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FAY

# International & Global Medical Insurance program customised to meet your needs

Gulf Insurance & Reinsurance | gig GULF INSURANCE GROUP

# From Origin to Excellence


Company Address and Contact Details:

**Gulf Insurance and Reinsurance Company**
Kuwait City, Sharq Area Al-Shuhadaa' Street
Kipco Tower – Floor 41 & 42

TEL: **(+965) 22961666**
Email: **customer.serve@gig.com.kw**


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# FAY Policy Wording

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# Preamble

In consideration of the payment of the premium and in reliance upon the statements made by the Policyholder on the Application Form and subject to the terms and conditions of this Insurance Policy and any attachment forming part of it, the Insurance Company (Gulf Insurance and Reinsurance Company - GIRIC) agrees with the Policyholder named on the Application Form and guarantees to provide the benefits and healthcare services or their related expenses incurred by the Insured as set forth in the Applicable Scope of Coverage.

# 1. General Terms And Conditions

## Article 1: Insurance Policy

The Individual/Family Application Form of the Policyholder and any Insured, the Preamble, the Definitions, the General Terms and Conditions, the Applicable Scope of Coverage with its Limitations and Exclusions, the Policy Schedule, the Insured's Guide as well as any Attachment(s) and Endorsement(s) to any of the aforementioned, shall constitute the entire contract between the parties hereto (herein referred to as the Insurance Policy)

Any amendment or addition to the Insurance Policy shall be void, unless it has been made in writing and is signed and sealed by the Insurer. No Insurance intermediary has the authority to amend this Policy or waive any of its provisions.

## Article 2: Policy Validity

The validity of the Insurance Policy begins from the Effective Date and terminates on the Expiration Date as specified in the Policy Schedule.

## Article 3: Applications

Both the initial Individual/Family Insurance Application and any subsequent Applications by persons proposed for Insurance must be submitted using the special forms provided by the Insurer. The Insurer reserves the right to reject any initial or subsequent Application without any obligation to justify the decision or to accept it under any terms that are deemed appropriate. In case a deposit or payment on account is made before the acceptance of the application, such advance payments do not constitute consent to the submitted application. The Insurer reserves the right to reject the application. In such a case, the Insurer must refund the advanced amount to the Applicant for Insurance.

## Article 4: Applicable Scope of Coverage

The Applicable Scope of Coverage per Insured is set forth in the corresponding Policy Schedule. The Policy Schedule frames the coverage provided in respect of that Insured while specifying the basis of indemnity, the class, limits, Co-payment, Deductible(s) Excess, Insurer's participation(s), any specific Exclusion(s) and any special terms applicable at each level of service or benefit, depending on the nature of the healthcare services, the Provider and the Territory of Occurrence.

## Article 5: General Limitations

Coordination Payment Clause:
Except for what is mentioned in the conditions of this policy, the insurer shall only reimburse its proportional and net of any deductibles share of the costs of treatment for those injuries or illnesses that can be reimbursed by any law or legislation or other health system.

Territorial Scope:
Coverage applies to the healthcare services and their related expenses incurred in the territories specified in the Policy Schedule and to the extent stated therein.

Financial limitation:
As specified in the Policy Schedule under limit per case/for the Policy Period and as per the territorial scope. Financial limitations shall be defined under the aggregate limit per policy for all territories.

## Article 6: Premiums

The premiums due by the Policyholder to the Insurer as defined in the Policy Schedule are payable in advance by the Policyholder according to frequency of payment agreed upon between the Policyholder and the Insurer and as specified in the Policy Schedule. The coverage provided by the Insurer under this Insurance Policy shall not commence until the first installment is fully paid



In the event the Insurance premium is not paid on the due date, the Insurer will notify the Policyholder of the amount payable within 30 days also informing the Policyholder that otherwise this Insurance Policy will be canceled and the Policyholder will be liable for the amount due until the date of Cancellation. The premium payment is substantiated exclusively and solely by the issue of a relevant receipt from a legally authorized representative of the Insured.

