MO ASSURANCE HEALTH POLICY

WHEREAS THE Insured designated in the Schedule hereto has by a Proposal and declaration, dated as stated in the Schedule, which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to **MO ASSURANCE COMPANY LTD**., (hereinafter called the COMPANY) for the insurance hereinafter set forth in respect of person(s) named in the Schedule hereto (hereinafter called the Insured person) and has paid premium as consideration for such insurance,

COVERAGE: NOW THIS POLICY WITNESSES that, subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any disease or suffer from any Illness (herein defined) or sustain any Injury (herein defined) and if such Illness or Injury shall require any such Insured Person, upon the advice of a duly qualified Medical Practitioner/surgeon to incur Outpatient Treatment expenses or Hospitalization Expenses (herein defined) at a Hospital in Tanzania or abroad as authorized by the Company, the Company will pay to the Hospital or reimburse the Insured person, amount of such expenses as would fall under different heads mentioned in the Policy Schedule and are Reasonably and Customarily incurred in respect thereof by or on behalf of such Insured Person.

PART A: SCOPE OF COVER:

The policy covers the treatment for Outpatient, Inpatient and Treatment abroad (India and Kenya only) subject to a maximum annual limit specified in the schedule and the terms of contract. (Contract attached with specific limits agreed).

PART B: DEFINITIONS

This section explains the meaning of certain words and phrases in this agreement.

Accident: A sudden, unanticipated or unforeseen, specific event which occurs at an identifiable time and place, normally external to the victim and beyond his/her control, the nature of which may endanger the beneficiary's life or may briefly cause a significant deterioration in his/her condition if the appropriate care is not given quickly to him/her.

Adult: All principal members and their spouses on the schedule of insured persons who are under the age of 65 (Sixty-Five) years and whose premium is the current listed adult rate.

Agreement: The contents of this Policy read in conjunction with the completed and signed proposal form, members' application forms and the Certificate of Insurance. Together with these make up the contract.

Beneficiary: Person(s) for whom the insured recognizes the right to receive the corresponding health insurance cover as outlined in the benefit of a health scheme he/she has paid for.

Benefit schedule: The particular benefits provided by the health schemes bought for the principal members and their registered dependents who appear on the Schedule of Insured Persons. It states the type of expenses covered and the maximum amount paid for each particular benefit during the period of cover, subject always to the terms, conditions and exclusions of this agreement.

Child / children: A principal member's son(s) and/or daughter(s) under 18 (eighteen) years of age or in continuous full-time education financially supported in full by the principal member up to twenty-five years of age.

Chronic condition: A medical condition that requires continuous treatment for four months or more and appears on the chronic registration form.

Dependent: A spouse and children of the principal member below 18 years. A separate package of Parents of Principal member is agreed under separate terms and conditions and premium to be added as agreed for the parents.

Date of entry: The date on which cover for each of the members listed in the Schedule of Insured Persons first commenced.

Emergency: A situation in which a member requires immediate hospitalization and treatment to prevent a

medical condition that arises from an accident, injury or sudden illness, threatening the life health of the member.

Evacuation: Transfer of a member for medical and/or surgical treatment abroad for an illness or condition whose health solution is confirmed unavailable in Tanzania. This transportation covers the insured and one accompanying person in economy class or on a commercial airline to the airport nearest to the health facility chosen for treatment.

Healthcare provider: A person or place recognized by the Company including:

a. a registered medical practitioner, general practitioner, physician, specialist, surgeon, anesthetist, pathologist or radiologist;
b. a private or other hospital, clinic, nursing home, free standing theatre or rehabilitation service;
c. a registered nurse of nurse-aide including services for terminally ill patients;
d. a blood transfusion services and supplies;
e. a pharmacy for drugs requiring a doctor's prescription, and run by a registered pharmacist;

Hospital: Any registered and approved institution which has all the relevant inpatient facilities to provide medical and surgical treatment and nursing care for sick or injured people.

Hospitalization: A situation where a person spends not less 24 hours in a hospital for medical or surgical treatment following an accident or an illness.

