PGH
PREFERRED GLOBAL HEALTH
The Patient Organization

Preferred Care Program

GIG
KUWAIT

December 2022

شارع أحمد الجابر - شرق - الكويت
ص.ب. 24518 الصفاة 13106 الكويت
Ahmed Al-Jaber St., Al-Sharq, Kuwait
P.O.Box 24518 Safat 13106 Kuwait

لمعلومات إضافية عن خدماتنا أو عناوين
فروعنا تفضلوا بزيارة موقعنا الإلكتروني
For more information about our services
or our branches please visit our web page

www.gig.com.kw

gulfinsurance

Preferred Care TM
THE POLICY

Group Policyholder (if applicable):	
Group Policy Number (if applicable):	
Policyholder:	
Policy Number:	

Gulf Insurance and Reinsurance Company (herein referred to as the Company) will pay the benefits provided in this Policy. Gulf Insurance and Reinsurance Company makes this promise subject to all of the Policy provisions. Throughout this Policy, "We, Us, and Our" means Gulf Insurance and Reinsurance Company. This Policy is issued in consideration of the application of the Policyholder, the application of each Covered Person, and the payment of the required Subscription Fee.

The Policyholder should read this Policy carefully and contact Us with any questions.

Signed for Gulf Insurance and Reinsurance Company.

SCHEDULE OF BENEFITS

The following is a summary of the benefits and their limits of coverage:

Maximum applicable annual limit per Covered Person For all covered Medical Treatments, specialist and medical staff fees, hospital charges at hospitals approved by PGH, travel and accommodation expenses, taken together, per person for the Policy Year	US Dollar $ 2,000,000
Sub-limits Within the limit of the annual maximum, the following sub-limits shall apply:	
1. Travel and accommodation expenses for the Covered Person or the Covered Person and one accompanying person A. Travel and accommodation expenses per Episode of Treatment (Subject to maximum accommodation US $ 300 per day) B. Travel and accommodation expenses for the Pre-Transplant Evaluation (subject to maximum accommodation US $300 per day)	 $ 20,000 $ 8,000
2. Travel and accommodation expenses for a live donor of an organ (Subject to maximum accommodation US $ 300 per day)	 $ 4,000
3. Transportation benefits in the event of death	$ 5,000
4. Maximum duration of an Episode of Treatment A. For treatment related to organ transplant – for the total combined duration of the Pre-Transplant Evaluation and the Transplant Procedure Episode of Treatment. B. For Cancer treatment (Except that an extra 245 days will be added to the maximum duration for continued or prolonged cancer treatment) Total C. For all other Episodes of Treatment	IN DAYS 365 120 245 365 90

COVERED BENEFITS

This insurance covers the cost of Benefits arising from Covered Treatment which has been approved by PGH following the completion of the Pre-Treatment Review and Approval Process.

A. COVERED TREATMENTS

Medical Treatment is approved through the Pre-Treatment Review and Approval Process following a Primary Diagnosis of:

1. Cancer as defined in Definitions
2. ardiovascular and Heart Disease requiring:
    - Cardiac (Heart) Surgery to correct narrowed or blocked coronary arteries by means of bypass grafts, to correct valvar abnormalities, or
    - Interventional Cardiology Procedures (coronary angioplasty) to correct the narrowing of two or more coronary arteries by means of dilating or opening the vessels, or
    - Major Vascular Procedures to repair one or more of the aorta, carotid, iliac, femoral, and cerebral arteries.
3. Intracranial Neurosurgical Procedures are performed to remove a tumor or to repair an intracranial blood vessel. Procedures performed for conditions related to trauma or injury are excluded.
4. Major Organ Transplants, from a living donor, of the lung, liver, kidney, pancreas, or bone marrow with specific coverage as defined in Organ Transplant Benefits.

B. COVERED BENEFITS

Medical Treatment

Medically Necessary services or supplies including Inpatient Medical Treatment and Outpatient Medical Treatment which a Covered Person receives and is provided by a Participating Practitioner, Participating Hospital, facility, or recognized supplier based in the USA in relation to a Covered Treatment approved by PGH for an Episode of Treatment.

The Maximum Duration (in days) of an Episode of Treatment is stated in the Schedule of Benefits. With prior approval, the Maximum Duration of an Episode of Treatment may be increased, as stated in the Schedule of Benefits, in the event of continued or prolonged cancer treatment requiring inpatient acute care or intensive outpatient medical monitoring Excluding Adjuvant Therapy, Palliative Care or Hospice Care.

Travel and Accommodation

Reasonable costs necessarily incurred and arranged by PGH Care Management Services for the Covered Person and one accompanying person up to the Limits shown in the Schedule of Benefits per Episode of Treatment for:

- A round trip by scheduled airline service to the USA (or to London, England for persons that are eligible) for the Covered Person and one accompanying person; and

- Cost of accommodation in the USA (or in London, England for persons that are eligible).

