orient اورينت

Paid Up Capital: Dhs. 500,000,000

Registered under Federal Law No. (6) of 2007
Certificate No. 14 dated 29th December 1984
Commercial Registration 51814

رأس المال المدفوع: ٥٠٠،٠٠٠،٠٠٠ درهم
مسجلة طبقاً للقانون الإتحادي رقم (٦) لسنة ٢٠٠٧م
شهادة رقم ١٤ بتاريخ ١٩٨٤/١٢/٢٩م
رقم السجل التجاري ٥١٨١٤

Policy wording
Northern Emirates online Plan
NEMed,NEMED-*Lite &NEMED-Basic*

SECTION - A

PREAMBLE:

This document is intended to describe the basic purpose of the Insurance Policy and includes a description of the General Scope of Coverage, a list of General Exclusions, details of the General Terms and Conditions and some Definitions of the most commonly used words or phrases.

The overall purpose of this Insurance Policy is to provide cover to eligible Beneficiaries (Northern Emirates Visa holders) for reasonable and customary expenses incurred through the Medically Necessary Treatment of Medical Conditions and Bodily Injuries under the terms and conditions of this Insurance Policy as agreed with the Policyholder. The Insurance Policy will be governed by applicable Federal law of the United Arab Emirates.

In consideration of the payment or agreement to pay the Premium, and on the basis of the request and statements made by the Policyholder on the initial e-Application Form, and subject to the terms and conditions of this Insurance Policy for Better Healthcare and any attachment forming part of it, , the Insurer agrees with the Policyholder and guarantees to provide the Benefits and Services and their related expenses incurred by each beneficiary as set out in this Insurance Policy.

Acceptance and use of the Emirates ID automatically implies acceptance of all the terms, conditions, limitations and exclusions of this Policy.

Orient Insurance PJSC orient P.O.Box 27966, Dubai, UAE

The Insurer | The Policyholder

Note: Throughout this Insurance Policy, the masculine gender shall be deemed to include the feminine, the singular to include the plural and the plural the singular

******This Policy Document is a standard document. To know the benefits applicable on your policy, please refer to the Table of Benefits specific to your policy******

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SECTION - B

GENERAL SCOPE OF COVERAGE:

Family of In-Hospital Benefits:

Basic Benefit:

This coverage shall apply in conformity with the Applicable Scope of Coverage Schedule, (Article 4) and as specified in the table of benefits, in the event of Non- Excluded Cases of Medical Conditions or Bodily Injuries requiring Hospitalisation, and/or Day-Hospitalisation 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 Hospitalisation Class as specified in the Schedule
- Intensive care unit and coronary artery disease treatment
- Surgeon and anaesthesiologist fees
- Hospital services (surgery, theatre, anaesthesia, 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 Hospitalisation).
- Various therapies including physiotherapy, chemotherapy, radiation therapy, etc.
- Physician and other specialist hospital consultations related to the original cause of covered Hospitalisation.
- In-Patient Maternity services as laid out in the Table of Benefit
- 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

Family of Out-of-Hospital Benefits:

Basic healthcare services: Out-patient in authorized out-patient clinics and health centres only within the designated Network list mentioned in the Table of benefits for each plan.

Referral procedure:

No treatment may be provided by specialists or consultants without the insured first consulting a General Practitioner another competent UAE authority. The GP must make his referral together with reasons.

1. Physician Consultations:

   This coverage in conjunction with the Benefits hereinafter defined:

   - 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 Applicable Scope of Coverage, (Article 4) in the event of Non-Excluded Cases requiring the conduction of Diagnostic Tests not requiring Hospital Confinement, as prescribed by a Physician and approved by the TPA as Medically Necessary. Prior approval is required for certain diagnostic tests/procedures.

