GROUP MEDICAL INSURANCE

POLICY NO: P1/10/6002/18/00022

INSURED

Northwestern University
Education City, P.O Box 34102
Doha - Qatar

PERIOD

FROM : 01/08/2018
TO : 31/07/2019
Introduction

This Policy is a contract of insurance between the Company (hereinafter referred to as "We/Us/Our") and the Policyholder (hereinafter referred to as "You/Your"). The Application form, Policy schedule, Table of benefits and Membership cards issued form part of the contract and must be read together with this Policy.

The information provided to Us by or on behalf of You, Primary insured and/or their Dependants on the Application form and Policy addenda thereto is the basis of this contract and is deemed to be incorporated in this Policy. The truth of the information and answers in the Application form shall be conditions precedent to Our liability to make payment under this Policy.

The cover provided shall be determined by applying the rules defined herein together with the Policy schedule, Table of benefits and Membership cards issued to You. Any benefit not shown in the Policy schedule, Table of benefits and Membership cards is not provided for under this Policy. You shall examine the Policy, Policy schedule, Table of benefits and Membership cards carefully to make sure the required protection has been provided.

In consideration of Your payment of Premium in full, and upon the receipt of proof of Claim, We undertake to pay for Eligible medical expenses of Acute phases of illnesses or Accidents incurred by Insured members during the Policy period, subject to the terms, conditions and exclusions of this Policy.

For the entirety of this Policy, the use of masculine pronouns shall be deemed to indicate both masculine and feminine and the singular shall be deemed to include the plural and vice versa, where appropriate.

Both parties hereto have executed and delivered this Policy as of the Effective date, stated in the Policy schedule.

[Signatures]

Policy No: P1/10/6002/18/00022
Insured: Northwestern University
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SL NO.</th>
<th>DESCRIPTION</th>
<th>PAGE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Policy Schedule</td>
<td>Page 4</td>
</tr>
<tr>
<td>2</td>
<td>Policy Definitions</td>
<td>Page 6</td>
</tr>
<tr>
<td>3</td>
<td>Scope of Cover and Table of Benefits</td>
<td>Page 12</td>
</tr>
<tr>
<td>4</td>
<td>General Policy Exclusions</td>
<td>Page 16</td>
</tr>
<tr>
<td>5</td>
<td>General Policy Terms and Conditions</td>
<td>Page 19</td>
</tr>
<tr>
<td>6</td>
<td>Claims Administration</td>
<td>Page 23</td>
</tr>
<tr>
<td>7</td>
<td>About GlobeMed - Third Party Administrator</td>
<td>Page 25</td>
</tr>
</tbody>
</table>
## 1 POLICY SCHEDULE

### ATTACHING TO AND FORMING PART OF POLICY NO. P1/10/6002/13/00022

<table>
<thead>
<tr>
<th>BENEFITS DETAILS</th>
<th>Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Maximum Limit Per Person</td>
<td>QAR 500,000/-</td>
</tr>
<tr>
<td>Territory of Cover</td>
<td>Qatar, Arab Countries, SEA (Bangladesh, Bhutan, Burma, India, Indonesia, Malaysia, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, Vietnam, &amp; Korea)</td>
</tr>
<tr>
<td>Emergency Treatment</td>
<td>Worldwide for a maximum period of 90 days during the policy period</td>
</tr>
</tbody>
</table>

### INPATIENT (Subject to Prior Approval)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Accommodation</td>
<td>Private Room</td>
</tr>
<tr>
<td>Intensive Care Units Costs</td>
<td>Covered</td>
</tr>
<tr>
<td>Accidental and Emergencies</td>
<td>Covered</td>
</tr>
<tr>
<td>Surgical Operation and Procedures</td>
<td>Covered</td>
</tr>
<tr>
<td>Second Medical Opinion</td>
<td>Covered</td>
</tr>
<tr>
<td>Nursing Fees, Medical Expenses</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescribed Medicines, Drugs, Dressings</td>
<td>Covered</td>
</tr>
<tr>
<td>Surgeons, Anesthetists &amp; Physicians Fees</td>
<td>Covered</td>
</tr>
<tr>
<td>Blood, plasma &amp; blood substitutes</td>
<td>Covered</td>
</tr>
<tr>
<td>Oxygen and other medical gases</td>
<td>Covered</td>
</tr>
<tr>
<td>Prostheses and Surgical appliances</td>
<td>Covered</td>
</tr>
<tr>
<td>Post Hospitalization Treatment received within 90 days of being discharged from hospital</td>
<td>Covered</td>
</tr>
<tr>
<td>Reconstructive Surgery following an accident or surgery for an eligible medical condition</td>
<td>Covered</td>
</tr>
<tr>
<td>Rental of Wheelchair, Hospital bed, or Iron lung</td>
<td>Covered</td>
</tr>
<tr>
<td>Diagnostic tests,(X-rays-ECG, MRI, CT Scan, US, Angiography, ECG, Stress Test, Echo and Lab Services )</td>
<td>Covered</td>
</tr>
<tr>
<td>Pathology, X-Rays-diagnostic tests and Producers</td>
<td>Covered</td>
</tr>
<tr>
<td>Ophthalmology &amp; Eye care, (Consultation, Eye test, medical &amp; surgical therapy), Laser and optical expenses are not covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Physiotherapy (as requested by medical practitioner)</td>
<td>Covered</td>
</tr>
<tr>
<td>Treatment of allergic conditions</td>
<td>Covered</td>
</tr>
<tr>
<td>Acute (reversible kidney failure)</td>
<td>Covered</td>
</tr>
<tr>
<td>Cost for treatment by therapists and Complementary Therapy (Chiropractic,</td>
<td>Covered</td>
</tr>
</tbody>
</table>

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Policy No: P1/10/6002/18/00022
Insured: Northwestern University
<table>
<thead>
<tr>
<th><strong>Osteopathy and Acupuncture</strong> requested by medical practitioner</th>
<th>Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-patient rehabilitation (not work related)</strong></td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Hospice care &amp; Palliative care</strong></td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Terminal illness</strong></td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Accidental Damage to natural teeth, following accident (treatment as inpatient)</strong></td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Accommodation costs for one parent staying in hospital child up to max 18 yrs. - 30 days</strong></td>
<td>QAR 300/Night</td>
</tr>
<tr>
<td><strong>Nursing at Home</strong></td>
<td>QAR 300/ Night- 28 Days</td>
</tr>
<tr>
<td><strong>Casts, Trusses and Splints</strong></td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Inpatient Deductible Each and Every Claim</strong></td>
<td>NIL</td>
</tr>
</tbody>
</table>

**OUTPATIENT**

| **Diagnostic tests (x-rays, MRI, PET, CT scan, US, Angiogram, ECG, Stress test, Echo and Lab. services including hormonal tests & pathology diagnostic tests and procedures)** | Covered |
| **Pathology, X-ray and diagnostic tests** | Covered |
| **Specialists, Consultants, General medical practitioner and Family physician fees** | Covered |
| **Out-Patient home visits for emergency conditions** | Covered |
| **Post hospitalization treatment received within 90 days of being discharged from hospital** | Covered |
| **Medicine & Dressings** | Covered |
| **Blood, plasma & blood substitutes** | Covered |
| **Oxygen and other medical gases** | Covered |
| **Specialist Herbal Treatment** | Covered |
| **Day Care Treatment & Surgery** | Covered |
| **Out-patient surgical operations** | Covered |
| **Acute (reversible kidney failure)** | Covered |

