause, Normal Ageing and Senescence

The changes in and gradual deterioration of bodily function **characteristic of normal human life** including puberty, pre-menstrual tension syndrome, menopause, peri-menopause, andropause, ageing, Hormone Replacement Therapy and bone density tests, except as provided for under the Table of Benefits

Military Involvement

Medical conditions sustained by military, naval or air force personnel resulting from participation in any military, naval or air force operation or exercise.

Negligence

Any costs incurred for treatment required for injuries or illnesses that are a result of the member being negligent. Including but not limited to operating any kind of machine or machinery without taking due care to follow safety precautions.

Non-Essential Travel

Travel expenses incurred for journeys from the **country of residence**, specifically made for the purpose of obtaining medical **treatment**, unless **pre-authorised** by us under the **Emergency** Evacuation and Repatriation **Benefit**.

Non-Emergency Transport

Non-emergency transportation, other than **medically necessary** inter-**hospital** ambulance transportation, unless **pre-authorised** by us under the **Emergency** Evacuation and Repatriation **Benefit**.

Obesity

Treatment for Obesity and complications related to obesity, as well as associated treatments thereof such as but not limited to gastric bypass, gastrectomy, cholecystectomy, gall bladder removal if such treatments are for the purpose of weight control.

Over the Counter Drugs

The costs of medication, or any other substances, purchased on prescription when such medication and/or substances are available as over the counter purchases.

Palliative Treatment

Treatment that we determine to be Palliative **care** unless clearly defined in your Benefit Table.

Pre-Existing Medical Conditions (only applicable to non MHD plans)

A **pre-existing medical condition** that, within a 24-month period prior to the **date of joining**, or the date specified on the special terms section of members Certificate of Membership, has one or more of the following characteristics:

a. was **foreseeable**,
b. **manifested** itself,
c. the member had signs or symptoms of,
d. the member sought advice for,
e. the member received **treatment** for, or
f. to the best of the members knowledge, was aware existed.

After a period of 24 months continuous cover under the **plan**, **pre-existing medical conditions** may become eligible for **benefit**, if the member has not:

a. experienced symptoms,
b. sought advice,
c. required or received treatment, medication, or special diet in respect of such.

If a member has experienced any of the above, they will be required to wait a further 24 months from the last date of **treatment or medication** and must meet the above criteria, before being eligible to **claim benefit** for the **pre-existing medical condition** in question and related medical condition. This constitutes the rolling part of the **moratorium**.

The final adjudication of pre-existing medical conditions, and of further conditions related to thereof or considered to be complications thereof by the Alliance Health Medical Advisory Board is acknowledged by all parties to be binding and final.

Pregnancy and Childbirth

Costs associated with normal pregnancy and childbirth and any related conditions where the date of conception is within the first 12 months from purchase date of cover or Date of Entry whichever is later.

Complications of pregnancy costs arising where the date of conception is within the first 12 months from purchase date of cover or Date of Entry whichever is later.

Voluntary caesarean section costs. Medically Necessary caesarean costs due to previous non-emergency caesarean sections are subject to a 50% co-payment.

Pregnancy terminations on non-medical grounds, antenatal classes, midwifery costs when not associated with delivery.

Congenital abnormalities or **birth defects** except as provided for under the Table of Benefits.

All costs related to pregnancy, childbirth and post-natal health whether normal or complicated, unless **pre-authorised** by **us**.

Preventative Medicines

Treatment costs related to preventative medicines, except in circumstances where members may have been exposed to possible risks of injury, disease or illness under circumstances beyond their control. Malaria prophylaxis and vaccinations (except where stated in the Benefit Table), such as travel vaccinations, flu vaccinations, epidemics and pandemics, and any other vaccinations

Professional Sports
Medical conditions due to the participation in **professional and dangerous sports** or use of a weapon or firearm.

Psychiatric
Psychiatric/psychological disorders occurring within 24 months of taking out the plan. Psychiatric/physiological treatment or counselling for the following – drug, alcohol, substance and tobacco abuse, gambling, dementia, sexual dysfunction.

