Individual Medical Insurance Policy

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Individual Medical Insurance Policy

My Health. My Plan.

الوطنية للتأمين على الحياة والعام
NATIONAL LIFE & GENERAL INSURANCE
Ominvest Group
مجموعة أومينفست

Individual Medical Expenses Policy- Terms and conditions

IMPORTANT TERMS AND CONDITIONS ABOUT THIS INSURANCE
(Please Read and check the details of this Policy carefully to ensure its accuracy and see that it meets your requirements)

Introduction:

The Policy is an evidence of the contract between the Proposer (hereinafter be referred as "Insured") and National Life and General Insurance Company SAOG, (hereinafter referred to as the "Company/Insurer") an Insurance Company incorporated under the laws of the Sultanate of Oman.

The Policy, the Certificate of Insurance/Schedule, Table of Benefits, List of Designated Providers and any Endorsement thereon shall be considered as one document and any word or expressions to which a specific meaning has been attached in any of them shall bear such meaning throughout.

The Insurance Cover under this Policy to the Insured Person up to the Sum Assured specified Table of Benefits is and shall be Subject to (a) the terms, conditions and exclusion of this policy and (b) the receipt of premium up-to-date without any outstanding and (c) the information provided (including those provided in the Proposal form) by the Insured to the Company. The Company relies upon the information given by the Insured in the proposal form, and in any document(s) and statements called for by the Company and submitted by the Insured and the statements made to the Medical Examiner and are the basis leading to the issue of this Policy. The Policy is declared null and void in case any information given to the company is incomplete or inaccurate or untrue or misrepresented or material information is withheld or in case it is found that the Policy was issued on the basis of fake / tampered documents / proofs.

Insurance under this Policy is given subject to the Endorsements if any, exclusions, terms and conditions shown below and failure in compliance may result in the claim be denied.

It is deemed that Insured person have understood the terms, conditions & exclusions of the policy. More so, on the scope of the policy, the Pre-Existing condition definition and its exclusion clause and other exclusions under the policy.

(Free lookup Period:-The Insured Person is entitled to a full refund of premium if the coverage under the policy is cancelled upon written request of the Insured Person within 15 days from the date of commencement of cover. The Company reserves the right to decline the second application following the cancelation of the first application from the same insured person. The refund of premium is subject to the actual realization of the premium by the Insurer and also subject to no claim being preferred by the insured person during that period. Premium refund if any shall be made within sixty (60) days from the date of request).

DEFINITIONS

For the purpose of this policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this policy or related extensions/endorsement and shall be read along with the other terms ,conditions and exclusions specified in this policy and its endorsement, table of benefit, Certificate of Insurance/schedule.

IMPORTANT DEFINITIONS

Accident or Accidental mean an injury which is the result of a sudden, unexpected, fortuitous, visible and external event independent of the will of the insured and which may arise from a cause outside the individual's control. The cause and symptoms must be medically and objectively definable.

Age or Aged means completed years as at the Commencement Date

Accommodation charges is the charges for the insured member made by a hospital/clinic for inpatient or day care treatment including charges for beds, routine nursing and care services, house keeping, drugs, dressing and Medications etc. Any costs towards sundry expenses such as food (other than to the Insured), telephone charges, news paper etc…will not be covered.

Administrator means the person or organization, who has been appointed by the Insurer to provide administrative services on its behalf and at its direction.

Alternative medicines are the types of medical care that are alternative to the conventional allopathic medicine covered under this policy. Such medicines include but not limited to chiropractic, osteopathy, acupuncture, Chinese medicines, herbal medicines and massages…etc.

Annual maximum limit/Sum assured is the total amount that may be claimed in any one (1) Policy period by an insured member. These limits are shown in the Table of benefits and represents the maximum liability of the Insurer for each Insured person for any and all eligible benefits claimed for during the Policy Period,

Bodily injury is an identifiable physical injury on the body of the insured, caused by an accident requiring immediate treatment by a Physician, which occurred during the Policy period as specified in the Schedule and Table of Benefits.

Birth defect is any deformity arising during the antenatal stages of pregnancy or caused by/or during childbirth.

Chronic Condition is defined as a sickness, illness or injury which has one or more of the following characteristics:

- Is recurrent in nature
- Is without a known, generally recognized cure
- Is not generally deemed to respond well to treatment
- Requires prolonged supervision or monitoring
- Requires palliative treatment
- Leads to permanent disability

Commencement Date means the commencement date of this policy as specified in the table of benefits and /or Certificate of Insurance/Schedule

Congenital conditions are the conditions existing from the birth that constitutes a significant deviation from the common form or normal and for the purpose of this policy will include visible and latent structural deviations as well as chromosomal abnormalities. It shall also include abnormal external conditions which

is present since birth in the visible and accessible parts of the body or conditions which is present since birth whether inherited or not, but is internal and not visible.

Cosmetic surgeries are any operative procedure, or portion of a procedure, performed to improve the physical appearance and/treat a mental condition through change in bodily form.

Coinsurance/Co Pay is the specific percentage of admissible costs which the insured member must pay as cost sharing requirement under this policy.

Country of residence is the country where the insured lives for the greater part of the policy period.

Claim is an application to the Insurer for payment of expenses incurred under the benefits of the policy.

Day care treatment is the treatment received by the insured member in a hospital or day care facility during the stay, including a hospital room and nursing that does not medically require the patient to stay overnight and where a discharge note is issued.

Deductible/Excess is the cost sharing requirement under the policy and is first amount of a claim which has to be borne by the insured before the relevant benefits are payable under the policy. Deductible/Excess shall be specifically mentioned in the Table of Benefits and/or Certificate of Insurance/Schedule. In the event that the total cost of treatment is lower than the deductible/excess amount the insured will be liable to pay all the expenses incurred.