**Costs for treatment by therapists and complementary medicine practitioners & Complementary therapy (Chiropractic, Osteopathy and Acupuncture), requested by medical practitioner**

| | N/A |

| **Road Traffic Accident** | Covered |
| **Palliative ongoing treatment & medication** | Covered |
| **Physiotherapy as requested by medical practitioner** | QAR 3,000/- |
| **Ophthalmology & Eye care, (Consultation, Eye test and medical treatment), refraction and optical expenses related are not included)** | Covered |
| **Hormonal therapy other than infertility** | QAR 3,000/- |

**Outpatient Deductible Each and Every Claim**

QAR 25 Per Visit on Consultation Charges

**ADDITIONAL BENEFITS - INPATIENT and OUTPATIENT**

| **Cover for Pre-Existing / Chronic Conditions** | Covered |

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Policy No: P1/106002/18/0022
Insured: Northwestern University
<table>
<thead>
<tr>
<th>Hospital Cash Benefits (In-Patient) /</th>
<th>QAR 200 per night, maximum 180 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repatriation of Mortal remain</td>
<td>QAR 7,500/-</td>
</tr>
<tr>
<td>Psychiatric Treatment</td>
<td>QAR 10,000/-</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>Covered</td>
</tr>
<tr>
<td>Sport related Accident (Non Professional)</td>
<td>Covered</td>
</tr>
<tr>
<td>Visiting Doctor Consultation</td>
<td>QAR 300/-</td>
</tr>
<tr>
<td>Include Congenital Cases for Life Threatening cases</td>
<td>Covered</td>
</tr>
<tr>
<td>Oncology</td>
<td>Covered</td>
</tr>
<tr>
<td>Include Ambulance</td>
<td>Covered</td>
</tr>
<tr>
<td>Terrorism Coverage</td>
<td>Covered</td>
</tr>
<tr>
<td>Allergic Conditions</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable Medical Appliances</td>
<td>QAR 3,700/-</td>
</tr>
<tr>
<td>Organ Transplant- Surgical cost only</td>
<td>Covered</td>
</tr>
<tr>
<td>Vitamins and supplements- prescribed by Doctors - including test</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiotherapy and chemotherapy</td>
<td>Covered</td>
</tr>
</tbody>
</table>

**BASIS OF CLAIM SETTLEMENT**

Expenses incurred on treatment **Within the Network of Providers**

Expenses incurred on treatment **Outside the Network of Providers**:

* **Treatment in Hamid Hospital (IP/OP)** 100% of the eligible medical expenses **Inside Qatar**
  Reimbursement 80% of Actual eligible medical expenses **Outside Qatar (but within covered territory)** - Reimbursement 100% of the eligible medical expenses Reasonable & Customary Charges of Qatar Network

**Emergency Medical Expenses whilst on vacation or business visits abroad within the covered territory**

Reimbursement of 100% of the Reasonable & Customary Charges of Qatar Network, after application of policy deductible

**Treatment at Al Ahli and Al Emadi Hospital**

Direct Billing

**Network of Provider(s)**

As per List Attached

**PREMIUM**

**Premium Per Person Per Year**

QAR 1,940.00

**Total No. of Members**

330

**Total Premium**

QAR 640,200
PREMIUM PAYMENT WARRANTY

It is both a Term and a Condition of this Insurance Policy that (unless specifically amended by DBAC to the contrary), the Premium identified within the Policy provisions, must be paid in full by the Insured as per below schedule.

- Within 30 Days from Inception of the policy.

Should any additional Extension/s to the Policy Period Endorsement or Adjustment endorsement/s be issued under this Policy of Insurance, then the premium payable for such Endorsement/s must also be paid in full by the Insured within 30 days from the Inception Date.

Doha Bank Assurance shall have the specific right to deny the contract from the supposed inception date or Policy Period Endorsement date or Adjustment Endorsement/s date and repudiate and disavow all known or unreported losses that may occur, should the terms of this Premium warranee Statement not be complied with by the Policy holder or his authorized agents or intermediaries, in full.

In Witness whereof the undersigned being duly authorized by the Company has/have here unto set his/their hand(s) on 25/07/2018 at Doha, Qatar.

Authorized Signatory

P.O. Box 55853
Doha - Qatar
2 Policy Definitions

The following words, expressions or phrases used in the context of this Policy have specific meanings as given below. The defined words, expressions or phrases begin with bold Capital letters throughout the Policy.

2.1 Accident : Any sudden and unforeseen event that occurs beyond the Insured member’s control during the Policy period, resulting in bodily injury. This excludes accidental illness, surgical procedures and aggravation of a Pre-existing condition.

2.2 Accommodation type : Accommodation type, as identified in the Policy schedule, Table of benefits and Membership cards, corresponds to the Inpatient room type (suite, private, semi-private or shared room) to which the Insured member is entitled to.

2.3 Acute phase of an illness : An event characterized by a single episode of fairly short duration, requiring Treatment for normally less than fourteen (14) days, and from which the patient can be expected to return to his normal or previous state and level of activity.

2.4 Allopathic medicine : Type of medical care that uses substances, surgery, and Treatments specifically targeted against the Illness and intended to cure the Illness. This term is generally used to describe the conventional (or Western) approach to medicine.

2.5 Alternative medicine : Types of medical care that are alternative to the conventional Allopathic medicine covered under this Policy.

2.6 Annual maximum limits : Total amounts that may be claimed in any one (1) Policy period by an Insured member. These limits are shown in the Table of benefits.

2.7 Application form : A signed statement of facts made by the applicant for insurance, on the basis of which We carry out an underwriting in full accordance with the terms and conditions of this Policy. The Application form becomes part of the contract when the Policy is issued.

2.8 Birth defect : Any deformity arising during the antenatal stages of pregnancy or caused by/or during childbirth.

2.9 Chronic condition : An Illness that persists or would persist over a long period of time, which is not curable and requires regular Maintenance treatment.

2.10 Claim : The formal request for payment of Eligible medical expenses, incurred by an Insured member that qualify for reimbursement under the terms of this Policy.

2.11 Claim form : A document issued by Us which shall be used by the Insured member to set information in respect of the Claim incurred. Primary claim form and Secondary claim form are the two different types of forms used by Us.
2.12 Coinsurance: An insurance participation percentage borne by the Insured member towards the cost of Eligible medical expenses after he has met his applicable Deductible amount. The Coinsurance is specified in the Table of benefits and is expressed as a percentage of Eligible medical expenses after deduction of applicable Deductible amount.

2.13 Company/We/Us/Our: Doha Bank Assurance Company LLC

2.14 Consultant: A secondary care specialist locally licensed and recognized by the law of the country in which Treatment is provided and who, in carrying out such Treatment, is practicing within the scope of his licensing and training.

2.15 Consultation: Any medical advice from or encounter with a Physician or Consultant including the issue of any prescriptions for investigations, medications and physiotherapy.