## Article 7: Additions

The Policyholder has the privilege to add his/her following legal dependents to this Insurance Policy:

a. New born children of the Policyholder:
The Policyholder shall formally advise the Insurer within a period not exceeding 10 days from the date of birth by completing the Application Form and submitting a certified Birth Certificate. The Insurer undertakes to automatically issue an endorsement including the new born child without any proof of Insurability with the Enrollment date matching the date of birth. It is agreed and understood that the new born child shall be covered under the same Plan selected by the Policyholder on the initial Application Form completed by the Policyholder on behalf of all insured.

b. His/her new spouse:
Same process as per point (a) above in addition to providing the Marriage Certificate.

c. Legal Dependents and/or Household Personnel:
who were not included in the initial Application Form. The Policyholder has the right to request coverage under this Insurance Policy, The Insurer reserves the right to decline, accept on special terms or accept on standard terms, without giving any reason or justification to the Policyholder in regard to this decision.

Any addition to the Insurance Policy shall be void unless it has been formally acknowledged and accepted in writing, signed and sealed by the Insurer. The premium related to any formal addition, which shall be due by the Policyholder to the Insurer, shall be calculated on a pro-rata daily basis starting from the newly added Insured's Enrolment Date up to the Expiration Date.

## Article 8: Deletions

The Policyholder may formally request in writing the deletion of an Insured covered under this Insurance Policy from the Insurer without any delay; in this case the Insured's status is not any more in conformity with the definitions of Legal Dependents and/or Household Personnel.

The Policyholder can formally request the deletion of an Insured covered under this Insurance Policy from the Insurer prior to or at the Expiration Date, in the following cases:

- The death of the Insured to be deleted.
- Any proven duplication of coverage caused by the transfer of the Insured under another health scheme.

Any Insured is automatically deleted at the date of cancellation of this Insurance Policy according to the terms of Article 12, the Termination Date coinciding with the Policy Cancellation Date.

Any deletion within the Insurance Policy shall be void unless it has been formally acknowledged and accepted in writing, signed and sealed by the Insurer.

The premium refund related to the deletion which shall be due by the Insurer to the Policyholder shall be processed on a pro-rata basis starting from the Termination Date up to the respective Expiration Date. However, ***the insured will not benefit from any premium refund in case of usage of the medical card and/or submission of claim either by (direct billing or reimbursement).***

## Article 9: Policy Amendments

Any amendment on this Insurance Policy requested by the Policyholder during the validity of this Insurance Policy or on the Renewal Date must be formally requested in writing from the Insurer. The Insurer reserves the right to decline, accept on special or standard terms amendments required by the Policyholder. Any amendment to this Insurance Policy shall be void unless it has been formally acknowledged and accepted in writing, signed and sealed by the Insurer.
The Insurer shall credit or debit the Policyholder with the premium related to the accepted and implemented amendments, which shall be calculated on a pro-rata basis starting from the date of the amendment's implementation up to the Expiration Date.

## Article 10: Policyholder's Statements

This Insurance Policy, including its related additions, deletions and amendments, has been and shall be issued by the Insurer on the basis of the statements made by the Policyholder on the initial Application Form and on the subsequent written formal requests.
Any proven false statement(s) made by the Policyholder and/ of material information relating to the proposed Insured's state of health, professional activities and place of residence, shall result in the Insurer's right to cancel this Insurance Policy. The Policyholder must immediately inform the Insurer of any alteration that may occur during the validity of this Insurance Policy or at Renewal Date regarding the profession, activities and place of residence of the Insured covered under this Insurance Policy. The Insurer reserves the right to reconsider accordingly the Policy terms, conditions and premiums. This reconsideration includes the deletion of the insured.

## Article 11: Claims Notification

All In-Hospital treatment must be pre-approved before admission by the insurer.
In case of Emergency In-Hospital claim occurring at a Network or at a Non-Network provider, the Insured is obliged to notify the Insurer at least 24 hours before Discharge Date. Such notification can be in writing and/or verbally.

## Article 12: Cancellation

The Policyholder has the right to formally request the cancellation of this Insurance Policy from the Insurer and any premium refund related to a cancellation and being due by the Insurer to the Policyholder shall be calculated on a pro-rata basis starting from the Cancellation Date up to the Expiration Date. However, as per Article 8 the Insured will not benefit from any premium refund in case of usage of the Insurance Policy and/or submission of claim either by (direct billing or reimbursement).
The Insurer has the right to cancel this Insurance Policy in case of non-payment of premium according to the terms of Article 6 and in case of proven false statements and/or of material information according to the terms of Article 10 and when attainment of maximum age limit allowed in this policy and for any other reason and the insured will not be entitled in this case for any refund for the remainder part of the insurance period.

