MAISHA HEALTH FUND MEDICAL SCHEME POLICY

2021

Preamble

1. This policy may be referred to as the Maisha Health Fund Medical Scheme Policy. It provides the coverage parameters applicable in respect of the plans offered by Maisha Health Fund under the Scheme.

Application

2. This policy is applicable to all beneficiaries of the Maisha Health Fund Medical Scheme. This policy supercedes all previous coverage parameters. Maisha Health Fund reserves the right to offer special arrangements to selected clientele.

Definitions

3. In this policy and in the annexure, the following definitions shall apply, unless the context indicates otherwise:

"AHFOZ"	Association of Healthcare Funders of Zimbabwe which is a voluntary membership association that represents and furthers the common interest of medical aid societies of which Maisha Health Fund."Beneficiary" Persons who are members of the Scheme together with their dependents registered with the Fund
"Claim"	A bill or an invice that healthcare providers or member submits to the medical scheme in respect of settlement for healthcare products or services received by the member or dependant.
"Continuous claim"	A claim relating to hospitalisation where treatment occurs over successive days between admission and discharge of a beneficiary
"Dependant"	A person who is the Member's Spouse/Partner, child, relative or is financially dependent on the Member.
"EcoCash Wallet"	means an electronic wallet held with Econet Wireless (Private) Limited in the name of the Insured, Sponsor, and/ or Beneficiary.

“Health institution”	A facility or premise registered under the Health Professions Act that seeks to among other things diagnose, treat and mitigate illness, injury or disability in humans.
“Health Practitioner”	A person who is registered as such under the Health Professions Act
“Maisha Health Fund Products”	The various options available for a member in terms of award of benefits or payment of claims
“Member”	The person contributing to the Scheme.
“Membership”	Membership of the Scheme through the payment of Premiums in accordance with the Rules
“Medical Benefits”	An amount of money payable by the Scheme to or on behalf of a Member in respect of approved expenses incurred by a Beneficiary in accordance with the terms of the Scheme Rules
“Medical Services”	These are treatment protocols provided by Health institutions or practitioners and include, but are not limited to, consultation, pathology, radiology, inpatient, observation, transfers and pharmaceutical services
“Premiums”	Premium, means an amount of money a Member is required to pay to the Scheme in respect of a specified period of Cover.
“Reasonabilty”	Refers to a price for Healthcare Products and Services claimed being usual or standard, customary and reasonable to that which is prevailing in the market.
“Scheme”	Maisha Health Fund Medical Scheme.

Any provisions of a substantive nature, which are incorporated in the above Definitions, shall form part of these rules notwithstanding that they are not incorporated thereafter in these rules.

The Scope of the Scheme

4. The Scheme has been set up to provide its Members with a Medical cover arrangement. In return for payment of monthly premiums by Members, the Scheme will pay for Members' medical costs incurred at health institutions or practitioners.

Admission to Membership

5.1 Membership is open to all persons who are at least 18 years old and any other person that may be registered as their dependant. Persons under 18 years of age can only join as a dependant of a person who is at least 18 years of age. The upper age limit for joining is 74 years i.e. Members aged 75 years and above will not be admitted to membership either as a Member or Dependant.

5.2 Customers above the age of 65 years will need to provide proof of active registration with another medical aid society not more than 3 months prior to date of application

5.3 A dependant who is 18 years of age or below will be accepted and billed as a child dependant.

5.4 A dependant who is above 18 years will be accepted and billed as a student member upon furnishing of proof that they are a bona fide student with a reputable learning institution up to a maximum of 23 years. In the absence of the proof of being such, any dependant above 18 years will be accepted and billed as an adult.

5.5 Admission to membership shall be made after the acceptance of an application and payment by Maisha Health Fund. The prospective member will make an application by completing and submitting the Membership Application Form together with copies of identification documents, proof of residence and payment, to Maisha Health Fund. For the avoidance of

doubt it is hereby recorded that Maisha Health Fund reserves the right to reject an application made by a Prospective Member.

