OMAN UNITED INSURANCE CO SAOG

HEALTHCARE INSURANCE CONTRACT

A. PREAMBLE

This Policy is a contract between Oman United Insurance Co SAOG (hereinafter referred to as the **"Insurer"** and (hereinafter referred to as the **"Insured"**). In consideration of the payment of the Premium and on basis of the request and statements made by the Insured and subject to the terms and conditions of this Policy and any attachment forming part of it, the *Insurer* agrees and undertakes to pay for eligible medical benefits and healthcare services and their related expenses incurred by each *Beneficiary* as set forth in this Policy.

The information provided to the Insurer by or on behalf of the Insured is the basis of this contract and any non-disclosure or wrong disclosure of material facts therein shall invalidate the insurance cover and no benefits under the policy shall be payable.

Any benefit not shown in the Policy schedule, Table of benefits and Medical cards is not provided for under this Policy. Insured shall examine the Policy, Policy schedule and Medical cards carefully to make sure the required protection has been provided.

Throughout this *Contract*, the masculine gender shall be deemed to include the feminine, the singular the plural and the plural the singular.

For and on behalf of

Oman United Insurance Co SAOG

(The Insurer)

For and on behalf of

(The Insured)

B. DEFINITIONS

Words, terms, expressions and abbreviations used in the context of this *Contract* shall have the meanings set forth here below:

Insurance Terms

1. ***Insurer*:** The Insurance Company or *Payer* duly registered and licensed to operate in the country of issuance of this *Contract*.

2. **Insured:** The individual or legal entity applying for this *Contract* which acts as the principal in the capacity as well as in the name of and on behalf of any *Legal Dependents* or *Household Personnel* and whose *Application Form* has been *form*ally accepted by the *Insurer*.

3. ***Contract*:** The *Contract* or insurance policy (as defined in Article 1 of the *general terms* and *conditions*) whereby the *Insurer*, subject to the terms, provisions, limitations, *Exclusion*s and other conditions provided herein, guarantees the payment of the *Benefits* set forth in the *Schedule*.

4. ***Contract Schedule:*** The *Schedule* in which the *Beneficiary* and *Insurer* data are specified together with the specific conditions of the *Contract*. Listing of data includes: the *Contract* parties' data, the *Effective Date*, the *Expiration Date*, the *Beneficiaries*' data, the *Enrollment Dates*, the *Specific Exclusions* and related *Exclusion Waiting Period*s, if any, the Policy Period *Limits* when applicable, the *Hospitalization Class*, the *selected Plan/Products*, the *premium*, the *frequency of payment*, and reference to the *Applicable Scope of Coverage Schedule*.

5. ***Applicable Scope of Coverage Schedule*:** The *Schedule* which designates what *Plan/Product* or *Program*s have been selected by the *Contract holder* on behalf of the specified *Beneficiaries* (*Coverage*, *Limits*, *Deductible Excess*, *Co-Pay*, if any, Territoriality, Provider Network etc.).

***6. Application Form for Insurance* (*herein referred to as Application Form*):** A written statement of facts requested by the *Insurer* and duly completed and signed by the *Contract holder* on the basis of which the *Insurer* conducts *Underwriting* in full accordance with the general provisions of this *Contract*. There are two types of *Application Form*s.

6.1. ***Initial Application Form*:** The first *Application Form* completed by the *Contract holder.*

6.2***. Subsequent Application Form*:** The form that the *Contract holder* completes requesting the introduction of modifications to the *Contract* in force and/or transfer of *Beneficiary* in full conformity with the general provisions of this *Contract.*

7. ***Employee*:** Any person, *Actively at Work,* working on full time basis for the *Contract holder* and being remunerated accordingly.

***8. Enrolled Employee*:** Any *Employee* covered under this *Contract* as the result of the *Contract holder* application and the acceptance of the *Insurer* in conformity with the *Contractual* procedure.

***9. Legal Dependents*:** The unmarried children of the employee who are 18 years old or younger or below 25 if full-time students; the spouse(s) of the employee and any other relative who is considered by law as a legal dependent of the employee.

***10. Beneficiary*:** The *Contract holder*, *Legal Dependents* or *Household Personnel* listed in the *Application Form*/s or included thereafter, *form*ally accepted by the *Insurer* and listed in the *Contract Schedule* or in any subsequent *Endorsement* are considered as eligible *Beneficiary* and referred to as *Beneficiary* under this *Contract*.

***11. Category*:** The sub-group of beneficiaries within the group covered under this *Contract* and for which the *Contract holder* has selected per status a *Product* and decided upon particular considerations as specified in the *Schedules* and the *Beneficiary*'s master file.

***12. Active at Work*:** The work situation of any *Employee* reporting regularly and on a permanent/full time basis to his workplace and performing his usual and normal duties of his occupation in conformity with the employment conditions.

***13. Renewal*:** The continuance of coverage under a *Contract* beyond its original term by the offer and acceptance of a premium for a new policy term.

***14. Expiration Date*:** The day - month - and - year this *Contract* expires

15. Renewal Date: The day - month - and - year which coincides with the *Expiration Date* of this *Contract*.

***16. Cancellation Date*:** The day - month - and - year this *Contract* is cancelled as a result of the *Contract holder*'s written notice and/or as a result of the non-fulfillment of the *Contract holder*'s obligations as set forth in the general terms herein.

17. ***Addition Date*:** The day - month - and - year the *Beneficiary*'s coverage starts as the result of joining the organization during the currency of policy.

***18. Deletion Date*:** The day - month - and - year the *Beneficiary*'s coverage is terminated as the result of deletion from this *Contract* at the request of the *Contract holder*.

***19. Standard Exclusions*:** The combined list of *Exclusion*s that are specified under *Product Exclusions* and *Plan Exclusions*.

***20. Product Exclusions*:** The *Exclusion*s which are applicable under this *Contract* to all *Plans*.

***21. Plan Exclusions*:** The *Exclusion*s which are attached to a specific Plan.

***22. Specific Exclusions*:** The *Exclusion*s resulting from the *Underwriting* process which are applied specifically to a certain *Beneficiary*.

***23. Exclusion*:** Specific illness/es, treatment/s, service/s or cause/s that are expressly not covered under this *Contract*.