2.16 Country of domicile: The country of which the Insured member holds a passport. Where the Insured member has more than one passport, the Country of domicile shall be the country which the Insured member has declared on the Application form.

2.17 Country of residence: The territory in which the Insured member permanently resides and from where the Policy was issued.

2.18 Daycare treatment: Treatment where the Insured member requires hospitalization in a Hospital for specialized medical attention and care before, during and after the Treatment, but not requiring an overnight stay. Such Treatments cannot be performed on an Outpatient basis.

2.19 Deductible: A specific amount of Eligible medical expenses that must be incurred and paid for by the Insured member before benefits are payable under this Policy. This amount is payable by the Insured member per each outpatient Consultation, except for a follow-up visit within ten (10) days for the same illness and at the same Physician or Consultant. If the Eligible medical expenses are less than the Deductible amount, then the Insured member will be liable to pay all the expenses incurred. The Deductible amount is stated in the Policy schedule, Table of benefits and Membership cards.

2.20 Dentist: A registered or licensed dental practitioner who is legally authorized to practice dentistry in the country in which Treatment is received.

2.21 Dependant: Primary insured's spouse, children and step children who are eligible for coverage according to the Eligibility conditions set forth in this Policy.

2.22 Designated providers: Hospitals, clinics, laboratories, diagnostic centers and pharmacies with whom We have agreements to provide covered benefits, in accordance with the terms of the Policy, to the Insured members and are included under the list of Designated providers attached to the Policy schedule.
2.23 Diagnostic procedures: Any tests for diagnosing illness, including pathology, laboratory, x-ray, FCQ, medical scanning and imaging techniques and interpretation of the results by a Physician or Consultant.

2.24 Due date: The date of renewal of cover as shown on the Policy schedule and the Membership card, or the date on which any subsequent installment of Premium falls due.

2.25 Effective date: The date, shown in the Policy schedule and the Membership card on which cover under this Policy commences.

2.26 Eligible medical expenses: Medical, surgical, or any other expenses necessarily incurred by an Insured member and are in relation to benefits, as being eligible for coverage under this Policy. These could involve specified medical services' fees or Reasonable and customary charges.

2.27 Emergency: An injury or Illness which happens suddenly and whose acute symptoms are of such severity that the absence of Treatment within twenty four (24) hours is medically expected to result in a serious threat to the life, health, bodily function and/or organ of the patient.

2.28 Endorsement: A contractual document issued by Us subsequent to this Policy, introducing alterations to this Policy in full conformity with its provisions.

2.29 Expiry date: The date, shown in the Policy schedule and the Membership card on which cover under this Policy ceases.

2.30 General exclusions: Excluded Illnesses, items, Treatments, procedures and their related or consequential expenses, which are not covered under this Policy. These exclusions are shown in the General exclusions list.

2.31 Hospital: An establishment, which is legally licensed in the country of Treatment, as a medical or surgical Hospital and provides Allopathic medicines.

2.32 Hospital accommodation and services: All Medically necessary treatments and services provided by or on the order of a Physician or Consultant to the Insured member when admitted as a registered Inpatient or for a Daycare Treatment to a Hospital.

2.33 Illness: Any kind of health condition not otherwise excluded by the Policy which is sustained by an Insured member during the Policy period and occasions the necessity for the Insured member to receive care and attendance from a Physician or Consultant.

2.34 Inpatient treatment: Treatment where the Insured member requires hospitalization for a minimum of one (1) night, for specialized medical attention and care, before, during and after the Treatment. Such Treatments cannot be performed on an Outpatient basis.
2.35 Insured member: Any Primary insured or his Dependants who has fulfilled the Eligibility conditions and is named in the Policy schedule and Membership card.

2.36 Join date: The date, shown on the Policy schedule on which an Insured member was included under this Policy and becomes eligible for cover.

2.37 Maintenance treatment: Any Treatment or procedure, the primary purpose of which is to offer temporary relief or control of Illness of symptoms rather than to cure the Illness causing the symptoms.

2.38 Medically necessary treatments: Any medical, surgical or other services that an Insured member requires provided such services are:
   i. Essential and related to the Illness presented
   ii. Rendered in accordance with generally accepted medical practice and professionally recognized standards
   iii. Not Treatments that are generally considered as experimental or unproven

2.39 Membership card: A personalized card issued by Us in the name of each Insured member, identifying him as an Insured member and facilitating his access to the benefits covered under this Policy and provided by Our Designated providers.

2.40 Moratorium period: The period an Insured member has to wait before he becomes eligible for a benefit. The Moratorium period is measured from the Insured member’s first Join date.

2.41 Non-designated providers: Hospitals, clinics, laboratories, diagnostic centers and pharmacies with whom We have no agreement to provide covered benefits, in accordance with the terms and conditions of this Policy, to the Insured members and/or are not included under the list of Designated providers in Your Policy schedule. Benefits received at such Providers will be on reimbursement basis.

2.42 Nursing at home: Rendering the medical services of a nurse in the Insured member’s home in the Country of residence when prescribed by a Consultant and related directly to an Illness for which the Insured member has received Inpatient treatment in accordance with the terms and conditions of this Policy. This benefit is provided in lieu of a Hospital admission where a skilled nurse, under the supervision of the treating Consultant, can provide the necessary care at home for the remaining length of stay of a particular admission or procedure.

2.43 Outpatient treatment: All Medically necessary treatments and services that do not require hospitalization during the day or overnight nor necessitate specialized medical attention.

2.44 Overall limit: The maximum amount that an Insured member may Claim during the Policy period for all the benefits covered under the Policy.
2.45 Physician : A registered medical practitioner who is legally licensed to practice Allopathic medicine in the country in which Treatment is provided and who in carrying out such Treatment, is practicing within the scope of his licensing and training.

2.46 Physiotherapist : A qualified, registered practitioner of physiotherapy.

2.47 Policy : The document evidencing the terms, conditions, benefits and price of the cover applicable to the Insured member. The Policy constitutes of:
   i. The Application form(s) duly completed and signed by the Insured member(s)
   ii. The Policy schedule
   iii. The Table of benefits and General exclusions
   iv. The general terms and conditions
   v. Membership cards
   vi. Endorsements to any of the aforementioned
   vii. Membership guide, for information and guidance

2.48 Policyholder/You/Your : The applicant for the insurance coverage, acting in the name of the Primary insured and their Dependents, whose application is formally accepted by Us and protection is provided under this Policy.

2.49 Policy period : The period of this Policy stated in the Policy schedule and the Membership card from the Effective date to the Expiry date.

2.50 Policy schedule : A list issued by Us in which information on the contractual parties are specified, together with the specific conditions of this Policy including but not limited to both parties data, the Effective date, the Expiry date, Policy name and number, Premium and Premium payment details, benefits details (including Annual maximum limits and benefits annual Sub-limits, Territorial limit, Deductible amount and percentage of Coinsurance, if applicable), Designated providers list, membership list including Insured members details (name, date of birth, gender and Insured members’ Join dates), and the Policy’s special conditions, if any.

2.51 Pre-authorization : Review and approval of Treatments by Us prior to or concurrent with the Treatment date to ensure that they are undertaken within the scope of cover of the Policy terms and conditions, benefits and exclusions.