Illness: Any change in health diagnosed and confirmed by a legally recognized medical doctor during the life of the policy and which is not comprised or derived from either of the following two groups:

- **Congenital disease:** the disease that exists at the moment of birth as a consequence of hereditary factors or complaints acquired during the pregnancy.
- **Pre-existing disease:** the disease that the insured suffered prior to the date of taking out this policy, even if it was not diagnosed.
- Suicide attempt, alcohol intoxication or drug abuse.

Immediate family member of insured: Spouse and children.

Insured person: Within the validity period of the policy the person aged 3 month up to 65 years, whose name and address are specified in the policy with respect to whom the policy has been paid for.

Insurer or Company: The insurance company, Mo Assurance Company Limited registered and authorized in the country in which this insurance policy is issued and subscribed.

Infertility: Primary or secondary inability to bear children. This can be either due to congenital or acquired causes

Life threatening condition: A critical medical condition, covered by a member's plan, which in the opinion of specialist healthcare provider constitutes a life-threatening situation which requires immediate inpatient treatment.

Member: Either a principal member or registered dependent who appears on the Schedule of Insured Persons and for whom the premium to be covered by in the health scheme is paid.

Member application forms: The application forms that anyone, wishing to get a health cover of the insurer, must complete honestly, fully and accurately about themselves and any of their dependents.

New Born baby (full term / mature baby): Any baby born between 35 weeks and 42 weeks.

Parent accommodation: The necessary accommodation for a parent who is accompanying a child (under 18) during a rescue or evacuation.

Period of cover: A period mentioned in the policy schedule for which the premium has been received and accepted. The period of cover will continue, subject to the terms and conditions of this agreement, provided the Company receives the premiums from the insured on or before the due date. If a premium is not received by the Company on or before its due date, the period of cover will end from the day unpaid premium is due.

Policy holder: Natural or legal person who has subscribed the policy with the Company and who is bound by the obligations arising therefore.

Post hospitalization: A period of 90 days after a member has been hospitalized in which the medical services, related to the conditions for which the member was hospitalized, are covered.

Pregnancy (Normal): Pregnancy from the day of conception to the day of spontaneous delivery (SVD) or Caesarean Section (CSD).

Pregnancy (Abnormal): Pregnancy with complications that include but not limited to early bleeding, miscarriage, leakage of amniotic fluid, intrauterine fetal death, pregnancy induced hypertension, ectopic pregnancy, excessive liquor/inadequate liquor, abnormal lies (breech/transverse/oblique), congenital malformed fetus/newborns (e.g., Neural tube defects/ hydrocephalus/ spinal bifida/ encephalus/ anencephalus/ conjoined twins/ orthopaedician.

Premium: The amount the insured is required to pay annually for the insured and their registered dependent(s) listed on the Schedule of Insured Persons.

Premium due date: The date on which the annual premium falls due.

Pre-term / premature baby: Any baby born between 28 weeks and 37 weeks.

Principal member: Anyone who has completed a member application form and has been accepted by the Company to be covered under the health scheme

Proposal form: The completed application form duly signed on behalf of the insured and their registered dependents for whom the cover is requested.

Psychiatric treatment: Any valid admission for a psychiatric disorder for a member as per agreed terms and conditions.

Reasonable and customary: The costs that the Company shall be liable to refund a member on the basis of the general cost of similar medical services obtainable at approved providers.

Registered dependent: A spouse or child of a head of family or principal member or a parent (incase included in the policy) who has been accepted by the Company as a member and for whom premiums have been received.

Renewal date: The date a member confirmed to extend membership for another year.

Rescue: Transportation of a member from a place where his/her life is mentioned to be in danger due to lack of relevant health service to a nearest place where the facility is available.

Senior: Any existing member on the Schedule of Insured Persons who is 65 (sixty-five) years of age or over and whose premium has increased to the current listed senior rate.

PART C: TERMS OF CONTRACT:

1. Important terms

This agreement, together with the Membership form and the policy document make up the contract between the insured and the Company. The completed, signed and dated membership form is an integral part of the agreement and the cover provided. The terms of this agreement apply to

the insured and all the members as stated on the Schedule of Insured Persons.