Quarantine/Isolation
Treatment in a quarantine/isolation ward or unit, nursing home, hydro, spa, health farm or similar establishment.

Reasonable and Customary
Any treatment costs that we consider not **Reasonable and Customary**.

In other words, if **your treatment** charges are higher than the usual cost of **treatment made** by the majority of service providers in the country where **you** received the treatment, **we** will only pay up to the amount which is usually charged in that country.

Routine Health Checks
Routine examinations including but not limited to gynaecological investigations, routine tests, normal hearing tests, new born neo-natal care, inoculations and vaccinations unless specifically defined in **your** Benefit Table.

Search and Rescue
Any costs incurred in Search and Rescue.

Second Opinion
A Second Opinion from a medical practitioner or medically trained person unless authorised by us. The administrators of the Multimed fund may allow or require a second opinion from a registered medical professional and reserves the right to submit for adjudication conflicting opinions to the Medical Directors of Multimed for resolution

Septoplasty
Septoplasty and/or Rhinoplasty for the correction of a deviated septum except where such surgery is required to correct damage which may have occurred in an accident that took place after the member's join date.

Sleep Disorders
Sleep apnoea, sleep **related** breathing disorders, snoring, or insomnia.

Suicide or Self Harm
Suicide, attempted suicide and/or any wilful, self-inflicted **medical conditions**. Self-exposure to needless danger, except in an attempt to save human life. Members who require treatment to remedy the effects of an attempted suicide are restricted to emergency medical services and casualty for stabilisation up to a maximum cost of $1,500 and for no more than 24 hours.

Tattooing and Body Piercing
Ear or body piercing and tattooing, and any treatment required following these.

Transportation Costs Related to Organ Transplants
All and any costs related to the identifying, sourcing and transportation of a donor organ for the member's use in receiving an organ transplant

Treatment After Expiry of the Plan
Treatment after the **expiry date** of the **plan**, or after the **expiry date** of a members cover, whichever occurs first, unless the **plan** or the member has been renewed and the membership contribution paid and the **treatment** is eligible.

Unauthorised Treatment
Any treatment that, subject to this **Agreement**, requires authorisation and has not been authorised.

Venereal and Sexually Transmitted Disease
Treatment of venereal and sexually transmitted diseases including but not limited to genital warts, syphilis, gonorrhoea, genital herpes, chlamydia, pubic lice, trichomoniasis – except where such conditions may have been the result of an incidence rape, assault or abuse.

Vitamins, Supplements
Vitamins and supplements.

Waiting Period
A benefit **waiting** period, as detailed on your table of
benefits, not being satisfied.

War and Civil Unrest
Treatment resulting from acts of war, invasion, act of foreign enemies, hostilities (whether declared or not), civil war, rebellion, revolution, insurrection, mutiny, military or usurped power, riot, strike, lockout, military or popular uprising, civil commotion, martial law, loot, sack or pillage unless the member sustains bodily injury whilst an innocent bystander.
If the member sustains bodily injury whilst an innocent bystander, then the member is only covered up to a maximum amount of US$250,000 per member per incident.

DEFINITIONS

Accident means a sudden unexpected or unforeseen external event resulting in **bodily injury** to a member.

Accompanying Person means a spouse, parent, step parent, parent-in-law, brother, brother-in-law, step brother, sister, sister-in-law, step sister, child, step child, grandchild or guardian.

Acute condition means a disease, injury or illness that is likely to respond quickly to **treatment**, which aims to return **you** to **your** previous state of health or leads to **your** full recovery.

Agreement means the entire contents of this booklet as well as **your** fully completed and signed **application form** and **your certificate of membership**.

Application Form means the **application form you** completed and signed on behalf of your dependants.

Area of Cover means Africa and surrounding islands.

Benefit/Benefits means the coverage provided by this **plan** and any extensions or restrictions shown in this **Plan Agreement,** Certificate of Membership and the Table of Benefits.