2.52 Pre-existing condition : Any bodily injury or Illness or its Related condition that is medically existing prior to the enrolment date of the Insured member, whether it is known or not known to him, and necessitates the Insured member to receive care and Treatment.

2.53 Premium : The amount You pay in exchange for insurance coverage.

2.54 Primary claim form : A pre-printed Claim form used for Outpatient and Emergency Treatments. It is also used for Pre-authorization of Treatment requests, as required under the terms and conditions of this Policy.
2.56 **Primary insured**: An employee of the Policyholder or any member of a legally established non-profit organization Policyholder (e.g. association, union and the like) who has fulfilled the Eligibility conditions and is named in the Policy schedule and Membership card.

2.56 **Provider**: Any person (Physician or nurse) or institution (Hospital, clinic, medical center, pharmacy, laboratory, physiotherapy center or other paramedical institution) that is licensed to provide Allopathic medicine.

2.57 **Reasonable and customary charges**: The amount we recognize for payment for a particular medical procedure. It is based on what is considered "reasonable" for that procedure in accordance with the market price, in the country where the treatment was provided or in the Country of residence, whichever is less.

2.58 **Related condition**: Any Illness considered to be either an underlying cause of or directly attributable to another specific Illness.

2.59 **Secondary care**: Treatment delivered by a Consultant following referral for further Treatment from a Physician.

2.60 **Secondary claim form**: A Claim form used for Daycare and Inpatient treatments (Hospital admissions). It is generated by Our computer system when a request for Pre-authorizing Treatment is approved.

2.61 **Sub-limits**: Maximum Annual maximum limits that may be Claimed in respect of any one (1) benefit. If the Sub-limit is stated to be full refund, then Our maximum liability for the benefit shall be the Policy's Overall limit.

2.62 **Table of benefits**: A schedule issued by Us showing the extent and nature of benefits, Deductible amount and percentages of Coinsurance applicable under this Policy.

2.63 **Territorial limit**: The geographical limits within which Treatment may be received and are stated in the Policy schedule and Table of benefits.

2.64 **Treatment**: A medical or surgical procedure, the sole purpose of which is to cure an Illness and not to alleviate long-term Chronic condition.
3 Scope of Cover and Table of Benefits

Cover under this Policy is in respect of expenses incurred in respect of the following, subject to the terms and conditions, General exclusions, covered benefits and limitations as per the Table of benefits.

3.1 Inpatient and Daycare

3.1.1 The scope of cover for inpatient and daycare benefits includes the following:

i. Hospital accommodation & services according to the Accommodation type. These include:
   a. Room and meal charges
   b. Consultants’ & Physicians’ fees
   c. Surgeons’ & anesthetists’ fees
   d. Surgery fees
   e. General nursing care
   f. Diagnostic procedures
   g. Operating theatre charges
   h. Recovery room charges
   i. Intensive care unit charges
   j. Drugs and medications served in the Hospital
   k. Dressings
   l. Other eligible services while hospitalized

ii. Post-operative physiotherapy, if Medically necessary

iii. Ambulance

v. Parent accompanying an insured child under eighteen (18) years of age

vi. Hospital cash benefit if the Treatment is received in a government Hospital where the Treatment is provided free of charge

vii. Nursing at home, for recovery and in lieu of Hospital stay up to a maximum of fourteen (28) days per admission or procedure

3.1.2 If the Policy excludes outpatient benefit, the inpatient and daycare benefits shall be extended to include post-operative follow-ups, as stated below:

i. Post Medical Admissions: One (1) follow up visit to the same Provider, if requested by the treating Physician, for review of progress of the post discharge status of the illness, for which admission was required. Maximum period for this follow up shall be within fifteen (15) days from the date of the Insured member’s discharge from the Hospital.

ii. Post Surgeries: Two (2) follow up visits and physiotherapy sessions to the same Provider, if requested by the treating Surgeon & if medically necessary, for post discharge review and management of the surgically intervened illness. Maximum period for these follow ups shall be within forty five (45) days from the date of the Insured member’s discharge from the Hospital.

3.2 Outpatient

3.2.1 The scope of cover of outpatient benefit, if covered as per the Policy schedule and Table of benefits, includes the following:

i. Physicians’ Consultation fees

ii. Diagnostic procedures

iii. Prescribed drugs

iv. Physiotherapy on referral by a Physician & if Medically necessary

v. Bandages, splints, crutches and plaster casts only if Medically necessary and prescribed by a Physician
3.3 Emergency Treatment Abroad

3.3.1 The scope of cover of Emergency Treatment abroad, if covered as per the Policy schedule and Table of benefits, includes Emergency Treatments related to covered benefits, whilst Insured members are outside the Country of residence for business or holiday trips, subject to the following conditions:

i. Obtaining Our Pre-authorization within forty eight (48) hours of the Emergency Treatment. Insured members shall use the assistance services provided by Us, as outlined in the member’s guide, provided to You along with other Policy documents at the commencement of this Policy. Failure to comply may result in the eventual decline of the Claim.

ii. Cover is limited to eligible benefits while the Insured member is admitted at the Provider. Follow up visits and investigations are excluded.

iii. Application of separate Deductible and/or Coinsurance, as stated in the Table of benefits.

iv. Cover outside the Country of residence shall be for a maximum period of forty five (45) days duration, for any single journey.

v. Unless otherwise stated in the Table of benefits, Treatment received outside the Country of residence shall be paid at the actual cost or the Reasonable and customary charges, whichever is less.

3.4 Treatment Abroad other than Emergency

3.4.1 The scope of cover for non-Emergency Treatment abroad (that is, when an Insured member seeks Treatment outside the Country of residence), if covered as per the Policy schedule and Table of benefits, includes Treatments related to covered benefits, subject to the following conditions:

i. Obtaining Pre-authorization prior to seeking Treatment for services, as specified under Article 6.5.1. Failure to comply will result in the eventual decline of the Claim.

ii. Application of separate Deductible and/or Coinsurance, as stated in the Table of benefits.

iii. Treatment received outside the Country of residence will not be covered if travel was not pursuant to an advice of the treating Physician or Consultant.

iv. Unless otherwise stated in the Table of benefits, Treatment received outside the Country of residence shall be paid at the actual cost or Reasonable and customary charges, whichever is less.

3.5 Repatriation of Mortal Remains

3.5.1 If covered as per the Policy schedule and Table of benefits, We will pay for Insured member’s mortal remains to be transported to his Country of domicile, should death occur due to an injury or Illness covered under this Policy whilst outside the Country of domicile.
3.6 Maternity

3.6.1 The scope of cover of maternity benefit, if covered as per the Policy schedule and Table of benefits, includes the following:

i. Physicians' Consultation fees
ii. Antenatal care, delivery and post natal care
iii. Caesarian section, if medically necessary
iv. Hospital services
v. Vitamin and mineral supplements
vi. Complications arising from pregnancy
vii. Legal abortion, approved as medically necessary by a physician and us
viii. Care of the child whilst the mother is in hospital
ix. Standard laboratory tests for newborn babies

3.6.2 Moratorium Period: Maternity benefits shall not be available to insured member until the elapse of the Moratorium period, as specified in the Table of benefits. This shall mean that an insured member cannot claim for any investigation or treatment related to the maternity during the specified Moratorium period.

