أسفـــار

ASFAR

Policy Wording

GIG

KUWAIT

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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 Group - Kuwait, (GIG - Kuwait)** 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.

The Insurance Policy, Policy Schedule, Table of Benefits, the completed Insurance Application, and any attachments constitute 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

- Persons are eligible to enroll in this insurance program only if they are **active insured members under an existing local Group Medical Insurance policy with GIG- Kuwait.**

  If the Insured has dependents registered with him under the group insurance policy, then all of them must participate with him in this same program.

- The insured member must be a legal resident of Kuwait.
- Members must not be traveling outside Kuwait (whether a business trip or a vacation) for more than 60 consecutive days per visit.
- The maximum allowed age at entry is 65 years old.
- 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.

  III. Continuous coverage under **GIG- Kuwait** Group Medical Insurance policy.

1. General Terms and Conditions

Article 1: Insurance Policy

The Individual/Family Application Form of the insured member, the Preamble, Definitions, General Terms and Conditions, Policy Schedule (including Applicable Scope of Coverage with its Limits and Exclusions), the Insured's Guide as well as any Attachment(s) and Endorsement(s) to any of the aforementioned documents, 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 stamped by the Insurance Company. No Insurance intermediary has the authority to amend this Policy or waive any of its provisions.

Article 2: Policy Period & Validity

The Policy Period is for one full year.

The validity of this Individual Medical Insurance Policy (ASFAR) will remain as long as the insured member is still insured under GIG-Kuwait Group Medical Insurance Policy.

Article 3: Insurance Applications

New Insurance Applications and any subsequent Applications by persons proposed for Insurance must be fully completed by the applicant using the special forms provided by the Insurance Company. Each application will be subject to medical underwriting and the Insurance Company reserves the right to reject any new or subsequent Application without any obligation to justify the decision, or may accept it under any special rates, terms, and special conditions that are deemed appropriate.

If any payment or prepayment is made to the account prior to acceptance of the application, such advanced payment does not constitute acceptance of the application and the Insurance Company reserves the right to refuse the application and return the advanced payment to the person requesting the insurance.

Article 4: Applicable Scope of Coverage

The applicable scope of coverage which is the Schedule of Benefits approved for each insured is set out in the insurance Policy Schedule. The Policy Schedule contains the coverage provided to the insured and determines the basis of compensation, the degree and the financial limits, participation, deduction, and limits of coverage, and any special exceptions/exclusions and any special conditions related to the level of service or benefit depending on the nature of the Healthcare services, the Network of Medical Providers and the Territory of Occurrence (Country of Treatment).

Article 5: General Limits

Coordination Payment Clause:

Except as provided in the Terms & Conditions of this policy, the Insurance Company will not compensate for expenses related to Treatment of injury or sickness that are recoverable by any law, legislation, or other Health insurance system except its financial proportional share from claim payable amount after deduction of applicable deductibles and/or co-payments.

Territorial of Cover:

Only outside Kuwait – It is the geographical area of coverage as set out in the Policy Schedule.

Financial Limitations:

The maximum amount paid by the Insurance Company for specific Benefits Covered under the terms of this Policy, Financial Limitation will be specified in the Policy Schedule.

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 provided these dependents must be already insured with him/her under **GIG-Kuwait Group Medical Insurance Policy.**

A. Newborn children of the Policyholder:

The Policyholder must formally advise the Insurance Company by submitting a completed Insurance Application, with a certified Birth Certificate and a valid Group Medical Insurance card for the requested newly added member. After which the Insurance Company undertakes to issue an endorsement for including the newborn child.

B. His/her new spouse:

The same process will be followed as per point (a) above in addition to providing the Marriage Certificate.

Any addition to the Insurance Policy shall be void unless it has been formally acknowledged and accepted in writing, signed, and stamped by the Insurance Company. The premium related to any

formal addition, which shall be due by the Policyholder to the Insurance Company.

shall be calculated on a pro-rata daily basis starting from the Enrollment date of the newly added Insured dependent Enrolment Date up to the main Expiration Date of this policy.