***24. Covered Cases*:** Any *Claim* that is covered according to the conditions of this *Contract*.

***25. Underwriting*:** The process of risk evaluation conducted by the *Insurer*, through the questionnaire supplied in the *Application Form*s prior to issuance of the *Contract* and any other related *Endorsement*.

***26. Substandard Terms*:** Special terms allowing coverage of the *Beneficiary* under this *Contract* as a result of *Underwriting* (i.e. Additional *premium* and/or *Specific Exclusion* and/or special limits).

***27. Exclusion Waiting Period*:** The limited period following a *Contract*'s *Effective Date* where certain *Contract Benefits*, illnesses, conditions, treatments or services are not eligible to be covered. Specified conditions which have *Exclusion Waiting Period*s are not covered for the currency of the policy in the event the *Beneficiary* becomes ill with the condition during the *Exclusion Waiting Period*.

***28. Exclusion Waiver Date*:** The date the *Exclusion Waiting Period* is over.

29. Co-Pay: The final participation according to defined percentage in the Eligible Claims expenses of the *Beneficiary* further to the terms of this *Contract* and/or *Co-Payer* participates according to the defined percentage. The Insurer shall be liable to the balance of the *Eligible Expenses*.

30. Co-Payer: An entity or a person participating with the *Insure*r in the payment of an *Eligible Expense,* in accordance with a defined percentage as specified under the *Contractual Schedule* and/or the *Applicable Scope of Coverage Schedule.*

***31. Gross Premium*:** The amount to be paid by the *Contract holder* for the insurance coverage including applicable taxes and *Underwriting* adjustments, when applicable.

32. Eligible Expenses: Expenses covered by the *Contract* inclusive or not of *Specific Deductible Excess*, *Aggregate Deductible Excess*, *Co-Pay* shares and/or limits as defined in the *Applicable Scope of Coverage* and *Partnership Schedule*.

***33. Specific Deductible Excess*:** The amount of money as specified in the *Applicable Scope of Coverage* to be paid by the *Beneficiary / Contract holder for specific services*.

***34. Aggregate Deductible Excess per Beneficiary*:** The accumulated amount of money relating to *Eligible Expenses* specified in the *Applicable Scope of Coverage* which are paid by the *Contract holder* on behalf of a specific *Beneficiary*, in addition to *Specific Deductible Excess* and/or the *Contract holder's Co-Pay* if and when applicable during the period of this *Contract.*

35. Eligible Claim**:** *Eligible Expenses* minus *Specific Deductible Excess*/*Co-Pay*, within the limits of liability of the *Insurer* as defined in the *Applicable Scope of Coverage* and *Contract Schedule*.

36. Concurrent Coverage: *Eligible expenses* that are either payable under another insurance policy or pertain to treatment at Government hospitals that is provided free of charge.

37. Pre-Existing Condition**:** Any *Beneficiary's* health condition known to the *Beneficiary* and/or to the *Contract holder* that exhibited symptoms or was a consequence of *Injury* or illness for which medical, surgical and/or pharmaceutical treatment, medical diagnosis or advice was provided prior to the *Beneficiary*'s *Enrolment Date*.

38. Undeclared Pre-Existing Condition**:** The non-disclosure of any *Pre-Existing Conditions* relating to symptoms, diagnosis, health conditions by the *Beneficiary* and/or by the *Contract holder* acting on behalf of the *Beneficiaries,* when completing any *Application Form* related to this *Contract*.

38. Declared Condition**:** Every *Pre-Existing Condition* that was declared by the *Contract holder* in an *Application Form*.

39. Hazardous Activity: Any Activity which exposes the *Beneficiary* to serious injury or illness such as but not restricted to piloting, motorcycling, mountaineering, underwater activities using artificial breathing apparatus, parachuting hang-gliding, motor-racing, etc.

40. Proof of Insurability**:** The medical and/or non-medical documentation supplied by the *Beneficiary* which may be necessary for the evaluation of the *Application Form* during the *Underwriting* process.

41. Cash Indemnity**:** A lump sum payable to a *Beneficiary* in relation to eligible *Benefits* as specified under this *Contract* and the *Applicable Scope of Coverage* when applicable.

42. Endorsement**:** Any amendment to the existing *Contract*, usually addition or deletion of an insured or *Plan/Product* changes.

<u>Coverage Terms</u>

***43. Product*:** The packaging of *Plans* offered by the *Insurer* and selected by the *Contract holder* in the *Application Form*.

44. Plan/Product: The covered Families of Benefits, Families of Services, covered Clauses, *Exclusion*s, the method of *Claim*s handling, territorial limits, financial restrictions etc. that are offered by the *Insurer* under a given *Product*.

45. Annual maximum limit: is the total amount that may be claimed in a Policy period by an insured member. These limits are shown in the Table of benefits.

***46. Family of Benefits*:** A grouping of one or more *Family of Services* (e.g. In-Patient, Out-Patient, Maternity, Dental and Optical) which categorizes healthcare services which are covered through a *Product* under a given *Contract*.

47. Family of Services: The grouping of services which are medically related to each other and are associated to Families of Benefits such as but not limited to room & board, radiology, laboratory, pharmacy, surgery, etc.

48. Services: Related sub-grouping of items which comprise a given Family of Services.

***49. Scope of Coverage*:** A pre-defined frame in which the *Beneficiary* is covered by the *Insurer* (e.g. in addition to the *Family of Benefits*, the territorial limits, financial limits or other parameters).

***50. Inpatient Treatment*:** Treatment where the insured member requires Hospitalization for a minimum of 18 hours including one (1) night for medical attention and care, before, during and after the Treatment. Such Treatments cannot be performed on an Outpatient basis.

***51. Outpatient Treatment*:** *Physician*'s consultation, prescribed drugs, diagnostic tests and treatments which do not require *Hospitalization* or necessitate specialized medical attention and care in a *Hospital* before, during and after the procedure.

52. Co-insurance: is the percentage of costs the insured member must pay.

53. Deductible/excess: is the first amount of a claim which has to be borne by the insured member before the relevant benefits are payable under the policy. In the event that the total cost of treatment is lower than the deductible amount the insured will be liable to pay all the expenses incurred.

