



## **GROUP HEALTH INSURANCE CONTRACT**

**The Policyholder**

**Main-Benefits-Covered**

**PRIME INSURANCE LTD**

**MIC BUILDING, KN2, AVE,  
NYARUGENGE PO BOX 2753  
KIGALI, RWANDA**

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## FIRST SCHEDULE

Policy Number	C-D-072024-xxxxx
Effective Date	xxx/11/2024
Name and Address of Insured	The Policyholder TIN Number: xxxxxxxx Kigali, Rwanda PO Box 6304 Kigali
Period of Insurance	From xx/0x/2025 to xx/0x/2026 (both days inclusive)
Policy Limits	Benefit limits per Member/family/person calculated in accordance with the Second Schedule
Premium Payable	The sum of individual premium calculated in each policy year for each Member, such premium being computed in accordance with the Second Schedule
Payment of premiums	Annually in advance on the xx of March each year
Age Limits	Main member: 18 – 65 years
Currency	Rwandese Francs (RWF)
Governing Law	Rwandan legislation governing insurances
Benefits Covered	Inpatient Outpatient Maternity Dental Optical Chronic Conditions Wellness Package Overseas Care Last Expense
Co-Pay/Deductible	10% Copay on outpatient and 100% No-Copay for Inpa & Mate
Accessible Service Providers	Local Cover or Regional Cover
Intermediary	Direct Business

## SECOND SCHEDULE

### **Territorial Scope**

The policy shall cover the medical services provided within EAC territory (Rwanda, Kenya, Uganda, and Tanzania). Medical services provided in India shall be covered in this policy only on a strict referral basis. The referral must be approved by PRIME INSURANCE LTD.

### **Effective Date of Cover**

The cover shall be valid:

- a) For non-excluded diseases or accidents occurring after the signing date of the contract
- b) For new-born babies, as soon as PRIME INSURANCE LTD approval is given, provided that:
  - Their parents are already insured.
  - Application for cover has been submitted with acknowledge of receipt within the four (4) weeks following the birth, and accompanied with a questionnaire - proposal provided for. Absence of reply on behalf of PRIME INSURANCE LTD within a period of three (3) weeks from the date of Subscriber's application shall be equivalent to company's consent.

### **Scope of Cover**

The health insurance scheme provides for medical and surgical expenses reasonably incurred by the insured members as a direct result of their sustaining accidental bodily injury and/or illness and/or a disease within the period of insurance.

Employees actively in service between the ages of 18 years and 65 years are eligible for cover.

#### **i) Inpatient Cover**

This covers the medical costs incurred whilst a member is admitted to hospital; it covers among other things, the costs of the hospital bed (private standard room), Doctor (s) and anesthetist's bills, expenses incurred from theater operations, pharmacy, laboratory and investigations reasonably incurred by an insured member within the cover limits as shown in the benefits and premium tables of this contract document. This cover will be accessed on credit facilities within the expansive panel of our healthcare provider partners.

## **ii) Outpatient Cover**

This cover consists of:

General Out-patient Services: Out-patient services provided by or on the order of a physician who is licensed as a general practitioner.

Specialist Out-patient Services: Out-patient services provided by or on the order of a physician who is licensed as a specialist or consultant.

Out-patient Laboratory and X-ray Services: Laboratory testing, radiographic and procedures used to diagnose or treat medical conditions. Such services must be prescribed or ordered by a physician.

Out-patient Prescription Drugs: Drugs and medicines, the use of which is restricted to the order of a physician and prescribed for use by the Member as an out-patient.

## **iii) Maternity Cover**

Covers pregnancy related costs from the beginning of pregnancy to delivery, including prenatal care, anomaly ultrasound, deliveries, scheduled or subsequent cesarean section, and post-natal care. The benefit shall cover delivery fees, consultation and treatment for both mother and child only during the period of confinement/admission in the hospital. Also covered are costs arising out of a miscarriage 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. This benefit does not extend to dependent children.

## **iv) Dental Cover**

Dental covers the costs of filling, x-ray and extractions including surgical extractions, including anesthesia fees.

Excludes expenses arising from replacement or repairs of old dentures, crowns, bridges and plates unless directly caused by accidental injury, and expenses related to orthodontic treatment of a cosmetic nature unless caused by accidental injury.

## **v) Optical Cover**

Optical covers cost of glasses and eye testing and is subject to pre- authorization by PRIME INSURANCE LTD.

Excludes expenses arising from

- Replacement of optical frames with the 1-year policy period except in case of an accident
- Replacement of lenses within one year unless there is a degree change that is medically proven or if the member has undergone eye surgery.
- Plano and photo chromatic lenses.

### **vi) Chronic Conditions**

This caters to inpatient and outpatient treatment of chronic or recurrent conditions, and their related medical care and treatment services. The following list of chronic conditions are covered:

- Hypertension
- Diabetes insipidus, Diabetes mellitus
- Hyperthyroidism, Hypothyroidism
- Anaemia
- Asthma
- HIV/AIDS
- Lung fibrosis
- Stroke
- Epilepsy
- Cystic fibrosis
- Muscular dystrophy
- Osteoporosis, Osteoarthritis
- Chronic renal disease

The total coverage under this section in any one period of insurance shall not exceed the limits specified and the cover shall be available at PRIME accredited and contracted specialized facilities.

The Chronic Package waives the waiting period for large groups (greater than 10 members) and caters for outpatient treatment of chronic conditions.

### **vii) Overseas Care**

This caters for treatment costs arising from a condition that warrants treatment not available in Rwanda will be covered subject to preauthorization by PRIME INSURANCE LTD including the cost of treatment, and prescribed drugs.

