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FAY Medical Insurance

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Policy Wording

GIG KUWAIT

January 2024

شركة الخليج للتأمين وإعادة التأمين
برج كيبكو - الطابق 39
شارع خالد بن الوليد
شرق، قطعة 5
هاتف: 1802080 965+
البريد الإلكتروني: customer.serv@gig.com.kw

Gulf Insurance and Reinsurance Company
KIPCO Tower 39th Floor
Khaled Ibn Waleed Street
Sharq, Block 5
Kuwait City, Kuwait P.O.Box 1040 Safat 13011
Tel: +965 1802080
Email: customer.serv@gig.com.kw

2007/1684
سجل تجاري: 323485
رأس المال المدفوع: 25,000,000 د.ك
مرخصة بالتأمين التقليدي

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FAY Policy Wording

Preamble

In consideration of the payment of the premium due, and in reliance upon the statements made by the Policyholder on the Application and subject to Limits, General Terms and Conditions, and Exclusions of this Insurance Policy and any attachment forming part of it, the Insurance Company (Gulf Insurance & Reinsurance Company) agrees to provide the Policyholder named on the Application with the medical benefits specified in the Table of Benefits as set forth in the Applicable Scope of Coverage during the validity period of the policy and signed by both parties in contract.

The Insurance Policy, Policy Schedule, Table of Benefits, the completed Insurance Application, and any attachments constitute as one part and must be read and understood.

Any words, phrases, and expressions used anywhere within this Policy have specific meanings assigned to them as explained in the Definitions Section listed at the end of this document, unless otherwise expressly stated within the Policy.

Eligibility Requirements

1. The insured member must be a legal resident of Kuwait.
2. Members will not be traveling outside Kuwait (whether business trip or vacation) for more than 90 consecutive days per visit.
3. Maximum allowed age at entry is 65 years old.
4. The following conditions will apply in case of New Enrollments and Renewals under such program:
   i. Individual medical underwriting that will be based on the completed medical application form and/or available claims experience if any.
   ii. Valid residency in Kuwait in case of expatriates.

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 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 is the period of 12 consecutive calendar months from the Effective Date when your policy began and terminates on the Expiration Date as specified in the Policy Schedule or from each Policy Anniversary if this Policy is renewed, during which this Policy is in force.

Article 3: Insurance Application

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.

If there are any changes to the information provided in the Insurance Application Form after the Policyholder or the Legal Dependents sign it and before we accept the application, please let us know straight away.

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 another 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 the 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 expiry of the policy (If there are claims registered) 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. Newborn children of the Policyholder:

The Policyholder shall formally advise the Insurer within a period not exceeding 30 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 newborn child without any proof of Insurability with the Enrollment date matching the date of birth provided:

- Either parents have been covered under this policy for 12 months or more prior to the child's birth;
- The newborn was not born as a result of assisted reproduction technologies, ovulation induction treatment, or fertility treatment by either parent or was not adopted or born to a surrogate.

The application for the newborn(s) (including if there are multiple births when either parent had fertility treatment or pregnancy followed assisted reproduction), can only be accepted once the Insurer receives a fully completed application form and any other proof of insurability. It is agreed and understood that the newborn 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. The Insurer reserves the right to reject the application.

B. His/her new spouse:

Same process as per point (a) above in addition to providing the Marriage Certificate.

C. Legal Dependents:

Who was not included in the initial Application Form? The Policyholder has the right to request coverage under this Insurance Policy, for his/her Legal Dependents.

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 of the main policy.

The coverage under this Policy is limited to the Insured whose Principal Country of Residence is Kuwait only.

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 anymore 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 is 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 a 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 or 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 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/ or 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 do one or more of the following:

- Cancel this insurance policy and end all cover immediately;
- Refuse to pay any claims;
- Recover from the insured any loss caused by the break;
- Refuse to renew the policy;
- Impose different terms to the cover.

The Policyholder must immediately inform the Insurer of any alteration that may occur during the validity of this Insurance Policy or at the 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 the Policy terms, conditions, and premiums accordingly.

Article 11: Claims Notification

All In-Hospital treatment must be pre-approved before admission by the insurer. In case of an 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 the Discharge Date. Such notification can be in writing and/or verbally

In some other cases, the Insurer may also ask the Insured to complete additional forms. The Insurer will need the Insured to complete these forms as soon as possible, but no later than 30 days after the Insured's Treatment starts (unless there is a good reason why this is not possible).

