MINISTRY OF FINANCE

No. 2015

REGULATIONS MADE IN TERMS OF THE FINANCIAL INSTITUTIONS AND MARKETS ACT No. 2015

The Minister of Finance has under section 438(7)(a)of the Financial Institutions and Markets Act 2015 (Act No xx of 2015) made the regulations set out in the Schedule.

MINISTER OF FINANCE WINDHOEK 2015

SCHEDULE

FINANCIAL INSTITUTIONS AND MARKETS ACT, 2015 [Act No. • of 2015]

INSURANCE POLICIES TO BE EXCLUDED FROM THE DEFINITION OF BUSINESS OF MEDICAL AID FUND IN SECTION 308

Regulation No. MAF.R.7.1

made by the Minister under section 438(7)(a) of the Financial Institutions and Markets Act, 2015

Definitions

1. (1) In these regulations, unless the context otherwise indicates, a word or expression to which a meaning has been assigned in the Act shall have that meaning and-

(a) "the Act" means the Financial Institutions and Markets Act, 2015 [Act No. • of 2015], and includes the regulations prescribed under the Act and the standards and other subordinate measures issued by NAMFISA under the Act.and

(b) "hospital" means a state hospital or private hospital established in accordance with the provisions of the Hospitals and Health Facilities Act, 1994 (Act No. 36 of 1994).

Insurance Policies excluded from definition of "business of medical aid fund"

2. A health policy offered by a registered insurer shall be **excluded** from the definition of **"the business of a medical aid fund"** as defined under section 308 of the Act and shall be regarded not to be in contravention of section 310(1) of the Act if that policy is listed under the heading "Category" in Table A below, and-

(a) meets the criteria; and

(b) provides the policy benefits

associated with the applicable category as set out in the Table A below.

Table A

Category	Type of policy	Policy benefits	Criteria
1.	Lump sum or income replacement policy benefits payable on a health event	Covers contingency expenses associated with insured persons experiencing a specified health event and/or loss of income as a result of a health event, provided the insured person can provide evidence of loss of income	(a) Policy benefits are one or more lump sums assured stated in Namibia Dollar terms; (b) The aggregate of the policy benefits payable under all policies issued by an insurer and its related parties to a specified person may not exceed the maximum amount referred to in regulation 4 per day per insured person; (c) Contract must provide for an annual term and monthly premiums; (d) An elimination or deferred period may apply before policy benefits are paid.
2.	Frail care for persons over the age of 60 years	Covers custodial care (assistance with activities of daily living)	(a) Policy benefits are one or more sums assured stated in N$ terms or ascertainable on a pre-determined basis set out in the policy; (b) Policy benefits may be paid out in kind or to provider of a relevant health service; (c) Policy benefits may be linked to actual costs or expenses of a relevant health service; (d) Policy benefits may be paid on a prefunded or immediate needs basis;

			(e) An elimination or deferred period may apply before policy benefits are paid.
3.	HIV and Aids	Covers expenses for HIV related testing and HIV and Aids treatment on an employee group basis for employees and their dependents, to the extent that such expenses are not covered by a Medical Aid Fund	Same as for category 2
4	Emergency Evacuation or Transportation	Covers guaranteed access to and utilisation of specialised medical transportation and/or guaranteed hospital admission to ensure that the insured person is admitted to an emergency health facility and stabilised, only to the extent that such expenses are not covered by a Medical Aid Fund	(a) Policy benefits are ancillary to the main policy benefits provided under the policy; (b) Policy benefits may be payable in kind or to the provider of a relevant health service; (c) Policy benefits may be linked to actual costs or expenses of a relevant health service that is medically necessary to stabilise the health of the insured.

3. A health policy contract referred to under regulation 2 may not –

(a) unfairly discriminate directly or indirectly against any person on the grounds of race, gender, age, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health, or similar grounds;

(b) provide for a waiting period during which the policyholder receives healthcare treatment or services that must elapse before the policyholder is eligible to receive benefits (note this is not referring to elimination or deferred periods at point of purchase which covers the exclusion for any benefits during the period before the policy becomes effective for benefit payouts);

(c) provide that the policy holder or life insured must be a member of a medical aid fund;

(d) entitle the insurer to refuse any claim for policy benefits on the grounds that the life insured had experienced a health event prior to the commencement of the applicable cover (note non-disclosure provisions will still apply); and

(e) in relation to a policy referred to in category 1 of Table A in regulation 2-

(i) provide policy benefits that are fully or partially linked to indemnifying the policy holder against medical expenses incurred as a result of a relevant health service; and

(ii) allow for cession or payment of any policy benefits payable under the policy to a provider of the relevant health service.

4. The maximum amount referred to-

(a) under category 1 of Table A under regulation 2 is N$5000,00 (five thousand Namibia dollar) per day; and

(b) under category 2 of Table A under regulation 2 is N$500,00 (five hundred Namibia dollar) per day,

with an annual escalation from the effective date of this regulation by the Consumer Price Index (CPI) annual inflation rate published by the Namibia Statistics Agency (NSA).

Marketing and Disclosures

5. Any marketing activity or marketing material or policy documentation in respect of policy contracts referred to under regulation 2 must-

(a) not identify that contract by the term "medical" or "hospital" or any derivative thereof;

(b) not in any manner create the perception that the contract-

(i) indemnifies a policyholder against medical expenses incurred as a result of a health event; or

(ii) is a substitute benefit offered by the medical aid fund;

(c) display the following statement in clear legible print in a prominent position:

"This is an insurance policy provided by a registered insurer, not a medical aid fund. The cover it provides is no substitute for that of a medical aid fund. This policy does not provide cover equivalent to medical aid fund benefits."; and

(d) in relation to policy contracts referred to in category 1 of Table A and regulation 2, in addition to paragraph (c), display the following statement in clear legible print in a prominent position:

"Subject to regulation 7(2), the intention of the policy is to pay an amount of money to the policy holder upon the occurrence of a specified health event. This policy can not be ceded and payments under the policy are not allowed to be made directly or indirectly by the insurer or any agent, broker or third party to a provider of a relevant health service whatsoever".

Limitations on combination of policies and reporting

6. (1) A financial institution registered under the Act must:

(a) not develop and offer health policies referred to in this regulation which policies collectively may result in the aggregate of policy benefits of those policies being similar to the objectives of Chapter 7 of the Act;

(b) three months prior to introducing or launching a new health product referred to in this regulation, submit to NAMFISA a written summary of the details, terms and conditions of that policy; and

(c) provide NAMFISA with a written summary of benefits, terms and conditions and marketing material of other health policies referred to in this regulation.

(2) NAMFISA shall within three months after receipt of the submission of information referred under sub-regulation (1) advise the financial institution whether in its opinion the benefits, terms and conditions and marketing material of the health policies are contrary to the exemption conditions provided under this regulation. (Note the full period is 3 months which period will include time before introducing and launching a new health product)