PRIME INSURANCE LTD will reimburse claims related to emergency treatment incurred while the principal member is temporarily outside the country on official duty as long as the period is not exceeding 6 (six) weeks at any one visit.

Requirements include:

- Referral letter from the facility or specialized consultant.
- A letter from line ministry/department to the Director of Medical Services supporting the referral.
- Approval letter from the Director of Medical Services.
- Pro-forma invoice from the referred facility.
- A PRIME approved agent may assist members to identify appropriate facilities and make travel arrangements.

### **viii) Wellness Package**

This caters to One annual health check-up for both principal and spouse and is subject to pre-authorization. The following tests will be assessed:

- Lipid profile (Total cholesterol, LDL, HDL ,Triglycerides )
- RFTS (Urea, Creatinine) and LFTS (SGOT,SGPT,GGT)
- Blood sugar (Fasting glycaemia)
- Urinalysis (culot, gram)
- Mammogram (for women over 40 years old)
- PSA (for men over 40 years old)
- HIV test
- Resting ECG
- FBC (Full Blood count)
- Hepatitis B (HBSAG)

### **Policy Limits**

Under the Second Schedule, the policy limits are determined in the below table of services.

### **GENERAL CONDITIONS**

- Ambulances covered within the country
- Hospital Accommodation standard private at Rwf 56,000 in Rwanda and maximum USD 100 outside Rwanda, VIP room on top-up.
- Intensive Care, High Dependency Units and Theatre charges
- Certified medical practioner fees
- Pathology, X-ray, Ultrasound, ECG and Computerized Tomography, MRI Scans
- HIV/AIDS and related ailments
- Listed MOH Immunizations for children and antenatal mothers
- Automatic addition of staff subject to extra premium on prorated basis
- Automatic addition of new born and spouse at no extra premium
- Automatic deletion of member leaving the scheme upon receipt of letter from the HR with no requirement for returning the medical card
- Vaccine for Hepatitis B and any vaccine part of Rwanda's EPI (Expanded Program of Immunization)
- Inpatient and Outpatient coverages for Chronic and Pre-existing conditions
- Drugs/Medicines, Dressings, and Internal Surgical appliances
- Dental services (Routine dentistry excluding dentures, braces crowns and bridges)
- Optical Services, contact lenses and Frames covered up to 50% of the overall Optical limit

- Congenital Conditions/pre-term babies covered as a sublimit of Inpatient limit
- Health Education and Awareness programs through our internal medical doctor at inception and on request
- Reimbursement where no partnership in place with Prime within 3 working days after reimbursement form completion and submission of the subjected medical invoices
- Family planning at Rwf 30,000 per visit
- Overseas medical cover during vacations/official visits maximum 6 weeks per staff per year settled on reimbursement using reasonable and customary rates in EAC
- Ante-Natal and Post-Natal package through our internal medical doctor
- Chronic condition prevention and management package through our internal medical doctor
- Treatments for Covid-19 are covered and 2 PCR tests per annum for travelling members
- One annual health check-up for both the principal member and spouse

<b>ANNUAL CEILINGS</b>
<b>TREATMENT</b>
<b>OUTPATIENT - Standalone benefit – Rwf XXXX Per Family</b>
Routine outpatient consultation including specialist referrals
X-Rays, Pathology, Diagnostic tests & procedures
Radiology X-ray, Ultrasound, EEG, ECG and computerized tomography, MRI scans
Prescribed physiotherapy
Prescribed counselling conducted by a psychiatrist
Prescribed drugs and dressings
Pre and Post Natal Care
Vaccinations part of Rwanda's EPI (Expanded Program of Immunization)
Baby Friendly Vaccine
<b>INPATIENT - Standalone benefit - Rwf XXXXX Per Family</b>
Bed limit: Standard Private Room maximum Rwf XXX – VIP Room on top-up
Pre-existing chronic condition (Inpatient Sublimit) – Rwf XXXX Per Family
Congenital Defect (Inpatient Sublimit) – Rwf XXXXX Per Family
Non-accidental inpatient ophthalmology (Inpatient Sublimit) – Rwf XXXX Per Family
Non-accidental inpatient dental (Inpatient Sublimit) – Rwf XXXX Per Family
Psychiatric treatment
Post-hospitalization for surgical and accidental cases
Emergency local road ambulance services leading to admission
Emergency Air evacuation subject to pre-authorization
Overseas cover - for a maximum of 6 consecutive weeks

Lodger fees
External Appliances cover following an accident or surgical procedure
<b>DENTAL - Standalone benefit – Rwf XXXX Per Person</b>
Fillings, X-Rays, Extractions, Anesthesia fees
<b>OPTICAL - Standalone benefit – Rwf XXXXX Per Person</b>
Consultation and Eye testing
Lens on prescription
Frame/Spectacles limit (50% max. for frame)
<b>MATERNITY - Standalone benefit – Rwf XXXXX Per Family</b>
<b>CHRONIC CONDITIONS – Within INPA &amp; OUTP</b>
Chronic/recurring conditions outpatient limit; Prescribed drugs and dressings; Magistral preparations (pharmacy); Aerosol sessions; Specialist Acts; Treatments by ultraviolet, light or infrared rays; Treatment of tumor by radium therapy and roentgen-therapy; Treatments by dialysis (renal insufficiency); Treatments by radioactive isotope; Any treatments carried out in sessions. Abnormality, disability or constitutional malformation treatment.
<b>WELLNESS PACKAGE - Within INPA &amp; OUTP</b>
<b>OVERSEAS CARE - Within INPA &amp; OUTP</b>
<b>COPAYMENT: 10% Copay on outpatient and 100% No-Copay for Inpa &amp; Mate</b>
<b>LAST EXPENSE - Standalone benefit – Rwf XXXXX Per Case</b>

### Stoppage of Cover

Cover shall be discontinued collectively on the very termination day of the contract and, individually, on the day when any insured person resigns or retires from Contracting party's job and, in any case, not later than end of the year when the insured person reaches his/her 65th year of age. In case of confirmed fraud, PRIME INSURANCE LTD shall reserve the right to remove the insured person from its list.