At renewal of the Policy, the Moratorium period will be waived only for insured members who have completed the period on the expired Policy. For insured members who have not completed the Moratorium period, cover under the renewed Policy will begin upon completion of the balance of the period.

All new joiners at renewal and during the Policy period of the renewed Policy will be subject to the same Moratorium period, as specified in the Table of benefits.

3.6.3 Exclusions: The following treatments and services are excluded:

i. Investigations or treatments related to maternity within two hundred eighty (280) days from the insured member's Join date, unless otherwise stated in the Table of benefits
ii. Abortion due to voluntary, psychological or social reasons, and its consequences
iii. Elective cesarean deliveries, if not medically necessary

3.7 Dental

3.7.1 The scope of cover of dental benefit, if covered as per the Policy schedule and Table of benefits, includes the following:

i. Dentist's Consultation
ii. Related Prescription
iii. Extractions
iv. Amalgam / Composite Fillings
v. Root Canal Treatment

3.7.2 Exclusions: The following treatments and services are excluded:

i. Routine dental treatment including but not limited to cleaning and scaling
ii. Gum Treatments (whitening & polishing), dentures, bridges, crowns & implants
iii. All other fillings than amalgam, including but not limited to composite and glass ionomer
iv. Cosmetic Treatments
v. Temporary Teeth Treatments
3.6 Optometry / Optical

3.6.1 The scope of cover of optometry benefit, if covered as per the Policy schedule and Table of benefits, includes the following:

i. Vision tests to diagnose the following errors of refraction:
   a. Hyperopia
   b. Myopia
   c. Astigmatism
   d. Anisometropia
   e. Presbyopia

ii. Plain lenses only for the correction of the above mentioned errors of refraction

3.6.2 Exclusions: The following Treatments and services are excluded:

i. Spectacle frames
ii. Contact lenses
iii. Photochromic lenses
iv. Surgeries for corrections of errors of refraction
v. Cataract, unless Pre-existing condition in covered under Your Policy
vi. Diabetic retinopathy, unless Pre-existing condition in covered under Your Policy
vii. Glaucoma, unless Pre-existing condition in covered under Your Policy
viii. Retinal detachment, unless Pre-existing condition in covered under Your Policy
ix. Strabismus
x. Ptosis
xi. Ophthalmic surgery

3.6.3 Notwithstanding the above, all ophthalmic conditions are covered, irrespective of the optometry benefit.

3.9 Pre-existing Condition

3.9.1 The scope of cover of Pre-existing condition, if covered as per the Policy schedule and Table of benefits, includes the following:

i. Any Pre-existing condition and its curative and Maintenance treatments

ii. Any Illness that is diagnosed during the Policy period and requires regular Maintenance treatment

3.9.2 Exclusions: The following Treatments are excluded:

i. Hereditary blood cell diseases (e.g. sickle cell disease, hereditary spherocytosis and the like)
ii. Bleeding disorders (e.g. thrombocytopenia, hemophilia and the like)
iii. Autoimmune Diseases (e.g. systemic lupus erythematosis, myasthenia gravis, multiple sclerosis and the like)
iv. All types of Hepatitis
v. Renal failure and dialysis
vi. Cancer Treatment
vii. Cardiovascular Diseases
4 General Policy Exclusions

This Policy does not cover expenses arising directly or indirectly for any tests or Treatments for the following:

4.1 Any expense incurred after the age of 70 years or in connection with a medical condition existing before the age of 14 days.

4.2 Services, except those listed, normally delivered at a clinic, physician's office, medical center or out-patient facility and which do not require hospital confinement.

4.3 Treatment where the required protocols / approvals have not been followed / obtained except in case of emergency in which case Insurers are notified within the time limit specified under the Policy. In case of treatment taken outside the appointed network of providers, such claims to be submitted to Insurers within the time limit specified in the Policy. All medical expenses incurred outside the network provider shall be processed on reimbursement basis subject to policy conditions and application of policy deductible, reasonable and customary charges.

4.4 Treatment or test that are not for a specific medical condition, or is not medically mandatory, or is not listed in the relevant Scope of Benefits.

4.5 Costs of Pre-existing conditions, or conditions related or due to a pre-existing condition unless specified as covered in the Table of Benefits up to the limits specified therein. The automatic waiver of pre-existing conditions does not have any effect on the other exclusions listed in the policy, that remain in full force and effect. In all cases, the Policyholder and the beneficiary(ies) remain subject to the requirement of full disclosure of their health conditions and any facts relating to them. Any false declaration or non-disclosure of material fact, discovered at any time, will render this Policy null and void from inception.

4.6 Unless Pre-existing condition is covered, Maintenance treatment of Chronic conditions, except for necessary investigations until a diagnosis for the condition is confirmed.

4.7 Home visits

4.8 Services or Treatment or Tests at Health Hydros, Rest Home, Health Resorts, Massage Centers, Spas, Nature Clinics, Sanatoria and the like, custodial care, period of quarantine, special diets and weight control, or long term care facility that is not a Hospital, costs related to convalescence even when the initial treatment was eligible.

4.9 Admissions for rehabilitation and isolation purposes

4.10 Routine medical examinations or regular check-ups.

4.11 Medical certificates and examinations for residence, employment or travel.

4.12 Provider registration fees, and medical report charges unless requested by Us.

4.13 Vaccinations (Except for children up to the age of 6 years if it is covered), inoculations, routine medical examinations, check-ups, medical certificates, treatment or tests in respect of allergies, screening, all preventive treatments etc,

4.14 Circumcision

4.15 Cosmetic, plastic, reconstructive or restorative Treatments, unless necessitated by a covered accidental injury, with treatment pre-approved by the TPA, on behalf of the Insurer, carried out within six months of the accident.

4.16 Cosmetic products such as shampoos, soaps, hair stimulants, hair removers, moisturizers, creams or other similar products.

4.17 Alternative treatments including but not limited to ayurvedic (such as herbal medicine), holistic medicine, hypnosis, yoga, acupuncture, homeopathy, chiropractic and other similar Treatments unless it is covered in the table of benefits.

4.18 Any Illness caused by, or resulting from sexually transmitted illnesses, including genital warts, venereal disease, any Treatment or test for acquired immune deficiency syndrome (AIDS) and any AIDS/HIV ARC Related conditions howsoever acquired or named unless it is covered in the table of benefits.

4.19 Prosthesis and medical appliances including but not limited to knee brace, collar brace, lumbar support, heel pads, arch support and hearing aids unless is listed in the table of benefits.