5.6 The date of joining will either be the first day of each month or the actual date of receipt and acceptance of payment and application by Maisha Health Fund. The parameters are as follows:

i) **First day of the month** : *For those observing waiting periods*

If payment is received before the 10th of the month, cover commences on the first day of that month. If payment is received after the 10th of the month, cover commences in the subsequent month.

ii) **Actual date of receipt and acceptance of payment and application**: *For beneficiaries whose waiting periods are waived or not applicable*

5.7 Cover will commence on the date when payment and the application are received and accepted by Maisha Health Fund. A payment equivalent to a full month's premium for respective package and billing group will be required in both circumstances of the joining date as per point 5.4 above.

5.8 The application form in respect of joining may be amended by Maisha Health Fund from time to time whenever it is considered necessary.

5.9 A Membership card or certificate will be issued when a beneficiary has observed the full consultation waiting period where applicable.

5.10 A reprinting fee shall be charged for any card replacements where the cause for the reprint originates from the Member.

Premiums

6.1 Premiums for the subsequent month should be paid by the 27th day of the preceding month. (Premiums are paid in advance).

6.2 Failure to pay premiums for the subsequent month by 27th day of the preceding month, will result in membership being suspended effective the first day of the subsequent month. Where treatment is received when

subscriptions are in arrears, such claims will not be honoured by Maisha Health Fund. Cover will only resume from date on which payment has been made if the claim is not a continuous one.

6.3 A member in premium arrears will be suspended for a maximum of 3 calendar months, after which their membership will be terminated effective the first day of the fourth month without notification to the member. Where Membership has been suspended, the continuity of benefits is subject to the payment of all outstanding premiums plus one month's subscriptions.

6.4 Following termination, a **new** application can be submitted to Maisha Health Fund and the acceptance of the application shall be at the discretion of Maisha Health Fund and shall be subject to the prevailing waiting periods and conditions that apply to new applications at that time.

6.5 Premiums can be paid either by cash or directly into Maisha Health Fund bank account or by any other electronic means as advised by Maisha Health Fund from time to time. The Member or member representative **must** communicate payment of premiums to Maisha Health Fund.

6.6 Where application was done using the mobile phone, premiums will automatically be deducted from the customer's Ecocash Wallet unless this functionality is disabled.

6.7 When applying for membership the prospective member must choose the currency in which their benefits will be denoted and premium paid. A member can only be on one package at a time.

Benefit Policy

7.1 With the exception of those benefits where it is stated to the contrary, all benefits accrue and renew yearly.

7.2 The applicable benefit year is equivalent to 365 days / 366 days in a leap year. This runs between 1 March to 28 February or 29 Februarery in a leap year.

7.3 For those joining in the course of the benefit year, yearly benefits will be pro-rated and claims be processed likewise.

7.4 There are basically two limits in respect of each claim. The **per treatment** limit and the **per benefit** limit. The per treatment limit will generally refer to the applicable AHFOZ tariff code and limit for that treatment, or in its absence, to the benchmark amount which is determined by Maisha Health Fund from time to time. The per benefit limit, refers to the cap on the benefit category to which the treatment is defined by Maisha Health Fund. For consistency and fairness, it is agreed that this classification provided by Maisha Health Fund is final and members or beneficiaries will not contest this.

7.5 The per treatment limit takes precedence in the processing of each claim, up-to the point where the per benefit limit has been exhausted. When the per benefit limt has been exhausted, the reverse will occur.

7.6 Members will incur a shortfall in instances where the Healthcare Providers rates or charges for medical services are higher than Maisha Health Fund's per treatment limit. .

7.7 Maisha Health Fund reserves the right to recommend members to less expensive treatment options. This includes but is not limited to requesting for three quotations on some forms of treatment or limiting quantities of a service or product accessed even through one's limits may generally permit.

7.8 The exception on yearly benefits are on the following.

- **Maternity**: For unsuccessful pregnancies (ectopic, miscarriage and non-criminal abortion) the member can access the balance of their two year benefit within two years for maternity.
- **Optical Appliances:** Member can access the balance of their benefit over a three year period.
- **Glucometer and BP machine :** Member can access either device once per three years up to the relevant sub-limit.
- The applicable orthodontic treatment limit shall be spread over a four year period.

7.9 Members become entitled to access medical benefits as soon as their premiums have been paid and they have been issued with appropriate membership confirmation documents such as a card or a certificate.

