PROSPERITY LIFE

Essential Health

ESSENTIAL HEALTH
(GROUP SCHEMES) EFFECTIVE 2026

The Essential Health Insurance Plan offers in and out of hospital insured benefits for the treatment of HIV/AIDS in accordance with the insured benefits at the Agreed tariff.

INSURER STANDARD TERMS AND CONDITIONS

Subject to the terms, conditions and provisions of the policy, the Insurer agrees to pay the Principal Insured Person for an insured incident occurring during the period of cover up to the limit of indemnity stated and based on the benefit option selected for each section of the policy.
The application and relevant documentation form the basis of the policy agreement.

1. DEFINITIONS

The Policy and Schedule must be read as a summary document and forms the basis of the contract between the Insured and the Insurer.

"Accident" means an unintentional, violent, external and visible bodily injury.

"Area of Cover" will include Namibia and South Africa, Lesotho, Eswatini, Mozambique, Botswana, Zimbabwe, Zambia and Angola. Claims will be paid according to the Insurance Benefit structure.

"**Benefit Year"** means the Insurer's benefit year, being 1 January to 31 December.

"Claim" mean compensation requested by the Insured for an insured incident according to the benefit schedule of the insurance policy selected.

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

"Emergency evacuation" means suffering acute illness, life-threatening bodily injury for which the Insured Person is recommended by a designated practitioner to be transported by air or road ambulance for treatment at a different location.

"Exclusions" means the conditions and/or services excluded under this policy.

"FIA" means Financial Intelligent Act, 2007 (Act 3 of 2007) (FIA Act). The Insurer is regulated by the Long-term Insurance Act, 1998 (Act 5 of 1998) and must comply with the (FIA Act), which requires the Insurer to verify the identity of the Policyholders and to keep proper supporting records thereof.

"Funeral policy" means a contract in terms of which the Insurer, in return for a premium, undertakes to provide on the death of the insured, benefits as stipulated in the Schedule of benefits.

"Group" means any number of employees, in relation to employers who are Premium participants.

"Hospital" means a registered institution providing diagnostic and therapeutic facilities for surgical and medical diagnosis treatment and care under the supervision of registered staff and/or medical practitioners.

"Inception Date" means the joining date of the Policyholder upon approval of the Insurer notwithstanding the date indicated on the application form, and provided premiums are received for such joining date.

"Illness" means any one somatic illness or disease, which manifests itself during the period of insurance.

"Incident" means any one accident or illness, which causes an Insured Person to be confined to hospital and to undergo medical or surgical procedures, or where emergency evacuation is required due to that one accident or illness.

"Insured Person" means a Policyholder who elects to insure under the policy.

"Insurer" means Prosperity Lifecare Insurance Limited (Reg. No. 03/LT/13).

"Medical and Surgical Procedures" means any procedure listed based on the Prosperity rate insured and further based on the terms and conditions of the insurance policy selected.

"Medical Practitioner" means a legally qualified and registered medical practitioner.

"MVA" means motor vehicle accident identified within a number of vehicle classes including cars, buses, motorcycles, off-road vehicles, light trucks and regular trucks. Powered wheelchairs are specifically excluded from being considered motor vehicles.

"NAMFISA" means the Namibia Financial Institutions Supervisory Authority established by Act 3 of 2001 as statutory regulatory body.

"Nominated Beneficiary" means the nominated person entitled to be paid the benefits provided for in terms of the Funeral Policy, upon the death of the Policyholder. Such nominated beneficiary must be related by blood or marriage or by custom or tradition.

"Policyholder" means a person who elects to insure under this policy provided that he/she has not attained the age of 60 (sixty) at commencement of insurance.

"Participating Employer" means the employer named in the schedule employing the eligible employee under a contract of service or apprenticeship.

"Pre-existing Condition" means any illness or physical infirmity for which the Insured was diagnosed or received medical treatment or advice prior to membership.

"Premium" means the annual premium payable by the Policyholders to the Insurer before commencement of cover.

"Pro-rated Benefits" means benefits are allocated as per the Insurer's benefit year: 1 January to 31 December. Any Policyholders that join the Insurance plan during the course of the year will receive pro-rated benefits on all benefits, to be calculated on the number of months within a benefit year that the Policyholders are on is on the Insurance plan.

"Prosperity Benchmark Tariff" refers to the scheme rates applied to claims made by Namibian healthcare providers, based on the standard tariffs established by the Namibian Association of Medical Aid Funds (NAMAF) and adjusted by an additional percentage. This adjustment is set at 150% of NAMAF tariffs

"Rate Insured" means the tariff structure used by the Insurer based on the Prosperity Benchmark Tariff.

"Residence" means Living or dwelling in a certain place permanently or for a considerable length of time. The place where a person makes his/her home and work, or where he/she dwells permanently or for an extended period of time.

"Risk Rate" means a penalty placed on the premium of the Insured due to age or claims patterns.

"Self-inflicted" means intentional injury caused by the person injured, where such person is aware of consequences that can happen e.g. drink and drive or suicide.