Dependant Primary insured's legally married spouse and she/he continues to be married to primary insured, children and legally adopted children.

Designated Medical providers is the Hospitals or medical centers or Pharmacies or Diagnostic centers specified in insurer's applicable network or health care providers with whom the insurers or its designated representatives have contracted to enable the insured to receive the treatment in accordance with the policy. It shall also include one or more medical provider from the Designated Medical Provider list chosen under this policy by the Insured with whom the Insured shall avail the medical services this policy. Designated Medical Provider applicable to the Insured under this policy shall be as specified in the Table of Benefits or Certificate of Insurance/Schedule. The list is available with the company and is subject to amendment from time to time.

Diagnostic procedures Any Investigation or tests for diagnosing Illness, including pathology, laboratory, x-ray, ECG, medical scanning and imaging techniques and interpretation of the results by a Physician or Consultant

Doctor/Medical Practioner/Medical Examiner is a person who holds a valid registration/licence issued from the appropriate authority and is thereby entitled to practice medicine within its jurisdiction and is acting within the scope and jurisdiction of his licence. It shall include the specialist doctor holding specialized qualification in the field of or expertise in, the treatment of the illness or injury being treated and shall exclude any person who is part of the insured persons immediate family. Immediate Family would comprise of the Insured persons spouse, dependent children, brother(s), sister(s) and parent(s).

Due date for remittance of premium by the insured to the insurer shall be the commencement date as specified in schedule of premium and its anniversaries or other alternate date agreed in writing between insurer and insured.

Eligible claims Eligible medical expenses covered under the policy and is net of specific deductible/excess and /or coinsurances and/or any other deductions within the limits of liability of the insurer as defined in the table of benefits.

Eligible expenses The actual expenses incurred by an insured member that are reasonable and customary for the medically necessary treatment/care and services, administered by or ordered by a qualified physician licensed to practice medicine.

Emergency can be affirmed in case of an accident, a disaster or any sudden 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. Only medical treatment through a physician, medical practitioner, or specialist and hospitalization that commences within 24 hours of the emergency event will be covered.

Expiry date The date shown in the Policy schedule and the Membership card (if provided by the insurer) on which cover under this Policy ceases.

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.

Grace Period means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a policy in force without loss of cointinuity benefits such as waiting period and coverage of pre existing conditions. Coverage is not available for the period for which no premium is received.

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

Hospitalisation/Hospitalised means the Insured persons admission into a Hospital or other medical service provider for a medically necessary treatment for a covered ailment under this policy as an Inpatient for a continuous period of 24 hours following an illness or accident occurring during the policy period.

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.

Hospital Cost Band means one or more Designated Medical Provider grouped by the Insurer or its administrator based on including but not limited to medical facilities available, claim cost etc., The Hospital Cost Band shall be specified in the Table of Benefits under the policy and insured is eligible to avail medical services eligible under the policy only with such Designated Medical Providers.

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 or specialist or surgeon.

Injury means any physical bodily harm sustained because of an accident occurring during the policy period

for which medical treatment by a Medical Practioner is required, but does not include any illness.

Inpatient 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

Insurer/We/Our/Us/Insurance Company/Company means National Life and General Insurance Company, SAOG

Insured member Any Primary insured or his Dependants (if insured) who has fulfilled the Eligibility conditions and is named in the Policy schedule and Membership card (if provided by the insurance company).

Intensive Care Unit means an identified section, ward or wing of hospital which is under the constant supervision of a dedicated Doctors, and which is specifically equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards/room.

Medically necessary treatments Any medical, surgical or other services that an Insured member requires provided such services are:

- Essential and related to the Illness presented
- Rendered in accordance with generally accepted medical practice and professionally recognized standards
- Treatments that are not generally considered as experimental or unproven
- Not in excess of the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity

Membership card A personalized card issued by the insurer 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 the Designated providers

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.

Non-designated medical providers Hospitals, clinics, laboratories, diagnostic centers and pharmacies with whom insurer 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 and subject to coinsurance as mentioned in the Table.

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.

Outpatient treatment All Medically necessary treatments and services that do not require hospitalization during the day or overnight for Inpatient treatment nor necessitate specialized medical attention or admitted for Day care procedures.

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.

Policy period The period of this Policy stated in the Policy schedule and the Membership card from the Commencement Date to the Expiry date subject to remittance of premium in full.

Policy Year means a period of twelve months beginning from the Commencement Date and ending on the last day of such twelve month period. For the subsequent years subject to the receipt of premium, "Policy year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve month period and as specified in the table of benefit and/or Certificate of Insurance/schedule.

Pre-authorization Review and approval of Treatments by Insurer or its Administrator 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.

Pre-existing condition Any bodily injury or Illness or its related conditions, ailments, that is medically existing prior to the Commencement date of the Insured member, whether it is known or not known to him, and necessitates the Insured Member to receive care and Treatment.

Premium The amount insured pay in exchange for insurance coverage.

Primary claim form A pre-printed Claim form used for Inpatient and Emergency Treatments. It is also used for Pre-authorization of Treatment requests, as required under the terms and conditions of this Policy

Primary insured An individual who has fulfilled the Eligibility conditions and is named in the Certificate of Insurance/schedule and Membership card.

Reasonable and customary charges The amount insurance company recognize for payment for a particular Medical procedure/treatment/medications. It is based on what is considered "reasonable" (as illustrated under cost of medical expense in General terms and Conditions) for that procedure/treatment/medications in accordance with the market price, in the country where the Treatment (if eligible as per table of benefits) was provided or in the Applicable Hospital Cost band of designated providers (as specified in the table of benefits) in the Country of residence, whichever is less.