### Refunding of Medical Care

No medical act, equipment/appliance, operation or hospitalization, shall be paid for unless it has been ordered by a medical doctor, a surgeon or dentist surgeon.

Neither in Rwanda nor abroad shall PRIME INSURANCE LTD cover extend to death-related charges; they shall be limited to medical fees of patients still alive. However, PRIME INSURANCE LTD can insert the option of “Funeral Fees” in this contract if needed by the Contracting party.

No medical treatment shall be covered unless it is performed by authorized personnel in an officially health facility approved by the Ministry of Health which, except in case of absolute necessity, must be approved by PRIME INSURANCE LTD.

The system to pay bills related to medical treatments is in general “indirect payment” whereby the beneficiary of health insurance pays his/her patient’s deductible/co-pay (if applicable) agreed on, then the provider gets the remaining payment of the bill at PRIME INSURANCE LTD.

The “direct payment” in which the insured pays all medical treatments bills and gets the refund at PRIME INSURANCE LTD is used as exceptional.

The insured person or the provider will be required to submit to PRIME INSURANCE LTD the fees notes or charges prescriptions paid, dated and indicating the names and forenames of the concerned insured person.

The notes must indicate the nature and date of treatment performed by distinguishing the cost of each of the treatments given.

Prescriptions must bear legible names and forenames of the insured person together with payment vouchers for pharmaceutical products.

### **Obligations of the Insured**

#### **i) Premiums**

The total initial premium is payable annually in advance at the beginning of the coverage period.

The above-described cover shall be granted in exchange for annual premiums amounting to:

<b>Premium Per Staff</b>	<b>RWF XXXXXX</b>
<b>Base Premium</b>	<b>RWF XXXXXX</b>
CBHI Contribution	RWF XXXX
Administration Fees	RWF XXXX
<b>Total Premium</b>	<b>RWF XXXXX</b>

#### **ii) Premiums on additions and deletions of members**

A prorated premium is payable immediately for anyone who becomes a member at any time during the coverage period.

Mid-term deletion of insured members: A prorated premium to the remaining days to policy expiry shall be reimbursed to the insured subject that no claims was incurred and/or reported in respect of the particular member(s) / family.

**APPLICABLE LEVY/TAX:** 5% of the Base Premium for Community Based Health insurance (CBHI) – Mutuelle de Santé

**Administration Fee:** Rwf 10,000 Per Life.

### **iii)Fraud**

If any claim made by the Insured shall be fraudulent or intentionally exaggerated or if any false declaration or statement shall be made in support thereof then this policy or member shall be voidable by PRIME INSURANCE LTD and applicable premium forfeited.

The Insurance Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his/her knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact is within the knowledge of the insurer.

### **Access to Services**

Prior approval must be sought to access treatment for the benefits listed below, accompanied by the pre-authorization form provided for.

PRIME INSURANCE LTD will then confirm eligibility, verify the benefit limits and issue an approval to the service provider authorizing the treatment. Before discharge from the hospital, members will be required to complete and sign a PRIME claim form.

Benefits requiring Preauthorization of treatments:

- Scheduled Inpatient hospital admission
- Scheduled Day Care hospital admission
- Childbirth/Delivery hospital admission
- Out of Country Inpatient treatment
- Physiotherapy Sessions
- Optical frames and lenses
- Any other condition specified in the schedule as requiring preauthorization

### **i) Credit Claims**

A Member will present the medical smart card at the PRIME insurance panel of Providers. Treatment will be rendered. Member and treating doctor should sign the PRIME insurance claim form which will be available at all Service Providers.

All invoices with the signed claim forms will be sent to PRIME by the Service Provider for processing of payment to Service Providers. The summarized member's utilization reports will be sent to The Policyholder. HR Office on a quarterly basis. Member statements will be issued directly to individual members upon request.

### **ii) Reimbursement claims**

The member must have the PRIME claim form signed by his/herself and the treating doctor. Original prescriptions, receipts, lab test referrals should be attached to the signed claim form and forwarded directly to Prime Insurance Ltd.

Note: Reimbursement to the member shall be done within 5 working days

### **Overseas referrals**

This medical cover is confined within the territorial limits of Rwanda.

## **THIRD SCHEDULE**

### **Definitions**

- 1. Accident** A sudden, unexpected, unforeseen and involuntary external event at a specific time and place resulting in external visible bodily injury to a member and occurring whilst this policy is in force
- 2. Beneficiary** The principal insurance holder, his/her legitimate eligible parties (his/her spouse and dependents) recorder on the individual membership card.
- 3. Bodily Injury** Bodily injury or physical suffering within 12 months of the Accident that caused it, as listed in the Policy's benefits table below. The injury cannot have any other cause such as a physical problem, weakness or illness that existed before the Accident. Injury includes exposure to the elements (having no shelter) because of an Accident. But it excludes any sickness or infection unless this was directly because of an accidental Bodily injury.
- 4. Chronic Disease** A condition(s) that requires medication and treatment for more than three (3) continuous months
- 5. Commencement Date** The date shown on the group policy, on which the policy first came into effect.