In cases of receiving treatment in outpatient clinics and in one of the medical centers that are not part of the approved network, and the insured did not benefit from the savings scheme

services, then the insured should notify the insurance company maximum period of 30 days from the date of treatment.

This notice includes submitting the claim with the related documents and original invoices as explained in the Insured Guide.

And in cases of getting treatment in Outpatient clinics within the approved network that has Direct, Settlement service the insured must not report a company Insurance, and the claim will not be subject to payment and refund. In this case, the insured must only use the insurance card.

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 cancellation and is 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 a claim either by (direct billing or reimbursement).

The Insurer has the right to cancel this Insurance Policy in case of non-payment of the 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 remaining part of the insurance period.

Accordingly, the Insurer shall have the right to terminate the Policy anytime if the Insured left the Kuwaiti territory for a period of 90 consecutive days during the contractual period. In this case, the Insured is entitled to a premium refund computed on pro-rata basis applied by the Insurer based on the period of time the Insured has been covered since the effective date of the Policy. There is no premium refund related to the plan under which the Insured would have benefited from a covered claim.

Article 13: Anti-Money Laundering

The insurer has the right to revoke any Insurance contract if the company 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 laundering 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 every 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 once 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 legislation, 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 the United States of America. The (re) insurer shall immediately end cover and stop paying claims on the policy, if the Policyholder or his Legal Dependents are directly or indirectly subject to economic sanctions, including sanctions against the Insured's country of residence.

The (re)insurer will do this even if the Insured has permission from a relevant authority to continue cover or premium payments under a policy. In this case, the (re)insurer can cancel the policy or remove a Legal Dependent immediately without notice, but will then tell the Policyholder if they do this. If the Policyholder knows that he or a Legal Dependent is on a sanctions list or subject to similar restrictions, the Policyholder must let the re(insurer) know within 7 days of finding this out.

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

The respective description of cover stated in the following sections shall apply in conformity with Article 4 of the General Terms and Conditions of this Insurance Policy and as specified in the Policy Schedule, comprising of all reasonable and necessary medical costs incurred in the event of any non-excluded Health Conditions unless otherwise agreed by the Insurer.

A. In-Hospital Treatment

Basic Cover

- For in-patient/in-hospital overnight stay, we pay for room and board in a basic standard single room. If multiple levels of a single occupancy accommodation exist within a given Hospital, it shall mean the lowest cost level.
- Intensive care unit, coronary care unit.
- Surgeon and Anesthesiologist fees.
- Hospital services (e.g., Surgery Procedures, Operating Theatre, Anesthesia, Pharmacy, Laboratory, Radiology).
- Use of Hospital medical equipment (e.g., heart and lung support systems).
- Intra-venous infusions, injections, prescribed drugs and dressings.
- Diagnostic and Laboratory tests, Pathology, X-rays, electrocardiograms, scans, Computerized tomography, magnetic resonance imaging and other such proven medical.
- Imaging techniques (Only related to the original cause of covered In-patient or Day-Care Treatment).
- Various therapies including Physiotherapy, Chemotherapy, Radiation therapy, if it is needed as part of the Treatment in hospital.
- Doctor Hospital visits (only related to the original cause of covered In-patient and Day-Care Treatment).

- Nursing care or special nursing care, if medically necessary and approved by us.
- Recipient (Insured) transplantation service of kidneys, heart, liver, lung or bone marrow.
- Ambulance services if medically necessary.
- Morgue expenses in the event of death of the insured following admission and during hospitalization for non- excluded bodily injury or sickness.
- Parent Accommodation fees for one parent staying with an Insured(s) their age is 16 or below who is receiving eligible treatment, and the child is a Legal Dependent covered by the policy.

In-patient Cash Benefit:

The following conditions will apply for Inpatient Cash benefit only if this benefit is mentioned as Covered in the Policy Schedule and according to daily sublimit:

1. Inpatient Treatment is at Governmental hospitals in Kuwait and it is free of charge and No hospital bills or charges will be submitted to us for payment.
2. Inpatient Treatment is for un-interrupted hospital stay & limited only to thirty (30) days of Hospitalization during the Policy Period.
3. The Medical Condition is covered as per policy terms and conditions.
4. Is limited to eligible covered members in the age between 18 years old up to 65 years old.
5. Does not apply for only one overnight stay of any Hospitalization.
6. Does not apply in case of Maternity related benefits whether delivery or complications of pregnancy.