Remarks:

- Addition date will be the actual date of receiving the Addition Request along with all required documents.
- Retrospective requests for additions are not allowed.
- Request for changing the Plan during the course of the Policy period will not be accepted in any case.
- All Family Members shall be Insured under the same Plan opted for the employee at the inception date of the Scheme. Provided they are all insured under the group local policy with GIG-Kuwait.

Article 8: Deletion of Insured Members

The Policyholder may formally request the insurance company in writing to delete an Insured covered under this Insurance Policy during the running of this policy, in the following exceptional cases:

- Death of the insured person whose cancellation is required.
- In case of canceling the current residency in Kuwait for the expatriate.
- The insured is no longer considered as a legal dependent for example, in case of divorce.

This individual policy (ASFAR) will be automatically canceled in case the insured member is no anymore covered under GIG-Kuwait Group Medical Insurance Policy. Accordingly, the deletion date for ASFAR policy will be the same as the deletion date of the member from GIG-Kuwait Group Medical Insurance Policy.

However, in case of the whole GIG -Kuwait Group Medical Insurance Policy is canceled or not renewed then the ASFAR policy will continue until its normal expiry date and therefore, the deletion date will be the expiry date of this ASFAR policy.

Premium refund for the deleted members is only provided in case of no incurred claims under this ASFAR policy and will be calculated on Pro-rata basis.

No premium refund in case of any incurred claims under this ASFAR policy. The final calculation will be done 3 months after the deletion date. Deletion or Cancellation requests should be sent to the insurance company in writing and must be formally acknowledged by the company (GIG-Kuwait).

Continuity of Cover

A grace period of 30 days after expiry/deletion date of this ASFAR policy is allowed to grant continuity.

Otherwise, the insured member will re-apply as a new member as per earlier advised eligibility

requirements.

Article 9: Policy Cancellation

The Insurance company may cancel this Policy without refunding any money for the remaining period in the following cases:

A. Non-payment of installments in accordance with the provisions of Article 6.

B. In the case of false statements and/or not disclosing material substantiated information in accordance with the provisions of Article 10.

Article 10: Policyholder's Statements

This Insurance Policy, including its related additions, deletions and amendments, has been and shall be issued by the Insurance Company 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 Insurance Company's right to cancel this Insurance Policy. The Policyholder must immediately inform the Insurance Company 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 Insurance Company reserves the right to reconsider accordingly the Policy terms, conditions, and premiums. This reconsideration includes the deletion of the insured.

Article 11: Claims Notification

All In-Hospital treatment including Day Care treatment must be pre-approved and issued with offcial approval by the Insurance Company before admission.

A. In-Hospital Treatment within the approved network:

In such cases, the insured person benefits from the system of providing services in the centers of the network. He does not have to inform the insurance company and he will not be subject to the payment and recovery system. The insured only has to use the insurance card and the hospital administration will communicate with the designated Third-Party Administrator of the claims for the necessary action and approval.

B. In-Hospital Treatment Outside the approved network:

The insured must obtain prior approval from the insurance company. If approved and after the completion of the treatment, the insured will submit to the insurance company within a maximum period of 60 days from the date of discharge from the hospital the completed claim form by the treating physician with the original invoices and medical reports for the refund in accordance with the principles stated in the Insured Guide.

In exceptional cases, like an Emergency In-Hospital treatment occurring, the Insured is obliged to

notify the Insurance Company within 48 hours from admission. Such notification can be in writing and/or verbally.

C. Outpatient Treatment:

Out of Hospital claims will be on a reimbursement basis (Pay and claim). Insured must provide the insurance company with a completed medical claim form and original invoice within a maximum period of 60 days from the date of treatment (please refer to Insured Guide). The reimbursed amount will be subject to Reasonable and Customary charges in the country of treatment. However, in the USA, the insured can use their insurance cards within the network to benefit from the direct settlement.

Article 12: 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 Insurance Company. The Insurance Company reserves the right to decline, accept on special or standard terms amendments required by the Policyholder. Any amendment to this Insurance Policy shall be void unless it has been formally acknowledged and accepted in writing, signed, and stamped by the Insurance Company.