2. Filling of member application forms

Before applying for a health insurance cover under this Policy the member is/are required to fill member application form/s honestly, fully and accurately, and all facts concerning the health of the insured member and that of all their registered dependents are fully disclosed.

3. Age limit

Minimum entry age will be from 3 months. However, a new born child will be covered within the limits of the mother for first 3 months. Maximum age is 65 years.

The insurer reserves the right to request for medical examination before renewal when deemed necessary.

4. Membership

The date of entry stated on the Contract should be the official commencement of the health insurance cover. However; this will only be applicable after the membership form is accepted and having received payment of the full premiums within the stipulated period.

The paid premium for each new membership year will be determined by the number of adults, children and senior members registered under the name on the schedule of insured persons and their plan type.

4.1. Member registration or withdrawal

Any new added dependent e.g., child or spouse has to fill dependent membership forms and all must be in the same plan or a lower plan as one of the principal members. Withdrawing cover for a member means that she/he must be deleted from a health scheme and should be effectively denied from accessing services.

4.1.1 Members changing health schemes

Any changes to the health scheme shall only be affected at policy renewal. If the insured or any registered dependents, wish to transfer to the health scheme with fewer benefits, the insured must inform the Company in writing. If the insured or any registered dependents, wishes to transfer to a health scheme with a wider range of benefits, the insured shall complete a new membership form and make a full declaration of any changes of the state of health of the insured and their registered dependents since the date of entry and submit along with a covering letter. If accepted, the changes shall be affected from the renewal date. Waiting period shall be applied if the state of health of the insured or any of their registered dependents has changed since the date of entry of insured or the Company may refuse to increase the cover or impose an extra premium or exclude some ailments at the sole discretion of the Company. No dependent shall be allowed to have a superior cover than the principal member.

4.1.2 Members who have another health insurance scheme

The Company must be informed in writing if a member or dependents of insured has any other health insurance cover or right to compensation for the cost of treatment from any other source. In such cases if the member has claimed from the insurer for any benefits related to treatment costs, the Company will only be liable to pay their proportionate share on the claim in reference to premium per health cover. Concealing or failure of disclosure information that a member or dependent(s) of insured owns another health cover from a different company will be considered as an act against the Company, and is subject to forfeiture of benefits and termination of membership with immediate effect without notice. There shall be no refund of premium in such an event and legal actions may be taken for that breach of contract.

4.1.3 The health cover provided

This contract applies for only the members listed on the Schedule of Insured Persons against the cost of the necessary, recognized medical treatment, covered under the chosen health scheme. All treatment and care will be carried out by the Company through approved healthcare providers. However, the Company may only pay for the reasonable and customary medical treatment charges.

4.1.4 Health schemes

The Health scheme schedule table accompanied clarifies the benefits a client is eligible in each health scheme the insured opt to take. The insured is expected to familiarize themselves with the benefits of a health scheme they chose. The Company will be liable to pay only for the benefits as

per health scheme schedule. There are stipulated maximum limit amounts for certain benefits as indicated in the benefits schedule that the Company will be liable to pay.

4.1.5 Last Benefit (Funeral)

The deceased member's family is eligible to get paid the agreed amount of the funeral benefit only if the full premium was paid before the incident has occurred.

5. Premium

5.1. Premium payment

The Company shall consider the insurance policy contract invalid retroactive to the date of inception if the second installment premium is not made within 90 days of policy inception.

5.1.1 Pricing and changes in Premium.

The Company reserves the right to determine or review, from time to time, rates of premium payable for adult, child or senior members. However inception of any member after the first month, Second month and third month and above the required member will be eligible to pay as shown on table below:

CATEGORY	LESS THAN 1 MONTH	1 MONTH	2 MONTHS	3 MONTHS and Above
	Premium	95% of the Premium	85% of the premium	75% of the Premium
M	574,463	545,740	488,294	430,847
M+1	1,059,466	1,006,493	900,546	794,600
M+2	1,544,383	1,467,164	1,312,726	1,158,287
M+3 and Above	1,855,000	1,762,250	1,576,750	1,391,250
Parent	656,478	656,478	656,478	656,478

However, those who will fall under the category of 3 months and above will have a waiting period on the below:

Maternity – 6 months
Dental – 3 months
Optical – 3 months
Inpatient – 1 week

5.1.2 Newborns registration in health scheme under the principal member

Newborn baby will enjoy the mother' cover for period of 90days from date of birth, thereafter registration will be required to make the newborn have her/his own health cover. An additional dependent Membership form needs to be completely filled and the insured need to pay the required additional premium to register the newborn as a new member.