   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 restricted to a list of formulary products to be published by DHA and/ or specified in the Table of Benefit and as approved by the TPA as Medically Necessary. Prior approval is required as laid down in the Table of Benefit

4. Physiotherapy:
   This coverage shall apply as specified in the Schedules in the event of Non-Excluded Cases requiring physiotherapy treatment as prescribed by the attending Physician (maximum of 6 sessions per policy). Prior approval is required for physiotherapy Treatment, which must be prescribed by the treating physician.

5. Minor Procedures:

   This coverage shall apply for Minor Procedures carried out on an outpatient basis. Prior approval is required as laid down in the Table of Benefit.

Maternity Family of Benefits:

This coverage shall apply in conformity with Article 4 of the General Terms and Conditions of this insurance policy and as specified in the Table of Benefit, in the event of Non-excluded cases relating to pregnancy and delivery.

Maternity Benefit – In-Hospital:

This benefit provides coverage for all Hospitalisation charges for delivery cases /or any complications including non-delivery maternity-related cases that may arise before, during or after delivery according to the applicable table of benefit incurred within the territorial scope of cover.
Complications and life-threatening cases are covered up to the In-Patient General Annual Limit

Maternity Benefit – Out-of-hospital:

This benefit provides coverage for the following Out-of-Hospital services for Pre-natal and Post-natal care and is subject to Prior-Approval:

- Physician Consultation
- Diagnostic Tests
- Pharmaceuticals

It includes ante-natal services restricted to 8 visits to Primary Health Care Centre,
and subject to the sub-limit as declared in the table of benefits.

All care provided by obstetrician for low risk or specialist obstetrician for high risk referrals

Initial investigations to include:

- FBC and Platelets
- Blood group, Rhesus status and antibodies
- VDRL
- MSU & urinalysis
- Rubella serology
- HIV
- Hep C offered to high risk patients
- GTT if high risk
- FBS , random blood sugar or HbA1c for all due to high prevalence of diabetes in UAE
- Visits to include reviews, checks and tests.
- Ante-natal care scans.

Newborn cover

As declared in the table of benefits.

Preventive services, vaccines and immunizations

Essential vaccinations and inoculations for new born and children as stipulated same as Federal MOH.

GENERAL EXCLUSIONS:

SECTION C

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 are Medically Necessary and which are covered under the Terms and Conditions of the Insurance Policy.

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

Excluded healthcare services except in cases of medical emergencies:

1. Diagnostic and treatment services for dental and gum treatments
2. Hearing and vision aids, and vision correction by surgeries and laser

List of Exclusions

A. Excluded healthcare services

1. Healthcare Services which are not medically necessary

2. All expenses relating to dental treatment, dental prostheses, and orthodontic treatments.

3. Home nursing; private nursing care; care for the sake of travelling.

4. Custodial care including

a) Non-medical treatment services;

b) Health-related services which do not seek to improve or which do not result in a change in the medical condition of the patient.

6. Services which do not require continuous administration by specialized medical personnel.

7. Personal comfort and convenience items (television, barber or beauty service, guest service and similar incidental services and supplies).
8. 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.
9. Surgical and non-surgical treatment for obesity (including morbid obesity), and any other weight control programs, services, or supplies.
10. Medical services utilized for the sake of research, medically non-approved experiments and investigations and pharmacological weight reduction regimens.
11. Healthcare Services that are not performed by Authorized Healthcare Service Providers.
12. Healthcare services and associated expenses for the treatment of alopecia, baldness, hair falling, dandruff or wigs.
13. Health services and supplies for smoking cessation programs and the treatment of nicotine addiction.

13. Any investigations, tests or procedures carried out with the intention of ruling out any foetal anomaly.

14. Treatment and services for contraception
15. 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.

External prosthetic devices and medical equipment.

16. 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.
17. Growth hormone therapy.
18. Costs associated with hearing tests, vision corrections, prosthetic devices or hearing and vision aids.
19. Mental Health diseases, both out-patient and in-patient treatments, unless it is an emergency condition.
20. 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.
21. 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.
22. Services rendered by any medical provider who is a relative of the patient for example the Insured person himself or first degree relatives.
23. Enteral feedings (via a tube) and other nutritional and electrolyte supplements, unless medically necessary during in-patient treatment.
24. Healthcare services for adjustment of spinal subluxation.