6. **Congenital Anomaly** A condition(s) which is present since birth, and which is abnormal with reference to form, structure or position, whether internal (not in the visible and accessible parts of the body) or external (in the visible and accessible parts of the body)
7. **Consolidation** Time from which the state of the injured person or patient is considered as permanent and presumed definitive.
8. **Co-Pay** A fixed amount required to be paid by the insured for a covered healthcare service.
9. **Date of Entry** The date shown on the certificate of insurance on which a member was included under this policy.
10. **Day Care Treatment** Any medical treatment, and/or surgical procedure which is
  - a. undertaken under General or Local Anesthesia in a hospital/day care center in less than 24 hours because of technological advancement, and
  - b. which would have otherwise required hospitalization of more than 24 hours.Treatment normally taken on an out-patient basis is not included in the scope of this definition.
11. **Day Hospitalization** Any stay, repetitive or not, lasting less than 24 h in a public or private health facility, where that stay is for the medical or surgical treatment or caused by a disease, an accident or a delivery.
12. **Deductible** An amount of money to be paid by the insured for healthcare services covered under the insurance plan before the plan begins to pay benefits for eligible expenses.
13. **Delivery Complications** The following cases: caesarean, puerperal fever, phlebitis.
14. **Direct Payment/ Reimbursement** System in which the insured pays all medical treatments bills and gets the refund at PRIME INSURANCE LTD.
15. **Disability** Malformation of human body, incapacity of the system to perform a function as a result of an accident or disease.
16. **Group** Any company or institution subscribing to the contract on behalf of its salaried personnel or members.
17. **Hospitalization** Any stay lasting more than 24 h in a public or private health facility, where that stay is for the medical or surgical treatment or caused by a disease, an accident or a delivery.
18. **Indirect Payment System** A system in which the insured pays a portion of the cost of treatment to the medical care provider while PRIME INSURANCE LTD refunds the remaining percentage to the medical care provider.
19. **Inpatient Care** Treatment for which the insured person has to stay in a hospital for more than 24 hours for a covered event.

20. **Insurance Year** Period of 12 months extending uninterruptedly between the effective date of the contract and its due date.
21. **Insured** Any person designated in the Particular Conditions and beneficiary of contract services and/or subscriber to the contract ages less than 65 years.
22. **Insurer** PRIME INSURANCE LTD.
23. **Law** Rwandan legislation governing insurances.
24. **Member** The principal insured.
25. **Network Provider** Hospitals or health care providers enlisted by PRIME INSURANCE LTD to provide medical services to an insured by a cashless facility.
26. **Outpatient** The Insured Person who is not Hospitalized but who visits a clinic/ Hospital / or any associated facility like a consultation room for diagnosis or treatment (encompassing but not limited to consultation, diagnostic tests & services, medicines/drugs, vaccination, Medical Procedure, external medical aid).  
  
However, any Insured Person undergoing any specified Day Care Treatment will not be considered as an Out-patient
27. **Particular** Any insured person not integrated in a Group or company insurance.
28. **Pre-Existing Disease** Any condition, ailment, injury or disease
- a. That is/are diagnosed by a physician within 12 months prior to the effective date of the policy issued by the insurer or its reinstatement
  - or
  - b. For which medical advice or treatment was recommended by, or received from, a Physician within 12 months Prior to the effective date of the policy issued by the insurer or its reinstatement
29. **Premium** Amount of money to be paid by the subscriber in compensation for cover offered by PRIME INSURANCE LTD.
30. **Principal Insured** Any worker party to the contract, staff member of the subscriber
31. **Prior Consent/ Preauthorization** Consent of PRIME INSURANCE LTD that must be given before the performance of some acts, examinations, services and prescriptions.
32. **Sickness** Alteration of health, diagnosed by a competent medical authority, leading or not leading to stoppage of work.
33. **Subscriber** The individual person or a legal entity that is a party to the policy, acting both for themselves, or on behalf of the insured.
34. **Waiting Period** Length of time immediately following the effective date of the contract and during which any charges incurred due to sickness, accident or maternity are not covered by the policy.

## Professionalism and Confidentiality

PRIME INSURANCE LTD undertakes to execute its duties in a professional manner to ensure delivery of quality services and the promptness in procedures. The parties undertake on behalf of themselves and their employees, agents and permitted subcontractors that they will keep confidential and will not use for their own purposes (other than fulfilling their obligations under the contemplated contract) nor without the prior written consent of the other disclose to any third party any information of a confidential nature relating to the other.

## Issuance of Medical Cards

The insurer undertakes to issue the medical insurance cards within 5 days upon receipt of the duly completed application and passport photo forms for each beneficiary. In the event of the loss of a medical card, PRIME INSURANCE LTD will replace it after the payment of RWF 4,000 by the member.

## Duration

The contract shall be entered for the duration determined in the First Schedule. In any case, that duration cannot exceed **one (1) year**, and without prejudice to cases of early termination provided for in the Termination article above.

Where the contract contains a clause of tacit renewal, it is, upon expiry, automatically renewed form year to year, unless it is terminated by either party at least **15 days** before the end of the year.

## Cancellation

PRIME INSURANCE LTD may cancel this Policy by sending Thirty (30) days' officially written notice to The Policyholder. and in such event, PRIME INSURANCE LTD shall refund to the The Policyholder. a pro-rata portion of the premium for the unexpired term of the current period of insurance. The Policyholder. may equally cancel this Policy by giving a Thirty (30) days' officially written notice to PRIME INSURANCE LTD and a prorated portion of the premium will be refunded based on the scheme's overall members' utilization for the covered period.