7.10 A prospective member joining without having been a member of a previous medical aid society or fund for a continuous period of at least two years will be subject to the following **general waiting periods**

GP Consultation	3 months
Specialist Consultation	6 months
Physiotherapy	6 months
Dental services	6 months
Optical services	6 months
Hospitalisation	6 months
Surgical operations	6 months
MRI and CT scan	6 months
Maternity	9 months
Antiretroviral Medication	18 months
Cancer Treatment	24 months
Dialysis	24 months
Orthodontic treatment	48 months

7.11 A prospective member who was a member of a previous medical aid, society or fund for a continuous period of at least two years and applies for membership with Maisha Health Fund within three months after terminating prior arrangement will be eligible for immediate cover on **out-patient treatment** upon submitting a membership certificate from the previous medical health funder.

The following waiting periods will apply

Specialist Consultation	6 months
Dental services	6 months
Optical services	6 months
Surgical operations	6 months
Hospitalisation	6 months
MRI and CT scan	6 months
Maternity	9 months
Antiretroviral Medication	18 months
Cancer Treatment /	24 months
Dialysis	24 months
Orthodontic treatment	48 months

7.12 A prospective member who may have been a member of a previous medical aid society or fund for a period of at least two years, but applies for membership with Maisha Health Fund after three months of termination of their membership with the previous medical aid society or fund will be subjected to waiting periods as per section 7(10).

Waiting periods on specialist services

Specialist services such as Hearing aids, Prosthesis and appliances, hip and knee braces: **24 months**.

Dentures, Crowns, Bridges : **12 months**

Glucometers : **6 months**

Orthodontics (correction of teeth structure): **4 years**

Lifetime benefits

The fertility benefit will be for the Vitality and Active packages only. Fertility will be covered once until a successful birth.

7.13 In cases where a Member is in violation of the waiting periods and a claim is submitted to Maisha Health Fund by a service provider, Maisha Health Fund will not honour such a claim.

7.14 Benefits are not transferrable between members. In addition, an exhausted benefit category cannot be subsidised by another benefit category.

7.15 Requests for cover on compassionate grounds for chronic patients shall be made in writing to the Tariff Committee. The acceptance or rejection of the request shall solely be at the discretion of this committee and no reasons will be given for such.

7.16 Benefits shall be pro-rated to the joining date.

7.17 Waivering of waiting periods for foreign currency denoted packages will only be considered when the prospective member is coming from a foreign currency denoted package.

Authorisation of Procedures

8 **All medical procedures** shall require prior authorization except life threatening cases. These include but are not limited to the following:

Cancer Treatment (chronic conditions treatment)

Dental procedures

Laparoscopy

Elective caesarean section

Thyroidectomy

Appendectomy

Hernia repair

Circumcision

Eye surgery

Purchase of Optical appliances i.e. Spectacles

Haemodialysis

Cancer Treatment

Benefit Exclusions

9.1 Although most medical conditions are covered, the Scheme shall not cover claims arising from or connected to the following:

- War, invasion by a foreign country, acts of foreign enemies, hostilities (whether war is declared or not), civil war, labour disturbances, active participation in strikes or the activities of locked-out workers, rebellion, revolution insurrection or military or usurped power, or the Member engaging in military duty or military exercises with any armed force of any country or international authority.
- Intentionally self-inflicted injury/medical conditions or attempted suicide, while sane or insane.
- Engaging in (or practicing for or taking part in training peculiar to) underwater activities necessitating the use of artificial breathing apparatus, climbing or mountaineering necessitating the use of ropes or guides, potholing, parachuting, hang-gliding, winter sports involving snow and ice, professional sports or racing other than on foot.
- Engaging in aviation, other than as a fare-paying passenger in a fixed-wing aircraft provided and operated by an airline or air charter company which is duly licensed for the regular transportation of fare-paying passengers, or in a helicopter provided and operated by an airline which is duly licensed for the regular transportation of fare-

paying passengers provided such helicopter is operating only between established commercial airports and/or licensed commercial heliports.