Operational Terms

***54. Claim*:** Information submitted by a Provider or by the *Contract holder* or by a *Beneficiary* to establish that medical services were provided to a *Beneficiary*, within the frame of the Benefits selected by the Contract holder, and from which processing for payment to the Provider or *Beneficiary* is made. The term generally refers to the liability of the *Insurer* for healthcare services received by one of the Beneficiaries.

55. ***Providers:*** A generic term for *Physician*s, *Hospital*s, clinics, medical centers or persons who are licensed to offer healthcare services.

Medical Terms

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

57. ***Hospital*:** Any public medical institution which is legally licensed and provides medical treatment to sick and injured person. The facility must consist of organized premises, possess the necessary technical and scientific equipment for diagnosis and surgical operations and should provide healthcare services 24 hrs a day by a team of staff of at least one resident *Physician* and qualified nurses. The term "*Hospital*" excludes out-patient clinics, sanatorium, physiotherapy centers, health clubs, retirement homes, nursing homes and similar institutions, including those specialized in substance abuse (drugs, alcohol).

58. ***Hospitalization*:** Any *Hospital Confinement* for a minimum of 18 hours including one night for *Medically Necessary* treatments or observation of any non-excluded disease, sickness or *Injury* which necessitates specialized medical attention and care in a *Hospital* before, during and after the treatment or observation and cannot be per*form*ed on an Out-of-*Hospital* basis.

***59. Confinement*:** An uninterrupted stay for a defined period of time in a *Hospital*, skilled nursing facility or other approved healthcare facility or program followed by discharge from that facility or program.

60. ***Day-Care*****:** Same day Surgery and medical treatment or diagnostic related to any *Non-Excluded Cases*, not requiring an overnight stay at a *Hospital* but nevertheless necessitating specialized medical attention and care in a *Hospital*, before, during and after the procedure.

61. Surgery**:** Any invasive procedure including laser use to diagnose, cure or rectify an illness, condition, defect or malformation. In this context, invasive diagnostic procedures such as endoscopy, catheterization (with the exception of rhino gastric, urethral, peripheral venous and/or arterial) angiography, as well as destruction of kidney stones or gall stones will be considered as *Surgery*.

62. Emergency**:** A health condition sustained as a result of sudden, non-excluded illness or *Injury*, raising a legitimate professional concern that there may be a significant medical problem necessitating treatment (medical or surgical) to be per*form*ed exclusively within the *Territory of Occurrence* which cannot be delayed and which requires immediate confinement to a *Hospital Emergency* Facility followed by *Hospitalization* or not. Admission to a *Hospital* facility must be conducted within 24 hours of the illness or *Injury* onset.

63. Maternity**:** Hospital Confinement for Normal or Caesarian Delivery, Medically Necessary Abortion or Miscarriage and/or any complications arising there from.

64. New Disease, Surgery, or Injury**:** Surgery and/or Disease and/or Injury non-related to a Declared Condition or to an *Undeclared Pre-Existing Condition*.

65. Chronic Disorder**:** A disease requiring a regular, lifetime treatment.

66. Unnecessary Treatment**:** A service or treatment which is not Medically Necessary.

67. Medically Necessary**:** In the opinion of the *Insurer*, services, drugs, supplies or equipment provided by a hospital or covered provider of healthcare services that the Risk Carrier determines are all of the following:

a) required for the treatment or management of an illness or injury

b) appropriate to diagnose or treat the patient's condition, illness or injury

c) are consistent with standards of good medical practice

d) are not primarily for the personal comfort or conveniences of the patient, family or the provider

e) are not a part of or associated with the scholastic education or vocational training of the patient or primarily for education or experimental purposes

f) in case of in-hospital care, cannot be provided safely on an non in-hospital basis.

g) given in the most cost efficient setting consistent with maintaining safe care.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug, equipment does not, in itself, make it medically necessary.

General Definitions

***68. Injury*:** Physical damage other than illness, including all related conditions and recurrent symptoms which are usually caused by an *Accident*.

69. ***Accident*:** An unforeseen and unintended event causing acute physical damage to a *Beneficiary*.

***70. Territory of Occurrence*:** The country where the *Beneficiary*'s health condition occurs, requires healthcare services and where related expenses were incurred.

***71. Abroad*:** Any country excluding the country where this *Contract* has been issued.

72. Reasonable and Customary: Medical Expenses as agreed between Insurer/TPA and Provider which conform to the level of charges made by the majority of Physicians and/or hospitals in the Sultanate of Oman.

73. Medical expenses: reasonable and customary costs and expenses for Medical, Surgical and Specialist Fees, Hospital, Nursing Home and Nursing Attendance Charges, Costs of Physiotherapy, Massage and Manipulative Treatment, Surgical and Medical Requisites, (provided they are recommended and/or prescribed by the treating Physician). All these expenses to be necessarily incurred and arising from Accidental Bodily Injury occurring or Illness manifesting itself during the policy period.

74. Designated providers: Providers who are part of Insurer/TPA network of clinic/hospitals where Medical Cards issued by the Insurer/TPA are accepted for cashless treatment for eligible medical conditions.

75. Non-Designated providers: Providers who are not part of Insurer/TPA network of clinic/hospitals where Medical Cards issued by the Insurer/TPA are not accepted for cashless treatment for eligible medical conditions. Any treatment for eligible medical condition, taken at Non- designated providers would be considered for reimbursement claim as per Reasonable and Customary charges.

C. GENERAL TERMS AND CONDITIONS

Article 1. *Insurance Policy* (herein referred to as *Contract*)

The Application Form/s duly completed by the *Contract holder* acting on behalf of himself and/or eventual other *Beneficiary*, the Preamble, the Definitions, the General Terms and Conditions, the *Schedules*, the *Beneficiary* User's Guide, the different options as well as any attachment and endorsement to any of the aforementioned shall constitute the entire *Contract* between the *Insurer* and the Contract holder. Any amendment or addition to this *Contract* 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 *Contract* or waive any of its provisions.

Article 2. C*ontract* Validity

The validity of this *Contract* (in regard to each *Product* selected) begins from to as specified in the *Contract*ual *Schedule*. However, each *Beneficiary* is covered under this *Contract* as from his Enrollment Date as specified under the *Contract Schedule* and/or any related Endorsement up to the *Expiration Date* of this *Contract*.

Article 3. *Application Form*

This *Contract* and its related endorsements have been issued by the *Insurer* on the basis of the *Contract holder* declarations. The *Insurer* reserves the right to reject any Subsequent Application which is not in conformity with the provisions of this *Contract*.