25. Healthcare services and treatments by acupuncture; acupressure, hypnotism, massage therapy, aromatherapy, ozone therapy, homeopathic treatments, and all forms of treatment by alternative medicine.

26. All healthcare services & treatments for in-vitro fertilization (IVF), embryo transfer; ovum and sperms transfer.

28. Elective diagnostic services and medical treatment for correction of vision

29. Nasal septum deviation and nasal concha resection.

30. All chronic conditions requiring hemodialysis or peritoneal dialysis, and related investigations, treatments or procedures.

31. Healthcare services, investigations and treatments related to viral hepatitis and associated complications, except for the treatment and services related to Hepatitis A.

32. Birth defects, congenital diseases and deformities.

33. Healthcare services for senile dementia and Alzheimer's disease.

34. Air or terrestrial medical evacuation and unauthorized transportation services.

35. 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.

36. Any inpatient treatment, investigations or other procedures, which can be carried out on outpatient basis without jeopardizing the Insured Person's health.

37. Any investigations or health services conducted for non-medical purposes such as investigations related to employment, travel, licensing or insurance purposes.

38. 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.

39. More than one consultation or follow up with a medical specialist in a single day unless referred by the treating physician.

40. Health services and associated expenses for organ and tissue transplants, irrespective of whether the Insured Person is a donor or a recipient. This exclusion also applies to follow-up treatments and complications.

41. Any expenses related to immunomodulators and immunotherapy.

42. Any expenses related to the treatment of sleep related disorders.

43. Services and educational programs for handicaps.

WAITING PERIODS:

SECTION D

Treatments for maternity, chronic and pre-existing conditions are covered as mentioned in the TOB.

SECTION E

GENERAL TERMS & CONDITIONS:

Article 1: Insurance Policy:

The e-Application Form duly completed by the Policyholder, acting on behalf of himself and Beneficiary, the Preamble, the Definitions, the General Terms and Conditions, the Schedules and the Beneficiary User's Guide, shall constitute the entire contract between the Insurer and the Policyholder. Any amendment to this Insurance Policy shall be void, unless it has been made in writing and is signed and sealed by the Insurer. No insurance intermediary has the authority to amend this Insurance Policy or to waive any of its provisions.

Article 2: Insurance Policy Validity:

The validity of this Insurance Policy (in regard to the Plan selected) begins from the Effective Date and terminates on the Expiry Date and mentioned in the certificate of health cover (referred to as CHC).

Article 3: e-Application:

This Insurance Policy has been issued by the Insurer on the basis of the Policyholder declarations.

The Insurer reserves the right to reject any E-Application, which is not in conformity with the provisions of this Insurance Policy.

The Insurer also reserves the right to withhold claims payments, suspend and/or terminate the Insurance Policy should any details of the E-Application or required documents be inaccurate or missing.

Article 4: Applicable Scope of Coverage:

4.1 In return for the Premium due by the Policyholder to the Insurer, the latter undertakes to cover the Beneficiary- under the specified Plan -as selected by the Policyholder on the E-Application Form and approved by the Insurer.

4.2 For the Plan selected by the Policyholder on behalf of the beneficiary, related Benefits are clearly described under relative Table of Benefits.

4.3 The applicable Scope of Coverage of a given Benefit included in the selected Plan related to a Beneficiary, encapsulates the liability of the Insurer taking into consideration:

- The General Exclusions
- Any special terms (Substandard terms)
- The services covered
- The Policyholder Co-Participation when applicable
- The limits when applicable
- The Territory of Occurrence
- The Provider(s) used
- The nature of care
- The Hospitalisation Class

4.4 The liability of the Insurer under this Insurance Policy towards the Policyholder related to each Benefit within the Plan is described in the applicable Table of Benefits. Any expenditure relating to the Beneficiary's Treatment shall be subject to the determination of the Eligible Claim due by the Insurer to the Policyholder.

