mij family
Medical Insurance Program

Tawuniya التعاونية

The Policy Wording

Policy wording for "MY Family" Medical Insurance Plans

In accordance with the Articles of Association as a Cooperative Insurance Company,Tawuniya (hereinafter called "the Company") may from time to time decide to distribute to the policyholders all or part of any annual surplus arising from the insurance operations. The amount, time and manner of and eligibility to such distribution are subject to the rules and regulations as stated in Article 70 of the Implementing Regulations of the Law on Supervision of Cooperative Insurance Companies. The policyholder having submitted to the Company an Application which shall be the basis of this contract and is deemed to be incorporated herein and having paid the Contribution. The Company hereby agrees with the policyholder that if an assured person whilst covered under this policy incurs Eligible Expenses, as herein defined as a result of an ailment the Company shall pay such Eligible Expenses in accordance with the benefits specified herein and the limits and sub-limits of the plan stated in the policy schedule subject always to the terms, conditions, limitations and exclusions of the policy.

Section 1: Definitions

For purposes of this insurance, the following terms, phrases and expressions, wherever mentioned in the policy or its endorsement or attachments, shall be construed as follows:

1. **Accident:** a sudden injury or a sudden and unforeseen event occurring during the period of insurance.

2. **Disease**: a sickness or illness that occurs to the beneficiary and necessitates medical treatment by a licensed physician before and during the period of insurance.

3. **Allergy:** the sensitivity a particular person has to certain kinds of food, weather or pollen, or acquires from plants, insects, animals, minerals, elements or other materials causing such person to develop bodily reactions from direct or indirect contact with such materials resulting in conditions like asthma, indigestion, itching, hay fever, eczema or headache.

4. **Beneficiary (Insured person):** the person (policyholder or dependent) included under the scheme and listed in the list of beneficiaries attached to this policy.

5. **Benefit:** the costs of providing health services included in the insurance coverage within the limits shown in the policy schedule.

6. **Premium (contribution):** the amount due by the policyholder in consideration of the insurance coverage granted under the policy during the period of insurance.

7. **Congenital Deformity:** the functional, chemical or bodily defect usually existing before birth whether hereditary or resulting from environmental factors.

8. **Insurance Coverage:** the basic health benefits granted to the beneficiary as described in the insurance policy attached to this schedule.

9. **Coinsurance /Deductible (co-payment):** the part (as determined in the policy schedule) that the beneficiary has to pay for health care received in-patient and out-patient clinics.

10. **Dependent:**

    a. Husband /wives registered as such in the records of the policyholder and residing legally in the Kingdom of Saudi Arabia.

    b. The policyholder's children and/or the children of a spouse and/or children officially sponsored that are residing in the Kingdom of Saudi Arabia; who are financially dependent on the policyholder and whose age ranges between Date of Birth and 25 years of age for male and 70 years of age for female (unmarried/ divorced/widows) at coverage inception date.

    Dependant spouses are eligible to cover up to their age 70 years

11. **Claim Supporting Documents:** all documents proving and establishing the beneficiary's age, nationality, identity and the validity of the insurance coverage, circumstances of the event giving rise to claim and payment of costs as well as other documents such as police report, invoices, receipts, prescriptions, physician's report, referrals and recommendations and any other original documents that may be required by the Company.

12. **Direct Billing or Company Billing:** the facility of non-payment granted to the beneficiary at one or more medical facilities appointed by the Company whereby all such costs are directly billed to the Company.

13. **Inception Date:** the date shown in the policy schedule on which insurance coverage commences.

14. **Effective Date:** the date chosen by the policyholder and approved by the Company to start covering a beneficiary under this policy or to add a beneficiary or delete him from the policy.

15. **Endorsement:** a document issued by the Company on its official forms dated and signed by an employee officially authorized by the company to establish the validity of any amendment to the policy that does not change the original coverage as requested in writing by the policyholder.

16. **Hospital:** a qualified medical facility approved by The Council of Cooperative Health Insurance and acceptable to the policyholder and the Company and licensed under applicable law to operate as a hospital and to provide treatment for which compensation may be claimed under this policy. The term "hospital" as used in this policy does not include hotels, pensions, guest houses, rest houses, sanatoriums, convalescence homes, quarantine, retirement or nursing homes, mental asylums or any place usually used to shelter and treat drug or alcohol addicts.