The sub-limit for travel and accommodation applies to the Covered Person and one accompanying person taken together.

Ambulance Benefits

Medically Necessary ambulance transportation in the USA (or in London, England for persons that are eligible) will be covered during an Episode of Treatment. Ambulance transportation is covered when rendered by a licensed private professional ambulance service, or an ambulance service that charges the public, providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

Repatriation of Mortal Remains

Costs in the event of death during an Episode of Treatment to repatriate the Covered Person's body or ashes from the USA (or from the United Kingdom for persons eligible for treatment in London, England) to his or her home country are covered up to the Limits shown in the Schedule of Benefits.

PGH Care Management Services

From notification of the potential need for a Covered Treatment, the Covered Person receives PGH Care Management Services in the form of Diagnosis Verification and Treatment Planning (DVTP), guidance, patient advocacy, help in obtaining the appropriate care in the USA, and the assistance of a PGH Personal Care Manager throughout the treatment while in the USA. The support is provided by the staff of PGH and a PGH Personal Care Manager in the USA. For persons eligible for treatment in London, England PGH Personal Care Management Services may be available on a more limited basis.

Alternative Treatment Location in the Event of Denial of US Medical Visa

In the event that the patient's medical visa for treatment in the United States is denied, the patient may receive treatment in London, England subject to the following conditions:

- The patient must provide written documentation from the US Embassy or Consulate in Kuwait that their visa to the US for medical treatment was denied.
- Gulf Preferred Care members that reside in the United Kingdom or other European countries are not eligible for treatment in London, England.
- The patient understands and acknowledges that PGH will not be able to provide the same level of Patient Care Services as in the US.

PGH selects and approves the hospital that will perform the treatment; patient cannot select or decide on the hospital, but they may suggest one. (Same Pre-Treatment Review and Approval process as for treatment in the US.)

C. Organ Transplant Benefits

Organ transplant benefits include three components:

1. The Pre-Transplant Evaluation;

2. Expenses related to procuring a donor organ; and
3. The Transplant Procedure.

1. Pre-Transplant Evaluation

The Policy covers:

- Preliminary examination and Medical Treatment in a Participating Hospital in the USA (or in London, England for persons that are eligible) in order to evaluate the Covered Person as a candidate for an organ transplant and/or the taking of bone marrow or stem cells from the Covered Person as required for a preliminary examination for a bone marrow transplant.
- Travel and accommodation costs for the Covered Person and one accompanying person for the Pre-Transplant Evaluation is subject to the sub-limit for travel and accommodation.

2. Procuring a Donor Organ

The Policy covers:

- Medical expenses associated with removal of the donor organ;
- Care and treatment of the live donor if the donor organ is received by a recipient Covered Person.
- Travel and accommodation expenses, subject to sub-limits, of a live donor if it has been established that the organ to be donated will be compatible;
- Costs of storing the donor organ in accordance with approved medical practice; and
- Transportation to and storage of the donor organ at the transplant site.

3. Transplant Procedure

The Policy covers the Medical Treatment, Travel and Accommodation, PGH Care Management Services, Ambulance Benefits, and Transportation Benefits in the Event of Death as defined in the Schedule of Benefits, above.

The Transplant Procedure Episode of Treatment starts three (3) days before the Transplant Procedure, or thirty (30) days before the bone marrow transplant.

The maximum duration (in days) of the Transplant Procedure Episode of Treatment is the maximum limit for treatment related to organ transplants stated in the Schedule of Benefits less any days utilized for the Pre-Transplant Evaluation.

If an organ transplant does not proceed as scheduled due to the medical condition or death of the Covered Person intended to undergo the transplant, covered costs are paid on the basis of the pre-approved transplant prior to the Covered Person's death, or the date on which the Participating Practitioner decides not to perform the organ transplant.

4. Availability of Donor Organs

The availability of donor organs cannot be guaranteed under the Policy. Organ transplants can only be performed when an organ from a live donor is available in accordance with the rules and

regulations that apply in the state in which the USA-based Participating Hospital is located or, for persons that are eligible for persons eligible for treatment in London, England organ transplants can only be performed when an organ is available in accordance with the rules and regulations that apply in the United Kingdom.

5. Organ Transplant Exclusions

The following exclusions apply to organ transplant procedures:

- Organs procured from a cadaver;
- Organ procurement, organ transplantation, or another medical service outside the USA;
- Costs incurred by a Covered Person who is in the USA waiting for a donor organ to become available;
- Costs incurred by a Covered Person while a transplant is delayed;
- Costs of acquisition or other considerations for an organ purchased on a commercial basis;
- Animal to human organ transplants;
- Artificial or mechanical devices designed to replace organs, either permanently or temporarily, or costs incurred in order to maintain an individual on an artificial device while awaiting an organ transplant;
- Renal dialysis, except dialysis during a pre-approved treatment; and
- Cardiac rehabilitation services, which are not part of the organ transplant treatment.