## Article 13: Anti Money Laundering

The insurer has the right to revoke any Insurance contract if the companyit could not accomplish the requirements of identification and activity verification for the insurer and/or for the insured, and notify the anti-money laundering unit- which is formed according to the current effective anti-money laundry law.

## Article 14: Subrogation

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

## Article 15: Currency

Any money payable to or by the insurer shall be in Kuwaiti Dinar.

## Article 16: Change of Law

This Insurance Policy is intended to conform to the law of the country in which the insurer's home office is located. If a conflict arises between this Insurance Policy and such law becomes effective after the Policy Effective Date, the insurer may, at its own option, renegotiate the terms of this Policy from the date such law becomes effective.

## Article 17: Duties

Any levies on the Insurance Policy applied by legislations, tax or stamp duty shall be borne exclusively by the Policyholder.

## Article 18: Sanction Limitation and Exclusion Clause

No (re)insurer shall be deemed to provide cover and no (re) insurer shall be liable to pay any claim or provide any benefit here under to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re) insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

## Article 19: Arbitration

All differences arising out of this Insurance Policy shall be referred to the decision of an Arbitrator to be appointed in writing by the parties in difference or if they cannot agree upon a single Arbitrator to the decision of three Arbitrators, one to be appointed in writing by each of the parties, and the third will be appointed by the Arbitrators, and the Kuwaiti arbitration law shall be applicable to the arbitration.



# 2. Insurance Benefits

## A. In-Hospital Treatment

### A1) Basic Benefit

This coverage shall apply in conformity with Article 4 of the General Terms and Conditions of this Insurance Policy and as specified in the Policy Schedule, in the event of non-excluded health conditions requiring Hospitalization, and/or Day-Hosp and/or Emergency Service, comprising all medical costs incurred while in Hospital:
- Room and board in a standard private room.
- Intensive care unit and coronary artery disease treatment.
-Surgeon and Anesthesiologist fees.
- Hospital services (Surgery, Theater, Anesthesia, Pharmacy, Laboratory, Radiology, etc)...
- Use of Hospital medical equipment (e.g. heart and lung support systems, etc...) Intra-venous infusions, injections, etc...
- Diagnostic and Laboratory tests, X-rays, electrocardiograms, scans, etc. (Only related to the original cause of covered Hospitalization).
- Various therapies including Physiotherapy, Chemotherapy, Radiation therapy, etc...
- Doctor Hospital visits related to the original cause of covered Hospitalization.
- Private Nursing care, if medically necessary
- Recipient transplantation service.
- Ambulance services if medically necessary.
- Morgue Expenses in the event of death of the Insured following admission and during Hospitalization for a non-excluded bodily injury or sickness
- Parent Accommodation fees for Insured(s) below 16 years of age.
- Psychiatric treatment including room, board and treatment.

## B. Out-Of -Hospital Benefits

### A1) Basic Benefit

This coverage shall apply in the event of non-excluded health conditions requiring Physician attendance, Diagnostic Tests and/or Pharmaceuticals and/or Physiotherapy

### B1) Physician Consultation

(including psychiatric fees)
This benefit representing the identifiable doctor visit fee which is specified in the Policy Schedule

### B2) Diagnostic Tests

This coverage shall apply in the event of non-excluded health conditions requiring the conduction of Diagnostic Tests. These tests include:
- X-Rays
- Laboratory
- MRI
- CT Scan
- Cardiac Catheterization, Echocardiogram, Holter ECG and Treadmill stress test.
- All Endoscopies including Cystoscopy, Arthroscopy, Gastroscopy, Colonoscopy, Laryngoscopy, Bronchoscopy and other, if conducted for Diagnostic purposes.
- Also includes other tests conducted for Diagnostic purposes.

### B3) Wellness & Preventive

The following routine health checkups are covered:
- Cancer Screening
- Mammogram
- Vaccinations
- General Labs:
- Liver profile
- Kidney profile
- Lipid profile
- Glucose –Tolerance test

### B4) Pharmaceuticals

This coverage shall apply in the event of non-excluded health conditions requiring Pharmaceutical treatment which comprises all drugs recognized as medicines and registered by Ministry of Health.

### B5) Complementary medicines

This coverage shall apply in the event of non-excluded health conditions by using alternative medical treatments aimed at restoring your normal physical functions. These treatments include:
- Acupuncture treatment
- Chiropractor treatment

### B6) Physiotherapy

This coverage shall apply in the event of non-excluded cases requiring rehabilitation through Physiotherapy sessions as prescribed by the attending Physician.