Birth defect means any deformity, anomaly, abnormality or disability, arising during pregnancy, or caused during childbirth.

Bodily injury means an identifiable physical injury.

Certificate of Membership (Membership Certificate) means the confirmation of cover issued by us. **Your Certificate of Membership** confirms the Multimed plan **you** have purchased, **your period of cover**, **your commencement date**, **your renewal date**, any **excess** amount, any **special terms**, **your country of residence**, **your area of cover** and a **schedule of covered persons**.

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

- it continues indefinitely and has no known cure
- it recurs or is likely to recur
- requires **palliative treatment**
- needs prolonged monitoring/**treatment**
- requires **specialist** training and/or **rehabilitation**
- it requires **long term monitoring,** consultations, check-ups and examinations
- is caused by changes to the body that cannot be reversed.

Claim/Claims means a course of treatment for a specific injury, illness, accident, medical condition or dental condition, which has been submitted by a member or their representative for settlement under the terms and conditions of the **plan**.

Close family member means a spouse, parent, step parent, parent-in-law, brother, brother-in-law, step brother, sister, sister-in-law, step sister, child, step child, grandchild or guardian.

Commencement date means the **date of joining** or any subsequent **renewal date** relative to a specific **plan year**, as specified on a valid **Certificate of Membership**.

Complications of pregnancy means **in-patient** or **day-patient treatment** received for a **medical condition** that arises during the antenatal stages of pregnancy or a **medical condition** that arises during childbirth and requires a recognised obstetric procedure. As an illustration we would consider treatment of the following:
- ectopic pregnancy (where the foetus is outside the womb)
- hydatiform mole (abnormal cell growth in the womb)
- retained placenta (afterbirth retained in the womb)
- placenta praevia
- eclampsia (a coma or seizure during pregnancy and following pre-eclampsia)

- diabetes (if you have exclusions because of your past medical history which relate to diabetes, then you will not be covered for any treatment for diabetes during pregnancy)
- post-partum haemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- miscarriage requiring immediate surgical treatment
- charges for other necessary care which is provided during hospitalisation for pernicious vomiting in pregnancy

Complementary medicine and treatment include osteopathic, chiropractic, acupuncture, herbal medicine, homoeopathy, naturopathy, reflexology, speech therapy, occupational therapy and anthroposophy. Eligible therapeutic interventions are restricted to those that (a) target the individual disease processes of conditions recognised by the World Health Organisation International Classification of Diseases or (b) to assist in the recovery of injury related trauma. Treatment for chronic, ongoing conditions is not eligible for benefits. Practitioners must be suitably qualified and registered with the appropriate, recognised professional governing body. Alliance Health reserves the right to refer adjudication of claims to the Alliance Health medical advisory board for assessment against the criteria of the treatment being considered (1) medically necessary (2) treatment of an acute condition and (3) effective treatment

Congenital abnormality means any abnormality, deformity, disease, illness or injury present at birth whether **diagnosed or not** including any condition or syndrome that is the direct and inevitable result of an underlying genetic condition.

Consequential loss means any costs incurred that maybe associated with a **claim** but are not covered under the **plan.** An example of this could be loss of earnings as a result of a **medical condition**.

Country of residence means the country in which **you** and **your dependants** live for the majority of the time (usually for a period of at least 6 months) during a **plan year**.

Critical means a **medical condition** which is unstable and serious, where the outcome cannot be medically predicted, prognosis is uncertain and the individual concerned is in danger of dying.

Date of joining means the date on which cover for the member and **dependants** shown on the Certificate of Membership under the **plan** first commenced.

Day-care treatment means being admitted for **treatment** at a **hospital** where a member is admitted and occupies a bed, but does not remain overnight.

Dental means that which affects the teeth and gums.

Dependant means a member's:

- legal spouse,
- unmarried child, stepchild or child legally adopted under 18 years attained,

The term **Partner** shall mean husband, wife or the person living with you in a similarly legally constituted relationship

Diagnostic tests/procedure means a **medically necessary** test or examination to investigate the cause of a member's symptoms.