PRE-TREATMENT REVIEW AND APPROVAL

Pre-Treatment Review and Approval

The Benefits including the provision of PGH Care Management Services afforded under this Policy are granted only if pre-treatment approval has been obtained from PGH for the Medical Treatment in question. Pre-treatment approval is granted through the Pre-Treatment Review and Approval Process, which determines that:

- The Covered Person is suffering from an illness or condition for which a Covered Treatment under this Policy is indicated; and
- The Covered Treatment required is Medically Necessary.

Pre-Treatment Review And Approval Process

Pre-treatment approval is required in order to be eligible to receive Benefits under this Policy.

The process is as follows:

STAGE 1- Notification and Information Gathering

- The Pre-Treatment Review and Approval Process commences upon notification to PGH by a Covered Person of the potential need for a Covered Treatment. The Covered Person must provide full details of the Primary Diagnosis made by a Qualified Local Medical Practitioner and any additional information required by PGH in order to commence the review.
- In cancer cases, the tumor must still be present as an initial condition of the Pre-Treatment Review and Approval Process; however, this provision does not apply in cancer cases wherein the tumor was entirely removed as part of the biopsy process needed to develop a primary diagnosis.

  A coronary angiogram will be required for cardiac surgery and cardiology procedures.
- PGH ensures that the information from/about the Covered Person, translated and summarized, if necessary, is made available for evaluation by a Participating Practitioner.

STAGE 2 – Diagnosis Verification and Treatment Planning (DVTP)

- PGH selects a Participating Practitioner specializing in the illness or condition for which the Primary Diagnosis has been given to (re)evaluate the Covered Person's medical records.
- The Participating Practitioner performs the Diagnosis Verification and Treatment Planning (DVTP) that verifies the exact nature of the illness or condition identifies treatment options, and recommends what course of treatment, in his/her opinion will produce the best results and determines whether the treatment is Medically Necessary.
- The Participating Practitioner produces a DVTP Report that is released to PGH for pre-treatment approval and to the Covered Person.

STAGE 3 – Pre-Treatment Approval and Treatment Options Review

- Based on the DVTP Report PGH will determine if treatment for the condition is a Covered

Treatment and, if Medically Necessary, will establish pre-treatment approval.

- A copy of the DVTP Report is released to the Covered Person and a member of the PGH Care Management Team will contact the Covered Person to confirm if pre-treatment approval has been granted.

  If granted, the PGH Care Management Team will explain the details of the DVTP Report to the Covered Person, answer questions, and discuss available treatment options both locally and in the USA.

  Based on the available treatment options, the Covered Person will then be given the opportunity to decide whether to pursue treatment locally, under their own local insurance arrangements or national health system, OR in the USA under this Policy.

- Should the Covered Person choose to access the Benefits provided under this Policy, PGH Care Management then organizes all medical contacts and arrangements, and travel and accommodation.

Timing for Pre-Treatment Review and Approval Process:

Upon initiating the Pre-Treatment Review and Approval Process:

i. Diagnosis Verification and Treatment Planning must commence within forty-five (45) calendar days following notification by the Covered Person to PGH of the potential need for a Covered Treatment unless there are delays beyond the control of the Covered Person.

ii. Approved Medical Treatment must commence within forty-five (45) days following confirmation from PGH to the Covered Person of pre-treatment approval unless there are delays beyond the control of the Covered Person.

Responsibility to Request Approval in Advance

It is the Covered Person's responsibility to initiate the Pre-Treatment Review and Approval Process, as described above, in order to be eligible for Benefits provided by the Policy.

Disclaimer for Prior Treatment

No coverage is provided under this Policy for Cancer, Cardiovascular, Heart Disease, Intracranial Neurosurgical Procedures, or Major Organ Transplants from a living donor if the Covered Person receives any non-PGH approved initial or prior treatment for that condition either in the United States or other countries.

For purposes of this disclaimer, Emergency Care and immediate procedures required for the patient's stabilization of cardiovascular or heart disease conditions are not considered initial or prior treatment.

IMPORTANT - No cover shall be provided under this Policy for any Medical Treatment or Treatment Plan (including multiple phases of treatment), and/or Travel and Accommodation expenses that were not FIRST approved via the Pre-Treatment Review and Approval Process at the commencement of such treatment or treatment plan. The Pre-Treatment Review and Approval Process cannot be activated at any time following commencement of any independently arranged medical treatment or treatment plan, including multiple phases of treatment.