5.1.3 Health Scheme Renewal

Once the insured and their registered dependents are covered by a health scheme the insured may continue to

renew cover annually, subject to the agreement and the benefits schedule in force at the time of each subsequent renewal date, and subject to changes in terms and premium rates as per clause 5.1.1 and payment of renewal premiums so determined by the Company on or before the renewal date.

5.1.4 Registered child dependent(s)

Any registered dependent child can continue to be covered under their health plan at the appropriate child rate for as long as they are unmarried and less than 18 (eighteen) years old at each subsequent renewal date, or less than 25 (twenty-five) years old in continuous full-time education that is fully financially supported by the parents.

When a registered dependent child marries, or reaches the age of 18 (eighteen) years at the policy renewal date or when he/she cease being in full time education, fully financially supported by the parents or, if he/she is in continuous education but have reached the age of 25 (twenty-five) at the policy renewal date he/she will no longer be eligible to be covered as a child under the health scheme.

5.2 Membership cancellation

5.2.1 The Company cancelling the insured membership

The health scheme of any member on the Schedule of Insured Persons who has misled the insurer or been in breach of this agreement, given the Company incorrect, incomplete or misleading information, concealing any

reasonable information which the insurer had asked for, conspired with a third party to obtain benefit from this plan, or submitted a claim which is in any respect fraudulent or unfounded shall automatically be subject to cancellation. In any of these circumstances member's cover from their date of entry is liable to be cancelled without any refund of premium, instead recover from the insured any benefit the Company has paid in relation to such claim.

5.2.2 Insured cancelling membership

In case the insured decides to cancel the policy, a notification in writing will be given to the Company and cancellation will be done with effect from the beginning of the month having received insured's instructions without backdating the cancellation of any membership, or from a date in the future as to be advised by the insured. Considering that no claims have been submitted in respect to the current period of cover, the insured will be refunded the unused portion of his/her premium. If any member has submitted a claim, no premium refund is due.

5.2.3 The Company cancelling the policy

Policy may be cancelled by the Company by sending a 30 (thirty) days' notice by registered letter to insured at his/her last known address and in such event he/she will be entitled to the return of any premiums corresponding to any unexpired period of cover, provided no claims are admitted and/or submitted which might be adjusted at a future date. However, if any member has not completed the balance premium after utilizing the services the company will

immediately suspend all medical services rendered to him/her and **strict action** will be taken against him/her.

5.3 Claims

5.3.1 Submitting a claim

If the insured or their registered dependent wishes to make a claim it must be submitted having fulfilled the following:

(a) All claims coming to the Company should be made on a recognized claim form of the Company. This form shall show the patient's name, date of birth, address, membership number and signature, the details of tariff code, diagnosis and treatment given and fees charged thereof and the healthcare provider's signature. This should be accompanied by admission forms signed by the Principal member or member over 18 years of age and the invoices as mentioned in (b) or (c) below.

(b) The original invoice of the local healthcare provider shall show the patient's name and address, the membership number and signature and must provide sufficient details of treatment, service or supply to enable the Company to determine the amount payable to the member or healthcare provider.

(c) The original invoice of the foreign healthcare provider for treatment received outside Tanzania, where the patient is referred by the healthcare provider and approved by the Company on the grounds that the treatment is not available in Tanzania. The Company before paying such claim may require further information as may be reasonably necessary and referral letter.

5.3.2 Basics when claiming

Claims shall be considered only if received by the Company during the month in which treatment was provided or during the two (2) following months. The responsibility of ascertaining whether or not the Company has made payment for the medical treatment incurred shall rest with the member. It shall be the duty of members to restrict medical expenses wherever possible to reasonable limits, such as they would accept if payment were for their own account.

Only the insured or their registered dependent has the right to claim for incurred medical expenses from the Company.