Related condition Any Illness considered to be either an underlying cause of or directly attributable to another Specific Illness.

Schedule/Certificate of Insurance means the Schedule/Certificate issued by Insurer and if more than one, the latest in time and shall always form part of this policy document.

Secondary care Treatment delivered by a Consultant following referral for further Treatment from a Physician

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 maximum liability for the benefit shall be the Policy's Overall limit.

Surgery/Surgical Procedure means an operative procedure for the correction of deformities and defects, repair of injuries, cure of diseases, relief of suffering and prolongation of life.

Table of benefits A schedule issued by Insurer showing the extent and nature of benefits, Deductible amount and percentages of Coinsurance applicable under this Policy and annexures thereto.

Terminal Illness: Advanced or rapidly progressing incurable illness incurred within the insurance period, where, in the opinion of the attending physician/specialist and chief medical officer of the insurer, the life expectancy is no greater than 12 months

Territorial limit The geographical limits within which Treatment may be received and are stated in the Certificate of Insurance/schedule and/or Table of benefits.

Treatment A medical or surgical procedure, the sole purpose of which is to cure an Illness and not to alleviate long-term Chronic condition.

Visiting Consultant shall be a Registered Medical Practioner not on regular employment for a salary with the Designated Medical provider or does not reside within the Sultanate of Oman for a greater part of a calendar or not a resident of sultanate of Oman or is a Medical Practioner visiting from foreign country.

SCOPE OF POLICY

1. Whereas the Insured as described in the Policy Schedule/Certificate of Insurance has by a proposal and declaration, more specified in the contract and is deemed to be incorporated herein, has applied to the Insurer through a proposal, for the insurance hereinafter set forth in respect of self or as a Guardian and named in the Policy forming part of the Schedule hereto and has paid the premium as consideration for such insurance.

2. Now this policy witnesseth that subject to the terms , conditions, exclusions and definitions contained herein or endorsed or otherwise expressed hereon, that if during the period stated in the Schedule or during the continuance of this Policy by renewal any Insured Person shall contract any disease or suffer from any illness or sustain any bodily injury through accident and if such disease or injury shall, require any such insured person,

3. (i) as an Outpatient - a consultation with a Duly Registered Medical Practioner and based on the advice of such medical practioner to carry a diagnostic procedure/test and procurement of medicines/drugs, and/or

   (ii) on the advice of a Duly Registered Medical Practitioner to incur hospitalisation / surgical treatment at any Clinic / Nursing Home / Hospital (hereinafter defined as Hospital) as an inpatient,

   during such period this Policy provides for payment to the Insured Person the amount of such

expenses as are reasonably and necessarily incurred thereof, in respect of such insured person, but not exceeding, in any one period of insurance, the limits indicated under the Table of Benefits within the Territorial limits as specified in the Table of Benefits and compliance to other Conditions of the Policy

4. Eligibility condition: Age Limit at entry shall be with a minimum of 14 days to 60 Years.

5. In order to be eligible for enrolment under the policy, the insured should be a resident of Sultanate of Oman or holding a valid visa for the stay in Oman

POLICY BENEFITS:

1. The Policy covers Reasonable and Customary expenses incurred towards medical treatment for the disease, illness, medical condition or injury contacted or sustained during the policy period stated in the Schedule subject to Table of Benefits, terms ,conditions, limitations and exclusions mentioned in the policy.

   Upon the happening of the event warranting the below benefits including optional benefits if opted by the Insured and agreed by Insurer to be covered in writing during the Policy Period, the Insurer will indemnify the Insured in respect of medically necessary costs up to the Limit of Indemnity (Sum assured) as described in the policy schedule and Table of Benefits for the expenses as detailed below and as per the terms, condition and exclusions of this policy:

   a) **Inpatient Treatment/ Hospitalisation Expenses**: If the insured is diagnosed with an illness or suffers Accidental Bodily Injury during the Policy Period specified in the Policy Schedule/ Certificate of Insurance, which necessitates his/her hospitalisation, the Insurer will reimburse the Insured Person's consequent hospitalization Expenses for

      - Room
      - Doctors Fees
      - Intensive Care Unit charges
      - Nursing Expenses
      - Surgical Fees, Operation Theatre Charges, Anaesthesia and oxygen and their administration.
      - Drugs and medicines in line with diagnosis / treatment
      - Laboratory, X-ray and other diagnostic / pathological tests in line with diagnosis / treatment
      - Costs of Prosthetic Devices if implanted during a surgical procedure
      - Dressing, Splints (ordinary) and Plaster Casts

      It is to be noted that the condition of the patient should warrant hospitalisation and positive existence or presence of an ailment/sickness/injury should be proved.

      An Insured Person who is admitted to Hospital and stays for a minimum period of 24 hours, for the sole purpose of receiving the treatment

b) **Day Care Procedures:** The Insurer shall cover for the Day Care procedure where such procedures are undertaken by an Insured Person as an in-patient in Hospital/Medical service Provider for a continous period of less than 24 hours. Any procedure undertaken on an Outpatient basis in a Hospital will not be covered. The following Ailments / Disease when treated in a hospital / clinic / nursing home, the minimum required 24 hour hospitalisation as specified in a) above will be waived:

a) D & C (dilatation and curettage)
b) Tonsillectomy
c) Lithothripsy (kidney stone removal)
d) Chemotherapy / Radiotherapy (Cancer Related)
e) Angiogram when related to Heart diseases
f) Piles (Stapler surgery)
g) Accidents necessitating POP Cast / Closed Reduction

c) **Pre- Hospitalisation Expenses:** If the Insured is diagnosed with an Illness which results in Hospitalisation and for which the Insurer accepts a claim, the Insurer will reimburse the Pre Hospitalisation Expenses for upto to 15 days prior to his / her hospitalisation. It is to be noted that such medical expenses is in fact incurred for the same condition for which the Insured Persons subsequent hospitalisation was required and the insurer has accepted such Inpatient hospitalisation 1 (a) above The Pre Hospitalisation period shall commence and ends within the Policy Period specified in the Policy Schedule / Certificate of insurance.