Pre-Treatment Review and Approval Process – Contact Information:

GIG Kuwait at Tel: 00965 2296 1666 or 1802080

Email: customer.serv@gig.com.kw

EXCLUSIONS

This Policy excludes the following

1. Pre-Existing Conditions and associated complications.
2. Medical Treatment arising from any diagnosis which is not a Primary Diagnosis.
3. Costs incurred as the result of active participation by the Covered Person in armed conflict, civil war, rebellion, terrorism, domestic unrest, riot, or mutiny.
4. Costs incurred that are associated with or resulting from nuclear reactions or the products thereof, unless this is a consequence of medical treatment.
5. Treatments which are Experimental or Investigative, unless specifically approved in advance.
6. Costs incurred to treat an illness or condition that is related to or caused by the Covered Person's attempt to commit or participate in a felony, or attempted suicide.
7. Costs arising from or attributable to the Covered Person being infected with Human Immunodeficiency Virus (HIV) or which, in the opinion of the Participating Practitioner, is related to condition(s) due to any Acquired Immune Deficiency Syndrome (AIDS).
8. Care provided by private nurses which were requested by the Covered Person.
9. Treatments provided solely as Physiotherapy, and/or occupational therapy, or rehabilitation of any kind; such Medically Necessary treatments will be covered if within an Episode of Treatment.
10. Adjuvant therapies.
11. Palliative Care and Hospice Care.
12. Emergency Care.
13. Costs of Covered Persons that are subject to government sanctions per the 'Sanction Limitation and Exclusion Clause' under 'General Policy Provisions.
14. Any medical treatment which has not been pre-approved.
15. Treatments which are Experimental or Investigative, unless specifically approved in advance.
16. Primary free medical care.
17. Unnecessary medical treatments .
18. Treatment is not described or under the supervision of a doctor or hospital is not practiced in the United States.
19. The treatment is provided by American doctors but they are not part of the network.
20. Any expenses resulting from failure of the insured person to attend an appointment with the participating doctor only if caused by circumstances of force beyond the control of the insured person.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility

Covered Persons, other than children, must be over 1 year of age and under 75 years of age, except as noted under Extended Age Eligibility below. Children, as defined in Family, may also be insured under the Policy, but all eligible Children must apply for coverage and be insured under the Policy. The Preferred Care group application and census form listing each group member to be covered must be submitted for each group. The Company is not under a duty to accept any person for coverage.

Residents of the United States of America

Residents of the United States of America are not eligible for coverage under this policy. Residency is defined as any United States Citizen, United States National, United States Resident Alien (as defined by the US Internal Revenue Service) (IRS), or any other person physically present in the United States of America for more than 183 days in any one calendar year.

Extended Age Eligibility

Covered Persons, at the end of the Policy Year during which they reach 75 years of age, may renew their Policy until they are 99 years of age.

Effective Dates

For individuals and families, the coverage becomes effective ninety (90) days after the membership application approval date.

For groups with 15 or more members, the coverage becomes effective on the membership application approval date.

For groups with fewer than 15 members, the coverage becomes effective ninety (90) days after the membership application approval date.

If, before the effective date of coverage:

A. A Covered Person develops an illness on the basis of which the Company had it known about it at the time of the application for the insurance, would not have accepted the applicant, coverage for that condition is excluded per the Pre-Existing Condition Exclusion.

B. A Covered Person is admitted to the hospital, the Covered Person must inform the Company of the reasons for admission and the date of discharge from the hospital. The coverage does not become effective until the Covered Person has been discharged from the hospital, with the provisions of Paragraph A above remaining in full force, and provides the Company with full information regarding the hospitalization.

The Policy is in force for One Policy Year and may be renewed as provided for in this Policy.

TERMINATION

Cancellation or Termination

The policyholder may cancel their policy by providing written notification to the Company at least 30 days before the policy renewal date. The Company may cancel the coverage with immediate effect if the Membership Fees are not paid when due, except as provided in the Grace Period provision. If the Membership Fees are not paid when due, the Company may give written notice of cancellation at least fifteen (15) days before the effective date of cancellation.

When this Policy terminates no further benefits will be provided except as described below in **Benefits after Policy Termination.**

It is not the Company's responsibility to notify any Policyholder or any Covered Person that the Policy has terminated for non-payment of the Membership Fee.

Grace Period

A grace period of thirty-one (31) days will be granted for the payment of the annual Membership Fee falling due on the Policy Anniversary Date. The Policy will remain in force during the grace period. If the required Membership Fees are not paid during the grace period, insurance will end on the Policy Anniversary Date. Unless not less than thirty (30) days prior to the Policy Anniversary Date the Company has delivered to the Policyholder or has mailed to his/her last address, as shown by the records of the Company, written notice of the Company's intention not to renew this Policy.

