Health Plus

PREAMBLE

Whereas the Policyholder, that is identified in the special conditions of this policy, filed an application which is considered as the founding basis of this policy and its purpose, and accepted to pay the premium cited in the special conditions of this policy,

Whereas Orient Insurance company (hereinafter referred to as the **Insurance Company**), after having reviewed the application, has consented to provide the insurance coverage specified in the special conditions and to the policy schedule attached to this policy,

Whereas the insurance company has contracted Nextcare (herein after referred to as the **Administrator**) to provide it with its administrative and technical services related to the healthcare policies of the insured individuals and groups and coordinate their relation with the healthcare providers adherent to its network.

Therefore, the insurance company undertakes to reimburse the coverage stated in this policy within the range and in conformity with the terms, conditions, limitations, and exclusions provided therein.

Accordingly, and in approval of its content, the Insurance Company has duly signed and stamped this policy document to be effective as of the date stipulated in the Policy Schedule attached herewith.

Stamp and signature of the Insurance Company:

GENERAL SCOPE OF COVERAGE

Family of In-Hospital Benefits

1. Basic Benefit

This coverage shall apply in conformity with the Applicable Table of Benefits in the event of Non-Excluded Cases of Medical Conditions or Bodily Injuries requiring Hospitalization, and/or Day-Hospitalization and/or Emergency in hospital services.

Prior approval is required for all In-Hospital Benefits. In the case of Emergencies, this is waived, but approval must be sought within 24 hours of admission

The following medical costs incurred while in Hospital are covered by this Benefit:

- Room and board according to the Hospitalization Class as specified in the Table of Benefits
- Intensive care unit and coronary artery disease treatment
- Surgeon and anesthesiologist fees
- Hospital services (surgery, theatre, anesthesia, pharmacy, laboratory, radiology, etc.)
- Use of hospital medical equipment (e.g. heart and lung support systems, etc.)
- Intravenous infusions, injections, etc.
- Diagnostic and laboratory tests, x-rays, electrocardiograms, and scans etc. (only related to the original cause of covered Hospitalization).
- Various therapies including physiotherapy, chemotherapy, radiation therapy, etc.
- Physician and other specialist hospital consultations related to the original cause of covered Hospitalization.
- In-Patient Maternity services as specified in the Table of Benefits
- Recipient transplantation service
- Ambulance services, if Medically Necessary
- Companion Room & Board expenses for Beneficiary below 16 years of age
- The cost of accommodation of a person accompanying an in-patient in the same room in
- cases of medical necessity at the recommendation of the treating doctor and after the prior
- approval of the insurance company providing coverage
- Emergency Mental health treatments
- Repatriation costs for the transport of mortal remains to the country of origin shall be covered, as defined in the Table of Benefits, in the event of death of the Beneficiary following hospitalization for a non-excluded Bodily Injury or Sickness

Family of Out-of-Hospital Benefits

1. Physician Consultations

The coverage hereinafter defined is offered in conjunction with the Table of Benefits:

- Diagnostic Tests
- Pharmaceuticals
- Physiotherapy

In the event of Non-Excluded Cases of Medical Conditions or Bodily Injuries requiring Physician attendance, diagnostic tests and/or pharmaceuticals and/or physiotherapy, this Benefit represents the indemnifiable consultation fee, as specified in the Schedules. A follow-up consultation within 7 days of the first consultation relating to the same Medical condition by the same physician is free of charge.

2. Diagnostic Tests/Procedures

This coverage shall apply in conformity with the Table of Benefits in the event of Non-Excluded Cases requiring the conduction of Diagnostic Tests not requiring Hospital Confinement, as prescribed by a Physician and approved NEXtCARE as Medically Necessary. Prior approval is required for certain diagnostic tests/procedures. For free access, claims and approval requests will be initiated by the network provider to NEXtCARE.

This coverage includes services such as:

- Cardiovascular procedures, including
    - ECG
    - Cardiovascular stress test
    - ECG monitoring
    - Signal- averaged electrocardiograph (SAECG), excluding the costs of any device
    - Nuclear Scans
    - Angiography
- Medical imaging, including
    - X - Rays.
    - Echocardiography (including Doppler echocardiography)
    - CT Scan
    - MRI
- Laboratory
- Blood tests
- Biopsy

3. Pharmaceuticals

This coverage shall apply in conformity with the Applicable Scope of Coverage (Article 4) and as specified in the Schedule in the event of Non-Excluded Cases requiring pharmaceutical Treatment. Pharmaceutical Treatment comprises all drugs recognized by the UAE Ministry of Health as prescription drugs (allopathic only) and as approved by the NEXTCARE CALL CENTER as Medically Necessary.

Prior approval is required for certain prescriptions based on nature of medications and cost of the claim. Approval request will be initiated by the network pharmacies to NEXtCARE

4. Physiotherapy

This coverage shall apply as specified in the Table of Benefits. Physiotherapy sessions as prescribed by the attending Physician will be subject to a maximum number of sessions as specified in the Table of Benefits. Approval request will be initiated by the network provider to NEXtCARE

5. Preventive services, vaccines and immunizations

This coverage shall apply for elective treatments only as stated in the Table of Benefits; Vaccination covered as per MOH schedule and requires preauthorization. Further details is as per the Table of Benefits.

6. Mental Health / Psychiatric treatments

This coverage shall apply for emergency treatments only as stated in the Table of Benefits

7. Alternative Medicine Treatments

If selected, this coverage shall apply for treatments related to Osteopathy, Chiropractic, Homeopathy, Acupuncture, Ayurveda and Herbal Treatments only as stated in the Table of Benefits

8. Minor Procedures

This coverage shall apply for Minor Procedures carried out on an outpatient basis. All Minor Procedures require prior approval of NEXtCARE

Maternity Family of Benefits

This coverage shall apply in conformity with the General Terms and Conditions of this insurance policy and as specified in the Table of Benefits, in the event of Non-excluded cases relating to pregnancy and delivery.

Maternity Benefit – In-Hospital

This benefit provides coverage for all Hospitalization charges for delivery cases and/or any complications including non-delivery maternity-related cases that may arise before, during or after delivery up to the financial limits as specified in Table of Benefits and incurred within the territorial scope of cover.

Maternity Benefit – Out-of-hospital

This benefit is covered up to the financial limit as specified in the Table of Benefits.

This benefit provides coverage for the following Out-of-Hospital services for Pre-natal and Post-natal care:

- Physician Consultation
- Diagnostic Tests
- Pharmaceuticals

CLAIMS PROCEDURES AND SETTLEMENT

A Personalised Access Card has been issued in the name of each Beneficiary facilitating his/her access to any of NEXtCARE's participating Network Providers with no cash payment being required except when the
Beneficiary has a deductible excess or co-participation to settle. The Beneficiary is always requested to carry his/her NEXtCARE Access Card together with a proper Identification document to be presented to Providers whenever medical treatment is needed.

A Network Claim, as defined in this Policy, is the Eligible Expenses relating to Healthcare services rendered to the Beneficiary on a Free Access Basis arranged by NEXtCARE with the Network Provider on Direct Billing to the Insurer. This includes Healthcare services that are provided to the insured member within the Network either by the visiting and/or honorary and/or part-time and/or community physicians and/or healthcare providers; where the NEXtCARE contracted Network tariff shall apply.