The Insurance Company shall credit or debit the Policyholder with the premium related to the accepted and implemented amendments, which shall be calculated on a pro-rata basis starting from the date of the amendment's implementation up to the Expiration Date.

Article 13: Anti-Money Laundering

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

Article 14: Subrogation

Once the Insurance claim has been paid in accordance with the current terms, the Insured subrogates his/her right to the Insurance Company to pursue any third party responsible for an injury. The Policyholder and the Insured transfer to the Insurance Company every relevant, substantial, and legal right. Both, the Policyholder and the Insured shall provide the Insurance Company with every possible assistance in the case the Insurance Company 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 Insurance Company.

Article 15: Currency

Any money payable to or by the Insurance Company shall be in Kuwaiti Dinar. For claims settlements, the Insurance Company will use the exchange rate that applied on either the date on which the invoices were issued or the last date of the treatment, whichever is later.

Article 16: Change of Law

This Insurance Policy is intended to conform to the law of the country in which the Insurance Company's home once is located. If a conflict arises between this Insurance Policy and such law becomes effective after the Policy Effective Date, the Insurance Company 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)Insurance Company shall be deemed to provide cover and no (re)Insurance Company 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) Insurance 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 the United States of America.

Article 19: Arbitration

The arbitration will only apply if allowed as per laws in Kuwait. 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

Health Services described in this section are ONLY Covered when:

1. Not Excluded.
2. Medically Necessary.
3. Treatment prescribed is related to the medical condition.
4. Provided by or under the direction of treating registered Physician.

Certain Health Services or Benefits are subject to separate restrictions and/or Deductibles and/or Co-insurance (if applicable) and/or Financial Limits as set out in the Policy Schedule.

A. In-Patient & Day Care Treatment

This coverage shall apply in the event of non-excluded health conditions requiring Hospitalization stay for over 24 hours, and/or Daycare, and/or Emergency Service, comprising all medical costs incurred while in Hospital:

- Room and board in a standard private room including nursing care.
- Intensive care unit if required and directly related to a currently covered illness or a common postoperative complication following a covered surgical procedure that necessitates special care other than normal.
- Surgeon and Anesthesiologist fees.
- Hospital services including but not limited to (Surgery, Theater, Anesthesia, Pharmacy, Laboratory, Radiology, etc.)...
- Use of Hospital medical equipment (e.g., Heart and Lung support systems, etc...) Intravenous Infusions, Injections, etc...
- Diagnostic and Laboratory tests, X-rays, Electrocardiograms, Scans, Advanced Imaging, etc.

(Only related to the original cause of covered Hospitalization).

- Pathology, radiology treatment, and/or tests, which are directly related to the current illness, necessitate admission.
- Cost of appropriate ambulance transport needed because of an emergency to the nearest available and appropriate local hospital within the country of treatment.
- Hospital Accommodation cost for an accompanying person (in the same room) to the insured member (children up to 16 years old) in case of critical conditions and as recommended by the treating Doctor.

Notes:

- All Non-Emergency Hospitalizations require prior approval from the Insurance Company while Emergency Hospitalization must be notified to the Insurance Company within a maximum of 48 hours from admission to the Hospital.
- Charges shall not be payable if related to any personal expenses during admission, nor hiring of additional medical staff from outside the hospital.
- Day Care treatment includes Professional fees, services, and supplies provided in a hospital setting when there is no overnight Hospitalization. This Benefit only applies to services, which cannot be provided in an Outpatient facility.

B. Out-Patient Treatment

Chronic medications are subject to 12 months waiting period from the joining date.

This coverage includes Physician Consultation, Diagnostic Tests and/or Pharmaceuticals and/or Physiotherapy.

- **Physician Consultation:** This benefit represents the identifiable doctor visit fee.
- **Prescribed Medications:** This coverage shall apply in the event of non-excluded health conditions if it is medically justified and directly related to the same medical covered current condition, and it comprises all drugs, recognized as medicines, prescribed by a physician and not given for experimental purpose nor proved ineffective based on established medical practice.
- **Diagnostic Tests:** This coverage shall apply in the event of non-excluded health conditions requiring the conduction of Diagnostic Tests, provided that medically necessary and directly related to the current covered medical condition. These tests include but are not limited to:
- Laboratory tests
- X-Ray
- MRI
- CT Scan
- Diagnostic Cardiac Catheterization, Echocardiogram, Holter ECG and Treadmill stress test.
- Endoscopies, if conducted for Diagnostic purposes.
- **Physiotherapy:** This coverage shall apply in the event of non-excluded cases due to either sickness or accident requiring rehabilitation through basic conventional Physiotherapy sessions as prescribed by the attending Physician up to the specific number of sessions in the policy schedule and subject to submission of a detailed report from the treating physician.

