PREMIER INSURANCE LIMITED

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PREMIER INSURANCE

Group Health Policy

Whereas the insured described in the schedule hereto have applied to PREMIER INSURANCE LIMITED (Hereinafter called the "company") for the insurance hereinafter set-forth on behalf and for the benefit of their employees and employees' dependents specified in the schedule and have paid or agreed to pay the premium as mentioned in the said schedule.

Now this policy witnesseth that subject to the terms, limits, provisions, exclusions and conditions contained herein or endorsed or otherwise expressed herein, the company undertakes that if at any time during the period stated in the schedule or during the continuance of this policy any of the insured's employees and their dependents covered under the policy shall, whilst anywhere in Pakistan, sustain any bodily injury or contract any disease or suffer from any illness then if such injury, disease or illness shall require, any such employee and his dependents on the advice of a registered medical practitioner(s), to undergo surgical or medical treatment which is covered under the policy, the company shall pay to the insured up to but not exceeding the prescribed limits stated under limits of benefits in policy schedule.

TERMS AND CONDITIONS

1. All premiums, including taxes, etc., shall be payable at the office of the company issuing the policy. The premium is payable in advance on quarterly basis. Thereafter, with the consent of the company, this policy may be renewed from year to year, on such terms, conditions and premium rates and on payment of such renewal premiums as the company may determine.

2. The due payment of premium shall be condition precedent to any liability of the company to make payment under this policy.

3. All notices required to be given by the insured to the company must be in writing addressed to the Branch/Zonal Office/Head Office of the company from where this policy was issued, and notice or knowledge of anything relating to this policy or any claim hereunder shall not be deemed to be notice to or within the knowledge of the company unless so given and no alteration in the terms of this policy nor any endorsement thereon, will be held valid unless the same is signed or initialed by an authorized representative of the company.

4. The insured shall give immediate notice to the company of any change in their business, trade or profession and business address as described in the schedule of this policy.

5. This policy can be terminated upon seven days notice from either side by recorded delivery letter at insured's last known address / company's Head Office as the case may be. The company shall refund unused premium to the insured where appropriate.

6. In the event that any of the benefits under this policy are available or become available during the currency of this policy to the insured person under any other insurance scheme or plan or program or arrangement established pursuant to any law or regulation of any Government body, then this insurance shall pay only a ratable proportion of the expenses incurred which, when added to such duplicate benefits, shall not be more than 100% of the benefits covered under this policy.

7. Any word or expression to which specific meaning has been attached shall bear such meaning wherever it may appear in this policy. Words in the masculine gender shall be deemed to include the feminine.

8. The due observance and fulfillment of the terms and conditions contained herein or endorsed or otherwise expressed hereon as they relate to any thing to be done or complied with by the insured and the truth of the statements made by the assured shall be conditions precedent to the liability of the company to make any payment under this policy.

9. The schedule of insurance, provisions and exclusions, schedule of benefits, clauses and endorsements incorporated herein are made a part of this policy and shall be read as one contract.

10. This policy shall be governed by and interpreted according to the law of the Islamic Republic of Pakistan.

11. If the company shall disclaim liability to the insured for any claim hereunder, and if any such claim shall not, within one calendar month from the date of such disclaimer, have been referred to arbitration under the provisions herein contained, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

12. In case any dispute or difference arises between the company and the insured concerning any matter arising out of this policy, such matter shall be referred to the decision of two arbitrators (who shall be disinterested parties) one appointed by the company and one by the insured in writing unless the parties agree to appoint only one arbitrator, such agreement to be reached within four weeks of one of the parties receiving written request to this effect from the other. In case either party shall refuse or fail to appoint an arbitrator within four weeks after receipt of notice in writing requiring an appointment, the other party shall be at liberty to appoint a sole arbitrator. The award of such arbitrators or their umpire (who shall have been appointed by the parties

in difference in writing before entering upon the reference and who shall be responsible for conducting the business of the arbitration) shall be final and binding upon all parties there to and such reference shall be a reference to arbitration within the meaning of the Arbitration law of Pakistan or of any statutory modification or re-enactment thereof presently in force and the obtaining of an award shall be a condition precedent to any liability of the company or any right of action against the company.