17. **Hospitalization:** registering a beneficiary as an in-patient staying overnight in a hospital following a referral from a licensed physician.

18. **Insurance:** proof of validity of the insurance coverage as witnessed by this policy, its schedule, endorsements or attachments.

19. **Licensed Physician:** a medical practitioner having received his qualification and officially licensed to practice medicine and is accepted by the policyholder and the Company to provide treatment for which compensation might be claimed under this policy.

20. **Limit of Coverage:** the maximum limit of the Company's liability as shown in the policy schedule in respect to any beneficiary and before applying the coinsurance/ deductible.

21. **Service Provider:** the government/non-government medical facility approved and licensed under applicable law to provide medical services in the Kingdom, such as hospital, diagnostic center, clinic, pharmacy, laboratory, physiotherapy or radiotherapy center.

22. **Pregnancy and Delivery:** any pregnancy and/or delivery, including natural delivery, Caesarean and abortion.

23. **Surgery or Same-Day Treatment:** surgery or treatment requiring preparation for admission to a hospital or treatment center without necessitating an overnight stay.

24. **Treatment in Outpatient Clinics:** the beneficiary's visit(s) to out-patient clinics for diagnosis or treatment of a disease.

25. **Company:** a cooperative insurance company licensed by SAMA to operate in the Kingdom of Saudi Arabia, and qualified by the Council to practice cooperative health insurance.

26. **Approved Service Providers' Network:** a group of health care providers approved by The Council of Cooperative Health Insurance and selected by the insurance company to provide health care to the policyholder/dependents and bill the insurance company directly whenever a beneficiary presents his valid insurance card, provided that such network include the three levels of health care:

    - Level 1: Primary health care.
    - Level 2: General hospitals.
    - Level 3: Specialized or referral hospitals.

27. **Grace Period:** the number of days during which the policy remains valid in case of non-payment of the total contribution shown in the schedule.

28. **Period of Insurance:** the period shown in the policy schedule during which insurance remains in force.

29. **Policyholder:** the natural or corporate person in whose name the policy is issued.

30. **Reasonable and Customary Medical Expenses:**

    a. The medical expenses compatible with level of fees charged by the majority of licensed physicians or hospitals in the Kingdom, provided such fees are for the treatment of a similar condition by physicians and hospitals of similar qualifications and standing to those which provided the treatment.

    b. The medical treatment that does not differ significantly from what a licensed physician considers acceptable as being usual and customary for any particular disease for which compensation for the costs of its treatment is recoverable under this policy.

31. **Basis of Compensation:** the procedure followed to compensate the policyholder for recoverable expenses paid by the beneficiary and claimed by him, after satisfying the coinsurance/deductible.

32. **Personal Risks:** any activities known to involve a high risk of exposing a person to an illness or an accident, or is expected to aggravate a previous illness or injury.

33. **Fraud:** intentionally misleading by a person or an entity with the intent to exploit health care and distort facts or the intentional deceit leading to obtaining benefits or offering of privileges that are excluded or exceeding the allowable limits for a person or entity.

34. **Misuse:** unintentional practices by individuals or entities that may lead to obtaining benefits or privileges they are not entitled to, but without the intention of fraud, misrepresentation or distortion of facts in order to obtain the benefit.

35. **Violent External Means:** any means resulting in accident or injury to the insured.

36. **Rehabilitation (Physiotherapy):** a complementary part of comprehensive health care service and its applications for rehabilitating a person. This policy covers Physiotherapy treatments when it is prescribed by the attending physician due to illness or surgery or accidents only and subject to Maximum twelve (12) Physiotherapy Sessions per person per policy year.

37. **Geographical limits:** all My Family plans provide coverage inside the Kingdom of Saudi Arabia. For only My Family Diamond, out of KSA is covered for emergency treatments whilst on vacations/business trips up to maximum 60 days per person per policy year and subject to 20% coinsurance.

38. **Detailed Annex to the policy:** an annex is attached to this policy containing instructions and procedures relevant to the application of this Policy.

Section 2:Eligible Expenses/Benefits

Eligible expenses, for the purpose of this proposal, mean charges actually made on the account of an ailment of an Insured Person for the services, materials and supplies ordered by a licensed physician which are not excluded under Section (3), provided that such expenses shall be necessary, reasonable and customary at the time and place in which they are incurred. In no event shall Eligible Expenses include any charge which is not Necessary, Reasonable and Customary.