C. Maternity Benefit

Maternity coverage (both outpatient and inpatient Maternity treatment) is subject to 12 months waiting period from the joining date.

This coverage shall apply as specified in the Policy Schedule for both inpatient and outpatient treatment related to normal pregnancy and childbirth, complications during pregnancy, miscarriage and legal termination of pregnancy.

- Pre and postnatal care.
- Consultant's Fees.
- Prescribed Medicines & necessary vitamins during pregnancy.
- Pathology & radiology tests related to pregnancy.
- Charges for Normal delivery, Caesarian, Legal Medical Termination of Pregnancy / Abortion, Miscarriage, hospital services, and nursing care of the mother.
- Ectopic pregnancy.
- Routine newborn care following birth from covered maternity cases is covered up to the remaining limit from the mother delivery limit.
- New Born Prematurity and congenital anomalies are only covered for in-patient treatments during the first 90 days following birth from a covered maternity case up to specific Limits in the policy schedule.

D. Alternative (complementary) medicine

This benefit is subject to 12 months waiting period from the joining date.

This coverage shall apply in the event of non-excluded health conditions by using alternative medical treatments that differs from conventional medicine aimed at restoring normal physical functions. These treatments are subject to 12 months waiting period and **up to specific Limits in the policy schedule and are limited to:**

- Acupuncture treatment.
- Ayurveda.
- Biofeedback.
- Chiropractic.
- Homeopathy.
- Naturopathy.

E. Wellness

This benefit is subject to 12 months waiting period from the joining date.

This coverage shall apply after continuing 12 months waiting period and covered **up to specific Limits in the policy schedule.**

It is limited to:

- Vaccination.

- Mammogram.
- Pap smear.
- Prostate screening.
- Colon cancer screening.

F. Epidemics

A limitation of KD 10,000 per person per year will apply for treatment of cases arising from internationally or locally recognized / declared epidemics / endemics / pandemics (including but not limited to Covid-19 cases).

3. Waiting Periods

List of Medical Conditions with applicable Waiting Periods

All Treatments including (medical, surgeries, services, tests, medicines, consumables, accessories, and prostheses) for the following conditions subject to the below Waiting Period applicable as from the joining /enrolment date provided that these conditions are NOT related to Pre-existing Conditions. As such Inpatient treatment for the below conditions will not be covered during the waiting period.

Provided it is NOT related to Pre-existing condition		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.	6 months
4	Maternity treatment includes both In-patient and Out-patient Treatment-related to normal pregnancy and childbirth (normal delivery or cesarean section), complications during pregnancy, miscarriage, and termination of pregnancy when medically necessary (legal abortion).	12 months
5	All Female reproductive system procedures: including but not limited to Fibroids, Myomectomy, Hysterectomy, Uterine Polypectomy...etc.	12 months
6	Varicose veins, Hydroceles, and Varicoceles not related to infertility.	12 months
7	Any treatment related to Spine and Knee joint Disorders or Surgeries. Except for car accidents or accidents that took place after the inception of the policy and details of which have been recorded by the competent authorities	12 months
8	Chronic Medications: Related to (Outpatient treatment) of covered disorders including but not limited to Diabetes, Hypertension, other Cardiovascular disease, Cholesterol, Epilepsy, Parkinson's Disease, etc.	12 months
9	Alternative medicine differs from conventional ways of treatment: including and limited to Acupuncture, Chiropractic, Ayurveda, Biofeedback, Homeopathy, and Naturopathy.	12 months
10	Wellness: including and limited to Vaccination, Mammogram, PAP smear, Prostate, and Colon cancer screening.	12 months