- The actions of any Member or the Member personal representatives contrary to the law.
- Driving a motor vehicle while the blood alcohol level of the Member is higher than that permitted by law, irrespective of whether such action causes an accident or not.
- Medical Services where there are no objective indications or impairment in normal health.
- The Member having taken a drug, unless it is proved that the drug was taken in accordance with proper medical prescription and not for the treatment of a drug addiction.
- Operations, treatments and examinations for obesity, cosmetic purposes or of the Member's own choosing which has no connection with any Illness.
- Services as a consequence of removal of fat from any part of the body, breast reduction or enlargement operations.
- Any treatment not recommended or administered by a qualified medical professional.
- Treatment due to cosmetic or plastic surgery except in the case of bodily reconstruction after Injury.
- Alcohol or drug dependence syndrome including treatment of any medical condition which, in the opinion of the Company, is considered to be either an underlying cause of, or directly attributable to, alcohol or drug dependence syndrome.
- Cosmetic, reconstructive, or remedial disorders, developmental disorders, whether or not for psychological reasons, and or any complications arising thereafter, unless required as a direct result of a covered medical condition
- Over the counter drugs

- Obesity, weight control medication and any other products that are purchased without a doctor's prescription
- Recreational devices and drugs such as condoms and Viagra, Contraceptives
- Lodgers' fees
- Vaccinations-yellow fever etc.
- Treatment by a medical practitioner who is in any way related to the member
- Illegal termination of pregnancy
- In vitro fertilisation

9.2 Should a medical claim be submitted to Maisha Health Fund in respect of excluded benefits such as those listed above, Maisha Health Fund will not honour such a claim.

Claim Policy

10.1 Maisha Health fund commits to settle medical claims as per the terms outlined for the various Maisha Health fund products.

10.2 For the range of Maisha Health Products, which may also be called Insurers or Funders when settling claims, reference is made to the per treatment limit, firstly, and the per benefit limit secondly. Table 1 outlines the Claim Policy referenced to the per treatment and per benefit limit which are explained in 7.4.

Table 1 : Claim settlement for healthcare products and services exclusing medication or drugs

Product Name	Per treatment limit	Per benefit limit

Main	Claim settled at 100% of the AHFoZ rate for Consultation services and 50% on all other services	Claim settled as per annual benefit limit for package or plan
USD Pure	Claim settled in full at Service Provider charge, subject to reasonability.	Claim settled as per annual benefit limit for package or plan
Indexed	Claim settled in full at Service Provider charge, subject to reasonability.	Claim settled as per annual benefit limit for package or plan

Table 2 Claim settlement for medication or drugs

Product Name	Per treatment limit	Per benefit limit
Main	Claim settled at the prevailing Maisha Health Fund drug file prices / reimbursement	Claim settled as per annual benefit limit for package or plan
USD Pure	Claim settled in full at Service Provider charge, subject to reasonability.	Claim settled as per annual benefit limit for package or plan
USD Funds	Claim settled in full at Service Provider charge, subject to reasonability.	Claim settled as per annual benefit limit for package or plan
Indexed	Claim settled in full at Service Provider charge, subject to reasonability.	Claim settled as per annual benefit limit for package or plan

10.3 For any products where application and joining was done using the mobile phone platform, claims are settled taking into account the per benefit limit only but subject to reasonability.

Change of Package

11.1 Changes in packages must be submitted before the beginning of the required month and cannot be made in retrospect.

11.2 Downgrading packages can only be done at the beginning of the year (i.e. effective March) and at least a calendar months' notice must be given.

11.3 When upgrading packages, the additional benefit limits for the rest of the year shall be provided on a pro rata basis from the date of change on the new package. Further, the benefit limits per category will only be increased after a period equivalent to the general waiting period of that category.

11.4 For upgrading packages, the premium rate for the higher package shall be payable for three (3) months before the benefits are upgraded.

Change of Membership details

12.1 Where Membership details change, a Member shall inform Maisha Health Fund immediately and at most within one (1) month of such change.

12.2 The Member may, where appropriate, arrange for another Member to contact Maisha Health Fund on their behalf.

12.3 Changes of membership details may include, but shall not be limited to:

- Change in address of any Member;
- Change in contact details (such as phone, e-mail, or fax numbers);
- Change in Zimbabwean residency status;
- Change in name;
- Change in marital status or de facto status of a Dependent; or
- A Dependent no longer eligible to be a Dependent.
- Death of a member

Medical Coverage for additional Dependants

13.1 A Member may freely add anyone as their dependant under the Scheme.

13.2 Each dependant shall be subject to the waiting period stipulated in section 7, except for new born children.

13.3 A new-born child, may be added as a dependant from its date of birth, without a waiting period provided that:

i) The application for the child's membership is lodged no later than one (1) month from the child's date of birth and that the full subscriptions for that month in which the child is born is paid.

ii) The mother has completed the nine months maternity waiting period.

