You're in control

AAR Insurance

AAR HEALTH SERVICES (U) LTD
MEDICAL INSURANCE
POLICY

POLICY START DATE:	
POLICY END DATE:	
POLICY NUMBER	

PREAMBLE

WHEREAS the Insured named in the Policy Schedule has applied to **AAR HEALTH SERVICES (U) LTD** through a signed proposal form (hereinafter referred to as AAR) for the medical insurance hereinafter specified in respect of the Insured and their dependents (hereinafter referred to as the Members) and has paid the premium as consideration for such insurance.

NOW THIS POLICY WITNESSETH that subject to the terms, conditions and exceptions contained herein or endorsed hereon and the Limit of Indemnity stated in the Schedule, and further subject to reasonable and customary charges, AAR will cover the Members medical expenses as herein defined in Section 2 (as selected by the Insured at the commencement of the period of Insurance) as the direct result of a Member.

(a) Sustaining accidental bodily injury during the period of insurance
(b) Suffering Illness and/or disease during the period of insurance

PROVIDED that as a condition precedent to the attachment of this insurance the Member shall have submitted, and AAR shall have accepted a Membership Application Form which shall be deemed to be incorporated herein and form part of this Contract.

The insurer and the Member shall be deemed to have disclosed all material facts relating to the risk insured by this policy in the Application Form or separately in a letter. In the event of misrepresentation or non-disclosure of such facts the Company shall be entitled to.

(a) Avoid this policy and all premiums paid in respect of the Member so affected shall be forfeited.
(b) Seek from the member to be reimbursed all costs incurred by the company as a result.

SECTION 1. DEFINITIONS

1. NAME

The name of the Medical Insurance Plan shall be the **AAR HEALTH SERVICES (U) LTD (AAR)** Medical Insurance Plan, hereinafter referred to as the "Medical Insurance Plan".

2. GENERAL

REGISTERED OFFICE

The registered office for purposes of the Medical Insurance Plan shall be that of the Insurer. The Insurer may from time to time give notice of any other registered office within Uganda, should circumstances so dictate.

INSURER

The Medical Insurance Plan is underwritten by AAR HEALTH SERVICES (U) LTD registration number 10102

MEDICAL RECORDS

The Insurer shall hold all medical, clinical and other diagnostic patient information confidential.

AMENDMENT OF POLICY

Notwithstanding anything contained in this Policy, the Insurer shall have the right to amend, alter, rescind cancel, or make any addition to this Policy or any clause contained herein and shall inform all parties in writing at least three (3) months prior to effecting such amendment, alteration, rescission, cancellation or addition.

NOTICES

Notices by AAR to the Employer may be sent by hand delivery or by registered post and e- mail to the Employer to the address given to AAR by the Employer on the Application Form or otherwise notified to AAR in writing. Notices to Membersshall be sent to the Employer by post shall be deemed to be effective on the third day following the date of posting.

GEOGRAPHICAL LIMITS

This policy shall be issued in the Republic of Uganda but may have East Africa or worldwide application subject to the Agreement between the parties as instructed by the attached Schedule

"AAR Network" a list of AAR's preferred provider organizations.

"Accident" shall mean any single unexpected external event, not being deliberately self-induced, occurring to a Member which immediately gives rise to a medical condition that did not previously exist, and which may require hospitalization to stabilize.

"Annual Limit" shall mean the maximum benefits to which the Member or Dependent are entitled to in terms of the Health Plan joined in respect of a benefit year.

"Approval" shall mean prior written approval by the Insurer.

"Assessment" shall mean risk evaluation to determine whether to cover a person in order to accept liability.

"Benefit exclusions" shall mean claims for conditions and or services that are not eligible for benefit from the Health Plan cover in terms of this agreement.

"Benefit Year" shall mean a period of twelve (12) months from the Commencement date. The Insurer in agreement with the Employer may from time to time determine another period as it may deem necessary.

"Chronic Disease" shall mean a diagnosed chronic condition that is recognized as life threatening which will require ongoing medication for a period longer than three (3) months.

"Claim" shall mean a claim for benefits in terms of this Policy and the option selected evidenced by an invoice indicating the amount payable on behalf of the Member to the Contracted Preferred Service Provider in respect of expenses, incurred by the Member and Member's Dependents.

"Claims review" shall mean the review of claims by AAR to determine liability and amount of payment for various services.

"Complementary Treatment" refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional western medicine is taught. Such medicine includes chiropractic treatment, enthesopathy, Chinese herbal.

"Congenital abnormality" means a medical condition that is present at birth or before birth or is believed to have been present since birth, whether it is inherited or caused by an environmental factor. (i.e., regardless of cause)

"Commencement date" shall mean –

- In respect of Employees, the date upon which the Employer is registered as an Employer for purpose of the Medical Insurance Plan
- In respect to individuals, the date upon which the principal Member is registered as a member for purpose of the Medical Insurance Plan.
- Contracted Preferred Service Provider, the date upon which a Service Provider has been contracted by the Insurer.

"Compliance" shall mean adhering to treatment / lifestyle protocols as defined, determined, and prescribed by the Company and can change from time to time.

"**Co- payment"** is the fixed amount which the member must pay at the medical service point.

"Date of Service" shall mean the date on which a consultation, visit, treatment, procedure or operation took place. In the event of hospitalization, it shall mean the date of admission to a hospital.

"Dependent" shall mean:

A registered dependent described below of a member enrolled as such as part of the Medical Insurance Plan and who is entitled to the cover in respect of the selected Option:

- Spouse of the Member, who is legally married,

who is not a member or dependent of any other registered or underwritten medical insurance plan covered by AAR?

- A child who has not reached the eighteenth (18th) birthday, who is single, not self-supporting, including a stepchild, adopted child and a foster child.
- A disabled child who has reached the eighteenth (18th) birthday, who due to mental or physical disability is not self-supporting, may on submission of the relevant supporting medical evidence for such condition, be granted dependent status.
- A child who has reached the eighteenth (18th) birthday, who is unmarried, is not self-supporting, has not reached their twenty fifth (25th) birthday and who is a full-time student at a registered school, college or University as confirmed by certificate from the institution at the beginning of each year. Provided that such membership is subject to annual review by the Company.

Subject to the discretion of the Company, the following persons, including but not limited to, shall be excluded from the definition of "dependent": siblings, parents, parents-in- law; domestic employees and their children.

"Dental" shall mean medically indicated treatment to and for teeth including fillings, root canal, basic gum diseases, cleaning, extractions and polishing.

"Dentist" shall mean a dental practitioner registered under the Uganda Medical Practitioners and Dentists Act.

"Disabled Child" shall mean a child suffering from a physical or mental handicap which necessitates special care.

"Downgrade" shall mean the change of a Member's Health Plan from a higher to a lower Health Plan benefit.

"Elective" shall mean a medical procedure that is performed by choice, as opposed to an emergency lifesaving procedure.

"Emergency" shall mean a sudden unexpected situation in which a Member requires immediate hospitalization and treatment to prevent a medical condition that arises from Accident, injury or sudden illness that could result in death or serious impairment of bodily functions

"Employee" shall mean a person in permanent, temporary or casual employment with an Employer.

"Employer" shall mean a corporate employer or other entity providing Employment to persons exceeding ten (10) in number.

"Employment" shall mean service in the active permanent employment of an Employer.

"Endoscopies" shall mean a medical procedure where an instrument is introduced into the human body to give view of its internal organs.