A Direct Claim as defined in this Policy is the Eligible expense directly settled by the Beneficiary and submitted by the Policyholder to the Insurer for reimbursement. Eligible expenses are inclusive of co-insurance, if applicable.

Out of pocket limit is the maximum aggregate amount of eligible expense the beneficiary should bear during the policy year out of co-insurance options as per the Table of Benefits.

Second Opinion

Coverage of certain Treatment as Network Benefits may require that the Policy Holder/Insured Member consult a second Network Physician prior to the scheduling of the Treatment. The Insurer will notify Policy Holder/Insured Member that the particular Treatment can only be obtained subject to a Second Opinion and will inform the Policy Holder/Insured Member of the required procedure for obtaining a Second Opinion.

In case of a difference between the NEXtCARE physician acting as an independent administrator and the treating physician, concerning the qualification of a Treatment and/or service as medically necessary and/or appropriate, the Insurer and/or Policy Holder/Insured Member can call for the Second Opinion, results of which will be final and binding.

1 IN-HOSPITAL DIRECTIVES

1.1 Within selected Territory

1.1.1 Network Claims

 If the Beneficiary chooses to be admitted in a Network Provider, upon presentation of the NEXtCARE Access Card, the Network Provider will directly co-ordinate with the NEXtCARE CALL CENTER for authorisation.

 For non-emergency cases, the Beneficiary is requested to check with the Network Provider, prior to the scheduled In-Hospital, Day Hosp, or minor surgery/procedure, treatment/admission, if the Network Provider has received the authorisation from the NEXtCARE CALL CENTER. The Beneficiary may directly contact the NEXtCARE CALL CENTER to confirm authorisation.

 For emergency cases, upon receipt of the Hospital notification (NEXtCARE Pre-hospitalisation Form) from the Network Provider, the NEXtCARE CALL CENTER shall immediately issue the authorisation for the eligible In-Hospital treatment.

 Outside U.A.E. the Beneficiary is requested to contact NEXtCARE CALL CENTER at the numbers shown on his Access Card

 A NEXtCARE Medical and Claims Professional Staff will be receiving the call and shall provide specialised and necessary assistance for the Beneficiary's Hospitalisation and arrange for the eligible Hospitalisation expenses to be billed directly to the Insurer.

 Unlike in U.A.E. where the Beneficiary can directly approach a Local Network Provider, the International Network Providers require that each and every case be arranged by NEXtCARE prior to accepting a Beneficiary on free access basis / direct billing.

The Beneficiary / caller is requested to provide the following information:
1. His Name and NEXtCARE Access Card Number.
2. His Telephone and Fax, when available.
3. Name, Telephone and Fax, when available, of the treating Physician.
4. Name of the Network Provider.
5. Hospitalisation reasons.
6. Date and Time of Admission.
7. Other relevant information, which may be required.

 NEXtCARE shall fax to the treating doctor the NEXtCARE Pre-Hospitalisation Form, which must be completed by the Doctor and faxed back to NEXtCARE.

 Once NEXtCARE has received the medical information, a decision regarding the coverage of the Beneficiary's case shall be taken and the Beneficiary shall be informed accordingly.

 For approved cases, NEXtCARE shall issue a Visa Form and arranged with the Network Provider for the direct billing of eligible In-Hospital charges.

 For disapproved cases, NEXtCARE shall issue a Denial Form informing the Network Provider, the Beneficiary/Policyholder and the Insurer that the admission is rejected and not eligible for coverage.

 When applicable, the Beneficiary is requested to settle directly to the Network Provider and prior to discharge any co-participation, non-Eligible Expenses like charges for telephone calls, additional food and/or any amount exceeding the Policy financial limit.

1.1.2 Direct Claims

 Reimbursement of Direct Claims as specified in the Benefit Description attached to the group policy wording

 Reimbursement of Eligible Expenses shall be effected upon submission of the required claims documents, as specified in Required Claims Documentation.

1.2 Outside Selected Territory:

Claims outside territorial scope are not covered, except for Elective and Emergency treatment as specified under the Table of Benefits

2 OUT-OF-HOSPITAL DIRECTIVES:

2.1 Within U.A.E.

2.1.1 Network Claims

- Upon presentation of the NEXtCARE Access Card to a Network Provider, the Beneficiary shall benefit from free access for Eligible Expenses relating to Out-of-Hospital services prescribed by the treating Physician except for any deductible and/or copayment if applicable, which should be settled by the Beneficiary directly to the Provider.

- For non-excluded diagnostic tests ordered by the treating Physician, the Beneficiary, is entitled to have the tests conducted as per the laid down prior approval protocol of NEXtCARE with network providers and mentioned under Table of Benefits. Please note that the protocol is subject to change by NEXtCARE time to time based on regulatory and administrative requirements

- For non-excluded medicines prescribed by the treating Physician, the Beneficiary is entitled to get the required quantity of the prescribed drug/s considered Medically Necessary for the treatment of acute diseases usually for a period of five to twelve days. Prior approval requirement is as per the laid down prior approval protocol of NEXtCARE with network providers and mentioned under Table of Benefit. Please note that the protocol is subject to change by NEXtCARE time to time based on regulatory and administrative requirements

- For chronic disease related medicines, when covered, the Beneficiary is entitled to receive the required quantity of the prescribed drug/s as prescribed by the treating physician; however quantity and duration of the course decide the prior approval requirement. Prior approval requirement will be as per the laid down protocol NEXtCARE with network providers and mentioned under Table of Benefits. Please note that the protocol is subject to change by NEXtCARE time to time based on regulatory and administrative requirements. Based on the duration of the treatment Beneficiary/Network Provider shall be requested to submit to NEXtCARE a medical report issued by the treating Physician including relevant investigation results explaining the Beneficiary's health condition and its history as well as the recommended treatment plan

- NEXtCARE shall issue an approval through any suitable administrative method on a monthly, quarterly or until the expiry date of the Insurance Policy depending on the medical condition of the Beneficiary, which may require some modification on the dosage, frequency or the drug it self.

- For non-excluded cases the requiring Physiotherapy prescribed by the treating Physician (not physiotherapist), NEXtCARE pre-approval is required before the service can be rendered to the Beneficiary.

- For non-excluded Dental treatment prescribed by the treating Physician, NEXtCARE prior approval is required before the service can be rendered to the Beneficiary

2.1.2 Direct Claims

Upon submission of original medical report(s), bill(s) and receipt(s), a Beneficiary is entitled to 100% reimbursement (subject to applicable deductibles and/or copayments as specified in the Table of Benefits) of Eligible Expenses if:

a) A Network Provider has refused to provide free access to the Beneficiary.
b) Free Access to the Network was suspended and then reinstated after the date of treatment.

All services from a Non – Network provider will be reimbursed as specified under the Table of Benefits

2.1.3 Out-of-Hospital Claims outside U.A.E

As per the relevant Benefit Description

3. Pre-Approval for Diagnostic/Therapeutic Procedures

Prior–approval from NEXtCARE is required for the certain diagnostic/therapeutic in-patient and outpatient procedures as specified in the Table of Benefits

4. a) Required Claims Documentation for Direct Claims

For the settlement of Eligible Expenses, the Beneficiary should submit to the Insurer the following documents within a maximum period of (60) days for claims incurred within UAE and (90) days for claims incurred outside the UAE from date of occurrence:

- Completed “ Reimbursement form “ from treating doctor.
- Original itemised receipts of payment for the amount claimed (Invoice must shown cost per service)
- Full and Detailed Medical Report, Diagnosis, Discharge summary from the treating doctor or referral letter from treating physician wherever applicable
- Copies of results of diagnostic test.
- Valid Prescription by a physician for pharmacy related claims
- Police Report /First-hand information report in case of accident related claims.
- Valid Passport with Exit and Entry stamps to and from country of residence in case the claim is incurred outside country of residence.
- **All documents should be either in Arabic OR in English. If the reports/invoices are in any other languages must be translated prior to submission**.