Elective means treatment that is medically necessary, and where the condition, if left untreated, would bring about the death or disablement of the member, but which is not considered to be an emergency requiring immediate medical treatment. Elective treatment is necessitated by a pathological change in the function or structure in any part of the body occurring after the member's join date.

Emergency means a sudden, unexpected **acute medical condition** or an unexpected **acute** exacerbation of a **chronic medical condition** that, without **treatment** within forty-eight (48) hours of onset, could result in death or serious impairment of bodily functions.

Evacuation means the costs of moving a member to the nearest centre of medical excellence within the area of cover as required for treatment that necessitates hospital admission in the event of a medical emergency or in the event that non-emergency treatment is not available in the member's country of residence. Evacuation costs are restricted to the costs incurred from Treating Facility to Hospital in an emergency or from Airport to Airport for non-emergency, subject to the benefits listed in the Table of

Benefits. Evacuation is subject to: (i) authorisation by Alliance Health (ii) to written instructions from the treating physician (iii) acceptance by a registered and qualified specialist Emergency Medical Service. In the case of an emergency, it is required that the member's condition is certified as stable. Costs are set as reasonable and customary at the discretion of Alliance Health.

Event means an adverse or damaging medical occurrence which may be the occurrence of a disease, or an injury, or some underlying condition requiring treatment.

Excess means the amount stated in the **Certificate of Membership** being the amount you must contribute towards each claim.

Expiry date means the end date of the **plan**.

Employee means any individual with a contract of employment with a duly registered private or public limited company.

Foreseeable means a **medical condition** that could be reasonably anticipated.

Home country means the country declared as such on the application form.

Hospice means an organisation providing services for patients with a **terminal** illness. **Hospice** care may be as an **in-patient** or **out-patient** at home, or at a centre for controlling pain and other symptoms.

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

Immediate family is defined as a parent, child, spouse or sibling.

Inception date means the date shown on the **Certificate of Membership** on which cover under the **plan** first commenced.

In-patient treatment means **treatment** at a **hospital** where a member is admitted and occupies a bed for one or more nights.

Member *and* ***Insured person(s)*** mean any person**s** specified in the **Certificate of Membership**.

Legal representative means a personal representative with legal standing (as by power of attorney or executor of a will).

Manifested means a **medical condition** that showed or demonstrated itself plainly.

Medical condition(s) means any injury, illness, sickness, disease, signs or symptoms.

Medical History Disregarded (MHD) means no special underwriting terms shall apply and no exclusion from cover will exist for eligible **medical conditions** that are known to have been in existence prior to the **date of joining** (subject to our acceptance). However, such eligible **medical conditions** will still be subject to all other **benefits**, terms and conditions of the **plan**.

Medical practitioner means a **person** who is licensed to practice medicine in the country where the **treatment** is provided and has obtained the primary degrees in medicine and surgery following attendance at a recognised medical school listed within the World Directory of Medical Schools published by the World Health Organisation.

Medically necessary / medical necessity means **treatment** that is medically appropriate and necessary to treat a condition that is covered under the terms and conditions of this **agreement**.

Moratorium means a waiting period of twenty-four (24) months from the **date of joining**, or the date specified on the special terms section of the members Certificate of Membership, that must have elapsed before **claims** for **pre-existing** conditions may be eligible under the **plan**. The lifting of the 24-month rolling moratorium is considered on request by the member. Where a member has in the 24 months prior to the request experienced symptoms of the condition or received medication or other treatment for a condition placed under a moratorium, the moratorium cannot be lifted.

Natural teeth mean any teeth that are original and organic and not artificial implants or replacements.

Non-paying patient means when a member is admitted as an **in-patient** or **day-care** patient and receives **medical treatment** in a **hospital** where no charges are billed.

Nursing at home means services of a **registered nurse** in the home of a member when prescribed and supervised by a **medical practitioner**, **consultant** or **specialist** and **related** directly to a **medical condition** for which a member is receiving **treatment** covered under a **plan**.