13. This policy gives the company, through its duly authorized representative, the right at reasonable times to inspect all books and record of the policyholder relating to the coverage affected hereunder. This also includes the right of the company to seek and ask for any record, and condition for policyholder to fulfill regarding evidence of insurability, eligibility for insurance, leave records, past medical record or any other record or document relevant to requirement of this policy, its execution or claims pertaining to this policy.

14. This policy gives the company the right to itself seek or for insured to provide second medical opinion, verification / certification for any claim or claim document filed by the insured under this policy.

15. Official correspondence with the company shall mean those made to company by the policyholder through its designated officers(s) only. Their names and specimen signatures will be conveyed to the company at the time this policy becomes effective.

16. Subject to acceptance by the company to insure and subsequent inclusion in the policy, the company will charge special premium in cases of employee, dependents, individual with pre-existing condition including pregnancy, high risk individuals and newborns requiring treatment / confinement at or within thirty days of their birth. The company reserves the right to refuse the insurability or inclusion of any individual it feels inappropriate for insurance under this policy.

17. The company may apply additional provisions for insurability and eligibility for insurance in case of non-employee group / contractual employees / dependents.
18. Mode of payment will be quarterly basis in advance.

19. Claim reimbursement duration will be 15 working days.

20. Dental treatment covered up to 70% of the OPD limit.

21. Premium for addition of employees will be on prorate time period basis however OPD premium will be charged for full year.

22. Premium for addition of children will be charged on full year basis irrespective of date of addition.

23. Refund of premium for deletion of employees subject to no claim will be prorata time period basis.

24. All pre-existing cases (Disclosed/Undisclosed) are fully covered and no special risk premium will be charged.

25. Pre & post hospitalization will be 30 days each.

26. System/Software for facilitation regarding update limits of insured persons will be provided within 15 days from the date of contract.

27. Unit rate for each category will be as Employee, Spouse, Children & Parents.

GENERAL CONDITIONS

POLICY CONTRACT: This policy and declaration documents (declaration Form), Endorsements if any and list of employees and their dependents constitute the entire contract between the insured and the company.

POLICY AMENDMENTS: The policy can be amended or changed at any time during the policy period to provide for addition or deletion of the employee or their dependents if covered, change in employee category or change in benefit limits (in advance before occurrence of loss), on written request of the policy holder subject to acceptance by the company and premium adjustments were applicable. Healthy newborns, born during the policy period may be included under the policy upon payments of additional premium.

- All addition premium will be payable at the time of induction of new insured unit into the existing policy. All additions of insured will be charged on short term (Prorata time period basis) premium basis. However OPD premium will be charged for full year. Annual premium will be charged in case of addition of all New Born babies, irrespective of period of insurance.
- All premiums relating to deletion of insured family / unit will be calculated and payable at the expiry of the policy. However cessation of cover will be effective from the date as mentioned under the general conditions of the policy ("Cessation of Cover" as given below)
- Premium related to deletion and exclusion of insured will be calculated on short term (Prorata time period basis) premium basis and payable subject to the no claim.
- The company reserves the right to charge extra premium / amend or cancel the policy / in event of decrease of number of insured units in the policy from the number at the time of inception.

CESSATION OF COVER: An insured person shall cease to be insured on the earliest of any of the following dates:

- The date on which employees ceases to be in service ,or
- The date on which maximum age eligibility limit is reached
- Any other date on which he / she ceases to be eligible for insurance, or
- The date on which policy terminates ,or
- The date on which a dependent gets employed or married.

POLICY TERMINATION / RENEWAL: This policy is for one year. However with the consent of the both parties, this policy may be renewed from year to year, on such terms, conditions and premium rates and on payment of such renewal premiums as the company may determine.

All claims till expiry date of the said policy shall be submitted within fifteen days from the date of expiry and no claim shall be entertained thereafter. The company has allowed one month's grace period as per expired policy terms and conditions. In case of the renewal it will be adjusted in the next policy and in case of non renewal the insured is liable to pay premium pertaining to one month grace period and such premium will be on short term basis. Cessation of cover for an employee automatically results in cessation of cover for all his/her dependents. The company also reserves the rights to terminate the insurance of any insured person at any time after giving notice to the insured in writing under intimation to the policyholder if he or any member of his family covered by this contract has at any time:-

a) Misled the company by misstatement or concealment or
b) agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to the company's detriment, or
c) Failed to act with the utmost good faith.