Failure to submit any one of the above documents shall entitle the Insurer to reject the entire claim.

4 b) Resubmission period for in-completed reimbursement claims which are returned to the beneficiary:

For settlement of eligible expenses in case of resubmission of claims the beneficiary should submit to the Insurer the missing documents / information within a period of 30 days from the date of receipt of notification. Claim becomes time-barred for payment in future if resubmission is not within 30 days of receipt of notification

5. The insurer reserves the right to change and/or modify the Claims Procedures and Settlement at any time subject to (15) days’ notice to be given to the Policyholder by the Insurer.

GENERAL TERMS AND CONDITIONS

Article 1: THE POLICY

The Application and Medical Questionnaire(s), of the **Policyholder** and the **Insured** if any, the Preamble, the Policy Schedule, (including but not limited to the Accepted Census List, and the special Limitations and/or Exclusions, if any), the Definitions, the General Terms and Conditions, the various Applicable Healthcare Plans including their relative Scope of Healthcare Benefits covered along with their Limitations and Exclusions, as well as any attachment(s) and endorsement(s) to any of the aforementioned, shall constitute the entire agreement of the parties hereto (herein referred to as the Policy).

Article 2: GENERAL SCOPE OF BENEFITS

In return for the premium paid by the **Policyholder**, the **Insurance Company** shall cover all usual, customary and reasonable healthcare services and their related expenses incurred by the **Insured** under an **Applicable Healthcare Plan** while this Policy is in force, subject to its Terms, Conditions, Limitations and Exclusions.

Article 3: GENERAL LIMITATIONS

a. **Financial limitation**
A financial limitation per contractual period is applicable per **Insured**, as specified on the Policy Schedule.

b. **Hospitalization Class:**
The hospitalization class per contractual period corresponds to the class of hospitality (or room and board) to which the **Insured** is entitled for under his/her In-Hospital Plan, as identified in the Policy Schedule, except as otherwise specifically stipulated in the In-Hospital Plan details.

c. **Network of Healthcare Providers:**
The limited network of healthcare providers to which the **Insured** is entitled to get covered Healthcare Services from, as identified in the Policy Schedule.

d. **Age**
Insurance Coverage date is limited to the **Insured** aged between day 0 and 99 years inclusive. Age is computed based on nearest birth date.

e. **Territoriality**
The Insurance coverage applies to covered medical expenses incurred in the covered territory as specified above under Definition, “Nextcare Healthcare Providers”, subject to the Terms, Conditions, Limitations and Exclusions provided herein.

Article 4: PAYMENT OF CLAIMS

a. Direct Payment

As a standard procedure, The **Insurance Company** shall effect, through the **Administrator**, the payments of claims directly to the Participating Provider and not to the **Insured**, based on a prior Approval of Coverage, as defined hereinafter, and up to the limits authorized therein, except in the cases where the reimbursement procedure is applicable.

Approval of Coverage

The Approval of Coverage is a decision taken by the **Administrator**, to cover a healthcare service requested by the **Insured** as per the policy conditions, provided that the requested Healthcare services are within the scale of usual, customary and reasonable; this decision may also determine the conditions and extent of the approved coverage.

Procedures for Approval

The Administrator may, upon the evaluation of each case, grant or deny the Approval of Coverage based on the Terms, Conditions, Limitations and Exclusions of the Policy. This decision is relayed to the insured and/or the hospital.

The procedures for Approval of Coverage provided for hereinafter are only applicable when the following procedures are complied with by the **Insured** depending on the following applicable cases:

i. In the cases of non-emergency admission to a Participating Provider, whether requiring an overnight stay at the hospital or not, as defined in the Policy, the Approval of Coverage must be secured by the **Insured** directly prior to his/her benefiting from a covered healthcare service by submitting the duly completed **Claim Form** to the **Administrator.**

ii. In the cases of emergency admission to a Participating provider whereby the health status of the insured requires at least an overnight stay in the hospital, as defined in the Policy, Approval of Coverage must be requested by the **Insured** from the Administrator either directly or through the hospital immediately upon admission.

In the cases of admission to an emergency room at a participating Provider not requiring an overnight stay, the **Insured** must present his/her **Access card** and ID to the hospital awaiting the **Administrator's** decision.

b. Reimbursement

Reimbursement is not allowed under this Policy unless specified in the Policy Schedule. If reimbursement is allowed, Reimbursement is an exceptional procedure strictly applied in the exclusive cases specified in this **Policy.** Based on that exceptional procedure, the Insurance Company reimburses totally or partially the amount of the invoice paid by the insured as fees and expenses of Healthcare Services under this policy, in compliance with the reimbursement conditions and procedures applicable exclusively in the following cases:

i. In instances of emergency treatments (as defined in the Scope of In-Hospital Benefits) at a non-Participating Provider, provided that the insured or one of his family members notify the **Insurance Company** or the **Administrator** within a time period of 24 hours from admission.
ii. When the **Insured** has secured the prior approval of Coverage from the **Administrator**, to be given upon the latter's discretion based on justified reasons, for healthcare services to be delivered at a non-Participating Provider.
iii. When the Insured's objection to a previously declined Approval of Coverage at a Participating Provider has been validated by the Administrator.

In the above instances provided, the following is applicable when reimbursement is covered:

For Elective treatment:

- If treatment was received within UAE but outside the members network. Reimbursement of the claim will be at 80% of the members Network rates.

- If treatment was received within the area of coverage where no network is available, reimbursement of the claims will be at 80% of usual and customary rates in that country. If, however, the actual incurred costs are lower than the usual and customary rates in that country, then the reimbursement will be 80% of the incurred cost.

- If treatment was received outside the area of coverage, reimbursement will be At 80% of the network tariff of the area of coverage. If, however, the actual Incurred costs are lower than the usual and customary rates in the network of The area of the coverage, then the reimbursement will be 80% of the incurred Costs.

For Emergency treatment:

- If treatment was received within UAE but outside the members network. Reimbursement of the claim will be at 100% of actual cost.
- If treatment was received within the area of coverage where no network is available, reimbursement of the claims will be at 100% of actual cost
- If treatment was received outside the area of coverage, reimbursement will be at 100% of the UAE network tariff.