Covered Children – Expiry of Coverage

Coverage for an insured child terminates at the end of the Policy Year during which the child reaches the age of 27 years or starts to live independently and is no longer financially dependent on the Policyholder. A child who has been previously covered as a dependent may apply to the Company within sixty (60) days after the termination date for his or her own Policy. Applications not submitted within sixty (60) days must be accompanied by a health declaration, and subsequently go through the usual acceptance procedure.

Covered Persons – Maximum Age Limit

Upon reaching the age of 99 years coverage cannot be renewed.

Renewal of other Covered Persons after Death of the Policyholder

Other Covered Persons under the Policy may be renewed after the Policyholder's death at the written request of one of the Covered Persons, or his/her legal representative, for the benefit of the other Covered Persons.

Residency

If a Covered Person's legal residence changes to a country where the Policy is not available, the coverage ends upon the next renewal date.

Benefits after Policy Termination

If coverage for a Covered Person under this Policy ends for any reason, Benefits for Covered

Treatment incurred by a Covered Person are payable only for an Episode of Treatment which was approved by the Company, or for which the Pre-Treatment Review and Approval Process had been initiated, while the Policy was in effect and subsequent pre-treatment approval was granted.

This means that the Covered Person's Qualified Local Medical Practitioner must have determined that the Covered Person had an illness or condition for which treatment may be covered under the Policy, and the Company must have been contacted in writing prior to termination, for the initiation of the Pre-Treatment Review and Approval Process. This extension of Benefits will continue until the Covered Person has completed that specific Episode of Treatment.

Policy Renewal

This Policy may be renewed for an additional Policy Year, in accordance with Policy terms, by the payment of Membership Fees, at the rates in force at the time of renewal, before the renewal date.

Subject to the regulations of the territory, the Company reserves the right not to renew a Policyholder's or other Covered Person's coverage.

CLAIMS

Payment of Benefits

Benefits are paid directly to Participating Practitioners, Participating Hospitals, airlines, hotels, and other service providers by or on behalf of the Company in accordance with the terms of this Policy.

PGH does not provide medical services/treatments, but, as a service provider, does pay on the Company's behalf for covered services/treatments received by the Covered Person.

Directly Incurred Expenses - Proof of Loss

If during an approved Episode of Treatment certain reasonable costs are necessarily incurred for Benefits provided under the Policy and inadvertently paid by the Covered Person himself/herself, claims must be submitted to PGH within ninety (90) days of the date on which the costs were incurred. This proof must identify the Policyholder, Covered Person incurring the expense, and the Policy number, describe the occurrence, extent, and nature of the loss, and include all applicable invoices and receipts. If a claim is not submitted within the specified ninety (90) days, entitlement to Benefits continues to exist if the Covered Person demonstrates that the invoices and receipts could not be reasonably submitted in time. Invoices and receipts submitted more than one (1) year following the date on which costs were incurred will not be accepted unless the delay was due to legal incapacity.

Settlement of Directly Incurred Expenses

Any reimbursement for Benefits due will be paid immediately when PGH receives written (or authorized electronic or telephonic) proof of loss. All losses for which this Policy provided periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

PGH will reimburse the Covered Person in US Dollars.

Payment of Non-Covered Items / Treatments / Services

Payment must be made by the Covered Person directly to providers, vendors, or other agents for goods, services, and treatments rendered that are not covered by the Policy.

Covered Person / Hospital / Practitioner Relationship

The choice of a USA or London, England -based Participating Practitioner or Hospital is at the sole discretion of PGH.

Benefits are non-Assignable

Benefits of payments cannot be assigned to third parties, except for the customary assignment of Benefits to a USA or London, England -based Participating Practitioner or Participating Hospital, which has carried out the Medical Treatment for which Benefits are paid.

Liability of PGH and the Company

PGH and the Company are not liable for any acts, omissions, or for any errors made by selected medical and other service providers or participating, or non-Participating Practitioners, or Hospitals.

Subrogation

The Company has the right to proceed at its own expense in the name of the Policyholder against third parties who may be responsible for an occurrence giving rise to a claim under this Policy.

MEMBERSHIP FEES

Membership Fee

The Membership Fees are age-based. The initial Membership Fee for each Covered Person is based upon the attained age on the Effective Date of Insurance and changes automatically when a Covered Person enters a new age bracket.

Payment of Membership Fee

Membership Fees are payable in advance of the Effective Date and Policy Anniversary Dates stated on the Policy. If the Membership Fee is not paid when due coverage will automatically terminate, subject to the Grace Period provision.

Company's Right to Revise Membership Fee Rates

The Company has the right to change any Membership Fee on:

- Any Policy Anniversary Date; and/or
- Any date on which the terms of this Policy are changed.

The Membership Fee will only be adjusted on an overall program basis. It will not be adjusted on an individual basis. The Company must notify the Policyholder at least thirty (30) days before revised Membership Fees go into effect.