B. Out-Patient Treatment

B.1. Consultations & Doctor Fees

This Policy covers visits to a General Practitioner (GP) or Specialist to diagnose or treat a covered Health Condition. If a covered Health Condition requiring immediate treatment arises outside of usual business hours, we will cover reasonable charges from the doctor for a home visit. The insurer retains the right to determine if a condition was suffciently urgent to justify a home visit.

B.2. Diagnostic Tests

Usual and necessary tests, where prescribed by a treating doctor to assist with a diagnosis, are covered for:

- Pathology (e.g., blood and urine tests)
- Radiology (e.g., X-rays)
- Advanced Diagnostics (e.g. MRI, CT, PET, Gait scans)
- Other diagnostic tests such an laboratory, ECG /EKG
- Endoscopies including Cystoscopy, Arthroscopy, Gastroscopy, Colonoscopy, Laryngoscopy, Bronchoscopy conducted for diagnostic purposes or on specialist referral

B.3. Prescribed Medicines, Drugs & Dressings

This Policy covers Medicines, Drugs & Dressings prescribed by your Medical Practitioner, where medically necessary for the condition being treated. For medicines and drugs, these shall be recognized as medicines defined under Conventional Treatment and must also be duly registered by the relevant government regulatory board within the country where treatment is provided. Please note, for medicines, drugs & dressings prescribed for any period after your policy has terminated will not be covered.

B.4. Physiotherapy

This coverage shall apply as specified in the Policy Schedule in the event of non-excluded cases requiring rehabilitation through Physiotherapy sessions as prescribed by the attending Physician Pro-Authorization is required.

B.5. Cancer treatment for radiotherapy and chemotherapy

Treatment costs when cancer is diagnosed after the Insured joining the Policy and for treatments delivered within the Period of Insurance on an Outpatient basis:

- Fees directly related to ongoing Cancer Treatment, including tests, scans, consultations and drugs.
- Radiation therapy and Chemotherapy.
- Treatments after acute stage treatment (meaning after surgery, radiation therapy or chemotherapy).

(Any Pre-existing Condition limitations apply to this benefit).

C. Dental Treatment

(Not covered under Plans FAY 5,000 and 10,000)

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

D. Maternity

Maternity benefit can be covered only for married females when all family members are included in the coverage.

The maternity benefit can be covered only if the pregnancy started after the policy start date (enrollment date).

Maternity coverage (inpatient Maternity services and treatments is subject to 12 months waiting period from joining date.

Please note, a single combined limit as detailed in your benefits table applies to the Insured's benefits for Pre/Post Natal Complications, Pre-Natal, Delivery (Childbirth), Post- Natal treatment expenses and New Born Care. Your chosen Deductible (if any) will apply to any Maternity related expenses incurred on an Inpatient basis including any applicable Waiting Period.

D.1. Pre/Post Natal Complications

Cover is provided for Maternity related conditions, not including the delivery (childbirth) itself (whether medically assisted or not), where the related complications are medically necessary and life threatening to the mother, after the Insured mother has been continuously insured under the Policy for 12 months. This includes the following conditions:

A. Antiphospholipid syndrome,
B. Cervical incompetence,
C. Ectopic pregnancy,
D. Gestational diabetes (if the Insured has exclusions because of her past medical history which relates to diabetes, the Insured will not be covered for any treatment for diabetes during pregnancy),
E. Hydatidiform mole – molar pregnancy,
F. Hyperemesis gravidarum,
G. Obstetric cholestasis,
H. Pre-eclampsia / Eclampsia,
I. Rhesus (RH) factor,
J. Miscarriage requiring immediate surgical treatment,
K. Post-partum hemorrhage,
L. Retained placental membrane.

D.2. Maternity Benefits of your Plan are provided except to child Dependents. Multiple pregnancies within a policy year are entitled to the single policy year's Maternity benefit amount.