CREDIT LETTERS: Every primary insured person / employee will be issued a credit letter/Health Card by the company. This letter/Card will also bear employees I.D. No. for future reference and computer identification specifically for purpose of claims. This credit letter/Card will also indicate briefly the summary of benefits covered under the policy. Any misuse of these credit letters/Cards will be the sole responsibility of insured.

Credit letter/Health Card of insured employee shall be immediately returned to the company upon exclusion from the policy of a primary insured or cessation of policy cover.

Issue of duplicate credit letter/Health Card, if lost, is subject to written request by the insured along with an undertaking signed by the person who require the duplicate credit letter/Card. Issue of new credit letter/Card on policy renewal is subject to return of expired credit letters/Health Cards.

EXAMINATIONS: The Company shall have the right and opportunity through its official or assigned medical representatives to examine the person of the insured when and so often as it may reasonably deem necessary either at the time of commencement or during settlement of the claim hereunder or otherwise.

TREATMENT AT PANEL / APPROVED HOSPITALS: In case credit facility at the company panel hospital is utilized, the employee is required to submit an attested photocopy of credit letter/Health Card duly signed by the employee along with a copy of national identity Card in case of adults. Credit arrangements are available for indoor treatments at these hospitals. List of these hospitals is provided to the insured at the time of policy commencement. The company may amend this list from time to time. Credit arrangements may change at anytime.

Hospital bills for availed facilities covered under the policy are directly settled by the company, excluding charges not covered under the policy, and any excess payments or payments demanded by the hospital for any reason.

PAYMENT OF CLAIMS: In case where indemnity shall be on a reimbursement basis, the benefits, payable under the terms of this policy, will be paid to the policyholder or to the insured person as agreed in writing. The company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent statement or advice whether by the insured or by any insured person or by any other person on their behalf.

The company holds all the rights to withhold, inspect, investigate, make deductions, and reject part or whole claim which it finds inappropriate, suspicious or fraudulent. No claim is admissible and payable in case a non-panel institution is utilized without prior permission of the company. The company reserves all rights to accept or refuse the request for utilizing a non-panel hospital particularly if a panel hospital is available in that area. In case any of the prescribed procedures is not followed, the company reserves the right to either negate or reduce the benefit amount to match the cost with its approved / panel hospital rates for such hospital confinements.

RE-IMBURSEMENT OF CLAIMS: Non panel hospitalization Claims should be submitted on the prescribed claim form of the company duly signed by the employee, the employer or designated officer and duly signed by & stamped by the attending doctor.

Claim submission to the company shall be accompanied by a covering letter from the insured designated officer giving details of the claim submitted. Claims submitted directly by the employee will not be entertained.

CLAIMS SUBMISSION PERIOD: All claims (**hospitalization, maternity, dread disease, specialized investigation, and outpatient department**) together with required supporting information / documents shall be submitted to the company within thirty days, where it is not reasonably possible to submit claims within thirty days, the claims may be submitted later with prior approval of the company but in no case later than ninety days of the date of commencement of the event which gave rise to the claim. Claims submitted after the period mentioned above will be considered as **time barred claims.** The company carries no liability to pay such claims.

This condition does not apply to the submission of the claims at the time of cessation of the policy where the claims shall be submitted to the company within 15 days.

RECOVERY OF THE EXCESS PAYMENTS: In case an insured person incurs any expense utilizing credit facility which is not covered under the policy and or is under the prescribed exclusion of the policy, then the policyholder would be responsible to recover such excess amounts from the primary insured person and pay the same to the company. Such amount shall include any cost containment features, amount in excess of limits and/or other expense, which are not covered under this policy. Settlement of hospital credit bills / expenses on account of any credit facility availed but not covered under the policy will be the sole responsibility of the insured / policy holder.

HOSPITALIZATION (IN-PATIENT)

All hospitalization should be authenticated by documents clearly indicating the reason for hospitalization by the referring specialist/consultant (physician, surgeon, gynecologist etc.) General practitioners, medical officers are required to make referrals to the concerned specialists for the purpose of hospitalization.
The Company reserves the right to reject any hospitalization which does not conform to accepted medical practice.