Article 4 . *Benefits*

Unless otherwise stated herein, the Insured shall be covered for the related non excluded medical expenses for In-Patient and/or Out-Patient treatments only arising out of Accidental Bodily Injury or Illness and above any amount he is entitled to, under a concurrent coverage (Social

Security or any other Fund of Insurance), up to the amounts he is entitled to under this Policy or the actual cost whichever is the lesser.

This cover undertakes treatments in the territory limits defined in the product only, but worldwide (**excluding USA and Canada**) in respect of business travel or vacation (of a period maximum up to **45** days) during the policy period, confined to emergency cases only and subject to prior approval of Insurer. This limit would be extended to a max of 90 days in special cases subject to leave approval by the company

For the specific cases (**treatments outside Sultanate of Oman**) reimbursement will be limited according to reasonable and customary price of applicable network in Oman at the time of the treatment and within the policy limit.

4.1. *Inpatient*

The scope of cover for inpatient benefits includes the following:

- Consultant's & Physician's fees
- Surgeon's & anesthetists fees
- Surgery fees
- General nursing care
- Diagnostic procedures
- Operating Theatre charges
- Recovery room charges
- Intensive care unit charges
- Drugs and medications dispensed in the Hospital
- Dressings
- Other eligible services whilst hospitalized
- Post operative physiotherapy, if medically necessary
- Ambulance
- Parent accompanying an insured child under ten (10) years of age (if covered)
- Hospital cash benefit if the Treatment is received in a government Hospital where the Treatment is provided free of charge.
- Nursing at home, for recovery and in lieu of Hospital stay up to a maximum of fourteen (14) days per admission or procedure (if covered)

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

- **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 innless, 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.

- **Post Surgeries:** Two (2) follow up visits and physiotherapy sessions to the same Provider, if requested by the treating surgeon, 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.

Following benefits are the optional benefits which are applicable only if Policy schedule, Table of benefits and the member ship cards mention that these benefits are covered.

4.2. Outpatient

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

- Physician's Consultation fees
- Diagnostic Procedures
- Prescribed drugs
- Physiotherapy on referral by a Physician
- Bandages and plaster casts used during procedure only if medically necessary and prescribed by a Physician.

4.3. Maternity

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

- Physicians' Consultation fees
- Antenatal care, delivery and post natal care
- Caesarian section, if medically necessary
- Hospital services
- Vitamin and mineral supplements
- Complications arising from pregnancy
- Legal abortion, approved as medically necessary by a Physician and Insurer
- Care of the child whilst the mother is in Hospital

Exclusions: The following Treatment and services are excluded:

- Investigations or Treatment related to maternity within the moratorium period of two hundred eighty (280) days from the Insured member's joining date, unless otherwise stated in the Table of benefits.
- Abortion due to voluntary, psychological or social reasons, and its consequences.
- Elective cesarean deliveries, if not medically necessary.

4.4. Dental

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

- Dentist's Consultation
- Diagnostic procedures
- Related prescription
- Extractions
- All fillings including amalgam, composite and glass ionomer fillings
- Gum and root canal Treatment

Exclusions: The following Treatment and services are excluded:

- Routine dental Treatment including but not limited to cleaning, scaling and polishing
- Dentures, bridges and crowns
- Cosmetic Treatment
- Replacement of Tooth

4.5. Optometry/Optical

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

- Vision tests to diagnose the following errors of retraction'
- Hyperopia
- Myopia
- Astigmatism
- Anisometropia
- Presbyopia

Plain medical lenses only for the correction of the above mentioned errors of refraction as prescribed by the Ophthalmologist.

If pre-existing condition benefit is included in the policy, then Treatment for the following conditions are covered:

- Cataract
- Diabetic Retinopathy
- Retinal detachment
- Glaucoma

- All Ophthalmic conditions other than those mentioned in the below exclusions

Exclusions: The following Treatment and services are excluded:

- Spectacle Frames
- Contact lenses
- Photo chromatic lenses
- Surgeries for correction of errors of refraction
- Strabismus
- Ptosis
- Ophthalmic surgery
- LASIK

Article 5. *Premium*

The *Premium* is the *Gross Premium* plus any applicable stamps and/or taxes if any.

The premiums due by the *Contract holder* to the *Insurer* as defined in the *Contract Schedule* are payable in advance by the *Contract holder* according to the frequency of payment agreed upon between the *Contract holder* and the *Insurer* and as specified in the *Contract Schedule*.

The coverage provided by the *Insurer* under this *Contract* shall not commence until the first installment is fully paid.

In the event the Premium is not paid within the grace period of 30 days starting from the due date, this *Contract* will be terminated and the *Contract holder* will be liable for the amount due until the date of Cancellation.

The *Premium* payment is substantiated exclusively and solely by the issue of a relevant receipt from a legally authorized representative of the *Insurer*.

Article 6. Enrollment

The *Contract holder* has declared in writing at the date of the initial application that all *Employee*s are enrolled on compulsory basis. By virtue of the *Contract holder* declaration, this *Contract* was underwritten and issued by the *Insurer*.

Similarly, the *Contract holder* should declare if the *Legal Dependents* per *Category* are to be enrolled on compulsory basis or not.

In accordance with the *Contract holder* declaration, it is agreed and understood that all *Employee*s without exception are to be included under this *Contract*.

Similarly, all *Legal Dependents* related to a specific *Category* for which the *Contract holder* has declared that enrollment of *Legal Dependents* is compulsory, are to be included under this *Contract*. However, *Legal Dependents* relating to a *Category* for which the *Contract holder* has not required and declared, the status of compulsory cannot be enrolled under this *Contract*.

It is fully agreed and understood that the enrollment rules as stated under this article form one of the basis of this *Contract*. The non-compliance by the *Contract holder* to these rules shall give to the *Insurer* the right to terminate this *Contract* from effective date without premium refund.

6.1 General Rule

The *Contract holder* has the right to require from the *Insurer* by completing and signing an *Application Form*, for the addition of new *Beneficiary*.

The *Insurer* shall restrict the enrollment of new *Beneficiary* which addition has been applied for by the Contract holder, to:

- New *Employee*s.
- New Spouse in case dependents are on compulsory basis for the concerned *Category*.
- New born child or new adopted child in case dependents are on compulsory basis for the concerned *Category*.