D.2.1. Pre-Natal Checkups and Treatments

As prescribed by your treating doctor. Prescribed, recognized supplements for pregnancy are covered.

D.2.2. Delivery (Childbirth)

- Hospitalization costs (room type to be the room type provided by your In-patient Benefits).
- Obstetrician.
- Normal delivery (childbirth), medically necessary assisted delivery or medically necessary caesarean.
- Medical care required by the mother and child immediately following delivery.
- Elective caesarean will be reimbursed only up to the cost of a normal delivery, the usual cost of which will be determined solely by the Insurer.
- Medically necessary termination of pregnancy as per applicable Kuwaiti laws and rules.
- Newborn baby coverage is restricted only for premature babies up-to the maternity benefit limit , if maternity benefit is covered.
- Newborn Care benefits are not available to Newborn children born as a result of assisted conception treatment or from any fertility treatment. Application for the newborn enrolment into a Policy may only be made within 30 (thirty) days after birth, and the Application will be subject to medical underwriting.
- In-patient of Congenital or hereditary conditions are not covered under this Newborn Care benefit.

3. Waiting Periods

A) All Inpatient Treatment or Hospitalization and Day case (including medical treatment, surgeries, services, investigational tests, medicines, consumables, accessories and prostheses and others) for the following medical conditions is subject to below applicable Waiting Period starting from joining / enrolment date provided that these conditions are NOT present before the enrollment in this scheme and/or NOT related to any Pre-existing condition. As such any Inpatient treatment (or Hospitalization) for below conditions will not be covered during the below mentioned waiting periods.

Medical Condition (provided that it is not pre-existing)		Waiting Period
1	Hernia repair.	6 months
2	Hemorrhoids, Anal Fissures and Fistula.	6 months
3	Tonsillectomy, Adenoidectomy, Turbinate Hypertrophy, Nasal septal deviation and Nasal Sinusitis.	12 months
4	Uterine Fibroids, Hysterectomy, Endometriosis.	12 months
5	Varicose veins, hydroceles and varicoceles (Varicoceles related to infertility will be excluded for lifetime).	12 months
6	Maternity (Applied on all admission procedures including delivery).	12 months
7	Any treatment related to Spine and Knee joint disorders and surgeries. Except for car accidents and accidents details of which have been recorded by the competent authorities.	12 months

B) The only OUT-PATIENT treatment that is subject to waiting period is the Medications for Chronic Medical Conditions which occur and diagnosed after enrollment under this scheme.

Medical Condition (provided that it is not pre-existing)		Waiting Period
1	Chronic Medications related to treatment of chronic disorders ex. Diabetes, Hypertension, other Cardiovascular disease, Cholesterol, Epilepsy, Parkinson's Disease, etc....	12 months

C) Dental Treatment that is subject to waiting period, unless otherwise specified as covered in the Policy Schedule:

Dental waiting period		Waiting Period
1	Basic , Complex Dental and Major Restorations	3 months

4. Standard General Exclusion

Life time Exclusions

The following certain medical conditions and Treatments, Items, Supplies and all their related or consequential expenses are not covered in this Policy **unless otherwise specified as Covered in the Policy Schedule or subject to specified Waiting Period.**

If you are unsure about anything in this section, please contact us for confirmation before you go for treatment. **IMPORTANT-PLEASE READ**

Personal Exclusion: Please check your Policy Schedule to see if you have any personal exclusions or restrictions on your plan. The exclusions in this section apply in addition and alongside and such personal exclusions and restrictions.

General note for all exclusions

For all exclusions in this section, and for any personal exclusions or restrictions as stated in your Policy Schedule, please note that:

- We do not pay for conditions which are directly related to excluded conditions or treatments
- We do not pay for any additional or increases costs arising from excluded conditions or treatments
- We do not pay for complications arising from excluded conditions or treatments.

Excluded – Non covered conditions/Treatments	
1	Pre-existing conditions and its related conditions/symptoms that were present before enrolment. Unless declared and accepted by the insurance company.
2	Any case excluded under Specific/Special 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 Insurance Company at least 24 hours before Discharge Date.
5	All cosmetic related medicines, products, treatments 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 Vision tests, treatment or surgery for the correction of refraction error. All kinds of eye contact lenses and eyeglasses.
7	Surgery for hearing correction. Unless they result from an accident. And all devices related to hearing
8	Elective-non accidental related dental and gum surgery.
9	Congenital, genetic and hereditary conditions and any related complication and birth defects and malformations.
10	Infertility and all fertility related treatment and In-vitro fertilization (IVF) and all related tests and/ or medications and/ or medical procedures and/or medical supplies. In addition, treatment for polycystic ovary, hormonal dysfunction and Varicoceles repair for purpose of fertility.
11	All cases related to Viral Hepatitis and their complications (except for Hepatitis A).