Obesity means any member whose body mass index (BMI) is ≥ 30.0 whether pre-existing or not.

$$\mathrm{BMI} = \frac{\text{mass (kg)}}{(\text{height}(\text{m}))^2}$$

Orthodontic means that which affects the structure, function, development or appearance of the teeth, upper or lower jaw or the oral cavity.

Out-patient treatment means **treatment** at a **hospital**, consulting room, or **out-patient** clinic where a member does not occupy a bed.

Palliative care means the active total care of the patient whose disease is not responsive to curative treatment. Control of pain, other symptoms, and psychological, social and spiritual problems is paramount. The goal of palliative treatment is the achievement of the best possible quality of life for patients and their families. The treatment should focus on the improvement of the quality of life instead of straining curative treatment approach. In palliative medicine, an interdisciplinary approach is inevitable and essential.

Physiotherapist means a person who is qualified to practice physiotherapy and is licensed by the appropriate authorities within the country in which **treatment** is being provided.

Plan means the contract between **you** and **us**, to provide cover in accordance with the Table of Benefits, General Conditions, Benefit Conditions and Benefit Exclusions contained within **your plan** documents.

Plan administrator means the person appointed by the **plan holder** to administer the member's group healthcare **plan**, and to act as co-ordinator with **us**.

Plan year means the period of 12 months, starting from the **commencement date**, as shown on a valid Certificate of Membership.

Plan holder means the person or organisation to which **we** have issued the **plan** and is named on a valid Certificate of Membership.

Post hospitalisation treatment means medically **necessary follow**-ups consultations physiotherapy tests and/or treatment required on an out-patient basis including **medical practitioners** and **specialist/consultant's** fees, and drugs and dressings immediately following discharge from **hospital** after **in-patient** or **day-care** **treatment**.

Pre-authorise(d), Pre-authorisation means a process through which a member seeks approval from **us** prior to undertaking **treatment** or incurring costs. **Pre-authorisation** may be revoked if new information subsequently negates a **claim**. Failure to obtain Pre-authorisation may invalidate a claim.

Pre-existing means any **medical condition** or **related medical condition** which:

- was foreseeable,
- manifested itself,
- the member had signs or symptoms of,
- the member sought advice for,
- the member received **treatment** for, or
- to the best of the members knowledge, was aware existed

Whether the condition had been diagnosed or not, at any time before the start of your cover. A related condition is any disease or illness or injury that is caused by a pre-existing condition or results from the same underlying cause as a pre-existing condition.

Preventative treatment means **treatment** carried out where no **medical condition** or symptoms are present.

Primary treatment means the medical care a patient receives upon first contact with a medical professional (such as a general practitioner), before referral to a **specialist/consultant** for further **treatment**.

Professional sports mean sports where **you** are being paid to participate and where any such payment makes up the principal source of **your** income.

Psychiatric means that which affects the mind, emotions or mental function of a person and requires the attention of an appropriately qualified and registered medical specialist. Psychiatric treatment is in the form of recognised mental therapies (e.g., psycho-analysis, aversion therapy, behaviour modification, electroshock therapy, self-hypnosis).

Reasonable and Customary Charges means the amount paid for the standard accepted treatment for an eligible medical condition or the costs of non-medical services in a geographic area based on what providers in the area usually charge for the same or similar service. A charge is considered reasonable and customary if it matches the general prevailing cost of that service within the geographic area. If your provider of medical services charges above the reasonable and customary charge, you may have to pay the remainder.

Registered nurse means a qualified nurse who is currently on the professional register of nursing in the country where **treatment** is provided.

Rehabilitation means treatment **aimed** at restoring health and/or mobility in order to allow the member to live a more independent life.

Related condition means a disease illness or injury resulting in a **medical condition** that is caused by a **pre-existing condition** or results from the same underlying cause as a pre-existing condition.

Renewal date is the anniversary of the **commencement date** of the **plan** as specified on a valid **Certificate of Membership**.