"Sum Insured" means the maximum amount payable to any eligible person specified in the Schedule of benefits.

"Traveling" means traveling in any area of cover.
"Treatment" means any form of investigation or examination by means of a consultation or treatment by a medical practitioner for the purpose of treating or monitoring an Insured Person's medical condition arising out of an insured accident.

"Underwriting Protocols" means the guidelines, as amended from time to time, used to underwrite risk and to determine and impose the exclusion level of Pre-Existing Conditions on Individual or on group Member basis.

The Insurer's liability is conditional on the Policyholder claiming the benefit and keeping to the policy Terms and Conditions.

BENEFIT

The maximum annual benefit payable per benefit year as stated in the Benefit Schedule is N$100 000.00 (one hundred thousand Namibia Dollars) per insured life. This annual benefit includes a Funeral Policy of N$10 000 (ten thousand Namibia Dollars) per Insured life.

Any services, excluded or not listed, will not be covered.

INCLUSIVE FUNERAL PLAN

Only the Policyholder will be covered for the duration of the policy.

Pre-existing Conditions, which could cause the death of any insured person will be excluded for a period of 6 (six) months for members of Participating Employer Groups and 12 (twelve) months for individual members. A Pre-existing Condition is any medical condition, physical defect, illness, or bodily injury that existed before the start date of a funeral policy and that causes the death of an insured person or beneficiary within the exclusion period.

Maximum entry age for principal member and his/her spouse is 60 (sixty).

- 3 (three) month general exclusion period for death as a result of natural causes, unless the death is the direct result of an accident.
- 6 (Six) month exclusion period for death as a result of a pre-existing condition for members of Participating Employer Groups
- 12 (Twelve) month exclusion period for death as a result of a pre-existing condition for individual members.
- 24 (Twenty-four) month exclusion period for death as a result of suicide.

All benefits payable shall be paid to the Nominated beneficiary. In the absence of a nominated beneficiary, the parent of a child or the legal spouse will be deemed the nominated beneficiary, failing which the benefit will be payable to the diseased Estate, Funeral home or the participating employer whose receipt shall in every case be a full discharge to the Insurer.

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In the event that no beneficiary can be traced, or there are no participating employer, and payment of the Funeral Home is made by a Family member, payment can be made to the Family member with sufficient proof to be provided that the cost of the Funeral was paid by the Family member, this proof should be in the form of an invoice and receipt from the Funeral home in the name of the Family member.

The benefit is subject to the benefits applicable to the benefit structure and the terms and conditions.

2. PRODUCT CONDITIONS

The plan is available for all permanent employees, regardless of whether they are medical aid members.

In-Hospital Treatment must be validated with the Insurer at least (48) forty-eight hours prior to the procedure being done. Emergency cases must be validated within (24) twenty-four hours after the incident occurred.

The benefit of the product only covers in and out of Hospital insured benefits for the treatment of HIV/AIDS.

Benefits are allocated as per the Insurer's Benefit Year. Any Principal Insured that joins the insurance plan during the course of the year will receive Pro-rated Benefits on all benefits, to be calculated on the number of months within a benefit year that the Principal Insured Person is on the insurance plan.

All benefits payable shall be paid to the Nominated beneficiary. In the absence of a nominated beneficiary, the parent of a child or the legal spouse will be deemed the nominated beneficiary, failing which the benefit will be payable to the diseased Estate, Funeral home or the participating employer whose receipt shall in every case be a full discharge to the Insurer.

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If the agreed tariff does not adequately define a procedure, then, the payment for such procedure will be established after consultation with a medical adviser appointed by the Insurer.

2.1. CLAIMS PROCEDURE

Every Claim submitted to the Insurer in terms of the Medical Insurance Plan and in respect of Service rendered as contemplated in this Policy, must contain the following particulars:

- Family name, initials and signature of the Policyholder or Spouse.
- The first name of the patient as per the Policyholder card.
- The name of the Medical Insurance Plan.
- The Policyholder number.
- The practice code/name of the supplier of the Service, where applicable.
- The practice code/number/name and specialty of the supplier of the Service where the Service Provider is in the employ or consulting on behalf of a Preferred Service Provider.
- The Date of Service.
- The nature and cost, according to the agreed tariff, of each Service Diagnosis or diagnostic code, where applicable.
- Copy of approved Policyholder validation when applicable.
- The name of the referring medical practitioner.

To qualify for insured benefits, a claim shall be submitted to the Insurer not later than the last day of the sixth (6) month from commencement of the first occurrence or hospital treatment for such incident.

No benefit payable shall carry interest.

The Insurer will not be liable to pay any benefits if the Insured or any Eligible Persons fails to comply with any Policy obligation.

2.2. CLAIMS SETTLEMENT

In the event of an Insured Person suffering an insured event, as defined, this necessitates the Insured Person to:

- Obtain any necessary day-to-day medical services from a registered Health Professional, where the Insured Person's insurance plan allows for day-to-day medical treatment benefits.
- Undergo Medical or Surgical Procedures, or treatment in as an in-patient in a hospital or similar registered medical facility.
- Require emergency medical evacuation.