6.2 Supporting Documents

Submission by the *Contract holder* of supporting documents relating to the required addition which are satisfactory to the *Insurer* are necessary for the validation of any eligible addition.

6.3 Effective Date

The effective date of any approved addition should match with:

For New *Employee*	: The official date of employment
For New Spouse	: The date of marriage
For New born child	: The date of birth
For New adopted child	: The date of official adoption

6.4 *Underwriting*

The initial *Underwriting* terms as applied on the effective date of this *Contract* shall be applied for all eligible additions which were required within a period not exceeding 30 days from the effective date of the required addition.

6.5 *Premium*

The *Premium* relating to any approved addition shall be calculated on pro-rata basis.

Article 7. Deletion

7.1 General Rules

The *Contract holder* has the right to require from the *Insurer* by completing and signing a *Application Form*, the deletion of *Beneficiary*.

The *Insurer* shall restrict the deletion of *Beneficiary* which deletion has been applied for by the *Contract holder* to:

- Deceased *Employee*s.
- Terminated *Employee*s (Retired, Resigned, Dismissed).

- *Legal Dependents* of *Employee*s eligible for deletion.

7.2 Supporting Documents

Submission by the *Contract holder* of supporting documents, relating to deletion request which are satisfactory to the *Insurer* is a pre-requisite for deletion validation

Among required documents is the return of the Medical Card of the *Beneficiary* for which deletion is applied.

7.3 Effective Date

The effective date of any approved deletion should match with one day following the date of death of the *Employee* or one day following the date of termination of the *Employee*.

7.4 Liability

The *Contract holder* shall be the sole and fully liable party towards the Provider(s) and/or in relation with any health expenses incurred by the deleted beneficiaries as from the effective date of deletion.

7.5 Refund *Premium*

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

- No refund will be payable for deleted Insured members who have registered any Claim under the Policy. Insured members, who did not report any Claim prior to their deletion date, premium will be refunded proportionately for the period remaining from the deletion date until the Expiry date of the Policy. Insurer shall pay the refund after ninety (90) days from the date of intimation of deletion, provided no Claims were reported within this period.
- No refund will be payable if Medical 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.
- Covered benefits arising from accident or illness occurring during the Policy period for Insured member shall cease immediately upon his deletion from the Policy.

Article 8. ***Category***

The *Contract holder* has declared in writing at the date of the initial application, the different categories of his group of *Employee*s in accordance with set criteria. Each *Employee* shall be enrolled at the initial effective date or at any subsequent effective date with his/her dependents under a specific *Category* in full accordance with applicable criteria.

Article 9. Amendments

The *Contract holder* has the right to require amendments on the initial *Contract* conditions.

However, any amendment other than the ones clearly defined under article 9 and 10 shall be subject to the *Insurer* new *Underwriting* process whose outcome may not be in line with the *Underwriting* terms applied at the effective date of this *Contract*.

Article 10. Endorsement Validity

Any addition, deletion or any other amendment can only be considered as accepted by the *Insurer* when and if a relevant endorsement is issued, sealed and signed by the *Insurer*.

Article 11 .*Claim*s Notification

Written notice shall be given to the Company as soon as possible after the occurrence of any Accidental Bodily Injury or Illness in respect of which a claim is to be made, but in any event within forty five days **(45)** of the date of such occurrence. All information and evidence required by the Company shall be furnished without expense to the Company and in such form as the Company may require. An Assured Member, as often as required, shall submit to medical examination on behalf of the Company and at the Company's expenses in respect of any Accidental Bodily Injury or Illness.

Article 12 .*Claim*s Receivability

12.1 In-Patient Family of Benefits.

It is agreed and understood that the Inpatient *Family of Benefits* is limited to *Eligible Expenses* arising from Inpatient admissions which have admission dates occurring within the validity period of this *Contract*. The liability of the *Insurer* ceases on the date of discharge and is limited to the services rendered during the Episode of Care not exceeding 30 days past the *Expiration Date* of the policy.

12.2 Direct Billing

Insurers 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, insurer will only reimburse the insured the agreed charges between insurer and the designated provider.

12.3 Reimbursement

If an insured member receives Treatment at a Provider other than the Designated providers, Insurer will reimburse the insured the cost of Eligible medical expenses provided completed Cash Claim form along with the following documents to support the claim within a period of fourteen working days (**14**) from the Treatment date provided all documents has been submitted.

- Original prescription
- Original detailed and dated receipt
- Pre-authorization form, if applicable
- Full and detailed medical and diagnostic reports
- Any other medical information that may be deemed necessary by Insurer.

Article 13. Subrogation

Once the Insurance *Claim* has been paid in accordance with the current terms, the *Contract holder* subrogates his/her right to the *Insurer* to pursue any third party responsible for an injury the *Contract holder* and the *Beneficiary* transfer to the *Insurer* every relevant substantial and legal right. Both, the *Contract holder* and the *Beneficiary* shall provide the *Insurer* with every possible assistance in the case the *Insurer* exercises the above right of subrogation. Should the *Contract holder* and the *Beneficiary* breach this obligation, they shall be responsible for any losses incurred by the *Insurer*.

Article 14. Cancellation

14.1 Contract holders right

The *Contract holder* has the right to formally request the cancellation of this *Contract* from the *Insurer*.

By doing so the *Contract holder* shall be the sole and fully liable party towards the healthcare providers and/or the *Insurer* in relation with healthcare expenses incurred by the present beneficiaries as from the *Cancellation Date* of this *Contract*.

To this effect, the *Contract holder* should make sure that the *Beneficiary* Medical cards have been withdrawn prior or at the *Cancellation Date*.

The premium refund relating to the cancellation of this *Contract* should be calculated on pro-rata basis. No refund will be allowed for Insured members who have registered Claims.

***14.2 Insurers* right**

The *Insurer* has the right to cancel the present *Contract* in the following instances:

a) Proven false statements made by the *Contract holder* as per Article 8,9,10, and

11.

b) Non-Payment of premium on the due date, although the insurer may at their discretion reinstate the policy if the premium is paid within 30 days of its due date .

c) Payments made in excess of the individuals benefit limits/sub limits

d) Treatments taken for excluded treatments

e) For claims made by the members who are not eligible for cover

f) In respect of the fraudulent use of membership cards.