d) **Post Hospitalisation Expenses:** If the insurer admits a claim and immediately following the Insured person's discharge, if he/she requires further medical treatment directly related to the same condition for which the Insured Person was hospitalised, the Insurer will reimburse the Insured Person's Post Hospitalisation Expenses upto 30 days following the discharge. The Post Hospitalisation period shall commence and end within the Policy period specified in the Policy Schedule/ Certificate of Insurance.

e) **Outpatient (Optional) :** The scope of cover of outpatient benefit, if covered as per the Policy schedule / Certificate of Insurance and Table of benefits, includes the following:

- Physicians' Consultation fees
- Diagnostic procedures
- Prescribed drugs
- Physiotherapy on referral by a Physician.
- Bandages, splints and plaster casts only if Medically necessary and prescribed by a Physician.

f) **Maternity (Optional):** The scope of cover of maternity benefit, if covered as per the Policy schedule / Certificate of Insurance 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 Us
- Care of the child whilst the mother is in Hospital
- Standard laboratory tests for newborn babies

Exclusions: The following Treatments and services are excluded:

- Investigations or Treatments related to maternity within moratorium period of two hundred eighty
- (280) days from the Insured member's Join 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

g) **Dental (Optional):** The scope of cover of dental benefit, if covered as per the Policy schedule / Certificate of Insurance 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 Treatments

Exclusions: The following Treatments and services are excluded:

- Routine dental Treatment including but not limited to cleaning, scaling and polishing
- Implants of any nature including but not limited to Dentures, bridges and crowns
- Cosmetic Treatments including Orthodontics.

h) **Optometry / Optical (Optional):** The scope of cover of optometry benefit, if covered as per the Policy schedule / Certificate of Insurance and Table of benefits, includes the following:

Vision tests to diagnose the following errors of refraction:Hyperopia

- Myopia
- Astigmatism
- Anisometropia
- Presbyopia
-

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

If both Pre-existing condition and Optical benefit is included in your 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 Treatments and services are excluded:

1) Spectacle frames
2) Contact lenses
3) Photo chromatic lenses
4) Surgeries for corrections of errors of refraction
5) Strabismus
6) Ptosis
7) Ophthalmic surgery.

i) Pre-Existing Conditions / Chronic Conditions.

Pre existing conditions are medical conditions or any related conditions for which symptom(s) have been shown at some point before the commencement of cover irrespective of whether any medical treatment or medical advice was sought. Any such condition or related condition about which insured member or insured member's dependents know, knew or could reasonably have been assumed to have known, will be deemed to be pre existing.

Chronic Condition is defined as a sickness, illness or injury which has one or more of the following characteristics:

- Is recurrent in nature
- Is without a known, generally recognized cure
- Is not generally deemed to respond well to treatment
- Requires prolonged supervision or monitoring
- Requires palliative treatment
- Leads to permanent disability

If the initial diagnosis of any chronic illness is during the policy period and pre existing conditions/ chronic conditions are not covered under the policy then the expenses incurred for the investigations till the diagnosis of the illness only will be covered and no further claim will be paid for the maintenance /monitoring of the condition.

j) Territorial Limits:

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

k) Pre-authorization:

Pre-authorization is required before the Insured member undergoes 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. In respect of long term medications, insurers reserve the right to approve the duration of medication on a periodic renewal basis. 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. For members who are eligible for a particular band of designated providers in the network, the referral for further treatment by any such designated provider shall be restricted to other designated providers within the same band. In such cases, the settlement of claim shall be restricted to the reasonable and customary charges of that applicable band of designated providers as illustrated under cost of medical expenses. In the absence of any facility sought from any of the applicable band of designated providers, then, insured members shall have the option to choose a designated/non designated provider available within the territorial limit as may applicable to that insured member and specified in the table of benefits. Also the insurer reserves the right to take second opinion before making an approval for treatment.

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

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.

The Pre-authorization shall expire automatically on the Insured member's deletion date or with the termination of the Policy.

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.

All the above benefits are subject to the Schedule, Table of benefits attached herewith and shall form and integral part of this policy.

GENERAL EXCLUSIONS

The Insurer shall not be liable under this Policy for any claim in connection with or in respect of:

1) Pre Existing/chronic disease and any disease, illness, medical condition, injury which is a complication of a Pre-Existing Disease prior to inception of the earliest commencement date of the policy.

12) Treatment not ordered or received from a registered medical practitioner or physician, Complementary medicine applications including but not limited to chiropractic, osteopath and Chinese medicines.

13) Convalescence, all health check-up, general debility, run down condition or rest, cure, Services, accommodation or treatment charges incurred in health hydros, spas, nature cure clinics, rest homes or any similar place even if it is registered as a hospital, residential stay in a hospital or any similar institution arranges wholly of 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.

14) Intentional self inflicted / intentional injury, suicide, alcohol or drug addiction/abuse or use of intoxicating substances, impairment of an insured persons intellectual faculties by abuse of stimulants or depressants or by the illegal use of solid, liquid or gaseous substance (whether prescribed or not).

15) Treatment of anorexia nervosa, Bulimia, loss of appetite and other such eating disorders, mental illness, psychiatric, behavioral disorders, psychological disorders or any form of treatment by a psychologist including but not limited to anxiety, insomnia, homesickness .

16) The Investigations into and treatment of obesity (including morbid obesity) and any other weight control/modification/maintenance programs, services, or supplies.