The Insurer shall compensate the Policyholder and/or Healthcare Professional in accordance with the standard Terms and Conditions of the Insurer and in terms of the Policy selected.

2.3. POLICYHOLDER VALIDATION AND BENEFIT REGISTRATION

The In-Hospital benefits of insurance policies will be payable provided that treatment or medical services was validated through the Insurer.

3. PRODUCT SCHEDULE

The insured benefits and premiums of each insurance policy are attached as Annexures hereto.

3.1. BENEFITS

Benefits are subject to the Terms and Conditions of the Insurer as well as any special Terms and Conditions specific to each insurance policy.

3.2. PREMIUMS

The Premium is due monthly or annually in advance and if it is not received by the Insurer on/or before the seventh (7th) day of the month of cover then this policy shall be deemed to have been cancelled at midnight on the last day of the preceding period of insurance.

Maximum contribution charge is for the Employee of the Employer only.

The Insurer shall not be obliged to accept any premium tendered to it after inception date or renewal date as the case may be but may do so upon such terms as it at its sole discretion may determine.

The Premium schedule of each insurance policy forms part of the Benefit Schedules as Annexures hereto and may change from time-to-day at the Insurer's discretion.

No claims will be payable if the monthly premium is not paid up to date on/or before the 7th day of each month.

4. POLICYHOLDER COVER

4.1. COMMENCEMENT OF COVER

Cover in terms of this policy commences on acceptance of the contract as approved by the Insurer, on the 1st day of the month following receipt of payment. Claims originated prior to date of commencement of cover will not be covered by the Insurer.

4.2. INSURANCE AMENDMENTS

The terms and conditions of the Insurer may be amended at the sole discretion of the Insurer.

4.3. CANCELLATIONS OR AMENDMENTS

Either party may give 30 (thirty) calendar days' notice of amendments or cancellation subject to the Terms and Conditions of the insurance policy selected. For policies paid on a monthly basis, there will be no premium refund for the remainder of the month in which the policy is cancelled.

Claims received upon cancellation of the insured policy will only be considered if such claiming incident commences no later than the last day of the six (6) months from the commencement of the first occurrence, or Hospital Treatment or medical services, before the date of cancellation with due consideration to available insured limits, which may be pro-rated upon cancellation.

4.4. WITHDRAWAL OF COVER

The Insurer may declare a policy or any part of it invalid in the event of any essential facts affecting the insurance not being disclosed or being misrepresented by the Insured, or in the event where Premiums were not paid on/or before the 7th day or the month of cover.

4.5. RISK RATE

The Insurer may give 30 (thirty) calendar days' notice of amending the policy, premiums and benefits of a Policyholder when the risk of such Policyholder has increased.

4.6. MISREPRESENTATION, MISDESCRIPTION OR NON-DISCLOSURE

- Misrepresentation, misdescription or non-disclosure of any material fact or circumstances in connection with this policy, a claim, or the application for this policy may result in this policy being cancelled, a claim rejected, or the policy voided from inception and all premiums forfeited.

- In the event that a benefit has been paid as a result of any misrepresentation, non-disclosure, misdescription or fraudulent action by an Insured Person or by any person claiming any benefit under this policy, such person will be required to repay or return the benefit paid. The Insurer shall be entitled to take legal action to recover the benefit and any costs involved.

5. GENERAL

The policy does not acquire any paid-up value or surrender value.

The table of benefits and rates insured applies in the area of cover.

The Policyholder shall submit claims to the Insurer within 6 (six) months of occurrence of incident. Failing to submit claims within prescribed period will result in forfeiting benefits under this Policy in respect of such claim.

The Insurer reserves the right to alter the terms and conditions of this policy if it is necessary to do so to comply with any changes in legislation of the NAMFISA.

Pre-existing Conditions will be excluded for a period as determined by the Insurer.

The Insurers' liability is conditional on the Policyholder claiming the benefit and keeping to the policy Terms and Conditions.

The Insurer shall not be liable for the failure of a broker or agent to adequately explain the Terms and Conditions of the policy and the Terms and Conditions of the Insurer, and each policy schedule will serve as guidelines for payment of benefits and collection of premiums.

6. INDEMNITY

Neither the Insurer nor any employee, broker/agent or Consultant shall be liable for any damage caused by any act, advice, or negligence or otherwise.

7. EXCLUSIONS

The Insurer shall not be liable for paying any benefits due to bodily injury, sickness, disease, death or medical evacuation directly or indirectly caused by related or in consequence of.

- War, invasion, hostilities, civil war, rebellion, revolution.
- Any condition for which an insured person received treatment or advice prior to becoming an insured person under the applicable sections of the policy unless otherwise agreed to by the Insurer.
- Misrepresentation, misdescription or non-disclosure of any material fact shall render this Policy voidable.
- The cost of any medical benefit other than prescribed in the benefit schedule.
- No claims will be payable if the monthly premium is not paid up to date on/or before the 7th day of each month.
- The benefits are not guaranteed in the failure of any agent or broker to adequately explain the terms, conditions, exemptions and exclusions of this policy.