Article 5: Priority Payer:

In case of any participation in a sick/health fund, such as but not restricted to, social security fund or a primary cover under an Insurance Company as a Priority Payer, this applicable scope of coverage shall be activated in excess of the priority payer's participation or refund, in full accordance with other terms and conditions provided herein. The priority payer specifications if any, and if applicable, are specified under the Policy Schedule.

Article 6: Co-Payer:

In case of the participation of a Co-Payer, the applicable Scope of Coverage of this Insurance Policy shall apply on a proportional basis with the Co-Payer when applicable. The Co-Payer participation percentage, if any, is specified in the table of benefits. The Insurer participation percentage being the balance of all the Co-Payers' Co-Participation subject to any other terms and conditions herein provided. This refers to original limit, in the case of co-participation; the co-participation option selected will reduce the original limit.

Article 7: Premiums:

The premium is the annual Premium plus any applicable stamps and / or taxes if any paid before policy inception The Premiums due by the Policyholder to the Insurer -as defined in online portal -is payable in advance by the Policyholder when applying for the policy online via orient insurance website.

The coverage provided by the Insurer under this Insurance Policy shall not commence until the annual premium is paid in advance.

The Premium payment is substantiated exclusively and solely by the issue of a relevant receipt from a legally authorised representative/online receipt of the Insurer or using any of the approved online mode of payment.

Article 8: Enrolment:

The Policyholder has declared at the date of filling the initial E-Application, a specified insured for this policy. In virtue of the Policyholder declaration, this Insurance Policy was underwritten and issued by the Insurer to cover only the designated insured.

Article 9: Underwriting:

9.1 Underwriting:

Applicable for parents and members age 60 and above.

Article 10: Cancellation:

10.1 Policyholder's Right:

Cancellation is only acceptable in case the Visa is cancelled with no refund

10.1 Supporting Documents:

Submission by the Policyholder of supporting documents relating to cancellation request, which are satisfactory to the Insurer, is a pre-requisite for cancellation .

10.2 Insurer's Right:

The Insurer has the right to cancel the present Insurance Policy in the following instances:

a) Fraud, Abuse and false statements made by the Policyholder and/or Beneficiaries
b) Non-Payment of due Premium.

Article 11: Claims Notification:

Refer to Claims Procedures and Settlement Section of this Policy.

Article 12: Claims Deceivability:

12.1 In-Hospital/ clinics Family of Benefits as per the designated Network list:
It is agreed and understood that the liability of the Insurer is limited and restricted under this Insurance Policy to any In-Hospital Eligible Expenses incurred within the validity of this Insurance Policy as per the policy terms and conditions.

12.2 Out -of -hospital Family of Benefits:
Treatment outside designated network is not covered.

Article 13: Subrogation:
Once the Insurance claim has been paid in accordance with the current terms, the Policyholder and insured subrogates his/her right to the Insurer to pursue any third party responsible for any Bodily Injury and transfer to the Insurer every relevant substantial and legal right. Both the Policyholder and the insured shall provide the Insurer with every possible assistance should the Insurer exercise the above right of subrogation. .

Article 14: Arbitration

14.1 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 an 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.

14.2 Medically Necessary Procedure:

In case of a difference between the TPA, 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 TPA Physician 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.

Article 15: Currency:

Any money payable to or by the Company shall be in United Arab Emirates Dirhams.

Article 16: Change of Law:

The laws of the United Arab Emirates govern this Insurance Policy. If following to an amendment of the law, which has come into force after the Effective Date of this Insurance Policy, a conflict has arisen with the conditions of this Insurance Policy the Insurer may, at its option, re-negotiate the conditions of this Insurance Policy from the date such amendment of the law becomes effective.