## Termination

The contract may be terminated before the date of its normal end:

- 1) By the Subscriber or PRIME INSURANCE LTD:
  - a) At each annual expiry date with a notice of at least 15 days, where it is a tacit renewal contract;
  - b) in case one of the following events occurs:
    - Change of profession,
    - Change in the civil status or marital scheme,
    - Professional retirement or definitive cession of professional activity due to any other cause,

- Where the contract aims at covering risks directly relating to the former situation and no longer existing in the new situation.  
The termination takes effect immediately.
  - c) in cases and conditions provided for by the premium and cover adjustment clause, where the contract includes such a clause.
- 2) By the Subscriber
- a) In case of cessation of the activity concerned with the contract
  - b) In case of important modifications of cover.
- 3) By PRIME INSURANCE LTD
- a) In case of non-payment of the premium
  - b) In case of omission or inaccuracy in risk statement at the time of subscription or during the period of contract
  - c) In case of serious aggravation of the risk.
- Termination shall be effective ten (10) days after its notification.
- 4) By both parties in case of bankruptcy or official liquidation of the subscriber or insurer.

### **Destination of the premium in case of termination**

In case of termination while the contract is still valid, the portion of the premium relating to the period not elapsed shall not become the property of PRIME INSURANCE LTD. It must be paid back to the subscriber if it has been collected in advance. However, in case of non-payment of the premium, PRIME INSURANCE LTD shall be entitled to the portion of the premium for the period already elapsed.

### **Form of termination**

The contract may be terminated by:

- Registered mail with acknowledgment of receipt, the period of time at the end of which the contract termination takes effect shall be calculated from the date on which that mail was received.
- Statement made with acknowledgement of receipt to the head office or its representative.
- Bailiff's act

Where termination is decided by PRIME INSURANCE LTD, the notification must be made through registered mail to the last known address of the subscriber.

## **Dispute Settlement**

If a dispute arises during the interpretation or execution of this contract, both parties will endeavor to settle it amicably. In case of failure, this contract will be construed in accordance with the laws of Rwanda and the parties submit to the exclusive jurisdiction of the Rwanda Courts. For matters not provided for or reserved under this contract, the parties declare to refer to the existing legal provisions and application.

## **Sanctions**

Any unwillingness, false and intentional statement, omission or inaccuracy in the statements of circumstances or aggravations mentioned in this Article, even though it has had no influence on the damage, shall be punished in the following conditions:

- In case of bad faith on behalf of the Subscriber, by nullification of the contract
- Where the bad faith of the Subscriber is not established, by a reduction of the compensation for the damage in proportion to the premiums paid in relation to the premiums which would have been due had the risks been accurately and fully declared.

## **Force Majeure**

Should the PRIME INSURANCE LTD be prevented from carrying out any of its obligations in terms of this policy because of Force Majeure, We will notify the Subscriber/Insured Persons of the circumstances and nature of the Force Majeure as well as the estimated duration and extent to which the Insurer's performance is made impossible.

Under such circumstances, the Insurer's obligations under the policy will be suspended until the circumstances causing the Force Majeure ends and the Insurer will not be liable to the Subscriber/Insured Persons for any damages whatsoever caused to the Subscriber/Insured Persons due to the Insurer's inability to perform its obligations in terms of the policy. In the event of Force Majeure, the Insurer may cancel the policy by giving 30 (thirty) days' notice.

## **Final Provisions**

For the performance of the acts, tests or treatment of the insured, the health professional or facility shall be the only one responsible for the complications, incidents or accidents that might occur during the practice of medical art.

## Exclusions

### Exclusions that apply to Hospitals

- Amounts recoverable from other insurances such as Rwanda Social Security Board (RSSB), Mutuelle De Santé, GPA etc.
- Professional activities of the insured (work accidents or occupational diseases), except subrogation.
- Charges incurred before the effective date of the contract or after the date of stoppage of cover; either collectively at the level of the contract, or individually at the level of each principal insured and his/her family, and in that case, even if on that date the principal assured or a member of his/her family is undergoing treatment for a disease or an accident contracted during the period covered.
- Diseases or accidents caused by natural disasters such as nuclear fuels, ionizing radiations emitted suddenly and fortuitously by radioactive products or waste from reactors and having contaminated the surroundings of that source of emission (whether the latter is fixed or moving).
- Diseases or accidents resulting from the civil war or foreign war, people's upheavals, riots, free-for-alls, except in case of self-defense.
- Operations of military origin for both land, sea and air force.
- Participation of the insured as a competitor in races, matches or bets (except friendly sports competition among amateurs).
- The practice of dangerous sports, even as an amateur: boxing, mountain sports, water sports, skin diving or underwater fishing, windsurfing, rugby, skiing, alpinism, karting, speleology, hockey on ice, big-game hunting, polo, racing on horseback, rugby, league football, motorcycling or motor racing etc.
- Bodily injury suffered while directly involved in an illegal activity.
- Disease or bodily injury suffered while handling or using of explosives.
- Injury or illness while flying unless travelling as a paying passenger on commercial business airlines.
- Drug addition, consequences of drunkenness, or state of alcoholism, and attempt of suicide and voluntary mutilation by the insured.
- Accident occurring while driving any motor vehicle while the alcohol content in the blood or urine is over the legal limit
- Charges incurred for any treatments, drugs, apparatus, hospitalization, prescribed or performed by medical doctors, surgeons, medical auxiliaries not holding the required degrees, or by bonesetters and healers.
- Rehabilitation except as expressly provided under the benefit for Inpatient Care.
- Stays in convalescence, cure or rest homes.