4. General Exclusion

Lifetime 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 a 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

I. **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 to and alongside such personal exclusions and restrictions

II. **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 that are directly related to excluded conditions or treatments
- We do not pay for any additional or increased 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 & Accepted by GIG - Kuwait
2	Any case excluded under Specific/Special Exclusion(s) and clearly mentioned in the Policy Schedule.
3	Convalescence, Rehabilitation, Spa.
4	All types of Hair fall and related treatments.
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	Weight loss drugs and investigation, Bariatric surgeries and its related complications, diet clinic, or diet programs.
7	All Kinds of preventive treatment and procedures and all general check-ups.
8	All Vision tests, treatment, or surgery for the correction of refraction errors. All kinds of eye contact lenses and eyeglasses.
9	Circumcision (adult and child) and all related complications.

Excluded – Non-covered Conditions/Treatments	
10	Congenital, Genetic, and Heredity conditions treatment received after 90 days following birth.
11	Learning, behavior, and developmental difficulties.
12	Sleep, Speech, and Psychiatric disorders and all related services and treatment.
13	Artificial limbs and joints. Prosthesis and Arthrosis unless pre-approved by the company.
14	Supplying or fitting of physical aids /devices including but not limited to: Hearing aids, walking sticks, Wheelchairs, and 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	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.
16	Health Services and associated expenses for sex transformation operations, voluntary sterilization, and for reversal of sterilizations. Contraceptive supplies or services. All services related to sexual dysfunction.
17	Sexually transmitted diseases (STD) and conditions including and not limited to Syphilis, Gonorrhea, and Genital warts.
18	Renal Dialysis.
19	Aging-related conditions are limited to dementia, Alzheimer's, and Menopause.
20	All cases related to 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.
21	Work-related accidents.
22	All substances, which are not considered medicines and all alternative medications without proven efficacy and/or considered experimental from the Insurance Company aspect based on established medical practices except medically necessary therapeutic vitamins in case of reported deficiency.
23	Tonics, anabolic, fat burners, Milk formula, lozenges, antiseptics, chewing gums, nutritional supplies, herbal medicine (unless specified as the first line of treatment), Glucosamine compounds, and Hyaluronic acid products
24	Experimental, investigational Health services and associated expenses unless mentioned in the table of Benefits.
25	Any treatment, tests, medications, medical procedures, and medical supplies which are related to a specific symptom and/or disease and considered medically unnecessary Or those which are not prescribed by a treating Physician or directed to In-Hospital by a non-Physician.
26	Organ implants and /or transplantation
27	Acquired Immune Deficiency Syndrome (AIDS), and any conditions or diseases related to AIDS/HIV.

Excluded – Non-covered Conditions/Treatments	
28	Abuse of alcohol or drugs, substance or solvent abuse, narcotics and, addictive conditions or disorders, and all services and supplies that are part of smoking cessation programs and used for the treatment of nicotine addiction.
29	All cases requiring In-Hospital stay/treatment, which have not been notified to the Insurance Company within 48 hours from admission date.
30	Suicide attempts, voluntary self-injury, and injury resulting from Committing or attempting to commit an illegal action.
31	Earthquakes, floods, volcanic eruptions, landslides, 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	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
35	Dental products such as toothpaste, zymofluor, dental floss, toothbrushes, and other items or drugs are used for dental care purposes.
36	Upper and lower jawbone surgery (including that related to the temporomandibular joint) except for direct treatment of acute traumatic injury or cancer. No Coverage is provided for orthodontic surgery, jaw alignment
37	All Dental and Gums surgery.
38	All cases related to Viral Hepatitis and their complications (except for Hepatitis A).
39	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.
40	Surgery for hearing correction. Unless they result from an accident. And all devices related to hearing.
41	Alternative medicine, including but not limited to: hypnosis, massage therapy, and similar treatments. Except as stated in the Schedule and the Insurance Policy.
42	Drugs, mental tests, mental disorders, and all related cases and anorexia nervosa.

5. Definitions

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

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

2. **Acute medical conditions:** Diseases, illnesses, and injuries, which have a known medical treatment and cure where recovery shall be short-term.

3. **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.