Claims for medical treatment provided in Tanzania shall be acceptable for assessment and payment, if the healthcare provider giving the treatment or service is currently registered with the relevant statutory body in Tanzania and who falls in the list of the approved practitioners or Centers of the Company.

Claims from self-referrals and non-adherence to the policy terms and conditions shall render claim of the insured invalid. All members shall consider details of the nature of an illness or their treatment to be confidential on any claim lodged with the Company.

5.4 Settling of claims

5.4.1 Local Claims

Upon receipt of claims from the healthcare providers, the Company shall make necessary assessment and payment shall be made directly to the healthcare provider, with whom the Company has agreements.

5.4.2 Foreign Claims

If the member happens to receive inpatient medical or surgical treatment and/or services out of Tanzania on self-referral basis and without pre communication to the Company on referral from a hospital in Tanzania then the Company will not be responsible for paying the treatment, accommodation and travel expenses that she/he might have incurred.

In case of emergency hospitalization abroad with a pre-notification and acceptance from the Company, the member shall pay the bills and submit all the bills along with the invoices to the Company on his/her return to the country of origin. Invoices in such instances must show sufficient details to enable the Company to assess them and reimburse to the member or pay the provider what is considered a reasonable and customary charge. The information required for such claims to be processed shall be the approval letter of insurer, proof of travel (e.g., original boarding card, copy of the passport page on which arrival visa in the country in which the emergency treatment was provided is stamped), original invoice document, drug and other receipts and full medical report for the procedure and/or treatment. Member's name and membership number must appear on the invoice for it to be accepted as a valid claim.

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

If one of the members listed on the Schedule of Insured Persons is claiming for an illness or injury that was caused by some other person or organization (a third party) the insured must inform the Company in writing immediately, or provide full information on the claim form. The benefits in accordance with the terms of the agreement shall be paid provided the insured takes all reasonable steps to protect recovery of all such claims and payments from the person at fault. If the insured is able to recover the cost of any treatment paid by the Company, the insured must pay that amount to the Company. If such payment is not made, the Company has the right to recover all such claims paid by them from the insured.

5.4.4 Discretion

The Company shall ensure that in case of emergency, the necessary rescue is arranged to transport the member to the nearest suitable medical facility within Tanzania. Whenever deemed necessary the Company shall endeavor to ensure that a qualified doctor and/or nurse are on board when the ground ambulance undertaking the rescue. If for any reason beyond the control of the Company or if, in the opinion of a doctor, The Company shall approve evacuation services to members if they are so entitled to such service and if they are so ill or injured that their life is in immediate danger and they cannot obtain adequate medical treatment in the location within Tanzania. A designated medical officer who will decide on the necessity of an approval for such evacuation services in consultation with the treating doctors at the health facility serving a member.

5.4.5 Liability

The Company shall not be liable for any injury or loss suffered by the member if the rescue or hospitalization is delayed, hindered or prevented by any circumstances whatsoever beyond their control including, but not limited to, acts of war, civil commotion or strife, lockouts, 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 regulations or any other regulations having the force of law, adverse weather conditions or ground ambulance for any reasons whatsoever, or breakdown in or failure of communications for any reason.

The Company shall not be liable for any injury or loss sustained by the member in the course of undertaking a rescue as provided by the relevant Carriage by legislation in the local jurisdiction. The Company shall only undertake a rescue only if the medical opinions indicate that the member's life or limbs are threatened with loss.

The Company may charge back and recover from the member the full cost of a rescue or hospitalization in circumstances if in opinion the accident, injury or illness giving rise to such rescue and/or hospitalization could have been prevented or its consequences mitigated by the member taking due and reasonable precautions which they failed to do. Whether or not particular medical case falls into any particular category will depend upon the circumstances of the case, and the decision of the Company is final.