- Beauty treatments (beauty care, nose lifting, etc.), fattening, slimming or rejuvenation cures, water cures, preventive immunization fees, sterility remedial treatments, any treatment or interventions aiming at rectifying all sorts of abnormalities, disability and constitutional malformations (deafness, blindness, club feet, flat feet, deformities etc.).
- Plastic or cosmetic surgery unless it is an accidental injury that occurs while the insured person is already covered by this contract.
- Prescriptions exceeding a period of thirty days except when the prescriber has ordered a renewal for the same period of time with a maximum duration of six (6) months.
- Drugs taken unless following the manufacturer's instructions and prescribed by a licensed Doctor.
- Renewal of non-prescribed drugs.
- Nutritional and vitamin supplements (dietetic) unless prescribed as part of treatment.
- Any prophylactic or preventive treatment unless purchased as part of cover.
- Complications arising from abortion unless necessitated by a medical condition.
- All artificial limbs with the exception of implants in trauma, orthopedic and visceral surgery.
- Physical and mental impairment, or psychiatric illness and psychoneurosis unless resulting from accidental injury during cover.
- Sex-change operation or similar procedure.
- Alternative treatment and pain relief, e.g., traditional treatments, acupuncture or herbalists etc. Any hospitalization undertaken in nature, cure clinics, or hydro's will not be covered.

### **Exclusions that apply to Pharmacies**

- Cosmetic and Beauty products
- Dermatological soaps unless prescribed by a dermatologist
- Dental prophylaxis (Mouthwash, toothpaste etc.) unless prescribed by a dentist.
- Antiseptics used for home care and other care products
- Hormonal replacement treatment
- Infertility related drugs and supplements
- Contraceptives or medicines related to contraception.
- Dietary and vitamin supplements unless prescribed as part of treatment
- Weight management unless prescribed as part of treatment
- Energy tonics
- Vaccination of adults
- Medical & Diagnostics Equipment
- Diabetic sugars
- Baby milk & Formula

This contract is established in two (2) copies and takes effect subject to the provisions of the Schedules and to any other conditions and provisions endorsed or written and signed for PRIME INSURANCE LTD by its authorized representative(s)

In Witness whereof this Policy has been Signed at Kigali, on the .... March 2025

For and on behalf of

**THE SUBSCRIBER**

**THE INSURER**

**THE POLICYHOLDER**

**PRIME INSURANCE LTD**

SAMPLE CONTRACT

## APPENDIX I: Underwriting Guidelines

### **Commencement of coverage**

This policy will only commence once the application form has been accepted by PRIME INSURANCE LTD and the Subscriber has paid the Premium due in full. No backdated changes will be allowed.

All completed application and amendment forms are valid for a period of 30 (thirty) days from the date of declaration as indicated by the applicant.

If the application for coverage under this policy is approved by PRIME during a month within a Policy Year, then the Commencement Date of cover will be the first day of the month immediately following the month in which the application for coverage is approved. Alternatively, an Insured Person can opt for immediate coverage, but will be charged the full month's premium.

All Dependents must be registered under the same Benefit Plan as the Principal Member. A Dependent cannot select a different Benefit Plan to that of the Principal Member.

In the case of newborns, application should be made within 4 (four) weeks of the date of birth, a copy of the birth certificate or hospital confirmation reflecting the baby's name must be provided with the application.

If the newborn is registered within the 4-week period, coverage will commence from date of birth. Any Claims incurred for the newborn during this period may be submitted for payment once the newborn has been registered. Premiums will be charged from the first day of the month immediately following the month of birth.

If the newborn is not registered within 4 (four) weeks of birth, then coverage under this policy will not commence from the first day of birth. Instead, coverage for the newborn will commence as specified above and subject to underwriting.

In the event of an emergency should the newborn require in-hospital care immediately following the birth and prior to discharge, the newborn will be covered under the mother's policy for In-Patient benefits only for the first 2 (two) weeks from date of birth.

### **Age Limit**

This policy will not cover a new applicant over the age of 65 years old. An existing Insured Person who was less than 65 years old when cover under this policy originally commenced but who subsequently aged beyond 65 years old, will continue to be covered under this policy not later than the 31st of December of the year when the insured person reaches his/her 65th year of age.

## **Residence**

The Insured Person must reside in the country in which this policy is issued or registered in order to qualify for coverage under this policy, except where otherwise agreed beforehand between the Subscriber and the Company.

## **Changing Benefit Plans**

An Insured Person can only change their Benefit Plan at policy renewal subject to giving PRIME INSURANCE LTD written notice 30 (thirty) days prior to policy renewal.

## **Renewal**

At the renewal date (usually at the end of each policy year) the policy may be renewed for a further term of 1 (one) year subject to the mutual agreement between the Company and the Subscriber on the renewal terms. At policy renewal, the Company will review the benefits, policy conditions and premiums subject to the mutual agreement of the Company and the Subscriber and subject to the Company giving the Subscriber 60 (sixty) days advance notice of the renewal terms in writing.

If renewal terms are not agreed and finalized by the renewal date, the cover of all Insured Persons will cease from the 1<sup>st</sup> day following the policy renewal date.

## **Non-disclosure**

If an Insured Person makes a false declaration or knowingly fails to disclose that he has or is suffering from an illness or condition, then PRIME INSURANCE LTD reserves the right to:

- Impose Waiting Periods,
- Impose Premium loadings,
- Specifically exclude benefits in respect of a particular medical condition, disease, disorder or disability that existed at the time of application for coverage under this Policy.
- Terminate the cover of the Insured Person
- Recover any or all medical costs incurred in respect of this condition from the Insured Person

The Insurance Company shall notify the Insured Person in writing of any limitation, premium loading, or specific exclusion imposed or termination of the policy.