"Evacuation" shall mean the transportation of a Member from a hospital in one geographical region to another where medical facilities are considered by the Company to be inadequate for the medical case to a hospital in another geographical region where facilities are deemed adequate to manage the case.

"Exclusions" shall mean the conditions and / or services not eligible for cover based on the health plan option.

"Health Plan Option" shall mean the benefit structure provided as part of the Medical Insurance Plan, selected by the Policy Holder.

"Health Promotion" shall mean a Plan that the Company has put in place for the management of a chronic disease.

"Hospital" means any institution that meets all of the following criteria:

- Have diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of patients and sick persons by or under the supervision of the staff of medical practitioners.
- Provides nursing service supervised by registered nurses or nurses with equivalent qualifications.
- Is not, other than incidentally, either a mental institution or a convalescent home.
- Is not a place of rest for the aged or a place f o r treatment of drug addiction or alcoholism or a health hydro or natural cure clinic or similar establishment?
- Is not an institution providing long-term care for the blind, deaf, dumb or other handicapped persons?

"Illness" shall mean a state of physical and/or mental ill- health.

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

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

"Individual" shall mean the principal person who applies for the policy cover in his personal capacity and not as an Employee of an Employer.
"Insurer" shall mean the registered insurer underwriting the Medical Insurance Plan.

"Lateral Movement" shall mean movement from either Employer to Individual Membership or vice versa. The movement shall be subject to the Company's underwriting rules.

"Lapse" means membership not renewed for a period of three months from the date of expiry.

"Limit of Indemnity" This is AAR's liability as limited in events and amount to the limits and sub- limits specified in the Schedule /Policy Document/ Health Plan as applying to each item or type of cover provided. The overall maximum limit stated thereon is the maximum amount recoverable under this Policy

as a whole by any Member during any one period of insurance and in total in respect of any one covered claim or event.

"MRI" shall mean Magnetic Resonance Imaging.

"Maternity" shall mean the period during pregnancy and six weeks after delivery of the baby.

"Maternity Beneficiary" shall mean the female adult Member who shall be entitled (principal or spouse) to a treatment protocol.

"Medical Advisor" shall mean a person qualified as a medical practitioner or specialist who is registered with the Uganda Medical Association and is appointed by the Insurer for purposes of the Medical Insurance Plan to provide medical expertise on matters referred.

"Medically necessary/ medically indicated/ medical necessity" means treatment prescribed by the member's medical practitioner, attending specialist/ consultant, who is appropriate for the medical condition and is in accordance with accepted medical standards.
"Member" shall mean any person entitled to the policy cover in accordance with the selected Option of the Medical Insurance Plan as set out in the Policy.

"Membership Application Form" shall mean the prescribed Company's form which a potential Member shall complete and forward to AAR.

"Membership Fee" shall mean the financial contribution payable by the Employer/ Member to AAR for the health plan approved by AAR.

"Optical" shall mean the benefit governed by Company protocol that covers for visual aids caused by the deterioration of eyesight.

"Ophthalmology" shall mean the benefit governed by medicine and surgery which deals with the diagnosis and treatment of eye disorders.

"Outpatient" shall mean any treatment and management of a patient that does not require medically indicated overnight confinement or stay in a hospital facility.

"Permanent Total Disability" shall mean a medical condition not existing prior to the Accident, injury or illness immediately preceding hospitalization, which the Company has specifically agreed to provide for, and which condition in the Company's opinion precludes any possibility of a Member continuing to lead his former life and/or return to his previous employment after discharge from hospital.

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

"Policy Holder" shall mean the person who for the time being is the legal holder of the policy for securing the contract with the Insurer in terms of this Policy, whether such person shall be an Employer, Individual or any other legal or natural person, and which person is responsible for the payment of Premiums in terms of the Policy.

"Pre-Authorization" shall mean the written prior Approval of the Insurer, required for all hospital admissions, scans, dental and optical treatment.

"Pre-Existing Condition" shall mean a condition for which medical advice, diagnosis, care or treatment was recommended or received during the period prior to the date on which application for membership in terms of the Policy was made.

"Preferred Provider Organization" shall mean a medical provider that has been appointed by the Company by means of a written agreement.

"Premium" shall mean the annual amount of money payable by the Policy Holder to the Insurer before commencement of cover.

"Prescription" shall mean the medicine, which is prescribed by a registered medical practitioner and approved by AAR to do so for a condition under treatment, provided that such prescription shall not exceed one (1) month's supply unless approved by AAR and in the case of inpatient treatment shall not exceed fourteen (14) days

"Reasonable and Customary" shall mean those services, costs or charges which do not exceed the general level provided or charged in the locality where the service, cost or charge is provided or incurred, when furnishing comparable treatment, services or supplies to individuals of the same
sex and of similar age and income, for a similar disease or injury.

"Recommended Tariff" or **"Tariff"** shall mean the agreed fees between the Insurer and a Contracted Preferred Service Provider.

"Rehabilitation" means treatment aimed at restoring health and/or mobility in order to allow the member to live a more independent life after a definite diagnosis and management. These will include but not limited to crutches, corsets, in-sole inserts, wheelchairs, prosthesis, physiotherapy and occupational therapy.

"Reimbursement" shall mean a monetary refund to a Member for pre-authorized services provided in an area with no Preferred Provider.

"Renewal date" means the anniversary of the commencement date of the health plan as specified on the valid Policy document and/or schedule.

"Rescue" shall mean the ground or air ambulance transportation of a Member who has suffered a serious medical Emergency from the scene of the Emergency to the nearest suitable hospital where stabilization and management of the condition can be provided.

"Resident" shall mean domiciled in Uganda.

"Supplementary Benefits" shall mean additional optional benefits described in the Health Plan or otherwise which are excluded in the plan and be provided as an addition to the health plan.

"Suspension" shall mean the temporary denial of medical services by AAR at its discretion.

"Termination" shall mean the cessation of the contractual relationship between AAR and the policy holder.

"Territorial scope" shall mean East Africa i.e., Kenya, Uganda and Tanzania.

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

"Treatment Overseas" shall mean medical or surgical treatment offered to a Member outside the Territorial scope.

"Room Limit" shall mean the cost of accommodation per night including the standard meals served by the hospital.

"Service" shall mean any consultation, visit, treatment, procedure, operation or admission to a Hospital of a Member.
"Underwriting Protocols" means the guidelines, as amended from time to time, used to underwrite risk and to determine and impose the exclusion level of Pre-Existing Conditions on Individual or on group Member basis.

"Upgrade" shall mean the change of a Member Health Plan from a lower to a higher benefit.

"Waiting period" The period from the commencement date during which a member is not entitled to any benefit except in the event of an accident as per the Policy Schedule.

SECTION 2. BENEFITS

1. A Member and/or his Dependent are entitled to benefits in terms of the Policy as per the Option which has been chosen and paid for.

Overall Limits.

1. Each Option sets out specified Annual Limits, applicable to Members and Dependents. The Annual Limits differ according to the Option chosen by the Member.
2. The Member who joins the Medical Insurance Plan during the course of a Benefit Year will be entitled to full benefits subject to Annual Limits based on the health plan option chosen.
3. The Member who resigns during the course of a Benefit Year will be entitled to benefits, subject to Annual Limits pro- rated on a daily basis at termination date, unless otherwise agreed to by the Insurer.
4. Notwithstanding anything contained in this Policy, benefits payable in terms of one Option shall not be transferable to any other Option.