12	All medications, procedures, health services, expenses, and all related therapies, supplies, and medical examination related to sex transformation operations, all types of contraception, assisted reproduction, fertilization, impotence and sexual dysfunction.
13	All substances, which not considered as medicines and all alternative medications without proved effcacy and/or considered experimental from Insurance Company aspect based on established medical practices except medically necessary therapeutic vitamins in case of reported deficiency.
14	Supplying or fitting of physical aids /devices including but not limited to: Hearing aids, walking sticks, Wheel chairs, any artificial device, either external or implanted, that substitutes for or supplements a missing or defective part of the body. In addition to 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 equipment or Emergency Room treatment.
15	Vaccinations and all kinds of preventive treatments and procedures including but not limited to immunizations, allergy testing and destination etc..
16	Work related accidents.
17	Renal Dialysis.
18	Aging related conditions limited to dementia, Alzheimer's, Menopause and osteoporosis.
19	All cases related to undeclared hazardous activities including but not limited to piloting. Motorcycling, mountaineering necessitating the use of ropes, underwater activities Requiring the use of artificial apparatus, parachuting, hang, gliding and motor racing.
20	All cases resulting from the Insured taking part actively in the regular armed forces and or any paramilitary force. In addition, 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.
21	Any treatment within the hospital, examinations or other procedures that may be performed in outpatient clinics without endangering the insured's health for any risk.
22	Any treatment, tests, medications, medical procedures, or medical supplies that are not related to a specific disease or specific symptoms or related to a specific disease and / or symptoms and considered medically unnecessary or those that were not prescribed by the treating physician and all the cases that were hospitalized by non-physician.
23	Health services and associated expenses for experimental, investigational. Alternative medicine including but not limited to Acupuncture, Acupressure, Hypnotism, Rolfing, Massage Therapy, Aromatherapy and Homeopathic Treatments.
24	Artificial limbs and joint. Prosthesis and orthesis..
25	All cases resulting from alcoholism and use of drugs. All services and supplies that are part of smoking cessation programs and use for the treatment of nicotine addiction.
26	Sexually transmitted diseases (STD) and conditions including but not limited to Syphilis, Gonorrhea, Genital virus, Hepatitis B, Acquired Immune Deficiency Syndrome (AIDS) etc.....
27	Acquired Immune Deficiency Syndrome (AIDS), and any medical conditions or examinations related to it.
28	Sleep and Speech disorders and all related services and treatment.
29	All Mental and psychiatric disorders and related services and treatments. Bulimia and anorexia nervosa.
30	Suicide attempts, voluntary self-injury and injury resulting from Committing of or attempts to commit an illegal action.

31	Earthquakes, flood, volcanic eruption, landslide and other natural hazards.
32	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.
33	All services attained/incurred outside the Territorial Coverage as per the Policy Schedule.
34	Circumcision (adult and child) and all related complications.
35	Dental under FAY Local KD 5,000 and KD 10,000 plans.
36	Convalescence, Rehabilitation, Spa.
37	All types of Hair fall and related treatment.
38	Weight loss drugs and investigation, Bariatric surgeries and its related complications, diet clinic or diet programs.
39	All Kinds of preventive treatment and procedures and all general check-up.
40	Learning, behavior and developmental disorders.
41	Tonics, anabolic, fat burners, Milk formula, lozenges, antiseptics, chewing gums, nutritional supplies, herbal medicine, Glucosamine compounds and Hyaluronic acid products.
42	Dental products such as toothpaste, zymofluor, dental floss, toothbrushes ,and other items or drugs used for dental care purposes.
43	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, or jaw alignment.
44	Maternity benefit under FAY Local KD 5,000 plan with 15% co-payment.
45	Pregnancy including Delivery (childbirth), caesarean section, abortion, termination of pregnancy, miscarriage or any related complications, any treatment, investigations or complications of pregnancy following assisted conception, or via any assisted reproduction technology or fertility treatment, other than eligible services claimed under the Maternity benefits where specifically provided on the Policy Schedule.