## **Membership cards**

A membership card, per beneficiary, is only issued upon receipt of a fully completed application form and if the Premium due has been paid in full.

The membership cards issued to each insured person as proof of coverage under this policy remains the property of the Company and must be returned to the Company on

cessation of coverage. Any utilization of the card to access healthcare services thereafter will result in the insured person, whose cover has been terminated, and the Subscriber, being liable in respect of the cost of such Claims.

Should the card be lost or stolen it is incumbent on the Subscriber and/or Insured Person to inform the Company immediately, failing which the Subscriber and/or Insured Person could be held liable for any Claims paid through misuse. The cost for producing additional card(s) will be at the cost of the Subscriber and/or Insured Person.

The utilization of the membership card by any person other than the Insured Person, with the knowledge or consent of the Insured Person, is an abuse of the benefits of the Benefit Plan and will be dealt with by the Company as an act of fraud.

### **Underwriting**

For Late Joiners the following may be applied at application for membership or in cases of non-disclosure

- A Waiting Period of up to 24 months applicable for a specified condition, benefit limit (including maternity), avocation, occupation or general health status.
- A Premium loading in respect of a specified condition, avocation, occupation or general health status.
- A lifetime exclusion of cover in respect of a specified condition, avocation or occupation.
- Decline cover

Should an Insured Person undergo a Life Changing Event and apply to be admitted or re-admitted as an Insured Person within 30 (thirty) days of the Life Changing Event taking place, he or she shall be registered as an Insured Person without the imposition of any underwriting.

For corporate clients only the following is applicable:

- No underwriting shall be imposed on an Insured Person in respect of whom application is made for membership within 30 (thirty) days of a specified period of secondment by the Employer.
- It is compulsory for an employee to apply for coverage under this policy within 30 (thirty) days of the policy Commencement Date or employment date of the employee in order to obtain coverage with no underwriting; such employees must be registered as from the date of employment or policy Commencement Date or underwriting will apply.
- Dependents who apply for coverage within 30 (thirty) days of the policy Commencement Date or employment date of the employee will obtain coverage with no underwriting; such Dependent must be registered as from policy Commencement Date or employment date or underwriting will apply
- In the case of a newborn, application must be made within 4 (four) weeks of the birth date in order to obtain coverage with no underwriting; such Dependents must be registered as from their date of birth or underwriting will apply

- In the case of an adopted child or child placed in the custody of an Insured Person, application must be made within 4 (four) weeks of the adoption or custody date in order to obtain coverage with no underwriting; such Dependents must be registered as from date of adoption or legal custody or underwriting will apply.
- In the case of a newly married Spouse or Partner, they must be registered for coverage under this policy within 30 (thirty) days of the marriage date or date of co-habitation, such Dependent must be registered as from date of marriage or date of co-habitation in order to obtain coverage with no underwriting otherwise underwriting will apply.

No underwriting will apply to a new subsidiary company acquired by an existing employer group provided application is made within 30 (thirty) days of the acquisition and the group size exceeds 9 employees.

All new applicants are required to complete a Health Questionnaire which forms the basis of the contract.

All application forms must be duly completed, together with the signature and date of declaration. Any additional information, due to constraints of the form, can be completed on a separate sheet of paper.

All completed forms are valid for a period of 30 (thirty) days from the date of declaration as indicated by the applicant.

Persons who do not join within the timelines specified above will be subject to underwriting.

### **Premiums**

Premiums are payable annually in advance from the date of cover placement and by no later than the 30th day of cover placement.

The first Premium payment must be physically received into the Company's nominated bank account before the Commencement Date of this policy to enable activation of benefits for Insured Persons.

Amendments to Insured Persons will be invoiced monthly on pro rata basis unless agreed upon in advance on inception of the policy.

The Company reserves the right to review Premiums at any time during a Policy Year due to unforeseen changes in policy taxes or legislation.

The Company reserves the right to suspend benefits to Insured Persons if the Subscriber has not paid the full amount of the Premium due by the 14<sup>th</sup> of the month in which it became due. When the full amount of Premiums is paid, the Company shall reinstate benefits to Insured Persons.

## **Adjustment of Benefits and Premiums**

The Insurer reserves the right to appropriately adjust the Premiums or benefits payable (including any applicable covers) and the charges levied under this policy if:

- any legislation or regulation (including tax legislation or regulation) affecting this policy, or the Insurer is introduced or changed, or
- the legal interpretation or understanding of any legislation or regulation (including tax legislation or regulation) affecting this policy or the Insurer has changed.

The Subscriber and Insured Persons (as applicable) will be notified in writing when these changes will take place.

### **Terminated members**

Where the Insured Person has resigned and has outstanding Claims Debt, the Subscriber is responsible for the immediate payment of the Claims Debt.

If Claims Debt is not paid within 90 (ninety) days of the debt becoming due, the policy will be suspended. The Subscriber will be informed in writing.

## **APPENDIX II: Claims Guidelines**

PRIME INSURANCE LTD will act in good faith in all our dealings with the Subscriber and Insured Persons. The Subscriber/Insured, in turn, must ensure that the following are observed:

The payment of treatment costs under this policy is subject to Our agreed tariffs in the relevant country where treatment is received. Where no tariffs have been agreed with a medical service provider, claim payments will be reimbursed subject to what We consider to be Reasonable and Customary charges in the country where treatment is received. The Insured Person is liable for treatment costs in excess of Our agreed tariffs or what we consider to be Reasonable and Customary Charges

All disorders or injuries existing simultaneously which are due to the same or related causes or any one accident shall be considered as one sickness or accidental bodily injury.