SECTION F

CLAIMS PROCEDURES AND SETTLEMENT:

The below is the General Claims Procedures and Settlement:-

Linking the policy benefits to the insured Emirates ID facilitates his/her access to any of participating Network Providers with no cash payment being required except when the Insured Person has a deductible excess or co-participation to settle. The Insured Person is always requested to carry his/her Emirates Identification document to be presented to Providers whenever medical treatment is needed.

A Network Claim, is the Eligible Expenses relating to Healthcare services rendered to the Insured person on a Free Access Basis arranged by Insurer

with the Network Provider on Direct Billing to the Company. This includes Healthcare services that are provided to the Insured person within the Network either by the visiting and/or honorary and/or part-time and/or community physicians and/or healthcare providers; where the contracted Network tariff shall apply.

Out of pocket limit is the maximum aggregate amount of eligible expense the Insured person should bear during the policy year out of co-insurance options. This is not applicable to Maternity in hospital claims.

Treatment Outside territory for In-patient Emergency/Elective Treatment is provided to the Insured person based on the terms indicated on the Table of Benefit (T.O.B) specific to their policy.

For emergency cases, the Insured Person/his next of kin/Policyholder should call the dedicated TPA 24/7 call Centre (NEXtCARE at 04-270-8800), as soon as possible or, at the most, 24 hours within admission or prior to discharge date whichever is earlier.

In-Hospital Directives:

1.1 Within Selected Territory
1.1.1 Network Claims

- If the Insured person was referred by a general practitioner, consultant or specialist at designated outpatient clinics' to be admitted in a Network Provider, the Network Provider will directly co-ordinate with the TPA for the authorisation.
- Outpatient treatment is not eligible to be provided by Network hospitals.
- For critical emergency cases, upon receipt of the Hospital notification (Pre – hospitalisation Form) from the Network Provider, the TPA shall immediately issue the authorisation for the eligible In-Hospital treatment.
- Insured Person is requested to Call 24/7 Help Line Number 04 2708800 provided at the acknowledgment email sent to the sponsor at time of purchasing the policy online.
- TPA Medical and Claims Professional Staff on behalf of ORIENT Insurance Company will be receiving the call and shall provide specialised and necessary

assistance for the Insured Person's Hospitalisation and arrange for the eligible Hospitalisation expenses to be billed directly to the Company.

- No service is provided outside territory of coverage as per the table of benefits.
- For declined cases, TPA shall issue a Denial Form informing the Network Provider, the Insured Person/Policyholder that the admission is rejected and not eligible for coverage.

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2 Pre-Approval for Diagnostic/Therapeutic Procedures

2.1 Notification and authorisation are required for the following diagnostic/therapeutic in-patient and outpatient procedures prior to treatment.

Angiography	Herpes tests
Arthogram	Holter monitoring
Barium enema	Hysterosalphingography
Barium meal	IVP
Bronchoscopy	Mammogram
Colonoscopy	MCU
CMV	MRI
CT-Scan	Myelogram
Doppler studies	Oral Cholecystogram
Echocardiography	Pap smear
EEG Rubella tests	
EMG Sigmoidoscopy	
Endoscopy	Stress tests
Excretory urography	Thyroid function tests
FNAC Toxoplasma tests	
Gastroscopy	Hormonal Tests not related to HRT

Exception:

- The procedure has been already implicitly pre-authorised in relevant in- hospital pre-approval process mentioned under points 1.1.1

SECTION G

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.

Cancellation and refund based on policy terms and conditions.
For NEMED and NEMED-Lite: no refund .

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:
Also called **Table of Benefits** .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.

Reimbursement:
To receive money in repayment for money you have already spent or an expense you have already incurred.

It is not applicable in this policy

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:
Before the issuance of a medical insurance policy, the applicant is evaluated on the basis of the applicant (to be insured) medical history in order to set the premium rate for the policy. This is known as medical underwriting

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

User's Guide:
The booklet or pamphlet provided by the Insurer to the Policyholder, which explains how to get benefit from this Insurance Policy coverage.

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.

SECTION H
Attachments:

- Table of benefits
- Network list

Available at Orient Insurance website www.insuranceuae.com

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