<u>When the members cannot benefit from Reimbursement as per policy terms</u>

For Elective treatment:

- If treatment was received within UAE but outside the members network claim will not be reimbursed
- If treatment was received within the area of coverage where no network is available, claim will not be reimbursed.
- If treatment was received Outside the area of coverage, claim will not be reimbursed

For Emergency treatment:

- If treatment was received within UAE but outside the members network. Reimbursement of the claim will be at 100% of actual cost.
- If treatment was received within the area of coverage where no network is available, reimbursement of the claims will be at 100% of actual cost
- If treatment was received outside the area of coverage, reimbursement will be at 80% of the UAE network tariff.

b. **Procedures of Reimbursement**

Within a period of 60 days from the date of the claim (being the date of the patient discharge from Hospital) incurred in UAE, or within 90 days from the date of claims incurred outside UAE, the insured must address a written request for reimbursement directly to the insurance company together with all the requested original supporting documents in English or in Arabic otherwise, the claims will be rejected. The requested documents are mainly the original detailed bill, the original receipt, the settlement of the invoice, and the medical discharge report. In addition to that, the Administrator may ask the Insured to disclose copies of his medical file, especially the medical records related to his reimbursement claim (e.g. medical reports, medical documents, and the examination results).

c. Expenses viable for Reimbursement

i. In the instances provided in the above mentioned sub-sections d (i), the reimbursement of the incurred fees and expenses is based on the preferential tariff applicable to the Insurance Company at an equivalent Participating provider.
ii. In the above instances provided for in sub-section d (ii), the reimbursement will be effected at a rate of 80% (eighty percent) only of the incurred fees and expenses that the insured paid at a non-Nextcare participating provider on the basis of the preferential tariffs applicable to the Insurance Company at an equivalent Nextcare participating provider in UAE, if the treatment is available in UAE at the time of the incurred expenses. **If the treatment is not available in UAE, the preferential tariffs will be calculated as average cost of the treatment at the equivalent providers in the covered territory.**
iii. In all the reimbursement cases, the total approved fees and expenses cannot exceed the financial limitation as identified in the Policy Schedule.
iv. The reimbursement of all claims will be effected in United Arab Emirates Dirhams (AED)

Article 5: WAIVER OF MEDICAL CONFIDENTIALITY

a) The policyholder, in his name and on behalf of the insured's, hereby authorizes the Insurance Company and/or the Administrator to access all their medical information and inspect its accuracy and completeness through all feasible means, particularly through participating and non-participating providers (e.g hospitals, physicians, laboratories…), other insurance companies and any other risk carrier.

b) The policyholder in his above stated capacity grants the Insurance Company, the Administrator, and any of their delegates, absolute, conclusive, and irrevocable authority to access their medical files and all the information included therein and receive copies thereof, waiving to that effect the medical confidentiality to their benefit, regarding all the medical files, whether related to current specific healthcare conditions or to past ones, as well as all the claims incurred during the validity period of the policy. The Administrator and/or the Insurance Company shall have the right to refer the Insured / Policyholder to any of the healthcare providers or pharmacies in this regard.

c) In this respect, the Insurance Company and/or the Administrator are entitled to request the examination of the policyholder and his subordinate persons/insured's, and to enquire about their past and actual state of health and its evolution and investigate the accuracy and completeness of the claims, without exception (e.g. review the medical and administrative files) whenever and as often as it may reasonably require prior to, during, and after the delivery of any healthcare service. The Insurance Company shall have the right to refer the patient to a specialist or medical committee of its choice to examine him and check the medical case under question.

d) The policyholder and the insured also hereby authorize the Administrator and its delegates to provide the attending physicians of the Policyholder / Insured, with the information available at their end about their state of health or about the approval or rejection decision of their medical coverage. Such information can be provided by any means chosen by the Administrator, either through email, SMS, or any other medium.

Article 6: PREMIUMS

a. Premiums are annual, payable by the **Policyholder** per the Terms and Conditions specified in the Policy Schedule. The policyholder is responsible for paying charges, levies, all taxes and stamp duties.

b. The payment of the premium in whole at the time of first application or renewal application does not bind the **Insurance Company** and does not constitute acceptance of the submitted application. The **Insurance Company**'s acceptance can only be affected by the formal initial quotation and premium settlement.

c. If the **Policyholder** fails to effect the payment of any due premium as indicated in the Policy Schedule, then the **Insurance Company** shall have the right to cancel the Policy from its inception or from its renewal date, as applicable, without any premium refund. In all cases, and until the payment is effected, the **Insurance Company** may freeze all benefits under the Policy and therefore may deny coverage of the **Insured** healthcare benefits.

Article 7: CONTRACTUAL PERIOD AND RENEWABILITY

a. The contractual period of this Policy is identified in the Policy Schedule, starting as of the effective date till the expiry date. No termination notice is required and no grace period allowed for.

b. None of the two parties in this policy is obliged to renew; however, both parties may agree to establish a new policy either with the same conditions or with different terms and preferences once the Insurance Company has studied the renewal application submitted by the policyholder. In this case, the Insurance Company shall have the discretionary power to decide whether to renew or not.

c. In the instance where the renewal application is rejected by the Insurance Company, the full amount of premium deposit will be refunded to the applicant.

d. The renewed Policy will enter into force and effect for a new contractual period as of the date appearing in the new Policy Schedule attached to the Renewal Application and under the Terms, Conditions, Limitations and Exclusions set therein or in the new Policy documents that may be issued (e.g. Policy Schedule, Scope of Benefits).

Article 8: CANCELLATION OF POLICY BY THE POLICYHOLDER

a. This Policy is subject to cancellation by the **Policyholder** upon the receipt by the **Insurance Company** of a written notice accompanied with the **membership card- if applicable.**

b. The **Policyholder** is only entitled to a premium refund computed on the Gross premium based on **pro-rata basis** applied by the **Insurance Company**.

Article 9: CANCELLATION OF POLICY BY THE INSURANCE COMPANY

The insurance company has the right to consider this policy cancelled without the need for recourse to the Judicial or Arbitral Authority in case of non-payment by the **Policyholder** of the premium due and in the case of false declaration.

Article 10: FALSE DECLARATION AND NON-DISCLOSURE

a. Any false declaration or non-disclosure made by the **Policyholder** or the **Insured** will render this Policy null and void from inception, without the need for a written notice, and without any premium refund.

b. Without prejudice to the rights of the **Insurance Company** to terminate the Policy or consider it null and, the **Insurance Company** may deny any benefit under the Policy in case of any false declaration or non- disclosure of a health condition by any of the **Insured** until the Policy is modified in order to exclude the health conditions and/or medical systems object of the false declaration or disclosure, which will thus constitute and be considered as a special exclusion to the Policy.

Article 11: ADDITION OF NEW INSURED

Addition

Applicable Rules

The Policyholder has the right to require from the Insurer, by completing and signing an Addition Form, accompanied with supporting documents, the addition of new Beneficiaries such as new employees, newly wedded spouse or new born children of an already enrolled employee on a compulsory basis.

Enrolment Date is:
The Eligibility Date is:

New Employee	-	The Official date of employment in accordance with the Policyholder internal rules.
New Spouse	-	The date of marriage
New-born child	-	Covered from Date of Birth.

If request for an addition is made within 14 days following the eligibility date of a beneficiary, his/her Enrolment Date will be such eligibility date. Otherwise, the Enrolment Date of a Beneficiary is the date on which the Insurer accepts such addition.

Supporting Documents

Submission by the Policyholder of supporting documents, relating to addition requests, which are satisfactory to the Insurer, is a pre-requisite for addition validation. Among the documents required are the Visa, Emirates ID, Passport copy, letter from HR (for married employee) etc.

Addition Date

The Addition Date of any approved addition is the day of intimation. There can be no back-dating of insured members.

Article 12: DELETION OF INSURED

Deletion

Applicable Rules

The Policyholder has the right to require from the Insurer, by completing and signing an Deletion Form, the deletion of Beneficiaries such as deceased or terminated employees and their Dependents.