17) Prosthesis, corrective devices and medical appliances/equipments including but not limited to hearing aids, spectacle frames or contact lenses, wheelchairs, crutches, artificial limbs and the like. External medical equipment of any kind used at home as post hospitalization care including cost of instrument used in the treatment of sleep apnoea syndrome (C.P.A.P), continuous ambulatory peritoneal dialysis (CAP.D.) and Oxygen concentrator for Bronchial Asthmatic condition.

18) Charges incurred at Hospital / Nursing Home/Clinic, primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies or treatment / procedures not consistent with or incidental to the diagnosis. Any Treatment not considered as medically necessary or any substance not considered as medicine such as but not limited to tonics, slimming pills. Cosmetic preparations including but not limited to hair removers, skin care products, moisturizing lotion, creams and other similar products, scalp and hair lotions, alopecia, wigs/toupee, shampoos.

19) Treatments resulting from racing of any form, treatments to injuries arising out of Insured Person's participation in any hazardous activities, including but not limited to scuba diving, motor-racing, parachuting, hang-gliding, rock or mountain climbing and the like whether professional or as leisure time activity , whether part time or full time, voluntary or paid.

20) Any travel or transportation costs or expenses unless specified as covered under the table of benefits.

21) Any pharmaceutical products which are not on the approved list of drugs and which are not

2) During the first twelve months from the inception date of the Policy, the expenses on treatment of Benign Prostatic Hypertrophy, Hysterectomy for Menhorrhagia or Fibromyoma, prolapsed of genitourinary/intra-abdominal organs, Hernia, Hydrocele, Cholelithiasis, Knee Replacements due to Arthritis, Hip replacements, Rheumatism and other degenerative disorders, dysfunctional uterine bleeding, endometriosis , stones in the urinary and biliary systems; surgery on ears, surgery on skin/internal tumors/cysts/nodules/polyps; treatment for benign tumors or malignant conditions or for organomegaly, surgery on joints, treatment for prolapsed intervertebral discs, surgery for gastric or duodenal ulcers, Fistula in Anus, Piles, Sinusitis and related Disorders.

3) All illnesses/diseases/defects/injuries/surgical intervention, which are pre existing when the cover incepts for the first time and any subsequent complications thereof will be excluded. For this purpose, the policy commencing from a date after a break in the earlier policy will be treated as a new policy and the time limit of 12 months coverage exclusion above shall apply from the date of fresh inception of the policy.

4) If an enhanced sum insured on renewal of the policy is made by the insured, and any ailment contracted during the earlier policy the limit of Indemnity would be that of the earlier policy and not the enhanced sum insured for that particular ailment.

5) All Dental, Optical and maternity benefits, unless listed in the table of benefits.

6) Any expenses related to Birth defects, Developmental disorder, hereditary conditions, Congenital Ailments / Diseases, including but not limited to Atrial Septal defect (ASD) / Surgery to correct deviated septum and hypertrophied turbinates, whether internal or external, with or without the knowledge of the insured.

7) Claims for Genetical disorders or cryopreservation, implantation of living cells or living tissues, whether autologous or provided by a donor, expenses towards stem cell treatment / diagnosis.

8) Cosmetic treatment or Circumcision unless necessary for the treatment of an illness not otherwise excluded in this Section or required as a result of Accidental Bodily Injury and pre-authorised by the insurer.

9) Routine ear examination, routine foot care, routine medical examinations or check-ups, Medical practitioner fees for the completion of a claim form or other administration charges, medical certificates and examination for residence / employment or travel, Vaccination, inoculation, cosmetic treatments (including any complications arising out of or howsoever attributable to any cosmetic treatments or the replacement of an existing breast implant), aesthetic treatments, experimental, investigational or unproven procedures or treatments, devices and pharmacological regimens of any description.

10) Expenses on Vitamins and tonics unless forming a necessary part of the treatment covered under this policy for injury / illness / disease as certified by the attending physician

11) All Treatment / Expenses related to Auto Immune Diseases

considered to be medically necessary for the specific treatment of the medical condition or bodily injury, Outpatient prescribed or non-prescribed medical supplies over the counter drugs including but not limited to elastic stockings, bandages, gauze, syringes, diabetic test strips, and similar products; non-prescription drugs and treatments and other pharmacy exclusions as defined in Annexure II.

22) Treatment for any illnesses or injuries resulting from active or passive participation in War, riots, illegal activity, invasion, acts of foreign enemies, hostilities whether war be declared or not, civil war, revolution, insurrection, mutiny, martial law, terrorism or terrorist acts, Passive War Risks.

23) Treatment for any illness or injuries arising from chemical contamination, Ionising radiation or contamination by radioactivity from any nuclear waste or from combustion of nuclear fuel or otherwise; or the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof, or asbestosis or any related condition resulting from the existence, production, handling, processing, manufacture, sale, distribution, deposit or use of asbestos, or asbestos products.

24) Expenses / treatment towards Invitro fertilisation (IVF), gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, Embryo Transport, Donor ovum, Semen and related costs, infertility or sub-fertility or assisted conception procedure or sterilisation , expenses towards family planning procedures, Sex change operations and related treatments.

25) Any treatment or test or condition directly or indirectly caused by HIV (Human Immune deficiency virus) or associated with Human T-Cell Lymphotropic Virus type III (IITLB-III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS, Sexually Transmitted Diseases, Veneral Disease and all related medical conditions, its consequences and complications.

26) Unless specified in the table of benefits as covered, all costs incurred towards Ayurvedic, Naturopathy, Siddha and all other alternative methods of medical treatment except allopathic.

27) Any Terminal Illness condition after the point at which it is certified by the attending Doctor to be of such a nature that further medical treatment may serve to stabilise or maintain it but is unlikely to result in a material improvement within a reasonable timeframe.