Road ambulance means road ambulance transportation as required due to an **emergency** or **medical necessity** to the nearest available and appropriate local **hospital**.

Routine health check means any diagnostic test/screening carried out where no **medical condition** or symptoms are present.

Senescence or **biological aging** is the gradual deterioration of function characteristic of normal human life that on the level of the organism results eventually in death after maturation.

Specialist/consultant means a **medical practitioner** who is practicing and holds in the country where **treatment** is provided:

- a **consultant** appointment, or equivalent, or
- a recognised certificate of higher **specialist** training in the field of medicine for which the **Treatmen**t is required.

Terminal means an advanced or rapidly progressing incurable **medical condition** which in the opinion of a **medical practitioner** is expected to lead to death.

Therapist means a chiropractor, osteopath, homeopath, acupuncturist or Chinese herbalist who is qualified and licensed in the country in which **treatment** is being provided.

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

Trip means a journey, or period of travel which does not exceed the duration specified on the members **Travel Optional Add-on**

Plan Certificate of Membership. The **trip** includes the dates of departure from and the return to the **country of residence** (of the member), as declared by the **plan holder**.

We/us/our means the Medical Aid Society as detailed in the **Certificate of Membership**.

You/your means the **plan holder** or member.

Multimed Private Medical Cover – UW TYPE 24 MONTH MORATORIUM

The term UW TYPE refers to the Underwriting Type which is the underlying approach to risk management inherent in the design of the Multimed product. In layman's terms this is that membership to Multimed schemes cannot be used for the treatment of any pre-existing conditions unless they can be shown to have been once off acute conditions. As such once a person joins a Multimed plan there is a moratorium placed on the use of benefits for all pre-existing conditions*.

If after a period of two years of membership, a member has not experienced any signs or symptoms of ill health related to the pre-existing condition, and has not required and treatment (including medication) for the problem, then we would be in a position to provide benefits for any future health problems. This benefit really applies to once off injuries and traumas.

The wording of the Multimed plan agreement (which forms the contract between the member and Alliance Health) also specifies that the member should not seek advice from any medical professionals, or undergo any testing regarding the pre-existing condition for the entire 24-month period of the moratorium (as below).

If a member has experienced any signs or symptoms of ill-health, or received treatment, testing or advice for a pre-existing condition during the first 24 months of membership to Multimed, then they will be required to wait a further 24 months from the last date of ***treatment or medication*** *and must meet the above criteria, before being eligible to* ***claim benefit*** *for the* ***pre-existing medical condition*** *in question and related medical condition. This constitutes the rolling part of the* ***moratorium****. The final adjudication of pre-existing medical conditions, and of further conditions related to thereof or considered to be complications thereof by the Alliance Health Medical Advisory Board is acknowledged by all parties to be binding and final.*

Under the ***Accident*** *and* ***Emergency*** *medical treatment outside* ***<u>of your specified Area of Cover</u>****, the cost of Road Ambulance is covered from the scene of the accident to an appropriate Medical Facility if and where available. Air ambulance services plus pre-existing and related medical conditions will not be covered.*

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IMPORTANT: Whether or not we have pre-authorised costs, if it transpires that your medical condition or treatment is not covered by your plan, you will be responsible for all the costs. If we have already settled the medical costs on your behalf, you will be responsible for repaying to us the full amount that we have paid within 30 days of notification.
The final adjudication of treatment as medically necessary and/or of pre-existing medical conditions, and of further conditions related to thereof, or considered to be complications thereof, by the Alliance Health Medical Advisory Board is acknowledged by all parties to be binding and final.

As such, membership to Multimed is certainly not suitable for any persons with ongoing chronic conditions at the time of joining. However, in such cases we would recommend membership to an alternative plan such as Northern Alliance.

In line with guidelines issued by the Financial Services Authority of the UK, and as per Best Practice (as demonstrated by Interglobal who have similar stance in their underwriting), **we continue to display the original plan underwriting on the member's card at every renewal.** The original underwriting basis of the Multimed contract never changes, although clearly in many cases there may be little or no consequential impact on the members use of benefits as the membership is renewed year in, year out. We are very sorry for the inconvenience and distress caused to us members by this practice.