13.4 In the absence of the mother's membership from Maisha Health Fund, the nine months maternity waiting period shall be referenced to the principal member. Where there is non-compliance to points 13.3, i) and ii) both inclusive, the **general waiting periods** in respect of membership will apply for the new born child.

Cancellation of Membership by a member

14.1 Subject to a minimum of one (1) month notification period:

- A Member can terminate their Membership entirely;
- A Member may remove any Dependents from the Membership;
- A Member's Spouse/Partner or Dependent aged at least 18 years may leave the Membership; and
- A Dependent aged below 18 years may leave the Membership with the agreement of the Member.

14.2 Unless otherwise permitted by Maisha Health Fund, the actions referred to in clause 14.1 must be authorised in writing, may not have retrospective effect and must be in accordance with any other arrangements specified by Maisha Health Fund.

14.3 There will be no recourse to premiums by a terminated member whether they have claimed before or not.

Suspension

15.1 The grounds for suspension are as follows:

a) Failure to pay premiums by the 1st of each month as provided in section 6.2

b) When a member obtains improper advantage for the purposes of this Rule, “improper advantage” means any advantage, monetary or otherwise, to which a Member or person is not entitled under the Scheme Rules.

15.2 Membership shall be suspended up to a maximum of three (3) months. In this case, membership shall be reinstated subject to a request by the Member, settlement of outstanding dues and any other requirements stipulated by Maisha Health Fund at that time.

15.3 When membership is suspended, the entitlement to benefits from the Scheme is also suspended.

15.4 The totality of a continuous claim: where admission falls within the dates when membership was suspended will not be honoured outrightly.

15.5 Failure to reinstate membership within three (3) months will result in membership being terminated.

Termination of Membership

16.1 Maisha Health Fund has the right to terminate Membership, on its own authority. This authority shall be exercised under the following circumstances:

16.2 Membership shall be terminated without notice where a Member has been suspended for three (3) consecutive months and has failed to reinstate their Membership.

16.3 Membership shall be terminated where in Maisha Health Fund’s opinion, the member has obtained an improper advantage, acted dishonestly or has prejudiced Maisha Health Fund.

16.4 A Member or person who has acted improperly shall also be liable to prosecution

16.5 Following termination, a **new** application can be submitted to Maisha Health Fund and the applicant shall be subject to all the waiting periods and conditions that apply to new applications at that time.

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Procedure on Termination of Membership by Maisha Health Fund

17.1 Maisha Health Fund has the authority and right to suspend and ultimately cancel a Membership and benefits entitlements, if to the best of Maisha Health Fund's knowledge the Member has given false information or misleading information or has attempted to claim a benefit with false or misleading information

17.2 In the event that Maisha Health Fund invokes this rule; they shall provide the Member with at least one (1) months' notice in writing including the reasons for the termination

17.3 Members are obliged to co-operate in any investigations on any matters that are prejudicial to the interests of the Scheme and upon request, must provide authorization for Maisha Health Fund to investigate any claim. Failure to do so shall result in Membership and benefits entitlements being cancelled.

17.4 Should a medical claim be submitted to Maisha Health Fund in respect of terminated members, the member shall be liable to settle all such claims.

Medical Benefits

18.1 The levels of medical benefits arising from being a member of the Scheme are classified according to the category in which a specific member falls.

18.2 The rates and benefits are specified in the rates and benefits schedule. These are subject to interpretation and change at the discretion of Maisha Health Fund.

18.3 When a Member has been suspended pending an investigation, the Members' benefits shall also be suspended.

18.4 Foreign holiday travel shall not be covered until a comprehensive list of service providers is available from Maisha Health Fund. This rule shall be revised at that point. Members travelling on holiday are to get alternative cover.

Settlement of Claims

19.1 Claims made against the Scheme by a service provider for medical services rendered shall be settled within and up to sixty (60) days from the date of receipt of the claim by Maisha Health Fund.

19.2 A claim that is submitted after 90 days from the last day of treatment will be considered stale and will be rejected for processing and payment.

19.3 The following information shall be provided when claims are being submitted to the Scheme for settlement:

- The service provider's name, registration number and address;
- The patient's full name and address;
- The date of service;
- The description of the service;
- The amount(s) charged; and
- Any other information that Maisha Health Fund may reasonably request.