28) Skin disorders like warts, keloid, acne and mollusum contagiosum.

29) Benefits recoverable under workmen's compensation act / insurance, Motor Insurance, social insurance and personal accident.

30) Home visits / consultations/ special nursing / Charges by a provider for telephone consultations.

31) Hospital Record Charges, Special Nursing Charges, Transport Charges, incidental and miscellaneous Expenses, Telephone Charges, Attendant Charges and other Non-Medical Expenses. Personal comfort and convenience items or services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.

32) Hormone Replacement Therapy.

33) Diseases defined by the WHO as epidemic/pandemic.

34) Treatment received outside the territorial limits described in the table of benefits and/or expenses incurred where the insured has travelled against medical advice. Elective Treatment unless pre authorized by the insurer.

35) Costs incurred in connection with locating or the acquisition of a replacement organ or any costs incurred for removal of the organ from the donor, transportation costs of same and all associated administration costs.

36) Treatment of any allergic condition or disorder, however, the initial visit to diagnose an allergy will be covered.

37) Kidney dialysis.

38) Claims directly or indirectly occasioned by happening through, or in consequence if, 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.

39) Consultations or Treatment of speech and voice problems.

40) Loss of hearing unless caused by a medical condition covered under the policy, hearing aids, ear and body piercing.

41) Experimental unproven treatment or drug therapy or non prescribed drugs/medical supplies.

42) Expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.

GENERAL CONDITIONS

1 Policy Period

Unless specified otherwise in schedule of premium, this Policy is an annual contract. Subject to payment by the Insured of the required Premium it shall commence from the Commencement date and terminate at the Expiry date, specified in the Policy schedule.

2 Annual Maximum limits

The liability of insurer is limited in amount to the Overall limits and Sub-limits stated on the Policy schedule and Table of benefits.

3 Cost of Medical Expenses

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

For ex: if the treatment charged for the covered illness for the inpatients are charged at the cost of 100 in hospital "A", at the cost of 120 in hospital "B" and at the cost of 800 in hospital "C".The reasonable and customary charges shall be arrived at the average of hospital "A" and the hospital "B" as per the calculation below:

Reasonable & customary charges = {100+120/ 2}*110% = 121

Approximately 121-125 shall be paid in this case.

In case of the insured prefers to take treatment in Hospital C, he /she shall be liable for excess charges other than the reasonable and customary charges and the insurer shall not be liable for anything above the said reasonable and customary charges.

The insured shall have the option to select his preferred clinic for treatment. However the maximum refund shall be limited as per the above calculation.

4 Treatment abroad other than emergency

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

- Obtaining Pre-authorization prior to seeking Treatment for services, as specified above. Failure to comply will result in the eventual decline of the Claim.
- Application of separate Deductible and/or Coinsurance, as stated in the Table of benefits.
- 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.
- 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 of applicable Hospital Cost Band of Designated Medical Provider in Oman, whichever is less.

5 Transportation cost for Treatment abroad

If transport and overseas medical expenses benefit is covered as per the Policy schedule and Table of benefits, the 'inpatient' benefit shall be extended to include transportation costs of the Insured member and a companion (escort) subject to:

- A recommendation and referral by a Secondary care provider. For the companion, only if the Insured member (patient) is unable to walk

- Obtaining Pre-authorization before the date of travel
- Actual amounts up to a maximum limit of RO 500 per person
- Economy class air fare
- Cost of treatment plus the cost of airfare (insured and escort) is more economical than doing the treatment in Oman under the Hospital Cost band of designated providers which the member is eligible for and specified in table of benefits

6 Claims Procedure:

a) Claims under this policy will be administered by the Insurer or its Administrator(s)

b) Direct Billing: This Policy provides for Direct Billing Access at designated medical providers i.e. those hospitals empanelled by the Insurer or its Administrator(s). Insurer has an arrangement that allows for direct submission of Claims by the designated medical providers. The Insurer reserves the right to include, exclude, upgrade, degrade any Designated Medical provider/Medical Practioner/ Medical Service within a Designated Medical Practioner to/from a particular Band of Hospital/ clinic/pharmacy/labs/diagnostics centers as may be applicable to the insured under this policy and specified in the table of benefit and Membership cards. The Designated Medical Provider applicable to this policy shall be specified in the Table of Benefits/Certificate of Insurance/Schedule of Premium or on the Medical Card. The access for direct billing is restricted only to those designated medical provider specified in the Table of Benefit. Insured member shall use the facilities of the designated Providers, by presenting their member ship cards to the providers at the time of their visits. If an Insured member pays for the treatment at a designated medical provider, Insurer will only reimburse the Insured the agreed / negotiated charges between Insurer and the designated provider, provide such services or the medical condition is covered and medically necessary to the diagnosed condition and the insured is eligible to access such designated medical provider.

c) If Direct Billing Facility is availed, the Insurer or its Administrator(s) will directly settle the Hospital Bills, subject to fulfilment of specified formalities by the insured and policy terms and conditions.

d) For medical treatments at Designated Medical Providers pre authorisation shall be availed by the providers for medical services warranting pre authorisation from the Insurer or its Administrator(s).

e) Reimbursement: Unless agreed in writing by the Insurer, there shall be no reimbursement of claims from any non designated provider. If agreed for reimbursement of a claim in writing by the insurer, the Claim form and other mandatory claim documents as listed in the claim form are to be submitted within 45 days from the date of discharge or availing medical services and shall be settled within 30 days of receipt all document required documents including but not limited to duly filled in claim form along with any other document to support the claim, as specified in the claim form or any other document requested by the insurer.