4.20 Obesity, insomnia, anorexia & baldness.
4.21 Treatment of mental, nervous, psychological and related disorders including alopecia. Myalgic Encephalomyelitis or Chronic Fatigue Syndrome, nervous breakdowns and similar conditions. Psychological testing and evaluation

4.22 Vitamins, mineral supplements, hormones replacement therapy, steroids and organic preparation unless it is covered in the table of benefits

4.23 Skin disorders like warts, skin tags, keloid, acne, and molluscum contagiosum

4.24 Maternity care, as specified under Article 3.8 of this Policy, if not included in the Policy schedule, Table of benefits and Membership cards

4.25 Dental related services, as specified under Article 3.7 of this Policy, if not included in the Policy schedule, Table of benefits and Membership cards

4.26 Dental and gum treatment or tests unless eligible and pre-approved following a covered accidental injury within 6 months of the accident

4.27 Optometry/Optical Treatment and surgeries for correction of refraction errors, as specified under Article 3.8 of this Policy, if not included in the Policy schedule, Table of benefits and Membership cards

4.28 The surgery and costs of all kinds of organ transfer and transplantation, including bone marrow transplantation except for the surgery related to the cornea transplant, where the operation is covered but not the cost of the cornea. The cost of all kinds of prosthesis and orthosis replacing an organ, limb or any function of the human body including resorbable prosthesis, except for:

a) valves relating to heart surgery

b) prosthesis related to post-traumatic accidents (excluding artificial limbs) that have occurred while the Policy or its subsequent renewals is in force. In this latter case, the prosthesis is covered if it is provided to the Insured immediately after the accident and while his coverage under the insurance company system is in force without interruption since the accident

c) coronary stand up to a maximum amount of USD 1,000/- per insured per contract period and/or any duplicate or supplementary coverage

d) mesh related to hernia surgery, provided that the hospitalization related to the above conditions is covered as per the Policy provisions.

4.29 Infertility, impotency, sexual dysfunction, contraception, sterilization or other similar conditions

4.30 Birth defects, congenital illness, hereditary conditions including neurologic diseases, attention deficit disorders, treatments for developmental delay and learning difficulties and growth disorders, as well as the complications arising therefrom. Birth defect, congenital cases and hereditary conditions are defined as follows: diseases, anomalies birth defects and deficiencies present at birth, either in an evident manner or in a potential manner triggered at a later stage.

As special exceptions to the above general exclusion, the following congenital cases are covered only in the instances where the Insured was medically eligible at birth, and covered under the Insurance Company System without interruption since he/she attained 14 (fourteen) days of age from a covered maternity: hernia, thyroglossal cyst, pyloric stenosis, urinary reflux, gastroesophageal reflux, epispadias, hypospadias, bladder exstrophy and exstrophy of lower abdomen, posterior uretal valves, megaureter, hydronephrosis and L-P junction, diaphragmatic hernia, esophageal atresia, omphalocele and laparoschisis, duodenal atresia, intestinal atresia, congenital megacolon (hirshprung), imperforate anus, biliary atresia, bronchogenic cyst, cystic adenomatoid malformation, and tongue tie.

In addition to the above, the Insurance Company shall also cover the In hospital medical treatment of transient neonatal jaundice, for newborn babies under Insurance Company system, medically eligible, as from birth and irrespective of the period of stay of the mother.

Such extension does not constitute any vested right for the newborn baby, in any other cover or benefit of whatsoever kind.

4.31 All transportation costs, ambulance expenses including both road and air ambulance occurring during trips specifically made for the purpose of obtaining Treatment, unless otherwise mentioned in the policy schedule

4.32 Corrective Treatment for hearing defects
4.33 Any medical expenses directly or indirectly due to hazardous activities or sports, such as, but not limited to, the following:

   a) Aerial activities (except as a passenger on a standard air-line), such as light aircraft, mono-plane, ballooning, parachuting, hang-gliding, bungee jumping.
   b) Winter sports such as sleighing, skating, tobogganing, etc.
   c) Water sports such as power boats, water/jet skiing, snorkeling, diving, etc.
   d) Horse riding activities such as hunting, jumping, polo, racing, etc.
   e) Climbing sports such as pot-holing, abseiling, rock climbing, mountaineering
   f) Participation in any kind of race, rally or competition, motorized or otherwise
   g) Martial arts of any kind, including boxing, judo, karate, wrestling, etc.
   h) Other high risk activities such as contact sports, including soccer, rugby, etc.
   i) Regular or voluntary forces such as air-force, navy, army, police, security, firemen, etc.
   j) Wagers, bets, dares, challenges, trialing, record attempts, etc.

4.34 Treatment or Tests caused by, contributed to, or resulting from self-inflicted injury, suicide attempt or threat, willful exposure to risk, illegal or forbidden act, use of alcohol, intoxicants, hallucinogenic, willful third party negligence, illegal drugs or any drugs and medicines that are not taken in the dosage or for the purpose as prescribed by the Physician.

4.35 Any procedure or treatment related to the cardiovascular system. This exclusion will be waived 3 months following the Enrollment Date of the Insured, unless it falls under a pre-existing condition in which case exclusion number 5 will apply, except as stipulated otherwise in the Policy Schedule.

4.36 Treatment or Tests related to Hemodialysis and Arterio Venostomy.

4.37 Hospitalization or surgery directly or indirectly related to: Hernia, vertebra disc, hemorrhoids, tonsilllectomy, cataract, tuberculosis, ulcer, children paralysis, kidney diseases and woman genital organs.

The restrictions under paragraph will be dropped after one year insurance.

4.38 Treatments resulting from participating in war (declared or not), invasion, acts of foreign enemies, hostilities whether war be declared or not, civil war, rebellion, revolution, acts of terrorism, strikes, riot, civil commotion, crimes or illegal acts on the part of the insured or any illegal act, including resultant imprisonment and any Accident or illness incurred while serving as a full-time member of a police or military unit.

4.39 Injury caused by nuclear fission, nuclear fusion or radioactive contamination, chemical or biological warfare.

4.40 All exclusions specifically mentioned under Article 3 of this Policy.

4.41 Treatment relating to senility and age related disorders.

4.42 All kinds of treatments of the Parkinson disease including surgery.

4.43 Tubal ligation including all control procedures and related treatments or tests.

4.44 Treatment or tests for birth control including sterilization and IUD, or for infertility including IVF, impotence, varicocele etc.

4.45 Abortion unless medically necessary.

4.46 Turbineectomy (excision of hypertrophied or enlarged turbinates will be covered after a waiting period of 12 months. Septoplasty, correction of a septal and rhinoplasty shall however be excluded.

4.47 Treatment for work related conditions and treatment that should be covered by workman’s compensation schemes and benefit concurrently covered elsewhere.

4.48 Durable medical appliances (e.g. Nebulizer), Pap smear and mammogram unless it is covered in the table of benefits.

4.49 Sex change operations and related treatments.

4.50 Treatment of sleep related breathing disorders, including snoring, sleep apnea, jet lag or work related stress and any related condition.

4.51 Treatment of speech, voice problems and cochlear implantation.

4.52 Any medical prescription related to special diet, weight control, children's food or baby supplies.
5 General Policy Terms and Conditions

5.1 Policy Period

This Policy is an annual contract. Subject to Your payment of the required Premium it shall commence from the Effective date and terminate at the Expiry date, specified in the Policy schedule.

5.2 Eligibility Conditions

The coverage under this Policy will be provided to all Insured members who fulfill the following conditions:

5.2.1 Primary insured: i) all full-time permanent employees who are registered with the General Organization for Social Insurance, subject to the employee being actively at work or on normal annual leave, at the time of his Join dates. If the employee is absent from work through reasons of injury or illness, his cover will commence after he has been actively at work for a period of two (2) consecutive weeks, ii) members of a legally established non-profit organization who have, at their first Join dates, reached the age of eighteen (18) but not more than sixty five (65) years. Following attainment of age sixty five (65), the Primary insured shall only continue in force by the timely payment of renewal Premiums until his seventy fifth (75th) birthday.