Eligible Expenses shall therefore include charges for the following:

A. All expenses of medical examination, diagnosis, treatment and medicine, according to the Policy Schedule.

B. All expenses of in-patient treatment including surgical operations, one-day treatment or surgery and pregnancy/delivery.

C. Treatment of Dental and Gum diseases.

D. Preventive measures specified by the Ministry of Health such as vaccinations, maternity care and childcare.

Section 3: Limitations and Exclusions

A. The policy does not cover the claims arising of the following:

   (1) Intentional self-inflicted injury.

   (2) Ailments arising out of the abuse of certain medicine, stimulants or depressants or by the use of alcohol, narcotics and the like.

   (3) Cosmetic surgery or treatment unless necessitated by an accidental bodily injury not otherwise excluded in this Section.

   (4) General health examinations, vaccinations, drugs or prophylactics which are not required for medical treatment of an ailment provided for herein (excluding the preventive measures specified by the Ministry of Health such as vaccinations, maternity care and child care).

   (5) Pregnancy and maternity treatment for children.

   (6) Treatment, which the Insured Person receives without charge.

   (7) Convalescence and general physical health programs and treatment at social care centers.

   (8) Any ailment or injury arising as a direct result of the Insured Person's occupation.

(9) The treatment of any venereal or sexually transmitted diseases that are medically recognized.

(10) Medical expenses for the treatment period following the diagnosis of the HIV (Human Immune Deficiency Virus) and/or HIV related ailment including AIDS (Acquired Immune Deficiency Syndrome) and or any mutant, derivative or variation thereof.

(11) All services and treatments related to dental implants or prosthesis or orthodontics or bridges fixed or moving, except occasioned by violent external means.

(12) All tests for sight and hearing correction and audiovisual aids, unless ordered by a licensed physician.

(13) Transportation expenses of the Insured Person as a patient within the cities of Saudi Arabia through means of transportation other than licensed ambulances or ambulances belonging to the Saudi Red Crescent Society.

(14) Hair loss, alopecia or wigs.

(15) Any psychiatric treatment or nervous or mental disorder.

(16) Allergy testing of any nature, other than those relating to the medicine or diagnosis or treatment.

(17) Devices, medicines, procedures and/or hormone treatment related to birth control, contraception or conception, sterility, impotency or infertility, and in-vitro fertilization or any other artificial insemination procedures.

(18) The pregnancy, delivery and the newborn babies resulting from in-vitro fertilization or any other artificial insemination procedures.

(19) Any congenital weakness or deformity unless considered danger to the life of the insured person except for cases to be treated according to a medical decision at the medical facility that is appointed by the council.

(20) Any additional costs or expenses incurred by the companion of the Insured Person during his in-patient or stay at the hospital, except room and board in a hospital for one companion, such as the mother accompanying her child up to 12 years of age or as required by medical necessity at the sole discretion of the treating physician.

(21) Acne treatment or obesity or overweight related treatment.

(22) Any cases of organ and bone marrow transplantation or implantation of any prosthetic devices replacing an organ.

(23) Personal Risks mentioned in the definitions section of this Policy.

(24) Drugs and alternative medicine treatment.

(25) Artificial Limbs and helping limbs.

(26) Natural changes resulting from menopause of the insured including menstrual changes.

(27) Physiotherapy treatments, more than twelve (12) sessions per person per policy year.

(28) Any medical expenses related to Kidney dialysis.

B. The Policy does not cover the health benefits in case of claims arising directly from:

(1) War, invasion, acts of foreign enemy, hostilities (whether war be declared or not), civil war.

(2) Ionizing radiation by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.

(3) The radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or nuclear component thereof.

(4) The Insured Person engaging in or taking part in armed forces or police service or operation.

(5) Riots, strikes, terrorism or any similar acts.

(6) Air or sea travel except as a passenger.

Section 4: General Conditions

1. **Proof of Validity:** this policy represents the basic level of insurance coverage granted to beneficiaries and shall not be valid unless confirmed by a schedule duly signed by an employee officially authorized by the company. Likewise, any addition to this policy shall not be valid unless confirmed by an endorsement duly signed by an employee officially authorized by the company.

2. **Records and Reports:** the policyholder must maintain a record of himself and his dependents covered under this policy comprising for each person his full name, sex, age, nationality, classification and other basic information that might affect the administration of this insurance and the determination of its premium rates. The Company shall given the right and opportunity, whenever it so requires, to examine those records and verify the accuracy of the information provided by the policyholder. The Company undertakes, whenever requested, to supply the policyholder with any information concerning the beneficiaries that he might wish to examine.