### B7) Speech Therapy

This coverage shall apply in the event of non-excluded cases requiring rehabilitation through Speech therapy sessions as short term due to sickness.

## C. Dental Benefit

### A1) Basic Benefit

This coverage shall apply as specified in the Policy Schedule as follows:
- Consultations
- X-Ray
- Extractions
- Amalgam/ Composite
- Root Canal Treatment
- local Anesthesia
- Prescribed drugs
- Scale/Polish
- Crown/Bridge
- Implants

### D. Maternity Benefit

This coverage shall apply as specified in the Policy Schedule:
- Maternity follow up
- Diagnostic tests
- Medications and Vitamins
- Normal Delivery and C/Section
- Legal Abortion

### E. Optical Benefit

The following is covered:
- Test for Error of refraction
- Consultation
- Lenses and contact lenses

### F. Congenital and hereditary Benefit

(up to 90 days after birth)
This coverage is subject to medical underwriting and shall apply as specified in the Policy Schedule: of congenital and hereditary conditions including any abnormalities, deformities, illnesses or injuries present at birth OR only present because they have been passed down through the generation of your family.

### G. Global Emergency Services

This coverage shall apply as specified in the Policy Schedule as follows:
- Evacuation
- Repatriation
- Hospital Admission Assistance
- Compassionate Visit

# 3. Standard General Exclusions

## A. Exclusions with Waiting Periods

In-Hospital cases, and all related surgeries, services, tests, medicines, consumables, accessories and prostheses are excluded from coverage under the Insurance Policy until the expiration of Waiting Period applicable from joining and or eligible.

| | Exclusion | Waiting Period |
|---|---|---|
| 1 | Hernias | 6 months |
| 2 | Hemorrhoids, Anal Fissures and Fistula | 6 months |
| 3 | Tonsils, Adenoids, Deviated Septum, Sinusitis, Turbinate Hypertrophy | 12 months |
| 4 | All Female reproductive system procedures | 12 months |
| 5 | Varicose veins, Hydroceles, Varicoceles (not related to infertility). | 12 months |
| 6 | Any related spine procedures and knee Surgery except for car accidents and accidents details of which have been recorded by the competent authorities | 12 months |
| 7 | Chronic Medications related to treatment of chronic disorders ex. Diabetes, Hypertension, other Cardiovascular disease, Cholesterol, Epilepsy, Parkinson's Disease, etc... (Out Patient) | 12 months |
| 8 | Acupuncture , Chiropractor & General Lab | 12 months |