PANEL HOSPITAL

Every primary insured is issued credit letter/Health Card to avail credit facility at approved panel hospitals. In case credit facility at the company's panel hospitals is utilized, the employee is required to submit a photocopy of credit letter/Health Card duly signed by the employee along with a copy of National Identity Card in case of adults. Credit arrangements are available for in-door treatment at these hospitals.

INTIMATION / PRIOR APPROVAL

Where indemnity is on re-imbursement basis in case of a scheduled hospital confinement (i.e. other than an emergency) in a hospital, which is not an approved hospital, the employee must first seek prior approval from the company by submitting a cost estimate from the physician for the hospital confinement and procedures to be carried out. The company would then issue an approval letter, a copy of which should be sent along with the claim papers for settlement of claim within four weeks of discharge from the hospital. Settlement of such claims shall be on reimbursement basis.

The policy holder or primary insured person shall inform the company in writing when hospitalization is required and before such treatment is undertaken except in case of medical emergencies. In case of medical emergencies intimation shall be given within forty eight hrs of such hospitalization but before discharge from the hospital (whichever is earlier). Intimation shall mean intimation given by or on behalf of the insured to the company at its head office or respective branch, with information sufficient to identify the Insured, the hospital and the physician.

NON-PANEL HOSPITAL CLAIM REIMBURSEMENT

In case where the indemnity shall be on a reimbursement basis, a completed claim form together with required supporting information / documents shall be submitted to the Company within thirty days, Where it is not reasonably possible to submit claim within thirty days, the claim may be submitted later with prior approval of the Company but in no case later than ninety days of the date of commencement of the event which gave rise to the claim.

The hospital shall comprise all necessary facilities and standards to constitute a hospital. In case of hospitalization facility utilized at small clinics/nursing homes, not in conformity with accepted standards and regulations, claims will not be entertained.
Reimbursement of claims (hospitalization/maternity) of such institutions that are managed and run by simple general practitioners (not constituting and less than 24 hour qualified specialist/consultant supervision) is neither admissible nor payable unless prior permission is granted by the company under extraordinary circumstances.

DEFINITIONS

1. **PREMIER HEALTH** is a division and part of Premier Insurance Limited. In this policy where ever Premier health is used it will invariably mean Premier Insurance Ltd.

2. **INSURED PERSON** means an individual whose name is included in the policy schedule and satisfies the evidence of insurability as required under the policy conditions.

3. **EMPLOYEE** means an insured person who is in full time active service with the policy holder.

4. **FULL TIME ACTIVE SERVICE:** An employee will be considered to be in full time active service on any day if he is then performing or is capable of performing in the customary manner all of the regular duties of his employment on the last scheduled working day. A dependent will be considered to have satisfied the evidence of insurability on any day if he is then able to perform all the normal activities of a typical person of the same age and sex, and is confined neither at home nor in a hospital or any other medical facility.

5. **FAMILY** means employee, spouse, dependent children and dependent parents if covered under the policy.

6. **DEPENDENT** means and includes the legal spouse of an employee (other than a legally separated spouse) or the person living with the employee in a legally recognized husband and wife relationship who is registered as such in the record of the assured. Dependents also include unmarried children, stepchildren and legally adopted children, living with and residing in the employee's house or absent there from only to attend an educational institution and dependent upon the employee for support and also extends to unmarried children, step children who are over 18 to 25 years of age if attending a full time college or a university whilst having the same permanent residence as the employee.

7. **SICKNESS/ILLNESS/AILMENT** means an illness of the insured person which becomes manifest during the period of insurance and is perceived by a registered qualified medical practitioner to necessitate immediate medical treatment not otherwise excluded from the policy.

8. **ACCIDENT** means an unexpected, unusual and specific event which occurs during the period of insurance, at an identifiable time and place. In this policy "On Road Accident" means Road Traffic Accident (RTA) ONLY. Off Road Accident" means all those accidents not involving RTA even if its occurrence is on the road.

9. **ACCIDENTAL BODILY INJURY** means physical injury caused by an accident which is sustained by an insured person during the period of insurance and occasions the necessity for the insured person to receive in-patient care and attendance from a hospital.

10. **PRE-EXISTING CONDITION** means injury or illness or related or consequential or recurrent condition for which treatment or medication or advice or diagnosis was sought or received one year prior to commencement of this policy for the concerned insured person or which was known or should have been reasonably known to exist prior to the commencement of this policy for the insured person or in respect of which the need for treatment was foreseeable at inception of this policy whether or not treatment or medication or advice or diagnosis had been sought or received.