A. INPATIENT BENEFITS

AAR will indemnify the insured for medical expenses listed below as per the Recommended Tariff up to a maximum of the benefit limit as specified in policy schedule, provided that the services that were received at the Preferred Provider are approved by AAR and that Preauthorization has been obtained in writing:

1. Hospital accommodation fees, theatre fees, drugs, injections, material, dressings and materials used in theatre. Member's maintenance in any Hospital, Nursing Home or Sanatorium is subject to a second opinion by AAR's appointed medical advisor.
2. Costs of services provided by general practitioners, specialists, technicians and physiotherapists in hospital only.
3. Radiology and pathology (scans and MRI's are subject to Pre- Authorization by the AAR).
4. Medication on discharge, "To Take Out", which is subject to maximum dosage for a fourteen (14) day period.
5. Road ambulance and rescue services to hospital. Cost of other transport or airfares for journeys within Uganda incurred in case of emergency in an attempt to save human life.
6. Hospitalization excludes consultations and all treatment prior to and after the period of hospitalization.
7. AAR shall provide to the discharged Member one consultation to the Medical Advisor Post hospitalization.
8. Attendance of a qualified Nurse at the residence of the Member, when confined to bed by a doctor's directive.
9. Day Care Surgery.
10. AAR must be fully informed of and approve scheduled hospital admission at least forty-eight (48) hours before such admission, and in the event of an Emergency, not later than twenty-four (24) hours after admission to hospital.

TREATMENT OVERSEAS

Emergency Treatment Overseas for International cover.

While the Member is temporarily outside the territorial scope, he/she is entitled to only emergency inpatient services and benefits to a total value limited by the stated maximum sum applicable to the relevant Health Plan. This entitlement only extends to one or more periods abroad totaling not more than forty- five (45) days in any one visit or in event of the visit exceeding this total, it applies to the first forty-five (45) days abroad. AAR will not provide any outpatient, scheduled or non-Emergency hospital services outside the territorial scope. Payment for claims incurred shall be on reimbursement basis at the discretion of AAR.

Scheduled Treatment Overseas

AAR will indemnify the Insured for any costs incurred for a medical condition that warrants referral for treatment overseas provided the treatment is not available in Uganda and it is certified by the Company's independent Medical Practitioner as being necessary in advance of such travel and treatment. There has to be written authorization from AAR approving the overseas referral. Such referral will be to AAR's preferred provider at the recommended tariffs.

AAR shall reserve the right to a second medical opinion from a Peer Review or a team of specialist medical practitioners.

Special Exclusions

AAR shall not be liable for payment in respect of: -

1. Expenses incurred in connection with and/or incidental to abortion not of medical indication as prescribed by laws of Uganda, cosmetic related services of the reproductive system, including infertility, intentional termination of pregnancy, prevention of pregnancy (family planning) and artificial cultivation of pregnancy

2. Expenses incurred in connection with Home Nursing or accommodation charges for any residential stay in hospital or registered nursing home which is arranged wholly or partly for domestic reasons or where treatment of any disease, illness or injury is not required or which could reasonably be provided whilst living in a normal place or residence, accommodation for permanent residence in a nursing home or hospital, a period of quarantine or isolation.

B RESCUE AND EVACUATION:

AAR shall, on being notified of an Emergency that requires Rescue, arrange for a Company approved air or ground to undertake the Rescue of the Member. The following terms and conditions shall apply.

1. Whenever it deems necessary, the AAR shall endeavor to ensure that a qualified doctor and/or nurse are on board the air or ground ambulance undertaking the Rescue.
2. Depending on the severity of the injury or illness a member may be flown either as a passenger on a commercial airline or on a chartered aircraft. AAR will base the decision on the medical and logistical circumstances of the case.
3. The aircraft captain undertaking an air rescue shall have sole discretion to decide how evacuation shall be undertaken. AAR will not be liable for injury or loss suffered by a member as a result of this decision.
4. AAR shall endeavor to transport an ill or injured Member directly to a destination to enable him to receive medical attention at a suitable hospital. If for any reason beyond the control of AAR or if in the opinion of a doctor or the aircraft captain the condition of the ill or injured person is such that it is necessary to terminate the flight or depart from the flight schedule or change the airfield of destination, AAR and the Member shall be deemed to have authorized such termination, departure or change as the case may be without thereby incurring any liability.
5. AAR shall not be liable for any injury or loss suffered by a Member if the Rescue or hospitalization is delayed, hindered or prevented by any circumstances whatsoever beyond its control including but not limited to acts of war, civil commotion or strife, lock-outs, stoppages or restraint of labor from whatever cause whether partial or general, government interference or restrictions, fire, flood, acts of God, compliance with international, national or local civil aviation regulations or any other regulations having the force of law, adverse weather conditions or the immobilization of aircraft or ground ambulance for any reason whatsoever, or breakdown in or failure of communications for any reason.
6. AAR shall not be liable for any injury or loss sustained by a Member in the course of undertaking a Rescue or the relevant Carriage by Air legislation in the local jurisdiction.
7. AAR will only undertake a Rescue or provide medical services if a member is seriously injured or ill and requires immediate hospitalization. AAR maycharge back and recover from a Member the full cost of a Rescue or hospitalization in circumstances where AAR would not have judged such Rescue or hospitalization necessary had it been correctly appraised of the medical condition of the Member prior to such Rescue or hospitalization, or if in its opinion the Accident, injury or illness giving rise to such Rescue or hospitalization could have been prevented or its consequences mitigated by the Member taking due and reasonable precautions which he failed to do. Whether or not a particular medical case falls into any particular category will depend upon the circumstances of the case.
8. AAR will facilitate the provision of Reasonable and Customary care, and other medical services and treatment when transporting the Member to hospital. The costs of all these services together

will be limited by the annual limit applicable to the relevant benefit. AAR has the right to decide who shall provide the appropriate service.

9. AAR will only provide evacuation to a member who is entitled to such service and who is so ill or injured that his life is in immediate danger and who cannot obtain adequate medical treatment in the geographical region where the Emergency arises. AAR will decide on the necessity for such Evacuation in consultation with the treating Medical Advisor. AAR will pay for any one parent or guardian of a member who is under eighteen years of age to accompany him.

i. AAR reserves the right to seek the advice of its own medical advisor whose opinion will be binding upon all parties to the contract.

ii. AAR's maximum liability shall not exceed the annual limit stated in the Schedule.

C MATERNITY BENEFITS (Where applicable)

AAR will indemnify the Member the proportion of expenses shown on the Policy Schedule arising from childbirth provided the Member is admitted in a hospital.The benefit shall cover delivery fees, consultation and treatment for both mother and child during the period ofconfinement/ admission in hospital. AAR shall also payfor cost arising out of miscarriage, complications duringpregnancy and abortion provided that such abortion shall be certified by a gynecologist and/ or a psychiatrist as being necessary to preserve the mental and/or physical health of the mother. AAR has the rightto require the mother to be examined by a specialist of its choice.