Supporting Documents

Submission by the Policyholder of supporting documents, relating to deletion requests, which are satisfactory to the Insurer, is a pre-requisite for deletion validation. Among the documents required are the Membership Cards of the particular Beneficiaries.

Deletion Date.

The Deletion Date of any approved deletion is the day following the date of death or termination of the Employee provided request for deletion is made promptly and Membership Card returned to the Insurer. Otherwise, the Deletion Date is the date on which the Membership Cards is returned to the Insurer.

c. Refund of Premium

The **Policyholder** will be entitled to a premium refund for a deleted **Insured** (computed on pro-rata basis) provided that the latter did not benefit from the coverage of any medical claim during the last contractual period including any claim that is currently under reimbursement.

Article 13: REIMBURSEMENT OBLIGATION OF THE POLICYHOLDER

The **Policyholder** shall be liable to reimburse the Insurance Company all claim amounts paid by the latter in the following cases:

a. Any undue payment (e.g. deductible).
b. If the **Insurance Company** pays in excess of the limits of benefits provided in the **Policy**.
c. Abuse or misuse usage of the benefits provided for under the **Policy**.
d. Abuse or misuse usage of the **Access card**, or any other document delivered with the Policy document.
e. Breach of the provisions of the policy

Article 14: LOSS OF THE ACCESS CARD

In case of loss of the **Access card**, the **Insured** must immediately notify the **Insurance Company** in writing, failing which any expenses incurred based on the usage of the non-reported lost **Access card**, shall be borne by the **Policyholder**.

Article 15: NON-WAIVER OF RIGHTS

Without prejudice to the rights of the **Insurance Company** under common Law or under the Policy (particularly, provisions of Articles 1 (b) and 14), any coverage granted by the **Insurance Company,** in some instances, to the **Insured** beyond or contrary to what is strictly provided for herein in terms of Scope of Coverage, Exclusions, Limitations or procedures may neither be interpreted as an implied waiver of the latter, nor constitute an acquired right for the **Policyholder** or the **Insured**.

Article 16: SUBROGATION

Once the Insurance claim has been paid in accordance with the current terms, the Policyholder and Beneficiary subrogates his/her right to the Insurer to pursue any third responsible for any Bodily Injury and transfer to the Insurer every relevant substantial and legal right. Both the Policyholder and the beneficiary shall provide the Insurer with every possible assistance should the Insurer exercise the above right of subrogation. Should the Policyholder and the Beneficiary breach this obligation, they shall be responsible for any losses incurred by the Insurer.

Article 17: NOTICES

All notices and notifications must be sent by registered mail, telegram or Courier Service; they are considered valid and lawful if sent to the addresses of the parties hereto appearing in the Policy Preamble, Policy Schedule, or in the **Policyholder's Application**. Any change of address is ineffective, unless notified in writing to the other party.

Article 18: HEADINGS

The headings contained in the Policy are for convenience of reference only and are not intended to define, limit or describe the scope and intent of any of its provisions.

Article 19: LEGAL RECOURSE

All disputes relating to the implementation, interpretation or cancellation of this **Policy** between the parties hereto (i.e. **Insurance Company** and **Policyholder**) shall be resolved by the competent courts in UAE according to the applicable law.

ARBITRATION

Medically Necessary Procedure
In case of a difference between the Insurance company's appointed doctor, acting as an independent administrator, and the attending Physician concerning the qualification of a service or Treatment as Medically Necessary, the parties can call for the arbitration of a Medical Committee, which will take the final decision. The Medical Committee shall be composed of three members – the attending Physician, the Insurance company's appointed Doctor and a third independent Physician agreed upon by the first two.

The committee will meet in neutral territory, and its decision will be taken by majority vote. This decision will be reported in duplicate documents, one for each party, and must be signed by all the Physicians. If any of the Physicians refuses to sign the documents, this refusal should be reported in the documents. The Insurer undertakes to accept the decision of this Medical Committee.

General Differences

All differences relating to claim amount arising out of this Insurance Policy shall be referred to the decision of an arbitrator to be appointed in writing by the parties. If the parties cannot agree upon a single arbitrator, then two arbitrators should refer the matter for review, one to be appointed in writing by each of the parties. Should the two arbitrators fail to agree then the arbitrators should appoint and independent umpire in writing. The umpire shall sit with the arbitrators and preside at their meetings and the making of an award shall be a condition precedent to any right of action against the Insurer.

If the Insurer disclaims liability to the Beneficiary, his/her legal personal representatives or any claimant, for any claim hereunder, and such claim is not within 12 calendar months from the date of such disclaimer referred to arbitration under the provisions herein contained, then the claim shall be deemed for all purposes to have been abandoned and shall thereafter not be recoverable hereunder.

GENERAL EXCLUSIONS

This Insurance Policy is intended to provide cover for expenses incurred for Medical Treatment of Medical Conditions or Bodily Injuries which, in the opinion of both the treating physician and the MCC doctor, are Medically Necessary and which are covered under the Terms and Conditions of the Insurance Policy.

Eligible exclusion list is referred to table of benefit attached herewith.

This Insurance Policy does not cover, amongst other things, expenses arising directly or indirectly from the following:

Exclusion for Health Authority Abu Dhabi HAAD
(Applicable for residents/ work permits within Abu Dhabi & Al Ain)

1. Healthcare Services, which are not medically necessary
2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.
3. Domiciliary care; private nursing care; care for the sake of travelling.
4. Custodial care includes Non- Medical treatment services; or Health- related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
5. Services which do not require continuous administration by specialized medical personnel.
6. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies).
7. Healthcare Services and associated expenses for replacement of an existing breast implant. Cosmetic operations which improve physical appearance and which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Breast reconstruction following a mastectomy for cancer is covered.
8. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
9. Medically non-approved experimental, research, investigational healthcare services, treatments, devices and pharmacological regimens.
10. Healthcare Services that are not performed by Authorized Healthcare Service Providers, apart from Healthcare Services rendered in a Medical Emergency.
11. Healthcare services, treatments & associated expenses for alopecia, baldness, hair falling, dandruff or wigs.
12. Supplies, Treatment and services for smoking cessation programs and the treatment of nicotine addiction.
13. Non-medically necessary Amniocentesis
14. Treatment, services and surgeries for sex transformation, sterility and sterilization

15. Treatment and services for contraception
16. Treatment and services related to fertility / sterility (treatment including varicocele / polycystic ovary / ovarian cyst / hormonal disturbances / sexual dysfunction).
17. Prosthetic devices and consumed medical equipment, unless approved by the insurance company
18. Treatments and services arising as a result of hazardous activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities
19. Growth hormone therapy.
20. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.
21. Mental Health diseases, in-patient and out-patient treatments, unless the condition is a transient mental disorder or an acute reaction to stress.
22. Patient treatment supplies (including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments, excluding such supplies required as a result of Healthcare Services rendered during a Medical Emergency).
23. Preventive services, including vaccinations, immunizations, allergy testing and desensitization; any physical, psychiatric or psychological examinations or testing during these examinations.
24. Services rendered by any medical provider relevant of a patient for example the Insured person and the Insured member’s family, including spouse, brother, sister, parent or child.
25. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during treatment.
26. Healthcare services for adjustment of spinal subluxation, diagnosis and treatment by manipulation of the skeletal structure, by any means, except treatment of fractures and dislocations of the extremities.
27. Healthcare services and treatments) by acupuncture; acupressure, hypnotism, rolfing, massage therapy, aromatherapy, homeopathic treatments, and all forms of treatment by alternative medicine.
28. All Healthcare services & Treatments for in-vitro fertilization (IVF), embryo transport; ovum and male sperms transport
29. Elective diagnostic services and medical treatment for correction of vision
30. Nasal septum deviation and nasal concha resection.
31. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related test/treatment or procedure.
32. Treatments and services related to viral hepatitis and associated complications, except for treatment and services related to Hepatitis A.
33. Birth defects, Congenital diseases for newborn &/or Deformities unless life-threatening.