11. **REGISTERED MEDICAL PRACTITIONER OR PHYSICIAN** is a person legally licensed to practice medicine in the country and who is rendering such practice and practicing within the scope of his license and training and includes doctors of medicine, general practitioners, specialists, consultants, registered hakeems and homeopaths.

12. **PRESCRIBED DRUGS** are the medications whose sale and use are legally restricted to the order of a physician and do not include items that may be purchased without a physician's prescription.

13. **HOSPITAL** means an institution which is licensed under the law of the country in which it is located and exists primarily for carrying out surgical operations or providing treatment of a nature which only medical practitioners can provide and which renders 24 hours medical and nursing care. This definition is extended to include maternity homes.

14. **APPROVED HOSPITAL** means a hospital approved by the company to provide treatment for which a benefit may be payable under this policy. A list of currently approved hospitals is attached to this policy. This company reserves the right to amend this list from time to time.

15. **HOSPITAL SERVICES** are medical treatments provided during the period of insurance to the insured person who is admitted as a registered patient in a hospital. These include room and medical charges, use of hospital medical facilities and all medical treatments and services prescribed by a physician.

16. **GENERAL OUTPATIENT SERVICES** are outpatient services provided or prescribed by a physician who is licensed as a general practitioner.

17. **SPECIALIST OUTPATIENT SERVICES** are outpatient services provided or prescribed by a physician who is licensed as a specialist or consultant to whom the insured person has been referred by another physician/general practitioner.

18. **HOSPITALIZATION** means the insured person's member's stay in the hospital for a minimum period of 24 hours for either medically necessary treatment or observation of any disease, sickness or bodily injury. Hospital confinement directly or indirectly related to maternity (pregnancy / childbirth) / dread disease is excluded from this definition.
19. **Hospital Confinement** means that an insured person is registered as a bed patient in a hospital and incurs daily room charges. Successive periods of hospital confinement, due to same or related causes, not separated by more than sixty days, shall be considered to constitute as one continuous period of hospital confinement (referred to as Per Confinement) unless the second period of confinement results from wholly unrelated cause or causes.

20. **PRE AND POST HOSPITALIZATION** Treatment means Consultation / treatment / investigation received before and following discharge from hospital for 30 Days prior to hospitalization & 30 Days after hospitalization, respectively, and related to in- patient treatment covered under the policy for reason of which hospitalization occurred. Charges payable for treatment shall not exceed the limit of hospitalization as prescribed in the policy schedule of the benefits. Post consultation is payable provided that the follow-up consultations and treatment is made with the same doctor (Surgeon / physician) for the same ailment.

21. **SURGICAL OPERATION** means an operation by incision, which is carried out in a hospital and normally requires the use of an operation theater. Successive surgical operations, performed as a result of same or related causes. Surgical operations relating to maternity (pregnancy / childbirth) / dread disease are excluded from this definition.

22. **EMERGENCY TREATMENT** means necessary medical treatment arising from an accident or conditions where treatment is required immediately to prevent loss of life or serious deterioration of the patient' s health.

23. **DAY CARE SURGERIES"** means medically approved same day procedures where the insured is not required to occupy a bed overnight.

24. **HOSPITALIZATION EXPENSES"** means reasonable and customary costs and expenses for in-patient medical / surgical specialist fees, nursing attendance charges, cost of physiotherapy and manipulative treatment, surgical and medical requisites. All these expenses to be necessarily incurred and arising from accidental bodily injury occurring or illness / sickness manifesting itself during the policy period.

- **MEDICAL EXPENSES** means all reasonable and customary costs incurred during the period of insurance in respect of medical, surgical, or remedial treatment given by a physician together with hospital services, ambulance charges laboratory and x-ray services.
- **LABORATORY AND X-RAY SERVICES** are laboratory testing procedures and radiographic & nuclear medicines procedures used to diagnose and treat medical conditions. Laboratory and x-ray services are included as specialist's outpatient's services if they are provided or prescribed by a physician who is licensed as a specialist or consultant.