AAR shall not be liable for payments in respect of expenses resulting from any existing pregnancy for health plans with a waiting period. The total payable amount under this section in any one period of insurance shall not exceed the maternity limit specified in the policy Schedule. This benefit only applies to the principal or spouse

D OUTPATIENT BENEFITS (Where applicable)

The medical expenses listed below shall be considered for payment at the Recommended Tariff as agreed to between AAR and the Preferred Provider, up to a maximum of the benefit limit specified in the schedule of the selected option, provided that treatment rendered by the Preferred Provider was approved by AAR:

1. All general practitioners and specialist consultations, treatments, and investigations (inclusive of pathology and x-ray) provided. This includes outpatient visits, out of hospital consultations and procedures in rooms.
2. Medication prescribed by the general practitioner and/or specialist and dispensed by an approved pharmacist.
3. The following terms and conditions shall apply; Specialist Treatment, when a medical case is referred by a General Practitioner (GP) the Member shall be referred to AAR's panel of Preferred Provider. The referral shall beaccompanied by authorized documentation.
4. Child vaccinations will be as per the UNEPI list, must be obtained from the prescribed providers and will count as a visit.
5. Nutritional Services and advice includes a Consultation by a Nutritionist included in AAR's panel of preferred providers.
6. Antenatal care is Care of pregnancy and pregnancy related conditions from conception to delivery. Covered under antenatal care is antenatal profile, one
7. Non-diagnostic ultrasound, Management of complications related to pregnancy and Supplements as per AAR's guidelines.
8. Postnatal Care is the period from delivery to six (6) weeks after delivery. This covers delivery related complications excluding contraceptive management.
9. All of the above benefits are subject to the overall limit and internal sub-limits as stated in the schedule, co-payable, visit fees and levy where applicable as published from time to time.

E DENTAL EXPENSES:
OUTPATIENT ONLY (Where applicable)

In consideration of the payment of an additional premium AAR will indemnify the Member for the cost of dental treatment described below:

1. The cost of Dental Consultation resulting in treatment expenses, inclusive of Anesthetists fees, Hospital and Operating Theatre cost, covering Consultation, Simple extractions, Difficult extractions, Fillings (temporary, permanent, amalgam, composite, GIC), Scaling and polishing, Gum surgery, Root canal treatment, Pulpotomy & Minor Oral surgery.
2. The cost of Dental Treatment to the teeth or damage to dentures caused solely by accidental external and visible means or as a result of disease other than normal decay.

Special Exclusions

AAR shall not be liable for payments in respect of: -

1. Dentures, bridges and plates unless damage to the said dentures bridges and plates becomes necessary as the result of bodily injury sustained by the Member caused solely and directly by accidental external and visible means.
2. The cost of orthodontic treatment of a cosmetic nature unless such treatment becomes necessary as the result of bodily injury sustained by the Member caused solely and directly by accidental external and visible means or as a result of disease other than normal decay.
3. The maximum amount recoverable in any one Period of Insurance shall be subject to the Limits of Indemnity specified in the policy schedule.

F OPTICAL EXPENSES:
OUTPATIENT ONLY (Where applicable)

In consideration of the payment of an additional premium the Company will indemnify the Member for the cost of eye treatment, prescribed lenses, Dioptric power +/- 0.25 D and more, replaced once every 2 years membership upon producing the defective pair of frames or lenses to the maximum benefit per member for the year.

The maximum amount recoverable in any one Period of Insurance shall be subject to the Limits of Indemnity specified in the policy schedule.

Special Exclusions

The Company shall not be liable for payments in respectof: -

- The replacement of frames before 2 years unless directly caused as a consequence of an accident giving rise to an injury to an eye.
- The replacement of lenses unless necessitated in the course of further treatment in connection with the contingency insured hereby.
- The cost of contact lenses

G LAST EXPENSE (Where applicable)

AAR will pay the Insured in respect of funeral expenses provided that the total payment in any one period of Insurance shall not exceed the limit stated in the policy Schedule and the cause of death is a condition that is covered.

AAR shall, upon written notification of the death of a Member while this Policy is in force, pay to the Insured's appointed beneficiary, the amount specified in the policy Schedule to cater for the funeral expenses.

H OVERALL ANNUAL LIMIT

AAR shall not be liable for payments in respect to treatment for conditions for various sub limits if the Overall Annual Limit (OAL) has been exhausted.

I SUPPLEMENTARYBENEFITSOR EXTENSIONS (Where applicable)

Permanent Total Disability benefit.

It is hereby agreed that if during the period of insurance an Insured Person becomes permanently disabled as a result of an Accident AAR will pay to the Policyholder or their legal representatives the amount of benefit specified in the policy Schedule.

Hospital Cash benefit (where applicable)

It is hereby agreed that following a stay in hospital for treatment which is medically necessary, the insurer will pay the insured a benefit for every 24 hour period that the insured will be hospitalized. The benefit amount payable every 24 hour period is shown in the attached health plan option.

J COVID-19 COVERAGE EXEMPTION

AAR will provide cover for COVID-19 cases which may include testing, treatment and care at the Government designated facilities within the chronic Benefit limits as per chosen health plan option.

Severely ill cases requiring ICU will be covered within the set chronic benefit limit per policy cover and those with no chronic benefits shall be covered up to the limit for chronic conditions developed while on cover. Recommended treatment or tests outside the designated government facilities require pre-authorization.

SECTION 3. EXCLUSIONS

Unless otherwise decided by the Insurer in writing and signed by a duly authorized representative of the Insurer, no expenses incurred in connection with any of the following shall be payable in terms of the MedicalInsurance Plan:

1. Selective and/or planned surgery for an individual member within the first three (3) months following theCommencement date.
2. Expenses incurred by a member or Dependent in thecase of or arising out of willful self- inflicted injury, attempted suicide or suicide.
3. Treatment of obesity and slimming preparations.
4. Patent foods or baby food, and similar aids, sunscreens, shampoos and skin cleansing remedies.
5. Persons involved in domestic and biochemical remedies.
6. Medical costs related to or incurred following participation in any clinical trials or any research projects.
7. Cosmetic procedures including but not limited to gastroplasty, bat ears, blepharoplasty, breast augmentations, dermabrasions, liposuction, part and/ or full nasal reconstructions, lipectomies, face lifts, revision of scars or such other procedures that the Medical Advisor deems cosmetic, except in the event of and resulting from trauma or cancer.
8. Cosmetic treatment and plastic surgery, whether or not for psychological purposes, including treatment for obesity, investigative procedures or treatment of a routine nature, unless arising from an accident.
9. Treatment for injuries arising out of voluntary participation in riots, demonstrations, unrest and civil war or war.
10. Medical examinations for employment, insurance or physical fitness purposes or costs in respect of examinations and inoculations for international travel as well as food handlers' examinations.
11. Travel expenses other than emergency ambulance costs.
12. Injury or sickness caused by alcohol or drug abuse.
13. Holidays for recuperative purposes.
14. Private nursing or residential stay in a private hospital or Health Hydro's.
15. Patent proprietary drugs available to the general public without a Prescription) and homoeopathic drugs.
16. Stop smoking aids.
17. Vitamins, tonics and mineral supplements unrelated to a specific medical condition and which have not been prescribed by a doctor.
18. Treatment for infertility and artificial insemination.
19. All costs in respect of Pre-Existing(chronic) Conditions that were specifically excluded in writing when the Member joined the Medical Insurance Plan, or whichwere not disclosed on the members' application form shall not be coverable. There will be a 12 months waiting period for all chronics developed on cover. Refer to page 10 and page 11 for a list chronic condition non coverable.
20. All costs relating to the purchase of medicines prescribed by a person not registered as a Medical Practitioner legally entitled to prescribe such medicines.