Where an insured person exhausts his/her limit of cover as specified under this policy, such benefits as had been extended to him/her by virtue of this policy may not be reinstated during currency of the policy.

### **In-network treatment**

If an Insured Person goes to Our Provider Network for treatment, then We will arrange direct payment for the cost of treatment to the healthcare provider up to the specified benefit limits and subject to the conditions of this policy. An Insured Person must always present his/her membership card to the healthcare provider in order to receive treatment.

### **Out-of-network treatment**

On Benefit Plans with Provider Networks no Claims will be paid directly to a non-network provider. The amount refundable for non-emergency claims incurred by the member outside of our panel of providers shall be 80% of the negotiated rates and tariffs that would have otherwise been paid had the member used a service provider in our panel.

### **Out of country treatment**

For the Benefit Plans that include overseas treatment, in the case where an Insured Person goes for treatment outside the country where this policy is issued, PRIME will only fund treatment at Our Provider Network. If there is no Provider Network in a specific country, we will pay Claims at what we consider to be Reasonable and Customary Charges. No costs related to travel and accommodation are funded for out of country treatment.

Claims for treatment outside of country of residence will be converted at exchange rate valid on the date of service or discharge in the case of hospitalization.

### **Requirements for the submission of a Claim**

In order to process and pay a claim the following information must be clearly provided on the account:

- Policy/Membership number
- Patient Name and Surname
- Date of birth
- Diagnosis
- Date of service (for Hospital please include admission and discharge dates)
- Detailed Treatment or Service description for each item received/provided (i.e. name of medicine, ward level)
- Quantity (e.g. 30 Disprin, 3 days in general ward)
- Tariff code (if available)
- Amount charged per service or treatment received
- Name of treating Healthcare professional
- Facility/Hospital Name

- Total charged (which must add up to the amounts charged individually on the account)
- Pre-authorization number (if applicable, where the service requires Pre-authorization)
- Referral letter (if applicable)
- Proforma Invoice from the referred facility (if applicable, and in case of Overseas treatment)
- Proof of payment in the case of a refund to the Principal Member. The only document we will accept as proof of payment is a receipt or proof of electronic (EFT) payment. If the correct proof of payment is not attached, the account will be rejected.
- Signature of the patient or Principal Member if the patient is a minor
- Signature of the provider
- Date of the account and account reference number

Failure to observe the above Claim conditions, without any reasonable explanation, may invalidate a Claim. It is recommended that the Insured Person keeps copies of any medical information that he sends to PRIME INSURANCE LTD. This will help the Insured Person keep track of what is owed to him and will be helpful if he needs to follow up on his Claim.

### **Period of Claims Submission**

In event of any illness or accident-giving rise to a claim under this policy, the Insured person shall as soon as possible send notification in writing to the company (within 24 hours in the event of admission) and submit a duly completed claim form within 60 days of the treatment or discharge date. The company shall not be liable to pay claims submitted after expiry of this period.

### **An Insured Person must make sure that he or she can afford treatment**

The Company can determine if an Insured Person is eligible for a particular treatment in terms of his policy, as well as advise him whether he has funds available to pay for it (within benefit limits stated in the benefit table). However, it is up to him/her to confirm that he has funds available by checking with PRIME or referring to the benefit table and asking the Doctor or Hospital what the charge for treatment will be.

### **Services or benefits that requires Pre-authorization**

For certain services or benefits the Insured Person must obtain Pre-authorization from the Company. Services or benefits that require Pre-authorization include:

- Hospitalization (elective and non-elective)
- Dental services
- Optical services
- Chronic ailment treatment (in- and out-patient)
- Renal (Kidney) dialysis (in- and out-patient)
- Specialized radiology (in- and out-patient)
- Emergency Evacuation and air ambulance services (in-country and international)
- Chronic medicines
- Appliances and prosthesis
- Organ transplants
- Compassionate travel
- Overseas Treatment
- Repatriation of mortal remains
- Non-emergency ambulance services
- Annual Medical Examination

The relevant managed care application form and clinical information should be provided to PRIME INSURANCE LTD at least 48 (forty-eight) hours prior to the Dependent obtaining the treatment/service.

In case of an Accident or hospitalization in the event of an emergency, written notification together with reasonable available supporting medical information must be submitted to PRIME within 48 (forty-eight) hours of the event, or if it is a weekend or public holiday, on the next working day.

Where Pre-authorization is required and is not obtained. We reserve the right to:

- Decline funding or
- Apply a co-payment of 20% of the total value of the Claim

### **Second Opinion**

PRIME INSURANCE LTD may require a second opinion in respect of diagnosis, proposed treatment or medicine which may result in a Claim for benefits, and for that purpose the relevant beneficiary shall consult a dental or Medical Practitioner nominated by PRIME and at PRIME's cost. In the event that the second opinion proposes different treatment or medicine to the first, PRIME may require that the second opinion proposals be followed.

## **Fraudulent and Unfounded Claims**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy, but which are found fraudulent later shall be repaid by all recipient(s)/Subscriber(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

- the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;
- the active concealment of a fact by the insured person having knowledge or belief of the fact;
- any other act fitted to deceive; and
- any such act or omission as the law specially declares to be fraudulent

In the case where the Company finds fraud, any of the following, or a combination of the following sanctions may be applied:

- immediate termination of the policy
- termination of the Insured Person's cover
- instituting civil and/or criminal legal action

The Insurance Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.