5.4.6 Non payable costs

The insured should be aware that there are some costs and expenses which are not payable on the cover based on the health scheme. The insured and his/her dependent(s) shall ensure that they read and understand this section and make efforts to explain this to insured's family to capture these instructions. The Company shall not pay for expenses arising from the following:

a. Alcohol, drug and Solvent abuse

Any treatment required for, or arising from any self-inflicted injuries or illness or pathological states caused by the voluntary consumption of addictive drugs or alcohol, narcotics, toxic substance or solvent, or medicines acquired with or without a medical prescription, as well as any kind of mental illness or mental imbalance.

b. Birth defects and congenital conditions

Any treatment for, or arising from birth defects or congenital conditions including any abnormality, disease, illness or injury present at birth whether diagnosed or not, hereditary conditions or any deformity arising during the antenatal stages of pregnancy, or caused during child birth are not payable unless otherwise stipulated in the policy schedule.

c. Organ and tissue transplants:

Any medical services and associated expenses incurred for organ and tissue transplants, irrespective of whether the insured is the donor or recipient.

d. Contamination

Any treatment for conditions arising directly or indirectly from chemical or biological contamination however caused or from contamination caused from nuclear fission, ionizing radiation or by radioactivity from nuclear fuel or waste.

e. Cosmetic Surgery

Any operation or treatment which is not medically essential, including surgical or treatment of a cosmetic nature whether or not such operation or treatment have been advised on psychiatric grounds is not covered.

However, surgical operation to restore the appearance of the insured after an accident (reconstructive surgery), or after surgery for breast cancer, provided the accident and/or breast surgery occurred after the member's date of entry and provided the original treatment for the accident or breast cancer surgery was initially paid for by the Company will be payable and subject to limit as on policy schedule.

f. Criminal Activity

Any treatment arising from or related to injuries sustained whilst engaging in a criminal or fraudulent, serious negligence or reckless actions including those actions of the insured in a state of derangement or under

psychiatric treatment costs, for which are themselves exclusive, or unlawful acts e.g., suicide, abortion and such other acts are not covered.

g. Experimental drugs and treatments

Any treatment which in the reasonable opinion of the Company is experimental, or has not been proved to be effective based on established medical practice is not covered.

h. Fetal Surgery

Any surgery undertaken on a child whilst it is in the mother's womb is not covered.

i. Health hydros and sauna baths

Any health hydro's, sauna baths, exercise centers or any similar establishments or private beds registered as nursing homes attached to such establishments or a hospital where the hospital has effectively become the member's home or permanent abode is not covered.

j. Infertility

Any investigation and treatment for infertility and all other related procedures, including laparoscopic drilling of the uterus not covered.

k. International / Regional follow up visits

Any international and/or regional follow up visits- covered as per schedule.

l. Menopausal treatment

Any cost of medication to treat the symptoms of menopause not covered.

m. Exposure to danger from Professional sports willingly

Any treatment and services arising as a result of hazardous activities including but not limited to any of the aerial flight, any kind of power vehicle race, water sports, horse wrestling, bungee jumping and any professional sports or activities reasonably considered by the Company, at its discretion, as being of a dangerous nature without limiting the generality thereof including but not limited to parachuting, gliding, paragliding, parascending, water diving involving the use of any artificial apparatus, unless the member holds an open water diving certificate and is diving with another certified diver or the member is diving with a certified instructor, both no deeper than 30 meters below the surface, hand gliding, or any occupation reasonably considered by the Company, at their discretion, as being of a dangerous nature, without limiting the generality thereof, including, but not limited to mining, construction and security unless previously disclosed and accepted by the Company.

n. Routine and periodic health examinations and vaccinations

Any medical examinations, arising from pension fund and long-term insurance requirements, travel documents requirement, immigration, flying licenses and the like. Also, routine health checks, vaccination or preventative treatment **unless pre-stated in the policy schedule.**

o. Search and rescue

Any search and rescue operation, in case a member is lost in a remote area.

p. Surgical or medical appliances or equipment

Any supplying, fitting or hiring of physical aids and devices like crutches, walking sticks, wheelchairs, etc. unless provided for under the schedule of benefits.

q. Travel and companion costs

One return economy air ticket of commercial flight for the patient and one accompanying person to the nearest airport where the hospital is located will be payable. Meal and accommodation for the patient ONLY is inclusive in the treatment expenses. (Coverage includes child age under 12 and ambulatory patient)

The companions' costs of food, lodging or transportation of a companion or relative who is caring for the patient

whilst in hospital or being evacuated or under medical confinement of any kind will not be payable. If any benefits are to be given for these, it shall be defined in the policy schedule.