In case of the *Insurer* legitimately canceling this *Contract*, no premium refund shall be due to the Contract holder.

The company may cancel this policy by sending seven days notice by registered letter to the Assured at their last known address.

The premium payment is substantiated exclusively and solely by the issue of a relevant receipt from a legally authorized representative of the *Insurer*.

Article 15. Legal Jurisdiction

This policy shall be construed and have effect in accordance with the laws of the Sultanate of Oman.

Article 16. Other Insurance or Liability

If at the time any claim arises under this Policy, there is any other insurance covering Medical Expenses incurred by the claiming Assured Member, the Company shall not be able to pay or to contribute more than their ratable proportion of any such claim.

Article 17. Arbitration

All differences arising out of this *Contract* shall be referred to the decision of an Arbitrator to be appointed in writing by the parties in difference or if they cannot agree upon a single arbitrator to the decision of two Arbitrators, one to be appointed in writing by each of the parties, or in case the Arbitrators do not agree of an Umpire appointed in writing by the Arbitrators before entering upon the reference. 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 Company.

If the Company shall dis*claim* liability to the *Beneficiary*, his/her legal personal representatives or any *Claim*ant for any *Claim* here under and such *Claim* is not within 12 calendar months from the date of such dis*claim*er referred to Arbitration under the provisions here in contained, then the *Claim* for all purposes shall be deemed to have been abandoned and shall thereafter not be recoverable here under.

Article 18. Currency

Any money payable to or by the Company shall be in Omani Rial (OMR). For treatment *abroad* the amount payable shall be based on the exchange rate prevailing at the date of treatment/sickness.

Article 19. Change of Law

This *Contract* is intended to conform to the law of the country in which the *Insurer* home office is located. If a conflict arises between this *Contract* and such law becomes effective after the *Contract* Effective Date, the *Insurer* may, at its own option, re-negotiate the terms of this *Contract* from the date such law becomes effective.

Article 20. Duties

Any levies on the *Contract*, tax or stamp duty shall be borne exclusively by the Contract holder.

Article 21. Claim Denials

Insurers have the right to decline or return submitted Claims under the following conditions:

- Incomplete Claim Form
- Submitting photocopies of receipts, prescriptions, diagnostic services or others
- Treating Physician's signature and seal of the Clinic is not on the claim Form
- Tests, drugs and Treatments not prescribed by the Physician's.
- Diagnosis and Treatment are not medically relevant. Any decision of what constitutes diagnosis and treatment not medically relevant rests with insurer and any such decision shall be final.
- Tests or Treatments for which Pre-authorization is required in accordance with the terms and conditions of this Policy, but for which Pre-authorization has not been obtained
- Services received are within the General exclusions of the Policy.
- Tests, drugs and Treatments not medically necessary for the conditions presented. Any decision of what constitutes diagnosis and treatment not medically relevant rests with insurer and any such decision shall be final.
- Expenses in excess of the reasonable and customary charges.
- Claims are submitted after forty five (45) days from the date of treatment
- Expenses exceeding Annual maximum limits
- Treatments after the Policy has expired
- Receipts issued by one provider but services given by another provider
- Treatment was before the Insured member's join date or before the Effective date of the Policy.

Article 22. Appeals on Claim denials

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 or within one (1) month of denial of claim.

Insurers reserve the right to deny any objections received after the said period.

Article 23. Pre-Authorization

Pre-authorization is required before the insured member undertakes any Treatment for the services mentioned as per the Annexure I of this policy:

Pre-approval must be taken prior to the procedures, or treatment taking place. The insurer shall authorize such treatment as falls within the scope of the Policy. Arrangements have been made with

the designated providers to facilitate pre-authorization but where treatment is sought outside the designated provider's network; it is incumbent on the insured to obtain pre-authorization and to follow required procedures so as to ensure that the claim is reimbursed in accordance with the Policy.

Emergency treatment does not require any pre-authorization. However for Emergency Treatments, an insured member must notify Insurance Company within 48 hours of his admission or prior to his discharge, whichever is earlier. Insurer reserves the right to deny the request for Pre-authorization of the Emergency Treatment, beyond the said 48 hours period, if such notice is not provided.

Pre-authorization is valid for a maximum period of 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 14 days period.

Pre-authorization shall expire automatically on the Insured members deletion date or with the termination of the Policy.

Pre-authorization does not guarantee either payment or the amounts of claim. 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.

STANDARD EXCLUSIONS (Annexure I)

The items procedures and medical conditions listed below and their related or consequential expenses are excluded from the coverage provided under this policy unless specifically stated to be included in the table of benefits or endorsement(s) to this policy:

1. All pre-existing conditions, unless agreed otherwise in the schedule of benefits.
2. Services, accommodation or treatment charges incurred in Health Hydros, Spas, Ayurvedic Resorts/Centres, Nature Cure Clinics, Rest Homes, Rehablitation Centres or any similar place even if it is registered as a hospital, residential stay in a hospital or any similar institution arranges wholly or partly for domestic reasons and which is not directly related to treatment, or beyond the period required for recovery from treatment. Services received before the effective date of coverage or during an inpatient stay that began before the effective date or services received after coverage ends.
3. Routine medical examinations or check-ups, routine eye and ear examination, routine foot care, optometric examinations (vision tests), spectacles, contact lenses and correction of vision, vaccinations, inoculations, medical certificates and examination for residence, employment or travel. Optical or Maternity or complications of pregnancy or Dental and/or orthodontic treatment unless listed in the table of benefits.
4. Any pharmaceutical products which are not on the approved list of drugs and which are not considered to be medically necessary for the specific treatment of the medical condition or bodily injury as per the list attached to the policy contract.
5. Elective/cosmetic treatment or circumcision unless medically necessary and pre-authorized by the insurer.
6. Bulmia, anorexia nervosa, obesity, baldness, anxiety, insomnia, homesickness, loss of appetite and any other eating disorders. Health Services and associated expenses for the surgical treatment and non-surgical, medical treatment of obesity (including morbid obesity), and any other weight control programs, services, or supplies.
7. Tests or treatment related to contraception or sterilization, infertility, impotency, sexual dysfunction or any similar condition.
8. Birth defects, congenital illness or hereditary conditions, Deviated Nasal Septum & Nasal Conchae and associated conditions, Septoplasty, maternity examinations/complications and any treatment/conditions related to or caused by pregnancy and childbirth, unless listed in the table of benefits.
9. Treatment of mental illness and psychiatric and development disorder unless related to treatment covered by the policy or listed as covered in the table of benefits.
10. Any treatment or test for acquired immune deficiency syndrome (AIDS) and AIDS/HIV related conditions or sexually transmitted diseases, self inflicted injury, suicide alcohol or drug addiction/abuse
11. Treatments resulting from racing of any form and professional participation in hazardous sports.
12. Treatment for any illnesses or injuries resulting from active participation in war, riots, civil disturbances, terrorism, acts against any foreign hostility, whether war has been declared or not treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.
13. Unless otherwise provided for under the plan and listed in the table of benefits, treatment of chronic conditions including palliative treatment.
14. All vaccinations and routine or preventive medical examinations including routine follow up consultations.
15. Treatment received outside the territorial limits described in the table of benefits and/or expenses incurred where the insured against medical advice.