34. Healthcare services for Senile dementia and Alzheimer's disease
35. Air or Terrestrial Medical evacuation except for Emergency cases or unauthorized transportation services.
36. Circumcision healthcare services.
37. Inpatient treatment received without prior approval from the insurance company including cases of Medical Emergency which were not notified within 24 hours from the date of admission.
38. Any inpatient treatment, tests and other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health
39. Any test or treatment, for purpose other than medical such as tests related for employment, travel, licensing or insurance purposes.
40. All supplies which are not considered as medical treatments including but not limited to: mouthwash, toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions) and all equipment not primarily intended to improve a medical condition or injury, including but not limited to air conditioners or air purifying systems, arch supports, convenience items / options, exercise equipment and sanitary supplies.
41. More than one consultation or follow up with a medical specialist in a single day unless referred by a physician.
42. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or recipient.
43. Services and educational program for handicaps.
44. Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.
45. Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type
46. Healthcare services for injuries and accidents arising from nuclear or chemical contamination.
47. Injuries resulting from natural disasters (including but not limited to) earthquakes, tornados and any other type of natural disaster.
48. Injuries resulting from criminal acts or resisting authority by the Insured Person.
49. Healthcare services for patients suffering from AIDS and its complications.
50. Healthcare services for work illnesses and injuries as per Federal Law No. 8 of 1980 concerning the Regulation of Work Relations, as amended, and applicable laws in this respect.
51. All cases resulting from the use of alcohol, drugs and hallucinatory substances.
52. Any test or treatment not prescribed by a doctor.
53. Injuries resulting from attempted suicide or self-inflicted injuries.
54. Diagnosis and treatment services for complications of exempted illnesses.
55. All healthcare services for internationally and locally recognized epidemics.
56. Venereal sexually transmitted diseases.

Exclusion for Dubai Health Authority (DHA), Northern Emirates & Outside UAE

1. Healthcare Services which are not medically necessary
2. All expenses relating dental treatment, dental prostheses, and orthodontic treatments except Emergency cases (Elective treatments will be covered only if the "Dental Benefit" is chosen and fully as specified in the table of benefit)
3. Home nursing; private nursing care; care for the sake of travelling.
4. Custodial care including
5. Non-medical treatment services;
6. Health-related services which do not seek to improve or which do not result in a change in the medical condition of the patient.
7. Services which do not require continuous administration by specialized medical personnel.
8. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies)
9. All cosmetic healthcare services and services associated with replacement of an existing breast implant. Cosmetic operations which are related to an Injury, sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body and breast reconstruction following a mastectomy for cancer are covered.
10. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
11. Medical services utilized for the sake of research, medically non-approved experiments and investigations and pharmacological weight reduction regimens.
12. Healthcare Services that are not performed by Authorized Healthcare Service Providers.
13. Healthcare services and associated expenses for the treatment of alopecia, baldness, hair falling, dandruff or wigs.
14. Health services and supplies for smoking cessation programs and the treatment of nicotine addiction.
15. Any investigations, tests or procedures carried out with the intention of ruling out any foetal anomaly.
16. Treatment and services for contraception
17. Treatment and services for sex transformation, sterilization or intended to correct a state of sterility or infertility or sexual dysfunction. Sterilization is allowed only if medically indicated and if allowed under the Law.
18. External prosthetic devices and medical equipment.

19. Treatments and services arising as a result of hazardous activities, including but not limited to, any form of aerial flight, any kind of power-vehicle race, water sports, horse riding activities, mountaineering activities, violent sports such as judo, boxing, and wrestling, bungee jumping and any professional sports activities.
20. Growth hormone therapy.
21. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.
22. Mental Health diseases, both out-patient and in-patient treatments, unless it is an emergency condition.
23. Patient treatment supplies (including for example: elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-prescription drugs and treatments, excluding supplies required as a result of Healthcare Services rendered during a Medical Emergency.
24. Allergy testing and desensitization (except testing for allergy towards medications and supplies used in treatment); any physical, psychiatric or psychological examinations or investigations during these examinations.
25. Services rendered by any medical provider who is a relative of the patient for example the Insured person himself or first degree relatives.
26. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during in-patient treatment.
27. Healthcare services for adjustment of spinal subluxation.
28. Healthcare services and treatments by acupuncture; acupressure, hypnotism, massage therapy, aromatherapy, ozone therapy, homeopathic treatments, and all forms of treatment by alternative medicine. (Elective treatments will be covered only if the "Alternative Medicine benefit" is chosen and fully as specified in the table of benefit)
29. All healthcare services & treatments for in-vitro fertilization (IVF), embryo transfer; ovum and sperms transfer.
30. Elective diagnostic services and medical treatment for correction of vision.
31. Nasal septum deviation and nasal concha resection.
32. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related investigations, treatments or procedures.
33. Healthcare services, investigations and treatments related to viral hepatitis and associated complications, except for the treatment and services related to Hepatitis A.
34. Birth defects, congenital* or hereditary conditions including but not limited to neurological diseases,

attention deficit disorder, development delay and learning difficulties This exclusion is waived for eligible new born children or newly adopted children whose respective date of birth or date of official adoption, falls after the effective date of the initial Policy, only in respect of the following cases which can be corrected by surgery: Hernia, Thyroglossal cyst, Pyloric stenosis, Urinary reflux, Gastro-esophageal reflux, Epispadias, Hypospadias, Bladder extrophy and extrophy of lower abdomen, Posterior uretheral valves, Megaureter, Hydronephrosis and U-P junction, Diaphragmatic hernia, Esophageal atresia, Omphalocele, Euodenal atresia, Intestinal atresia, Congenital

35. Healthcare services for senile dementia and Alzheimer’s disease.
36. Air or terrestrial medical evacuation and unauthorized transportation services.
37. Inpatient treatment received without prior approval from the insurance company including cases of medical emergency which were not notified within 24 hours from the date of admission
38. Any inpatient treatment, investigations or other procedures, which can be carried out on outpatient basis without jeopardizing the insured Person's health
39. Any investigations or health services conducted for non-medical purposes such as investigations related to employment, travel, licensing or insurance purposes.
40. All supplies which are not considered as medical treatments including but not limited to: mouthwash,toothpaste, lozenges, antiseptics, milk formulas, food supplements, skin care products, shampoos and multivitamins (unless prescribed as replacement therapy for known vitamin deficiency conditions); and all equipment not primarily intended to improve a medical condition or injury, including but not limited to: air conditioners or air purifying systems, arch supports, exercise equipment and sanitary supplies.
41. More than one consultation or follow up with a medical specialist in a single day unless referred by the treating physician.
42. Health services and associated expenses for organ and tissue transplants related to a donor only. This exclusion also applies to follow-up treatments and complications.
43. Any expenses related to immunomodulators and immunotherapy.
44. Any expenses related to the treatment of sleep related disorders.
45. Services and educational programs for handicaps.
46. Injuries or illnesses suffered by the Insured Person as a result of military operations of whatever type.
47. Injuries or illnesses suffered by the Insured Person as a result of wars or acts of terror of whatever type.
48. Healthcare services for injuries and accidents arising from nuclear or chemical contamination.