5. Definitions

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

Accident

Any sudden and unforeseen event arising solely, directly and independently of all other causes resulting in bodily injury effected through external, violent and visible means. That is beyond the insureds' will and not intentional.

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.

Acute medical conditions

Diseases, illnesses and injuries, which have a known medical treatment and cure where recovery shall be on short term.

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.

Active Treatment of Cancer

Treatment intended to shrink, stabilize, or slow the spread of the Cancer and not given solely to relieve the symptoms.

Amendments

Any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by the Company and the policyholder. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those specifically amended.

Annual Financial Limitation

This is the Maximum Indemnity amount payable by the Insurance Company to the Covered Person towards Eligible Expenses during Policy Period; as set out in the Schedule of benefit.

Approved Healthcare Provider by TPA

Centers providing Healthcare services inside / outside the state of Kuwait (i.e., Hospitals, clinics, pharmacies and laboratories). Healthcare providers list is subject at any time during the policy period to amendments (i.e., addition and / or deletion of a provider) without policyholder's prior approval or notice.

Associated Conditions

A symptom, disease, injury or illness that has one or more of the following characteristics:

- Health Condition(s) caused by or related to directly or indirectly to a Pre-existing Condition; or
- Health Condition(s) in which the underlying condition (Disease, injury or illness) is generally known to be same with the underlying disease that cause a Pre-existing Condition; or
- Risk factor(s) that is generally or directly known to be a Health Condition that may cause or is arising from a Health Condition that may cause Pre-existing Condition.

Cancer

A malignant tumour, tissues or cells, characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Chronic Condition

A disease, illness, or injury, which has at least one of the following characteristics:

- It needs ongoing or long-term monitoring through consultations, examinations, check-ups, or tests.
- It needs ongoing or long-term control or relief of symptoms.
- It requires your rehabilitation or for you to be specially trained to cope with it
- It continues indefinitely
- It has no known cure
- It comes back or is likely to come back.

Chronic Conditions include, but are not limited to, Chronic Inflammatory Diseases -Chronic Arthritis - Heart and Arteries diseases – Cancer - Diabetes and its complications- Epilepsy - High eye pressure - chronic kidney diseases - Osteoporosis, Chronic Respiratory Diseases – Asthma - Immune Deficiency - Auto Immune Diseases, etc.

Claim

A written demand made to the Insurance Company, submitted pursuant to a Claim Form, by or on behalf of a Covered Person for the payment of eligible expenses under this Policy.

Company Insurer

Gulf Insurance and Reinsurance GIRI, also known as the First Party in the insurance contract. In addition, is also the insurer.

Complementary Medicine Practitioner

An acupuncturist, chiropractor, homeopath, or osteopath who is fully trained and legally qualified and permitted to practice by the relevant authorities in the country in which the treatment is received.

Congenital/ Genetic and hereditary Condition

Any abnormality, deformity, or illness that existed at birth whether diagnosed, known, or unknown to the patient or his guardian.

Consultant / Treating doctor

A surgeon, anesthetist, or physician who is:

- Legally qualified to practice medicine or surgery following attendance at a recognized medical school, and
- Recognized by the relevant authorities in the country in which the treatment takes place as having specialized qualification in the field of, or expertise in, the treatment of the treated disease, illness, or injury.

By recognized medical school, we mean a medical school listed in the World Directory of Medical Schools as published from time to time by the World Health Organization.

Country of Origin / Home Country

The country where the insured member was born.

Country of Residence

The country in which the insured member has his habitual residence at the time this Policy first Issued or at each subsequent Renewal Date.

Coverage

The entitlement by a Covered Person to Health Services provided under the Policy, is subject to the terms, conditions, limitations, and exclusions of the Policy. Health Services must be provided (1) when the Policy is in effect; (2) prior to the expiration date and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

Co-Payment

The percentage of Eligible Expenses which the Covered Person is liable to pay for certain Healthcare Services under the Policy as set out in the Policy Schedule.