25. **REASONABLY AND CUSTOMARY** hospitalization expenses which conform to the level of charges made by the majority of hospitals in Pakistan and in the respective city / area of Pakistan in which such expenses claimed hereunder were incurred for similar treatment and hospitals to be similarly qualified and of similar standing as those in respect of which claim is made.

MATERNITY CLAUSE

Following expenses on account of maternity/childbirth are payable under maternity clause:-

a. Pre-natal and post-natal expenses are included in the maternity limit as stated in the policy schedule.
b. Charges made by a physician or licensed midwife for delivery.

c. Hospital charges including nursery care for the baby, while the mother is confined in the hospital.
d. Charges for circumcision of new born baby maximum of Rs.3000, payable subject to available balance in the maternity limit.

Subject to the maternity expense limits and any cost containment features indicated in the schedule, the following conditions shall apply:

1. Maternity benefits are available for the dependent wives and for married female employees only covered under the policy.

2. The benefit limit under this clause shall apply to only two pregnancies, including any and all complications in connections with the pregnancy.

3. All legal therapeutic miscarriages/abortions are considered maternity claims and are payable as per normal maternity limits of the policy.

4. Hospitalization in regard to investigation and treatment of primary and secondary infertility is not payable under maternity or under hospitalization cover.

5. Antenatal and Postnatal maternity claims are not payable under O.P.D. account.

6. The enhanced cesarean limit as shown on the schedule shall apply only to deliveries involving abdominal cutting and/or extra uterine conceptions (Ectopic Pregnancy) and in no event shall include procedures such as episiotomies, spontaneous vaginal deliveries (S.V.D.S), forceps, assisted deliveries, vacuum assisted deliveries and breech deliveries which shall be covered under the normal pregnancy limit.

SPECIALISED INVESTIGATION CLAUSE

Specialized investigation (S.I) cover can only be utilized provided a qualified specialist/consultant has advised the relevant specialized investigation and prior approval from the company will be necessary except in case of an emergency.

The S.I. annual limit covered under the policy is mentioned in the schedule.

Only the following five investigations are covered under "specialized investigation" cover. No other investigation is payable under this cover.

1. **Thallium Scan**
2. **Angiography**
3. **Endoscope**
4. **MRI**
5. **CT Scan**

DREAD DISEASE CLAUSE

Dread disease cover will become operational only after formal approval of the company.

"Dread Disease" expense means reasonable and customary charges for all medically necessary treatment and services provided by or on the order of a physician to the insured person, on acquiring a dread disease as defined herein, during the policy period and diagnosed during the same period.

GENERAL CONDITIONS

The following conditions are applicable to this clause.

1. The dread disease cover under this clause is available only to persons for whom a benefit limit is defined in schedule under the dread disease benefits section.

2. Dread disease cover is not valid for any particular dread disease or diseases included in the dread disease cover.
3. The cover granted by this clause shall cease to be in effect automatically on
   - Termination of insurance cover under the basic policy or
   - The insured person attaining the age of 60 years.

4. The prescribed limit of this cover is valid for one policy year; each expense to be debited to the respective account. The dread disease benefit limit shall apply to all expenses arising from anyone or a combination of dread diseases that the insured may acquire during the period whilst the insured person is covered under this clause.

5. It is a requirement under the clause that the insured be in good health at the commencement of coverage.
6. Written notice of claim shall be submitted to and received at the office of the company within fifteen days of the dread disease being diagnosed together with sufficient evidence to prove the

diagnosis of dread disease. Diagnoses of disease under dread disease cover has to be made by relevant and qualified specialist / consultant of that disease. The company reserves the right to require a medical examination at its own expense.

7. Any hospital confinement for this purpose would be subject to approval by the company. If approved, the company would then make arrangements for providing credit facility with any approved hospital that provides facilities for care of such illnesses.

Subject to the dread disease limits and any cost containment features indicated in the schedule, and the policy conditions and provisions contained therein, the company shall pay for expenses of hospitalization and post hospitalization of an insured person, in connection with treatment of a dread disease named and defined as under:-

- Management of acute Myocardial Infarction (Heart Attack)
- Coronary artery by-pass grafting.
- Cerebro vascular Accidents (CVA-Stroke)
- Management of all type of Malignancies (Cancer)
- Management of Renal Failure (Kidney Failure)
- Major Transplants
- Major Burns
- Aids Complex
- Liver Cirrhosis
- Paralysis
- Brain Tumor
- Hepatitis B&C
- No disease other than those mentioned under the dread disease cover is payable under this benefit.