49. Injuries resulting from natural disasters, including but not limited to: earthquakes, tornados and any other type of natural disaster.

50. Injuries resulting from criminal acts or resisting authority by the Insured Person.
51. All cases resulting from the use of alcoholic drinks, controlled substances and drugs and hallucinating substances.
52. Any investigation or treatment not prescribed by a doctor.
53. Injuries resulting from attempted suicide or self-inflicted injuries.
54. Diagnosis and treatment services for complications of exempted illnesses.
55. All healthcare services for internationally and/or locally recognized epidemics.
56. Healthcare services for patients suffering from (and related to the diagnosis and treatment of) HIV – AIDS and its complications.

WAITING PERIODS

Waiting period on Chronic and Preexisting conditions will be applicable as mentioned in the Table of Benefits

DEFINITIONS:

Words, terms, expressions and abbreviations used in the context of this Insurance Policy for Better Healthcare shall have the meaning(s) set forth here below:

Accident:
A sudden, unplanned and unexpected external event not under control of the Insured Person that results involuntarily in bodily injury occurring whilst the Policy is in force.

Acute:
A Medical Condition which is brief, has a definite end point and which the Company, on Advice or General Advice determine responds to and can be cured by Treatment.

Advice:
Any consultation from a Medical Practitioner or Specialist including the issue of any prescriptions or repeat prescriptions.

Appliances:
Devices and equipment when used as an integral part of a medical procedure administered by a Medical Practitioner or Specialist.

Benefits:
The insurance coverage provided by this Policy and any extensions or restrictions shown in the Policy Schedule or in any endorsements (if applicable).

Cancellation:
It is termination of the policy subject to receiving a written request from the policyholder or a no-objection letter (NOC) - for the insured to have the authority to cancel the policy-and submission of physical card (if applicable). The policy holder is entitled for a refund.

Cancellation and refund based on policy terms and conditions:

Pro-rata cancellation:

The cancellation of an insurance policy with the return of unearned premium credit being the full proportion of premium for the unexpired term of the policy, without penalty for interim cancellation and calculated at minimum of a monthly basis.

In case of visa cancelation; Refund will be calculated considering the one-month grace period provided that cancellation proof is submitted with the request.

Cancellation date will be considered once all requested documents are provided

Call Center:
Professional services Center operating 24 hours, all year around, staffed with a team of Medical and Claims administrative specialists working for MedNet to support and monitor the proper application of the Insurance Policy. The MCC provides Beneficiaries and Providers with medical and claims and membership eligibility, carries out pre-approval reviews, provides appropriate authorizations, takes decision in the name and in behalf of the Insurer as to whether or not grant Free Access to the specific healthcare services under consideration and evaluates submitted claims in order to approve payment.

CHC (Certificate of Health Cover):
Provided once the policy is purchased and issued online.

- Validity of the certificate is 3o days
- Declares the policy number
- Mention policyholder and insured name
- Confirms inception and expiry dates of the policy.
- Confirms premium paid

Chronic Condition:
A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:—
• it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
• It needs ongoing or long-term control or relief of symptoms
• It may require rehabilitation or the patient to be trained to cope with it.
• It continues indefinitely
• It comes back or is likely to come back.

Co-insurance:
The percentage of the total value of the incurred expenses for which the Policyholder is responsible.

Commencement Date:
The date shown on the CHC on which cover under this Policy commences. For the purpose of this Policy the time of the start of cover will be 00:01am on the date shown on the CHC.

Congenital Anomaly:
A condition existing at or from birth which is a significant deviation from the common form or normal and for the purposes of this Policy will include both visible and hidden structural body deviations as well as chromosomal abnormalities.

Country of Nationality:
For the purpose of this Policy this will be the country for which the Insured Person holds a passport.

Country of Residence:
The country in which Insured Members has his/her habitual residence (residing for a period of not less than six months per Period of Cover) at the time this Policy is first taken out or at each subsequent Renewal Date.

Day-Patient:
Same day surgery, treatment or investigations not requiring an overnight stay at the Hospital but, nevertheless, necessitating specialized medical attention and care in a Hospital before, during and after the surgery, treatment or investigation, but do not medically necessitate an overnight stay in a Hospital.

Dental Practitioner:
A person who is licensed by the relevant licensing authority to practice dentistry in the country where the dental Treatment is given.

Drugs and Dressings:
Drugs, medicines and dressings prescribed by a Medical Practitioner or Specialist.

Dependents:
A spouse or adult partner and/ or unmarried children who are not more than 18 years old and residing with the Policyholder, or 23 years old if in full-time education or un-married at the date of joining or at any annual Renewal Date.

E-application:
Form filled online via orient website where all information is provided by the policy holder, requested documents uploaded, confirmation of approval to the policy terms and conditions and premium paid.

Emergency:
A situation or condition placing the Policyholder in an immediate life-threatening situation.

Evacuation:
Costs incurred in moving an Insured Person from the place of incident to the nearest appropriate medical facility, as determined by the attending Medical Practitioner or Specialist in conjunction with the Third Party Administrator.

Excess:
The amount payable by an Insured Person in respect of expenses incurred before any Benefits are paid under the Policy.

Free Access:
The medical providers where Insured Members are able to obtain medical Treatment for valid Medical Conditions and where the expenses will be settled directly by the Company. Insured Members are still responsible for any Co-insurance or Excess applicable to the Policy which must be settled directly to the medical providers at the time of treatment.

Please Note: - Where an Insured Member receives Treatment for a Medical Condition that is not covered within the terms of the Policy, Policyholder remain liable for the costs of such Treatment, which must be settled in full upon request.

Pre-existing Condition:
Any illness, sickness, disease or other physical, medical, mental or other condition, disorder or ailment where, in the opinion of a medical practitioner appointed by the Insurer, signs or symptoms of the condition existed at any time in the period prior to the Insured Member becoming insured under the Policy. The test applied relies upon signs or symptoms of the condition being present and not on an eventual diagnosis. It is not necessary for the Insured Member or his doctor to know what their condition is or was at the time of taking out the policy. In forming an opinion, the Insurer appointed medical practitioner who makes the decision must take into account information provided by the Insured Member's treating doctor.

General Advice:
Advice from the relevant professional body as to establish medical practice and/ or the established medical opinion in relation to any Medical Condition or Treatment

Geographic Area:
The Geographic Area which will apply to the Policyholder will be shown in the table of benefits.

Hereditary:
Transmitted from parents to offspring

Hospital:
An establishment which is legally licensed as a medical or surgical Hospital under the laws of the country in which it is situated.

Hotline Assistance:

Professional service center operating 24 hours, all year round, staffed with a team of Medical and Claims administrative specialists to support and monitor the proper application of the Insurance Policy. The claims centre team at TPA provides Beneficiaries and Providers with medical and procedural guidance and information through telephone inquiries; advises claims and membership eligibility; carries out pre-approval reviews; provides appropriate authorisations; takes decision in the name and on behalf of ORIENT Insurance PJSC as to whether or not grant Free Access to the specific healthcare service under consideration and evaluates submitted claims in order to approve payment.