Custodial care

Means

1. No health-related services, but only assistance in the daily living activities, or
2. Health-related services, and that is provided to help and assist the patient which do not seek to treat/cure or
3. Services, which do not require continued administration by trained medical personnel.

Day-care Treatment / Surgery

Treatment, which for medical reasons requires the patient to enter & occupy a hospital bed during the day, but not overnight.

Delivery

Hospitalization for normal or medically necessary cesarean delivery, medically necessary abortion or miscarriage or any complications arising therefrom.

Dental Practitioner

A person that is legally qualified and permitted to practice dentistry by the Ministry of Health in the country treatment is received.

Diagnostic Services

Laboratory & Histopathology tests and X-ray services are necessary to diagnose and treat Medical Conditions including tests associated with Pregnancy, Maternity, and childbirth.

Donor

A person (alive or deceased) from whose body, one or more organs have been extracted with the intention to transplant them (totally or partially) into the body of another person (Recipient) via an Organ Transplant.

Effective Date

Is the date that Coverage becomes effective, which may be either the Enrollment Date of a Covered Person or the date on which Coverage started or renewed.

Eligible Expenses

Usual, Customary, and Reasonable Charges for Covered Healthcare Services, incurred while the Policy is in effect.

Emergency Case

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 outpatient basis.

Enrollment Date

The original effective date of coverage for a covered person.

Expiration Date

The day (at 00:00 midnight local time), month, and year from which the Policy expires; as set out in the Policy Schedule.

Experimental, Investigational, or Unproven Services

Medical, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Company makes a determination regarding Coverage in a particular case, are determined to be:

A. Subject to formal review and approval by local medical authorities for the proposed use;

B. The subject of an ongoing clinical trial.

C. Not demonstrated through prevailing pre-reviewed published medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

General Exclusions

Health Benefits and services excluded and not

covered and listed in Section 4 of this Policy, which apply to all Covered Persons.

General Lab Tests / Routine Check Up

Means any diagnostics tests/screening carried out where no medical necessity or symptoms are present.

Hospital

An establishment licensed by the Ministry of Health, as a medical or surgical institution.

Injury

Bodily damage other than Sickness including all related conditions and recurrent symptoms.

In-patient Cash Benefit

This Policy covers a fixed amount, for each day (twenty-four hours) of uninterrupted Hospitalization as an In-Patient Treatment for Covered Medical Condition in a free of charge Kuwaiti Hospital (public and/or governmental) provided that treatment is free of charge and no bills will be submitted for reimbursement of treatment-related expenses. Coverage will be as per policy terms and conditions.

In-Patient Treatment

Treatment, which for medical reasons normally, requires you to be admitted to a hospital and to stay in a hospital bed overnight or longer.

Insured Guide

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

Insured Member

The policyholder, the legal dependents listed in the Application, and whose names are disclosed by policyholder to be covered

and accepted by the Company to be Insured hereunder, in respect of whom the Company has issued a written acceptance for the benefits under this Policy.

Intensive Care

Treatment in an intensive care unit (ICU), intensive therapy unit (ITU), high dependency unit (HDU), or coronary care unit (CCU) which gives constant monitoring after an operation or illness.

Insurance 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.

Plan

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

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.

Medical Appliances/tools

Devices and equipment used as an integral part of a surgical procedure.

Insurance Policy

The contract (as defined in Article 1 of the General Terms & 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.

Medical Necessity

Healthcare services and supplies which are determined by the Company to be Medically Appropriate & Necessary to diagnose/treat a medical condition which must meet acceptable standards of medical practice, and

A. Necessary to meet the basic health needs of

the Covered Person; and

B. Rendered in the most Medically Appropriate manner and type of setting appropriate for the delivery of the health Service, taking into account both cost and quality of care; and

C. Consistent in type, frequency, and duration of treatment with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and

D. Consistent with the diagnosis of the condition; and

E. Required for reasons other than the convenience of the Covered Person or his or her Physician; and

F. Demonstrated through prevailing pre-reviewed published medical literature to be either:

   1. Safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,

   2. Safe with promising efficacy for treating a life-threatening Sickness condition in a clinically controlled research setting.

The definition of Medically Necessary used in this Policy relates only to Coverage and differs from the way in which a Physician engaged in the practice of medicine may define Medically Necessary.