f) Subject to (e) above, In case of claim on reimbursement basis for Inpatient or Day care procedures or outpatient medical service, preauthorisation of the claim need to be obtained from the Insurer or its Administrator detailing the policy number, name of insured, member ID number, nature of illness / injury, and name and address of the hospital and attending doctor from the date of hospitalisation. Please refer to Annexure I for services which warrants pre authorisation of Insurer or its Administrator.

g) Subject to (e) above, If the insured persons for any reason chooses not to use a Designated Medical Provider or opts for a Higher hospitalisation Class or otherwise breaches the terms of the authorisation obtained pursuant to General condition then at the discretion of the insurer, the amount payable by or on behalf of the Insurer shall be reduced as per the terms and conditions of the Policy by applying the Co-payment / Coinsurance/Excess/Deductible specified in the Table of Benefit or at the reasonable and customary expenses applicable for the same ailment at the Designated Medical Provider less the copayment,/coinsurance/excess/deductible, whichever is lower.

7 Claim Denials:

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

- Submitting incomplete Claim form
- Attaching photocopies of receipts, prescriptions, diagnostic services or others
- Absence of Treating Physician's signature and seal
- Tests, drugs and Treatments not prescribed by Physicians
- Diagnosis and Treatment are not medically relevant/necessary. Any decision of what constitutes diagnosis and treatment not medically relevant/necessary rests with insurer and any such decision shall be final
- Tests or Treatments for which the 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 or sub limits
- Treatments or medical expenses incurred after the Policy has expired
- Treatment was before the Insured member's Join date or before the Commencement date of the Policy

The insurers reserves the right to call for adequate medical and other related documents as may be deemed necessary for the claim lodged. The insurers reserves the right to seek any second opinion on to the medical condition on the insured before granting any approval for treatment or accepting the claim liability.

8 Appeal 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. Insurer reserve the right to deny any objections received after the said period. Insurer will review the justifications received and payments for any approved Claims will be made within thirty (30) days from the date the justifications were received.

9 Payment of Claim

1. Claims under this policy shall be payable in Omani Riyals as per the terms, conditions and exclusions stated in the policy document.
2. The Insurer shall not be liable to pay any interest /penalty for sums paid or payable under the policy.

10 Misdescription

This policy shall be void and all premium paid hereon shall be forefeited to the Company, in the event of misrepresentation, misdescription or non disclosure or suppression of any material fact.

11 Cancellation of Policy:

By the Insured:

As long as no claim has been lodged by the Insured Person during the policy period, the Insured person shall cancel the policy and the Insurer will refund to the Insured Person pro-rata premium for the unexpired Policy Period subject to a maximum of 50% of the annual premium.

Upon the Cancellation or non-renewal of this Policy, all ID Cards shall immediately be returned to the Insurer or Administrator at the Insured Person's expense and the Insured Person and each Insured Person agrees to hold and keep harmless the Insurer and the Administrator against any and all costs, expenses, liabilities and claims (whether justified or not) arising in respect of the actual or alleged use or misuse of such ID Cards prior to their effective date of cancellation. The Insurer shall pay the eligible refund after sixty (60) days from the date of request of cancellation , provided no claims were reported till that period.

By the Insurer:

The Insurer reserves the right to cancel the policy by giving 30 days notice to the Insured. Such notice shall be deemed sufficiently given, if posted by a Registered Post and addressed to the insured at the last address mentioned in the policy. In the event of cancellation by the Insurer and if no claim has been lodged by the Insured Person during the policy period, then Insurer will refund to the Insured Person pro-rated annual premium for the unexpired Policy Period.

12 Subrogation

1) The insured under this policy shall at the expense of the Insurer do and concur in doing, permit to be done all such acts and things that may be necessary or reasonably required by the Insurer for the purpose of enforcing any civil or criminal rights and remedies or obtaining relief or indemnity from other parties to which the Insurer shall or would become entitled or subrogated upon the Insurer shall or would become entitled or subrogated, upon the Insurer paying the benefits provided under this Policy, whether such acts and things shall be or become necessary or required before or after the settlement of claim to the Insured or claimant by the Insurer.

2) The insured shall not do or cause to be done anything that may cause any prejudice to the Insurer's right of subrogation;

3) The Insured agrees that any recoveries made shall first be applied in making good any sums paid out by or on behalf of the Insurer for the claim and the costs of recovery.

13 Fraud

If the Insured Person shall:

a. make or advance any claim knowing the same to be false or fraudulent in amount or otherwise, and/or
b. permit another person to use his ID Card or use another's ID Card,
then this Policy shall be void in relation to that Insured Person, all claims or payments due shall be forfeited and all payments made if any shall be repaid by that insured person in full.

14 Governing Law

The construction, interpretation and meaning of the provisions of this Policy shall be determined in accordance with Omani law. The section headings of this Policy are descriptive only and do not form part of this Policy for the purpose of its construction or interpretation.

15 Entire Contract

The Policy constitutes the complete contract of insurance. Only the Insurer may alter/amend the scope, the benefit, the definition, terms and conditions of this Policy. Any such alteration/amendment by the insurer shall be notified to the insured with 30 days notice. If such alternation/amendments are not acceptable to the insured, then the insured has the right to cancel the policy and provisions of cancellation (specified elsewhere in this policy) as if effected by the Insurer shall apply. Any alteration that may be made by the Insurer shall be evidenced by a duly signed and sealed endorsement on the Policy. Insured should not have any objection in taking over the defence on settlement of any claim, initiate legal action to get compensation from anyone for payments that have already been made by insurer.