## B. Lifetime Exclusions - Continued

| | Exclusion |
|---|---|
| 1 | Pre-existing conditions. |
| 2 | Any case excluded under Specific Exclusion(s) and clearly mentioned in the Policy Schedule. |
| 3 | Visiting Doctor fees that exceed fees of the resident doctors of the service provider hospitals. |
| 4 | All cases requiring In-Hospital stay/treatment which has not been notified to the Medical Call Center at least 24 hours before Discharge Date. |
| 5 | All cosmetic related medicines, products, and surgery (unless mandated by a covered accidental injury and is an essential part of treatment, occurring during the Policy's Contractual period) |
| 6 | All substances which are not considered as medicines and all medications that are not registered under Ministry of Health except medically necessary therapeutic vitamins unless it is supported by lab results confirming the deficiency. |
| 7 | Outpatient medical supplies including but not limited to (Elastic stockings, bandages, Gauze, Syringes, Diabetic test strips, and like products); Unless it is a part of Emergency Room treatment. |
| 8 | Any In-Hospital treatment, tests and other procedures which can be carried Out patient without jeopardizing the health of Insured. |
| 9 | All kinds of preventive treatments and procedures Exception: Mammograms, Cancer screenings and Limited General lab tests as listed in policy Schedule |
| 10 | Any treatment, and/or tests and/or medications and/or medical procedures and/or medical supplies test which is non-related to a specific symptom and/or disease. Or those which are not prescribed by a treating Physician. |
| 11 | All cases directed for In-Hospital by a non-Physician. |
| 12 | Surgery for the correction of refraction error. |
| 13 | Varicoceles related to infertility. |
| 14 | Any surgery for correction of acuteness of the sense of hearing and hearing aids |
| 15 | Upper and lower jawbone surgery (including that related to the temporomandibular joint) except for direct treatment of acute traumatic Injury or cancer. No Coverage is provided for orthodontic surgery, jaw alignment. |
| 16 | Congenital and heredity conditions treatment received after 90 days following birth. |
| 17 | Circumcision (adult and child) and all related complications |
| 18 | All fertility related treatment and In-vitro fertilization (IVF) and all related tests and/or medications and/or medical procedures and/or medical supplies. |
| 19 | All cases related to Viral Hepatitis and the complication except Hepatitis A. |
| 20 | Health Services and associated expenses for sex transformation operations, voluntary sterilization and for reversal of sterilizations. Contraceptive supplies or services. All services related to fertility/infertility as Varicoceles or polycystic ovary/ ovarian cyst or hormonal disturbances etc. and sexual dysfunction. |
| 21 | Work Related accidents. |
| 22 | Dialysis. |
| 23 | Aging related conditions such as Senile dementia, Alzheimer's, Menopause and Osteoporosis. |
| 24 | All cases related to hazardous activities such as piloting. Motorcycling, mountaineering necessitating the use of ropes, underwater activities Requiring the use of artificial apparatus, parachuting, hang, gliding and motor racing. |
| 25 | All cases resulting from the Insured taking part actively in the regular armed forces and or any paramilitary force. And All cases resulting from war, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, mutiny, revolution, martial law and Any Act of Terrorism. |
| 26 | Experimental, investigational Health services and associated expenses. |
| 27 | Artificial limbs and joints. Prosthesis and Arthrosis unless pre-approved by the company. |
| 28 | Alternative medicine including but not limited to Acupressure, Hypnotism, Rolfing, Massage Therapy, Aromatherapy and Homeopathic Treatments. |
| 29 | All cases resulting from alcoholism and use of drugs. All services and supplied that are part of smoking cessation programs and use for the treatment of nicotine addiction |
| 30 | Sexually transmitted diseases (STD) and conditions including and not limited to Syphilis, Gonorrhea, Genital warts, Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex(ARC) tests and the like, however these syndromes have been acquired or named will be excluded. |
| 31 | Pharmaceuticals & tests for Mental and Psychological disorders and all related cases |
| 32 | Suicide attempts, voluntary self-injury and injury resulting from Committing of or attempts to commit an illegal action. |
| 33 | Earthquakes, flood, volcanic eruption, landslide and other natural hazards. |
| 34 | All cases resulting from nuclear contamination, i.e. any exposure to ionizing radiation, radioactive contamination, nuclear processes, military material or nuclear waste of any kind. |
| 35 | All services attained/incurred outside the Territorial Coverage as per your Policy Schedule. |

# 4. Definitions

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

## 1. Insurer/The Company:

The Insurance Company (Gulf Insurance and Reinsurance Company-GIRIC) duly registered and licensed to operate in the country of issuance of this Insurance Policy.

## 2. Insurance Policy:

The contract (as defined in Article 1 of the General Conditions) whereby the Insurer, subject to the terms, provisions, limitations, exclusions and other conditions provided herein, guarantees the payment of the benefits set forth in the Policy Schedule, its Modules and Appendices (referred to as Policy Schedule hereinafter).

## 3. Policyholder:

The applicant for this Insurance Policy acting as the principal in his/her own capacity as well as in the name and on behalf of his/her Legal Dependents and/or Household Personnel and who's Application has been formally accepted by the Insurer.

## 4. Legal Dependents:

The unmarried children of the Policyholder who are under 18 years old or below 25 if still a full-time university student, and the Spouse(s) of the Policyholder.

## 5. Household Personnel:

Any person employed on a full time basis by the Policyholder for work at home and being active at work such as housekeeper, cooks, driver, butler, maid, gardener, etc...

## 6. Insured:

The Policyholder, the Legal dependents and the Household Personnel listed in the Application for this health Insurance or included thereafter, formally accepted by the Insurer and shown in the Policy Schedule or in any subsequent endorsement thereon are considered under this Insurance Policy as eligible Insured and referred to as insured hereinafter.

## 7. Enrollment Date:

The day (at 00:01 local time), month and year when the Insured has been enrolled and covered for the first time under this Insurance Policy or enrolled and covered under an initial Insurance Policy which has been renewed without any interruption.

## 8. Effective Date

The day (at 00:01 local time), month and year on which the Insurance Policy takes effect for the first time or for each subsequent renewal.