5.2.2 Dependents: The Dependents of the Primary insured are eligible for coverage under this Policy, provided they are:

i. The legal spouse of the Primary insured who is under sixty five (65) years of age at his Join date and is residing with the Primary insured.

ii. The unmarried children, step children and legally adopted children of the Primary insured provided they are aged, at their Join date fourteen (14) days minimum and eighteen (18) years maximum, are resident with the Primary insured and are dependent upon him for support. In the event of the age being beyond eighteen (18) years and upon submission of relevant proof of education, such children shall only be eligible if they are full-time students at a school, college or university and are not beyond twenty four (24) years of age.

iii. If any Dependant is also eligible to participate as a Primary insured under this Policy, such Dependant shall not be eligible as a Dependant.

iv. When both spouses are insured as Primary insured, any children shall be eligible only as Dependents of the husband.

5.3 General Limitations

5.3.1 Annual Maximum limits: Our liability is limited in amount to the Overall limits and Sub-limits stated on the Policy schedule and Table of benefits.

5.3.2 Cost of Medical Expenses: Our liability with respect to the cost of Eligible medical expenses hereunder claimed is limited to the actual cost or the Reasonable and customary charges, whichever is less.

We shall be the sole arbiter of what constitutes "Reasonable and customary charges". Insured members in doubt shall submit to Us a quotation for the cost of Treatment and seek Pre-authorization before the Treatment is undertaken.

5.3.3 Territorial Limits: This Policy shall apply to Eligible medical expenses incurred within the Territorial limit specified in the Policy schedule and Table of benefits.
5.4 Policy Termination

5.4.1 The Policy will automatically terminate upon non-payment of Premium on the Due date, although We may at Our discretion reinstate the Policy if the Premium is paid within thirty (30) days of its Due date.

5.4.2 Either party may terminate the Policy at any time, by giving thirty (30) days notice in writing of their intention of terminating the Policy, subject to proportionate refund the Premiums for the remaining period until the Expiry date, less twenty percent (20%) of annual Premium for all Insured members who have not registered with Us any Claims. No refund will be payable for Insured members who have registered Claims.

5.4.3 You shall return all Membership cards and other materials facilitating the Treatment before the termination date. If You do not return, You will be the sole and fully liable party towards the Provider and/or Us in respect of any expenses incurred by the Insured members from the termination date of this Policy.

5.4.4 If any of the Insured members makes false or fraudulent Claims or acts fraudulently or in purposeful breaches of the terms and conditions of the Policy, then We have the right to terminate the Policy or delete the Insured member, with immediate effect and forfeit all the benefits and Premiums without prejudice to Our other rights.

5.4.5 Covered benefits arising from Accident or Illness occurring during the Policy period shall cease immediately upon the termination or non-renewal of this Policy.

5.5 Members Enrollments

5.5.1 Primary Insured: Existing Primary insured's coverage begins with the commencement of this Policy.

5.5.2 Dependents: Primary insured's Dependents are eligible for coverage on the Effective date of the Policy. You shall enroll with Us all Your existing Dependents from the Effective date of the Policy, otherwise the Dependents not declared will not be eligible for coverage until the next renewal of the Policy.

5.5.3 Addition: You may at any time, upon completing and sending Us the relevant request form along with the following supporting documents, add new Primary insured and his Dependents or new Dependents of existing Primary insured to the Policy:

i. Certificate of employment for new Primary insured
ii. Certificate of marriage for spouse
iii. Certificate of birth for new born child
iv. Certificate of legal adoption for newly adopted child

Such new Primary insured and/or Dependents shall become eligible for coverage from the date of the receipt of Your addition request.

Premium relating to any approved addition prior to the Policy's (10th) month shall be calculated proportionately for the remaining period until the Expiry date. A minimum premium of twenty five percent (25%) will be charged for any addition from the Policy's tenth (10th) month onwards.
5.5.4 **Deletion:** You may at any time, upon completing and sending Us the relevant request form, delete Primary insured and their Dependants from the Policy subject to:

- Submission of completed deletion request form, issued by Us
- Return of Membership cards and other materials facilitating Treatment prior to the deletion date

The deletion shall be effected from the date of the receipt of Your request for deletion.

The Premium refund relating to any approved deletion shall be calculated in accordance with the following conditions:

a. No refund will be payable for deleted Insured members who have registered with Us any Claim. Insured members who did not report any Claim prior to their deletion date, will be refunded proportionately for the period remaining from the deletion date until the Expiry date of the Policy. We shall pay the refund after ten (10) days from the deletion date provided no Claims were reported within this period.

b. No refund will be payable if Membership cards and other materials facilitating Treatment are not returned. The amount of refund will be reduced proportionately if the return of Membership cards and other materials facilitating Treatment are delayed. In addition, You will be the sole and fully liable party towards the Provider and/or Us in respect of any expenses incurred by the deleted Insured member from his deletion date, until the Membership card and other materials facilitating Treatment are returned.

c. Covered benefits arising from Accident or Illness occurring during the Policy period for your Insured member shall cease immediately upon his deletion from the Policy.

5.6 **Premiums**

5.6.1 All Premiums stated in the Policy schedule are payable to Us in advance of the Due dates as shown in the Policy schedule.

5.6.2 Payment of the Premium is Your responsibility. If Your payment is not made on or before the Due date, We have the right to withhold payment of the Insured members' Claims and/or access to Treatment, or terminate the Policy with effect from the Due date.

5.6.3 You shall not offset against Premiums due any amount owed by or Claimed from Us under this Policy or any other agreement.

5.7 **Policy Alteration**

5.7.1 Your suggestion to alter any terms and conditions of this Policy other than the ones clearly defined under Article 5.5 will be considered for incorporation only at the renewal of the Policy.

5.7.2 At renewal of the Policy, We also may add or alter any terms and conditions of this Policy including the Premiums or any administration procedures, as may deem appropriate by Us.

5.7.3 We reserve the right to change terms and conditions of, or cancel, the Policy at any time notwithstanding any other provision of this Policy if You or any Insured member has:

- Not acted in good faith or has misled Us by withholding any fact material to this Policy
- Ceased to physically reside in the Country of residence for more than one hundred eighty (180) consecutive days during any Policy period
- Breached the terms and conditions of this Policy
- Not paid the Premiums due
5.8 Medical Records

5.8.1 In compliance with applicable laws and regulations concerning medical records, on behalf of the Primary insured and their Dependents, You authorize Us to have physical access, including copies of their records which are maintained by the treating Provider, in respect of Treatments incurred under the terms of this Policy.

5.8.2 We agree to maintain strict confidentiality of such records.

5.9 Recovery

5.9.1 In accordance with the terms of this Policy, You are liable for all Claims paid by Us to the Designated providers, for Insured members under the following conditions:
   a. For excluded Treatments
   b. Claims paid for Insured members who are no longer eligible for cover
   c. Claims paid for Insured members during any period when Premiums are in arrears
   d. Fraudulent use of Membership cards by any of the Insured members

5.10 Subrogation

5.10.1 We have full rights of subrogation and may take proceedings in any of the Insured member’s name, at Our expense, to recover for Our benefit the amount of any payment made under this Policy due from any third party responsible for the Eligible medical expenses incurred.