Mental and psychiatric Illness

A mental or bodily condition marked primarily by suffcient disorganization of personality, mind, and emotions to seriously impair the normal psychological, social, or work performance of the individual.

Medical Network

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

Non- Network

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

Out-Patient Treatment

Treatment, which does not require to be admitted to a hospital or stay in a hospital bed.

Organ Transplant

An operation of moving an organ(s) from the Donor to the Recipient.

Palliative Care

Any Treatment given to offer temporary relief of symptoms. Palliative Treatment is not given to cure the Medical Conditions causing the symptoms.

Policy

Is the policy issued, the initial request of the Policyholder, the Policy Schedule, any Attachments, Amendments, and Riders which constitute the agreement regarding the Benefits, exclusions, and other conditions between the Company and the Policyholder.

Policy period

The period beginning on the start date or renewal date (specified in the contract) and ending on the day before the next renewal date.

Policy fees

Any charges in addition to the Policy Premium that are payable and due by the Policyholder.

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 who's application has been

formally accepted by the insurer.

Policy Schedule

A major and integral part of this Policy which shall include all the details, particulars, and specific conditions of this Policy including the (1) Effective Date, (2) Expiry Date, (3) Policyholder name and address, (4) Policy number, (5) Premium, (6) Premium payment details, (7) Applicable Healthcare Plans, (8) Covered Healthcare Services and Benefits with their corresponding Maximum Indemnity, (9) Territory of Cover, and (10) any specific additional terms, exclusions and/or limitations and (11) signatures.

Pre-Existing Condition

Pre-existing medical condition or / dental treatment for which:

- Medication, advice, or treatment have been received, or
- Symptoms have been experienced

Whether diagnosed, known, or unknown to the patient or his guardian prior to the enrollment date of the insured.

Premium Rate

The periodic fee is required for each Primary Insured and each Enrolled Dependent as stipulated in the contract.

Prescription Drugs

Pharmaceuticals, which can be obtained only through a prescription written by the licensed treating physician.

Prosthesis

An artificial device designed and used to replace a missing or defective body part.

Example: knee brace, spinal supports, stent, plates, etc....

Orthosis

Are devices that are placed outside of the human body but are adjacent to it, used to fix or help the joint to its function.

Prosthetic Device

An artificial device, either external or implanted, that substitutes for or supplements a missing or defective part of the body, e.g., artificial limbs and pacemakers.

Provider

A Physician, Hospital, group practice, pharmacy, or any facility, individual, or group of individuals that provides a health care service.

Psychiatric Treatment

Treatment of mental and psychological conditions or disorders, including emotional and eating disorders.

Qualified Nurse

A qualified Nurse whose name is currently on the Register or Roll of Nurses maintained in the country in which the treatment Takes place.

Reasonable and Customary 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 in case treatment is not available in the private sector.

Reconstructive Surgery

Surgery, which is incidental to an Injury, Sickness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

Rehabilitation Treatment

Treatment aimed at restoring health or mobility in order to allow the insured member to live a more independent life.

Renewal Date

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

Repatriation Of Mortal Remains

In case an Insured member died the Mortal Remains will be repatriated to country of origin.

Sickness

Physical illness or disease. The term «Sickness» as used in this Policy does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Specific Exclusions

Non-Covered services or Benefits that are specific to the Covered Person.

Surgical Operation

The treatment of disease, injury, and deformity by operation or manipulation, including consultations immediately before and after the operation, and all essential aftercare before you leave hospital.

Schedule Of Benefit

Is the summary of the benefits of your policy including the limits & deductibles.

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 no longer holds or upon the cancellation of this Insurance policy.

Therapists

A physiotherapist, occupational therapist, orthotics› or a speech therapist who is legally qualified and is permitted to practice as such in the country where the treatment is received.

Treatment

Surgical, medical, or other procedures the sole purpose of which is to diagnose, cure or relieve a Medical Condition.

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.

Waiting Period

Period of time starting from the Enrollment Date of the Covered Person during which a specified medical condition or type of treatment shall not be Covered under this Policy. All applicable Waiting Periods are listed in the Policy Schedule, and on any exclusion that are specific to the Covered Person applying for Coverage.

Waiver date

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

Policy Year

The twelve (12) months from the Insured's Policy start date or last renewal date.

6. 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.