GENERAL EXCLUSIONS (CHRONIC CONDITIONS)
The exclusions are applicable to Retail, SMEs and corporates with no cover for chronic conditions (This list is not conclusive).

CENTRAL NERVOUS SYSTEM

- Alzheimer's Disease
- Multiple Sclerosis
- Parkinson's Disease
- Seizure Disorders
- Stroke
- Epilepsy and other seizure diseases
- Bell's palsy
- Brain cancers
- Dawns syndrome
- Amyotrophic lateral sclerosis
- Cerebral palsy
- Cerebral spinal fluid leaks
- Multiple sclerosis

CARDIOVASCULAR SYSTEM

- Angina
- Atherosclerosis
- Congestive Heart Failure
- Hypercholesterolemia
- Hypertension
- Ischemic heart disease
- Myocardial Infarction
- Other Cardiac diseases
- Shock
- Stroke
- Varicose veins
- Leukemia
- Cerebral aneurysm

RESPIRATORY SYSTEM

- Asthma
- Chronic Obstructive Pulmonary Disease
- Cystic Fibrosis
- Pulmonary Hypertension
- Emphysema and Pulmonary interstitial disease
- Chronic Sarcoidosis
- Chest wall cancer
- Lung cancer
- Bronchiectasis
- Apnea

MUSCLULO-SKELETAL SYSTEM

- Gout
- Chronic spinal cord injury
- Chronic low Back Pain
- Muscular Dystrophy
- Osteoarthritis
- Osteomyelitis
- Osteoporosis
- Rheumatoid Arthritis
- Systemic lupus Erythematosus
- Bone cancers
- Arthritis

ENDOCRINE SYSTEM

- Diabetes Mellitus
- Hyperparathyroidism
- Hyperthyroidism
- Hypo-parathyroids
- Hypothyroidism
- Obesity
- Thyroid cancer
- Diabetic retinopathy
- Pancreatic cancer & other disorders

DIGESTIVE SYSTEM

- Cirrhosis
- Colorectal Cancer
- Crohn's Disease
- Hemorrhoids
- Chronic Hepatitis
- Chronic Pancreatitis
- Peptic Ulcer Disease
- Ulcerative Colitis
- Irritable Bowel Syndrome
- Gastro esophageal reflux disease
- Liver cancers
- Liver cirrhosis
- Fatty liver disease
- Alcoholic liver disease
- Hepatitis
- Chronic bile duct disease
- Previous bypass surgery

DERMATOLOGICAL SYSTEM

- Acne
- Alopecia
- Hirsutism
- Nail Disorders
- Skin Cancer
- Cosmetic surgeries
- Keratosis
- Melanoma & other skin cancers
- Keloids
- Adult cystic fibrosis

REPRODUCTIVE SYSTEM

- Benign Prostatic Hyperplasia
- Endometriosis
- Menopause
- Prostate Cancer
- Sexual Dysfunction
- Breast cancer
- Uterine cancer
- Infertility
- Uterine myomas (Fibroids)
- Ovarian cancer

VISUAL DISORDERS

- Cataracts
- Glaucoma
- Macular Degeneration
- Retinitis pigmentation
- Retinal detachment
- Trachoma

ENT DISOREDERS

- Chronic tonsilitis
- Adenoids
- Chronic sinusitis
- Voice disorders
- Laryngeal Cancer
- Orophanegeal cancer
- Hearing disorders & aids
- Throat cancers

DEVELOPMENTAL DISORDERS

- Autistic disorder
- Delayed milestones
- Asperger syndrome
- Developmental deformities
- Congenital diseases

MENTAL DISORDERS

- Alcoholism and related disorders
- Anxiety disorders
- Attention Deficit/Hyperactivity Disorder
- Dementia
- Major Depression
- Post-Traumatic Stress Disorder
- BAD
- Suicidal or intentional self-injury

URINARY TRACT SYSTEM

- Pyelonephritis
- Polycystic kidney disease
- Glomerulonephritis
- Lupus Nephritis
- Kidney stones
- Kidney cancer
- Bladder cancer
- Urinary tract cancers

21. All costs arising out of injuries sustained whilst participating in professional sports.
22. All costs for services rendered by:
    a. Persons not registered in terms of the Medical Insurance Plan with the Insurer, as a Contracted Preferred Service Provider, in the approved manner.
    b. Any institution/hospital, not registered in terms of any law and as a Contracted Preferred Service Provider.
23. All costs arising out of injuries sustained whilst participating in speed contests with the assistance of any type of mechanical apparatus including, but not limited to motor vehicle racing, motorcycle racing of any description, boat racing and ski racing, aircraft racing, diving and aerobatics.

24 All costs arising out of injuries sustained whilst participating in activities which are in the insurer's view inherently hazardous including, but not limited to active voluntary service in any military or paramilitary organization, martial arts, parachuting, hang gliding, paragliding, bungee- jumping, advanced mountain climbing, river- rafting, kayaking as well as other activities where the member or dependent deliberately exposes himself or herself to substantial danger.
25. All costs by which the annual limits of a member or dependent in respect of the relevant options are exceeded, for any treatment.
26. All costs relating to the difference in the tariff actually charged by the contracted preferred service provider and the tariff.
27. All costs arising out of treatment which include:
    a. Costs relating to private suites unless covered in terms of the relevant Option.
    b. Psychotherapy treatment (rest cures, institutionalization, isolation, quarantine, sanatorium care) unless otherwise provided for under the terms and conditions of the health plan.
    c. Costs relating to special dentistry including dental implants, periodontics, oral surgery and procedures performed under general unaesthetic for Member's Dependent who have reached the eighth (8th) birthday.
    d. Costs relating to private nursing unless provided in terms of the relevant Option.
    e. Costs relating to contraception and or sterilization.
    f. Costs relating to circumcision unless medically recommended.
    g. Costs relating to non- medical treatment.
    h. All costs related to sunglasses (e.g., Ray bans) or to the tinting of white lenses.
    i. All costs related to interest charged and legal fees arising out of overdue medical accounts unless it is proved to be as a consequence of fault on the Insurer's part.
    j. All costs relating to treatment consequential to medical procedures not otherwise covered in terms of the Medical Insurance Plan.
    k. All costs for the boarding of the mother in maternity cases once discharged and boarding in any other cases unless otherwise agreed to by the Insurer.
    l. Any costs arising out of an injury sustained by a member and/or Member's Dependent as a result of the willful act of a family member.
    m. Any costs arising out of a member and/or Member's Dependent donating any human tissue.
    n. Any costs pertaining to maternity benefits for a registered female individual member or spouse beneficiary for a period of one (1) year from date of joining. This applies to ONLY retail members and SME schemes
    o. Any costs pertaining to maternity benefits relating to the pregnancy of registered female child beneficiaries herein referred as third generation pregnancies which are excluded in full.
    p. Any other care as may be determined to be non- medically necessary including but not limited to:
    q. Repairs and adjustments of orthopedic appliances
    r. Birth reports
    s. Death reports
    t. Telephone charges
    u. Labor charges and technician fees
    w. Administration charges and costs
28. Nuclear, naval, military or air force service operations or participation in operations of a planned military nature. Operations or participation in operations conducted by the civil or military authorities against bandits, terrorists or other such elements.
29. Any expenses for which the Member has been or can be reimbursed from any otherInsurance or source including benefits received under any Workmen's Compensation Act or Government Schemes or Compensation except in respect of any excess of expenditure beyond the amount recovered from such other Insurance or source.