In our business at Alliance Health, we do strive for transparency and to follow ethical practices. I would trust that our commitment to paying for diagnostic testing up to the point of diagnosis in the case of members with suspected pre-existing conditions, and our commitment to responding in detail in good faith to all queries would demonstrate this.

A pre-existing condition is defined as any condition that, within a 24-month period prior to the* ***date of joining**, or the date specified on the special terms section of members Certificate of Membership, had one or more of the following characteristics:*

- *a. was* ***foreseeable****,*
- *b.* ***manifested*** *itself,*
- *c. the member had signs or symptoms of,*
- *d. the member sought advice for,*
- *e. the member received* ***treatment*** *for, or*
- *f. to the best of the members knowledge, was aware existed.*

MULTIMED MORATORIUM BUY-BACK

There are three types of moratoriums as follows:

(a) Rolling moratorium

(b) Fixed moratorium

(c) Moratorium buy-back (new concept)

(a) **Rolling Moratorium:**

A rolling moratorium is a stated period from the date of joining that must have elapsed before claims for pre-existing conditions may be eligible under the plan. Pre-existing medical conditions may become eligible for benefit if the member has not

- experienced symptoms,
- sought advice and
- required or received treatment in respect of such.

If the member has experienced any of the above, you will be required to wait for a further stated period from the last day of treatment. This constitutes the rolling part of the moratorium.

(b) **Fixed Moratorium:**

This applies when a member has declared pre-existing conditions upon joining and is advised to wait for a specific period of time before the condition is eligible for cover. This is more like a waiting period.

(c) **Moratorium buy-back (New Feature):**

The principle of moratorium buy-back will apply after full underwriting with an outcome that makes it possible for a specific condition to be covered with a loading. The terms of buying back the moratorium are determined by whether the underwriting outcome was expressly for a fixed or rolling moratorium. In the case of fixed moratorium, a member will pay the percentage loading amount for the duration of the moratorium. In the case of rolling moratorium, the member will buy-back by means of paying the percentage loading for the duration of the loading.

IMPORTANT CHANGES TO BENEFITS 2017 -2021

Description	Benefit
Additional Congenital Benefit	An additional benefit of USD 10,000 for the treatment of congenital conditions when the condition has only manifested after the member's join date and cannot be considered a pre-existing condition by normal definition
Bone Marrow Transplants	Specific clarification that surgical costs of bone marrow transplants are covered in full as medically necessary treatment under in-hospital benefits, but that costs related to donor search costs and donor testing, are not eligible for benefit
Customary and Reasonable	Further definition to note that awards are limited to the USD rates charged at inception of the Service Provider Service Level Agreement, or the previous year, unless otherwise negotiated
Dental Implants	Inclusion of dental implants as eligible for benefit as per fillings, crowns and bridges under the relevant dental benefit
Dental Surgery	Medically necessary dental surgery is eligible for benefit whether in or out of hospital
Dental Treatment (Accidental Damage)	Medically necessary dental surgery for the treatment of accidental damage to teeth is eligible for benefit whether in or out of hospital
Diagnostic testing for cardio-vascular disease	The advanced imaging benefit to include coronary calcium scans for the accurate assessment of both acute and chronic cardio-vascular disease
Epidurals for pain control during childbirth	The maternity benefit includes the full costs of prescribed epidurals as medically necessary for pain control during the birthing process
Evacuation by Commercial Airline	The benefit is limited to reasonable and customary charges, which may be established by way of comparing three quotations
Idiopathic scoliosis – equipment benefit	Members diagnosed after their join date with idiopathic scoliosis can utilise relevant benefits for equipment that provides effective treatment and which may obviate requirements for higher cost surgical interventions
Kidney Dialysis	The benefits for kidney dialysis are restricted to in-hospital treatment of acute kidney failure or acute on chronic episodes
Maternity Benefits	This benefit can be utilised as per the benefit table for the biological child of a member, restricted to the membership benefits of the mother
Maternity Benefits Waiting Period	The maternity waiting period for a spouse does not apply in cases when the father has been a member for 5 years or more
New-born Benefits	To specify that these benefits are from either the mother's benefit, or from the father's benefit, but cannot be amalgamated from both parents
Physiotherapy benefit for recovery from joint surgery	To include costs of prescribed physiotherapy treatment for recovery and rehabilitation after knee surgery, including the use of registered cold pressure devices
Stem Cell Tissue Storage	Inclusion of stem cell tissue storage benefit for new born infants (50% co-payment applies)
Free Personal Accident Cover	In addition to medical cover provided in cases of an accident, cover will also be provided in case of accidental death and accidental permanent disability. The cover is underwritten by Alliance Insurance and is up to US$25 000.
Short Term Cover for returning immediate family	Cover for immediate family members visiting a plan holder for a maximum of 90 days. The cover is only for Accidents and Emergencies only and exclude cover for any pre-existing conditions
Moratorium buy back	Moratorium buy-back will apply after full underwriting with an outcome that makes it possible for a specific condition to be covered with a loading. The terms of buying back the moratorium are determined by whether the underwriting outcome was expressly for a fixed or rolling moratorium.
Silver (Benefits 32 to 36)	Now covered up to $2,000 per medical condition for outpatient consultative & diagnostic costs for treatment 30 days prior to hospitalisation and for up to 90 days immediately following hospitalisation.
Out Patient Pathology and Lab Tests (Benefit 32)	Increase in benefit from $500 to $800 per member per year.