r. Refund for service before enrolment

Any treatment given as under is **not covered**

1. Before enrollment as member
2. After removal of member
3. During any period for which premium is not paid.

s. Treatment that is not covered under the benefit schedule

Any treatment given by a relative or any other family member, who happens to be accompanying the patient (like spouse, brother, sister, or child) unless qualified under the scheme.

t. Service refusal by the insured

Any treatment or service of illness or injuries resulting from refusal, and/or delay on the part of the insured or persons responsible for him/her in accessing service recommended by the healthcare provider of the Company is not covered.

u. Treatment supplies

Any patient treatment supplies including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products, non-prescription drugs and treatment excluding such supplies required as a result of healthcare services rendered during a medical emergency. (To be covered as per policy terms and conditions)

v. Epidemics

Any internationally or local recognized epidemics (as per policy terms and conditions)

w. Natural hazards

Any treatment or service arising from extra-ordinary natural phenomena such as floods, earthquakes, landslides, volcanic eruptions, storms, aerolites and in general any extra-ordinary atmospheric, metrological, seismic or geographical phenomenon or any other natural catastrophic event. (not covered)

x. War Risks

Any treatment for any conditions arising directly or indirectly from events or actions of the armed forces in peace time, or as a consequence of riot, strike or civil commotion, civil war, rebellion, revolution, insurrection or military or usurped power, any declared or undeclared war or the like, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not) and any conflicts or international interventions using force or duress or, terrorism committed by a person or persons acting on behalf of or in connection with any

organization, or military operations of whatever type.(not covered)

y. Reimbursements

Any unauthorized inpatient hospitalizations, non-prescribed medicines/ procedures and non-emergency treatments and procedures. (not covered)

6. Treatment outside Tanzania

Any treatment and/or procedure done outside Tanzania shall require the authorization of the Company as justified by the designated medical officer consulted by the Company. (unauthorize procedures/admissions not covered)

In case of an emergency hospitalization abroad the member shall be required to report to the Company, the right on admission or within 24 hours of the local time at the place of service after accessing such services**.** Failure to report this in time poses disqualification of any kind of claim that may later be raised in relation to treatment refund.

7. Maternity Benefit (If applicable)

Member shall be eligible for maternity annual benefits. There will be no waiting time for maternity but will be subject to limit as per policy schedule. Antenatal package will be covered as inpatient as a sublimit of maternity benefit. Any treatment of new born baby up to a period of 30days will be falling under the mother's maternity benefits. (As per policy term and conditions)

7.1 Normal Pregnancy benefits

a. Normal delivery
b. Post-partum admission limited to 42 days post delivery date.

7.2 Benefits under Abnormal Pregnancy

a. Antepartum admission for any pregnancy related condition
b. Elective/Emergency Caesarean Section
c. Post-partum admission limited to 42 days post-delivery.

7.3 Benefits under Pre-term/ Premature Babies

a. Post-natal hospitalization limit of 42 days for all related
complications.
b. Admission in post-natal for treatment under incubator

7.4 Benefits not covered under Maternity

a. Surgical separation of conjoined babies.
b. Surgical correction of sex organs abnormalities and differentiation.
c. Organ transplant
d. Circumcision of non-medical indication.
e. Prosthesis
f. Heart surgery
g. Induced abortion not medically indicated (Subject to information

from provider for medical reasons).

h. Surgical corrections of congenital malformations

8. Cessation of membership

Membership is subject to cease due to reason of withdrawal from contract/policy or terminated for reason of misconduct or death of the member. Membership cards should be surrendered to the employer within two weeks of termination of the contract and in turn submitted to the Company. Use of the cards after contract has been terminated is counted illegal and is subject to legal actions.

9. Interpretation of terms

In the event of any conflict in the interpretation of terms of contract, the terms specified in the Schedule shall prevail over the terms specified in the contract and the discretion of the company.

Acknowledgement by the Insured/insurer person /organization

As per the policy terms and conditions signed under membership form by the insured, the policy binds the insurer and insured under the given contract.

Mo Assurance Company Limited

Principal Officer