Membership Fee – Changes in Covered Person

The Membership Fee charged because of the addition or deletion of a new Family member will be prorated for the time to the Policyholder's next renewal. The deletion of a Covered Person will result in a refund of the unearned Membership Fee from the first day of the month following the deletion.

Membership Fee Changes with Age

Membership Fee changes because of a Covered Person's change in age will occur automatically and will be charged beginning at the next renewal date following the date when the Covered Person changes from one age group to another.

Death of a Covered Person

The death of a Covered Person will result in a refund, in the event that there is an unearned Membership Fee, from the first day of the month following death.

It is the Policyholder's responsibility to notify the Company of the terminating event of any Covered Person covered under the Policy.

GENERAL POLICY PROVISIONS

Entire Contract and Policy Changes

The Policy (including any endorsements or amendments, if any), the signed applications of the Covered Persons, all signed exclusionary amendments (exclusions), and any documents submitted by or on behalf of the Covered Person as evidence of insurability, constitute the entire contract of insurance. Any statements made by the Covered Person will be treated as representations and not warranties. After three (3) years from the date of issue of this Policy, or any change in the Policy requested by the Covered Person, no such statement shall void the insurance, reduce the Benefits, or be used in defense of a claim for loss incurred (as defined in the Policy) after the expiration of such three (3) year period.

To be valid, any change or waiver must be in writing (or authorized electronic or telephonic communications). It must be signed by the Company's President or Secretary and be attached to the Policy. No agent has the authority to change or waive any part of the Policy.

Change in Conditions

The Company is entitled to revise the conditions of this Policy with effect from a date to be determined by the Company in writing to the Policyholder. The Policyholder is entitled to cancel the Policy within thirty (30) days of receiving notification of the change, in which case, the insurance ends on the date on which the revision is to take effect.

Misstatement of Age

If the age of a Covered Person has been misstated, and the misstatement has an effect on the Membership Fee amount, an adjustment of the Membership Fee will be made retrospectively. In the event that the age of a Covered Person has been misstated and if, according to the correct age of the Covered Person, the coverage provided by this Policy would not have become effective, or would have ceased prior to the acceptance of any Membership Fee or Membership Fees, then the liability of the Company during the period the Covered Person is not eligible for coverage shall be limited to the refund, upon request, of that part of such Membership Fee paid for the period not covered by the Policy.

Records and Clerical Errors

The Policyholder must furnish PGH with all data and notifications required for coverage under this Policy, furnished on forms or in the format approved by the Company.

Clerical errors in recording or reporting data will not alter this contractual agreement. Upon discovery of errors, the appropriate adjustment will be made to remedy the errors.

Covered Persons are not entitled to Benefits that constitute an overpayment, or Benefits that are paid as a result of a mistake made by the Company or PGH. The Covered Person will reimburse the Company or PGH for any such payments directly received.

Authorization to Release Information

For the proper evaluation and processing of a claim, it is necessary for the Company and its

agents, including PGH, to have access to all information which they deem necessary to that end. The Covered Persons will therefore grant authorization for the provision of medical data to the Company, to PGH, to their authorized agents, and to the Participating Hospitals and Practitioners. Failure to grant authority may result in the denial of a claim.

The Company and its agents, including PGH, shall treat such information as confidential in accordance with the legislation in the field of privacy and medical confidentiality.

Notice of Address Change

The Policyholder is responsible for notifying the Company of any address change within sixty (60) days of such change. the Company is only responsible for mailing notices or any other correspondence to the last known address of the Policyholder.

Applicable Law

This Policy is entered into and is subject to the laws of Kuwait. All actions at law arising from or out of this Policy will be brought and maintained in Kuwait. The Policyholder and Covered Persons under this Policy consent to jurisdiction in Kuwait for all actions arising from or out of this Policy.

Arbitration

If any difference or dispute of any kind whatsoever arises between the Policyholder, or a Covered Person, and the Company with respect to:

- The Policy; or
- Any claims; or
- Any other matter, thing, or liability arising or alleged to have arisen under the Policy;

the dispute shall be referred to the decision of two (2) arbitrators, one (1) to be chosen by the Company and one (1) to be chosen by the other party, with the power given to the arbitrators to appoint an umpire.

The costs of and connected with the arbitration will be paid by the parties involved at the sole discretion of the arbitrators or umpires, who will also have the power to take evidence and complete the production or exhibition of documents. The award under this arbitration will be final and binding upon both parties.

Other Insurance with the Company

Insurance effective at any one time for the Covered Person under a similar policy or policies with the Company is limited to the one such policy elected by the Covered Person, his or her beneficiary or estate, as the case may be, and the Company will return all Membership Fees paid for all other such policies. A person may not be insured as both a Covered Person and a dependent under a similar policy or policies of the Company.