Out Patient Expense

This benefit can be availed on reimbursement basis only.

This section provides coverage for outpatient treatment due to sickness or accidental injuries. Eligible outpatient treatment expenses include:

- Doctor Fee.
- Medicines & drugs.
- Minor Operations
- Laboratory and X-Ray tests.
- **ALL** Dental Care related expenses
- Eye sight testing is Covered but (Provision of appliances such as spectacles, lenses is strictly excluded).

OPD treatment taken by the Hakeem and Homeopaths will be covered up to Rs. 1200/. Per week.
Dental treatment will be allowed up to the 70% of total OPD annual limit. It covers dental consultation & dental acute medical diseases & diseases of gums. Orthodontic procedure making an placement of prosthesis (e.g dentures, crowns etc) scaling & polishing are excluded.
When submitting an OPD claim for re-imbursement, the following documents duly attested by the authorized personnel must be submitted:

- All original bills with dates.
- Doctor's Prescription for all medications and laboratory tests.
- Photocopy of " Premier Hospitalization Credit Letter"

When the claim papers are complete, payment will be made within the available OPD limit to PRAL for onward delivery to the concerned employee.

Exclusions

This policy does not cover the following expenses/charges:

1. Confinement or surgical / medical operation or procedure not recommended by a legally licensed / registered physician, surgeon, or specialist.
2. Accidents, mental illness and any sickness or condition arising from drug abuse, alcoholism or an insured's criminal act.
3. Self-inflicted injuries while sane or insane, including attempt to suicide.
4. General check-ups, routine physical examinations, routine preventive measures and or rest cures, confinements which are primarily for diagnostic purposes.
5. Supply or fitting of eye-glasses , contact lenses, laser corrective procedure for errors of refraction, radial keratotomy, corneal transplant , excimer laser or any hearing aids.
6. Cost of limbs or supporting equipments for revival or correction of the function of the body, rehabilitation aid equipment like wheelchair, crutches etc.
7. Personal comfort items like charges for telephone and meal.
8. In-hospital dental examinations, x-rays, extractions or fillings unless necessitated due to accidental injury occurring while the insured was covered under the policy.
9. Cosmetic or plastic surgery unless necessitated due to accidental injuries occurring while the insured is covered under the policy. Medication used for cosmetic reasons dietary products / supplement, medicated pediatric milk products even if advised by a physician.
10. Medical expenses or cost of management of rehabilitation of handicapped children.
11. Expenses directly or indirectly resulting from or consequent upon congenital defects and deformities of any nature whatsoever both physical and mental.
12. Treatment / procedure requiring prosthetic implants (except intra-occular Lens).
13. Test, treatment and investigation relating to infertility, sterilization, contraception and any related complication.
14. Injuries while traveling by air or marine transportation except as a fare paying passengers in a licensed aircraft or marine transport being operated by a licensed airline / sea line according to a public schedule.
15. Injury or illness due to a war, invasion, civil war, revolution, insurrection or military uprising and the insured taking part in paramilitary forces, treatment from natural hazards such as earthquake, landslide etc.
16. Injuries, disease or illness directly or indirectly due to or arising from mountaineering, rock climbing, hunting, steeple chasing, polo or winter sports or racing or engaging in any hazardous activities such as aviation or ballooning and injuries resulting from involvement in any terrorist and unlawful activities.
17. Ionizing radiations or contamination by radioactivity from any nuclear fuel & nuclear waste.
18. The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear components thereof.
19. Naval or Military or Air force or Police Force operations planned or conducted against bandits, terrorists or other like elements.
20. Deliberate exposure to exceptional danger (except in an attempt to save human life) or the insured person's own criminal act.
21. Rest cures, sanatorial or custodial care or period of quarantine or isolation.
22. Any treatment or procedure performed on unborn fetus.
23. **AUTOIMMUNE DISORDERS:** In cases of life threatening connective tissues disorders (e.g. SLE) & other Auto-immune disorders (e.g. Autoimmune hemolytic anemia) arising during the course of existing policy year only two-hospitalizations cover will be available in that policy year subject to acceptance by the company .