5.11 Currency

5.11.1 All payments made by either party shall be made in Qatari Riyals. Amounts paid or received by Us in any other currency shall be converted to that currency at the prevailing market rate of exchange at the date such transaction is entered on Our books.

5.12 Expert Opinion and Arbitration

5.12.1 Any differences in respect of medical opinion in connection with the results of an Accident or Illness shall be referred to two (2) medical experts appointed in writing by the two (2) parties to the dispute, one to be appointed by each party. If the two (2) experts are unanimous in the opinion, then it shall be binding on both parties. If they are not unanimous in their opinion, then the matter shall be referred to arbitration as hereinbelow.

5.12.2 Subject to Article 5.12.1, any dispute or difference between the parties in respect of this Policy shall be referred to a sole arbitrator mutually agreed, failing which, appointed by the Qatari Court. The decision rendered by such arbitrator shall be final and binding.

5.13 Governing Law

5.13.1 This Policy shall be governed by and construed in accordance with the laws of State of Qatar.

5.14 Enforcement

5.14.1 You and Us are the only parties to this Policy. Other Insured members will have no right to enforce this Policy or any part of it.
6 Claims Administration

6.1 Notice of Claim

6.1.1 Notice of any Claim must be submitted on a fully completed Claim form along with other supporting documents within a maximum of thirty (30) days from the Treatment date. Supporting documents shall include the following:

i. Original prescription
ii. Original detailed and dated receipt
iii. Pre-authorization form, if applicable
iv. Full and detailed medical and diagnostic reports
v. Any other medical information that may be deemed necessary by Us

6.2 Settlement of Claims

6.2.1 Direct Billing: We have an arrangement that allows for direct submission of Claims by the Designated providers. Insured members shall use the facilities of the Designated providers, by presenting their Membership cards to the Providers at the time of their visits. If an Insured member pays for the Treatment at a Designated provider, We will only reimburse You the agreed charges between Us and the Designated provider.

6.2.2 Reimbursement: If an Insured member receives Treatment at a Provider other than his Designated providers, We will reimburse You the cost of Eligible medical expenses within twenty one (21) working days, provided completed Claim form along with any other document to support the Claim, as specified under Article 6.1.1 are submitted to Us within a period of thirty (30) days from the Treatment date. The amount paid will be the Reasonable and customary charges for the Medically necessary treatments, less any applicable Deductible and/or Coinsurance, as specified in the Policy schedule, Table of benefits and Membership cards.

6.3 Claim Denials

6.3.1 We have the right to decline or return submitted Claims, under the following conditions:

i. Submitting incomplete Claim form or missing medical report
ii. Attaching photocopies of receipts, prescriptions, diagnostic services or others
iii. Treating Physician's signature and seal is not on the Claim form
iv. Tests, drugs and Treatments not prescribed by Physicians
v. Diagnosis and Treatment are not medically relevant
vi. Tests or Treatments for which Pre-authorization is required in accordance with the terms and conditions of this Policy, but for which the Pre-authorization has not been obtained
vii. Services received are within the General exclusions of the Policy
viii. Tests, drugs and Treatments not Medically necessary for the conditions presented
ix. Expenses in excess of the Reasonable and customary charges
x. Claims are submitted after thirty (30) days from the date of Treatment
xi. Expenses exceeding Annual maximum limits
xii. Treatments after the Policy has expired
xiii. Treatment was before the Insured member's Join date or before the Effective date of the Policy
6.4 Appeals on Claim Denials

6.4.1 Settlement of eligible Claims shall be considered final unless objections along with supporting justifications are received in writing along with relevant reports and facts within a maximum of one (1) month from the date of receiving the payment. We reserve the right to deny any objections received after the said period.

6.4.2 We will review the justifications received and payments for any approved Claims will be made within fourteen (14) days from the date the justifications were received.

6.5 Pre-Authorization

6.5.1 Our Pre-authorization is required before the Insured member undertakes any Treatment for the following services:

i. All Inpatient and Daycare treatments and services, as specified under Article 3.1 of this Policy.
ii. Computerized tomography (CT Scan) and magnetic resonance imaging (MRI)
iii. Physiotherapy sessions & if Medically necessary
iv. Outpatient investigations including endoscopies, hormone profile, immunological tests (such as thyroid function tests, immunofixation electrophoresis, anti nuclear antibodies tests and the like), echocardiography, stress test and holter monitoring
v. Long term medications (more than one month)
vi. Maternity Treatments (Inpatient only)

6.5.2 For Emergency Treatments, an Insured member must notify Us within twenty four (24) hours of his admission or prior to his discharge, whichever is earlier. We reserve the right to deny the request for Pre-authorization of the Emergency Treatment, beyond the said twenty four (24) hours period, if such notice is not provided.

6.5.3 Pre-authorization is valid for a maximum period of fourteen (14) days from the date of issue. The Insured member shall obtain a new Pre-authorization, if he does not utilize it within the said fourteen (14) days period.

6.5.4 Notwithstanding Article 6.5.3, the Pre-authorization shall expire automatically on the Insured member's deletion date or with the termination of the Policy.

6.5.5 Pre-authorization does not guarantee either payment or the amount of Claims. Eligibility for and payment of Claims are subject to review of detailed medical reports, investigation results, diagnostic results, discharge summary, Medically necessary treatment and all the terms, conditions, provisions and exclusions of the Policy.
GlobeMed a Third Party Administrator (TPA) is a specialized service company that has a privileged cooperation relationship with specific Preferred Provider Networks (PPN) of hospitals and other healthcare service providers in Qatar and Outside Qatar.

GlobeMed Qatar LLC is licensed by the Qatar Financial Center Authority (QFC) and is located in the Qatar Financial Center 3rd Floor, Office No. 302, West Bay, Qatar.

Doha Bank Assurance Company LLC has appointed GlobeMed as the Third Party Administrator to support the Network Access to insured members and for processing the claims submitted by insured members.

The contract telephone numbers and hotline numbers of GlobeMed is provided below for assistance, clarification and pre-authorization relating to claim related issues:

**State of Qatar**

| Land Telephone Numbers | Tel: + 974 44056999  
|                        | Fax: + 974 44056990  
|                        | During the working days Sunday to Thursday from 8 am to 5 pm (members can also call at the above number after office hours, the calls will be diverted to the hotline contact numbers as provided below, automatically) |
| Hotline Numbers        | + 974 6664 4423  
|                        | Accessible 24 / 7, 365 Days  
| Email of Dr. Jaber Samer | sjaberr@globemedqatar.com  
|                        | Accessible 24 / 7, 365 Days  
| International Customer Support | + 961 1 485 666  
|                            | Accessible 24 / 7, 365 Days  

Outside Qatar please contact International Customer Support Center as soon as reasonably possible prior to hospital admission, giving full details of the medical condition, proposed treatment details along with the health provider details. The International Help Center will advise you if they have sufficient information to confirm your cover. If not, they will advise you what further information is required. When sufficient information has been made available to appraise your claim, they will verbally confirm the basis of cover and will dispatch written confirmation to you.