19.4 Service providers and Members shall submit claims for services only in respect of Members and beneficiaries who are current, valid Maisha Health Fund membership card holders and have provided positive identification as proof of membership.

Refunds

20.1 Should a member happen to pay cash at any service provider, the member shall be entitled to a refund within thirty (30)working days of receipt of the claim subject to availability of the member’s benefit limits and subject to the Maisha Health Fund tariff award regime for the service received.

20.2 For a claim to be eligible for refund, the claim should be stamped by the Service Provider and should be accompanied by a receipt for the cash paid and bank details for the principal member. The claim should be submitted and received by Maisha Health Fund within 90 days of treatment. The member should also fill in the Maisha Health Fund Claim Refund form and provide the requisite details for payment of the refund. After 90 days, such a claim will be stale and will not be accepted for payment.

20.3 For a claim to be eligible for refund, the claim should be stamped by the Service Provider and should be accompanied by a receipt for the cash paid and bank details for the principal member.

Service Charges that Exceed Authorised Levels

21 Where a service provider's charges for any treatment or procedure exceeds a member's benefit limit, or the Maisha Health Fund tariff reference benchmark, Maisha Health Fund shall pay up to the limit of the benefit or the tariff.

Treatment to be provided by recognised providers

21.1 Medical Benefits are payable only where treatment is provided by a recognized service provider, except in life threatening cases where exceptions may be made at Maisha Health Fund's' discretion.

21.2 The Scheme recognizes the following service providers:

(a) Established Hospitals, Hospice Providers and Nursing homes and

(b) Medical and Alternative Medical Practitioners and Ancillary service providers, who are in Independent Private Practice, and for each relevant class of service or treatment, satisfy all applicable Health Professions Act Recognition Criteria.

Providers who fail to meet Recognition Requirements

22.1 The Scheme shall not meet any claims where it has reasonable grounds to believe that:

a) premises or facilities do not meet the definition of Hospital as set out in the Scheme Rules, or

b) an ancillary service provider is not in Independent Private Practice, or

c) an ancillary service provider does not meet a relevant Health Professions Act Recognition Criterion.

Recognised Providers who cease to meet Recognition Requirements

23 The Scheme may decline to pay benefits in respect of any claim, and suspend or cancel the provider's recognition for the purpose of paying benefits where it has reasonable grounds to believe that:

a) a Hospital has ceased to meet the definition as set out in the Scheme Rules, or

b) an ancillary services provider has ceased to be in Independent Private Practice, or

c) an ancillary Service Provider has ceased to meet any recognised Recognition Criterion.

Confidentiality

24.1 All information relating to the Scheme and its membership shall be classified as confidential information.

24.2 All information relating to the affairs of the Scheme shall be kept in a manner that preserves confidentiality

24.3 No one shall disclose to non-members any information relating to the Scheme that is classified as confidential without obtaining authority from Maisha Health Fund

24.4 Anyone that discloses any confidential information without Maisha Health Fund’s authority shall face disciplinary action.

Notification to Members

All correspondence in relation to the medical cover shall be sent to the Principal Member

25.1 Maisha Health Fund shall notify Members whenever it amends the Scheme rules where such change may lead to a material change to the scope, level or amount of benefits payable to Members.

25.2 Members shall also be notified whenever premiums payable by the Members have been reviewed.

25.3 Maisha Health Fund shall, before any such change contemplated above takes effect, take all reasonable steps to directly notify all affected Members in writing, explaining the change in plain English at least thirty (30) days before the change is effected.

25.4 Maisha Health Fund shall send any necessary correspondence to the most recently advised cell-phone number, e-mail address, postal address, of the relevant Member.

Provided that the Maisha Health Fund may also notify affected Members of any such change by explaining the change in a Scheme publication or website generally available to Members.

Queries and Complaints

26 Maisha Health Fund makes no warranty that the services will meet member's requirements, be uninterrupted, complete, timely or error free and accepts no liability should a member be unable to access benefits and/or services.