16 Contribution

If at the time of any loss covered by this Policy and there shall by any other Insurance covering the same loss / liability, whether it be effected by or on behalf of the Insured person, then the Insurer shall not be liable for more than its rateable proportion thereof. For example, if the insured has OMR 3000 as the sum assured of a policy with the insurer and another insurance policy of OMR 2000 with another insurance company covering the same loss/liability, in case of any liability the insurer would settle 3/2 of the claim value not exceeding the limit of indemnity under the policy existing with National Life.

17 Territorial Limits

This cover granted under this Policy is valid in respect of Illness or Accidental Bodily Injury sustained by the Insured Person during the Policy Period within the territorial Limits specified in the Table of Benefits. In respect of treatments availed outside the territorial limit specied in the Table of Benefits, the Insurer's liability to make any payment shall be to make payment Omani Rial Equivalent, for medical services or procedures rendered in or undertaken in elsewhere other than in Oman subject to a maximum of reasonable and customary charges of the applicable Hospital Cost specified in the Table of Benefit.

18 Change of Address

The insured must inform in writing of any change in his / her address.

19 Renewals

The premiums are annually reviewable. All application for renewal of policy must be received by us before the end of the policy period. The Company will give notice in writing about the change of premium revised terms, conditions and exclusion applicable to renewal policy year for the Policyholder. In case the Policyholder does not wish to pay the revised premium, then the policy shall be lapsed. Insurer has the absolute discretion to offer the renewal terms. If the Insurer decides to renew then, the terms and conditions, exclusion, renewal price etc., shall be at the absolute discretion of the insurer. The Insurer shall not be bound to accept any renewal premium nor give notice that such is due.

20 Cumulative Bonus

A 10% cumulative bonus will be applied on the Original Annual Limit for the next policy year under the policy after every claim free policy year, provided that the policy is renewed with us and without break. The maximum cumulative bonus shall not exceed 50% of the original annual limit. The Cumulative Bonus will be lost if the policy is not renewed on the date of expiry or if the insured prefers to change to another plan at time of renewal. In event of claim in any subsequent year, the cumulative bonus earned shall be withdrawn after the renewal of the policy and the original Annual Limit will apply for at the time of such renewal.

21 Compliance with Policy Provisions

Failure to comply with any of the provisions contained in this Policy shall invalidate all the claims hereunder.

22 Policy Transfer

Transferring of interest in this Policy is not allowed.

23 Authority to obtain Medical Records / Other Claim Papers

a) The insured person hereby agree to and authorizes the disclosure, to the Insurer or the Administrator or any other person nominated by the Insurer/Administrator, to all other information and documentation in respect of the claim and / or the Insurer's / Administrator's liability

b) The insurer and the Administrator agree that they will preserve the confidentiality of the documents collected

24 Insurer's Liability

25 The Insurer's Liability in respect of all claims admitted during the period of Insurance shall not exceed the Individual Sum Insured for the Insured person as mentioned in the Policy. The Insurer shall not be held responsible for any outcome of the medical treatment under the policy.

26 Termination of Insurance cover

The insurance cover under this policy shall automatically cease at the earliest of the following:

a) The date Insured ceases to be a resident of Sultanate of Oman.
b) The date the Insured attains the age of 65(ie,65th birthday)
c) Policy expiry date is attained, unless renewed
d) Date of death of Insured
e) Non-payment of Premium or renewal Premium before the current Policy expiry date.
f) The claims incurred during the Policy year reaches the Annual Maximum Limit specified in the Table Of Benefit.
g) Insured becomes a person of unsound mind.
h) Date of cancellation of Policy

27 Legislative Changes:

All benefits payable under the Policy including the premiums are subject to prevailing laws and other enactments made from time to time and any statutory levies as may be applicable will be charged as per the prevailing rates & regulations and will be recovered completely and directly from the policyholder.

Annexure I: List of Services requiring Pre –Authorisation

Preauthorization is required before the insured undergoes any of the following medical services:

1. Inpatient treatments implying all treatments 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 hospitalization can be for medical management or surgical interventions which cannot be confined within the purview of outpatient / daycare management.
2. Day care management or procedures wherein neither a continuous 24 hours 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

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. Long term medications for more than 30 days.

16. All Claims in excess of threshold limit agreed with the Designated medical provider from time to time by the Insurer or its TPA (if any).

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.

In respect of services listed above if availed as a Outpatient benefit, such services shall be availed by Insured only if the Outpatient benefit is opted and specified as covered under the Table of Benefits.

Annexure II: Pharmaceutical Exclusion list as per the General Exclusion of the policy

- Vitamins and Minerals (unless prescribed along with antibiotics).
- Vaccinations
- Medication given for infertility
- Contraception/ Birth Control
- Medications for Psychiatric/ Psychological problem and Mood Altering Medications (if not covered under the Table of benefits)
- Soaps and Shampoos (Both medicated and non-medicated)
- Cosmetics preparations (Creams / Lotions)
- Supplementary medicines i.e. iron, Calcium, Magnesium, etc.,
- General Antiseptic Solutions (e.g.Savion/ Dettol)
- Tooth Brushes/ Dental Floss/ Tooth Paste
- Mouth Gargles/ Mouth Washes / Throat Spray, Lozenges, Inhalers
- Baby Formulae
- Contact Lens Preparations,
- Supports (of any type) including but not limited to Crutches, Braces, Slings, Lumbar Supports/ Corsets, Cervical Collars, Other Joint Supports, Heel pad/ Arch Support, Orthopaedic Shoes, Wheel chair, Belts
- Support Stockings/ Pantyhose
- Medical appliances, devices and equipment including but not limited to Breast Pumps, Massage machines, Exercise machines , Nebulizers, Thermometer, Blood pressure/sugar monitor, C Pap machines
- Orthotics, Mouth Guards
- Bandages, Crepe Bandages (unless medically necessary and prescribed by physician)
- Hormonal Replacement Therapy
- Medicines related to Acne