SECTION 4 TERMS AND CONDITIONS

MEMBERSHIP / MEMBER

Cover may be granted in the sole discretion of the Insurer to:

- An Employee of an Employer who has been or may be accepted as a member, subject to medical underwriting.
- An Individual who has been subjected to medical underwriting and who has subsequently been accepted as a member.
- A Dependent of a Member who has been registered as such under the Medical Insurance Plan, subject to medical underwriting.

TERMS AND CONDITIONS OF MEMBERSHIP

1. A prospective Member shall, prior to enrolment, complete and submit to the Insurer the membership registration form. The same is not applicable to corporates with a hundred lives and more.
2. The applicant and his Dependents shall before be admitted to membership, furnish such information as the Insurer may require, including detailed medical history reports. Where the Insurer has requested additional medical examinations, the Insured will cover the cost of such examinations.
3. The Member's Dependent shall be entitled to the Dependent benefits as set out in the Option benefit schedule.
4. The Member may not change Options during any Benefit Year but may select a new Option for any succeeding Benefit Year, subject to the terms and conditions of this Policy and which new Option shall only take effect form the first day of the relevant succeeding Benefit Year.
5. A person who has not reached the eighteenth (18th) birthday may not become a Principal Member.
6. No person who has reached the sixty-fifth (65th) birthday for Employer groups (10 or more Principal Members) or sixtieth (60) birthday for Individual Members may be admitted as a new Member. Any alterations to the same will be at the discretion of the insurer.
   - The Insurer may notwithstanding anything to the contrary contained in this Policy:
   - Exclude any Employee, Individual or Dependent from membership.
7. Defer the acceptance of any application for membership provided that any such applicant may be re-instated on compliance with such terms and conditions as the Insurer may determine.
8. The Insurer or its duly authorized representative shall be entitled to contact the Member and/or the Member's Dependent and/or relevant medical practitioner or Contracted Preferred Service Provider for the purpose of case management and cost containment.
9. In cases of illness of a protracted nature, the Insurer shall have the right to advise that a Member or Member's Dependent consult a Contracted Preferred Service Provider that the Insurer may nominate.
10. . The Insurer reserves the right at any time to exclude or impose a waiting period, the duration of which shall be decided upon by the Insurer regarding the cover of a Pre-Existing Condition, a Chronic Disease, Pregnancy and Childbirth and illness or ailment of the Member and/or Member's registered Dependent. This will apply only to Retail, SMEs and schemes below 100 lives.

11. The Insurer reserves the right at any time to refer the Member and/or the Member's Dependent toa Contracted Preferred Service Provider for the provision of treatment of an illness of a protracted nature, a Pre-Existing Condition, a Chronic Disease, Pregnancy and Childbirth and illness or ailment of the Member and/or Member's Dependent.
12. No Member and/or Member's Dependent shall be entitled to change health plan option during a Benefit Year. Any Member and/or Member's Dependent wishing to change the health plan option during a Benefit Year shall first terminate the existing membership and then apply afresh for the new option. However, a member and/or Member's Dependent can change the option at the renewal of the policy for the following Benefit Year.
13. On admission to the Medical Insurance Plan all Members and Dependents shall be bound by the terms and conditions of this Policy and any amendments thereto and shall only be entitled to benefits subject to such terms and conditions or any amendments thereof.
14. Upon replacement of an existing member, the new member will be charged a fee of 20,000 ugx for a new card.
15. For a member who has more than one spouse, a special rate may be charged in respect to the additional spouse.

CHANGE OF DEPENDENT STATUS AND MEMBER INFORMATION

1. The Member shall inform the Insurer within three (3) days of the occurrence of any event which may result in any one of his/her Dependents no longer satisfying the conditions in terms of which he/she may be a Dependent, and the registration and cover of such Dependent shall immediately cease upon the date that he/she no longer satisfies the conditions.
2. The Member whose marital status (legal or customary) changes subsequent to joining the Medical Insurance Plan and who wishes to register his/her Dependents, must notify the Insurer within fifteen (15) days thereof.
3. The Employer and/or Member must notify the Insurer in writing of any change of address. The Insurer shall not be held liable if Member's rights are prejudiced or forfeited as a result of failure to comply with this requirement.

MEMBERSHIP CARDS

1. All Members shall be provided with a membership card, containing his/her particulars.
2. The membership card remains the property of the Insurer and shall be returned to the Insurer on cessation of Membership.
3. Should the card be lost or stolen it is incumbent on the Employer/Individual to inform the Insurer immediately, failing which the Employer/ Individual could be held personally liable for any Claims paid through misuse. The cost of producing amended /additional card(s) will be borne by the Employer /Individual.
4. The lost membership card will be replaced at a cost of Ugx 20,000 to be paid by the employer.
5. The utilization of the membership card by any person other than the Member or the Member's Dependent, with the knowledge or consent of the Member or the Dependent, is an abuse of the benefits of the Medical Insurance Plan and will be dealt with by the Insurer in accordance with Clause 4.2.
6. A registered Dependent whose membership expires, during a Benefit Year will no longer enjoy the benefits from the date when such a change happens.

CESSATION OF MEMBERSHIP

1. The Member who is an Employee and who ceases to be an Employee during a Benefit Year shall cease to be a Member, from the last day of Employment. In such case all rights of the Member to medical benefits in terms of the Medical Insurance Plan shall cease from the last day of Employment except for Claims in respect of Services rendered prior to the last day of cover of the Member in terms of the Policy. Any additional notice period between the Employer and the Member shall not extend the policy cover of the Member.
2. In the event of any Member withdrawing from the Medical Insurance Plan, refunds for Premiums shall be considered in accordance with the Premium Refund Policy as set out in Clause 4.4.
3. The Employer shall be entitled to nominate a new Member in place of a Member who ceases to be employed by the Employer provided that all membership formalities are completed for the new Member and as longer as the employee who has ceased to be a member has not utilized.
4. The Agreement may be terminated by either party by giving the other party ninety (90) days written notice to the last known address of the insured or insurer. The agreement shall be deemed terminated at the of such notice period and refund of membership fees proportionate to the remaining months of membership to the renewal date of the agreement shall be allowed

5. The Policy shall terminate on the death of the Member if there is no Dependent at the discretion of the employer.
6. Failure to pay Premiums will result in the suspension of cover in terms of the Policy. In such a case the Insurer may refuse to pay benefits in respect of any Member and/or his Dependent for so long as any amount due to the Insurer in terms of the Medical Insurance Plan remains unpaid by the Policy Holder
7. remains due and unpaid for a period of sixty (60) days from the due date for the payment of the Premium all cover in terms of this Policy shall terminate in respect of any such Member and the Members' Dependents in which even the Member will need to reapply for cover which may be granted in the sole discretion of the Insurer and subject to such conditions as the Insurer may decide to impose.
8. Other instances where the benefits of the Member's Dependents may be terminated at the discretion of the Insurer are as follows:
9. Whenever he or she becomes the member or a dependent of a member of another medical insurance plan underwritten by AAR.
10. In the case of a Spouse, whenever the Spouse is divorced from the Member.
11. A Member shall forthwith notify the Insurer of any circumstances which may result in a Dependent ceasing to qualify as a Dependent.
12. Cover in terms of this Policy in respect of a Member and his/her Dependents shall automatically terminate in the event of any breach of warranty, misrepresentation or fraud and the Member or Member's Dependent shall forthwith cease from the date of such breach, misrepresentation, or fraud to qualify for any benefits in terms of the Medical Insurance Plan. Any benefits paid by the Insurer after such date shall be repayable upon demand with interest at the commercial rate.