27 For queries, assistance and complaints the member can contact Maisha Health Fund's Offices:

Maisha Health Fund (Private) Limited
Cassava Office Building, 1906 Borrowdale Road, Borrowdale, Harare
08677020267

Membership Department: 0778 775 200-2

Claims Department: 0778 775 203

APPENDIX: MAISHA HEALTH FUND MEDICAL SCHEME

1. Packages available & access levels

- Vitality – Access to private ward in Grade A hospitals
- Active – Access to 2 bedded ward in a Grade A hospitals
- Classic– Access to General ward in a private hospital
- Standard – Access to General ward in private hospitals grade B to F
- Starter Plus- Access to consultation by a General Practitioner. All other services exclusively for government, mission and council facilities
- Starter – Exclusively for government, mission and council facilities

2. Benefit Limits Structure

Package	Vitality	Active	Classic	Standard	Starter Plus	Starter
Principal per member (ZWL)	7,759	5,145	3,675	2,532	1,307	653
Child	5,472	3,430	1,879	1,143	653	653
Student	6,207	4,116	2,940	2,026	653	653
Over 65yrs	9,393	6,452	4,411	3022	653	653
Annual Global Limits	4,083,705	3,266,964	2,450,223	1,225,112	653,393	326,696
Hospitalization • **Prosthesis** • **Cancer** • **Dialysis**	1,306,786	1,045,428	784,071	392,036	209,086	104,543
Pathology	245,022	196,018	147,013	73,507	39,204	19,602
Radiology	387,952	310,362	232,711	116,386	62,072	31,036
Physiotherapy	122,511	98,009	73,507	36,753	19,602	9,801
Dental • **Orthodontic Treatment**	163,348	130,679	98,007	49,004	26,136	13,068

Optical	81,674	65,339	49,004	24,502	13,068	8,167
Drugs	306,278	245,022	183,767	91,883	49,004	245,02
Anesthetic	257,273	205,819	154,364	77,182	41,164	20,582
Consultation	265,441	212,353	159,264	79,632	42,471	21,235
Gynecology	130,679	104,543	78,407	39,204	20,909	10,454
Maternity	245,022	196,018	147,013	73,507	39,204	
Hearing aids	163,348	130,679	98,009	49,004	26,136	19.602
Surgery	408,371	326,696	245,022	122,511	65,339	32,670

Package	**Vitality**	**Active**	**Classic**	**Standard**	**Starter Plus**	**Starter**
Principal per member (USD)	95	63	45	31	16	8
Child	67	42	23	14	8	8
Student	76	50	36	25	8	8
Adult (65yrs+)	115	79	54	37	8	8
Annual Global Limits	50,000	40,000	30,000	15,000	8,000	4,000
Hospitalization • **Prosthesis** • **Cancer** • **Dialysis**	16,000	12,800	9,600	4,800	2,560	1,280
Pathology	3,000	2,400	1,800	900	480	240
Radiology	4,750	3,800	2,850	1,425	760	380
Physiotherapy	1,500	1,200	900	450	240	120
Dental • **Orthodontic Treatment**	2,000	1,600	1,200	600	320	160
Optical	1,000	800	600	300	160	100
Drugs	3,750	3,000	2,250	1,125	600	300
Anesthetic	3,150	2,520	1,890	945	504	252
Consultation	3,250	2,600	1,950	975	520	260

Gynecology	1,600	1,280	960	480	256	128
Maternity	2,000	1,600	1,200	600	320	160
Hearing aids	3,000	2,400	1,800	900	480	240
Surgery	5,000	4,000	3,000	1,500	800	400

The yearly limit with respect to fertility will be USD1,000 subject to the hospitalisation limit.

3. Sub limits

- Nebulisers (including inhalers) are treated absolutely as drugs.
- Glucometers and Blood pressure monitors shall have a three (3) year follow up period.
- Ostomy bags deduct from Hospitalisation and hence the corresponding waiting period applies.
- Dentures shall be subject to the dental limit i.e. no other limit shall be imposed. There is also no follow up period i.e. only the dental annual limit and initial waiting period shall be used.
- Orthodontics shall be subject to a four (4) year waiting period, and a four (4) year follow up period.
- Hearing aids shall have a five (5) year follow up period.

The sub-limits shall only be fully available in the case that no other deductions have been made on the “Other” benefit category.

4. Miscellaneous

- Oncology, Dialysis, Cancer Treatment deduct from hospitalisation and drugs in the absence of a Chronic add on.
- For adjudication purposes, a maximum of 4 fillings is to be recognised per treatment as is medical practise.