16. Costs incurred in connection with locating or the acquisition of a replacement organ or any costs incurred for the removal of the organ from the donor, transportation costs of same and all associated administration costs.
17. Prosthesis corrective devices or durable appliances and medical appliances that are not surgically required, including hearing aids and/or any substance not considered as medicine.
18. Complimentary medicine applications such as chiropractic, KKT and Osteopathy treatments.
19. Treatment of any allergic condition or disorder, however, the initial visit to diagnose an allergy will be covered.
20. All substances which are not considered medicines such as but not limited to mouthwash, toothpaste, lozenges, antiseptic solutions, milk formulas, food supplements, skincare products, sanitary pad, shampoos etc.
21. Home visits unless it is an emergency as defined in the policy definitions.
22. Hormone replacement therapy (HRT) and Hormone related treatments unless carried out as part of or immediately after a surgical procedure which is covered under the table of benefits to this plan.
23. Skin disorders like warts, keloid, acne, Lipoma and Mollusum contagiosum
24. Any treatment or test, second or subsequent opinion for which the required insurer's pre-authorization is not obtained.
25. Benefits recoverable under Workmen's compensation act insurance.
26. Claims directly or indirectly occasioned by happening through, or in consequence of, aviation, other than as a fare paying passenger in a fully certified passenger carrying aircraft, flown in the course of licensed operation for the transportation of passengers by properly licensed crew.
27. Consultations or Treatment of speech and voice problems.
28. All Auditory Accessories, Eyeglasses and contact lenses.
29. Loss of hearing unless caused by a medical condition covered under the policy, hearing aids, ear and body piercing.
30. Any medical prescription relative to a special diet, weight control, children's food, baby supplies, slimming pills, scalp and hair lotions and shampoos etc.
31. Vitamins or multivitamins are not covered. However, vitamins prescribed by a doctor along with antibiotic are covered. Also, in case of severe vitamin deficiency, wherein injectible vitamins are prescribed, same would be covered.
32. All maternity related benefits unless provided for under the plan and listed in the table of benefits.
33. Claims for cryopreservation, implantation of living cells or living tissue, whether autologous or provided by a donor.
34. Registration Fees, Medical practitioner fees for the completion of a claim form or other administration charges.
35. Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under the plan.
36. Road Traffic Accidents where the claim is payable under Motor Insurance Policy
37. All Hepatitis except Hepatitis A are not covered
38. Upper and lower jawbone surgery (including that related to the tempanomandibular joint) except for direct treatment of acute traumatic Injury or cancer. No Coverage is provided for orthodontic surgery, jaw alignment, or treatment for the tempanomandibular joint.
39. Custodial care; domiciliary care; private duty nursing; respite care; rest cures. (Custodial care means (1) non-health related services, such as assistance in activities of daily living, or (2) health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing or (3) services which do not require continued administration by trained medical personnel.)

40. Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
41. Health Services and associated expenses for cosmetic and/or reconstructive treatment and procedures.
42. Health Services and associated expenses for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens, except for Health Services which are otherwise Experimental, Investigational or Unproven that are deemed to be, in the Company's judgment, Covered Health Services. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
43. Health Services that are performed outside of the country in which this contract is issued, unless prior approval is received from the Company, or International Coverage is provided through a separate Rider.
44. Any Health Services and associated expenses for alopecia, baldness, hair falling, dandruff, wigs, or toupees.
45. Services and supplies for smoking cessation programs and the treatment of nicotine addiction are excluded.
46. Non-Medically Necessary amniocentesis.
47. Health Services and associated expenses for sex transformation operations, voluntary sterilization and for reversal of sterilizations. Contraceptive supplies or services. All services related to fertility/infertility as varicocele or polycystic ovary/ ovarian cyst or hormonal disturbances etc. and sexual dysfunction. VaricoCele and associated conditions in Males are not covered. PCOD & associated conditions in Females are not covered
48. Growth hormone therapy.
49. Outpatient prescribed or non-prescribed medical supplies including elastic stockings, ace bandages, gauze, syringes, diabetic test strips, and like products; non-Prescription Drugs and treatments. (Bandages, gauze etc. are covered as a part of emergency treatment given at any medical facility)
50. Mental Health and/or Substance Abuse Services, including pharmaceuticals, in-patient and out-patient treatments.
51. Services rendered by a Provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
52. Internal feedings (infusion formulas via a tube into the upper gastrointestinal tract) and other nutritional and electrolyte supplements, unless done as a consequence to other Medically Necessary Inpatient care.
53. All cases resulting from alcoholism use of drugs & hallucinatory substances.
54. Senile dementia, Alzheimer's disease, Menopause and Osteoporosis.
55. Acupuncture; acupressure; hypnotism, Rolfing; massage therapy; aromatherapy;.
56. Health Services and associated expenses for in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and any related prescription medication treatment; embryo transport; donor ovum and semen and related costs, including collection and preparation.
57. Elective non-accident related surgery for correction of refraction errors and/or Improvement of vision (quantitative or qualitative).
58. Charges by a provider for telephone consultations.