ABUSE OF PRIVILEGES

1. Subject to the provisions of Clause 3, the I n s urn e r may, notwithstanding the provisions set out in the Policy, exclude from benefits or terminate the cover granted in respect of an Employer, Member or Member's Dependent whom the Insurer suspects on reasonable grounds of abusing the Medical Insurance Plan at any time during the course of a Benefit Year.
2. In such a case the Insurer shall be entitled to claim that the Member refund any sum paid resulting from such abuse of the Medical Insurance Plan.
3. In addition to the remedies set out in Clauses 9 the Insurer reserves the right to lay criminal charges against the person, Member or Contracted Preferred Service Provider, reasonably suspected of so abusing the Medical Insurance Plan.

PREMIUMS

1. The Insurer shall determine Premiums to be paid and shall notify the Employer, Member or Individual, as the case may be, in writing of the Premiums payable one month prior to the commencement of each Benefit Year. The Insurer may in addition to the above amend the Premiums or levy additional Premiums by means of a one (1) month's written notice in the event of the Claims experience over any period justify such amendment or additional Premium.
2. Premiums shall be paid annually in advance, in respect of contributions made by Employers on behalf of their Employees and annually in advance in respect of an Individual, or as otherwise agreed in writing

In case of any cover shorter than 3 months, minimum premium charged will be 3 months premium equivalent.

3. Where an Employee assumes duty 3 months or less to expiry of the medical insurance plan a 3-month premium will be charged.

PREMIUM REFUNDS

1. A refund of membership fees proportionate to the remaining months of membership to the renewal date of the agreement shall be allowed in respect of any member deleted from the scheme as long as the member has not utilized.
2. In instances where an Employer wishes to request a refund for an exited employee, such application must be lodged with the Insurer, only if payable in accordance with Clause 4. The refund of Premium shall be calculated on a pro rata basis for the remaining period for which cover would have been provided in respect of such exited employee.
   The balance of the Premiums shall be refunded 30 days following a written request from the member or employer. The refund request should be accompanied with the respective bank details.

LIABILITY

1. The Employer shall give the Insurer notice in writing, within three (3) working days of termination of Employment, of each of the Member's Employees leaving the Employment of the Employer and the date of such termination.
2. The liability of the Member shall be limited to the balance of the unpaid Premiums due up to the date of termination and not paid by the Employer, together with any sum required by theInsurer to be refunded to the Insurer in terms of Claims paid in terms of the Medical Insurance Plan, outside the benefits to which the Member / Or the Member's Dependent is entitled to. In the event of the Member's policy cover ceasing, any amounts still owing by such Member shall be paid over to the Insurer and shall be a debt due by such a Member to the Insurer and recoverable by it.
3. The liability of the Insurer shall in all cases be limited to either the overall Annual Limit of the Option specified in the Policy in the normal course of events, or the annual Premium received by the Insurer, where it is the opinion of the Insurer and/ or its Medical Advisor that fraud, abuse, over utilization or excessive Claims have occurred in respect of a Member or his/her Dependents.

PROVIDER TERMINATION

Provider empanelment and service provision terms: AAR shall on-board service providers based on quality assurance, client's needs and based medical practices. The contract can be terminated by either party based on:

1. If upon mutual agreement the services are no longer reasonable and customary from the provider to AAR
2. If the provider has been proven or is suspected with any form of medical fraud
3. If AAR fails to meet its obligations as per the contractual terms.

CLAIMS PROCEDURE AND PAYMENT

1. Every Claim submitted to the Insurer in terms of the Medical Insurance Plan in respect of the rendering of Service as contemplated in this Policy, must contain the following particulars:
   - Family name, initials and signature of the Member or Spouse.
   - The first name of the patient as per the membership card.
   - The name of the Medical Insurance Plan Option.
   - The membership number.
   - The practice code/name of the supplier of the Service, where applicable.
   - The practice code/number/name and specialty of the supplier of the Service where the service provider is in the employ or consulting on behalf of a Preferred Service Provider.
   - The Date of Service.
   - The nature and cost, according to the Tariff, of each Service.
   - Diagnosis or diagnostic code, where applicable.
   - Copy of approved Pre-Authorization when applicable.
   - Copy of the service record on the Health Passport.
   - The name of the referring medical practitioner.
   - Signature of the attending practitioner
   - No photocopies or telefaxed accounts will be accepted.
2. To qualify for benefits, a Claim shall be submitted to the Insurer not later than the last day of the second (2nd) month following the month in which the Service was rendered.
3. It shall be the responsibility of the Member and the Contracted Preferred Service Provider to ensurethat the Claims submitted do not include any treatment or service related to Exclusions as per Clause 3
4. The Member and the Member's Dependent must use the Services of only a Contracted Preferred Service Provider.
5. Where a Member has paid an account to a non-service provider, the account together with the receipt and all the required Claim submission information, together with a detailed motivation, must be submitted in support of a refund. The refund, if approved, will be done according to the Recommended Tariff, if in excess of the Recommended Tariff.

5. Hospital admissions, scans, dental and optical treatment and any exclusion without a Pre-authorization, shall result in the non-payment ofsuch a claim. Pre-Authorization is the responsibilityof the Member and the Contracted Preferred Service Provider. In the event of an emergency admission, the Pre-Authorization must be obtained from the Insurer within twenty-four (24) hours of such admission or during the office hours of the first business day following a Sunday or a public holiday.
6. Where the Service of a Contracted Preferred Service Provider is utilized for Emergency Transportation, Medical Treatment, Provision of Medication and Hospitalization, the Insurer reserves the right to only meet Claims by such a Contracted Preferred Service Provider in accordance with the Option Benefits. This Policy and any amendments thereto shall take precedence over any agreements entered into with such Preferred Service Provider.
7. A statement setting out particulars of the circumstances in which any injury was sustained shall support Claims for treatment of injuries. It is a requirement of this Policy that a Member and the staff representative of an Employer and the Contracted Preferred Service Provider certify such a Claim.
8. The Insurer shall only pay Claims in accordance with the Tariff and selected Option, and to the extent so agreed with the Contracted Preferred Service Provider, directly to the Contracted Preferred Service Provider who has rendered such treatment or service.
9. Where the Medical Insurance Plan has paid an account or portion of an account, or any benefit, to which the Member or Dependent is NOT entitled, whether payment is made to the Member or to the Contracted Preferred Service Provider, the amount of any such overpayment shall be recoverable from the payee.
10. Unless otherwise agreed to by the Insurer, a Claim not in accordance with the Recommended Tariff shall not be paid. The Insurer may pay directly to the Member the benefit to which the Member may have been entitled to, had the account been rendered in accordance with the Recommended Tariff. Any outstanding balance due to the Contracted Preferred Service Provider shall be payable by the Member/Employer.
11. Where the Insurer is of the opinion that a Claim is incorrect or unacceptable for payment based in this Policy, the Insurer shall notwithstanding the provisions of any other clause herein, notify the Member, Employer and the Contracted Preferred Service Provider, within (15) fifteen days after receipt thereof and shall state the reasons why such Claim is incorrect or unacceptable for payment. The Member and/or the Service Provider shall thereupon return such corrected Claim as provided for in Clause 4.7(1) duringthe time frame provided for in Clause 4.7(2) The Member must disclose to the Insurer any amount, which has been recovered or may be recovered by the Member as compensation from any other insurance or any other source, in respect of any illness or accident. Such amount shall be deducted from the Claim payable by the Insurer in terms of the Option benefits in respect of such accident or illness, provided that the Insurer may in its discretion decide in any particular case to make such deductions or make part of such deduction only.
12. The Medical Insurance Plan shall not pay any Claim pertaining to any Exclusion, see Clause 3 for which a Member and/or Dependent has received treatment. In such case the payment for such treatment shall be payable directly by the Member or Employer.
13. Payments to Members may be affected as follows:
    - Employee of an Employer: Any Claim owing to a Member/Employee will be paid to the Employer.
    - Terminated Members: Any Claim owing to a person whose policy cover has been terminated, may be retained by the Insurer for a period of three (3) months from the date on which his policy cover ceased or was terminated; thereafter the balance will be refunded to the ex-Member.