## 9. Expiration Date:

The day (at 00:01 local time), month and year on which the Insurance Policy expires.

## 10. Renewal Date:

The day (at 00:01 local time), month and year that coincides with the Expiration date.

## 11. Termination Date:

The day (at 00:01 local time), month and year on which the Insured's coverage is terminated as the result of his/her deletion at the request of the Policyholder and/or in case his/her status as Legal Dependent and/or Household Personnel no longer holds or upon the cancellation of this Insurance policy.

## 12. Cancellation Date:

The day (at 00:01 local time), month and year on which this Insurance Policy has been cancelled as a result of the Policyholder's written notice and/or as a result of the non-fulfillment of the Policyholder's obligations as set forth in the General Terms herein.

## 13. Medical Call Centre:

Professional service center operating 24 hours all year round staffed with a team of medical and claims administrative specialists working for the Company to support and monitor the proper application of the Insurance Policy. The Medical Call Centre provides the Insured with guidance and information through telephone inquiries at no cost; and verifies eligibility, carries out pre-admission reviews, and takes the decision in the name and on behalf of the Insurer as to whether or not to grant Free Access to the specific healthcare service under consideration.

## 14. Hospital:

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

## 15. Physician:

Any doctor of medicine (MD) who is duly licensed and qualified under the law of jurisdiction in which treatment is provided.

## 16. Medical Network:

Member Physicians, Hospitals, Clinics, Medical Centers, Pharmacies, Laboratories and Physiotherapy centers forming the Company network through a special and formal contractual arrangement whereby these providers agree to avail the Insured with Free Access to their healthcare services in conformity with the terms of this Insurance Policy and as set forth in the Policy Schedule.

## 17. Non-Network:

Any Physician and Health institution, Hospital, Clinic, Medical Center, Physiotherapy center and Pharmacy which are not part of the network.

## 18. Territory of Occurrence:

The country where the Insured's health condition has required healthcare services and where the related expenses were incurred.

## 19. Medical Card:

A personalized card issued in the name of each Insured, facilitating his/her access to the healthcare services covered under this Insurance Policy and provided by the Network.

## 20. Free Access / Direct Billing:

The Insurer's undertaking of direct settlement to the Network of all Eligible Expenses incurred by the Insured and related to non-excluded cases net of any applicable Policyholder's Co-Payment and/or Deductible Excess and/or any underlying health fund participation and within the limits of liability of the Insurer as defined in this Insurance Policy.

## 21. Pre-Hospitalization Form:

A form that must be completed by the attending Physician of the Insured and submitted to the Medical Call Centre prior to In-Hospital treatment. It is a mandatory pre-requisite to benefit from any In-Hospital coverage.

## 22. Hospitalization:

Any Hospital confinement for a minimum of one (1) night due to any non-excluded health condition and which cannot be performed on an Out-Patient basis.

## 23. Surgery:

Any necessary medical manual and/or instrumental treatment of injuries or disorders of the body duly registered by local authorities or approved by FDA.

## 24. Day-Case:

Same day services comprising all Surgical and other procedures related to non-excluded health conditions, not requiring an overnight stay at a Hospital but nevertheless necessitating specialized medical attention and care in a Hospital

## 25. Emergency:

A health condition sustained as a result of sudden, non-excluded sickness or bodily injury, raising a legitimate concern that there may be a significant medical problem necessitating treatment (Medical or Surgical) to be performed exclusively within the Territory of Occurrence which must not be delayed and which requires confinement to a Hospital Emergency Room/ Facility followed by Hospitalization or not. Emergency treatment in an Emergency Room is only covered in case treatment cannot be performed on an out-patient basis.

## 26. Accident:

An unexpected violent and sudden event causing physical bodily injury (injuries) to the Insured.

## 27. In-Hospital Treatment:

A Hospitalization or Day-Case or treatment/observation in an Emergency Room/ Facility or in a Hospital, which cannot be performed on an Out-Patient basis.

## 28 Delivery:

Hospitalization for normal or cesarean delivery, medically necessary abortion or miscarriage and/or any complications arising there from.

## 29. Out-Of Hospital Treatment:

Benefits that may be offered under this Policy in respect of services such as Doctor's consultation, Prescribed drugs, Diagnostic tests, Physiotherapy treatment, etc. and which do not require Hospitalization or any In-Hospital treatment/ observation.