In-patient:
An Insured Person who stays in a Hospital bed and is admitted for one or more nights solely to receive Treatment.

Insured Person:
Individual person stated by the policyholder when purchasing the policy and is eligible for all policy terms and conditions.

Maternity:
Hospital Confinement for Normal or Caesarean Delivery, Medically Necessary abortion or miscarriage and/ or any complications arising therefrom, ante – and post- natal treatment as Medically Necessary.

Medical Condition:
Any injury, illness or disease

Medical Practitioner:
A person who has attained primary degrees in medicine or surgery by attending a Medical School recognised by the World Health Organisation and who is licensed by the relevant authority to practice medicine in the country where the Treatment is given.

Medically Necessary:
A medical service or Treatment which in the opinion of a qualified Medical Practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the Insured person’s condition or the quality of medical care rendered.

Network:

Providers forming the MedNet Network (s) through a special and formal contractual arrangement whereby they agree to avail the Beneficiary, usually on his Access Card presentation, with Free Access in a direct billing basis to their healthcare services in conformity with the terms of this Insurance Policy and as set forth in the Policy Schedule and in the Beneficiary User’s Guide.

Non Excluded Cases:
Any specific illness or Treatment that is covered, and not listed under the General Exclusion.

Non Network Provider:
Any Providers that are not part of the Network.

Out of Hospital:
Physician’s consultation, prescribed drugs, diagnostic tests and Treatment not requiring Hospitalization nor necessitating specialized medical attention and care in a Hospital before, during and after the procedure.
Out of Pocket limit:

Out of pocket limit is the maximum aggregate amount of eligible expense the beneficiary should bear during the policy year out of co-insurance options.
Partnership Schedule:
In which additional information is specified (Priority Payer details if any, Co-payer percentages, etc.).

Physician:
Any doctor of medicine (MD) duly licensed and qualified to render the Treatment provided under the law of jurisdiction in which such Treatment is provided.

Plan:
The combination of Benefit offered by the Insurer and selected by the Policyholder on the Application Form.

Policyholder:
Initially the applicant for this Insurance Policy for Better Healthcare acting in the name and on behalf of, his Employees and their Legal Dependents whose Application has been formally accepted by the Insurer.
By virtue of acceptance, this Insurance policy has been issued and the applicant becomes the Policyholder.

Policy Schedule:
In which all Beneficiary and the insurer information are specified, together with the specific conditions of this Insurance Policy (the Contractual Parties, Data, the Effective Date, the Expiry Date, the Benefits Date, the Enrolment Dates, the Category, the Specific Exclusion and related waiting periods if any, the life time limits when applicable, the hospitalization class, the selected plan, the Premium, the frequency of Payment and any reference(s) to other schedule(s).

Pre-existing Condition:
Any illness, sickness, disease or other physical, medical, mental or other condition, disorder or ailment where, in the opinion of a medical practitioner appointed by the insurer, signs or symptoms of the condition existed at any time in the period prior to the insured Member becoming insured under the Policy. The test applies relies upon signs or symptoms of the condition being present and not on an eventual diagnosis. It is not necessary for the Insured Member or his doctor to know what their condition is or was at the time of taking out policy. In forming an opinion, the Insurer appointed medical practitioner who makes the decision must take into account information provided by the Insured Member's treating doctor.

Premium:
The periodic payment required for providing coverage and to keep Insurer policy in force.

Priority Payer:
An entity identified under the partnership Schedule as being the first party fully liable towards the Eligible Expenses of a specific Beneficiary up to a certain limit, which is specific under the Partnership Schedule. The Insurer shall be liable to pay any amount of any Eligible Expenses exceeding this limit.

Program:
The combination of Plans offered by the Insurer and selected by the Policyholder on the application Form.
Proof of Insurability:
The process of completing an Application Form and submitting it to the Insurer for Underwriting.

Providers:
A generic term for Physicians, Hospital, Clinics, Medical Centers, Pharmacies, Laboratories, Physiotherapy Centers and other Paramedical Institution or Persons who are licensed to offer healthcare services.

Renewal:
New coverage under a new Insurance Policy following a previous team and the acceptance of the Premium for a new Insurance Policy insurance periods.

Renewal Date:
The day (at 12:00 Midnight local time) month and year on which a Renewal takes place and which coincides with Expiry date.

Schedule:
Technical addenda forming an integral part of this Insurance policy which further define the details of this Insurance Policy. The Policy Schedule, the Scope of Coverage Schedule and the Table of Benefits (where applicable).
Scope of Coverage Schedule:
In which the Plan\Program selected by the Policyholder on behalf of the Beneficiaries is specified showing for each Family of Benefits Coverage, Limit, Deductible Excess, Co-Participation, etc. May sometime also be referred to as the Table of Benefits.

Second Opinion:
Second opinion is an opinion obtain from an additional health care professional of to the same clinical standing and specialty. This opinion maybe either prior to or after the performance of a medical treatment or surgical procedure, whereby it will then confirm the diagnosis, medical necessity and/or appropriateness of the Treatment given.

Sickness:
See disease.

Specific Deductible Excess:
The amount of money stated in the Applicable Scope of Coverage Schedule to be borne by the Policyholder in respect of the particular service under consideration.

Substandard Terms:
Special terms under which a Beneficiary is covered under this Insurance Policy (i.e. Additional Premium and/or special limits and/or Waiting Period) as a result of an Underwriting.

Surgery:
Any invasive procedure, including laser use, whose aim is to diagnose/cure disease or damage and/or rectify a defect or malformation. In this connection, invasive diagnostic procedures such as endoscopy, cauterization (with the exception of rhino gastric, urethral, peripheral venous and/or arterial), angiography as well as destruction of kidney or gallstones will be considered as Surgery.
Table of Benefits:
Describes the scope of cover and modalities of claims payment and is part of the contract.

Territory:
The country (or group of countries) as selected by the Policyholder to allow Beneficiaries to access Benefits defined in the Table of Benefits.
Territory of Occurrence:
The country where Beneficiary's health condition has required healthcare services and where the related expenses were incurred.

Treatment:
A generic term to include all healthcare services provided under this Insurance Policy, including In-Hospital Treatment and Out-of-Hospital Treatment and embracing all In-Patient services, Out-Patient Consultations, Diagnostic Tests and Procedures, prescription of medicines, minor surgery and procedures, physiotherapy, dental care etc.

Undeclared Pre-Existing Condition:
The non-disclosure or error by the Beneficiary and/or from the Policyholder acting on behalf of the Beneficiaries, in completing any part of the Application for this Insurance Policy of Pre- Existing Condition relating to health, (symptoms, diagnosis condition), or any other details (explicitly or implicitly).

Underwriting:
The process of evolution to which the Insurer submits all Application forms prior to issuance of the Insurance policy and any other subsequent related Endorsement in full conformity with the provision of this Insurance Policy.

Unnecessary Treatment:
A service or Treatment, which is not Medically Necessary.

Visa Form:
The form issued by the MCC, for the attention of the Insurer, Policyholder and the Network Provider, confirming eligibility of the Beneficiary and guaranteeing the direct billing issued by the Network Provider to the Insurance according to the Applicable Scope of Coverage, upon which Free Access in granted.

Waiting period:
The period of time starting from the first Enrolment Date of the Beneficiary during which an Exclusion is in force under a specific covered under this Insurance Policy.

Waiver Date:
The date of termination of the Waiting period after which an Exclusion is deleted.