Physical Examinations and Autopsy

The Company and/or PGH, at its own expense, has the right and opportunity to examine a

Covered Person when and as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. The Company and/or PGH, at its own expense, also has the right to request an autopsy in the case of death, unless the law forbids it.

Legal Actions

No action at law or in equity can be brought to recover on the Policy: (1) before sixty (60) days following the date proof of loss was given to PGH or the Company; or (2) after three (3) years following the date proof of loss is required.

Sanction Limitation and Exclusion Clause

The Company shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim, or provision of such benefit would expose the Company 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.

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in the Policy.

Adjuvant Therapy

A course of action following the 'Episode of Treatment'. Adjuvant therapy occurs after the conclusion of the 'Episode of Treatment' and takes place outside of the United States, (or outside the United Kingdom for patients that are eligible for treatment in London, England) usually in the patient's home country. Adjuvant therapy may include chemotherapy, radiation therapy, hormone therapy, biological therapy, and/or rehabilitation therapy. However, for purposes of this policy, chemotherapy and radiation therapy are not considered adjuvant therapies when those treatments are part of the Episode of Treatment.

Application Approval Date

The date on which the membership application has been approved and accepted by the Company.

Cancer

Any malignant tumour is positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue with or without spreading metastasis.

For the above definition, the following are not covered:

All cancers are histologically classified as:

- Non-invasive cancer if operable and radically excisable without any remnants, metastases, or re-proliferation.
- As having borderline malignancy or low malignant potential.
- Any skin cancer (including cutaneous lymphoma) other than malignant melanoma having caused invasion beyond the epidermis (outer layer of skin).
- Cancer in the presence of Human Immuno-deficiency Virus (HIV).

Cardiovascular and Heart Disease

Any structural or functional abnormality of the heart, or of the blood vessels supplying the heart, that impairs its normal functioning.

Company

Gulf Insurance and Reinsurance Company-Kuwait.

Covered Person

Each person insured under the individual or group policy as defined by the policyholder.

Diagnosis Verification and Treatment Planning (DVTP)

Based on the Primary Diagnosis, a remote diagnosis review and case analysis and suggested course

of treatment protocol based on medical records provided by the Covered Person or the Covered Person's Qualified Local Medical Practitioner and performed by physicians at Harvard Medical School affiliated hospitals. A DVTP is required as part of this Policy's Pre-Treatment Review and Approval Process which must be completed before any claims can be made under this Policy. To provide additional support and assistance to the Covered Person, PGH Care Management Services may also have a DVTP performed even when medical services and treatment are to be provided beyond the scope and coverage of the Policy.

Emergency Care

Medical or other health treatment, services, products, or accommodations provided to an injured or ill person for a sudden onset of a medical condition of such nature that failure to render immediate care would reasonably result in deterioration of the injured person's medical condition.

Episode of Treatment

A time period that begins on the Covered Person's arrival in the USA (or the Covered Person's arrival in London, England for patients that are eligible) for a Covered Treatment, which has been approved through the Pre-Treatment Review and Approval Process and ends when the Covered Person has been medically approved to return home. Benefits for Medical Treatment under this Policy apply only to costs incurred during the Episode of Treatment.

An approved treatment plan that involves multiple phases is considered a single Episode of Treatment.

If a complication related to a Covered Treatment or requirement of additional Covered Treatment occurs within thirty (30) days after the end of an Episode of Treatment, such additional treatment will be regarded as part of the original Episode of Treatment. This means that the number of days of the additional treatment is counted towards the calculation of the maximum number of days covered for the Medical Treatment and Travel and Accommodation expenses of the original Episode of Treatment, and the related expenses and fees will be paid according to the Schedule of Benefits.

Experimental / Investigative

Means a treatment, service, procedure, drug or use of a drug, facility or use of a facility, equipment or use of equipment, or supply (each hereinafter called "treatment") deemed by the Company and/or PGH, on the basis of the following considerations, to be Experimental or Investigative in nature:

1. If the approval of a government authority is required before the treatment and it has not yet been given at the time when the treatment is to be provided; or
2. If according to generally accepted medical standards within the Participating Hospitals, the treatment has not been recognized as safe and as possibly effective for the condition in question, irrespective of the question whether the treatment is legally permitted for use during testing or other studies on human beings; or
3. If, in the case of a medicine, therapy, or device, the treatment has not been approved for use by the United States Food and Drug Administration.

Family

The husband, wife, or legal domestic partner and his or her natural or adopted children, stepchildren, or foster children who are over 12 months of age and under the age of 27 years living at home. Children living away from home are also counted as part of the Family if they are living away from home for the purpose of the study and are financially dependent on the covered parents.

Group Policyholder (if applicable)

The firm, company, or organization named in the Group Policy Schedule.