3. Eligibility

a. For policyholder: any person satisfying the definition of "policyholder" shall be qualified for insurance in accordance with the policy schedule.

b. For dependents: any person satisfying the definition of "dependent" shall be eligible for insurance in accordance with the policy schedule provided that such person is a dependent of an eligible policyholder. If a person defined as "dependent" is also eligible for insurance as a policyholder, his benefits as "dependent" shall be discontinued according to this policy. If both the wife and husband are living permanently together and are insured as policyholder, their children shall only be eligible for insurance as dependents of the husband.

Policyholder and all of his eligible dependants must be reported for coverage at the inception without any selection and any addition to the policy during currency of the policy period will not be allowed other than newly married wives and new born dependent children.

4. Payment of premiums

The policyholder shall pay the insurance premium due on each insured person upon commencement of the insurance coverage.

5. Effective Date of Coverage

Coverage shall become effective for a policyholder after a 30 day period from the date of total due premium paid to the Company. The policy period will be one year from the inception date shown in the policy schedule.

6. Addition and Deletion of Beneficiaries and Relating Premiums

a. The policyholder must immediately notify the Company in writing of all new eligible dependents to be covered by insurance after the inception date of the policy. The Company shall calculate the additional premium due for immediate payment for persons added to the list of insured persons on proportional basis from the date of their inclusion in the cover.

b. The policyholder must advise the Company in writing, within thirty days from the required termination date, of all beneficiaries (policyholder and/or dependents) whose insurance coverage to be terminated before the end of the period of insurance. The Company shall not refund the proportionate part of the premium whose claims exceeded 75% of the annual premium.

7. Termination of Beneficiaries' Insurance Cover:

a. For policyholder: coverage under this policy shall be automatically terminated in the following cases:
   1. If the policy period ends as defined in the policy schedule.
   2. Upon exhaustion of the maximum limit of benefits provided for in the policy.

b. For dependents: coverage under this policy shall be automatically terminated in the following cases:
   1. The dependent no longer qualifies as " dependent" as defined in Definitions, Paragraph 10 (b) of this Policy.
   2. If the policy period ends as specified in the schedule.
   3. Upon exhaustion of the maximum limit of benefits provided for in the policy.

c. Payment of recoverable expenses in respect of any illness in progress that leads to continued hospitalization on the date of termination of coverage shall continue for as long as required for such illness, but not beyond 365 days from the date of onset of said illness that led hospitalization and within the limits of cover indicated in the policy schedule.

d. In case this policy is terminated for any reason, the policyholder must immediately return to the Company all health insurance cards issued, relating to direct billing of the company by assigned healthcare providers' network. This also applies to the termination of any beneficiary's cover. The policyholder shall be liable to reimburse the Company for all medical costs and expenses resulting from his failure to comply with this rule.

8. Verification of the Beneficiary's Condition

a. The Company has the right and should be given the opportunity, to have the beneficiary for whom a claim was submitted for recoverable expenses examined by a qualified medical facility at the expense of the Company for up to two times within sixty days following submission of the claim.

b. The policyholder or the beneficiary shall cooperate with the Company and allow all necessary measures that may reasonably be required by and paid for by the Company for the purpose of preserving its rights, recoveries or legal compensations from third parties. He may not assign such rights except with the Company's explicit or implicit consent.

9. Non-Duplication of Benefits: in case of a claim for recoverable expenses due under this policy for a beneficiary also covered for the same expenses under another insurance, plan, program or the like, the Company shall then be responsible to pay such costs and become subrogated in the rights of the beneficiary to claim from others their proportionate share of such claim.

10. **Basis of Direct Billing of the Company by the Assigned Healthcare Providers' Network:** the Company shall issue for each beneficiary a medical insurance card allowing him to receive healthcare at the assigned healthcare providers' network without being asked to pay the costs of such services.

    The assigned service providers shall send to the Company on a monthly basis all invoices relating to medical expenses incurred in accordance with this policy. The Company will audit and process such expenses and advise the policyholder whenever expenses reach the maximum limit of benefit. In case such limit is exceeded, the Company shall have the right to claim the surplus costs from the policyholder within a period not exceeding (60) days from the date of his notification thereof.