LIST OF SHORTFALL CODES

0	Claim OK
A	System Error
B	Required Information Missing
C	Benefit Exhausted
D	Excess of Tariff
E	Global Limit Exhausted
F	Claim Control Totals Mismatch
G	Claim Dates Mismatch
H	Other
I	Excess of Schemes Award
J	Member Not Registered at Treatment
K	Dependant Not Registered at Treatment
L	Firm Not Registered at Treatment
M	Out of Date Claim
N	Duplicate Claim
O	Treatment Follow Up Period Not Claimable
Q	Benefits Exhausted Service Type
U	Award Reduced to Generic Price
V	Claims Suspended
X	Sex Related Tariff
Y	Age Related Tariff
Z	Generic Drug Quantity Reduced
A1	Treatment Excluded from Schemes Benefits
A2	Waiting Period Applicable Before This Type of Service Is Claimable
A3	Tariff Class Demoted
A4	Claim Has No Details
A5	Provider Cannot Carry Out Treatment
A6	Provider Class Too High
A7	Subscriptions Not Up to Date
A8	Hospital Class Too High for Scheme
A9	Treatment Award Not Found
A10	Treatment Requires Referring Provider
A11	Treatment Requires Authorisation
A12	Member Suspended at Treatment
A13	Claim relates to a pre-existing condition
A14	Incomplete Claim
A15	Over the counter drug (OTC)
A16	Advance Award
A17	Treatment Before Application Approval
A18	Co-Payment

It is our intention to provide you with an excellent service at all times. If you feel that we have made an unfair decision regarding the adjudication of your claim, or that we have not provided you with a first class standard of service, or that our service could be improved: please address your concerns in writing to: The General Manager, Alliance Health, 7 Fleetwood Road, Alexandra Park, Harare. Please provide your full contact details and your membership number together with as much information as you can regarding your query, comment or complaint.

Contact Details

For any comments, queries or suggestions, please contact us:

HARARE

7 Fleetwood Road, Alexandra Park, Harare

2nd Floor, Joina City, CBD, Harare

BULAWAYO

7 Oak Avenue, Suburbs, Bulawayo

24-hour Call Centre numbers: +263 772 126 120 / 08677000716 / 08677020406

General and claim queries – clientservices@healthzim.com

Claim submissions – claimsteam@healthzim.com

www.alliancehealth.co.zw

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