DISPUTES

1. The decision of the Medical Advisor will be prima facie proof of any of the following facts:
    - The nature of any physical defect, physical illness, physical deficiency or injury in a Member or Member's Dependent (all of which shall hereinafter be referred to as the "Condition").
    - The nature of any service required dealing with the Condition.
    - The level, type and duration of the service appropriate to any Condition.
    - Whether the place or treatment facility is appropriate to any Condition.
    - The occurrence or otherwise of any abuse of privilege including but not limited to fraud, abuse or unnecessary utilization of medical benefits.
2. Any dispute arising out of the provision of benefits shall be referred to the Medical Advisor.

3. Any dispute / complaint between the parties to the Insurance or Health Management contract may first be resolved amicably between the parties without the intervention of a third party and / or the dispute / complaint shall be escalated to the Insurance Regulatory Authority of Uganda or Ombudsman in accordance with the InsuranceAct and Regulations before resorting to other mediation, arbitration, litigation or any other form of dispute resolution.

4. Process in any legal proceeding against the Insurer may be served at the registered office of the Insurer. The legal costs relatedto any legal proceedings shall be carried by the claimant, unless specifically otherwise determined by a Court with jurisdiction.

WITNESS THEREOF both parties have set their respective hands on the date of this agreement above mentioned.

Signed for and on behalf of

CLIENT:

(Its duly authorizes signatories)

Name: ……. Name: ……

Signature: ……. Signature: ……

Designation: …… Designation: …….

Signed for and on behalf of

AAR HEALTH SERVICES (U) LIMITED:

Name: …….

Signature: …….

Designation: ……

SHOULD YOU NEED ANY ASSISTANCE OF OR CLARIFICATION

CONTACT US ON:

Customer Service Department

+256 414 560 900

Emergency Department

+256 703 268 810 | +256 414 255 991 | +256 712 255 991

Email

info.ug@aar-insurance.com

Over all Annual Limit	**Covered to Ugx60,000,000**
Exclusive Care and Case Management tailored for the individual	
Inpatient Benefits (Pre-authorisation will be required)	
Illness Hospitalisation cover	**Covered to Ugx30,000,000**
Accident Hospitalisation cover	**Covered to Ugx30,000,000**
Admissions to Intensive Care & high care units for Non Chronic Ilness	**Covered upto Ugx25,000,000 within Illness Hospitalisation Limit**
Admissions to Intensive Care & high care units for Accident	**Covered upto Ugx25,000,000 within Accident Hospitalisation Limit**
Admissions to Intensive Care & high care units for Chronic (subject to chronic waiting period)	***Covered Upto CDL Limit***
Hospital Room Limit Per Night within hospitalization limit	**ugx150,000**
Pre-existing Conditions	**Not covered**
Chronic conditions developed on cover (CDL)	**Covered UptoUgx 6,000,000 within Illness Hospitalisation Limit**
Oncology tests, drugs & consultation, Chemotherapy and radiotherapy	**Covered Upto CDL Limit**
Treatment of covid-19 and related co-morbidities	**ugx1,500,000**
Nursing fees, medical expenses and ancillary charges	**Covered**
General Surgery, Surgeons', consultants', anaesthetists', medical practitioners' fees	**Covered**
Reconstructive surgery	**Covered UptoUgx 6,000,000 within Accident Hospitalisation Limit**
Inpatient Opthamology	**Covered UptoUgx 6,000,000 within Accident Hospitalisation Limit**
Inpatient Dental Treatment	**Covered UptoUgx 6,000,000 within Accident Hospitalisation Limit**

Psychiatric treatment	**Covered UptoUgx 6,000,000 within Illness Hospitalisation Limit**
Congenital and genetic conditions defects	**Covered UptoUgx 6,000,000 within Illness Hospitalisation Limit**
Inpatient treatment of HIV/AIDS and all opportunistic infections	**Covered up to CDL Limit, as per WHO guidelines and procedures**
Rescue Cover (Uganda only)	***Covered***
Ambulance Cover(Uganda only)	***Covered***
Maternity for Principal Member or Spouse	**Normal Delivery-Ugx1,500,000, Caesarian Section-Ugx1,800,000**
Outpatient Cover	**Covered to Ugx3,500,000**
Pre-existing Conditions	**Not covered**
Chronic conditions developed on cover (CDL) ***(Subject to a waiting period)***	**Covered UptoUgx 1,500,000 within Outpatient Limit**
Oncology tests, drugs & consultation, Chemotherapy and radiotherapy	**Covered Upto CDL Limit**
Treatment of covid-19 and related co-morbidities	**ugx375,000**
Antenatal and Postnatal Treatment (Postnatal is subject to maternity waiting period)	**ugx500,000**
Psychiatric Treatment	**Covered UptoUgx 1,500,000 within Outpatient Limit**
Congenital and genetic conditions defects	**Covered UptoUgx 1,500,000 within Outpatient Limit**
Dental Cover (Uganda only)	***Covered to Ugx400,000***
Optical Cover (Uganda only)	***Covered to Ugx400,000***
Outpatient treatment of HIV/AIDS and all opportunistic infections	***Covered up to CDL Limit, as per WHO guidelines and procedures***

Annual Health Checks(Basic Medex): Complete blood count test, Random blood sugar test, Breast Exam and VIA for Females above 30 years, PSA for males above 45 years	**Covered upto Ugx100,000 within Outpatient Limit**
Permanent Total disability benefit for Main Member	**Covered upto Ugx3,500,000**
Last Expenses	**Covered upto Ugx1,500,000**
Minimum age when joining	1 month
Enrollment Medex Required	45 years
Maximum age when joining	60 years
Chronic conditions developed on cover	12 months
Illness Hospitalisation	90 days
Maternity cover	12 months
New Applicant subject to underwriting	7 working days
Exclusions	Refer to contract

Enrollment Notes:

- This cover doesn't include bills incurred while in Rwanda & South Sudan.
- All Medical bills incurred outside the contractual Network on this cover will not be covered by AAR Insurance
- **Preexisting conditions** will not be covered under this Cover
- Illness Hospitalization, maternity and Chronic conditions developed on cover are subject to waiting periods
- All claim incurred in providers where AAR has no affiliate will be covered if pre-authorized and if reported with genuine receipts within 48 hrs.
- All Hospitalizations must be Pre-authorized through the Case Management Arm of AAR Insurance
- The quoted standard premium can be increased at point of underwriting by AAR based on the risk profile presented at that point
- Immunizations & vaccinations are not covered