## 30. Chronic Condition:

A condition requiring a regular uninterrupted lifetime treatment.

## 31. Policyholder Co-Payment:

The percentage of healthcare cost as stated in the Policy Schedule to be borne by the Policyholder. In respect of the service or benefit under consideration.

## 32. Eligible Expenses:

All expenses for healthcare services delivered to the Insured which are identifiable or covered under this Insurance Policy after allowing for any Specific Deductible Excess defined hereinafter, applicable at the level of such service(s) as provided.

## 33. Specific Deductible Excess per Service/Benefit:

The amount of money stated in the Policy Schedule to be borne by the Policyholder in respect of the service or benefit under consideration.

## 34. Aggregate Deductible Excess per Insured:

The amount of Eligible Expenses relating to an Insured person to be borne by the Policyholder over an accumulation period as specified in the Policy Schedule before any Insurance coverage applies during the validity of the Insurance Policy. Whenever this Aggregate Deductible Excess is satisfied within the accumulation period, the Insurance coverage shall apply in respect of that Insured for any Eligible in hospital Claim only based on the geographical area specified in the policy schedule.

## 35. Eligible Claim:

Any claim falling within the Applicable Scope of Coverage as set forth in the General Terms and Conditions of this Insurance Policy shall qualify as an Eligible Claim under this Insurance Policy.

## 36. Pre-Existing Condition:

Any health condition known to the Insured and/or Policyholder whether was diagnosed and known to the insured or not, or is a consequence of injury or illness for which medical, surgical and/or Pharmaceutical treatment or advice was provided prior to the Insured's Enrollment Date.

## 37. Undeclared Pre-existing conditions:

The non-disclosure by the Insured at the date of application, for this Insurance Policy, of pre-existing conditions restrictively relating to health conditions specifically inquired about, in the Application Form, if any.

## 38. Undeclared hazardous activities :

The non-disclosure from the Insured at the date of application, for this Insurance Policy, of a hazardous activity(ies) which was/were specifically inquired about, in the Application Form, if any.

## 39. Waiting Period:

The period of time starting from the Enrollment Date of the Insured during which a specific or general medical condition shall not be covered under this Insurance Policy.

## 40. Waiver date:

The date of termination of the Waiting Period after which the exclusion related to a specific or general medical condition is deleted.

## 41. Plan:

The combination of Benefits offered by the Insurer and selected by the Policyholder on the Application Form and documented in the policy schedule.

## 42. Act of Terrorism:

Including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological, or ethnic purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

## 43. Medical Case:

All cases and/or reasons and/or services and/or treatments and/or the covered diseases in the Insurance Policy and their complications, which falling within the medical cases limitation stated in the policy schedule for the same diagnosis.

## 44. Medical Necessity:

Medical Treatment/Services or supplies that is needed & necessary to diagnose/treat a medical condition which must meet acceptable standards of medical practice. Considering the quality and not the luxury of the member or the physician.

## 45. Insured Guide:

A booklet that provides information on how to benefit from the Insurance Policy.

## 46. Reasonable and Customery Charges:

Fees for Covered Health Services which, as determined by the Company, are either: (1) for Network Providers, the contracted charge; or (2) Is the average of the cost to perform a similar or comparable treatment of the same category within Company's network inside or outside Kuwait.

## 47. Policy Schedule:

The insurance certificate which contains information related to insured personal detail, Type of cover, Territorial scope of coverage and Special exclusions if any and other details related to the type of plan enrolled.

## 48. Complimentary Medicine Practitioner:

An acupuncturist, or Chiropractic who is fully trained and legally qualified and permitted to practice by the relevance authorities in the country in which treatment is received.

## 49. Rehabilitation:

Treatment in the form of a combination of therapies such as physical, occupational and speech therapy aimed at restoring full function after an acute event such as stroke.



# 5. Policy Schedule Clarifications

1. Foreign Currencies Referred to in This Policy under Limits and Deductible Excess Shall be converted into Kuwaiti Dinars at the date of Claim(s) Invoicing and Eligible Amounts and/or Balances Shall is Adjusted Accordingly.

2. Reimbursement of Non-Network claims will be according to the reasonable and customary charges in the network.

3. In case of rendering health care services at a network provider on direct billing basis, the agreed contractual rates including any applicable Co-payment(s) and/or Deductible(s) shall be applied.

4 . Special exclusions are stated in the policy schedule under each insured name if such exclusions exist.