4. **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.

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

6. **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.

7. **Annual Aggregate Limit:** This is the Maximum Indemnity amount payable by the Insurance Company to the Covered Person towards Eligible Expenses during the Policy Period; as set out in the Policy Schedule.

8. **Approved Healthcare Provider by TPA:** Centers providing Healthcare services 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 the policyholder's prior approval or notice.

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

10. **Chronic Condition:** A Medical Condition requiring regular uninterrupted lifetime treatment.

11. **Congenital/Genetic Condition:** Any abnormality, deformity, or illness that existed at birth whether diagnosed, known, or unknown to the patient or his guardian. Including birth defects, congenital diseases, anomalies & or deformities.

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

13. **Delivery:** Hospitalization for normal or cesarean delivery, medically necessary abortion or miscarriage and/or any complications arising therefrom.

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

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

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

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

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

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

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

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

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

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

24. **Insurance Company/The Company:** The Insurance Company (Gulf Insurance Group- GIG-Kuwait) is duly registered and licensed to operate in the country of issuance of this Insurance Policy.

25. **Insurance Policy:** The contract (as defined in Article 1 of the General Conditions) whereby the Insurance Company, subject to the terms, provisions, Limits, 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).

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

27. **Insured Guide:** A booklet that provides information on how to benefit from the Insurance Policy.

28. **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.

29. **Medical Call Centre:** Professional service center operating 24 hours all year round staffed. The Medical Call Centre provides the Insured with guidance and information through telephone inquiries at no cost.

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

31. **Medical Case:** All cases and/or reasons and/or services and/or treatments and/or the covered diseases in the Insurance Policy and their complications, which fall within the medical case limitation stated in the policy schedule for the same diagnosis.

32. **Medical Necessity:** Medical Treatment/Services or supplies that are needed & necessary to diagnose/treat a medical condition which must meet acceptable standards of medical practice, considering the quality and not the luxury of the member or the physician.

33. **Medical approved Network:** The group of doctors, hospitals, clinics, medical centers, pharmacies, laboratories, and physiotherapy centers licensed by the concerned official bodies, which means that the provider has a participation agreement in effect with the Insurance Company in which this group of providers agrees to provide medical services to the insured under the terms of the insurance policy.

34. **Non-Network:** Any Physician and Health institution, Hospital, Clinic, Medical Center, Physiotherapy center, and Pharmacy which are not part of the network

35. **Organ Transplant:** An operation of moving an organ(s) from the Donor to the Recipient.

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

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

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

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

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

41. **Policy Schedule (Table of Benefits):** The insurance certificate which contains information related to the insured personal detail, Type of coverage, Territorial scope of coverage and Special exclusions if any, and other details related to the type of plan enrolled.

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

43. **Plan:** The combination of Benefits offered by the Insurance Company and selected by the Policyholder on the Application Form and documented in the policy schedule.

44. **Rehabilitation:** Treatment in the form of a combination of therapies such as physical, occupational, and speech therapy aimed at restoring full function.

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

46. **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) the average of the cost to perform a similar or comparable treatment of the same category within Company's network inside or outside Kuwait.

47. **Specific Exclusions:** Non-Covered services or Benefits that are specific to the Covered Person or to the group.

48. **Specific Deductible Excess per Service/Benefit:** The amount of money stated in the Policy Schedule to be borne by the Policyholder in respect of the service or benefit under consideration.

49. **Surgical Operation:** Any necessary medical procedure involves the use of instruments or equipment. Includes consultations immediately before and after the operation, and all essential aftercare before you leave the hospital.

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

51. **Territory of Cover:** It is the geographical area of coverage as set out in the Policy Schedule. Territory Of Cover may differ between one Category and another under the same Policy.

52. **Territory of Occurrence (Country of Treatment):** The country where the Insured's health condition has required healthcare services and where the related expenses were incurred.

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

54. **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.

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

56. **Waiting Period:** The period of time starting from the Enrollment Date of the Insured person during which a specific or general medical condition or type of treatment shall not be covered under this Insurance Policy. All applicable Waiting Periods are listed in the Table of Benefits, Policy Schedule, and Policy Wording.

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