Pre – Authorization Procedure (Annexure II)

Pre-authorization is required before the Insured employee undertakes any Treatment for the following services:

1. Inpatient treatments implying all treatments where the Insured member requires hospitalization for a minimum of 18 hours including one (1) night, for specialized medical attention and care, before, during and after the treatment. Such hospitalization can be for medical management or surgical interventions which cannot be confined within the purview of outpatient / day-care management.

2. Day care management or procedures wherein neither a continuous 18 hours including one (1) night hospitalization is involved nor is within the scope of Outpatient treatment.

3. All Outpatient Surgical procedures, including but not limited to:

a) Incision and drainage

b) POP application

c) Chalazion excision

d) Sebaceous Cyst/ Dermoid Cyst excision

e) Renal Dialysis

4. All medical Imaging studies including but not limited to the following :

a) MRI (Magnetic Resonance Imaging)

b) CT (Computerized Tomography)

c) IVP (Intravenous Pyelogram)

d) Mammogram

e) Hysterosalpingogram

f) Bone Densitometry

g) Doppler Studies

h) Barium Studies

i) MCU (Micturating Cysto Urethrogram)

Please note that routine X-rays do not require preauthorization.

5. All endoscopic procedures including but not limited to :

a) Gastroscopy

b) Colonoscopy

c) Sigmoidoscopy

d) ERCP

e) Cystoscopy

6. Cardiac Studies including but not limited to:

a) Echocardiogram

b) Stress Echo

c) TMT – Tread Mill Test

d) Holter Monitoring

e) Ambulatory Blood Pressure Monitoring

7. Investigations and treatment for Oncology and related diagnostic investigations including but not limited to:

a) Fine Needle Aspiration Cytology

b) Surgical biopsy

c) Histopathology

d) Pap Smear

8. All pre-procedural serology tests including AIDS and all tests related to viral serology including but not limited to:

a) Rubella

b) CMV (Cytomegalovirus)/ Toxoplasma/ Malarial parasite

c) Herpes

d) Viral Hepatitis

9. All hormonal tests including but not limited to:

a) Thyroid Function Tests

b) Follicle Stimulating Hormone

c) Luteinising Hormone

d) Prolactin

e) Testosterone

10. Neurological investigations including but not limited to:

a) Electroencephalography

b) Nerve Conduction Studies

11. Intra Articular Injections including but not limited to:

a) Injection Hyalgan

b) Injection Depomedrol

12. All vitamin and mineral estimations including but not limited to :

a) Vitamin D

b) Vitamin B 12

c) Calcium

d) Magnesium

13. Physiotherapy.

14. Nursing at Home

15. Chronic medications for more than 30 days.

16. Non-chronic medication for more than 10 days

Note: Treatment for emergency conditions shall not require pre-authorization, but such cases are to be notified to the company within 48 hours of the emergency treatment.

Emergency shall mean in case of an accident, a disaster or any sudden/unexpected beginning or worsening of a severe illness resulting in a medical condition that presents an immediate threat to the insured member and therefore requires urgent medical measures by a doctor to prevent long term impairment of the insured health

ANNEXURE III

Pharmaceutical Exclusion List as per the General Exclusion '4' of the Policy

1. Vitamins and Minerals (unless prescribed along with antibiotics).
2. Vaccinations
3. Medication given for infertility
4. Contraception/ Birth Control
5. Medications for Psychiatric/ Psychological problem and Mood Altering Medications (if not covered under the Table of Benefits)
6. Soaps and Shampoos (Both medicated and non-medicated)
7. Cosmetics preparations (Creams / Lotions)
8. Supplementary medicines i.e. iron, Calcium, Magnesium, etc.,
9. General Antiseptic Solutions (e.g. Savion/ Dettol)
10. Tooth Brushes/ Dental Floss/ Tooth Paste
11. Mouth Gargles/ Mouth Washes / Throat Spray, Lozenges
12. Baby Formulae
13. Contact Lens Preparations,
14. Crutches, Braces, Slings, Lumbar Supports/ Corsets, Other Joint Supports,
15. Support Stockings/ Pantyhose
16. Breast Pumps, Massage machines, Exercise machines
17. Nebulizers, Orthopedic Shoes, Heel pad/ Arch Support
18. Orthodontics, Mouth Guards
19. Bandages, Crepe Bandages, Supports (any type), Cervical Collars
20. Hormonal Replacement Therapy
21. Medicines related to Acne and other skin conditions like vitiligo etc.

OTHER CONDITIONS (ANNEXURE IV):

1. The policy is issued based on the quotation issued by Oman United Insurance Company S.A.O.G.

2. Warranted that full yearly premium is to be paid in advance and in no case it should get delayed by maximum 30 days from the start of the cover. Any delay beyond 30 days in paying full annual premium would result in withdrawal of insurance coverage without giving any further notice. In case of cancelation of cover due to delay in premium payment, proportionate premium for covered period would remain payable.

3. Dental, Optical, Maternity, Psychiatric, Congenital conditions etc. are not part of basic cover.

4. For claims outside Network, reasonable and Customary Charges would be applied subject to actual amount spent. Usual and Customary Rate (UCR) or Reasonable and Customary Charges (RCC) - both are one and same.

5. Submission of claims for treatment at non designated clinics must be submitted to OUIC within 30 days from the date of treatment.

6. Though all efforts are taken to maintain or expand the network but due to various reasons, a provider can be removed from a particular network during the policy period with an intimation of 15 days.

7. The scheme is compulsory for all members unless refused coverage on account of age limit etc. by OUIC. Similarly, if dependents are added, all members must enroll all dependents unless refused coverage on account of age limit etc by OUIC.

8. This policy can be cancelled by giving notice of 30 days before policy anniversary by either side. For any such cancelation, proportionate refund in premium would be made for members with no claim during the covered period.

9. Any deletion of member would result in proportionate refund of premium from the date of submission of original medical care provided no claim gets incurred by such exiting members.

10. Injury or illness covered under Workmen's compensation arising out of insured's occupation and injury or illness due to RTA are not covered under group medical scheme.

SPECIAL CONDITIONS (ANNEXURE V):

Terms and Conditions mentioned under SPECIAL CONDITIONS (Annexure V) overrides any condition put under Annexure I, Annexure II, Annexure III & Annexure IV.

Special Conditions under Annexure I
- None

Special Conditions under Annexure II
- None

Special Conditions under Annexure III
- None

Special Conditions under Annexure IV
- None