    In case the policyholder default in paying such costs to the Company within the specified period, the Company shall have the right to raise the issue in accordance with the substantive and procedural laws and regulations of Committees for Resolution of Insurance Disputes and Violations. The Company has the right to delete or replace any or all of the healthcare providers assigned for purposes of this policy, during its validity, provided it is coordinated with the policyholder, and replacements of the same level are appointed.

    In case of lost of medical ID cards issued by the insurer, the policyholder shall be liable to reimburse the Company for all medical costs and expenses resulting from that medical ID card(s).

11. **Coinsurance/Deductible:** without prejudice to the facility of direct billing of the Company, a compulsory and binding condition that the beneficiary pay the coinsurance /deductible, if any, at the healthcare center, and any attempt by the beneficiary withhold payment shall be considered breach of the terms and conditions of this policy whose validity shall be suspended in respect of such beneficiary until the deductible is paid.

12. **Reimbursement Basis:** in case of emergency, a beneficiary may obtain urgent medical treatment in centers other than those assigned by the Company on reimbursement basis. In such case, the Company shall compensate the policyholder, in accordance with the policy's terms, conditions, limitations and exclusions, for recoverable costs and expenses on the basis of prevailing prices, provided that it provides the Company with the supporting documents it requires, within 30 days from incurring such costs.

13. **Cancellation:** the Company may cancel this policy at any time by mailing to the policyholder written notice of such intention at least 30 days in advance of the cancelation date. Due to:
    - None payment of due premium.
    - Breach of contract conditions/ terms.
    - Any violation described under Forfeiture clause.

    The policyholder can cancel the insurance policy at any time, and in such case, the Company shall be liable to refund to the policyholder, within 90 days from the cancellation date, provided there are no unpaid or outstanding claims, the remaining part of the premium for each insured person whose claims did not exceed 75% of the annual premium. The refundable amount shall be calculated on proportional basis :

    (Refund = annual premium ÷ 365 days x number of the remaining days)

    In case the policyholder stops paying the costs exceeding the maximum limit of benefit within the period specified in Article (10) of the General Conditions of the policy and due as a result of the arrangement for direct billing of the Company, the Company shall have the right to withhold refund of premiums, if any, and use such amounts to compensate for the expenses paid to the service providers which should have been paid to the Company by the policyholder.

14. **Forfeiture:** in the event of fraud, the company is not required to return any part of the premiums to the policyholder. In the event of misrepresentation from the commencement of the policy, the company should return premiums paid after deducting expenses to the policyholder.

15. **Approvals:** the Company's reply to approval requests from service providers to provide health service to beneficiaries shall be within a period not exceeding sixty minutes from the time of receipt of such request.

16. **Gender:** for purposes of this policy, words using the masculine gender are deemed to include the feminine gender.

17. **Notices**

    a. Any notice or other correspondence to the Company as required by this policy shall be written or printed.

    b. The Company shall inform the consumer of the expiry date of the insurance policy 15 working days prior to the expiry date.

18. **Compliance with Policy Provisions:** as a condition preceding any liability of the company, the policyholder and beneficiaries should strictly comply with and execute all requirements, conditions, obligations and commitments stated in this policy.

19. **Profit Sharing:** 10% of the net surplus shall be distributed to the policyholders directly, or in the form of reduction in premiums for the next year. The remaining 90% of the net surplus shall be transferred to the shareholders' income statement as stated by the Implementing Regulations of the Law on Supervision of Cooperative Insurance Companies.

20. **Settlement of Disputes:** any dispute or controversy arising out of or in connection with this policy shall be subject to or governed by the substantive and procedural laws and regulations of Committees for Resolution of Insurance Disputes and Violations. The Committees for Resolution of Insurance Disputes and Violations shall be the only competent bodies to deal with such matters.

Note: the Arabic text is approved for the official use while the English is just a guide.

* The insurance products provided by Tawuniya Insurance Company are subject to Value Added Tax (VAT), except life insurance (Takaful). A 5% of the premiums and administrative fees are added to all policies issued starting from 1 January 2018.

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9200 19990
www.tawuniya.com.sa
/tawuniya
Download Tawuniya app

T +966 11 252 5800
F +966 11 400 0844
9200 19990
www.lawarliya.com.sa

Head Office
6507 Thumamah Road (Takhassusi)
P.O. Box 86959 Riyadh 11632
Kingdom of Saudi Arabia