Hospice Care

Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. Care is rendered either on an inpatient basis or in the home setting for a terminally ill patient. Often referred to as "palliative" or "supportive" care, hospice care emphasizes the management of pain and discomfort and the emotional support of the patient and family.

Inpatient Medical Treatment (Hospital Admission)

Inpatient Treatment comprises the following:

- Pre-admission tests
- Room, board, and nursing in a Participating Hospital
- Medical Treatment
- Physiotherapy
- Medicines, aids, and dressings

If available, the Covered Person will be offered a standard private room. If no standard private room is available, a standard double room will be offered until a standard private room becomes available.

'Concierge' or luxury-style hospital rooms are not covered. However, the patient may stay in a 'Concierge' or luxury hospital room and pay the difference between such a room and the hospital's standard private room (also subject to availability and physician approval).

Medically Necessary (or Medical Necessity)

Medical Treatment for an illness or condition for which a Covered Treatment under this Policy is indicated and which:

- Is in accordance with the diagnosis of the Covered Person's illness or condition; and
- Is in accordance with the standards of good medical practice within the Participating Hospitals; and
- Is necessary for reasons other than the convenience of the Covered Person or his or her Qualified Local Medical Practitioner(s).

In relation to hospital admission, Medically Necessary also means that, on the basis of the medical symptoms or condition of the Covered Person, the treatments or supplies cannot safely be provided

to the Covered Person without hospital admission.

Medical Treatment

Medically Necessary services or supplies including Inpatient Medical Treatment and Outpatient Medical Treatment which a Covered Person receives and is provided by a Participating Practitioner, Participating Hospital, facility, or recognized supplier, based in the USA in relation to a Covered Treatment approved by PGH for an Episode of Treatment.

Membership Fee

The amount of the insurance premium plus the service fee for PGH programs.

Outpatient Medical Treatment

Outpatient Treatment comprises the following:

- Medical Treatments for which Inpatient Treatment is not required
- Medicines, aids, and medical supplies for the Medical Treatment
- Radiotherapy
- Physiotherapy
- Nursing Care visits on an outpatient basis

Palliative Care

An interdisciplinary approach dedicated to improving the quality of life for people with chronic, life-threatening, progressive, or terminal illnesses. Palliative Care focuses on relief of the pain, stress, and other debilitating symptoms of serious illness and is medical or comfort care that reduces the severity of a disease or slows its progress rather than providing a cure.

Participating Hospital

A top 1% US hospital listed in 'US News and World Report – Best Hospitals' or in London, England, and approved by PGH for the specific case that is under consideration for coverage under this policy.

Participating Practitioner

The USA or United Kingdom licensed, practicing medical doctor who is affiliated with a Participating Hospital. These Participating Practitioners are Board certified in their defined medical specialties. A Participating Practitioner does not include the Covered Person, a relative of a Covered Person, or a member of the Covered Person's household.

Preferred Global Health (PGH)

Preferred Global Health, Ltd. (PGH) is a company incorporated in Bermuda, registration no. EC22801. PGH is an organization that develops and manages medical programs. PGH manages medical claims and provides care management services in the USA.

PGH Care Management Services

A range of services, provided by PGH including, but are not limited to:

- Advising, advocating, educating, and supporting the Covered Person and their family during the Episode of Treatment;
- Coordinating communication and medical logistics with Participating Practitioners and Hospitals; and
- Arranging travel and accommodation for Covered persons and their accompanying persons.

PGH Personal Care Manager

A Medical Professional, with advanced knowledge of PGH's Covered Treatments, patient advocacy, and methods of clinical quality control accountable for coordinating and customizing PGH's Care Management Services to meet the needs of the Covered Person and their family during an Episode of Treatment.

Physiotherapy

Physiotherapy is treatment using physical aids (hydrotherapy, heat or similar aids, physical aids based on biochemical and neurophysiological techniques) in order to restore maximum function and/or to prevent or limit full or partial disability following illness or surgery. These treatments must be prescribed by a Participating Practitioner.

Policy

The contract between the Company and the Covered Person or the Group Policyholder (if applicable) which governs the terms and conditions of the insurance.

Policy Year

The twelve (12) month period from the Covered Persons effective date of coverage.

Pre-Existing Conditions

Any health condition known to the insured and/or policyholder whether or not it was diagnosed and known to the insured 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 policy effective date.

Primary Diagnosis

The diagnosis that first identified the condition prior to any treatment and for which the DVTP was initiated. The cost of the primary diagnosis is not covered under this policy.

Qualified Local Medical Practitioner

A doctor or specialist who is responsible for the ongoing medical care of the Covered Person in his/her home country

and is registered or licensed to practice medicine under the laws of the country in which they practice other than:

1. A Covered Person; or
2. A member of the immediate Family of the Policyholder or of a Covered Person: or
3. An Employee or Director of the Policyholder.